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March 27, 2012

VIA MAIL: Executive Director Carole Catalfo, Senator Roger Manno, Secretary Joshua Sharfstein VIA EMAIL: ccatalfo@dhmh.state.md.us, Roger.Manno@senate.state.md.us, jsharfstein@dhmh.state.md.us

Carole Catalfo, Executive Director Maryland Board of Physicians 4201 Patterson Ave Baltimore, Maryland 21215

Dear Ms. Catalfo,

I am in receipt of your letter dated March 9, 2012, in which you inform that my case will remain closed absent a legally sufficient basis to support a violation of the Medical Practice Act.

Ms. Catalfo, last month Dr. Sharfstein characterized your appointment as "the right person at the right time" to address concerns of underperformance at the Board of Physicians. At that time, Chairman Paul Elder told an interviewer that the Board often receives complaints that are investigated and closed without action for various reasons, but that *in many instances, additional evidence or complainants are offered and the case is reactivated, using both the older and more recent information*.

In light of the above I asked Senator Manno to contact your agency, and I am truly disappointed that you have chosen to rubberstamp its previous decision rather than move in a new and positive direction. I respectfully urge you to rethink your position and to consider using my father's case as a litmus test for achieving the competence and transparency you undoubtedly wish to foster.

The new evidence and sworn testimony that I presented to the Board clearly implicates multiple grounds under §14-404. While the terms *unprofessional conduct, patient abandonment, filing a false report* and *making a willful misrepresentation* leave room for interpretation, they certainly cannot all be summarily dismissed in the face of sworn testimony, as explained below:

In the final days of my father's hospitalization at Holy Cross, he was, in effect, euthanized against both his wishes and mine, by the doctors who treated him. The day before my father died, attending physician Dr. Shahid Shamim documented in his <u>progress notes</u> that my father was in acute respiratory distress, that he discussed the matter with me, that he called pulmonologist Dr. Kariya and that he ordered an ICU consult. The <u>death summary</u> written by Dr. Nawaz (the admitting & attending physician) adds detail, informing that Drs. Shamim and Kariya had a long conversation with me for further management because "the patient needed intubation at the time." It concludes by stating that I decided not to intubate my father, that my wishes were honored and that my father died the next day.

I took vigorous exception to the above, describing in my original <u>complaint</u> to your agency the undocumented presence of pulmonologist Dr. Jay Weiner, who in fact *refused* my impassioned plea for intubation, telling me that my father was "dead the day he got here" before walking away together with Dr. Shamim. To reiterate: the essence of my complaint - the Alpha and Omega of what I brought to your attention in January of 2006, was the abandonment of my father by his attending physician, Dr. Shahid Shamim, and by the undocumented pulmonologist he called in for an emergency consult, Dr. Jay Weiner.

It would take another two years to prove, but I did provide you with concrete proof of Dr. Shamim's abandonment of my father, in the form of Dr. Shamim's own sworn testimony that your agency accepted for review. Dr. Shamim had a very detailed recollection of the events in question, testifying under oath to the following:

- He was my father's attending physician and he understood my father's code status to be "full code," requiring intubation.
- My father was "recovering well," his condition steadily improving, and the plan of care on March 25, 2003 was for discharge to rehabilitation.
- He found my father to be in critical condition on March 26, 2003. He determined that the central, life-or-death issue was whether my father needed intubation, and he called in pulmonologist Dr. Jay Weiner for an emergency consult.
- He did not discuss the question of intubation or code status with me.
- He ordered tests at Dr. Weiner's behest and turned care of my father completely over to Dr. Weiner.
- He left the hospital without any knowledge of, or involvement in, the urgent treatment decisions that needed to be made, even though he was the attending physician.

Dr. Shamim's notations in the medical chart make no mention whatsoever of his handing over the care of my father to Dr. Weiner, yet he remembers doing so clearly and unequivocally. Dr. Shamim's testimony matches and confirms what I have been conveying to you all along.

Among the questions that your investigators needed to ask:

- How could Dr. Shamim fail to document his handoff of my critically ill father to Dr. Weiner at the very moment that pivotal decisions needed to be made?
- How could Dr. Weiner fail to document his presence and his accepting of responsibility for my father's care and for the treatment decisions that were ostensibly made?
- If Dr. Shamim turned my father's care over to a "nonexistent" doctor Weiner when my father was rapidly deteriorating and when he required life-sustaining treatment, who was responsible for providing this treatment?

Ms. Catalfo, please help me understand what the threshold requirements are for a charge of unprofessional conduct, patient abandonment, filing a false report or making a willful misrepresentation - and how a complaint like mine could be permanently closed after a *preliminary* investigation, without so much as contacting any of the principals.

I implore you to please conduct a new and serious investigation, taking the above into consideration and holding the bad actors accountable. Posthumous respect for my father and future deterrence mandate no less.

Sincerely,

Alexander H. Neustadter

Board's reply