IN THE CIRCUIT COURT OF OUTAGAMIE COUNTY

STATE OF WISCONSIN

SCOTT SCHARA, individually, and as the Administrator of the Estate of Grace Schara,

Plaintiff,

vs. Case No. 23-CV-345

ASCENSION HEALTH, ASCENSION NE WISCONSIN, INC. d/b/a ASCENSION NE WISCONSIN - ST. ELIZABETH CAMPUS, GAVIN SHOKAR, M.D., DAVID BECK, M.D., DANIEL LEONARD, D.O., KARL BAUM, M.D., RAMANA MARADA, M.D., HOLLEE MCINNIS, R.N., ALISON BARKHOLTZ, R.N., WI INJURED PATIENTS AND FAMILIES COMPENSATION FUND, JOHN DOES 1, 2, 3, 4 - MEDICAL PROVIDERS,

Defendants.

Video-Recorded Deposition of GAVIN SHOKAR, M.D.

Wednesday, May 22nd, 2024

1:07 p.m. - 6:21 p.m.

at

St. Elizabeth Hospital
1506 South Oneida Street
Appleton, Wisconsin

Job No. 166818B
Stenographically Reported by Rosanne E. Pezze, RPR/CRR
Certified Realtime Reporter

Video-Recorded Deposition of GAVIN SHOKAR, M.D., a witness in the above-entitled action, taken at the instance of the Plaintiffs, pursuant to Chapter 804 of the Wisconsin Statutes, pursuant to Notice, before Rosanne E. Pezze, RPR/CRR, Certified Realtime Reporter and Notary Public, State of Wisconsin, at 1506 South Oneida Street, Appleton, Wisconsin, on the 22nd day of May, 2024, commencing at 1:07 p.m. and concluding at 6:21 p.m.

A P P E A R A N C E S:

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A P P E A R A N C E S (continued):

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ALSO PRESENT: Ms. Deborah Schmidt, Risk Manager
Mr. Scott Schara
Ms. Megan Sczygelski, Videographer

I N D E X

E X H I B I T S

(Original exhibits attached to Original transcript; copies of exhibits are attached.)

R E Q U E S T S

(None.)

TRANSCRIPT OF PROCEEDINGS

VIDEOGRAPHER: Good afternoon. We are on the record. Today's date is May 22nd, 2024 and the time is 1:07 p.m. This is the video-recorded deposition of Gavin Shokar, M.D. in the matter of Scott Schara versus Ascension Health, et al., Case No. 23-CV-345 venued in the state of Wisconsin, Circuit Court of Outagamie County.

This deposition is being held at St. Elizabeth Hospital, 1506 South Oneida Street in Appleton, Wisconsin. The reporter's name is Rosanne Pezze. My name is Megan Sczgelski. I'm the certified legal videographer. We are with Lexitas Legal. Would the attorneys present please introduce themselves and the parties they represent, after which the court reporter will swear in the witness.

MR. FRANCKOWIAK: Attorney Jason J. Franckowiak on behalf of defendants St. Elizabeth Hospital, Ascension and the nurses.

MR. POJE: Jason Poje, P-O-J-E, from Corneille Law Group appearing on behalf of Dr. Marada.

MR. GUSE: Attorney Randall Guse of the

Otjen Law Firm appears on behalf of Dr. Baum, Dr. Beck, and Dr. Shokar.

MR. PFLEIDERER: Attorney John Pfleiderer from Mendenhall Law Group appearing on behalf of plaintiff.

MR. EDMINISTER: Attorney Michael Edminister appearing on behalf of the plaintiff.

MR. BIRNBAUM: Attorney Aaron Birnbaum appears via zoom on behalf of Dr. Daniel Leonard.

MR. GILL: Attorney Jeremy Gill appears on behalf of the Fund.

GAVIN SHOKAR, M.D., having been first duly sworn on oath, was examined and testified as follows:

E X A M I N A T I O N

BY MR. PFLEIDERER:

Q Good afternoon, Dr. Shokar. As you heard on the read-off, my name is John Pfleiderer. I'm an attorney. I represent the plaintiff in this matter, as you just heard.

A Um-hmm.

Q Would you please state your full name for the record.

A Yes. It's Gavin Singh Shokar.

Q And Dr. Shokar, are you familiar with the case of

Grace Schara versus Ascension Health?

A I am.

Q Are you aware that you are a defendant in that case?

A I am.

Q Okay. Did you do anything to prepare for your deposition today?

A Clarify.

Q You are currently at a deposition.

Are you aware of that?

A Yes.

Q Did you do anything to prepare to -- prepare for your --

A I reviewed -- I reviewed the documents sent by Dr. -- by Randall Guse here and his office, and kind of reviewed those notes, yeah --

Q Okay.

A -- pertaining to the case.

Q Okay. Did you review anything else?

A I did not.

Q Now, I'm not interested in any kind of notes or communications that you've had with Mr. Guse or any kind of comments that he would have put on any of those documents that were directed towards you.

But without sharing any of those

details, would you please tell me what documents you reviewed.

A I reviewed the medical record documents, which included my notes from the 12th and the 13th. There was a few of them; the morning note, a conversation note from the afternoon on the 12th, the 13th, my medical note, and then the death summary, as well as some lab orders, vital signs, that kind of stuff that were per the document that I was sent.

Q And when you say the death summary, are you referring to the discharge summary?

A Correct, yes.

Q And you said you reviewed labs, vitals, and was there a third thing?

A Labs, vitals, nursing notes that were sent to me, yes.

Q And at first there you said you had reviewed medical record documents.

The medical record documents that you reviewed, are those the ones that you just described?

A Correct.

Q Were there any medical record documents that you reviewed that you did not just describe?

A No.

MR. GUSE: One clarification. You were also sent the consent to treat, and you reviewed that.

A Correct.

BY MR. PFLEIDERER:

Q When you refer to the consent to treat, are you referring to the form which gives general consent upon entering the hospital and also the financial agreement?

A I believe so. It was a document sent to me pertaining to that, yes.

Q Did the document that you reviewed, did it have a signature on it?

A I don't believe so.

Q Did it have anything written in a place where a signature might be found?

A I'm not sure. I just saw -- I saw a printed name, but I -- honestly, I kind of skimmed the document as it wasn't really pertaining -- it was something that was introduced to me recently.

Q So you had not seen that document before. It was presented to you to review prior to this deposition?

A Correct.

Q Okay. Not including any conversations with your attorney, Mr. Guse, or any other of your attorneys, have you ever discussed that document with anyone else?

A No.

Q In regard to the labs that you reviewed, do you remember which labs you reviewed in preparation for this deposition?

A Um, let me think. It was not particular lab values as far as I recall. It was more the lab orders and what was ordered at what times. A large portion of those was labs that were associated with tube feeding orders. There was ABG orders. But again, I don't recall reading any of the actual lab values apart from what had been listed in my notes.

Q And when you say notes, you're referring to your --

A My notes.

Q -- progress notes?

A Correct, yes.

Q Not any personal notes that you would have made?

A Correct, yes. Of the documents that I reviewed, which were the only documents that I had reviewed.

Q Then in regard to vitals, do you remember

specifically which vitals you reviewed in preparation for this deposition?

A I reviewed the vitals that were listed in my progress notes as well as the vitals that were listed in the nursing or the supplementary data from the package that Mr. Guse sent me from, I believe, the nursing parts of the document. Yeah.

Q When you say -- did you say supplementary data or supplementary notes that were provided to you?

A It -- so the document that was sent to me had my notes in it, and then it had a dozen -- a couple dozen pages of, like, orders, and nursing, you know, what the nurses wrote in little sentences. And there was, like, two or three pages in that that had, like, in the nurse's section the, you know, the data that they put down, which would be blood pressures. That was really the only vitals that I could see in that document.

Q And last, you said that you reviewed nursing notes, correct?

A Correct. In the document that was sent to me there was, again, about two pages or so of, you know, little sentences of updates that the nurses would put through the day.

Q Sure. And were those nursing notes primarily

related to dates of service in which you were treating Grace Schara?

A Correct. There was -- there was, I believe, a couple from like the 10th or the 11th, which I was not treating Grace at that time.

Q Okay. And I apologize, because I did not go there first.

You did treat Grace Schara in October of 2021 at St. Elizabeth Hospital?

A I did.

Q Okay. So we're going to loop back sort of to the intro section now.

You are a medical doctor, correct?

A Correct.

Q M.D.?

A Correct.

Q And achieving a medical doctor requires formal education, correct?

A Correct.

Q Where did you attend high school at?

A I went to Iroquois Ridge High School in Oakville, Ontario in Canada.

Q Did you finish high school there?

A I did.

Q And did you attend undergrad?

A I did.
Q Okay. Where did you attend undergrad?
A I went to the University of Western Ontario in London, Ontario.
Q And did you select a major while you were at that school?
A I did.
Q What did you select?
A I did a double major in medical sciences as well as biology, with a subspecialty in the medical science division in pharmacology and toxicology, and anatomy and cell biology.
MR. PFLEIDERER: Madam Court Reporter, would you please read that last answer back to me, please.
(Answer read.)
A Can I interject? Pharmacology and toxicology, anatomy and cell biology.
BY MR. PFLEIDERER:
Q Are you saying there's -- that's two things and not four? You're grouping the two?
A Yes.
Q Okay.
A It's the way the program was broken down.
Q Sure. Did you finish that in four years?

A I did.
Q Good for you.
Did you begin -- I'm assuming you went to medical school?
A I did.
Q And did you begin medical school immediately after you graduated from undergrad?
A I did.
Q And where did you go to medical school at?
A I went to Ross University School of Medicine.
Q Is that in Michigan?
A No.
Q Okay. Where is that at?
A That's a -- their primary base is in Dominica in the West Indies; Portsmouth, Dominica.
Q Dominica. Okay. And I think I know, but can you just remind me where the West Indies are?
A If you take a flight from Miami or Antigua and you go south of there, it's kind of in the Atlantic Ocean.
Q Sort of by the Caribbean?
A Caribbean, correct.
Q Why did you go there?
A It was a very good option for me.
Q What do you mean by that?

A I was on an off-cycle. To attend a medical school in Canada or the U.S., I would have to wait two years. They were offering a trimester entrance in January. I made the decision to go to med school, and it was the only place I interviewed at, actually, and was accepted at so that I can begin medical school without having to wait another couple of years.

Q Um-hmm.

A Because I had switched my plan from going into doing a master's and a Ph.D. first.

Q What year did you begin medical school at -- you said Dominica?

A Ross University School of Medicine is the -- yeah, is the school.

Q When did you begin at Ross?

A That was in 2008, January.

Q And did you finish medical school at Ross?

A I did.

Q Did you ever attend any other medical school?

A I did not.

Q And what year did you finish med school at Ross?

A 2012.

Q Did you participate in a residency following graduation from medical school?

A I did.
Q And where did you participate?
A I went to Southern Illinois University in Decatur, Illinois.
Q When would that residency have started? In 2012?
A Correct.
Q Was there a specialization affiliated with that residency?
A Yes. It was a family medicine residency program.
Q Okay. Did you complete that residency?
A I did.
Q When did you complete it?
A 2015.
Q When you finished the residency, was it still family medicine?
A Correct.
Q Okay. What did you do after you completed, professionally, what did you do professionally after you completed your residency in 2015?
A I moved back to Canada, Toronto, and developed or built up a solo practice, from which then I transitioned to a group practice and then decided to go to hospital-based practice.
Q So you would have started your solo practice in 2015?

A Correct.
Q When did you join the group practice?
A 2016.
Q Okay. You joined an existing group practice?
A Correct. I migrated my office to an existing group practice. It was a better model of care than -- than solo practice.
Q What do you mean by a better model of care?
A In Ontario, there's several models of care. There's fee-for-service care, there is FHGs, or family health groups, and there are -- there is another model. You know, these are kind of exclusive for Canada.

The family health group offers a more robust coverage for your patients to be seen after hours and before hours, more covering support with other physicians since you collaborate with four other physicians. So it was a more beneficial structure to offer more services. It allowed for a collaborative venture, you know, to hire a nurse so that they can, you know, offer nursing services as well.

Q Sure.
A So it was just -- that was the reason for that.
Q When did you begin hospital practice?

A 2018.

Q Sounds like group practice was pretty good. Why did you switch to hospital practice?

A I had an affinity for hospitalist-based practice during residency. I was quite good at it. I was told to go into hospitalist-based practice. I decided to return home instead. Outpatient family medicine practice was something that was more attainable when you're going from the U.S. training medical system back to Canada.

And then during that time period I realized my colleagues were right, I was better off doing hospitalist-based medicine, and I decided to reenter that field.

Q Where did you begin your hospital-based practice? Who employed you, I mean?

A Sure. Sound Physicians in Tyler, Texas was my workplace, at Christus Mother -- Christus Trinity Mother Frances Hospital.

Q Is that a Catholic hospital?

A It is.

Q And what -- you said you were doing outpatient family medicine?

A I was doing -- you mean in Canada?

Q No, at the Catholic hospital in Texas.

A No. I was an inpatient hospitalist physician.
Q When you say hospitalist, what do you mean by that?
A The hospitalist is a field of medicine in which you exclusively see patients who are admitted to the hospital. It's a designated field, you know, to take care of more complex general care cases of varying -- you know, covering all specialties for anybody coming in, they need an attending, you know, to quarterback their care. And so that's what is provided for anybody who doesn't have a family physician or internal medicine doctor coming into the hospital to round on their inpatients, which doesn't happen everywhere.
Q If this question makes sense to you, how would you compare a hospitalist with an intensivist?
A The general -- you know, I would -- my definition of it would be an intensivist is somebody who is critically care trained who generally practices in the ICU setting and is usually trained in pulmonary critical care or anesthesia critical care.

As far as the hospitalist is usually trained in family medicine or internal medicine and, you know, the scope of what they do

is a little -- is a bit different because of -- because of the types of patients they see.

Q Sure.

A Yeah.

Q Did I ask you if you had any board certifications?

A You did not.

Q Okay. Do you have any board certifications?

A Yes, I am board certified in family medicine.

Q Any others?

A That is all.

Q When did you become board certified in family medicine?

A 2015, the same summer that I graduated from residency.

Q Okay. So you're working at a -- you started working at a Catholic hospital there in Texas in 2018?

A Correct.

Q How long did you work at that hospital for?

A I was there until September 2020.

Q September 2020.

Did you ever work in the ICU while you were at that hospital?

A Yes. It was an open ICU.

Q What does that mean?

A It means that generalist physicians also see patients in the ICU in collaboration with a intensivist.

Q Am I correct in understanding that the intensivist would sort of oversee the work of that hospitalist physician?

A No.

Q Okay. What would be the relationship? You said in collaboration with the intensivists.

What would be the relationship between that intensivist and the hospitalist, in your experience at the Texas hospital?

A Sure, sure. The general collaboration as exists amongst all hospitals, most hospitals, I would say, in general, if a patient is ventilated, mechanically ventilated, intubated, the ICU physician, a/k/a the intensivist, is the, you know, pretty much the main physician that sees that patient. And in those scenarios the generalist physician either no longer continues rounding or continues rounding depending on the hospital.

Q Did you say the generalist physician?

A Yes. That is --

Q Are you using that interchangeably with a

hospitalist physician?

A Correct. Correct. Sorry.

Q No problem.

A Would you prefer --

Q No. I just want to make sure -- you can use whatever words you want.

A Okay. In non-vented patients, the hospitalist is -- still remains as, you know, kind of like the quarterback of the manager of the care with the consultation from the intensivist.

Q Okay. What was the last part? In conversation --

A With a consultation -- in consultation with the intensivist. I usually don't use the term "intensivist," by the way. I use the critical care doctor, so I'll use those interchangeably.

Q Sure. No problem.

Am I correct in understanding that for a generalist physician to provide care in the ICU at this hospital in Texas, there would need to be collaboration with a critical care physician?

A Yes.

Q Okay.

A Um-hmm.

Q And I know this is just the converse, but a generalist physician could not provide treatment

in the ICU without consultation with an ICU doctor?

A The ICU domain is usually an ICU physician's domain. I mean, that's their field.

Q Yeah.

A The structure of that unit is different from the general wards. They have much more closer critical care or nursing one-to-one needs, one-to-two needs, which means one nurse to one patient, one nurse to two patients, and that has oversight with an ICU or critical care physician.

Q Yep. In going back to your job change September of 2020, did you go to another hospital?

A Yes.

Q Okay. What hospital did you go to?

A I came here to St. Elizabeth, in October of 2020 is when I started.

Q Can you describe your job title or position at St. Elizabeth when you got to St. Elizabeth in October of 2020?

A Yes. It was the same, you know, job description. It was a hospitalist physician. Same rough role as what I was doing before.

Q You said a rough role. Why do you say that?

A My job changed a little bit in Texas. I was

selected to be in the Louis & Peaches Heart Hospital --

THE STENOGRAPHER: In the what? In the what hospital?

THE WITNESS: In Texas.

THE STENOGRAPHER: You said in Louis?

A Oh. I was selected to be a physician at the Louis and -- Louis & Peach Heart Hospital, which is a -- kind of a select area in the Christus Trinity Mother Frances Hospital.

And in that role, my job primarily focused on cardiovascular and pulmonary health. It was a pulmonary ICU IMC, CVICU, CV -- and transplant center -- or valve center. Sorry.

Q Are you talking about your job in Texas?

A Correct, yes. So when I transferred here and when I came here, it reverted back to a general, like a regular hospitalist physician role.

Q How long did you hold the position, as you say, of a regular hospitalist at St. Elizabeth?

A I stayed here until, I have to think now, April or March of 2022. Yes.

Q And was -- until you left -- I'm assuming you left in April, March or April of 2022?

A Yes. I transferred to another Ascension facility,

'cause I actually was in the process of moving to Chicago at that time.

Q In the time period of August of 2020 when you came to St. Elizabeth through March or April of 2022 when you transferred to another Ascension hospital, was your position that of a regular hospitalist?

A Yes, an inpatient hospitalist, correct.

Q Okay. And did you work in the ICU at St. Elizabeth like you did at the Texas hospital?

A Yes.

Q Okay. Did St. Elizabeth have -- strike that.

When a generalist physician at St. Elizabeth is working in the ICU, is there a similar requirement that a critical care physician be collaborating on that case with that general hospitalist?

A Yes.

Q Okay. And you mentioned earlier that you did treat Grace at St. Elizabeth, correct?

A Yes.

Q Okay. Was Grace in the ICU at St. Elizabeth?

A Yes.

Q Okay. Did you have an intensive care -- or sorry, a critical care physician collaborating with you

on Grace's case?

A Yes.

Q Okay. Who was that physician?

A They rotated, but the one that I was interacting was Dr. Gandev. He was on the day prior and on the day -- on October 12th and October 13th is when he was working.

Q Is it correct that you only provided care to Grace on October 12th and October 13th?

A Yes.

Q So, is it correct that Dr. Gandev would have been that consulting critical care physician the entire time you were treating Grace?

A Correct.

Q You mentioned earlier that in March or April of 2022 you transferred to another Ascension hospital; is that correct?

A Yes.

Q And was that hospital in Chicago?

A Yes.

Q What hospital was that?

A That's St. Mary's -- St. Mary's and Elizabeth Medical Center in Chicago.

Q Okay. When you first took that transfer, what was your position at that Chicago hospital?

A The same role, hospitalist physician.
Q Do you work at that hospital now?
A I do.
Q Do you still have the same role that you did when you first transferred there?
A No.
Q Okay. What role do you have now?
A I'm the medical director of the hospitalist division.
Q I believe you said hospitalists division?
A Yeah, the medicine department, essentially. I'd note that role starts June 1st.
Q Of?
A Of this year.
Q Oh. It will start --
A It will start June 1st, yes, but my roles and responsibilities have already begun.
Q Would you consider that a promotion?
A Yes.
Q Okay. Before you got this promotion, was your job the same as it was when you first arrived at that Chicago hospital?
A Yes.
Q Okay. We're going to take a look at some records, I think the notes that you referenced that you had

reviewed.

A Sure.

MR. EDMINISTER: 60?

MR. PFLEIDERER: Just as soon as I get the right folder.

(Discussion off the record.)

BY MR. PFLEIDERER:

Q Mr. Shokar, the -- I'm going to hand -- sorry. Dr. Shokar.

A Thanks.

Q Dr. Shokar, I just handed you what's been marked as Exhibit 70. There at the top it says Progress and Staffing Note.

Do you see that?

A Yes.

Q Okay. This note purports to be authored by you.

Do you recognize this note?

A I do.

Q Okay. Is this one of the notes that you reviewed in preparation for this deposition?

A Yes.

Q Okay. Did you author this note?

A I did.

Q Okay. Does this note appear to be a true and accurate representation of that note as you

authored it? You can take a second to read it if you want.

MR. FRANCKOWIAK: Counsel, could you identify the Bates stamp on this document?

MR. PFLEIDERER: This is Ascension 00041.

A This looks the same.

BY MR. PFLEIDERER:

Q The date of service on this note is October 12th, 2021.

Do the notes in this document relate to Grace's condition on October 12th of 2021?

A They do.

Q Okay. And then on the second page there, the time of dictation of this note appears to be 10:18 a.m.

Do the notes in this document relate to Grace's condition on or about that time on October 12th, 2021?

A They reflect the time prior to, you know, that morning up until that time.

Q Because this would have to be observed before you dictated it?

A Correct.

Q So we can assume that these observations would

have been made shortly before you dictated this note?

A Correct.

Q Okay. And do you attempt to dictate notes soon after you make these observations?

A I try to.

Q Okay.

A Sometimes you see a few patients in a row and then dictate them all in a batch. It just depends on the day.

Q So you may dictate notes after you've seen a few patients and then do them all at once?

A Correct.

Q But you would try to get the notes dictated by, let's say, the end of the shift?

A Yes.

Q Okay. Besides the time of dictation, is there any way to tell when these notes were -- or I guess the observations that led to these notes were made?

A Not on the document. I mean, they would be -- have been observed between, you know, 7:00 and 10:00, I guess, of when this document was dictated, but they are a reflection of my morning assessment of Grace.

Q Okay. At the top -- I'm looking at the Subjective there at the top, you stated that Grace was comfortable and calm.

Do you see that?

A Yes.

Q Is it your recollection that Grace was comfortable and calm on October 12th shortly before 10:18 a.m.?

A Yes.

Q Okay.

A At the time of evaluation.

Q Of course. And continuing, you state that Grace was, quote, "somewhat cooperative."

Do you see that?

A I do.

Q Is it your recollection that Grace was somewhat cooperative that morning?

A I do. When I -- I will clarify cooperative. Cooperative is usually, you know, in -- in my examination, history taking examination, when I see a patient, if they're able to, you know, breathe in, breathe out when I ask them to participate in the examination. In this instance she was not cooperative in regards to talking to me because she was relatively nonverbal

to myself. But, you know, I could say that she was, you know, trying.

Q Trying to talk?

A Well, she was trying to interact, at least, you know, as best as she could that day.

Q Okay. Did you then attempt to talk with Grace?

A Of course, yeah.

Q Okay. Did Grace have a BiPAP mask on at that time?

A She did.

Q Did you remove the BiPAP mask when you attempt to talk with her?

A No.

Q Does the BiPAP mask make it difficult for a person to talk in your experience?

A It does.

Q So when I see the phrase "somewhat cooperative," I interpret that as also somewhat not cooperative; is that fair?

A It was my best assessment of her ability to cooperate. I wouldn't say that she was belligerently not cooperative or anything like that. It was just my assessment of what her capabilities were at that time.

Q Okay. So if a BiPAP mask makes it difficult to

speak and her lack of cooperation, as you say, was her failure to speak verbally with you, what is the value of the observation of somewhat cooperative?

Does that question make sense to you?

A Not really.

Q Okay. You mentioned -- or you said earlier that a BiPAP mask makes it difficult to speak, correct?

A It makes it difficult to -- there's two elements of speech; one is the person trying to speak and one understanding what the person is saying, or hearing, basically saying what you can hear.

On one element, with a BiPAP mask on, you have air pushing into your mouth. And so, you know, it depends on if someone's able to, you know, talk loud enough over the pressure that's being supplied through the mask.

And then the other aspect is, you know, is it loud enough for the person to hear, and so you generally have to lean in and try to, like, you know, hear them. When I put "somewhat cooperative" when you're asking her questions, the effort to actually communicate was not there, but the effort to breathe in and breathe out and do

the physical aspects of an examination were. And that's more reflective of what somewhat cooperative would mean.

Q Understand. Thank you.

Are there any other aspects of Grace's behavior that you can recall that were not cooperative as you meant it here in this note?

A Not that I directly observed at the time of evaluation.

Q The second-to-last sentence at the end of the Subjective says "no concerns overnight."

Do you see that?

A Um-hmm.

MR. GUSE: Is that a yes? You have to say yes.

A Oh, I'm sorry. Yes.

BY MR. PFLEIDERER:

Q Thank you. That was a favor of your attorney to inform me.

MR. GUSE: Keep that in mind.

MR. PFLEIDERER: Yeah, I will. Thanks.

BY MR. PFLEIDERER:

Q What do you mean by -- I know this sounds like a silly question, but what do you mean by "no concerns overnight"? I mean, clearly Grace is in

the hospital, there are concerns.

A Um-hmm.

Q When you say "no concerns overnight," what do you mean by that statement?

A This was my first day seeing Grace. The information that I gather is, you know, to kind of find what her daily status is, incorporates the information that I'm able to ascertain in the interview, the information that I'm told after talking with nursing, and the information from family in the room.

Q Sure.

A And at the time of my initial evaluation on -- the first time I saw her, there were no reports directly given to me of issues that happened overnight. The family at bedside did not report any concerns overnight. And I didn't -- obviously couldn't, you know, get a direct report from Grace.

So when I write a statement like "no concerns overnight," it's in reflection of were there, you know, severe, acute medical problems or things that need to be -- that need to be -- well, I will put it into the subjective generally to say something happened, and then in

that way I can set up my note to address that objectively and then in an assessment and plan.

Q Okay. I'm going to switch down there to the objective.

A Sure.

Q There's a temperature of 99.9.

Do you see that?

A I do.

Q Was this one of the vitals that you reviewed in preparation for this deposition today?

A Yes.

Q Okay. Do you recall whether Grace's temperature was 99.9 degrees?

MR. GUSE: Objection. The document speaks for itself.

BY MR. PFLEIDERER:

Q I'm asking if he agrees with the document.

A Say -- you're asking me if I agree with the document?

Q Yes.

A The temperature that's recorded on the document is a temperature that has been taken not by myself but by nursing and listed in the computer at the time of my note.

Q You wouldn't have any reason to dispute that

Grace's temperature at the time it was recorded was 99.9 degrees, correct?

A Correct.

Q Is a temperature of 99.9 degrees, do you consider that above normal?

A A fever is 100.4. So technically, it's in the normal range. But it is -- I mean, I want everyone at 98 or so. I mean --

Q You said it might be approaching a fever?

A Might be approaching, but it's technically not a true fever.

Q Technically not.

In this sort of situation at this time you wrote this note, does that temperature, does that give you any concerns that tell you anything about the condition that Grace was in, and if so, what?

A Not by itself.

Q Okay. In conjunction with what would it give you a concern?

A The temperature of 99.9 in conjunction with an inflammatory response may lead me to the suspicion that, you know, something is going on and it needs to be monitored, essentially. Because an independent reading by itself is not reflective of

anything unless it's persistent or reaches to a true level, such as 100.4.

So it could reflect any type of stress in her body, anything, which she obviously was under duress because she was requiring BiPAP.

Q And a fever in conjunction with an inflammatory response, would that indicate you a possible -- indicate to you a possible bacterial or viral infection?

A It can.

Q Okay. At any time during your treatment of Grace did you ever consider whether she had a bacterial infection in her lungs?

A It's something that's always in the back of my mind as a possibility. Given the fact that she was in a frail state, in respiratory -- you know, with a respiratory ailment, there's always a possibility of a bacterial superinfection, an opportunistic infection that would, you know, become problematic. So it's always something that is considered.

Q Would you particularly consider bacterial infection in the case where steroids were also being prescribed?

A Steroids could lower the immune system to allow

for the opportunistic infection to cause problems, yeah.

Q And being that you considered bacterial infection or you said that it's always in your mind -- did I -- is that right, it's always in your mind?

A It's always in the back of your mind on a differential when you're presented with data that supports an infectious, you know, process.

Q Okay. So what, if anything, did you do to evaluate whether there was a potential bacterial infection in Grace?

A So when you're evaluating somebody for an infectious process, you also have to evaluate them for their differentials. And, you know, in this particular case we knew someone who had, you know, a viral infection, and there was somebody who -- this was somebody who had a viral infection with inflammatory response, which was known from -- you know.

And when you look at probabilities of different diagnosis, differential diagnosis that would supersede, that would be much higher than, you know, a bacterial infection, you correlate your evidence with things like laboratory results, imaging, such as the chest

x-ray, which I had reviewed, collaboration with your physicians, if needed, and then you basically make a clinical assessment on the likelihood and the probability of, you know, the diagnosis and if that's actually happening.

Q You said that at this point it was known that the infection was viral.

How was it known to you?

A The patient had been diagnosed with COVID.

Q Okay.

A Which is a viral infection.

Q Are you relying on anything else besides that diagnosis to determine that this infection was viral as opposed to bacterial?

A It's -- it's -- again, when you're looking at a differential diagnosis, you're looking at probabilities. And so if you have a known -- of a viral infection and, you know, a late phase COVID inflammatory response, that -- and then you have a syndrome, such as inflammation or whatnot or fever, you're going to place that with the highest likelihood and then move downwards.

And in this situation, for instance, you know, an inflammatory response from a complication or a light phase of COVID, which is

what had been the running diagnosis in the hospital up until I took care of Grace, and what I, on my review, it also seemed like would be the most likely diagnosis in an event of an inflammatory -- you know, an inflammatory cas -- inflammatory markers or infectious markers being elevated.

And it's my -- part of the difficulties of being a clinician is to use all the data in your clinical impression to weight what is most likely and what is less likely, because the intervention of such in its own right has its risks and rewards as well.

So in this particular case, my impression was an ongoing inflammatory response from my -- a post-viral syndrome from COVID.

Q Did you ever evaluate Grace's white cell count or neutrophil count?

A Yes.

Q And what were your interpretations of those? Are you looking there at that note, laboratory data, WBC 10.2.

A Yes.

Q Is that where you're looking?

A Yes.

Q What is a WBC of 10.2? What impression does that give you?

A It gives me an impression that there is a mild elevation possibly of her white blood cell count, in its own right is not something that I will jump on, you know, to make any conclusion of.

Generally, if you have an infectious issue --

Q When you say infectious --

A Um-hmm.

Q -- are you referring to bacterial infection or viral?

A Bacterial. My apologies. When you're dealing with a new infection, bacterial infection, and even possibly a new viral infection, you would see a jump up or spike up in your white blood cell count, so you'd actually trend that and you'd see it quite elevated or heading that way.

When you -- and again, that's one piece of your -- your tools and your evidence to try to figure out the overall picture. So in this case being 10.2, not significantly elevated, something to be monitored, and white blood cell counts also go up for other reasons besides infections.

Q Would you agree that broad-spectrum antibiotics are generally well tolerated in clinical patients?

MR. GUSE: Objection. Incomplete hypothetical.

BY MR. PFLEIDERER:

Q You can answer.

MR. GUSE: Are you talking about bacterial infections, viral infections?

MR. PFLEIDERER: Well, antibiotics are only being used for bacterial, so --

THE STENOGRAPHER: I'm sorry. I didn't hear you.

MR. PFLEIDERER: I'm sorry. I just said antibiotics are really only used for bacterial infections, so those are the ones I'm referring to. Antibiotics that treat bacterial infections.

A Can you repeat the question?

BY MR. PFLEIDERER:

Q Sure. Is it your opinion that broad-spectrum antibiotics are generally well tolerated by clinical patients?

MR. GUSE: Again, I'm going to object to the question as being an incomplete and improper hypothetical. You're talking -- if you can answer the question, go ahead, but --

A Sure. Depends on the patient. In general -- what does "in general" mean? Sorry. Can you clarify that? What patient population are we talking about?

BY MR. PFLEIDERER:

Q I would say the average person admitted into the clinical setting.

A Like a -- what -- so I'll help you out here.

Q Sure.

A If a -- patients admitted generally have an acuity attached to them. The general amount of patients that come into the hospital are not of a severe acuity, right, they're of a regular acuity. So in general, for a regular acuity or a low-acuity patient, they are well tolerated.

Q Let me ask you a better question.

A Um-hmm

Q In Grace's case, what were some of the risks of giving her antibiotics?

MR. GUSE: Objection. Assumes facts not in evidence, i.e. that there's a bacterial infection.

MR. PFLEIDERER: It doesn't assume that, but you can answer.

A Okay. Giving Grace antibiotics -- when I give

anybody antibiotics, first of all, you have to weigh the risks and benefits of giving that intervention. Okay.

So if you feel that there's no benefit for giving the medication, then the risks outweigh the benefits, and therefore, immediately there's no -- we don't -- I don't move along to are there going to be side effects of medicine I'm never going to give. Right?

BY MR. PFLEIDERER:

Q So at this time are you inferring that at this point you felt that there were zero possible benefits of giving antibiotics to Grace?

A My clinical impression did not support the use of broad-spectrum antibiotics as an intervention because I had not formulated a diagnosis. I didn't have enough evidence to formulate a diagnosis of a bacterial infection that would support the use of an antibiotic.

Q Was it your opinion at this time that you had collected enough evidence to formulate a diagnosis that she did not have bacterial pneumonia? In other words, had you ruled out bacterial pneumonia?

A Bacterial pneumonia is always in the back of my

mind as a possibility for a superinfection, as I previously said. But it's something that, again, we weigh as a differential to determine what the probability of a bacterial infection is and if that probability is high enough in your clinical impression to supersede the current diagnosis or other alternative explanation that's more probable.

Q And at what point would that probability be high enough?

A If Grace's white blood cell count, for instance, had spiked up and she was starting to produce, you know, cough with sputum, green phlegm, other signs of a pneumonia, chest pain, you know, blood in sputum, those kind of things, clinically, you know, you suspect maybe there's an alternate infection going on. Radiographically, you look at the type of infections and pneumonias that occur, and radiographically the most common pneumonia, for instance, would be a lobar pneumonia, you know, and you'd see a particular pattern on imaging. Less commonly are atypical pneumonias. You know, you look for all these kind of patterns and things that you can recognize that will support the consideration of a pneumonia.

Q When you were treating Grace -- thank you for that.

When you were treating Grace, did you ever become aware that Grace had a home CPAP machine?

A Yes.

Q Okay. With people who -- strike that.

Did the fact that she had a home CPAP machine ever cause you to consider that she had possible Legionnaires' disease? And why or why not?

A That would have been a clinical impression that would have been considered on admission, on initial presentation, as an uncommon pneumonia, you know. And usually it will, again, have a particular presentation that the, you know, initial clinicians would, you know, if their clinical impression was strong enough would test for and treat. Just because you have a CPAP machine doesn't mean you get Legionella, though. I mean, it's not -- it is a -- it is a possibility but it's not -- it's not a probability.

Q What is the presentation of that disease?

A You can have pneumonia with Legionnaires, but you also have some GI issues as well usually,

associated with things like air-conditioning and other things that give off moisture.

Q I'm going to go back to the note here.

A Sure.

Q Under Imaging, you state that chest x-ray from October 11th, 2021 revealing worsening pulmonary opacities, bilateral, concerning for pneumonia or edema. PICC in place.

Do you see that?

A Um-hmm. Yes. Sorry.

Q Thank you. It's a great witness that corrects himself on that.

First, can you describe what you mean by worsening opacities.

A The chest x-ray was the day prior to the evaluation that I did on Grace on the 12th; it was on the 11th. And it is a -- generally a reflection of when the radiologist reviews it from prior, or the clinician reviews it from prior, we can see a pattern to suggest if there's stability, improvement or deterioration.

So worsening pulmonary opacities in this case indicates that the presentation on the radiographic images looked worse than the prior, yeah.

Q And is that an interpretation that you're making, or are you getting that interpretation from somebody else in regard to what you wrote in this note?

A Sure. My -- my standard practice is I'll look at the images myself, and then I'll read the radiology report and see if we're aligned in that regard. But the radiologist generally has much more experience in reading radiographs, obviously, x-rays and whatnot, and so I will always rely on their interpretation over mine.

Q So you would read it yourself first so that you don't bias your opinion?

A Correct. I'll look at the images myself, yes.

Q And then you'll review the radiology report?

A And then I'll -- correct, and then I'll see what -- if it matches.

Q And if it didn't match, what would you do then?

A Usually I'll go up and talk with the radiologist or the pulmonary critical care doctor and we'll review the images on a PACS system monitor.

Q Um-hmm, try to work it out?

A And I'll -- I mean, that's also for my education as well, and radiology.

Q Sure. And you see there where it also says

"concerning for edema"?

A Um-hmm. Yes.

Q Thank you.

What did you do, if anything, to address this possible concern for edema?

A The -- the problem with x-rays is, when you have a read-out, they usually will put all possibilities depending on the type of radiologist that's reporting. Okay? And many times when you see patchy infiltrates, both sides of the lungs on an x-ray, it could reflect differential diagnosis, as I mentioned before. And then you have to match it with your clinical impression as well and what you're auscultating by ear with a stethoscope.

And so a lot of the times we run into a problem in which an x-ray will say pulmonary infiltrates, pneumonia, or a pulmonary vascular congestion or edema, and we kind of have to work out the impression of it.

The problem with -- in Grace's situation with the edema aspect of things, I didn't -- I didn't hear crack -- pulmonary rales, which is the general term for fluid in the lungs.

Q Is that crackling? Is that what you were about to say?

A Crackling, yes. And giving her the intervention, which would have been a water -- a diuretic like Lasix, would have dropped her blood pressure further. And she actually wasn't having much intake. You know, so I didn't -- again, you weigh in your clinical analysis of what's safe to do, you know, and so I don't think -- that's not something that I was going to intervene on if it wasn't matching with what my clinical impression was.

Q So, is it fair to say that you did not order Lasix because you were concerned about a drop in blood pressure, or is there another reason?

A I would not have ordered Lasix if I believed that she was overloaded with fluid, which I did not believe.

Q Got it. Looking at Assessment --

A Sure.

Q -- No. 3 says "malnutrition due to BiPAP requirement."

Do you see that?

A I do.

Q As you sit here today, do you agree that at the time you did this note Grace was malnourished due to her BiPAP requirements?

A I do.

Q Besides her BiPAP requirements, was there anything that indicated to you that Grace was malnourished, either a lab or a vital or some kind of visual appearance, or anything else?

A Mainly historical evidence that she was -- her intake was not great and her hospital stay was prolonged to the degree in which most people who enter the hospital in a critical care environment enter a katabolic state, lose protein mass, and become malnourished. And her respiratory drive was significantly elevated, which increases your metabolic requirement by about 25 percent, up to there, let's say.

Q Could you say that one sentence again, please.

A When you have respiratory distress and you're breathing at 40 times a minute, your energy needs go up.

Q Sure.

A And -- in which case you need nutrition to support your body and your cells. And if you don't, at some point they collapse.

Q So you mentioned increased metabolic state.

When you say malnourished due to her BiPAP requirements, are you saying that

because the BiPAP is on her face, she can't eat? Is that what has caused the malnourishment, or is there something about the BiPAP requirements except for the increased metabolic rate that is causing this malnourishment? That was a really long question. I'll break it up if you want.

MR. GUSE: Yeah, I'm going to object to the form the question as being vague.

MR. PFLEIDERER: That's fair. I'll ask another question.

BY MR. PFLEIDERER:

Q You just mentioned that people in respiratory distress have an increased metabolic rate, correct?

A Correct.

Q Do people on BiPAP have an increased metabolic rate just by something going on with their BiPAP, or is it the fact that they're in respiratory distress and on the BiPAP? Does that make sense?

A Yes, the --

MR. GUSE: I just want to be clear. You're talking about in general, not in Grace's case?

BY MR. PFLEIDERER:

Q Yes.

A In general. The underlying reason for the requirement of BiPAP would have led to the increased metabolic needs.

Q That was my question.

Okay. Looking at plan -- looking at No. 3 under Plan. Are you with me?

A Yes.

Q Okay. You say requiring Precedex at 0.6.

Do you see that?

A Yes.

Q Okay. When you say at the 0.6, is that a rate that you're giving?

A 0.6 is, as I wrote it, is the dose that she was on, you know, per hour.

Q It's a dose per hour?

A I believe, yes.

Q So that is a rate?

A Rate, yeah.

Q Yeah. And that is 0.6 what per hour?

A Milligrams.

Q Okay. And why, at this time, if you recall, did Grace require Precedex at a rate of 0.6?

A The -- when you're in an ICU setting with a BiPAP on with a -- at this point it was a moderate amount of pressure. She was at 15 over 12 in an

unfamiliar environment, undergoing stress, you know, you can get agitation, anxiety and agitation. And one of the modalities that we can use to help calm you down is the use of Precedex. Generally used if you are exhibiting behaviors that would impair things like keeping your BiPAP on or your PICC line in. You know, so that -- and the other reason you would use it is to control a respiratory rate that's already elevated to prevent it from going, you know, higher and then causing hypoxia, further hypoxia.

Q You just mentioned that Precedex is one of the modalities to calm someone down. Is that sort of the general purpose for this Precedex is to calm Grace down specifically?

A Yes.

Q Okay. And what other modalities besides Precedex would have been available in Grace's case to calm her down?

A There's only a few. One would be a benzodiazepine. She was also on a benzodiazepine to help in that situation as well.

Q Any modalities that are not pharmaceutical?

A Behavioral modification, you know, kind of

redirection, sun therapy, keeping the blinds open during the day, closed at night, kind of redirecting to prevent delirium. Family, you know, are usually huge assets to kind of help in that situation as well. Sometimes those are a little bit challenging, particularly in the COVID situations when you're in an isolation room.

Q You said behavioral modification. What do you mean by that?

A Let me return to redirection, behavioral redirection; trying to kind of use a humanistic approach to kind of calm someone down before intervening with medications.

Q During your treatment of Grace on October the 12th, did you witness anyone attempt any redirection or behavioral modification with Grace?

MR. GUSE: I'm going to object. I think that invades the Alt privilege, 'cause it's suggesting potential criticism of another caregiver, and I'm going to instruct you not to answer the question.

MR. PFLEIDERER: I'm just asking about what he saw. That's it. He's a fact witness.

MR. GUSE: To the extent that -- I will allow it to the extent of his observations.

Nothing further.

BY MR. PFLEIDERER:

Q That was the question.

Did you witness it?

A Let me think back. I think her family -- Jessica was in the room. And I -- I think -- I mean, obviously she was an asset to try to help, you know, calm Grace down. I didn't directly observe her doing so at the time, because during this assessment she was calm, so I didn't -- I mean, there was no need for a behavioral approach because she was alright at that time. But there was family that was able to assist in that event.

Q Is behavioral modification something that family would participate in, or would medical providers also participate in behavioral modification?

A Behavioral redirection can be given by -- we personally would appreciate any and all personnel that can assist. Often there's a staffing limitation to do so. It's -- it's not always -- I mean, honestly, it's not that successful a lot of the times. Yeah, it's -- it's an option. It's a good option.

Q Sure. Did you witness any providers attempting behavioral, as you say, redirection with Grace on

October the 12th?

A No.

Q Did you -- strike that.

Do you have any knowledge from any source about any medical provider attempting behavioral redirection with Grace on October 12th?

A Hm. I don't have knowledge of any of that.

Q You mentioned that often behavioral modification or redirection -- do you have a preference which one I say?

A Redirection is probably better. Modification ensues that we're trying to change somebody.

Q Sure. You mentioned earlier that behavioral redirection is often difficult due to staffing requirements that that entails.

Were there any issues with staffing on October 12th that would have prevented behavioral redirection from occurring from medical providers?

MR. FRANCKOWIAK: Objection. Foundation.

MR. GUSE: Join. Outside the scope of the witness' testimony.

MR. BIRNBAUM: I'll join, too. And John, if we can just agree that an objection by

one is an objection by all.

MR. PFLEIDERER: Yeah, that's fine. You can answer the question.

MR. GUSE: Subject to the objections, you can answer, Doctor.

A Oh, okay. Sorry. Can you repeat the question then?

MR. PFLEIDERER: Would you read it back, please.

(Question read.)

A Not that I'm aware.

BY MR. PFLEIDERER:

Q What about on the 13th?

MR. FRANCKOWIAK: Same objections.

MR. GUSE: Same objections and also vague as to talking about nursing, CNAs?

BY MR. PFLEIDERER:

Q I said medical providers, any.

A As I say, medical providers, generally we don't provide the behavioral redirection unless we're in the room to do it. And we rely on our nursing staff, CNAs, et cetera, to provide that and, of course, family members as well.

Q But your answer to the question, were there staffing issues that prohibited the behavioral

redirection on October 13th, your answer, like the 12th, would be no?

MR. GUSE: I'm just going to object. It misstates his testimony and you changed the question.

A Can you clarify if you meant physician staffing or --

BY MR. PFLEIDERER:

Q Strike the question. I'll ask it again.

I mean any medical provider, staff, whether it be physician, RN, CNA, anything.

A So incorporate everybody.

Q And I understand the nurses are typically the ones that are going to be doing this.

A I think there was adequate staffing.

Q Okay. I'm going back to the note. We're still on No. 3 of Plan.

Are you back with me?

A Um-hmm.

Q You state, "She is hyperventilating possibly from anxiety, which is going to impair her oxygenation." I'm sorry, Dr. Shokar. We're going to have to go back.

You mentioned sun therapy as a possible modality that could have been used to

calm Grace down.

Do you remember that?

A Yes.

Q Okay. Do you know if at any time during your care sun therapy was effectuated in Grace's room or with Grace?

A It's a -- when I say sun therapy, what I was alluding to was the -- keeping the blinds open so that any direct sunlight can enter the room to keep someone orientated and less agitated. It's an effective means in people who have delirium in the hospital, for instance. And I'm not aware if that was something that was employed. I have no idea.

Q Okay. All right. We're going to go back down to No. 3 of Plan.

A Sure, sure.

Q All right. So like I just said, but I'll repeat for clarity, you state, "She is hyperventilating possibly from anxiety, which is going to impair her oxygenation."

Do you see that?

A Yes.

Q Now, you used the words "going to impair."

Does this mean that at the time you

wrote this note you did not think that hyperventilation was impairing Grace's oxygen?

A Correct.

Q Okay. Does this mean that you thought it would in the future?

A It means that if you're hyperventilating, you could impair your oxygenation if you are not able to support the respiratory rate.

Q When you use the term "hyperventilating," is there a particular respiratory rate that you would consider the threshold for hyperventilating?

A There is a threshold, but it is dependent on a pattern and also the patient's presentation. Generally, you can say that someone whose respiratory rate is over 20 is hyperventilating if you, you know -- depending on if it's -- if it's a low acuity patient with some, you know, consideration that the respiratory rate is normally around 10 or 12 or so, and now all of a sudden it's up. So now they're hyperventilating, but you have to then understand what the context or the reason for that hyperventilation is.

Q Is hyperventilation more of a statement about respiratory rate or about blood gas?

A About respiratory rate.

Q Okay. So it would be fair to say that a high respiratory rate and hyperventilation, those are interchangeable terms?

A Yes.

Q You state that this hyperventilation is possibly from anxiety.

Do you see that?

A Yes.

Q You say possibly here.

What, if anything, did you do to investigate whether or not the hyperventilation was being caused by anxiety?

A Can you clarify?

Q Sure. You say possibly like you're not sure. Could be. Right?

A Um-hmm, um-hmm.

Q What, if anything, did you do to investigate whether the hyperventilation was in fact being caused by anxiety?

A Any time a clinical problem presents itself, I create a differential diagnosis, and each one has a weighted possibility. Anxiety being on the differential diagnosis for hyperventilation in this situation; the other being hypoxia from her underlying illness, which would then stimulate

hyperventilation to keep her as oxygenated as possible.

The problem that arises, if you -- if your body raises your respiratory rate to a level that is unstainable for oxygenation, then you start heading the other way again. So it's an appropriate -- hyperventilation is an appropriate response to an underlying condition. When you feel dyspneic --

Q What was that word?

A -- or when you feel like you have air hunger, when you feel short of breath, or if you actually are hypoxic when you have a low oxygenation, and therefore, psychologically, if you feel short of breath or in a panic attack, you're going to hyperventilate. And physiologically, if you actually are hypoxic, you're going to hyperventilate. So they're both on the differential in the situation.

Q At the time you made the observations that led to this note, did you observe that Grace was agitated?

A At the time of my evaluation, she did not seem agitated.

Q And how do you distinguish from anxious and

agitated in this kind of clinical setting here?

A Agitation in -- there's a lot of overlap, but anxious is more of a psychological presentation that causes agitation. Agitation could also be a physiological response that's causing agitation, you know.

Q You said agitation can be a physiological response that causes agitation?

A The terms are not interchangeable, but they have a significant degree of overlap. Anxiety is more reflective of a psychological or an emotional state that's causing agitation; whereas, agitation in its own right is actually the observed behavior.

Q A behavioral trait.

A (Witness nods.)

Q Yeah.

MR. GUSE: John, when you get to a good breaking point, it might be a good time. We've been going about an hour and a half.

MR. PFLEIDERER: Sure.

MR. GUSE: At a good breaking point now?

MR. EDMINISTER: I'm not sure he answered verbally to that last question, by the way. Did you get that, Rosanne?

THE STENOGRAPHER: I said "witness nods."

MR. EDMINISTER: "Witness nods."

MR. PFLEIDERER: Thanks, Mike.

A Yes.

MR. PFLEIDERER: Are we okay to change the nod to a yes?

MR. GUSE: So stipulated.

VIDEOGRAPHER: We are going off the record at 2:29 p.m.

(Brief recess taken from 2:29 p.m. to 2:44 p.m.)

VIDEOGRAPHER: We are going back on the record at 2:44 p.m.

BY MR. PFLEIDERER:

Q Hi, Dr. Shokar. Before we went on break we were discussing this October 12th note that you dictated at 10:18 a.m.

We talked about family helping with some of these anxiety or agitation issues.

Do you remember that?

A Yes.

Q When you did the observation that led to the creation of this note, was there any family in the room with Grace?

A I thought I saw Jessica, but I can't -- honestly, I can't definitively remember if she was in the room that day or the next day. I thought she was in the room, though. If I was to say, I would think she was in the room that day, yes.

Q I don't want you to guess.

A But again, I can't definitively say, yeah.

Q Okay. Continuing along with the subject of anxiety.

In October of 2021 while you were treating Grace, were you aware of any effects an anxiety could have on oxygen levels or oxygen consumption levels in a person with compromised pulmonary function?

MR. BIRNBAUM: Object to the form.

A Yeah. Can you -- 'cause I thought I just answered that.

BY MR. PFLEIDERER:

Q In October of 2021 while you were treating Grace --

A Um-hmm.

Q -- were you aware of any effect that anxiety could have on oxygen consumption in a person with a compromised pulmonary system?

A Yes.

Q Okay. And what would that effect be?
A As I was mentioning before, anxiety, if it increases the respiratory rate, you could have a decrease in the oxygenation if you have an alteration of your blood gases.
Q And is that because the oxygen consumption is increased during anxiety?
A That's a part of it. But also your PCO2, which is your carbon dioxide, also goes down, as you blow off more carbon dioxide in hyperventilation.
Q Is that why you said here on Plan No. 3, her last ABG revealed normal PCO2 and do not expect that the elevated respiratory rate or hyperventilation is impairing her oxygenation at this time.

Is that why you determined that it was not -- that the oxygenation was not impaired was that CO2 level?
A That's the objective part of when I evaluate for hyperventilation, if I have an ABG available, I can use that objective data to determine if there's actually truly a level of hyperventilation high enough that's going to physiologically affect the body. She was hyperventilating, but at that assessment it was not to a level in which it was impairing her carbon dioxide level.

Q Let's look at No. 6 under Plan. Do you see where it says PT, OT?

A Um-hmm, yes.

Q What does that mean?

A Physical therapy, occupational therapy.

Q And when you say physical therapy, occupational therapy, what are you saying? You're going to try to get physical therapy into the room or that they had been in the room?

What does that mean under Plan?

A It's a part of her overall plan, if she got to the point where physical therapy and occupational therapy can assist, increase her, you know, the deficits in which this illness had given her, to increase her strength and the rest of her ADLs, or active daily living, you know, measures. You know, it's something that we do for all hospitalized patients who end up inpatient, particularly prolonged stays, 'cause most of these patients develop some kind of debility physically, and so it's always a part of my treatment plan.

Q During the time you were treating Grace, did physical therapy ever get involved with Grace's care? Did she get to the point where that was possible?

A Not the days in which I saw her. I didn't -- I don't think they would have been able to engage with her. But they would make their own assessment, you know, to determine if that's -- if she was able to do that. But it's -- as far as I know, it was not something that was of precedence for the plan on those days.

Q During the time you were treating, did occupational therapy, were they able to get involved, to your knowledge?

A Not that I'm aware, and I don't think they did.

Q Okay. On October 12th, when you made the observations that led to the creation of this note, did you have any indication that Grace was going to die in the next day or two?

A No. There's a possibility, but from the assessment up until 10:00 when this note was dictated, my first time seeing her, and from the report I had been given, I was hopeful that she would continue on BiPAP and recover.

Q I'm going to hand you what's been marked as Exhibit 71. Do you have the exhibit?

A I do.

Q Do you see a 71 there at the bottom?

A I do.

Q This note purports to be authored by you. Do you recognize this note?
A I do.
Q Did you author this note?
A I did.
Q Take a second to read it, if you want, but my question is: Does this note appear to be a true and accurate representation of the note that you authored?
MR. BIRNBAUM: John, what is the Bates number on that document?
MR. PFLEIDERER: This is Ascension 00018.
MR. BIRNBAUM: Okay, thanks.
A Yes.
BY MR. PFLEIDERER:
Q Your answer is yes? True and accurate?
A Yes.
Q Okay. The date of service on this note is October 12th, 2021. Do the notes in the document relate to Grace's condition on October 12th, 2021?
A Yes.
Q And the time of dictation of this note appears to be, sorry, 1646 hours or 4:46 p.m. Do the notes of this document relate to Grace's condition and

activities taking place on or about that time on October 12th, 2021 or just before, as you clarified earlier?

A As I clarified before, be previous to the notes dictation and in the time between the previous dictation.

Q I'm looking at -- it's all one paragraph, so I'm going to try to direct you here.

You state at the end of the fourth line, beginning with "initially" -- do you see that?

A Yes.

Q Okay. You state, "Initially discussed with Cindy, the patient's mother, in regard to goals of care in regard to worst case scenario if she was requiring intubation, and she deferred me to her husband Scott."

Did I read that correctly?

A Yes.

Q Okay. The first "she" there would be Grace, correct?

A Yes.

Q And the second "she" is referring to Cindy Schara, correct?

A Yes.

Q Okay. Do you remember having this discussion with Cindy?

A Yes.

Q Okay. Do you remember where you were when you had this discussion?

A I was in the hospitalist room.

Q The hospitalist room, you said?

A Yes.

Q Is that a room for multiple hospitalists or just your office?

A It's a room for multiple hospitalists.

Q I'm assuming that this conversation was by phone and that Cindy Schara was not also in the hospitalist room with you?

A It was by phone.

Q Is it safe to assume that no one from the Schara family was with you at the time you made this call in the hospitalist room?

A Correct, yeah.

Q Okay. Do you remember anyone that was in the room with you when you made this call?

A Yes, there were some of my fellow hospitalists that was in the room.

Q Any nurses?

A No.

Q Are there ever nurses in the hospitalists room?
A No.
Q Special room, huh?
A I'll take that back. We have our own nurses that work with us, but they are of a different role. They're not, I'm assuming, the nurses you're talking about.
Q Sort of like administrative sort of nurses?
A Yeah, more for helping with cares at discharge, that kind of thing.
Q Was anybody with you on the phone? And by that I mean on your end in the hospitalist room, were you conferenced with somebody at the table with you? Was there someone else from the hospital participating in the call with you?
A No.
Q You said that you remembered this discussion with Cindy Schara.

Was there anyone else on the line that you were aware of?
A No.
Q Do you remember approximately how many minutes this phone call lasted with Cindy Schara?
A Probably about 10 to 20 minutes, ish, around maybe closer to around 10.

Q So your testimony would be about ten minutes?
A Yes, I think that's fairly accurate. It's -- honestly, it's hard to say because it was -- I mean, I made a second call after that and, you know --
Q Do you remember anything -- I guess I should start -- strike that.
What was your purpose for calling? Did you initiate the call? I'm sorry.
A I did.
Q Okay. Why did you initiate the call? What was the purpose?
A Um, it's kind of a long answer. If you bear with me, I can kind of get to that point.
Q Sure.
A Okay. The -- there's two aspects of care that I was looking at. One was obviously the clinical aspect, trying to do the best we can to help Grace. The other aspect was to, as she was -- she had a POA. She had -- her parents were making her decisions for her. To understand what they would want in, as I write, worst case scenarios, and the worst case scenario being if she crashed, if she basically had, you know, the need for resuscitation efforts.

And up until that point, my understanding was that verbally the Schara family, or Scott, had indicated to my previous physician, Dr. Baum, that -- I think it was, yeah, Dr. Baum or, you know, and I'm not sure who else, that he didn't want her intubated.

However, we didn't really have, and this is by report when I had a sign-out with Dr. Baum, a very clear understanding of the direction of care, you know, for -- for in worst case scenarios and moving forward.

And so what I do, and one of the purposes -- one of the main things I could offer in her case, given the fact that we didn't have much additional medications to help her in her particular state, it was a lot of supportive care, one of the things that I could offer was a significant amount of time to reestablish a rapport with the family, which at that point it seemed like there was a lot of, you know, events of hostility or problems with previous personnel.

And so I wanted to kind of have a fresh new angle, have, you know, a true, open, honest conversation, open forum, non-rushed, answer as many questions as possible. And those

things take time. And those are called goals of care conversations when you go over, you know, what to do when -- you know, worst case scenario, if someone is going to crash, but also, you undergo, you know, what to do in other scenarios or circumstances if the desired outcome, which is recovery, is not obtained.

And so I initiated this call to initiate this conversation with who was the POA at that time, Cindy, you know, who I was instructed was the one I was supposed to contact first from -- from, you know, from my previous physician and Dr. Baum.

And so that's who I called first to figure out, you know, this aspect of care, which was -- which was not solidified and very important, given the fact that, you know, as events continued through the day here, as you see that her BiPAP settings had increased, that her condition had actually changed, and so we really needed to solidify a plan for that instance.

Q And by plan, are you referring to code status?

A I'm referring to our goals of care, which includes code status. It's only one portion of a goals of care conversation.

Q Are there designated other portions?

A **A goals of care discussion is designed in a way in which we can bridge understanding of both parties. It's designed to first understand where the patient's side is coming from, what they understand of their condition, what their insight is, what their gaps in knowledge is, and then it is -- the next step is to provide as much information to fill those gaps so that when we're both on the same page, we can come to a reasonable and informed decision about what to do next.**

And so the conversation, the goals of care conversation, that was the purpose of the call.

A portion of that is to clarify the worst case scenario, which is, you know, if she crashes in the hospital, you know, what do we do? Because by default, we resuscitate, and resuscitation efforts generally incorporate CPR, the use of things like defibrillators or medications to help with the blood pressure and intubation. And it's usually all in tandem. And you can have a split type of approach, but those split-type approaches are kind of case by case after you -- given all the information having one

of these goals of care conversations.

So my objective for calling Cindy was to initiate a goals of care conversation so that we can be all on the same page and I can personally understand if they had insight into the condition and had reasonable informed consent to make a decision.

Q Got it. I'm going to sort of just continue through this note. Okay?

A Sure, sure. Yeah.

Q Where we were reading before, starting on the fourth line, it continues to say that she, being Cindy, deferred me to her husband Scott.

Is that how you remember it today?

A That's a summary.

Q I mean, just that specific fact, not the whole conversation. But ultimately, she deferred you to her husband Scott; is that correct?

A Yes. As the conversation continued as I was discussing her status through the day, you know, where she was at there in regards to her increased requirements for BiPAP, the first part of the conversation is always the clinical, you know, status of the patient at that time.

And then I led into the goals of

care conversation, as I previously had talked about. However, I was unable to continue that goals of care conversation because Cindy was, understandably, quite emotional. She had cried on the phone, and she then requested that I call Scott instead and defer to him, because she -- essentially, she just couldn't continue the conversation.

Q Did you ever specifically discuss a do-not-resuscitate code status or a DNR code status with Cindy on that first call?

A The conversation was heading that way, but, you know, the terminology may have been presented but there was -- there was no appropriate discussion about DNI/DNR with Cindy at that time, again, because she didn't have, you know -- she wasn't ready to talk about it, essentially. And again, she was really wanting Scott to talk about it on her behalf. And so approaching her about do you want to intubate her or -- you know, in these situations and, you know, after trying to embark on that conversation, I was unable to get through that I guess that -- that idea to have a formal -- to even consider a formal answer at that time.

Q You mentioned earlier that at the time that you

wrote this history and physical report that the condition had changed; is that correct? Am I remembering correctly, Grace's condition had changed?

A Yes. From 10:00 in the morning onwards, as you -- you know, as I've written, you know, her oxygen requirements increased, her BiPAP settings had increased.

Q So at the time that you made the observations that led to the creation of this history and physical report, did you believe at that time that it was likely that Grace was going to die in the next day or two?

A It was more probable, for sure. I mean, she was on max presser settings. The conversation of goals of care and code status became ever more pressing at that point. She was no longer -- my initial morning assessment was ABG may be improving, she's calm and comfortable. My report overnight, no events, everything's kind of status quo, you know, hopefully we can give her more time to recover. Now all of a sudden she's getting worse, and her oxygenation is worse and her BiPAP settings go up. So now the time that we have to kind of figure out goals of care shortens.

Q In your recollection or in your review of the medical record, is there anything that you think caused this change, or was this just the progression in Grace's disease or condition?

A At the time of the deterioration, I felt it was likely a progression of her condition. And then in retrospect, when the next day -- you know, on the 13th, it was -- it was confirmed in my mind that it was, most likely that was the case.

Q Did you entertain any other possibilities besides the progression of the disease?

MR. GUSE: Object to the form of the question as vague, ambiguous.

MR. PFLEIDERER: You can answer.

A I'm assuming you're alluding to like an additional superimposed infection or something like that?

BY MR. PFLEIDERER:

Q That, sure, that could be one thing.

A Sure, yeah. In the back of my mind, yes, but most likely a progression of disease.

Q Did you do anything to investigate whether there was a superimposed infection at the time of this deterioration?

A Not at that moment as we had data already presented from that day and the day prior.

Q What data specifically are you referring to?
A Her blood counts, you know, CBC, her electrolytes, and the x-ray from the day prior had already been reviewed.
Q Did you consider that the drug Precedex -- strike that.

Were you aware at the time that you made observations that led to the creation of this note that Grace was receiving Precedex?
A Yes.
Q Okay. Did you consider whether the Precedex that Grace was receiving led to the deterioration of her condition?
A It was considered but a low likelihood at that time, and felt the benefits of using the Precedex to help with the respiratory agitation outweighed the possibility of it causing, you know, the respiratory distress, particularly because she was tolerating the same medication for -- previously.

And, you know, the one thing that I look for in someone who's having issues with Precedex is seeing, you know, sedation and bradycardia being the more probable adverse effects of that medication.

You want me to continue?

Q I'm here to listen to you.
A **The other thing is that, you know, we didn't -- we don't have many tools to kind of help with the agitation aspect of things. As I was alluding to before, we have Precedex, which is the favorable medication given its ability to be turned off quickly, you know, and more favorable in an ICU setting.**

We have Ativan or another benzodiazepine which has a longer halflife, which is kind of secondarily preferred. And so if I was to turn off the Precedex, it would have to be for, you know, a reason in which I was seeing the need for. At that time I didn't feel that the Precedex was the cause of her condition deteriorating that afternoon. But it's something that, as I say is in the back of my mind, because I need more time usually to see and assess and see what's going on.

I mean, if we -- as time went on, we're noticing a trend that supports the medication being the reason for it, in which case then we would remove that medication. But at the time, all I was seeing was a worsening respiratory function.

Q You mentioned that Precedex was a drug that Grace

had tolerated previously, correct?

A Yes.

Q Okay. During your time treating Grace on the 12th and the 13th, were you aware of Grace during her stay at St. Elizabeth having any adverse reactions to Precedex?

A No.

Q Did you --

A Can I rephrase? On the 12th and the 13th?

Q Yes.

A The 13th, yes, the time I went in on the 13th and I turned off the Precedex when she was having some issues, that's when I had suspected Precedex may be a cause of -- a potential cause of bradycardia. I didn't want to continue that medication given her heart rate had started going down. So at that point was the first time. But prior to that event, no.

Q Do you remember what time you turned off the Precedex?

A That was on the 13th when I had entered the room in the p.m. of the 13th when she was hypoxic for quite some time and we were trying to improve her oxygenation. It was --

Q We can jump ahead.

A 5:00, 5:30.
Q Is there a particular note you want?
A The 13th note would help. The -- it was in the event that -- you know, the -- it was 5:30, I believe I was in the room.
Q Nope, that's mine. I'm sorry.
A But you can correct me on the time.
Q You want your progress note from the 13th? Is that what --
A I don't know if it's listed -- if the time that I was in the room is listed in the progress note. But, yeah, that might help. I mean, I believe it was --
Q You can hold onto it.
A Thank you.
Q Nothing?
A No, not in the progress note. Again, that was the event prior -- the same event in which I was called to the room because Grace was hypoxic, in the 50s. It was in the p.m. of 10/13.
Q You're talking about SPO2 of 50s?
A Correct, yes. She was SPO2 of 50s. I was called to room by nursing to evaluate further. It was -- I would say be around 5:30 or so, 5:50-ish maybe, in the evening. When I entered the room on my

primary survey, I had noted that her oxygenation was indeed 50 -- about 55 percent on the hospital oxygenation machine, but she had two other oxygen monitors on her at that time, a portable oxygen machine that was at 85 percent, and a finger oxygen machine that was at 99 percent or 95 percent, a finger pulse ox that was brought from home.

And on the monitor it had recorded that her heart rate was in the 50s. And at that point I turned off the Precedex, given the verbal order to turn off the Precedex.

Q Sure. And I don't want to mischaracterize, but to summarize what you're saying is you turned off the Precedex in response to Grace becoming hypoxic?

A Bradycardic.

Q Oh, bradycardic. And at that time did you know bradycardia to be a potential adverse side effect of Precedex?

A Yes.

Q At that time did you know hypoxia to be a potential adverse side effect of Precedex?

A CNS and respiratory depression, yes, it's uncommon.

Q When you say uncommon, what do you mean by that?

A I mean, again, in a differential figuring out what are the reasons for someone to be hypoxic, all of these probabilty -- all of these possibilities are on a differential, but we have to weight them based off of what's the most probable. And Precedex causing acute respiratory failure, as she had been on it for a while, and its rate of respiratory depression, I believe, is like 2 or 3 percent as far as I remember.

Q Two or 3 percent of Precedex causing acute respiratory failure?

A Of it causing an issue in regards to respirations. Much more commonly if you're going to have a side effect it will be bradycardia. Hence, why more commonly I look for bradycardia, but it is on the differential. Much lower. If you have a poss -- if you have something more probable, that's what you go with.

Q When you're determining these differentials -- and you keep saying "probability" a lot.

A Um-hmm.

Q What sort of data are you looking at to make these probability calculations in your differentials?

A It's essentially what essentially makes a doctor, to be honest. I mean, what you're asking is what

we learn in medical school and what we practice. What we practice is someone coming in with a condition, and we're not just saying it's this, it's definitely this, 100 percent.

What we're doing is we're creating a list of possibilities. You have five conditions that could be causing your problem. And then we weight it based off of the tools that we have, which is labs, imaging, you know, we -- anything, any evidence that we can bring. We use that information to then weight our differential diagnosis and what's the most probable to the most least probable. We use that information to rule out the least probable, you know, in order so that we arrive at only one or two diagnoses.

So every time I have a problem, I'm basically in my mind weighting these differential diagnoses. Because medicine's never 100 percent it's this, unless it's 100 percent that with a biopsy or something like that.

You know, so that's why I keep alluding to the possibilities and probabilities. In her case, hypox -- we -- the hypoxia she was suffering from, the probability of it being from a escalation of her post-viral syndrome from COVID

was much, much, much higher than any other differential, yet the differentials exist in my mind and -- you know, as possibilities. I didn't have enough evidence to support -- and when I say evidence, I mean I take all of this information and I use my expertise and my training to -- to make a clinical judgment. And that's why I say my clinical impression. I make a clinical judgment to figure out, you know, what is the most likely reason and what we need to intervene on first, and then what we can order on the background to kind of rule out or rule in things.

Q So I understand a lot of what you're saying is that you gain these evaluation tools through experience; is that correct?

A Yes, and study.

Q And study. Okay. What kind of things are you studying to help form these differentials?

A I mean, it's pretty -- I've studied my whole life. I mean, starting from, as you know, my undergrad selection, my medical school, residency, my clinical experience in -- you know, through COVID, you know, in the pulmonary IMC, you know, you -- you see patient encounter after patient encounter. You gain an understanding of how diseases, you

know, deviate from textbooks as a clinical or standard classical presentation, and then you see, as encounters go on, you know, all the different ways in which a patient can present and progress.

And there's many, many factors that are, you know, modified how a disease progresses. Again, they don't all travel the same way. That's just the majority of them travel one way.

So it takes patient encounters, it takes experience, it takes understanding of the disease process. You know, physicians are generally lifelong learners. We do continuing medical education. You know, we always try to keep up with our skill-set or, you know, at least you should. And that's -- I always strive to do it. That's what I do.

Q Have you ever read any studies that specifically discuss the use of Precedex?

A I read studies about Precedex use. There's not many of them, to be honest. You know, you have different levels of educational material from primary sources to summary papers, you know, that kind of summarize all the primary material.

Q Could you tell me any of the studies that you've reviewed in regard to the use of Precedex?

A Not off the top of my head, I can't quote a study.
Q I'm asking a site of study.
A Precedex in the use of ventilated ICU patients, Precedex in the use of non-ventilated patients with agitation. You know, I think those are really the only two. But this is quite a while ago, and it's not a medicine that I prescribe myself. It's an -- it's usually an ICU medication that's used in the ICU, in an ICU setting, because it does need to have, you know, monitoring associated with it.
Q Why is that?
A Because it's just -- it's on a drip formulation that needs to be titrated up and down, and usually you need to have a nurse do that watching for side effects, essentially. I'm obviously aware of the medication and I know about its side effects and adverse events --
Q Well, you were using it in your practice in October of 2021 while you were treating Grace, correct?
MR. GUSE: Object to the form of the question.
A She was on Precedex as a part of her care management. I was aware that she was on Precedex

and I was -- in consideration of her treatment plan, you know, I took that as a factor.

BY MR. PFLEIDERER:

Q You said earlier that you -- I think you said took over Grace's care from either Dr. Baum or you said it could be somebody else?

A It was Dr. Baum, yeah.

Q Okay. When you, as you said, take over the care of a patient --

A Um-hmm.

Q -- do you review that patient's chart as it relates to their stay at the hospital before you took care?

A Generally what happens is there's a sign-out the night before. So I was talking to Dr. Baum on the phone the night prior to my start date, which was October 12th. And we run the list of patients and highlight any, you know, management care plans or any, you know, things that we need to address.

On my day's start, that's when I review the record, and, you know, start looking at previous notes and, in large, what the daily assessment -- what the assessment is for the day. I go see the patient, and then continue formulating or continue with the management care

plan that's appropriate.

Q And did you do that in Grace's case?

A I did.

Q Okay. And did you review the nurses' notes when you took over Grace's care?

A Partially reviewed nursing notes, because the record that she was -- she was on like Day 15. That's an enormous undertaking to review a whole note --

Q You mean Day 15 of her admission to the hospital?

A Yes, correct, yeah. She was there for quite some time. I usually go back when I have, you know, seen all my patients, you know, and kind of addressed all the immediate problems for them, then I'll go back and start reviewing more data that was not rele -- you know, as relevant for that day's care.

So, for instance, in Grace's case, I reviewed all the notes for the day -- the day -- for the day prior and, you know, a couple days prior which would have included the nursing notes, yes.

Q And would you have eventually reviewed the nursing notes for all 15 of the prior days?

A Eventually, yes.

MR. GUSE: I'm going to object to the form. It misstates the evidence. She was not in the hospital for 15 days at this point.

MR. PFLEIDERER: Well, he just testified --

MR. GUSE: Counselor, you know that that's not true.

MR. PFLEIDERER: Who is to say whether it's true or not?

MR. GUSE: Because you have --

A Five days, yeah.

MR. GUSE: -- you have the records.

MR. PFLEIDERER: I'm asking what he remembers about the record. You're coaching him.

MR. GUSE: No. You are intentionally misleading him by --

MR. PFLEIDERER: I'm only saying his own testimony. That's it. I think you are leading him.

MR. GUSE: No.

A Sorry. I'm going to revise. Fifteen days from COVID onset, as far as I understand. I don't know why the 15 was stuck in my head there. But she was in the hospital since the 7th, it seems, you know, so it would have been five, six days of

notes. And yes, I would have gone through all the notes at some point.

BY MR. PFLEIDERER:

Q When you reviewed the notes, did you ever see any nursing notes about an adverse reaction to Precedex?

A No, not that I recall.

Q Are you aware that Precedex is manufactured or was developed by Pfizer?

A I was not aware of that.

Q Okay. Have you ever reviewed any information from the manufacturer of Precedex?

A You mean the drug information sheet?

Q Yes.

A A long time ago. I don't know exactly when, but at some point I did.

Q Were you aware while treating Grace in October of 2021 that respiratory failure was a possible adverse effect of Precedex when used for longer than 24 hours?

MR. GUSE: Object to the form of the question. Vague, ambiguous.

MR. PFLEIDERER: You can answer.

A I think you're alluding to the manufacturer warning, which has been further studied and, you

know, it is a possibility, but it's been used up to 14 days in ICU patients without any -- you know, as a safer alternative to benzodiazepine, so again, you have to weigh the risks and benefits.

BY MR. PFLEIDERER:

Q I'm not saying it was unsafe; I'm just asking if you know that it was a possible adverse side effect if used for longer than 24 hours?

A According to the initial manufacturer's data, I believe that was listed as that. But as I was saying, they've done studies afterwards which decreased the concern of that being a limitation to using it past 24 hours.

Q What studies are those? Can you cite any?

A That is from a summarization now of literature that would be presented on, you know, physician information databases such as Lexicomp, you know, drug or -- basic Lexicomp, yeah.

Q Do you have any such studies in your possession, not here, but anywhere?

A Like physically?

Q Like to copy on your computer or you printed a copy or it's in your office or something like that.

A I don't need to keep those copies because we're --

I have subscription services to services like Lexicomp that will give me this information readily accessible when I look for it.

Q Okay. You referenced, did you call it the manufacturer drug information? What did you call the document that you're referring to?

A It's kind of like the initial drug information that gets presented for when the drug gets first released.

Q Something you'd pull from the FDA?

A Yeah, and it's -- well, it would be the FDA one. And the reason it's been referenced for Precedex is because of that change in the initial use of Precedex, which was initially for only 24 hours given the FDA approval, you know, recommendation at that point.

But -- and the reason I know this is because in questioning previously, you know, 'cause many patients have been on Precedex more than 24 hours, it was something that was brought up and say, well, why are we using it more than 24 hours. And I was educated on the fact that it can be used more than 24 hours, you know, because they've done repeat studies to show that. And then I verified that that was the case, you know,

from secondary sources of information such as UpToDate or, you know, those kind of sources that kind of summarize medical literature.

Q Based on your study of these various sources that you've listed --

A Um-hmm.

Q -- is it your understanding that the risk of serious or nonserious adverse side effects increases when Precedex is used past 24 hours, or do you think it's the same, stays the same?

A I think any medication, when you use it, the longer you use it, there's going to be more concern.

Q Sure. Were you aware when you were treating Grace in October of 2021 that agitation was a possible adverse side effect of Precedex?

A No.

Q Were you aware in October of 2021 while you were treating Grace that hyperglycemia was a possible adverse side effect of Precedex? Hyperglycemia?

A No.

Q Were you aware in October of 2021 that fever was a possible side effect of Precedex?

A Yes.

Q Were you aware in October of 2021 that hypotension

was a possible side effect of Precedex?
A Yes.
Q And you already mentioned bradycardia, right?
A Um-hmm.
Q Were you aware in October of 2021 that acute respiratory distress syndrome also known as ARDS was a possible side effect of Precedex?
A Caveat -- respiratory depression as far as ARDS goes like -- which is a particular syndrome, no.
Q No, you were not aware?
A Of the particular ARDS syndrome, which she was already in. My general understanding of Precedex was it has a possibility of, you know, impacting the respiratory system, but as far as causing a acute respiratory distress syndrome that is defined as ARDS, no. That's a particular syndrome and which you treat a particular way when you have an inflammatory consideration in your lungs, you know, that changes the way that you oxygenate. It's well-known in the ICU and it's -- it has a very high mortality.
Q What was that last part?
A Has a very high mortality.
Q Mortality?
A Mortality.

Q ARDS you're referring to?
A Correct. And it can happen with many, many conditions, anything, really, that affects the lungs.
Q Okay. I think we had just finished talking about the conversation with Cindy Schara that she had to defer to her husband. Okay?
A Sure.
Q So I'm going to keep on moving. Am I to understand from this note that you then did in fact have a conversation with Scott Schara?
A Yes.
Q Okay. And how soon after, if you remember, was that conversation after you got off the phone with Cindy Schara?
A I called him right after.
Q Right after?
A Um-hmm.
Q Was Cindy Schara on the phone with Scott Schara when you talked to him?
A I assumed so, and I'll tell you why. I called Scott. The initial portion of our conversation was private. He then put me on speakerphone in conference with his family and told me that, you know, that his family was in the room.

His son-in-law, I believe, introduced himself. Another woman introduced herself. I'm not exactly sure who that was. I don't think it was Jessica. I think it was another --

Q Could it have been Cindy?

A And then the reason I say Cindy is because when -- after I had -- we had this long conversation and it was opened up to questions, you know, they went around, said do you have any questions, asked -- everyone asked their questions, and then I overheard them saying, Cindy, do you have any questions. And so I'm assuming she was in the room, but I do not recall her -- you know, speaking to her during that conversation.

Q You just mentioned questions. What questions, if any, do you remember the family asking you on that call?

A They were generally vague questions to -- like nonspecific questions just to clarify what had been discussed. His -- his son-in-law asked a few questions. I don't recall -- you know, they're like confirmation answers rather than anything as new material. So as far as the general conversation played out, I mean, it was kind of

the same --

Q Maybe it would be better if we started with the discussion then.

A Yeah, harder for me to kind of jump to that.

Q Sure, understand. Okay.

What's the first topic of discussion that you remember from that conference call?

A Presented it exactly how I started to present to Cindy, which was an update on her clinical condition. This was the call on the 12th, I'm assuming you're talking about?

Q I'm referring to the call referenced in your October 12th history and physical report.

A Great. Okay.

Q So you said update on clinical condition?

A Correct. So --

Q What was the clinical condition at this point?

A At this point I had relayed information of her increased BiPAP settings and escalation, you know, through the day, how, you know, it was kind of a status report of, you know, the events of the day thus far.

Again, all this kind of alluding toward the goal of cares conversation, so I had to

kind of present the status that she was at at that time, which was she was on BiPAP, you know, at fairly high settings of 20 over 15. She previously was on 15 over 12. Her FiO2 had increased, you know, she's malnourished. We should talk about nutrition, that kind of thing, which we ended up doing. But the first kind of concern was having that initial conversation about goals of care.

Oh, we did talk about, you know, modalities like proning to help her oxygenation and optimizing that as well. The next part of the conversation was more in regards to Scott's, I'd say, kind of grievances with the care team thus far.

Again, the idea of this conversation was really to start fresh. Okay? So it was really to -- I heard in report, for instance, and I was trying to throw all that out of the way to say, okay, let's -- obviously a miscommunication, obviously issues, let's get -- you know, let's restart. And I had the opportunity to do that as I was a new provider coming in and, you know, and I wanted to spend that time.

So the conversation after kind of reporting how she was doing for that day, you know, ended up being Scott telling me about the events that had passed from his perspective. And so that took up the next chunk of time which was, you know, his concerns about having to leave the hospital, all he was trying to do was turn alarms off and the BiPAP, and they're telling me I'm tampering with the machine, and that's not right. And he was telling me, you know, about how, you know, he felt like the nurses keep saying they're giving -- they're going above and beyond, but he doesn't feel they were, and there's a misperception that they feel they are but they're not actually doing that.

So -- and then he was -- he was concerned that everyone kept on asking about intubating Grace, and why -- why they keep telling me about having these concerns and questions about intubation, I don't want to intubate her. He, you know -- but it was -- so the second part of that conversation was basically that and me trying to offer some solace and understanding to try to, you know, again, not be biased in the assessment of the preceding events because that could -- I

didn't want that to impair the trajectory of the conversation and the decisions that we need to make in collaboration, you know, in the future like after -- and during that conversation.

So after that was all done, at some point we got put on speaker, and now is about the time when I started talking to him, you know, and initiating my goals of --

Q Were you on speaker the whole time?

A I don't know when -- no, no. Initially it was a private, it was just me and Scott talking, Scott and I talking, and then at some point he said I'm going to include -- I'm going to put you on speaker and include my family. And that was when I started talking about, you know, her condition and the scenarios and trajectory of what could happen.

And then in conclusion, after I talked about the scenarios, you know, the possibilities, after that was the code status conversation. So it was kind of in that order. Did you just want me to continue on the conversation?

Q Sure. You're getting all my questions.

THE WITNESS: That's okay?

MR. GUSE: I prefer to have a specific question on the table.

A Okay. Well, I'll wait. I'll stop there then.

BY MR. PFLEIDERER:

Q Okay. Sound's good. I kind of got some bullet points there about what you were talking about.

First was update on clinical. We were talking about your prior -- I know this is H&P, but we talked about your prior note. And it seemed like you were more optimistic at that time for Grace's future.

A Um-hmm.

Q Am I correct in saying you were less optimistic at the time this note was created?

A I was concerned. I was definitely concerned.

Q Okay, concerned.

A She showed a deterioration through the day. I was hoping it was a temporary deterioration and then we can go back to the other settings. At least I was hopeful it was a temporary consideration, but I had to, you know, at least be -- have some realistic weight and saying that this could be a progression as well and we need to have these conversations.

Q And earlier I said at this point, did you think

that Grace would likely die in the next day or two and you said it was more probable.

Did you express that heightened probability to the family on the phone that it was more likely that day that Grace would die in the next day or two?

A In a way, yes. I mean, I didn't say exactly like you just said it in regards to it's probable she's going to die. The problem was I was reaching in the context -- in a conversation structure which was -- it had to be in an optimistic fashion. I was talking to Scott about it. You know, he really did not appreciate and like the negativity that was surrounding the conversation, and everybody kind of, you know, alluding to the fact that she was going to die.

And I had to reapproach the conversation with that optimism in mind to say, listen, we're on the same page here, we want recovery, we want her to get better, and I'm treading carefully to say -- to not be like she's going to die today. Right?

Q Sure.

A But I was informing him of the deterioration and the level of BiPAP that she was on was extremely

elevated. I mean, these are very high settings. And, you know, and the fact that she had been on BiPAP for several days, and these are conversations that need to happen now and I need to have answers by this evening, as I documented as well, that she could crash any time. And, yes, if we have time, we can work things out, we can do things, and, you know, that's an allusion to the scenarios I presented him.

But, you know, I can't predict if she's going to crash at any moment, and she can crash today, she can crash overnight. I tell them we need to know this before tonight. I'm not here tonight, you know, can I have an answer for what you want to do in that worst case scenario if she crashes, you know, so that -- so in the conversation, the context of the conversation would have alluded to the fact that it was very severe, you know.

I think a reasonable assessment or understanding of that conversation would have assumed that this was severe. The fact that Cindy was crying when I was starting to talk about this means it was severe. I was under the impression that everyone knew this was a severe situation and

she could.

Q I want to correct what might be a typo here. There's a line starting with you had called Scott. Oh, yeah, right here. "I had called Scott and had a family conference with him and his children in regard to worst case scenario. BiPAP at max settings was ineffective for."

Is there a word missing after ineffective for?

A I'm trying to find this. One second.

Q Yeah, it's seven lines down. Nine lines down. Sorry. It's on the left side.

A Yeah. I'm trying to read this. Hold on.

Q Just go down the left side. There's a line beginning with ineffective.

A No, I'm reading it here.

Q Sure.

A I think it was just a typo. Or I mean the dictation is exactly what I said, but --

Q Are you saying the word "for" should not have been there?

A I'm not sure, to be honest.

Q Okay. All right. That's fine.

You say further down here -- I'm not sure how to get you there. The sentence

starts, "We spent over 60 minutes" -- sort of on the right side of the paragraph.

A Sure.

Q You got it?

A Um-hmm.

Q "We spent over 60 minutes during this conference to answer all questions that were posed and counseled as best as possible in regard to the unfortunate situation."

Are you saying here that the call itself lasted 60 minutes or that the question and answer session lasted 60 minutes?

A The whole call.

Q The whole call. And is that true to the best of your recollection today?

A It was roughly an hour. I mean, I don't have exact times. It was a very long time.

Q And now that we've sort of listed out these topics here, is there any other comments from Scott Schara that you can specifically remember regarding grievances with hospital staff? I think you mentioned grievances.

A Let me think. I -- there were, but I'm just -- I don't feel that I -- I know there were, but I don't -- I can't recall them enough to tell you

for certainty.

Q Okay. And then you mentioned that one of your goals with this conversation was to have a fresh start with the family.

Is it fair to say that you were trying to improve the family's relationship with hospital providers?

MR. FRANCKOWIAK: Objection to form.

MR. GUSE: Yeah, join. Vague and ambiguous.

BY MR. PFLEIDERER:

Q I'll reask that. What do you mean by you wanted a fresh start?

A My impression was, is that the hospital experience from the Schara family was not a -- one to their expectation.

Q Okay.

A And I wanted to understand why and try to recover some of that, what I assumed was like a feeling that -- how do I say this? He was -- he had to be, for instance, like removed from the hospital and there was all these, you know, things that happened prior, again, which I was trying to not pay too much attention to when I had these conversations.

But I wanted to be a fresh provider for him to kind of feel that he can connect with and -- one of the jobs as a general -- like a hospitalist is I'm like the liaison. I'm not just a quarterback of the -- you know, trying to get the care coordinated and everything like that, but I'm the person that has the most experience in conversations and the ability to communicate with the family.

And the fact that when I had rapport done was that they couldn't peg down, for instance, code status and this and that, and there was -- there were so many grievances, I felt like I was in a good position as a new provider in to kind of just go through it all, and let's -- let's start fresh.

You obviously can't start fresh, but as fresh as you can to kind of -- to try to get to a resolution --

Q Sure. I understand. Sure.

A -- you know, and an understanding of what -- what the family wanted.

Q Do you remember if on this call you ever specifically used the term "do not resuscitate"?

A On this particular call the conversation in

regards to code status and do not intubate and do not resuscitate largely revolved around do not intubate, largely revolved around do not intubate. I introduced the conversation about the futility of CPR if you're not going to intubate in someone who has irreversible causes and hypoxia. I introduced do not resuscitation as a concept, but the large amount of that conversation was about do not intubate.

And the reason for that was, because I'd introduced the conversations in tandem with each other, at that time my assumption was that talking about one in tandem with the other one, they would understand that what we're really trying to understand is resuscitation as a whole. Are we going to intubate, are we not going to intubate? If we're not going to intubate, you know, then we're basically seeing if she improves on BiPAP. And if she doesn't, then we have to have a tough conversation about things like comfort care, right? Because she's not going to survive if she goes -- if she deteriorates and you're not going to intubate her. Resuscitation efforts are not going to be fruitful for her.

And so that -- those concepts are

introduced, but the explanation of do not resuscitate happened the next day, you know, after it was apparent that -- you know, Scott, he needed more clarification on the do-not-resuscitate aspect of CPR and whatnot.

Q Did you ever -- strike that.

If Grace, I think you used the word crashed, but had pulmonary failure, you know, something like that, did you ever convey to Scott that if Grace was not intubated that she was very likely to die?

A I conveyed to him that she can crash any time.

Q Sure. Did you convey that if she were to crash and not be intubated that she would -- I don't know what probability -- but I'm going to say very likely die, did you convey that to Scott?

A I'm pretty sure that I conveyed that intubation -- if you're -- I really -- okay. I conveyed to him that if she's hypoxic, you know, and we can't reverse that with BiPAP, that her only method of oxygenating would be intubation. And that flowed into a conversation as far as if she crashed, then she needs to be -- then she would be intubated to restore her oxygenation as best as possible.

And if we're not going to intubate

her and she crashes, then they're not going to intubate her at that time either, because you're -- you don't want her intubated.

But I'm telling -- I implored the fact that I cannot predict when she's going to crash but she has the potential of crashing. That day, that night, you know, I need to know an answer as soon as your family can convene an answer, and I requested that, you know, I had that information by the night.

And he delivered it the next morning, and then we had a follow-up conversation the next morning about, you know, that incorporated that and more, because that conversation as well was about 45 minutes or so.

Q I think you said a moment ago that if Grace were to crash and she was not to be intubated, then you would have to have a difficult conversation about comfort care.

Am I remembering that correctly?

A I think you're confounding the two.

Q Sure.

A Do you mind if I clarify?

Q No, I don't.

A The conversation -- a big meat of the

conversation, and I believe this was also on conference, I was going over the scenarios of what could happen moving forward. Okay? And I was going over, you know, if she's on BiPAP and she -- the best scenario is for her to be on BiPAP and she gets better. Right? Settings go down, we wait, we wait, we wait, things get improved.

The second scenario is that she's on BiPAP and she becomes hypoxic, and we've maxed out on the BiPAP settings, and we have nowhere to go. And she's going to be hypoxic and starting to get -- you know, stay in a hypoxic state, as in her oxygen saturations are going to be below 90, below 88, you know, you know, in a situation where the tissues are going to be devoid, slowly getting more and more devoid of oxygen and will start shutting down.

And in that scenario, we talked about two options. One was intubate. That's the next step, you know, and the second option was don't intubate. And then if you don't intubate, you're kind of in a situation where, you know, is she going to be in this prolonged hypoxic stage and then get better, or is she going to be in this prolonged hypoxic stage and then start suffering

because she's on BiPAP to keep her going.

And then we introduced -- or I introduced the concept of, you know, again, because in the context of the conversation we want to be optimistic, we didn't really want to go down that path yet even though it was relevant.

I introduced that we could have a comfort care conversation at that time, if we have time. So she's prolonged hypoxic. It is reflected in the note as well.

Q When you say "at that time," you mean at that future time when that happens, not at the time of the phone call?

A Correct, at the future time, if we had the opportunity where she was hypoxic for a prolonged amount of time, and we, you know -- we would have to have a tough conversation to say should we switch to comfort care. And that's a completely different thing. That's now we're, you know, switching to nasal cannula and we're letting her pass peacefully with family at bedside because we know that, you know, the inevitable is near. And -- you know, but we weren't ready to have that conversation. But I had to elicit the actual scenario. I mean, obviously, if she's on BiPAP

max settings, not getting better, she could -- that potentially could happen.

And then after that we had a conversation about worst case scenario, which was the crashing, if she actually crashed. And in that case I need to know -- I mean, to be honest, every patient in the hospital needs to have a code status. We need to know what people want.

Q Sure.

A Because the staff can't take the time, call a family member in the event and figure out what they want at the time. Plus, the family's usually emotional, so they make irrational decisions or they don't make it in a clear, thought, logical way when you can have the conversation before. So it's always addressed, has to be addressed. And multiple providers, I believe, tried to address it and weren't able to. So the lead into this conversation was -- the end part was the code status.

Q I think I know your answer to this, but it's kind of been mixed into different things.

Was it your position in regard to Grace's care at this time that absent intubation CPR compressions would have been futile?

A Absolutely futile. In her situation they would not have helped anything.

Q And what do you -- why do you say it? Why are you so certain?

A CPR, resuscitating the heart is not an absolute thing. Okay? You have like a 23 percent chance of resuscitating someone's heart in the hospital. It's not that high. And people think, you know, you get CPR and you get your heart resuscitated. It's ugly. A lot of compression, you know, causes damage to the chest, rib fractures. All these things. It's not what you see on TV. I'm just going to throw that out there. That's if someone has a reversible cause, their heart stops, but hey, you can fix the underlying problem and you can resuscitate the heart.

In people who have irreversible causes and they're unable to -- we're not able to fix that, what ends up happening is if you do CPR, if you happen to, you know, get their heart started, which is much less chance if your -- you know, if you're tissue hypoxic, as in Grace's case with tissue hypoxia and malnutrition and been on BiPAP and under stress and all these things for days. Okay? The chance of resuscitation is very

low, less than 23 percent, I can comfortably say, much less.

And then what ends up happening if you have an irreversible cause, the heart just stops again. And so you end up just doing this vicious cycle of compressions and trauma to this person, and that's the end of their life; trauma, trauma, trauma. You know, it's irreversible -- if there's an irreversible cause, which was in her case, I couldn't fix her in a day. Compressions are futile.

And that's what I explained to Scott as well, that in the events where you're having respiratory failure, respiratory arrest leading to cardiac arrest, it's not the heart that stopped by itself, it was because of an underlying respiratory -- you can't fix it. The compression's not going to help. It's going to be a futile effort.

Q Got it. I'm going to go to another document, if you're okay?

A Okay.

MR. GUSE: At some point soon we probably should take another break. It's been about another hour and a half.

MR. PFLEIDERER: Sure, as long as -- I mean, I'm trying to keep moving, but if you need a break, that's fine.

MR. GUSE: Yeah, I mean I guess I need to know from a time standpoint what time you want to wrap up today.

MR. PFLEIDERER: I mean --

MR. GUSE: How long are you guys willing to go?

MR. EDMINISTER: Let's confer on that during a break and get back to you.

MR. GUSE: Okay. Sounds good.

MR. EDMINISTER: Okay.

VIDEOGRAPHER: We are going off the record at 4:00 p.m.

(Brief recess taken from 4:00 p.m. to 4:23 p.m.)

VIDEOGRAPHER: We are going back on the record at 4:23 p.m.

BY MR. PFLEIDERER:

Q All right. Dr. Shokar, earlier in the deposition I handed you Exhibit 73. Do you have that in front of you?

A I do.

Q Do you see the 73 at the bottom right?

A Yes.
Q Okay. This note purports to be authored by you. Do you recognize this note?
A I do.
Q Did you author this note?
A I did.
Q Does this note appear to be a true and accurate representation of the note that you authored?
MR. BIRNBAUM: And John, the Bates label on that one?
MR. PFLEIDERER: It is Ascension 00033.
MR. BIRNBAUM: Gotcha. Thank you.
A Yes.
BY MR. PFLEIDERER:
Q Okay. The date of service on this note is October 13th, 2021.
Do the notes in this document relate to Grace's condition on October 13th, 2021?
A Yes.
Q The time of dictation of this note appearing on Page 2 appears to be 1257 hours or just before 1:00 p.m.
Do the notes in this document relate to Grace's condition just before that time?
A Yes.

Q Up there at the top under the Subjective, first sentence is, "The patient was doing well on same settings of BiPAP this a.m. of 20 over 15 at 100 percent FiO2."

Is that your recollection that Grace was doing well on those settings that morning?

A She was stable, yes.

Q You continue, "She was unable to wean to 90 percent as she does desaturate to about 80s. She had an episode when she got agitated after being assisted to stool and her Precedex was increased to help control agitation as she is starting to pull out a PICC and remove the mask."

Are those sentences, do they match your recollection of events that morning?

A Yes.

Q And you say "Precedex was increased."

Was that your decision to increase the Precedex?

A It was not.

Q Okay. Whose decision was that?

A The Precedex order is ordered by the ICU attending, ICU consultant, as an order that can be carried out by nursing based off of their clinical

assessment. And so that's why actually she's in the ICU and why that medicine's used in the ICU, so that it can be titrated.

Q And you said the ICU physician is the one that ordered the Precedex in this case?

A The -- as far as I -- as far as I know, I didn't place the order. Usually it's placed by an ICU attending. I'm not sure which one.

Q Was Dr. Marada, was he the attending ICU physician?

A Not on the day that I was working.

Q Either day, the 12th or the 13th of October?

A I believe it was Dr. Gandev. That's who I interacted with.

Q You said that the ICU nurse is able to operate within her or his discretion to increase the dosage of Precedex; is that correct?

MR. GUSE: Objection. Misstates his testimony. You can answer.

A Generally, the ICU nurse is trained in the ICU. It's in their scope to carry out the orders. If they're on a drip that's titratable, they have the ability to titrate that dose.

BY MR. PFLEIDERER:

Q Up or down?

A Up or down, yes.
Q Okay. Is there --
A Usually with up, you -- you know, notify somebody that you had to do so; in that case the person or the team that had ordered it.
Q Is there a limit to how high a nurse can increase the titration of Precedex in the ICU?
MR. GUSE: Object to form, foundation.
MR. PFLEIDERER: Yeah, I'll ask another question.
MR. GUSE: Improper hypothetical.
BY MR. PFLEIDERER:
Q Yep. In regard to the order for Precedex that Grace was -- that was involved with Grace's care, was there -- do you know if there was a limit to how high a nurse could increase the titration of that Precedex?
A I'm not --
MR. GUSE: Hold on. Just -- are you talking in general limit, or are you talking specific to Grace's --
MR. PFLEIDERER: I'm talking about specific to Grace's care.
MR. GUSE: Okay. I'm going to object. I'm going to insert the Alt privilege. To the

extent that he may have been involved in that, he can answer, but to the extent that that limit was set, if such a limit was set by another provider, I'm going to instruct him not to answer.

VIDEOGRAPHER: Is your mic on, Mr. Guse?

MR. PFLEIDERER: I'm not asking about the standard of care. I'm just asking whether there was a limit set.

MR. GUSE: I stand by the objection. Because even asking in that form is really a backdoor way of getting at standard of care, and so I'm going to maintain my objection and maintain my instruction if he -- not to answer.

If he was involved in setting the limit or he made a decision setting the limit or determining the limit, he can answer that. But to the extent it was done by another medical provider, I am instructing Dr. Shokar not to answer.

BY MR. PFLEIDERER:

Q Okay. So I just want to make sure my question is clear for the record here.

Are you aware of a limit being set on that order?

A Can I answer that?

MR. GUSE: You can answer as to whether you're aware there was or not.

A I was not aware.

BY MR. PFLEIDERER:

Q Okay. So am I understanding correctly that a nurse under that order could titrate the Precedex up as far as they deem necessary?

MR. GUSE: Again, are you talking specific to Grace's case, or are you talking --

MR. PFLEIDERER: I'm talking about the order, the order, the Precedex order.

A Um, I don't know how to answer that. I'm not aware of the titration capabilities of that order. So I am aware that nurses can titrate based off of a -- based off of the instructions of an order or an ICU attending.

BY MR. PFLEIDERER:

Q You say in your note that Precedex was increased. Did somebody notify you that Precedex was increased?

A Nursing.

Q Okay. Do you remember who?

A The nurse in charge of that case on that day was Ms. McInnis.

Q And she's the one that notified you?

A I believe so, but I -- it could have been one of her colleagues.

Q Still looking at the Subjective. You said -- I'm on the fifth line, end of the fifth line, "She required restraints by the time of the interview with the goal to remove the restraints as soon as possible."

Do you see that?

A I do.

Q Is it your recollection as you sit here today that Grace did require restraints by the time of the interview?

A Yes. She was in restraints at the time of the interview, soft restraints to her wrists.

Q Do you know why she was placed in those restraints?

MR. GUSE: Object to form, foundation. You can answer if you know.

A My nursing report had indicated, as I had written, that she was more agitated. They had to increase the Precedex, and to prevent her from pulling off the BiPAP and her PICC line, which she was grabbing at, they had to place her in temporary soft restraints.

When I ended up seeing her was when

I found out this information as well, you know, clarified the information with the nursing because, obviously, I'm visually seeing that she's in restraints as well. Generally when restraints are placed, we try to remove restraints as soon as possible.

BY MR. PFLEIDERER:

Q Did anyone, to your knowledge, notify the family that Grace had been placed in restraints, any member of the family?

MR. FRANCKOWIAK: Objection. Foundation.

MR. GUSE: Join.

A I'm not aware.

BY MR. PFLEIDERER:

Q Okay. Do you know if anyone attempted to notify either Scott Schara, Cindy Schara or Jessica Vander Heiden that Grace had been placed in restraints?

MR. GUSE: Objection. Asked and answered.

MR. PFLEIDERER: I asked if he knew if anybody had successfully notified, not attempted to. You can answer.

A I'm not aware.

BY MR. PFLEIDERER:

Q Okay. In your experience at St. Elizabeth Hospital was it -- was it policy to notify the decision-maker or the patient's family that the patient had been placed in restraints?

MR. FRANCKOWIAK: Objection. Foundation.

MR. BIRNBAUM: Object to form and foundation.

MR. GUSE: Join.

MR. PFLEIDERER: You can answer.

A It -- I would have to -- I don't know the actual -- I don't recall an actual policy, but it's generally a good idea. You know, it's generally followed through that we would give that information. As far as the policy for timing and if it's absolutely, you know, written in there, I'm not aware.

BY MR. PFLEIDERER:

Q Okay. And why would it be a good idea?

A I mean, just in good communication with the family, you should notify if you have someone making the decisions for a patient who's -- you know, they should be aware that that kind of intervention was necessary.

Q Did you discuss these restraints on the morning of October 13th with Nurse Hollee McInnis?
A Yes.
Q And what do you remember from that discussion with Hollee McInnis?
A Let's get her out of restraints as quick as possible, you know. But that's easy to say, harder to do. It really depends on, you know, intervaled reassessments to determine when is the safe and appropriate time to do so. And the prerequisite for that would be, you know, having her not pulling at lines or less agitated to do so. So it's usually done in a trial fashion.
Q Did you say to Hollee McInnis that the family was not going to like it when they found out that Grace had been put into restraints?
A I don't recall that, but I mean, I could imagine me saying that, because I don't think they would. I wouldn't.
Q Did you have any conversations with Dr. Gandev, the Dr. Gandev that you had mentioned prior, did you have any conversations with Dr. Gandev regarding Grace's care on October 13th?
A After I had a conversation with Scott in the morning and changed the order in the computer and

doing that assessment, I did run into Dr. Gandev on the ICU ward. And I had informed him of the conversation that I had in regards to the change of code status, you know. And it was a relatively limited conversation, I would say. And that was roughly -- and he had mentioned, thank you, you know, thank you for taking the time to have that conversation, and that essentially, you know, if it's -- it's -- you know, it would be a good idea to just make sure that -- you know, if that's -- if that's the course that they wanted to go for, you know, might be the best course after all, is basically the paraphrasing of what he had said. But again, a brief conversation.

Q Just to be clear, you said you had that conversation in the ICU ward. Was that not in Grace's room?

A On the -- on the floor outside all the rooms of the ICU, in front of the -- a little to the -- I remember running into him, because I was walking left off the ICU, and I ran into him walking towards the ICU.

Q I think you're familiar with, from your testimony today, with Grace's sister Jessica Schara?

A I had some interactions with her, yes.

Q Do you have any knowledge of Jessica being sent home to shower on the morning of October 13th?

A In review, along this review pathway, I learned that, but at the time, no.

Q What do you mean by this review pathway?

A I learned after the fact, after the day that, you know, that nursing was helping Grace, I believe, to go to the bathroom, and that that's the time where she was getting agitated and the Precedex was increased at that point. And I learned this because it was -- that family had gone -- Jessica at that time had gone, you know, had stepped out of the room. I didn't know the particulars at that time that she had gone home to shower.

Q Do you understand or do you have any knowledge that Jessica was told to go home by nursing staff to shower?

A No.

Q Okay. You don't know whether she left on her own volition or because she was asked by nursing staff?

A Yeah, correct. I assume that she -- she had to step out and was going to return.

Q And earlier when you said that somebody had helped Grace go to the bathroom, you don't mean literally

go to the bathroom? You mean she defecated in the bed?

MR. GUSE: Objection. Foundation.

MR. FRANCKOWIAK: And form.

A No. I'm not sure, to be honest. I think they were trying to assist her to stool, as far as -- and I don't know if that was in the bed or to the bathroom, to be honest.

BY MR. PFLEIDERER:

Q You have no knowledge?

A I don't have knowledge, yes. Probably makes sense for it to be in the bed just given her status, but I don't want to discount the fact that she tried to get to the bathroom. I'm not really sure.

Q I'm looking at the -- I'm back to 73, Exhibit 73, looking at the second paragraph of the Subjective. It says, "I had a discussion with the family over the phone for roughly half an hour to an hour in" regard to -- or sorry, "in regards to code status once again as well as feeding options they have."

Do you remember this discussion with the family?

A Yes, I did. It was actually with just Scott, actually.

Q Just Scott?
A Yes.
Q And do you know where you were during this discussion?
A I was in front of the nursing station. I was sitting at the nursing station in front of Grace's room in the ICU.
Q Were any other medical providers participating on this call with you?
A No.
Q Either based on your recollection or anything in this note, do you remember when that call would have occurred?
A It happened just before I placed the DNI/DNR order. If you look at that timestamp, it would be right before that, for the hour preceding.
Q When you say just before that, do you mean -- you said a half an hour preceding?
A I was on the phone for half an hour to an hour, so it was -- after I got off the phone, that's when I placed the order, and I believe that would have been timestamped. I don't know when I dictated, if it was immediately after or it was like half an hour or an hour after.
Q I understand.

A It was late morning is the best I can give you. Yeah.

Q I'm on the fourth line of the second paragraph. It says, "We did discuss in regards to CPR resuscitation and the futility of doing CPR in the situation in regards to DNI, and they agreed in regards to not pursuing a resuscitation via CPR or defibrillation in the event of respiratory arrest leading to a cardiac arrest."

Is that accurate to your recollection?

A Yes, mostly. Respiratory arrest, respiratory distress used interchangeably.

Q Okay. You say, "In all regard, they want to continue full management without intubation."

What is meant by full management?

A The agreement after that conversation was in the effort to kind of have Grace survive, was that we were going to continue with the BiPAP therapy as long as possible, as long as possible. Because -- in the hope of optimism and hope, and we wanted to see if she would pull through. So that's what that means. The full management means continuing what we're doing right now.

Q What -- we'll get there later.

A Remember if I --

MR. GUSE: There's no question pending, Doctor.

A Okay. I was just going to clarify because I was rereading.

BY MR. PFLEIDERER:

Q You can clarify, please.

A It was -- if you remember when I was talking about the scenario where somebody was hypoxic for a prolonged amount of time --

Q Um-hum, I do.

A -- right? Then we'd have to make a decision as far as intubate or not intubate.

Q Yeah. Sort of the same thing in this conversation?

A Correct, yeah.

Q I'm starting a sentence here beginning with, "If there is deterioration" -- do you see that?

A Um-hmm.

Q Okay. It says, "If there is a deterioration and hypoxia without reversibility for a prolonged amount of time, we may consider at that time switching to comfort care after a discussion has been completed with family to see if that is the right time."

I know I asked you this before in regard to the other note.

But if you did switch to comfort care, I mean, what does that look like? Is that a different set of medication? Is that bringing all the family in? As you meant it in this note, what did you mean by that?

A It was a reflection of a scenario in which someone who's on BiPAP therapy with an irreversible injury and hypoxic for a prolonged amount of time, as I'd written --

Q Um-hmm, yep.

A -- and we had the time to reconvene with the family and have an appropriate comfort care conversation about is this the time, you know, to let her go, essentially.

And comfort care is basically a switching of the understanding that we're going to go away from full medical care to search and cure -- you know, and pursue a cure and a restoration, you know, and we're switching that to an understanding that there is no cure or restoration and she has -- she's going to imminently die in the hospital in the next, you know, few days.

And in that regard we prepare the family, prepare the patient, if they're able to be prepared, and we remove any interventions that are causes of suffering. In this instance, it would have been the high pressure BiPAP. We would have placed her on a high flow nasal cannula, which would not have supported her oxygenations in the least, and then she would have drifted off with the aid of any type of palliative medications to take away air hunger or any type of distress so that she could pass peacefully, you know, with family at bedside.

Q And what sort or -- what sort of palliative medications are you referring to?

A Generally palliative care physicians -- or in comfort care there's a comfort care order-set that is initiated. That comfort care order-set incorporates medications, you know, of a bunch of different symptoms that could be distressing; one being pain. So there'll be opiate medications for pain. One being anxiety, so there's usually benzodiazepines on that order-set. One is -- you know, for diarrhea, they would have Imodium. One is for constipation if it's distressing, have laxatives. They would have for secretions,

scopolamine patch. You know, so a variety of palliative medications set as p.r.n. to be given by nursing, you know, in the event, when they're doing their assessment that they feel that the patient is in distress.

Again, we've -- it was in the context where you have already determined that the goal now is to remove any suffering to allow the patient to pass peacefully. That is what comfort care in the hospital is. And if you have time, that is -- we usually discharge to, you know, home with hospice, which does kind of the same thing. But in the event some of those patients can't be discharged home because they're imminently dying or unstable to transfer, then we do that in the hospital under -- under comfort care.

Q And you mentioned that opiate medications would be used to sort of deal with the pain aspect of those different considerations and comfort care.

A It's used in two different ways, actually. It's used -- and for pain, it's a general consideration, but it's also used for air hunger and dyspnea, which is people -- that feeling of shortness of breath. It's often used in patients who have respiratory illnesses, COPD, end-stage

COPD, those kind of things where the route reason someone is going to pass is from their -- from not being able to breathe. So it will take away that feeling of I can't breathe and gasping.

Q Um-hmm. And when the doctor puts -- you mentioned a p.r.n. order, and I just want to clarify what that is. A p.r.n. order is essentially an as-needed order?

A Correct. It's not -- it's not a medication that's given at a scheduled time. It's an order that's given, you know, if on request, or offered if the person, like a nurse would, or a doctor, feels that it would be useful for that time.

Q And if I had an order that was p.r.n. to be administered at most every four hours, how would that be designated in the medical chart?

A You'd have the medicine, you'd have the dosing, and then you'd have the schedule -- p.r.n. schedule, such as Q4 p.r.n. or every four hours as needed.

Q And a Q4 designates every four hours?

A Correct. So if you give it -- you're unable to give it again for four hours unless you have an authorization to give it again.

Q Got it.

MR. PFLEIDERER: I thought you were about to lay a big objection on me.

MR. POJE: No. That's for later.

BY MR. PFLEIDERER:

Q Under your care, was Grace ever transitioned to a comfort care sort of medical plan or plan of care?

A She was not.

Q Okay. At the bottom of the Subjective -- are you with me? I'm on the 73.

A Um-hmm.

Q Right above the Objective.

A Yes.

Q It says, the patient -- "The patient was seen and examined at bedside today."

Would that examination have been done shortly before this dictation?

A Yes.

Q Okay. And by shortly I mean, for example, within half hour, 15 minutes?

A No.

Q Okay.

A I usually see the patients prior to talking with family. So in this situation, I was talking with family, I would have wanted to give them a clinical update of Grace at that time, and

therefore, I would have done my -- my round on her prior to that.

Q Got it. Do you remember if Grace's sister Jessica was at bedside when you examined Grace on this -- that led to these notes here?

A Yes. I documented that her sister was at bedside.

Q Did you have any conversations with Jessica during that examination?

A Not in that -- not really that morning apart from how was Grace doing for -- you know, I usually tried to get the family members' input as far as how they're feeling the family member is doing.

Q Do you remember anything else about talking with Jessica besides just how Grace was doing?

A I had a conversation with her later on in the day that was much more extensive. But at that time it was mainly to get a -- subjective pieces of data about how Grace was doing.

Q Got it. Was Grace verbal at this time, at the time of this examination?

A She was not. She was never verbal for me.

Q Never verbal. Do you remember Jessica asking you any questions during this examination?

A Not specific questions. Jessica did ask questions. They were mainly just in like general

questions, nothing specific. And -- and I can't recall specifics about any question because it was just kind of in the regular discourse of explaining what I was observing. But I can't recall exact specific questions.

Q And did you observe anything that would indicate that Grace was nonverbal either because of her respiratory condition, or was it because of the sedation, or either, or both, or neither?

A It's hard for me to answer, because the day preceding and the day of that you're -- that we're questioning were the only two days that I had to experience Grace. And both days were -- were similar in regards to her, you know, presentation to me in the morning, which was someone who's nonverbal, had a BiPAP mask on, was, you know, able to move and that kind of thing but seemed mildly agitated on this particular day versus the day before where she was calm. But overall, you know, it was -- I don't really have -- I can't allude to was it because of this or that.

Q That's fine. Yeah, I don't want you to speculate. Under -- I'm looking at the Objective now, vital signs. Are you with me?

A Yes.

Q I see a temperature of 101.4. I can't remember the number that you gave earlier in your deposition, but I believe that is considered a fever; is that correct?

A Yes.

Q Okay. And you don't have any reason to dispute that temperature reading, do you?

A I do not.

Q Okay. I'm looking at the Plan section on Page 2, No. 3.

Are you with me? Under Plan.

A Yes.

Q Says "Requiring Precedex increased rate to 1.4 due to significant agitation this a.m. with goals to wean back down."

Did I read that correctly?

A Yes.

Q What is the significant agitation that you were referring to in this note?

A That was the reported agitation from the nursing report that I verbally received that morning that indicated that she was having a lot of distress in the early hours of the morning where she was unable to prone anymore, you know, for a prolonged amount of time.

And the event in regards to the, you know, the stooling event where she got really agitated as well. So that is all recorded as a reflection of why the Precedex was increased, and I had it in my plan as under the, you know, medication that she was on and why it was at 1.4.

Q At the time of the examination that led to the creation of these notes, did you think that it was likely that Grace would die in the next day or two?

A I had my concerns, yes.

Q That's a yes?

A Yes.

Q Okay. And did you ever inform either Grace's sister Jessica or Scott or Cindy Schara that you thought that it was likely that Grace would die in the next day or two?

A Not in those words. I didn't directly say she's going to die in the next day or two. Again, we were in an air of optimism here. That was a very sensitive topic to say that she's going to die. She was still saturating -- you know, at the time of this note, she was still saturating above 88, 90 percent, and we were still able to keep her oxygenations there.

So I didn't have -- there was no prompt at that time to directly say she was going to pass away within 24 to 48 hours because she wasn't hypoxic at that time. I also thought it would not be received very well. But again, they did know the severity -- I thought they did know the severity of her situation given the data that I was informing them of.

Q Is there anything that you did not tell Scott Schara, Cindy Schara or Grace's sister Jessica because you did not think that it would be received well?

MR. GUSE: Object to the form of the question. Vague and ambiguous.

MR. PFLEIDERER: That's fair. Let me ask a better one.

BY MR. PFLEIDERER:

Q During the time that you were treating Grace at St. Elizabeth, was there anything regarding Grace's condition or medical care or treatment that you did not tell the parents or the sister about because you did not think it would be received well?

A No.

MR. BIRNBAUM: Object to the form.

BY MR. PFLEIDERER:

Q You can answer.

A Said no. Your question preceding was about if I directly told them that she was going to die in a day or two, and that's not something I can determine. You know, that's not something at that time or through the hospitalization I can say. I can say that there's a probability that she can pass, but I don't have like a crystal ball to say exactly when she's going to die or if it's going to be in that time period. And I did not withhold any information from them.

Again, the whole goal was to provide as much information and transparency as possible from my side. But within context. Because by me saying she's going to die today would have been a deterioration in the rapport and communication going forward, because then I would have been just like everybody else or whatever, you know, considerations there may be.

So I had to, again, tread carefully on giving them objective data and giving them as much information as I could without ruining that relationship or changing the care plan.

Q You are aware that Grace did die at St. Elizabeth

Hospital?

A I'm aware.

Q Did you ever communicate to the family that Grace's death was imminent?

MR. GUSE: Object to the form of the question.

MR. PFLEIDERER: I'm going to keep that question.

MR. GUSE: Vague and ambiguous. Plus, I also think it's been asked and answered.

MR. PFLEIDERER: You can answer.

A I believe I've answered this multiple occasions. I implored that she could die at any time. She can crash today, she can crash overnight, she can crash at any time. That infers the imminency of her -- and the severity of her situation. I inferred multiple times on how we were escalating her BiPAP, you know, and on this particular day how she's going through another inflammatory situation with the elevated fever and her labs looking a lot worse.

So it's -- it's like I gave them everything to come to a reasonable conclusion that this is on the horizon as much as I could. I had conversations that revolved around the fact that

this was imminent. But never did I actually say, within 24 hours your daughter's going to die. I didn't -- I didn't feel that was appropriate given the conversational perception of the family.

BY MR. PFLEIDERER:

Q Do you remember what time on the 13th Grace died, or she was declared dead? Excuse me.

A I think it was at 7:27, if I'm not mistaken.

Q 7:27 p.m.?

A Was that correct? 7:30-ish.

Q That doesn't sound wrong to me.

A I don't have her discharge summary, death summary in my hand.

Q Let's just assume that it was 7:27 for these questions.

Up until 7:27, was there ever a time where you thought for sure Grace was going to die, or do you not know until the moment she was dead?

MR. GUSE: Object to the form as vague and ambiguous.

MR. PFLEIDERER: You can answer.

MR. GUSE: Calls for speculation, but you can answer.

A The next big interaction I had with Grace was at

like 5:50 p.m. when I was called to the room due to the significant hypoxia that was going on. And we can obviously get into that as well.

But essentially, that required my attention over the next 40 minutes or so. What had to do -- you know, she was hypoxic. The interventions that I did during that time period allowed her oxygenation to reach an appropriate level again. When I left that room, her vitals were what they were before and oxygenation was 95 percent.

So I reasonably thought that, hey, she's going through an inflammatory crisis, but I was able to stabilize her again by initiating, you know, an adjustment to her care plan.

Then I called Scott right afterwards and explained to him the events that had preceded and that we were adding -- that morphine was given to help stabilize her respiratory situation, and that she was stable when I left the room. Monitored her while I was talking to him for 15 minutes. And then at that time, you know, after discussing all that, then left.

So there was not a moment to have

time pass enough where I could tell them that, oh, this is it. It was a scary moment, and I was hopeful that it was a -- a one-time event. But as the pattern suggests, you know, she was having a really tough time that day.

BY MR. PFLEIDERER:

Q So when you left, I can't remember the time, you said you started in the room at 5:50 in Grace's room, 5:50 p.m. approximately?

A Approximately. It was like quarter to 6:00-ish, yeah.

Q And about how long do you think that you were in the room?

A I was in the room for a good 15, 20 minutes, and then out of the room and talking to Scott for another 15, 20 minutes, which would place me around 6:30-ish or so. And around that time I had left the unit.

Q And at that time you thought that Grace had been stabilized?

A For that event, yeah. Yeah. She was not -- she was somebody who was, again, on high levels of BiPAP, in a very critical situation. Family was aware of the critical situation. We've had multiple discussions. That was kind of the next

thing in the line of, you know, what she faced, and we were able to get through it at that time.

MR. PFLEIDERER: We're going to be able to do it, Randy.

MR. GUSE: I'm counting on you.

MR. PFLEIDERER: It's going to happen.

BY MR. PFLEIDERER:

Q I'm under Plan, No. 6. I'm going to read it. "Goal of activity is to have her in a chair watching television."

Did I read that correctly? Do you want me to read the rest of it?

A Yeah, because it looks like there was a break in the sentence.

Q Are you referring to the period at the end of that sentence, or what do you mean?

A Correct.

Q Do you want me to read the whole thing?

A The period -- the sentence should incorporate the next sentence, because it hangs.

Q Okay, sure. Yeah, that's fine.

"Goal of activity is to have her in a chair watching television if she is lightly sedated as related by the family."

Are you saying the period should

not be there?

A Correct.

Q I see. Was this your goal of -- having her in the chair watching television, was that your goal at this time?

A Not at that immediate time, but it was in discussion with Scott where -- where, again, in the air of trying to visualize a, you know, an ideal resolution or a recovery for Grace. Some of the concerns was that we were, you know, sedating her too much and, you know, she's not moving, she's in the bed all day long, you know, and if we really wanted her to recover, you know, she likes watching TV, let's get her in a chair, let's lightly sedate her. So those are concerns brought up by Scott.

The sentence that was written down was a reflection of, you know, of the goals of care -- of what he wanted for her, for Grace, which was reducing sedation, if we can, getting her into a chair, getting her watching television, those things would perk up her mood, and, you know, she would be in a better position to recover.

Q So Section 8 under Plan, you state, "Code status

was reviewed with family and she is a DNR/DNI."
Do you see that?
A I do.
Q Did I read that correctly? Did I read it correctly?
A Yes, you did.
Q Okay. Does your statement here that says she is a DNR/DNI, does it conflict with your statement in the Subjective that says "they want to continue full management without intubation"?
A No.
Q Okay. Is that because in this case a DNR had the same practical effect as a DNI?
A No. It conflicts because the statement in the Subjective is in referring to continuing --
Q Sorry, doesn't or does conflict?
A It does conflict -- what did I say?
Q You said it does conflict. I'm asking you if your statement under No. 8 in Plan conflicts with your statement in the Subjective that says "they want to continue full management."
A It doesn't conflict because they're two different things.
Q Okay. Does -- does full management -- or sorry. Strike that.

Does DNI as a code status, does that still permit reversal of an opiate over-sedation?

A Yes.

Q Does it still permit reversal of Precedex over-sedation?

A Yes.

Q Okay. At this time, at the time that you did the examination that led to the creation of this note, did you observe Grace to be in any pain?

A Not pain. More distress.

Q And what did you observe about her that made you think that she was in distress?

A I mean, she was having a tough time with the BiPAP.

Q Was she trying to remove the mask?

A She was very fidgety. I mean, you could tell that she was unhappy. You know, again, she wasn't verbal to me, but I could just from her body language, she just felt very annoyed and bothered and just, like, had an overall agitation, moving around, that kind of thing.

Q Were you aware at the time you were treating Grace that Grace had Down syndrome?

A I was.

Q Okay. In regard to your treatment of Grace, did her diagnosis of Down syndrome, did that impact your care in any way?

A No.

Q Okay. You didn't adjust any treatments or any methods or modalities to account for Grace's Down syndrome?

A No, there's no need. She was a high-functioning Down syndrome. She had no -- on review, she had no, you know, altered anatomy or anything from like a cardiac perspective or pulmonary perspective, apart from obstructive sleep apnea, which was the only thing that was in consideration of her care. You know, we list those diagnoses mainly to create an awareness that if there are issues in association with Down syndrome that you should be aware of them.

Q Okay. We're going to go to the discharge summary.

A Okay.

Q I'm going to give it to you.

A Thank you.

Q Dr. Shokar, I just handed you what's been marked as Exhibit 74. Do you see the 74 there on the bottom right?

A I do.

Q This discharge summary purports to be authored by you. Do you recognize this discharge summary?
A I do.
Q Did you author this discharge summary?
A I did.
Q Take a moment if you'd like, but my question is: Does this discharge summary appear to be a true and accurate representation of the discharge summary that you authored?
A (Witness reads.) Yes.
Q The date of service on this discharge summary is October 13th.

Does this document relate to Grace's condition on October 13th, 2021?
A Yes.
Q And just to be fair, there are some comments in this note about how Grace presented, and obviously that did not happen on October 13th, correct?
A Correct, yeah. This is a summary of the entire hospitalization, which is what is generally reported out on a death summary.
Q This document reflects that you dictated this discharge summary on October 17th at 2239 hours; is that correct? Is that when you dictated this?
A It must be, yeah.

Q Okay. Is there any reason why -- or why would it be four days later after the death? Why would you have dictated it four days later?

A I thought about Grace's death -- let me rephrase. You don't have to dictate a note right away, essentially. I do that normally for progress notes and H&Ps, because it needs to be in the record for other staff to review, you know, so that they can manage -- they know what's going on and whatnot. When it comes to discharge summaries or death summaries, I usually -- I don't dictate those right away. Plus, I had to review, you know, the rest of the chart, you know.

Q Sure.

A And then, you know -- so this becomes more of like I'm not doing that right after she dies, you know. I'm doing -- I was not -- I was not on service either, so I didn't get the -- you know, I didn't have the -- really the time to kind of just do it right away. I had other duties as well.

Q That's fine. Approximately in the middle, if you go down the left side, you'll see a line beginning with "that" and then following that word.

Are you with me?

A Sorry. Where?

Q There's a sentence beginning, "There were multiple discussions," but the beginning of that line has the word "that." It's about halfway through the paragraph.

A Yes, yes, yes, yes.

Q So there's a sentence there, it says, "There were multiple discussions with family in regards to her plan of care and considerations for goals of care and worst case scenario."

Are there any conversations at the time of Grace's care that you had with Grace's family that we have not discussed today?

A Let me think. One, two, three -- just the conversation we had after the day of her passing.

Q Okay. And what day was that?

A That was on October 14th in the morning, I talked to Scott by phone, again, probably about a half an hour or so, kind of as a, you know, almost as a debrief, really, to go over the events of the preceding night.

Q And we established that Grace died on the 13th. You said this was the 14th?

A Correct, yes. This was the day after when I got in.

Q And did you initiate that call or did Scott

initiate that call?

A Every communication in the morning through the 12th, 13 and 14, generally I would call, but Scott would always beat me to the gun and actually request a call.

Q Me too. He does that to me, too.

A Yeah. So he -- I could say he requested it, but it was something that was going to be delivered to him regardless.

Q But you did talk with him on the 14th?

A I did.

Q Did Scott ask you the question on the 14th whether Grace's -- Grace would have lived if she was put on a ventilator?

A I believe so.

Q Okay. And how did you answer that question?

A Um, to be honest, I don't recall the exact specifics. What I went over, you know, was that somebody who has been on BiPAP for, you know, a few days and is developing fibrosis in the lungs as seen on her imaging, and has COVID, has a very poor prognosis of being -- you know, poor prognosis surviving intubation. It's generally understood about 10 to 20 percent or so.

Again, that was -- I don't know

confound -- 'cause I don't know if I talked to him -- I talked to him about that on the 13th. I'm not sure if I talked to him on the 14th.

Q Okay. But it could have been either day?

A One of the days, yes. It was definitely the 13th, because I had that conversation about -- very extensive about intubation -- let me rephrase.

I talked to him on the 12th about intubation and everything that it pertained inclusive of, you know, the chance of recovery from a COVID patient, the need for tracheostomy if you're going to be intubated after about seven to ten days, the need for a PEG tube, all that was discussed so that he can make an informed decision.

The 13th conversation established right away that, you know, they convened as a family and wanted definitely to be DNI, and then on questioning afterwards about DNR, he needed me to review that again, and so which we did.

And then on the 14th, he asked mostly, as far as what I recall, about morph -- you know, did you have to give morphine, would that have had any effect on, you know, her passing. And that's honestly what I mostly -- it

was a shock. You know, he -- I was trying to -- he just suffered a loss. I wasn't -- I wasn't -- I was trying to give him answers to his questions without imparting hurt.

Q Um-hmm. The fifth line from the bottom begins the sentence, "Unfortunately, on October 13th" -- do you see that?

A Yes.

Q Okay. It says, "Unfortunately, on October 13th, 2021 she," being Grace, "developed sudden and significant hypotension and bradycardia after being on high levels of BiPAP pressures for a few days."

Is it your recollection as you sit here today that she did develop sudden and significant hypotension and bradycardia?

A That was what was reported to me that that's what happened. It's a -- it's a way around saying she had a cardiac arrest, because I couldn't confirm myself she had a cardiac arrest.

Q Based on your treatment of Grace and your review of the records, do you have any idea on why those two conditions would suddenly develop?

A They -- they developed a bit -- remember when I went into that room, she was having a little bit

of bradycardia and I turned off the Precedex at that time to take away that as a confounding factor. But this is a consequence of hypoxia.

If you have, you know -- eventually if your tissues are hypoxic, you know, and you're not getting nutrition, your body's going to shut down and you end up suffering a cardiac event. That's what's going to happen. It's inevitable -- it ended up being an inevitable outcome, unless you had appropriate tissue oxygenation. So that's how it looks. You don't -- I mean, people who have respiratory issues, that's what ends up happening, you have bradycardia and you get hypotension.

Q In October of 2021 when you were treating Grace, did you know what the halflife of Precedex was?

A Six minutes. I did know.

Q Six minutes?

A Um-hmm. That's why I turned it off right away and waited.

Q While you were treating Grace in October of 2021, was Dr. Beck involved in any way with Grace's care to your knowledge?

MR. GUSE: Object to the form. Vague and ambiguous as to time.

BY MR. PFLEIDERER:

Q Okay. While he was treating Grace.

A Dr. Beck's a nocturnist. He took over care at 7:00 for me on the 13th and the 12th, I believe, because I think he was on that day, too. He works 7P to 7A -- I'm sorry, 6P to 6A. We switch off at 6 here, so he was on at 6, but I was still in the hospital by, you know, like I said, 6:30 on the 13th, so I signed out to him when I got back after I left the unit. Do you need me to clarify that?

Q Yeah, please. You just threw a couple times out.

A Sorry. I apologize. I'm confounding my new job.

Q No need to apologize. We're in a different time zone.

A Yeah, we're on different -- the schedule here was 6:00 a.m. to 6P, and then the nocturnist comes in 6P to 6A. And so we have 24-hour coverage in the hospital, but that's our shift times.

So I was here obviously till 6:30, you know -- you know, dealing with that crisis. When I eventually left the unit, I went back and we started preparing our sign-out for doctor -- for the nocturnist. So he was involved in that capacity where he covered over the night.

Q And you said that you left after the crisis at

approximately 6:30?

A Yeah, I think it was around there. It was late. Every night I was going -- the 12th and the 13th I was home late.

Q And you said at that point Dr. Beck took over care for you?

A Correct.

Q Okay. Dr. Shokar -- whoops -- I'm going to hand you what's been marked as Exhibit 75.

A Yes.

Q Okay. Did you get that piece of paper there?

A Yes, I did.

Q Is there a 75 there at the bottom?

A Yes, there is.

Q Okay. This is a record that I received from Ascension Health. I'm not asking you to testify as to its authenticity, but I am going to ask you a couple questions about some things in this document.

MR. BIRNBAUM: John, before you start, could you give me the Bates number, please?

MR. PFLEIDERER: Yeah, sure. I've been trying to do better about that, but I forget every time. It's Ascension 01008.

MR. BIRNBAUM: Thank you.

BY MR. PFLEIDERER:

Q This document purports to be a record for an order for morphine, and the time of the order here, just have to find it -- oh. The time of the order appears to be 1830 hours.

Is this, to the best of your recollection, did you put the order in verbally for morphine at 1830 hours?

A I don't know the time, but -- that seems a little late, but it was at the -- it was -- doesn't it say 1815 here? Is that not --

BY MR. PFLEIDERER:

Q That looks like the administration time. And what I'm wondering is, you give a verbal order maybe to Hollee McInnis, and then it doesn't actually --

A We were -- we were -- we were in like an event, right?

Q You were --

A We were in the room together --

Q Yeah, yeah.

A -- trying to stabilize Grace. So she was helping me. I gave the verbal. She got the med. She administered the med. She probably recorded it after, as far as what I'm assuming, because this time may not be reflective of the actual time. It

may have been prior.

Q Yeah, and that makes sense to me.

Down there at the bottom it says -- there's a bold type there, it says "SIG" and then next to that it says "p.r.n. Q4H"?

A Um-hmm.

Q Now, based on our discussion earlier, I interpret that to mean an as-needed every four hours order; is that correct?

A Correct, yeah.

Q Is that the type of order that you put in for morphine at approximately 1815 or 1830 hours?

A Yeah. Due to the success of the morphine administration in improving her oxygenation and the fact that we had turned off the Precedex, and I didn't have many tools -- I mean, you only have -- normally have two tools, Precedex, Ativan, to help with agitation. Her respiratory rate was 60, went down to 40. There was a definite improvement in her oxygenation as far as I could see on three different monitors that were attached to her. You know, so I felt that morphine was a good medication that we could use in the future, you know, to keep her -- you know, if she was having this event happen again in regards to, you

know, hypoxia from high respiratory rate, this would be the medication that we could potentially use to avert any further crises.

Q And just to be clear, you said that you turned off the Precedex prior to your order for morphine; is that correct?

A Correct. The first thing I did in the room after my primary survey was notice that the heart rate was lower than I would have liked. Knowing the effects of Precedex and the consideration of other modalities I could potentially use during that time period, the first thing I needed to do was remove Precedex. So that was initially discontinued.

Then we did the -- you know, then I was in there evaluating Grace for enough minutes that would pass where I'd feel reasonably confident that I could give another agent, which would have been the morphine, if I needed to, and determined that I did need to. I mean, she was breathing incredibly fast. She didn't wake up from not having Precedex or so. There's no other medication I really could have given at that time, apart from an opiate. And so I gave the lowest dose I could, which is a 2-milligram dose under

what is normally given. But, you know, I gave that to just wait and see what happens. And it seemed like the 2-milligram dose, you know, was sufficient enough to bring her respiratory rate down from 60 to 40 and her oxygenation up. I waited a bit. I went outside the room. I called Scott and monitored her from, you know, outside the room to see what, you know, what the effects of the morphine, if it was going to persist. And it seemed like she was doing okay by the time I left the unit.

Q On that phone call you had with Scott, did you tell Scott that Grace had had a good day?

A On that phone call?

Q Yes.

A I don't think so.

Q You don't think that you did say that, or you don't recall?

A No. What I would have said is that she's stable and that she's doing okay right now. I -- not that she had a good day. She didn't have a good day. We -- I called him prior to that indicating that she didn't have a good day. She was on 20 over 15. She was stable from her -- in regards to her oxygen saturations, whatnot, but she was in

febrile crisis. She had a fever and all that kind of thing. So she -- that was all reported to him. I said she was doing okay right now.

Q Sure. I get it.

A 'Cause, you know...

Q Was anybody else in the room with you when you discontinued the Precedex?

A Yeah. Nurse McInnis was there. She's the one that stopped it. She was in the room with me. And Jessica was there, too.

Q Did you give a verbal order to Nurse McInnis in that room to turn off the Precedex?

A Correct, yes, it was a verbal order.

Q And you said that was at approximately 5:45 p.m.?

A Yeah. I would -- I think so. It was like quarter to 5:00-ish.

Q Quarter to 6:00?

A Quarter to 6:00-ish. Sorry. Yeah. Around there. I don't know the specific time, to be honest, because it was all -- everything is moving fast when you're in those situations.

Q At any time -- at any time during your treatment of Grace, did you ever consider transferring Grace to another hospital?

A No.

Q Are you aware -- or I should say, or were you aware in October of 2021 while treating Grace of any synergetic effects of Precedex and morphine being used together?

MR. GUSE: Object to the form of the question. Vague and ambiguous. You can answer if you understand the question.

A I was aware.

BY MR. PFLEIDERER:

Q Okay. And what were you aware of?

A They are all CNS depressants.

Q And what does that mean?

A It means that Precedex, Ativan, morphine, these class of medications are all essentially depressants. And I was well aware that if you're going to combine depressants, you should be a bit careful, you know, about doing so. You don't just do it right -- you know, without context. You do it in -- if you need to, and you do it at a lower dose, which is what I implemented.

Q And that's because when there's too much of it, it can depress the central nervous system too much?

A Generally it's a dose-dependent issue. You know, like, for instance, with morphine, it's usually higher doses, accumulating doses.

You mentioned Precedex earlier regarding about time frame when morphine is used in an accumulated dose over time, you know. So you always want to -- you always want to keep that in consideration. If you are going to add a morphine derivative, you know, I didn't want to add it to three things, so I stopped the Precedex as fast as I could. But I had -- I was forced to kind of give something to help the situation out, and the only tool I had in the tool bag was morphine. And again, knowing that she had already had Ativan, too, I gave the lowest dose possible and then monitored.

MR. PFLEIDERER: What time is it?

BY MR. PFLEIDERER:

Q Dr. Shokar, before I give this to you.

In October 2021 when you were treating Grace, were you aware of the halflife of morphine?

A I was.

Q Okay. And what was it?

A It's like about -- it's an estimate of the duration being around three to four hours.

Q Three to four hours?

A Um-hmm.

Q I'm handing you what's been marked Exhibit 76.
Aaron, this is Ascension No. 00102 and the following four pages.
Sure. I guess before we get into this, when you were treating Grace in October of 2021, Dr. Shokar, were you aware of the halflife of Ativan or lorazepam?
A Yes.
Q Okay. And what was it?
A That's a longer one. That's like, you know, 40 hours or so.
Q Forty hours?
A Yeah. It's longer.
Q Dr. Shokar, this is a document that I received from Ascension Health. It purports to be a Medication Administration Summary for dexmedetomidine. Did I say that right? Tomidine?
A Sure. I mean Precedex. Yep.
Q Precedex, yep. And as you flip through these pages, you can see these purported administration dates by various nurses at different times including administrations on October 12th and October 13th when you were treating Grace Schara.
And assuming this medication administration is accurate now -- have you seen it

before?

A No. Apart from my review from the documents that Mr. Guse sent me.

Q Assuming it is accurate, it does reflect an actual order.

As Grace's treating physician, would you have the authority to modify this order for medication?

MR. GUSE: Object to the form of the question.

A Clarify.

BY MR. PFLEIDERER:

Q As her physician, could you have set a limit on the titration rate for Precedex?

MR. GUSE: Object to the form of the question. Vague, ambiguous, incomplete hypothetical.

BY MR. PFLEIDERER:

Q You can answer if you understand the question.

A I don't touch Precedex. I don't titrate Precedex. I stop it if I need to. I don't start and I don't do titration orders for it. That's in the realm of ICU.

Q Okay. Did you ever bring up any concerns -- strike that.

During your treatment of Grace Schara in October of 2021, did you ever raise any concerns regarding the use of Precedex to Dr. Gandev?

A I did not.

MR. PFLEIDERER: Take a quick break here? Wrap it up, hopefully, after that.

MR. GUSE: Yeah, that sounds good.

VIDEOGRAPHER: We are going off the record at 5:42 p.m.

(Brief recess taken from 5:42 p.m. to 5:53 p.m.)

VIDEOGRAPHER: We are going back on the record at 5:53 p.m.

MR. PFLEIDERER: 77.

BY MR. PFLEIDERER:

Q Dr. Shokar, I'm handing you what's been marked as Exhibit 77.

Are you familiar with a person named Lorna Speid?

A Not off the top of my mind. Who did you say it was?

Q Her name is Lorna Speid. Let me ask you a better question.

Are you aware of anyone filing a

complaint against you with Wisconsin DSPS in the past year or so?

A Yes.

Q Okay. And if I told you that person was -- or I'm sorry. Has there been only one or has there been more than one?

A There has been two, the first being Scott a month after, and then randomly more recently someone filed for the same situation --

Q And if I told you --

A -- which is this one.

Q -- that person was Lorna Speid, you would agree with that?

A Makes sense, yes.

Q This is a document that we received from a public records request to the state of Wisconsin.

Have you ever seen this document before?

A I did briefly review it before, I think.

Q Before this deposition?

A Yes.

Q In preparation for this deposition?

A No.

Q Okay. Do you know if you reviewed this document prior to it being --

MR. EDMINISTER: Submitted?

MR. PFLEIDERER: Well, let me strike that.

BY MR. PFLEIDERER:

Q Do you know whether this document was submitted to Wisconsin DSPS?

A I mean, I don't know that for a fact. I know that it was sent to me prior to -- or along that process of -- of the complaint, because Mr. Guse was the one that was helping me out for that.

Q And you mentioned that you did review this document. When you reviewed this document, did you find that it was accurate? To the extent --

A I --

MR. GILL: Counsel, this is Gill. Can I just impose an objection to form on the record?

MR. PFLEIDERER: What's the problem with the form?

MR. GILL: I don't think that there's any relevance or admissibility, but go ahead.

MR. PFLEIDERER: You can answer the question.

MR. GUSE: I'm sorry. Can you read back the question. I didn't catch it.

(Question read.)

A When I reviewed the document, I was happy with it. I didn't dissect it to a degree in which I could verify every aspect being completely accurate, but the overall context, I agreed with.

BY MR. PFLEIDERER:

Q Was there anything in this document that you saw that you believed to be inaccurate?

A I would have to rereview it, to be honest, but do you mean at that time?

Q Yeah, at that time.

A I signed off on it, so I'm assuming no.

Q Okay. This is the last -- well, probably the last thing that we're going to talk about. Okay.

(Discussion off the record.)

Q You're familiar with Scott Schara being the father of Grace Schara?

A Yes.

Q Are you aware that -- or do you have any knowledge of Scott Schara making public statements about your care of Grace while she was in the hospital?

A Yes.

Q Okay. And has anybody contacted you as a result of those statements, or has anybody threatened you, do you believe, as a result of the statements that Scott Schara has made?

A The fallout from that was in large part negative retaliation online in the -- in the aspect of commentary. I did not get any -- I did not receive any personal -- personal phone calls or anything like that.

Q Did you receive any personal threats?

A I didn't receive any personal threats.

Q Did you receive any in-personal threats?

A Clarify that.

Q I don't know. Just thought I'd ask.

And when you say commentary online, are you talking about -- where are you seeing this commentary?

A First commentary I saw was actually on -- just when you type in my name, there would be negative commentary on Dr. Gavin Shokar on Google, for instance.

Q When you type your name on Google, on a Google search?

A Um-hmm, um-hmm, yep. Obviously, every article that he has my name in is linked now to my name, so everyone who Googles me has that.

As well as, you know, the commentary that has come down on Google, I have to keep flagging to say it's inappropriate because

these are people that I don't even know and they don't know the context of things, and they're running on, you know -- I'm bound by HIPAA. I can't say anything. I'm not -- I do not talk about the case.

But the other side is able to talk about whatever they want to talk about. So it leads to, you know, an inappropriate perception of -- a non-balanced perception of events. And so the consequence is that I get negative reviews and negative commentary online, and questions and those kind of things. But...

Q And have those negative reviews, have they affected your career, professional job?

MR. GUSE: Object to the form, foundation, speculation. To your knowledge.

A The biggest effect they've had is on my psychological well-being, I would say. There was elements of security threats at the time when this was going on. There was additional security that had to be posted outside, you know, our car so we had to be exiting particular entrances and exits. It made me feel uncomfortable in Appleton in general, because I didn't know who was reading what.

And, yeah, so there was an overall sense of, you know, a safety issue on one end, a psychological issue on the other end. But as far as a monetary thing, I'm a shift worker. I get paid by shift. I have a job, so it hasn't been able -- I haven't had a problem thus far, but I transferred from an Ascension to Ascension facility. I have no idea if I put my hat in another system if they're going to Google review me and it's going to be deleterious to my career.

BY MR. PFLEIDERER:

Q What did you mean by elements of security threats?

A Ascension actually had a security person watching the exits when we entered and left because of all the negative commotion that was going on online.

The -- the overall sense from the hospital and all the physicians, nurses that -- you know, we were at -- a little bit at risk because of this. Because, you know, when you have this level of -- or this degree of response, you're going to have the concern that there's going to be -- it was going to be taken up a notch.

And the medium that was used by Scott and his family was -- the postings was on,

you know, places like Rumble.com and whatnot, which is, you know, the perception was that the audience of these media outlets would be more readily to take action into their own hands and, therefore, there was a perceived security issue because of that, because of the chosen outlets and the people associated and the commentary from those pieces of media that were produced, which included things like these people should all, you know, you know -- basically negative, untoward things of, you know, they -- I don't even -- I didn't really try to look at any of the stuff, to be honest. Initially it was just like rumors and reports and I saw one video, but that was it. So I can't really comment further on that.

Q As you sit here today, do you feel that there is a physical threat to your safety because of Scott's commentary?

A I still do.

Q You still do?

A I still do. It was another factor for me leaving here. Not the main one, but it was definitely a minor factor.

Q Has anybody ever personally in front of you ever expressed anger towards you?

A No. Actually, I'm thankful for that, yeah.

MR. PFLEIDERER: I think we're done.

MR. GUSE: A little louder, please?

MR. PFLEIDERER: We're done.

MR. GUSE: Okay. Thank you.

Aaron and Jeremy, maybe we can start with you guys on Zoom, if that's okay.

MR. BIRNBAUM: I don't have anything.

MR. GILL: Nothing here.

MR. POJE: I don't have anything.

MR. FRANCKOWIAK: Dr. Shokar, I just have a couple of clarification questions for you.

THE WITNESS: Sure.

VIDEOGRAPHER: Microphone.

MR. FRANCKOWIAK: My name -- oh. Put this on here.

VIDEOGRAPHER: Thanks.

MR. POJE: You're out of practice.

E X A M I N A T I O N

BY MR. FRANCKOWIAK:

Q I represent the hospital and the nurses, so I just wanted to clarify a couple of things.

Going way back towards the beginning of your deposition, there were some questions that were put to you as to whether or

not you had personally observed any staff at the hospital attempting to try to redirect Grace without medication, for example, to handle her -- her agitation without medication.

Do you recall being asked those questions?

A Yes, I do.

Q Okay. And you had mentioned that while you were in the room, you didn't necessarily see any such instances. Fair statement?

A Correct. Yeah.

Q When you would see -- when you would be in the hospital seeing Grace, she would be one patient that you would see, but you would have other duties with other patients in the hospital, too?

A Yes.

Q Okay. So when you would be in her grace -- or in Grace's room, would it be for limited periods of time at any given point?

A Yes.

Q Okay. And would you anticipate that the nursing staff would, of course, be -- have much more time to spend with Grace than you necessarily would?

A Yes, as a general structure, yeah.

Q Okay. So in terms of whether or not the nursing

staff was expending efforts to try any number of -- of behavioral modifications or redirection during times when you were not in the room, you wouldn't be able to speak to that, obviously?

A There's no way, yeah.

Q Okay. Now, I understand you also talked about --

A Also, there wasn't -- I mean, many of the first times there wasn't a nurse in the room when I saw her the first day, for instance. They're around, but they don't come in with me all the time. Right?

Q Oh. The nurses are in the room when you're not there all the time?

A Correct.

Q There also have been -- you were asked a number of questions on Precedex, for example, and you've mentioned what the halflife of Precedex is and you were aware she was on Precedex, and eventually you did order the stoppage of the Precedex on the 13th.

You remember testifying about that?

A Yes.

Q Okay. Would it be fair to state that at least up until the time that you ordered the stoppage of the Precedex, the value of the Precedex or the

benefit of the Precedex outweighed any potential drawbacks of the Precedex through that time?

MR. PFLEIDERER: Objection. You can answer. I just -- I'm just objecting. You can answer.

A Sure. I -- yes, I would assume that the advantage was outweighed -- outweighed, you know, the negatives. A large part of that -- a large part of the assessment of the value of Precedex and the response to that would be done via the nursing, you know, bedside, as well as in collaboration with ICU attending, yeah. Um-hmm.

BY MR. FRANCKOWIAK:

Q And if the nurses saw the increases in agitation, they would handle the Precedex titration?

A Correct, yes.

Q Okay. Now, I think you had also mentioned -- you also were asked some questions about that time on the evening or the late afternoon of the 13th when you were in the room managing the care of Grace, and I think you said you -- Hollee McInnis was there with you at the time.

Do you recall that?

A Yes, yes.

Q Okay. And it was during that time when, I

believe, you'd said you gave the verbal order for morphine which was then administered?

A Yes.

Q Okay. And I believe you'd also mentioned that after you were there in the room for a period of time after that to kind of monitor Grace to see how she was doing?

A From the morphine?

Q Yes.

A Yes. After I gave the morphine, I was in the room reassessing her, personally doing blood pressures on her. Hollee was as well, you know, making sure that things improved. That duration of time was a good ten minutes, I would say. I felt comfortable leaving that room that I could continue monitoring from outside the room. Hollee was still in the room, I believe.

Q Okay. And I think you had mentioned that when you left the room, based upon what you were seeing, her reaction to that medication, is that she had stabilized and you had believed she was stabilized because of that intervention, the morphine that you had ordered?

A Yes, definitely. I felt, like, relieved that, oh, my gosh, she stabilized, and her oxygenation --

you know, remember, there's three monitors attached to her, which was, you know, confusing.

Q Um-hmm.

A You know. And all three of them actually improved, so I was, like, okay, we have consistent reading, you know, her respiratory went back down to 40, which is what she was doing previously as well. It's not ideal, but it's still better than 60. And I felt the intervention was successful.

Q Okay. And then by the time you left the room and you had noticed that she was stabilized based upon what you were seeing after the administration of the morphine, was there any reason in your mind at that time to consider the use of a reversal drug for the morphine, that the morphine might need to be reversed in some manner for her safety?

A No, not at that time. Again, it was -- it was a small dose, 2 milligrams. It was one time. She hadn't been on opiates prior, you know. So if you're on larger doses, usually with like morphine equivalents of 50 and above is kind of -- you know, if you -- that's kind of when you start wondering about should we have naloxone handy, you know. Even below that, if you want, depending on the circumstances. But 2 milligrams, I didn't

have any -- any inkling to say that we needed to reverse 2 milligrams. That would have been --

Q And this was not a situation that required you to even consider a reversal drug, because it actually had the effect you wanted it to have?

A It worked, yeah. It worked. And if I reversed it, then the concern she would be back to square one with a respiratory rate that's too high and I don't have anything else to give. And we can't intubate, so...

Q Okay. I think you had also mentioned at the time during this same time about the Precedex being turned off, and you mentioned that Hollee was in the room. And Hollee was actually the one who turned the Precedex off?

A Yes, she was.

Q And did you see her turn the Precedex off?

A I saw her go to the IV, the area and was -- I mean, I didn't directly see her turn which pump off or whatnot, because I was managing Grace. But she did walk over and start fiddling with the IV.

Q And in terms then of when she actually put into the record like the timing of the record for when she turned it off, I assume you wouldn't be able to speak to that?

A I have no -- I have no idea when she did that. She was with me bedside, you know, I was telling her let's do this, do this. So in between she was trying to get back to the computer and floor, and I'm not -- you know, trying to order the morphine, trying to order this, you know, so I'm not -- I have no idea when she actually put the order in.

Q And I think as we looked -- I think you were shown like the medication order for the morphine. It looks like it was maybe given at -- was it 1815 but it was entered 15 minutes later. That's not unusual in a case of like an emergency situation?

A It's not unusual, no.

Q Okay. When Hollee gave her deposition, she mentioned that that period of time when the morphine was being given, the Precedex was being turned off, the condition -- this was kind of an emergency situation; would you agree?

A Definitely.

Q Okay. So in terms of in an emergency situation, that's where you would be giving the orders and you'd be administering medications and you'd worry about putting notes in the record after you've handled the emergency?

A Yes, correct.

Q Okay. I think you had also mentioned that you were aware that Grace had recently received some Ativan.

Do you remember around that time when you were in her room knowing that she had also received some recent Ativan?

A Yes.

Q Okay. And had Hollee informed you that she had given some Ativan?

A Hollee called me prior to me getting to the room --

Q Okay.

A -- and, you know, to kind of give me a report of, hey, you know, she's hypoxic and we tried proning and it's not working. And usually -- I had a conversation say, well, what's -- give me the status update, what's going on. Still very tachypneic, respirations are high, hypoxic, in the 50s. She didn't tell me that there was two other monitors on. I found out that later and whatnot, but -- you know, so she was saying -- you know, I tried to piece together what's the reason for it. In my mind, I'm kind of, like, is this just an escalation -- is this an escalation of the inflammatory response, is this, you know, the next

part of that, or is this -- could this be from anything else. And from her report, maybe she was anxious still, you know, agitated, she's -- respiratory is at -- pretty high.

So my order to her was let's get another -- let's give another dose of Ativan and I'll be down in a sec to kind of, you know, see what's going on.

Q Okay. So as I understand it, Hollee had given you a call and established contact with you, let you know how she was doing, and say, you know, Doctor, I just gave her a dose of Ativan and it's not -- it's not accomplishing what we needed.

A Yeah. She got the regular scheduled dose of Ativan at that time, I believe, but it wasn't doing anything, and it was kind of a starting dose as well, so we had room to go up on that if needed.

You know, she -- my -- my -- my idea was, okay, well, we already have Ativan going, let's give her another .5, make it a milligram. Because I think she just got Ativan like, I don't know, 15 minutes ago or something. Again, it wasn't doing anything for her.

So the only -- again, I had two

tools in the tool bag here, give a little bit extra Ativan or give -- or switch to morphine, and I wasn't going to do that without seeing her and seeing the situation. So the first step was give her an extra dose of Ativan, which is -- 1 milligram is not an unreasonable dose either. And then I went down to assess her.

Q Okay, okay. And that was -- I think you'd also mentioned because you were asked some questions about what a PRN, what it means to be like a PRN or Q4 or Q6, something like that.

A Um-hmm.

Q So if the Ativan in the record was a Q6, but the records do indicate that Grace was given a Q6 dose and then several minutes later Hollee administered a second dose --

A Um-hmm.

Q -- that would be consistent with her obtaining your order for that?

A Yeah.

Q And that's acceptable?

A Yeah. So she gave -- the initial dose was p.r.n. or as-needed dose, which was already in the medication, you know, list that she could give. But for her to give anything else, she'd have to

ask me. You know, she needs authorization. So I verbally ordered, you know, additional Ativan for her to see, you know, what the effect would be in hopes that it would reduce the respiratory rate or help her out a little bit in oxygenation purposes.

Again, the going theory was either she's declining and the next step is intubation, which we weren't going to do, or could there be something else going on like anxiety, you know, in which case -- and we already knew she was agitated. You know, she was on Precedex for that reason. So the logical conclusion would have been let's see if we can control the anxiety and agitation more. Maybe that will help with the oxygenation by reducing the respiratory rate.

ABGs had been pending all the time. It was like, you know -- also ordering ABGs at the time to -- to, you know, confirm from a -- from a quantitative reason or the blood gas to see if there's actually -- that PCO2 from before we were talking about, and that PO2 to see what's going on, yeah.

Q Okay. And in working with Hollee on the 12th and the 13th, to your recollection did she implement the orders that you gave her? Do you have any

reason to believe she didn't implement any of the records you gave her or anything like that?

A I mean, I would assume she implemented the orders. She's a good nurse. She basically -- I mean, the record probably reflects that she gave the extra dose, I'm assuming.

Q Okay.

A Yeah.

Q Okay. The last thing I have for you, I guess, Doctor, is that in looking -- you did obviously the discharge summary at the end that talks about the care.

A Um-hmm.

Q When you drafted that, did you have any reason to believe that Grace's death was related in any way to the administration of any of the medications that had been given to her on the evening of the 13th?

A No. No, no, no.

Q And as you sit here today, do you have any reason to believe that her death ultimately was the result of any of the medications or a combination thereof that were given to her on the 13th?

A No.

MR. FRANCKOWIAK: Thank you, Doctor.

That's all I have.

MR. GUSE: Doctor, I just have a couple clarifications questions.

THE WITNESS: Sure.

E X A M I N A T I O N

BY MR. GUSE:

Q One, you remember you were asked some questions at the very beginning about -- in your initial note about your commentary that Grace was somewhat cooperative.

You recall those questions?

A Yeah.

Q When you indicate in the note that Grace was somewhat cooperative, is that a criticism of Grace, or is that just simply a clinical observation?

A It's not -- that's not a criticism. That's just an observation to -- to -- it was more the opposite. It was trying to elicit the fact that she was trying.

Q So from your perspective, it was more of a -- it was meant to be more of a positive comment?

A Yes.

Q Again, based on your review of the records or the chart in preparing the death summary, did you see

any evidence that Grace's death was caused by a bacterial infection?

A No.

Q Any indication or any evidence in the record that Grace's death was caused by legionnaires disease?

A No.

Q You were asked some questions towards the end of counsel's questioning about -- concerns about your safety and some of the commentary.

Are you aware of whether or not you have been referred to as a killer or a murderer in publications?

A Yes.

Q Does that cause you to be concerned about your safety?

A Yes, I mean, for retribution sake.

Q You understand that this deposition today is being recorded by video?

A Yes.

Q Do you have any concerns about -- strike that.

Should this video be published on social media or in any other media, do you have -- would that cause you to be concerned about your safety?

A Yes.

MR. PFLEIDERER: Object. You can answer.

BY MR. GUSE:

Q Similarly, if the actual written transcript was published on social media, on Facebook, or some other medium, would that cause you concern for your personal safety?

A Yes.

Q Do you have concerns about the impact of this case in terms of the personal safety of your family?

A Yes.

Q Doctor, in terms of the care that you -- care and treatment that you provided to Grace Schara on October 12th and 13th, 2021, do you believe that the care and treatment you provided met the standard of care?

A Yes.

MR. GUSE: Thank you, Doctor.

MR. PFLEIDERER: Just a couple.

E X A M I N A T I O N

BY MR. PFLEIDERER:

Q Dr. Shokar, you just testified that certain commentary in this case would lead you to have concerns for the safety of your family.

A Yes.

Q Has anyone in your family received threats in regard to the commentary in this case?

A No.

Q Has anybody, to your knowledge, ever physically approached a member of your family?

A No.

MR. PFLEIDERER: Okay. That's all I have. Thanks.

VIDEOGRAPHER: Thank you. This concludes today's deposition of Gavin Shokar, M.D. We are going off the record at 6:21 p.m.

(Deposition concluded at 6:21 p.m.)

(Original exhibits attached to Original transcript; copies of exhibits are attached.)

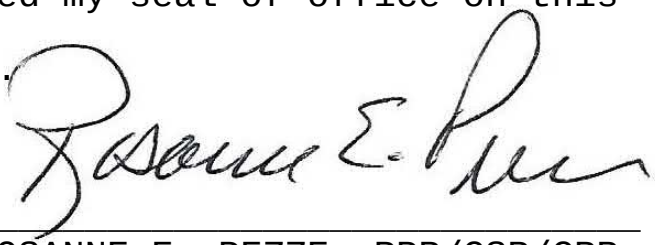
STATE OF WISCONSIN)
) SS:
MILWAUKEE COUNTY)

I, Rosanne E. Pezze, RPR/CSR/CRR and Notary Public in and for the State of Wisconsin, do hereby certify that the deposition of GAVIN SHOKAR, M.D. was recorded by me and reduced to writing under my personal direction.

I further certify that said deposition was taken at 1506 South Oneida Street, Appleton, Wisconsin, on the 22nd day of May, 2024, commencing at 1:07 p.m.

I further certify that I am not a relative or employee or attorney or counsel of any of the parties, or a relative or employee of such attorney or counsel, or financially interested directly or indirectly in this action.

In witness whereof, I have hereunto set my hand and affixed my seal of office on this 2nd day of June, 2024.



ROSANNE E. PEZZE, RPR/CSR/CRR
Notary Public
My commission expires January 10, 2026

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