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Introduction

Thank you for asking me to look at several issues for you that might be helpful to your efforts to achieve medical justice in relationship to the poor care delivered to your father which led to his untimely death

Analysis of Dr. Nawaz's Care

First of all, I think that the office chart used by Dr. Nawaz needs to be inspected for all of the following: a master problem list, a master medication list, the fax that is missing which may or may not have been signed as having been seen, etc. It would be way below the standard of care not to maintain such "database" master lists and yet share patients between four doctors. In a practice with 50% elderly (0026), this would be even more important; the elderly are fragile and need problems carefully tracked.

These database summaries in the front of an outpatient chart being absent would explain how easily Dr. Nawaz could lose the diagnosis and treatment of hypothyroidism and the ER miss of the pacemaker. Even if the medication level is going down slowly in the patient's blood, it is still going down at a point when the patient most needs thyroid support. According to Dr. Nawaz's own comments, the medication would be at half normal level after 10 days. The idea that one can forget the thyroid in critical care (always at "the bottom" of his list (0201)) is bizarre.

> "And it is not an uncommon thing when somebody comes acutely ill in the hospital to hold on the – on the Synthroid." (0197) [I would be tempted to ask him if he ever saw such a recommendation in any textbook unless there was some hint of a thyroid vermedication problem like a fast heart rate.]

No article or textbook would ever suggest stopping thyroid medication at the beginning of a serious illness.

Secondly, as Dr. Nawaz clearly lied about the number of hours of intubation and days in ICU though having the chart a long time, I would think his credibility as well as the chart's accuracy would be easy to impeach. I also don't believe Dr. Nawaz's explanation of his medical illness as coinciding with the delay in the charting and I think it might be useful to ask him under oath if he stopped all hospital work with his eye problem. As physician, I would think his many discharge summary errors would speak to his lack of credibility:

> Dictated: In ICU for "a couple of weeks"

Truth: ICU 3/13 to 3/21, then moved to IMCU; there is a big difference between ICU and intermediate care.

Dictated: "The patient was on a nasogastric tube at the time"
Truth: it was never accomplished.

Dictated: "We continued the other medications on this patient except for the blood pressure medications which he was taking at home …
Truth: he stopped the thyroid medication.

The fact that the dictation was months later would be meaningless as an excuse for inaccuracy because he had the chart when dictating. He could easily follow the issues – use of home medications, nutrition (see Attachment 22), intubation, days in ICU, etc. – rather than getting them all wrong. His effort was to take the illusion of care and try to make it look real and aggressive.

Next, Dr. Nawaz dodged the "practice incentives" question in his deposition (0052 and 0053) but such incentives are normally based these days upon number of patients one can carry on a prepaid roster. The art of success is to delay follow up exams such as, in this case, trying to turn Mr. Al Neustadter into the primary physician for his father. Notice how Dr. Nawaz tried to suggest that he could "rely on Mr. Alexander's treatment plan" (0042) as if he had delegated the MD role and as if the elderly always show early symptoms of illness [the opposite is true].

As to the reuse of Dyazide after a bad reaction, that is very substandard. The Physician Desk Reference of 2003 does not separate "allergy" (like a rash) and "side effects" in the way he tried to do in the deposition. Rather they talk about "adverse effects" (Attachment #23) whereby a physician would rarely ever take the chance again of giving a medication causing problems. His concept of retrying a medication to see if the problem happens again (0076 and 0077) is bizarre.

I did think he connected the Dyazide to his disadvantage in the sequence Dyazide causing hyponatremia causing confusion (0058). Then he added in "lethargic" on 0116. That would set up the increase risk of falling, sloppy swallowing, and pneumonia (suppressed coughing).

The idea that a patient would have a high white blood count and then have no repeat testing while we "see how the patient responds …" (0125) to the treatment of something else is very inappropriate. Despite infection always being at the "bottom" of his list – it is there. The normal standard would be to get a band count that day on the blood sitting in the hospital lab ready for such additions, to treat early infection, and to retest the CBC soon. But there is no effort to get a band count, order treatment, and follow up with a new CBC (0143).

Next, there is an effort to make all of his office visits "focused" (0154) as if there is no need to either know or think about the broad picture. In fact, Dr. Nawaz was clearly the primary care physician for this patient and needed always to keep the big picture of risk in view. [He finally admits to being the primary physician within 0237.]

His inpatient concept of nutrition after recovery (0206) perhaps works for middle age people but rarely for the elderly. I first learned about ICU nutrition from a Dr. Lewis and Hirschburg (UCSF) on our stroke unit in the 1970s, start right away! Otherwise the elderly lose ground too fast.

Dr. Nawaz's prediction that the "renal functions are going to be off" (0207) as a reason for lowering the antibiotic follow up dose makes no sense as he also thought that the patient did not need ICU at first because the blood pressure came up so rapidly in the ER. You cannot have it both ways.[1] And the 2003 PDR does not suggest any lower dose of Levaquin for the elderly in general. Thus his thought that "age of the patient" (0208) makes a difference does not match the PDR on Levaquin. He need only ask any hospital pharmacist on the phone to look it up and confirm the right dose or call in Infectious Disease.

The idea that all the consultants agreed on the low antibiotic dosage is really about a widespread point of view that one should not try so hard in this age group – the dead at the door theory of Dr. Weiner and the unauthorized DNR by Dr. Ball (0213-0220). Dr. Nawaz tried to suggest a whole different attitude in 0048 line B but he did not speak to the truth then.

The early extubation of Mr. Neustadter might well have been ordered by Dr. Weiner [the most negative of all the physicians] but the primary hospital physician could well have voted otherwise. It is very rare to take out a tube in the evening. For many reasons it is generally a morning event. I used to rest patients with morphine the night before since they would need more stamina without the tube – respiratory failure is really like a marathon since the work of breathing occupies such an effort.

As to his use of Ethics Committees to get "power of attorney" (page 74 or 00193), that sounds like his view of such a group designed as to empower physicians to decrease their efforts. And that is my general observation of the use of these committees in managed care. I far prefer the use of them at UCSF (reflected within this case's depositions) to help match family wishes with willing physicians.

Perhaps as a finale, one could ask Dr. Nawaz and Dr. Weiner if is not true in Maryland that the diagnoses sets the reimbursement for the hospital. (See Attachment F page 4) So had the patient been reintubated, the hospital would have had to take the cost burden. If Dr. Nawaz is now the head hospitalist (0302), he has proven himself to be very efficient with getting patients out of the hospital one way or the other. [His comments 0243] Isn't this why "You cannot keep the patient in the ICU for a very long period of time." ?? [0268]

A Brief Analysis of Dr. Shamim's Deposition

He is the Chief Hospitalist for Washington Adventist Hospital. Having recently studied the Adventist Health system including a trip to the Adventist headquarters in Maryland, I am quite sure that those who rise in this hospital system have also mastered how to be economically "efficient." That means a quick solution to patient problems to beat the Average Length of Stay

[1] I have to wonder if the HCH ER used Dr. Weiner through MDxL to decide where to send Mr. Neustadter, since he went to a unit far below that needed for septic shock.

(ALOS) of the DRG as described later. His migration from HCH to WAH in 2005 would not be, in my opinion, a step up in ethics. Rather it would be a lateral transfer.

Clearly Dr. Shamim's opinion of how lab tests were reviewed in Riar & Altschuler was quickly protected by his counsel. "There was no such particular guidelines written or anything" (0013) suggests no pattern. Of course, the office had a pattern for reviewing lab, as does every office hoping not to be sued.

The concept that Dr. Shamim was simply a "cross cover" (0022) for Internal Medicine sounds like Mr. Neustadter's team leader was someone else. But as the physician designated to make the note for the day, Dr. Shamim would be the one in charge. The Joint Commission frowns upon "team care" without someone being primary. In this case Dr. Shamim wants to make the pulmonologists into "a team of primary critical-care physicians." But he is taking the place of Dr. Nawaz who admitted he was the primary hospital physician (see again 0237 of Dr. Nawaz deposition).

He has tried to duck responsibility for the respiratory decisions because he left that up to the "team." He confined himself to antibiotic issues and liver function test analysis. I note that he left the Levaquin at a low dose and never called in Infectious Disease.

Analysis of Dr. Weiner's Deposition

[I will be looking for the explanation of how Dr. Weiner could be taking over the care for the downturn in condition on March 26, 2003 without making a note. Per his deposition, Dr. Shamim left the care in Dr. Weiner's hands and Dr. Weiner did nothing. The nurses cooperated with this absence of intervention without activating their many ways of calling in other opinions.]

Dr. Jay H. Weiner was deposed at his own office of Pulmonary Critical Care (PCC) in Kensington, Maryland on September 6, 2007.

He explains that his group practice includes Holy Cross Hospital, Shady Grove Hospital, and Montgomery General Hospital. Two physicians in his group focus on each hospital and then there is a night rotation (0013) whereby among eight call might occur on average (my understanding) of once a week. There is an alleged attempt to have each patient followed in the daytime by the same pulmonologist, but there is bound to be evening overlap at the very least.

The first prevailing attitude which comes forth in Dr. Weiner's deposition is one of superiority with a disdain for patient and family beliefs:

> Question (0038-0039) : "Do recall whether you told Dr. Nawaz your assessment that Mr. Israel Neustadter was actually terminal at the time you saw him on March 11 in your opinion?" …
>
> Answer: "… I'm an intensivist. Okay? I was – put on this planet to save people's lives."

Question (0093) "When you saw Mr. Israel Neustadter on March 27, was reintubation a reasonable course of action for him at that time? …

Answer: "Which Neustadter are we talking about?" [This was an outrageous response, revealing, I believe, an annoyance at being challenged about his mission on this planet.]

Later Answer: he is disdainful of the patient's son and legal representative, as being "so confused and conflicted and troubled" (0094) and "he could just not process it" (0058) - as if the life and death decisions should be so obvious – just follow the morbid predictions of death at the door.

Setup: Asked about Jewish beliefs on intensive care .. [remembering that the hospital is near a large Jewish community]

Answer: "It usually is based upon the person's rabbi, whether they're orthodox, conservative, or reform. The Jews do not have a pope." [This is another outrageous comment suggesting that each rabbi has his own opinion and any Christian leader – there being 38,000 Christian denominations - would look to the Pope for such decisions. The attitude I hear once again is that the physician with "27 years of experience" should dominate the hospital scene and be permitted the paternalistic approach of knowing what is best. Religious beliefs are too varied to need either respect or adherence. Families who are troubled should simply lean on senior and wealthy[2] pulmonologists to decide who is dead at the door.]

The second attitude which dominates Dr. Weiner's comments is that the patient had no hope which is the legal effect of keeping his chances below the 50% survival test. Some courts state that if a patient could not have survived more than 50% with no care, than there can be no proof of malpractice – more likely than not infliction of bad outcome. Dr. Weiner tries to work this into as many answers as possible. [That the hospital website – for which he is an ostensible agent, is full of hope against all disease - does not faze him.]

1. The care was "excellent" because "everything" was tried and "correct" (0019);
2. And "I was his pulmonary critical care doctor" who "sort of takes charge" (0022);
3. Decisions of intubation and extubation are "usually done by the pulmonary critical care doctor" (0075);
4. Elsewhere – the "buck" stops here (0023);
5. But then when it came to the extubation [really too early] the group becomes the amorphous decider as he calls in an order at 8 pm based on a conversation with Dr. Ball earlier in the day (0074) [This is outrageous in itself – extubation is done at the optimal time with optimal staff nearby – this is to say, if care is the goal; doing this in

[2] In the "market" of hospital work, planting the idea of minimal treatment against maximal diagnosis is very much in line with hospital's bottom line. Payments are made against Diagnostic Related Groups even though Maryland has opted to create less paperwork and thus have less auditing. The key to minimal treatment is to portray intubation as a painful illness unto itself – which will become apparent in Dr. Weiner's comments. On the other hand, ventilators are almost the very reason for the creation of pulmonary medicine experts.

the evening and transferring him out of the ICU was simply a way of withdrawing care.];
6. "Mr. Neustadter was terminally ill from the time he reached the hospital until the time he died." (0066);
7. Failure to thrive is a diagnosis in the elderly "Because he was dying." (0083) Nutrition would only "prolong his death." (0084).

Third, Dr. Weiner wants to emphasize that being old is a disease unto itself:

1. "He was 92 years old. He had diffuse pneumonia. His blood pressure was low. His mind was gone as he had septic encephalopathy." (0026-0027);
2. "…he had no swallowing reflex, he looked terminal, and since this is what I do for a living, it really wasn't much of a question in my mind." (0027);
3. "Yes. I told him that it was my opinion that the patient was terminal, that I thought he wouldn't make it out of the hospital." [My own opinion is that Dr. Weiner has been in this business too long and on call too many nights – he wants younger patients with more rapid improvements and better financial yield for hour of effort. He should probably take a pay cut and confine himself to his office. His "lumper or a spltter"[3] comment (0045) would suggest that he no longer can even tell if a patient is getting better or worse – and once bound to die on his score card who cares?]

As to the antibiotics, he cannot really answer what was going on:

1. Low doses of antibiotic fit proven poor renal function [which was not present] not age – see PDR on Levaquin;
2. Lack of coverage for anerobes fits community acquired pneumonia (CAP) and not aspiration pneumonia (the mouth having many aneurobes) – the "3%" of the time is his comment of risk [in good studies of aspiration pneumonia the result is about 50% - see article in Attachment A];
3. "Antibiotics would have made no difference" is only a self-fulfilling prophesy if you use much too low a dose for a deadly disease; waiting until the white blood count goes sky high as the point to change antibiotics is pathetic care.

His comment on resuscitation suggested that he wanted to avoid getting into the details of the decisions on life support: "So at some time or another, he was a code, but then sometime in the portion of the hospitalization, he became a no-code." (0052) That distorts the point that he, Dr. Weiner, was doing his best at all times to force the son by any method including humiliation to concede the care and get on with the death.

And with all conceding to Dr. Weiner even when he does not make a note, he was leading the parade of physicians (most apparent agents of the hospital) and nurses/pharmacists/complaint-coordinators (who were actual agents of Holy Cross Hospital) in the death-at-the-door theme.

[3] For the rest of physicians this is about how detailed you make your diagnoses – migraine vs. classic mixed headache including vascular and muscular contraction elements - not whether you bundle all episodes of an illness into one event.

The "code" paper was only a way to certify what was already being done – the withholding of care through the illusion of care: no nutrition, no thyroid medication, underdosing of antibiotic, lack of full spectrum antibiotic, too short intubation, etc.

As to the "horrible" (0080) illness of "neuromyopathy of critical illness," this diagnosis would be one that is reached after excluding treatable problems that make us all weak: hypothyroidism, malnutrition, extinguishing infection with proper antibiotics, tracheostomy if needed to avoid aspiration, repairing the Zenkers, poor time orientation[4], lack of visitors[5], etc. **What is really horrible is for a physician to lack interest in any of these dimensions and then to call it a mysterious muscular disease at the molecular (neuroendplate) level.** "There's no treatment for the neuromyopathy of critical illness other than if the patient gets better. And since I didn't really feel he had any chance of getting better …"

Basically, since he had given up already, why look for treatable causes of weakness? His thyroid medication would have drifted by this time to half of its steady-state level at a time of maximal stress – and not one physician cared because Dr. Weiner had declared through his notes that this was a non-treatment event. It was a vigil against the general rule that the predetermined payment for the illness has been already set (DRG thinking since 1985 for the ethically challenged).

As to the patient's ability to sit up unaided, "Nurses sit people up, three people hold them up." It did not matter to Dr. Weiner to read this since: "I thought that he would not make it out of the hospital, that he was terminally ill, that he was going to die, and that his care was futile." (0087) But all of this minimalist care still counts as care: "Now, come on, you never stop rendering care. You care for people that die." Care then could mean anything that involves circulating staff around a patient whether or not it is useful, medically appropriate, or within family wishes.

In the final day, physician abandonment (apparent agents) with nursing abandonment/enabling (actual agents) was the situation in which Mr. Alexander Neustadter was left by Holy Cross Hospital. The nurses later explained it through Dr. Schwab (he is, no doubt, a paid agent of HCH), saying that they did not want to give nursing care because it would interfere with the dying process. Who gave them that signal? Dr. Weiner did (though without the inclination to write much about it or to take real responsibility).

I find it interesting that though Dr. Eig said he had the care reviewed by the principal physicians and independent review, Dr. Weiner never recalls seeing the chart again (e.g. 0020 line 12-14). Was Dr. Eig doing anything beyond stalling? This is the new art of "active listening" with no intention of taking any other action – just an attempt to diffuse anger over time.

As a final comment, I find Dr. Weiner able to lie with ease – a necessary quality in this era of Managed Care and the illusion of effort. When asked …"whether you've ever held positions at Holy Cross Hospital." His answer was "No." (0015) But he was at one point the Associate

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[4] Years ago we called it "ICU-it is" in which the lack of day/night and current events structuring causes most of us to become disoriented, even astronauts. The latter get wake up music at the beginning of each "day."

[5] While the 8 pm visitors leave policy is a relief to the staff, it does not bode well for the elderly and their orientation to have family disappear at night. It is like a forced "nap" in preschool, designed for teacher respite.

Director of Medical Education at HCH (see outside bragging) on different website (Attachment #B).

When asked about Holy Cross Hospital he said, "… frankly don't know the difference of being on staff or having privileges." Physicians all know about hospital staff levels and the renewal of privileges that takes place every two years; **this comment is a complete fiction**. The goal is probably to picture himself as having some distance from the hospital. In fact, his privileges must be renewed every two years in a paper that gets signed all the way up including the Hospital Board. In his 27 year career working at three hospitals, Dr. Weiner would have gone through this process over 80 times.

As to no financial connection to HCH, I would be very surprised if the group did not have several contracts with HCH; e.g. 1) in which "Dr. Kariya is the head of respiratory therapy." [This service – like ER physician, radiologists, hospitalists, pathologists, etc. requires some negotiation – I believe – between the hospital and the physicians to provide a "service" more than simply a willingness to see those with money.] And, 2) there is probably a contract with MDxL for the screening of admission between the ER and hospital.

Dr. Weiner and Managed Care

The jaded approach of Dr. Weiner to Mr. Israel Neustadter suggested to me that his style was Kaiser-esque, Kaiser being one of the largest HMOs in the country and one that has actually crystallized a second ethic in competition with the Hippocratic Oath. This ethic is called the "group ethic" (See the Permanente Medicine Map – Attachment # J). And is the "wind" in the Permanente sails, the key to Permanente physician thinking. This does not mean that Dr. Weiner has direct links to Permanente but rather than his thinking appears to be parallel.[6]

When I put Dr. Weiner's name into Google, I came up with "MDxL" (See Attachment B). Before understanding what MDxL is, it is best to start with MCNET. Dr. Weiner was "… the founder of MCNET physician network." Physician networks allow one group of physicians – the organizers – to make money off the others. To the individual physician[7] these groups promise the negotiating power of a group. To the HMO and other health plans, they offer a group of physicians willing to watch over each other ("utilization review"), to ration care, and to take on risk. They offer nothing in this to patients – the ones who really take on the risk of rationing – but all of this is done behind the scenes.

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[6] Among my clear impressions of the hospitalists of Permanente during my 18 month experience within the HMO in emergency care: 1) half the patients I thought should be admitted were sent home, 2) there seemed to be a race to get family to concede ICU or aggressive care even before the patient was examined, and 3) the ICU was pictured as an intubation torture chamber. I often found myself telling the "hospitalist" to let it be "on your license," knowing that my time in the HMO would not be endless. This was the time when internists were choosing to be hospitalists (more pay) or outpatient focused.

[7] When I came into Fresno in 1997, I had to learn that one applies first to the IPA (Sante and a rival) and later to the Plans through the IPAs. The city had been divided up into competing IPAs and hospitals.

Dr. Weiner could have used his triple boards to a teaching advantage, but he chose instead to organize MCNET – a 470 participant physician group that had a marketable value. Not just "*a* founder" like Dr. Dennis Friedman, Dr. Weiner is rather described as "*the* founder." Those physicians I met and studied who have risen to the top are clever at providing the illusion of care.[8]

And, in fact, in the great merger frenzies of the 1996 act – resulting from the Balanced Budget Act of 1996 – MCNET was bought by "Doctors' Health" in 1996 – "a rapidly expanding physician owned management services organization that runs physicians practices." (See Attachment C). If organizers can promise the physician groups will hold together, huge profits can be made at the top,[9] e.g. Team Health. Or they can get in deep trouble as Doctors Health did in 1998 after Dr. Weiner's group sold out.[10]

As it is very hard to lift the veil off of these IPAs except in rare public disclosures – like when Team Health made an SEC public offering disclosure – one cannot trace Dr. Weiner's activities in these middle man adventures until he resurfaces in MDxL. The MDxL idea was that a hospitalist/office combination could avoid admissions by offering to the ER physician – too anxious to admit (thus the managed care villain) – the option of having a secondary screening in the ER by an intensivist arriving within two hours to try to head off the admission.

The whole selling point of MDxL – working in 2006 with four Maryland health plans (Attachment H – page 18) – is that patients can be sent home from the ER or have fewer consultants in the hospital with quicker discharge. That would appeal to health plans (overall cost risk) and hospitals (DRG risk and general Maryland capitation[11])

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[8] HMOs, while becoming progressively distrusted in America, have tried to export their styles to Australia. Sometimes an outside observer says it best. One such observer, Professor Brian Martin of the University of Wollongong, published his ten year study of this form of health care (54 pages of Attachment D):

> (Page 2) "As a consequence they maintain the illusion of care. They sell this illusion to others." (Page 18) Note the comment about the new funding system being like capitated Managed Care. It certainly stops the pressure to overservice. Like Managed Care it also introduces new pressures to underservice and deny care. As extensive materials on this website show, this has been happening for years to those aged care services (e.g. basic nursing) provided under capitated-like payments. (Then on page 19) "Patients are meat in the sandwich."

He is hopeful that Australia will not fall into the same trap. Often he is speaking about for-profit nursing homes, but he also talks about the for-profit IPAs like those Dr. Weiner frequented, sold to others or led.

[9] One of the groups I have worked for and analyzed is Team Health; a national group whose medical director makes $2 million a year. What Dr. Weiner made in the transaction would be of interest. How he continued to work within Doctors Health would be of interest.

[10] I think it would be useful to see if Dr. Weiner sold it in time or sold it due to falling value. In the latter case the IPA sometimes blamed the seniors' using up too many resources. He may already have had a problem with families asking for full care for an elder relative due to personal money lost in the IPA game. [Note that the profits are so high at the top of an IPA, that those that fail reform just as fast.]

[11] All Maryland hospitals are paid the same rate by a state strategy to ease federal paperwork.

Whether or not Mr. Israel Neustadter's plan fell within one of the four using MDxL or Dr. Weiner was called through the MDxL system (he can't remember who called him), his approaches reeked of care managed to the payer's advantage rather than the patient's advantage. Since the patient was hopeless in Dr. Weiner's world of profit through minimalization – simply not a business asset – the care did not really matter. The only object was to destabilize the religious reference points of the son.

One of the strategies used was simple abandonment. **At the critical juncture of re-intubation, Dr. Shamim states that he deferred the care to Dr. Weiner and left the hospital. Dr. Weiner, thus in charge of the patient, made no note. The patient had no physician advocate. This should be contrasted to the accreditation promises of Holy Cross Hospital discussed next.**

Holy Cross Hospital Accreditation

Holy Cross Hospital holds out to the public that it is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or "Joint Commission" for short. This is actually paid for by the hospital but serves as the pathway to Medicare funds, so it is not an optional hobby. Where Medicare has no choice – Guam Memorial Hospital or Corcoran District Hospital – best effort is used. Where Medicare has a choice, it will pay an accredited hospital and not use one that is not. In any case, the hospital chooses to advertise this as a sign of trust. Thus the guarantees to the Joint Commission become guarantees both to the government as well as to the public (potential patient source).[12]

Booklet - "2002 Hospital Accreditation Standards [or] HAS" - Note that the 2002 book has a section warning hospitals about misrepresenting what the hospital actually does as a cause for losing accreditation – particularly when it comes from high up in administration (e.g. Dr. Eig). See pages 18-19 about Truthfulness and "Good faith in accreditation." Anyone can spruce up notebooks and demonstrate the capacity to give patient oriented care and still not actually do it.[13] The warning on page 18 is "A hospital must never provide the Joint Commission with falsified information relevant to the accreditation process. The Joint Commission construes any efforts to do so a violation of the hospital's obligation to engage the process with good faith." Nor is a hospital ever to retaliate for any one reporting a problem to the Joint Commission.

Issues that may be known to the public are listed on page 21. It is not clear to me that very much internal information is available to the press or public. Within hospitals there is no particular

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[12] The elderly are sought out as patients despite the fact that with good care they cost more than they bring in. But with the illusion of care, profits can be made. Kaiser gets 20% of its profits from the elderly even though they are only 10% of its patients.

[13] Over the years I have seen many tricks played on the accreditation process. One was to paint ER plugs red, as if connected to the generator in case of power outage. Another was to lock up medications just on the day of inspection. A third was to decrease appointments to look less busy, or an ER would be extra-staffed to look caught up. The Joint Commission, as Kaiser noted, is really a paid "guest" – not really out to downgrade a big hospital. One hospital had no problem announcing "Welcome to the Joint Commission" in the face of a surprise visit, so that everyone could quickly do what was needed to pass.

effort to share inspection problems with the general staff. Perhaps the toll free hotline for complaints 1-800-994-6610 is a place to start asking about previous HCH reports.

Inspections are every three years if a three year maximum approval is granted. And before accreditation there is supposed to be a public notice that the inspectors are coming (page 27). The notice is supposed to go out to the public 30 days before (page 28). I have never seen this done in the spirit in which it is written.

The first issue of inspection is supposed to be about "Patient Rights." (See chapter beginning on page 67.) Hospitals all promise the type of material in the chapter – with the idea that the patient/family is informed of diagnoses, brought to the MD level as much as possible about available options, and given the deciding vote on the course of action. This is a promised autonomy. [Death on admission does not provide a clear diagnosis or a choice of care.]

Hospitals like to tack on to Patient Rights a list of Patient Responsibilities, as if this is some sort of two way contract. In fact, health care is not like a normal business contract because the hospital renders the patient instantly into a professional dependency. That is all about trust.

Notice that patient visiting hours must be referenced in terms of "therapeutic effectiveness." Thus Mr. Israel Neustadter would clearly benefit from having his son there and chasing the son out would be contra therapeutic. Hospitals are supposed to revolve around patient care and not staff comfort. The 8 pm visitors leaving time is only for hospital staff benefit and not a hospital law of any type.

On page 71 the requirement in RI.1 is clear – respect for "personal values and beliefs …" Holy Cross Hospital would have presented a policy guaranteeing this to the inspectors. Such notebooks are reviewed on the first morning of inspection.

On page 72 it is clear that the hospital holds out the guarantee of treatment and not Dr. Weiner's dead at the door approach where nothing really matters. If they do not have the will for care, the patient is to be given another physician or another hospital.

Patients are to be given a copy of their rights (page 77) Standard RI.1.4 on the way into the hospital room. At one point in the past (I recall 1997) these rights included not to be given quick care against a DRG goal of beating the Average Length of Stay (ALOS). Truly these are supposed to be AVERAGE length of stay and not used as a business tool for maximum length of stay. The hospital will often slip DRG papers on charts encouraging quick discharge and remove them at the end as not relevant to the care.

RI.4 (page 79) "The hospital operates according to a code of ethical behavior." That means that the hospital's mission statement must be reflected in the front line care. In the case of HCH the mission is to attract seniors with hundreds of symbols of trust and then allow Dr. Weiner to give minimal care. And whatever direction Dr. Weiner would set would then be reflected through the nurses, the pharmacists, the social workers, and the post care apologists.

The patient's history and physical must be done within 24 hours. This means that an office based physician like Dr. Nawaz has 24 hours to render a thorough picture of his patient so that care can be rendered appropriately. He never defined the patient's baseline activities. He did not bring over an accurate medication list, thinking that is the family's job. [History & Physical was dictated on June 19, 2003 and signed on June 29, 2003, more than 3 months after patient died.]

PE.1 – "A patient's cultural and family contexts and individual background are important factors …" Dr. Weiner simply asks how many patients of this age are still alive. There is no individual context or average life span of the patient in his family (very high), as the rest of us use.

Nutritional assessment comes up in many area. Note TX.4.5 on page 102. It does not say that if an attempt is made to put in an NG tube and it fails that nutrition can be ignored a few more days. This is even more clear starting on page 115. On page 116 "A more intensive plan for nutrition therapy may be indicated for patients at high nutritional risk." Certainly a patient working hard to breathe and elderly is at high nutritional risk.

On page 265 the hospital must be able to achieve "conflict resolution." This does not mean keeping the patient in the same physician group that is trying to minimize care.

Dr. Weiner's confusion over what is a medical privilege is no less than bizarre for this is one of the most important functions of the hospital structure. MS.1.1.3 on page 272 "All medical staff members have delineated clinical privileges that define the scope of patient care services they may provide independently in the hospital …"

As far as leaving Mr. Neustadter without any real treatment (Dr. Nawaz, Dr. Shamim and Dr. Weiner), the Joint Commission states on page 280 and MS.5.10.2 – "[Each applicant] pledges to provide for continuous care for his or her patients;" Dr. Weiner did say that the buck stops with him for respiratory care decisions (believing he was beyond time limits of being sued).

The medical history and physical must be of high quality per page 315. And the care of the patient by a specific physician at any point in time is important. (MS.6.5.1 – same page).

Booklet - 2003 Hospital Survey Process – This book comes at accreditation from the process of preparing for an inspection. A hospital holding out to be accredited would during any year of care be expected to have the standards expressed.

The general strategy is to prepare notebooks in the order of the survey requirements and to keep them in one location. (page 12). Even the tabbing within the notebooks should match the requirements.

The key phone numbers of the Joint Commission are listed on page 17 and l8. Most of them are in Illinois at the headquarters.

The hospital documents start with "Patient Rights and Organization Ethics" (page 29) usually occupying one notebook. This is where issues about withholding care are organized and

presenting to the inspectors. This area also is where there should be a process of complaint resolution. Ethics should be described in detail.

Under "Management of Information" (page 33) a hospital should describe how the caregivers communicate. That might be a place where what might see if a physician can turn over the care to another physician, go home, and no create notes to nursing or other physicians about who is running the show.

The inspection teams go to inpatient units and start asking questions. Samples that relate to patient rights are found on page 81. Questions relating to nutrition come up on the top half of page 81. Though physician offices do not generally get accredited,[14] the guidelines are clear, e.g. such as tracking chronic problems and medications lists (page 97). Dr. Nawaz and his office owners apparently did not use any such summary.

Nursing assessments within 24 hours are important (page 126) (note that the nurses at HCH made no effort to confirm outpatient medications and also missed the thyroid medication). These redundancies are meant to provide safety.

Nutrition is to be addressed within the first 24 hours. (See page 126 #10 = PE.1.3). There was no evidence of Mr. Neustadter's nutrition being checked for days.

I think the accuracy of a discharge summary would relate to #44 – page 126. Lying about time in ICU and time of intubation is just one of the many problems found.

As to the clinical privileges, they must be clear for each physician. See page 137 (MS.1.1.2) There is no way Dr. Weiner could be confused about this. The "reappointing" time framework is not mentioned but it is two years.

Involvement of HCH Actual Agents

In its "Fact Sheet" Holy Cross Hospital explains that they have 3200 employees in contrast to a medical staff of 1200, the later more likely to be part time involved. These employees are clearly "actual" agents of the hospital.

Nurses - Hospitals describe the nurses as the eyes and ears of the hospital, as patient advocates working toward the goal of quality. But when they join Dr. Weiner in leaving Mr. Israel Neustadter's room – after only hearing that the physician was dismissed – they joined in the response as if they are all one team – all of us or none of us. Clearly the nurses – if reflecting the life supporting values of the HCH website – should have become patient advocates and help Mr. Alexander Neustadter out of the situation of no care.

Pharmacists - The pharmacists are agents of the hospital and are trained to insure the correct dose of medication safely gets to patients. There is no evidence that any pharmacist posed the

[14] I led the University of California Student Health Service through outpatient accreditation, so as to be the first such outpatient student health group on the West Coast in 1981. I did so because I thought the standards matched my own and that we could transform the program in the process.

question of why the Levaquin and Rocephin were at half dose in light of normal renal function. And there does not appear to be enough medication withdrawals to match the antibiotic orders (20 doses against 34 times antibiotics should have been given). So it is likely he got no antibiotics at times.

Patient Relations (worksheet) - The Patient Relations staff are agents of the hospital and noted clearly (attachment #2) that Mr. Alexander Neustadter was not happy with Dr. Weiner. They did not inform Mr. Neustadter that an Ethics Committee might help him find a pulmonologist that would follow his lead. They heard that antibiotics were not being given and took no action. On March 27th there is a record of Mr. Neustadter asking Dr. Weiner to leave the room and then requesting another doctor. Patient Relations, representing the hospital, just showed the art of active listening and recording comments – but no resolutions.

The comment on 3/26/2003 that Nurse Chris Canfield "observed him pushing ice chips down his father's throat" would suggest the son actually putting his hand to the back of the throat and pushing ice toward his father's Zenker's diverticulum. It is clear to me that this is a fabrication, as such an act would certainly be documented in the nurses notes contemporaneously rather than phoned in the next day. I would suspect this entry was created either upon death or upon subpoena of the Patient Relations Worksheet, in an attempt to suggest that Mr. Alexander Neustadter's actions contributed to his father's death.[15]

House Staff - The resident physicians at HCH appear to be paid by the hospital and would be actual agents. The residents share in the missing of the thyroid medicine. Dr. Nawaz's comments that a resident's mention of DNR would have no weight is not true – such comments could influence care immediately thereafter. When a resident enters a note that he has called Dr. Shamim and Dr. Shamim does not remember the call, the benefit would be given to the logged chart notes of the resident.

Dr. Eig – I have little doubt that Dr. Eig is paid to provide physician responses to both patient and physician problems. Most large hospitals have the unpaid medical staff as well as a paid Medical Director.

<u>Involvement of HCH "Apparent" Agents (staff MDs)</u>

Hospitals have changed enormously during my career, my first job being during the Summer between college and medical school in 1964 as an emergency room "orderly." That was some 43 years ago. I took personal pride in patients being comfortable and respected, in securing their belongings in bags for safety, in the equipment in each examining room in the emergency room including the tongue blades being in order, and in trying to learn what I could in an area that became my career. My rotations took me through many hospitals including Cook County Hospital and the VA Hospital.

At that point in time hospitals and patients had a common enemy – disease. Medical directors generally rose to the top of hospitals by publishing and teaching. As medical students at Northwestern University we watched for any of our professors to mess up – like the Chief of

[15] Maryland is among five states where contributory negligence bars recovery.

Medicine missing a penicillin allergy causing a strange fever. We were taught that someday we would find just as much satisfaction out of carefully excluding illness in the elderly as we now were having from interacting with new and complex expressions of disease; that prediction came true for me.

I often write about the rise of "managed care" and the transformation of hospitals that it brought about. Certainly Germany's invasion of Europe led to the rise of the Henry Kaiser (and Bechtel nearby) shipyards and the Kaiser Health plan. Pearl Harbor further magnified the trend, allowing Kaiser to purchase clinics for very little at the end of World War II.

Jumping to the 1960s, I view the death of President Kennedy creating a public expectation of some sort of legacy. In my version of history, President Johnson was to be the one with the legislative experience (and barbeque ability) to bring President Kennedy's dreams into law. And as part of the Great Society, Medicare was enacted. It did well until it was recognized in the HEW part of President Nixon's cabinet, that Medicare was costing too much.

As the KaiserPapers.info webmistress Vicki Travis discovered, Mr. Edgar Kaiser brought in the answer to the Medicare problem – prepaid health care such as had been put together by Kaiser Permanente. Perhaps the greatest example of fraud to be caught on Oval Office tape recordings was not the Watergate break-in, but rather this recording:

> [Assistant to the President for Domestic Affairs John Ehrlichman to President Nixon]: "Edgar Kaiser is running his Permanente deal for profit… All the incentives are toward less medical care because … the less medical care they give them, the more money they make."

[From a February 17th, 1971 conversation. President Nixon said "Fine…" on the same tape in response to Ehrlichman's summary of Kaiser ethics. His speech the next day set off the rapid growth of HMOs and "managed care." Mr Edgar Kaiser was the CEO of Kaiser Permanente at the time.[16] The movie "Sicko" recently reviewed the above Oval Office conversation.]

The invention of the term "Health Maintenance Organization" (Attachment #24 - page 6) occurred within this huge tipping of resources toward "managed care" and against the private practice of medicine and against the patient. And it began to chip away at the moral fiber of physicians and hospitals. More money could be made by giving the illusion of care – Levaquin at 250 mg a day rather than 500 mg a day – than by really trying hard. The best hospitals – like Saint Agnes of Fresno (also in the Holy Cross system of Trinity Health) – tried to weather the storm by moving its campus toward suburban money and by depending on the growth of donations for service (an endowment accumulation of $2 billion by 2003).

[16] Mr. Edgar Kaiser was at the time the CEO of Kaiser Permanente. Kaiser has made a profit in all but two of its sixty years – the profit in 2007 perhaps going over $2 billion. The physicians get 50% of that – though if any of them blow the whistle they risk losing their share.

Many trends made hospitals even more like mean machines. There were the Diagnostic Related Groups which came in around 1985 where hospitals were to be paid by admitting diagnoses rather than by services performed.[17] Overnight every physician was supposed to come up with expanded diagnoses while also reducing admission time. (See the huge HCH ER list on Mr. Neustadter). Hospitals started to put on the chart papers later to be pulled off suggesting that a particular admission was worth an average length of stay (ALOS) of perhaps 4.2 days. Beat the time and the hospital makes money (and vice versa). This did not reward knowledge – the brightest physicians able to think of more unsuspected illnesses – but rather it rewarded those who could bounce patients through as quick as possible and ignore details (like losing thyroid medications because that was "at the bottom" of some doctor's list of priorities).

Those physicians who got into medical malpractice problems would – if tied to trying to help the hospital win – actually be promoted during the very court contest. (Dr. Nawaz is the chief hospitalist now at HCH – see picture caption in Attachment #16.) The hospitals have plenty of ways to reward hospitalists since they get some $50,000 to $60,000 of their $169,000 salary – same article – from hospitals for taking care of those without insurance.

The financial pressures have been magnified after the HMO industry took a "lockstep"[18] hit from the "Balanced Budget Act of 1996" in which some $300 billion was withdrawn over some five years from the hospital industry. That set off the closure of some 800 emergency rooms nationally, added dangerous crowding to all the others, and forced the merging of hospitals. Each system had its own strategy – the Adventists generally going into medium size towns and closing down the more ethical of two hospitals previously in competition.

As HMOs tried to whittle down hospital budgets and threaten to move whole groups of captive patients from one hospital to the other,[19] hospitals pushed their advertising especially each Fall to try to create a facility identity usually trying to become blurred into their lead physicians as if they were one organizational entity. And the public has generally no idea how the financial relationships are organized. This is what the courts have noticed and apparently in cases like Meija v. Community Hospital of San Bernardino (Attachment #5 and #6) in California, Burless v. West Virginia University Hospital, Inc. (actually two case combined - Attachment #7), others in summary (Attachment #8), and a summary of Maryland Law (Attachment #9), the hospital has increasingly had the burden to explain to the public that the physicians are not apparent agents.

The West Virginia Supreme Court took notice of these various trends around the country to decide the following (again Attachment #7):

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[17] Maryland as a state has opted to try to prove that it consistently beats the federal predictions of health care costs – thus MORE rapid turnaround of patients – so as not to have to individually validate each charge. And while this reduces bookkeeping, it is also patient unfriendly as less is actually done for each illness. The seniors always become the most vulnerable in such schemes as they accumulate allergies and illnesses.

[18] This phrase was used in the "Bleeding Edge" book displayed in the movie "As Good As It Gets."

[19] Pacific HealthCare actually moved a 65,000 patient population from one hospital to another in Fresno some years back just to make a few bucks, also knowing that most patients stop their care until they can sort out their trust alignments all over again in new systems. But in prepaid health, no patient activity is the best money.

1) "B. Apparent Agency … "As with most general rules [that physicians are technically independent contractors] there are exceptions to the independent contractor rule. We have previously recognized that one who, by his acts or conduct, has permitted another to act apparently or ostensibly as his agent, to the injury of a third person who has dealt with the apparent or ostensible agent in good faith and in the exercise of reasonable prudence, is stopped to deny the agency relationship." (page 9 of 20) … As explained in more detail below, modern hospitals and their relationships with the physicians who treat patients within their facilities are rather unique and complex. Thus, instead of relying on a general rule of apparent agency such as those quoted above, we believe a more particular rule is in order."

2) Though the court has previously expressed the concept of "apparent agency" in the conduct of physicians in an emergency room, it now chooses through this combination of two cases and opinion to go beyond the ER. "We do so now." (page 10 of 20). "In light of this modern reality, the overwhelming majority of jurisdictions employed ostensible or apparent agency to impose limited liability for the negligence of independent contractor physicians."

3) Next they quoted from a New York ruling:
"'Modern hospitals have spent billions of dollars on marketing to nurture the image that they are full-care modern health care facilities. Billboards, television commercials and newspaper advertisements tell the public to look to its local hospital for every manner of care, from the critical surgery and life-support required by a major accident to the minor tissue repairs resulting from a friendly game of softball. These efforts have helped bring the hospitals vastly increased revenue, a new role in the daily health care, and, ironically, a heightened exposure to lawsuits [.]'"

I believe that Holy Cross Hospital has merged very much into this modern day formula. If one Googles the search term "Holy Cross Hospital – Maryland" about 89,500 entries come up (Attachment #18). A sampling of the first thirty shows that many of them emanate from the hospital itself - emphasizing its quality, its size, its teaching relationships, its physicians, its building programs etc. There is no attempt to discuss the economics of shortening hospital admissions to make money or the many types of financial relationships present.[20]

The HCH website (selections also in Attachment #18) does, in fact, hold out to be a service center for most conditions and most people. And in its "Welcome to Holy Cross" religion – life

[20] In Fresno, when some of the cardiologists at Saint Agnes Hospital joined in a venture nearby called the Fresno Heart Hospital – mainly part of a rival system called Community Hospitals of Fresno – Saint Agnes Hospital retaliated by hiring its own Physician Director of Cardiology from the outside. I personally heard from the cardiologists as to their panic at losing their practices for having tried to solve backups in cardiac catheterization. Saint Agnes appears to have won the contest by opening up its North Wing with cardiac focus, the "Heart Hospital" having to expand its mission to include bariatrics, etc. The old image of hospitals as conduits for physicians to come and go – perhaps as courts are today with attorneys – has long gone in the managed care struggles. And liability for such change has come with it. In a physician newsletter, one Chief of Staff of a large hospital in California has wondered if some of the soul of the hospital has been lost in the hospitalist transition. The employed Medical Director of the hospital – similar to Dr. Eig – would not have such second thoughts, as hospitalists have enhanced the business aspect of hospital care and depersonalized the tough decisions.

support in general – is held out clearly – "Holy Cross is a faith-based, mission-driven community teaching hospital serving the residents … The hospital is a member of Trinity Health, the nation's third largest catholic health center system."

Religious affiliation is a mixed blessing. It attracts patients to symbols of charity and beneficence[21] that are thousands of years old and yet the hospitals do not want to be legally linked to the Church systems they suggest. For example, the Seventh Day Adventists suggest that Adventists Healthcare West is entirely separate from their main organization and not even part of their "health mission," and yet the symbols of religion are everywhere in the Adventist hospitals in California from the lawn to the website to the newsletters.

The HCH physicians are closely tied into the hospital as if part of the weave: "Over 1,400 leading physicians are affiliated with Holy Cross Hospital, many of them among the most renowned specialists and general practitioners in the area" gives the impression that the hospital has cultivated the top physician talent. "…in fact, we train physicians from around the country …" implies that the hospital is the teacher of physicians.

One hospital has tried to make patients sign otherwise in California (Attachment J) but there is the legal risk of bait in ads and switch when it is too late (at the door). The Attachments suggest that all physicians are completely independent – "Physicians are independent contractors …" This is tied to "all physicians" but is really not a court reality. Patients initialing that paragraph at a time of no choice illness would rather feel that the ads speak for themselves and the various contracting authorities also give the hospital great power over many physicians, ER, ICU, radiology, pathology, etc. In effect, the physicians are not really "Independent." This is only the wish of hospital Risk Management.

And "senior services" are part of that for which the hospital is "proud," as if offered by the institution and not just a private practitioner of the art of medicine passing through for the day. Finally, the popular phrases of "Keeping you healthy is our first priority" suggest that income for that care might be far down the list of considerations. The appeal to the elderly continues with "live better, healthier, and longer" with no hint that one might be "dead at the door" if sick at 90.

Under the six page HCH "Fact Sheet" the various self-compliments roll out to attract more patients:

1. The "largest community hospital in Maryland";
2. A "full range of inpatient and outpatient primary and specialty care services" – as if one could expect care cradle-to-grave within the institution's many departments;
3. The new buildings under construction will include special attention for problems like "cancer" and the "elderly";

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[21] As a Christian connected hospital, they would be expected to follow the admonition in Matthew that *as you might withhold from the "least of them" in society (e.g. the elderly) so are you doing to a representative of God*. And while another religion might not relate to the same holy book, they might appreciate the statement of beneficence to all implied in the symbols.

4. Being "accredited" by "JCAHO" is proclaimed although there is no sharing of required the "Patients' Rights" on the website – to know diagnoses, to participate in care decisions with well-informed autonomy;[22]
5. Annual revenue of $325 million does not explain if there is any "profit" or bonus system involved;
6. "Holy Cross Hospital also operates its own hospice and home care programs" - which sounds as if the medical director must be salaried; there is no mention that hospice is a profitable venture with new federal money once the active treatment is retired;
7. The "Cancer Unit" is also described as if self-run – no hint of physicians coming and going as private and independent contractors;
8. The hospital is heavily into research – no clarity on how the physicians interact financially;
9. Emergency care is described with no separation of physicians and the hospital and, in fact, contracts do exist for partial pay of the ER group (perhaps 30% - 40%);
10. "Senior Services" begins at the bottom of page 3 – picturing the "hospital" as the "largest provider of health care services for seniors in suburban Maryland" – clearly it is far more than buildings and nurses awaiting the arrival of private physicians;
11. The hospital also brags about "cultural awareness and sensitivity" although there seemed to be a general theme of talking Mr. Alexander Neustadter out of pursuing active care for his father.

The typical resident of the area (potential patient or member of a patient's family) reading all of these guarantees of life value and institutional care and sensitivity would perceive no separation between the physicians and the hospital. And that is precisely what the hospital wishes to achieve.[23]

The HCH "Find a Physician" section encourages the patients or their families to search for physicians through the hospital's medical staff. The idea is to commit to the hospital and thus to stay within the family of physicians offered.

Further searches of the hospital's online efforts include its quarterly "Holy Cross Health 60+" (Attachments #19 and #20) again trying to encourage the elderly to use the hospital. The topics roll out from stopping falling, to living with arthritis, to understanding heart rhythms, etc. And commonly physicians will be quoted within the articles as if again fused with the hospital, e.g. "… Alan Schneider, MD, a Holy Cross Hospital cardiologist who specializes in heart abnormalities …"

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[22] Was the patient's son clear that Dr. Nawaz was trying a low dose of Levaquin for a condition Dr. Weiner would consider to be dead at the door? Where is the autonomy of patient or surrogate decision? We are back to the paternalism that was to be forever discarded after the Nuremburg trials of unethical physicians. I believe six physicians were hung (see the book The Nazi Doctors).

[23] It is the same attempt of the Kaiser HMO to "fly the Permanente flag" in calling the organization "Kaiser Permanente" as an operational fusion of hospital and physicians.

There is no attempt to define the relationship between the hospital and the physician or any method of payment. Phone numbers lead into the hospital nurse coordinators. Patients and physicians are pictured together within the framework of the hospital, e.g. the patient survivor, the hospital nurse, and the hospital's radiation oncologist. (Attachment #19 - page 10). This fusion may well attract patients but it also should suggest apparent legal agency.

Not surprisingly the hospital uses the same magazine to look for donations, this time looking like a sculptured plant called "Gratitude." The goal of such money is to be prepared for the "aging" of the patients in the counties served. The message is that the hospital will care for the elderly even though insurance and government monies are "declining." The message is that the hospital will not take the lower road and reduce services to the elderly.

All through the pages "Medical Directors" are heralded as being part of Holy Cross Hospital. Once again there is no separation. "'Vertebroplasty takes only 30 minutes and usually does not require an overnight hospital stay,' says Philip Schneider, MD, an orthopedic surgeon and medical director of the Holy Cross Hospital Spine Center.'" (Attachment #20 – page 2 and 3 – pictured in the hospital and not in his office).

No surprise there is an effort at HCH to get "Advance Directives" out to seniors and their families as if they are empowerment documents. Actually all they do is reduce the number of family members to be pressured into no intubation, no ICU, and comfort care. And that is Dr. Nawaz' view of the Ethics Committee at HCH. HMOs have learned to make ICU into an intubation torture chamber.

The editorial panel is near the back. No surprise we find the "Director of Marketing" a key player in the magazine. Funding for the Health 60+ would come under marketing.

There is finally a note that "models may be used" in pictures and that "Personal health problems should be brought to the attention of physicians …" at a type size seniors will be unlikely to read. The overall message is to blend your life, finances, and health with the hospital, a place you can trust.

As to actually learning the mysteries of how many of the physicians get partially paid by the hospital, one has to get a hold of the public financial papers. Guidestar.com (Attachment #14) has been a good resource but payments for information have gone way up – now $1000 for premium service. One can also try to look at other sources like Attachment #21 – bonds. Hospital bonds and state financing mix in a way that somewhere one may be able to access Bond information books.[24]

The Pulmonary Intensivists would, from the perspective of patients (like Mr. Israel Neustadter) and the families of the patients (like Mr. Alexander Neustadter) be considered part of the hospital for many reasons including:

[24] Kaiser Hospital Bonds booklets talk of $25,000 per bond as the price for investing, with no need to declare interest due to the state authority connection.

1. That when Mr. Alexander Neustadter asked Dr. Weiner to leave the room due to his lack of willingness to fight the illness at hand, Dr. Weiner stated to the effect that "he wants us all to leave";

2. That when Mr. Alexander Neustadter asked the head nurse to help him get a substitute physician who might follow the guaranteed autonomy of his decisions, she was unable to do so;

3. That when Dr. Shamim deferred care to Dr. Weiner and the latter left no note, the impression was that Dr. Weiner could direct the decisions through the inaction of nursing rather than take responsibility for physician inaction with an actual chart note;

4. That HCH promotes physician directors as if they and the hospital are one.

Conclusion

Dr. Nawaz should have never tried Dyazide again on Mr. Israel Neustadter; if his group likes to retry medications that cause reactions, the office should be closed. The lab test which showed an elevated WBC needed attention, the prudent action being to check for bands while the sample was still available for three days. Clearly the Dyazide had touched off an aspiration event. Lack of attention to this problem led to septic shock.

The transfer of the patient to the ER without a problem list, a medication list, and an accurate note about what happened got everything off to the wrong start. The HCH ER added to the problem by trying to magnify DRG diagnoses while missing the simple – low thyroid and pacemaker. I believe they called Dr. Weiner through an MDxL contract with the AARP/PacifiCare Insurance; he was put in at too low a care level and with DNR.

Although the unit intensity was increased, Dr. Weiner and Dr. Nawaz worked off a dead-at-the-door approach by minimizing antibiotics, extubating too soon, failing with nutrition, failing to support thyroid, failure to analyze the pacemaker rate, failure to call infectious disease, etc. Then the duo of Dr. Shamim and Dr. Weiner managed to turn a bad episode into abandonment. The goal was to make sure the patient died by withholding care.

Religious beliefs – here appropriately magnified by death camp experiences with terrible family losses – were disregarded. The son – who was supposed to run the care strategy – was treated as if he was the problem. Dr. Weiner, an expert in withholding care, decided that less was better. Attempts to find a physician matching the son's wishes – the real purpose of Ethics Committees – did not exist. Nursing fell in line with the do-nothing approach.

To the extent that materials are still missing – like actual antibiotics given – and who was really in charge of the care, any time limits should be suspended against any legal rights possible. For if there is no accountability, there is no quality. The elderly around HCH are at high risk even as they are being courted to come in and trust.

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