

My 85-year-old father, Don Schmitt, was admitted to Lakeview Hospital in Stillwater, Minnesota, on November 14, 2021, with severe hypoxia and COVID-related respiratory illness. I was his medical advocate. He died there on December 2, 2021.

My father was unvaccinated. In the emergency department, I immediately refused remdesivir. After that refusal, I personally experienced the environment as hostile and confrontational. I became concerned enough that I called my brother and kept him on the telephone to witness the interaction. The medical record later states that remdesivir was outside the therapeutic window and that my father had stated he would not want it.

My father had a DNR/DNI and did not want mechanical ventilation. He also had a massive ventral hernia resulting from complications of a previous surgery performed at this same hospital. His abdominal organs were directly beneath the skin, making prone positioning unsafe and impractical. The medical record documents that he was unable to prone because of the massive hernia. I repeatedly advocated for treatment adapted to his individual condition and specifically warned staff that I believed the protocol being followed would kill him.

We requested treatments being advocated by FLCCC at the time, including ivermectin and high-dose vitamin C. The hospital refused our requests. My father wanted ivermectin. Our family became so desperate that we sought help obtaining it ourselves, including through a priest, because the hospital would not provide it.

We also tried to have my father transferred or released so he could receive care elsewhere. We explored obtaining our own oxygen and private medical transportation, but no transfer occurred.

His condition was not a continuous decline. On November 24, I contemporaneously reported that he had gone overnight using nasal cannula rather than BiPAP. On November 25, I was told by a nurse that he was improving. On November 26, I was told his vital signs and laboratory results were good. As physicians and nursing staff changed, we observed significant differences in his care followed by deterioration.

By November 27, we were extremely concerned about food, hydration, positioning and mobility. Our contemporaneous communications document our understanding that he was not being adequately fed and was receiving limited fluids. We repeatedly intervened. We brought his power chair from home because sitting upright relieved pressure created by his massive hernia. His medical record confirms the family's request for the chair.

By November 29, he was dependent upon BiPAP, but he explicitly told his physician that he did not want to give up. Despite this, we were repeatedly confronted with discussions of comfort care, and I experienced nursing staff encouraging him to give up.

On December 1, family members documented my father refusing additional pain medication. He said, "No. No more," and indicated that medication given earlier was still affecting him. Another contemporaneous message states that he wanted a clear head.

On December 2, the medical record documents PRN Dilaudid administered during his deterioration, including two administrations. While he was still hospitalized, we were working with an attorney on a cease-and-desist letter attempting to intervene in his care when we were notified that he was dying.

When we arrived, my father appeared to us to have already died. He remained in his chair with the oxygen mask on, and his body was moving from the force of the oxygen. We demanded its removal. We were told a physician would not arrive for approximately another 20 minutes. The hospital recorded his death at 9:15 PM.

I am willing to testify under oath and provide medical records and contemporaneous communications supporting my account.