1111 University Blvd West
Silver Spring, Maryland 20902
301-649-1319

January 3, 2006

Department of Health and Mental Hygiene
Maryland Board of Physicians
4201 Patterson Avenue
Baltimore, Maryland 21215

Dear Sir or Madam,

The four physicians named here committed very serious ethical and medical breaches of the standard of care in their treatment of my late father, Israel Neustadter, during February and March of 2003. The medical progress notes and the discharge summary were falsified to hide what occurred. I am asking you to set the record straight and to hold the doctors and hospital accountable for their actions.

Drs. Kariya, Weiner, Nawaz and Shamim deprived my father of the option of a second round of life support in his battle with pneumonia – never informing me that reintubation was required to give him a chance of recovering, and later refusing my demand for reintubation. They willfully ignored my father's religious beliefs and what they knew to be my wishes. In effect, the doctors decided that their dim view of the prognosis superseded their patient's desire to stay alive as long as possible, and his "unrealistic" son's desire to keep him alive.

They failed to comply in good faith with the Maryland Health Care Decisions Act, and committed numerous violations of Section 14-404 of the Maryland Code. In the process of ignoring the law, they also ignored my vigorous 91-year-old father, inferring nonexistent problems while treating a serious bacterial infection in a substandard manner.

These are the issues I ask you to investigate:

- Negligence by the admitting physician, Dr. Nawaz, in the days leading up to the hospitalization. Everything I shall describe, culminating in my father's death, might have been prevented had Dr. Nawaz adhered to the community standard of care.

- Legalities aside, my father's condition did not warrant cessation of treatment unless he, or I as his surrogate, requested such – and that clearly did not happen. He suffered no organ failure or catastrophic event during his hospitalization, and his condition was documented by Dr. Nawaz and by Dr. Heinz, a pulmonologist not named in this complaint, as improving each day. Prior to this he enjoyed good health other than mild dementia, was ambulatory, lived at home and performed all ADLs independently. He had no history of dysphagia, aspiration or pneumonia. Reintubation, in an effort to save his precious life, was medically justified.

- The records falsely state that I, as surrogate, was offered and refused life-sustaining treatment for my father and they omit a key encounter with the pulmonologist who, as stated above, actually turned down my *demand* for such treatment.

I sought to resolve this case with the administration of the hospital. Specifically, I brought this matter to the attention of Dr. Blair Eig, Vice President of Medical Affairs at Holy Cross Hospital, in March of 2004. I left with him a list of questions and a copy of the record that highlighted the issues of concern.

A couple of months later Dr. Eig called me to the hospital with the results of his peer review. "Although there are inconsistencies, the records describe adequate care given to your father," Eig said. He characterized the events leading up to my father's death as an apparent failure of communication between family and doctor, alluding to the multiethnic, multicultural environment that comprises today's Holy Cross Hospital. He added that, to his dismay, he has seen "a few such cases" during his tenure.

Please understand that there was no miscommunication or lack of sufficient communication in this particular case. I was the only family member involved, and the records show me to have been consistent and resolute in my instructions. I am fluent in the English language as are all the doctors involved. I continually informed them that any and all treatment decisions would be made in accordance with Jewish law (Halacha) and in consultation with our Rabbi. Every such decision that was made on my father's behalf served to confirm this. Additionally, Holy Cross Hospital is heavily used by the largest Orthodox Jewish community in the Washington metropolitan area, located in the Kemp Mill and Woodside neighborhoods of Silver Spring. Its doctors are familiar with our religious imperatives and their bearing on medical treatment.

Dr. Eig was not at liberty to elaborate on the findings of the peer review or the inconsistencies in the records, but offered to facilitate a meeting with the doctors who treated my father. This meeting finally took place on November 30, 2005, with Drs. Kariya and Nawaz in attendance.

I asked Dr. Kariya at the meeting why he didn't tell me that my father needed reintubation, apparently disregarding the Heath Care Decisions Act. Dr. Kariya replied that he thought my father was dying. He explained that he believed my father was suffering from *recurrent aspiration based on neurological decline,* rather than from a simple bacterial infection. He said that he did not view intubation as an option, any more than a craniotomy would have been an option had I requested such a procedure; hence there was no need to discuss the decision with me. I inquired as to the basis of Dr. Kariya's finding of recurrent aspiration, noting that my father had no such events in his medical history. He did not provide a substantive response.

Given Dr. Kariya's acknowledged lack of consultation with me, I reminded Dr. Nawaz of his discharge summary statement that Dr. Kariya and Dr. Shamim *had a long conversation with the son for further management because the patient needed intubation at the time. The family decided not to intubate*. I asked him if he could empathize with how I felt when I read that statement, now that it is understood that the statement is false. He did not reply.

I also informed him of an elevated white blood cell count 11 days prior to the hospitalization that was indicative of bacterial infection, and that he apparently overlooked. This, like my other points, was met with silence.

Dr. Kariya's failure to inform me that my father required reintubation to have a chance of survival, set the stage for the even more serious act of misconduct by his partner, Dr. Weiner, and by Dr. Nawaz's partner, Dr. Shamim, who refused my demand for intubation the following day. The hospital staff at the meeting would not comment on this either.

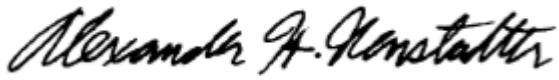
The medical records as a whole are both suggestive and corroborative of the above, depicting a struggle between myself and Drs. Kariya and Weiner over how aggressively to treat my father. An Orthodox Jewish pulmonologist who practices at Johns Hopkins put it this way: "There is an undue and inappropriate energy throughout the progress notes devoted to end-of-life issues." The records show these doctors to have been not only well aware of our religious orientation, but equally aware of the chasm between my desire for treatment and their view on this matter.

I contend that what they did to my father is an order-of-magnitude more serious than mere negligence because it was done deliberately and the consequences were horrific in every way. I submit to you that like most people, doctors are creatures of habit; the way this group treated my father may be merely an extreme example of the way they routinely practice medicine on the elderly.

Enclosed you will find my complaint, with footnotes referencing relevant pages in the physicians progress notes and test results. A personal diary, written in the days following my father's death, is also included.

Thank you for your attention to this.

Sincerely,



Alexander H. Neustadter

cc Rabbi Gedaliah Anemer
Rabbi Yitzchok Breitowitz

Drs. Lawton S. Cooper
Sidney M. Wolfe

9. Nature of complaint: *(Referenced medical records)*

Dr. Nawaz
On February 27, 2003 my father, Israel Neustadter, was feeling ill with a cough, a lingering cold and an uncharacteristic weakness. I took him to see Dr. Nawaz who ordered a BMP to rule out hyponatremia (my father was started on dyazide a few weeks earlier) and a stat CBC as well.[1]

The BMP revealed hyponatremia and the CBC showed an elevated white count of 14.3 with a left shift.[2] Dr. Nawaz called to tell me to discontinue the dyazide but made no mention of the high white count. My father's baseline WBC was in the 6-8k range. Guidelines on interpreting white count suggest that a count =>14k ***or*** one with a left-shift is usually indicative of infection, and must never be ignored even in the absence of symptoms.

Numerous doctors have explained to me that although Dr. Nawaz might be excused for focusing on hyponatremia alone had he not ordered the CBC, once he ordered it he was obligated to act upon it. Overlooking the CBC test results allowed an early-stage bacterial infection (the ER CT scan found only acute sinusitis) to advance to a life-threatening one.

One week later on March 5, 2003, I called Dr. Nawaz's office to report that my father was still sick. He was even more congested and was getting more lethargic. Dr. Nawaz ordered another BMP but failed to order a new CBC.

Dr. Nawaz called the next day to inform me that the sodium had returned to normal. He writes "D/W son" but doesn't elaborate on the nature of our discussion. I told him that I was increasingly concerned because my father's symptoms were not improving and in fact had taken a turn for the worse. He replied that he was not worried because "the sodium level has come back, so your father is alright." In comparing the new test results with those of a week earlier, he once again neglected to look at the original CBC results which at this point should have been of paramount concern.[5]

Over the weekend my father complained of dizzy spells, at one point losing his balance and falling but appearing unhurt. Sunday evening he was running a fever of 101.3 and early Monday morning March 10, 2003 I took him back to Dr. Nawaz's office. Based on hemodynamic instability he suspected sepsis and called an ambulance to take my father to Holy Cross Hospital.[6]

The first Physician Order Form written by the ER doctor on March 10 prescribed 500mg of levaquin, the standard daily dose for a man of my father's height, weight, age and kidney function. It also clearly displays the letters "DNR."[11] This was never discussed with me in the ER, where my father was accurately described as being in no apparent distress and not appearing acutely ill.[8] He was ambulatory, had no serious premorbid illnesses, and accomplished his ADLs independently.

The second Physician's Order Form written by Dr. Nawaz upon my father's transfer from the ER to his room cut his dose of levaquin to 250mg, ½ the recommended dose of this important antibiotic. Within hours of the first standard 500mg dose of levaquin, my

father's white count plummeted from 38.5k to 20k. For the next two weeks it hovered at 20k, and the doctors took no action and sought no advice from an ID specialist. The death spiral he suddenly went into directly correlates with a sudden jump in his count back to 40k. Drs. Nawaz, Shamim, Kariya and Weiner, negligently ignored the dangers of bacterial resistance in a symptomatic patient. My father's creatinine levels were in the .7 mg/dl range indicating ample kidney function and reserve. This was the window of opportunity to cure the infection.[12, 71-78]

In addition, there were major dosing discrepancies. The second Physicians Order Form mentioned above prescribed 250mg of levaquin, but for the first three days of his hospitalization the doctors' progress notes as well as the nurses' Kardex chart say he was given 500mg.[13,19,22,25] It is impossible to know what dose he actually received. On Sunday March 23, the levaquin was not delivered at all until I discovered the oversight late in the day.[130] I strongly suspected there were other such oversights, and therefore requested a pharmacy record of all antibiotics dispensed to my father, to know definitively what left the pharmacy. Holy Cross declined my request, stating that this type of report was not part of the record. I urge you to try to persuade the hospital to obtain this information.[107, 118]

Dr. Nawaz ordered a nutritional consult from Dr. Milton Koch on Friday, March 14, because my father had not eaten in 3 days and the nurses had difficulty inserting an NG tube. Dr. Koch recommended that PPN be started immediately.[32, 98] Dr. Nawaz neglected to order this nutrition on Friday and failed to order it on Saturday as well. My father was hooked up to a ventilator with no nutritional support. I alerted Dr. Ball (covering pulmonologist) on Saturday and he ordered the nutrition but mistakenly ordered central instead of peripheral nutrition, thus delaying the nutrition by an additional 24 hours.[36, 91] Dr. Nawaz's negligence ultimately cost my father a full week without nutrition, his prealbumin level sinking to 3.8 mg/dl.[79] A 91-year-old man was starving at the very time he needed all the energy he could get to fight his infection.

On Monday, March 24, Dr. Nawaz informed me that he was going on vacation and that my father would likely be transferred to the 7th floor rehabilitation unit in a day or two. He said my father needed a stat ultrasound of the gallbladder to check on elevated liver values, but failed to submit the required Physician's Order Form.[59] Dr. Shamim, who covered in his absence, submitted the order the following day, delaying the test by 24 hours.

<u>Dr. Kariya</u>

From his first entry in the progress notes on March 11, referring to my Yiddish-speaking father as a "demented older babbling male," Dr. Kariya, one of the two pulmonologists seeing my father regularly, repeatedly invokes the specter of end-of-life and makes clear that he knows he is at odds with me on this matter. On March 12, only two days into the hospitalization, he refers to me as an unmarried son who remains hopeful, perhaps unrealistically so. He told me of his own mother's death a year earlier, two rooms down the hall, and how "peaceful" it was. My father might have been better served with closer attention paid to his white count, renal function, cultures and antibiotic dosage.[16, 23]

Dr. Kariya did not see my father from March 12th until March 24th when he writes "not conscious to me," as if to refute the observations of his colleague Dr. Heinz as well as Dr. Nawaz, the nursing staff and the respiratory technicians regarding my father's level of

alertness.[55,57,58,59] He notes a white count of 22k and alludes to "obvious gurgling" but offers no medical help for either.

I suspect Dr. Kariya, and his partner Dr. Weiner, saw in my father a patient like many of the elderly they encounter; non-ambulatory, profoundly demented, admitted from a nursing home where chronic problems like dysphagia and aspiration are common. They may also have assumed that his pulmonary capacity and reserve was spent. I think there is a strong possibility they erred in this particular case, overlooking the basic tenets of infectious disease treatment and paying little attention to this specific patient, who was in very good health. He was ambulatory, and had no swallowing difficulty or history of aspiration, despite a longstanding Zenker's diverticulum. Fortunately for my father, I knew it made little sense from either a religious or medical perspective to give up on him, and I had no intention of doing so. **Unfortunately for my father, I was not given the choice**.

Failure to inform, failure to treat, failure to comply in good faith with HCDA

Dr. Kariya was the first physician to encounter my father in respiratory distress on Tuesday evening, March 25, entering the room soon after the crisis began. He writes that my father's breathing was tenuous and that his oxygen level plummeted after I gave him ice chips. "Son remains unrealistic, no new suggestions." He left the room and the floor without saying a word or rendering assistance, quite literally abandoning us.[63, 132]

The progress notes show that Dr. Kariya knew my father was in a life-threatening situation and knew he was at an impasse with me regarding the appropriate course of action. As such, the HCDA obligated him to solicit my instructions and either follow them, or certify, together with the attending physician, that doing so would be futile and that he was declining. He would then have been required to assist me in finding another doctor if I persisted in requesting reintubation. He did none of the above. He simply walked away from us. To state the obvious, had he spoken with me about such a pivotal decision and I elected not to try to save my father's life it would be reflected in his notes. It is not there because the discussion never took place. To belabor the obvious, had Dr. Kariya solicited my instructions, I (the "unrealistic" son) would have instructed him to put my father on a respirator without hesitation.

My father's sudden respiratory distress correlated with a rise in his white count back to a panic level, and Dr. Kariya was negligent in not checking for this. My father required an immediate reassessment of his antibiotic regimen and as high a dose as he could tolerate. This was a life-threatening bacterial infection and antibiotics are relatively noninvasive. Why wasn't any action taken?

As I watched his condition continue to deteriorate, I desperately called a resident, Dr. Al-Quatami, into the room for help. He initially said my father needed to be intubated but then inexplicably changed his mind and tried to dissuade me. At *his insistence* he contacted our rabbi to discuss the matter. Rabbi Anemer explained to him that Jewish law mandated intubation in my father's situation.

The notes show that Dr. Al-Quatami was attempting to render assistance, but the doctors he contacted appear to have advised him to handle the situation in a different manner. Dr. Al-Quatami writes "Contacted Dr. Shamim and discussed possibility of intubation. ICU

Dr. covering & Dr. Kariya was also consulted and agrees (at this point will readdress code status due to poor prognosis)" **It is important to find out what these doctors "agreed" to and when the code status was readdressed.**

Throughout the day my father was wide awake, breathing easily and talking to me and to his homecare assistant. Now in the evening, as his heart and respiratory rates were suddenly rising, his alveoli filling with fluid, these doctors appear to have reached a consensus to withhold life-sustaining treatment and possibly to change the code status! I was not informed of this, and certainly did not consent to it. I left the hospital late Tuesday night after Dr. Al-Quatami assured me that my father would be carefully managed with oxygen and watched closely "in case intubation is needed."[63, 132]

I returned Wednesday morning, March 26th, to find my father in a terrible condition. I frantically called Dr. Kariya into the room for help. Yet again the progress notes betray his view on what would constitute a "good" death for my father while at the same time demonstrating that he knew I was on a different wavelength and of a differing mindset. Indeed, in his opinion I wasn't even willing to process the possibility of an impending funeral. He was correct.[64]

There is no indication at this point either of a discussion with me about intubation, because no such discussion took place. Dr. Kariya notes a white count of 37.6k, but again fails to reassess the antibiotics in any way. As my father was full code, had vigorous kidney function and the goal was to treat his infectious disease and save his life, this can only be viewed as either negligence of the highest order or as Dr. Kariya imposing his "good death wish" on a hapless patient and family.

Drs. Shamim and Weiner

Dr. Shamim entered the room Wednesday afternoon just as I started to realize that my father required intubation. I was in essence forced to figure out the dynamics of respiratory distress with no outside assistance, and finally I did. Dr. Shamim confirmed that intubation was necessary. He left the room and returned with Dr. Weiner.

Willful misrepresentation, willful filing of false record, patient abandonment

The two doctors were with my father for a long period of time – perhaps 30 minutes, as Dr. Weiner spoke with me, listened to my father's breathing and ordered Dr. Shamim to obtain an arterial blood gas test. Dr. Shamim briefly left the room and returned as we waited for blood to be drawn and for the results to come back. Dr. Shamim's notation "called Dr. Kariya – ICU consult" is patently false. Dr. Kariya was not involved in this at all; Dr. Weiner was there in person. Likewise on the physician's Order Form, when Dr. Shamim writes "ABG – Call results to Dr. Weiner or Dr. Steve Kariya" he is knowingly falsifying the record. No one needed to be called – Dr. Weiner was in my father's room the entire time waiting with Dr. Shamim for the hand-delivered results to arrive. When they did, Dr. Weiner refused to intubate, telling me it was too risky to even attempt.[65,66,134] This was a willful misrepresentation in treatment. **Remarkably, Dr. Weiner failed to document in the medical record this critical visit of his to my father's room**.

The fact that an ABG test and ICU consult was even ordered late Wednesday afternoon indicates that life-sustaining treatment was under consideration. I ask you to determine

precisely when my father transitioned from full code to "actively dying with no further treatment planned."[119] Was it at this time? Was it a day earlier when he was alert, resting comfortably, telling me how hungry he was, asking me when he will be discharged and suddenly developing respiratory distress? And exactly when did a discussion with me about this take place?

I can only surmise that Dr. Weiner, like his partner Dr. Kariya, was trying to avoid what he believed would be a few more "fruitless" cycles of intubation and extubation – and perhaps a few more "fruitless" weeks of life, by simply not discussing it with me. Both of these doctors were playing god with my poor father, deciding, **outside the framework of the law**, that it would be best for him to die as soon as possible. I believe the events described above were falsified because I finally figured out (24 hours after the fact) that my father needed to be intubated and the doctors were now aggressively refusing my demand.[135]

Please allow a strongly felt personal remark: I know of only two times that my father's life was in the hands of another man. One was at Auschwitz, where Dr. Josef Mengele deemed him worthy of living. The other was 60 years later at Holy Cross Hospital, where Dr. Jay Weiner deemed him ready for death – but without the courage to put his name in the chart.*

I returned to the hospital early Thursday morning to be at my father's side, knowing death was imminent. Nomeda joined me as I held his hand and prayed for mercy. At 8:50 am his breathing collapsed and he began gasping for air, his monitors alarming. Not wanting to leave him in his final moments I pressed the nurse's call button numerous times asking for help. Each time I was told someone would be in right away. One full hour went by as my father was choking, his eyes tearing while Nomeda and I held him. As hard as it is to believe, this actually did happen.

Referring to the events described above Critical Care director Susan King writes: "Nursing probably knew that additional life support measures were not planned for your father and there was no action for them to take for a low pulse oximetry reading." In an environment where history taking is required, treatment plans laid out, progress notes written and DNR orders displayed, do the words *nursing probably knew* have any place?[119]

I try not to think about the suffering my father endured concomitant to his low pulse oximetry reading. I'm not sure the nurses were even aware that Nomeda and I were in the room watching him choke, his eyes tearing as he gasped for every breath. I was transfixed in prayer and the thought of his precious soul about to depart, but where was Holy Cross? Even if my father would have been charted as DNR or "no further treatment planned," shouldn't morphine or another medication to relieve my father's respiratory distress have been offered as an option? Shouldn't someone have been there? This is a man's worst nightmare come true.

What happened next is described in my diary and is beyond comprehension; Dr. Weiner refusing to talk to me and the hospital "unable" to provide another doctor in his place. I insisted that I must speak with another pulmonologist about what was happening and what my father's options were. Shift nurse Elaine Warren, hospital staffers Elise Reilly and Susan Mitchell, all told me they were unsuccessful in securing the services of another pulmonologist for my father.[137]

*Confirmed by trial testimony

Three months after my father's death, Dr. Nawaz, upon being placed on suspension for failing to file the required summary concerning my father's hospitalization, signed his name to a "death summary" laden with false and misleading statements.[105] This document can be seen as emblematic of the care my father received at Holy Cross Hospital. It states:

- *"Admitted to the hospital with aspiration pneumonia"* Dr. Nawaz indicated to me and in the progress notes that he believed my father had community-acquired pneumonia with no aspiration.[15] The ER CT scan found only acute sinusitis.
- *"The very next day the patient's respiratory condition became decompensated"* It was 3 days later.
- *"Son wished to buy some time"* I made clear to Dr. Nawaz from the outset that the aggressive treatment my father was receiving was a principled, firmly-made decision in accordance with Jewish law.
- *"The patient remained intubated for a few weeks"* He was intubated for 4 days.
- *"Multiple antibiotics were changed during the patient's stay in the intensive care unit"* How I wish this was true.
- *"He was placed on total parenteral nutrition for a short term"* He was placed on peripheral parenteral nutrition, which Dr. Nawaz failed to order and Dr. Ball mistakenly ordered as TPN.
- "G*I consult was obtained from Dr. Milton Koch"* This consult was obtained from Dr. Alan Diamond, who placed a PEG tube and shared my view on the treatment plan. He had a positive and hopeful outlook on the prognosis, as did I.[58]
- *"Eventually the patient was successfully extubated"* As stated above the tube was removed after 4 days and my father was sitting up and talking with Dr. Nawaz.
- *"The patient again developed aspiration pneumonia and respiratory-wise became decompensated again"* No evidence is presented that this was ever aspiration pneumonia. Respiratory distress correlated with a precipitous rise in the WBC that was ignored.
- *"Dr. Shamim and Dr. Kariya had a long conversation with son again for further management because the patient needed intubation at the time. The family decided not to intubate…"* This conversation never occurred.**
- *"On March 27, 2003, the patient was found to be unresponsive, without any breathing, no pulse, no blood pressure."* It was the doctors and hospital that were unresponsive, abandoning their patient and allowing him to die a painful death as his homecare assistant and son helplessly watched.[136]

In sum, the records make clear that these doctors broke the law, disobeyed what they knew to be my father's wishes and lied to hide their actions. They also demonstrate the doctors' troubling reluctance to aggressively treat an elderly man, even a relatively healthy one.

My father was tested early in life, in the Nazi death camps, in ways we cannot begin to comprehend, yet chose to embrace his religion in the most uncompromising way. Is there anyone who earned the right to fight for his life, on his terms and in accordance with his beliefs, more than Israel Neustadter? The thought that he was denied this as the end result of medical prejudice, or worse, of medical foul play, is unacceptable to me – and I would hope to you as well.

Board of Physicians reply

** Dr. Shamim testified that he *did not* discuss intubation with son
Dr. Kariya testified that intubation was *not* needed at the time.
According to Holy Cross Hospital intubation was never "recommended" for this patient.
Dr. Nawaz now admits he had no basis for this statement (he made it up).