Review of Israel Neustadter's care at Holy Cross Hospital by Dr. Paul Genecin, Professor of Internal Medicine at Yale Medical School and Director of Yale University Health Services.

PG Opinions:

1. Lack of appropriate pre-hospitalization treatment of s/s infection; this was Nawaz.

a. Lack of pre-hospitalization attention to high WBC contributed to bad outcome by ignoring early sign of infection, likely originating in sinus and/or pneumonia due to aspiration.

b. Likelihood that he would decompensate and aspirate due to lethargy and worsened mental status and become septic was increased by failure to treat early infection & by potentially over-treating with antihypertensive medication.

2. Lack of relevant information sent to ED; this was Nawaz.

a. Even as attending of record, he failed to give accurate history and background.

3. Lack of effort in ED to elicit info from Nawaz –since they could have called Nawaz and gotten the info. However, Nawaz was the attending of record and should have brought in the pertinent history.

a. Pt. Med list was good example.
b. Allergies.
c. Problem list
d. Info about his premorbid condition.

4. Actual history of events was missing, including his baseline mental status, which had acutely worsened.

i. In other words, he may have looked a lot worse in the hospital than his pre-morbid baseline (he was mildly demented but living good quality of life.) Assumption that he was worse off than he really was might have led providers to confuse delirium (acute and transient if properly treated) for worse dementia than he actually had. This could have led to less aggressive care. So adequate information from Nawaz was lacking and neither he nor hospital remedied this information gap.

5. Thyroid condition drops off list of problems and is not treated or even tested.

a. Hypothyroid state would have worsened status and prognosis.

6. His nutrition is treated as an elective, *even unimportant* issue despite failure to give nutrition. He had critical prealbumins (3.8 on 3/17- reported 3/19; 7.5 on 3/20 and 11.5 on 3/24) and observations about nutritional status made repeatedly by son.

a. Assessment of his nutritional status waited until prealbumin finally sent 3/17. This was a significant delay.

b. PEG took over a week. TPN started at least 5 days after admission despite son's realistic concern about starvation.

c. **Poor nutritional status led to catabolic state and deconditioning/ weakness; these were major issues contributing to inability to manage him once extubated.**

7. **Antibiotics: Mr. N. needed an ID consult, as his internist and pulmonologists did not seem to give his pneumonia therapy proper thought. This was not community acquired pneumonia; it was aspiration pneumonia.**
   a. **His ceftriaxone was at ½ the dose recommended for sepsis and his Levaquin was at ½ dose. This critical factor in lessening likelihood of recovery from pneumonia/sepsis.**
   b. **The choice of antibiotics was questionable, which also lessened the likelihood of cure.**

      i. **There is redundancy between Levaquin and Rocephin.**
      ii. **There is a gap in coverage for aspiration pneumonia, which mandates antibiotic regimen with good anaerobic spectrum.**

1 **eg Clindamycin (or high dose PCN G) plus Levaquin OR**
2 **eg monotherapy with Timentin or Zosyn (extended spectrum beta-lactams plus betalactamase inhibitor.)**

      iii. **His doctors needed to obtain an ID consult and it is perplexing that neither pulmonologist addressed the coverage of anaerobes.**

8. **His extubation was done prematurely on 3/17 when he still had lots of secretions and was lethargic, as well as starving.**

   a. **Evening at ~6PM unusual hour to choose, but this isn't really relevant in the big scheme.**
   b. **Nutrition not optimized and there was little evidence that he was 'ready to fly' off the vent at this point. (This is salient).**

9. **He should have been re-intubated before- and certainly when - airway problems became critical.**

10. **RN staff had duty to do complete assessment at admission and at times of transfer to different services- but they do no medication reconciliation – so Thyroid issue is unaddressed. They also have duty to reconcile DNR orders and ensure that order is consistent with wishes of son and aligned with plan of care.**

11. **RN staff documenting serious problems with pulmonary secretions and pulmonary toilet had duty to address airway protection with the MD staff. They are required to do patient assessment and to communicate with son as well as MD staff. Daily suctioning of patient who has ongoing problems with obvious aspiration needed a care plan and none was forthcoming. The nurses needed to do an assessment and work with the MD's on direction of care. Instead they treated Mr. N as terminal case.**

12. There is duty to prevent the preventable when medical situation is not futile. Examples of futile situations are persistent vegetative state, end-stage cancer, cardiogenic shock, massive stroke and end-stage dementia, etc.
    a. It does not appear that this needed to be Mr. N's terminal admission.
    b. If he had optimal care for infection, nutrition, aspiration risk due to Zenkers, he would not have died then.
    c. MD's and Rn's could have scheduled meeting with Rabbi(s) or ethics committee if there was difference of opinion about whether interventions would have been futile.

13. Since this wasn't futile care – and certainly the surrogate decision maker did not think so (and with good basis) - and since Mr. N. had problems with aspiration including pharyngeal dysphagia and Zenkers, his risk of aspiration was obvious and there was a duty to manage the airway before the catastrophe, rather than withholding care and letting him crash.
    a. He was observed to aspirate and reasons were known.
    b. A number of effective treatments existed to address this. This would have included trach. There are other surgical means of addressing this as well, including fixing Zenkers at some point.
    c. This was despite lots of respiratory toilet problems before intubation and after extubation, when he was observed to aspirate, had lots of problems with pulm toilet and eventually had ominous swallowing eval.
    d. The same applied to nutrition as soon as it was evident that he couldn't eat normally. Giving him nutrition was not futile care, yet it was withheld.

14. RN staff as well as the MD's have duty to ensure that the patient gets basic needs such as nutrition met.

15. He needed ICU care but only had it for the days he was intubated. Venue of care (regular floor, step-down units inappropriate) considering his tenuous status re: infection, malnutrition, and airway.

16. Haldol o/d'ed and not dc'ed as recommended on 3/20 by GI. This was factor in problems managing off respirator.

17. The benefits of effective medical treatment for Mr. N. outweighed the risks. He had a meaningful life to go home to. He had treatable problems. i.e., this was not futile care. These treatments were all low-risk and included:

    a. adequate nutrition,
    b. appropriate antibiotic therapy,
    c. standard care of his airway,
    d. thyroid hormone replacement therapy.
    e. There were no radical treatment interventions on the table.

18. The resources to provide the care Mr. N. needed were readily available.

a. Yet providers advised against intubation and airway care and withheld appropriate interventions, while they ascribed their own inconsistency in care to son's ambivalence.

i. Son would inevitably have been ambivalent in this wrenching situation and care givers had duty to help with clarification by transparently addressing issues including abx, airway, nutrition, thyroid, etc.

b. They tried to delegate to son the decision to withhold care- when it was by no means clear that this is what son intended. (In fact, to the contrary.)

c. Son couldn't have been expected to meaningfully direct his father's care without information and transparency– yet critical information was withheld, while interventions that would have helped Mr. N. were also withheld.

i. The son could not "hold the bag" for decision making without transparency and guidance from impartial, sympathetic care givers.

ii. Clinical staff seemed to prefer to struggle with son and write derogatory things about him than to provide adequate care for father.

d. Many notes seem to indicate that the son was a confusing and confused guide as to how much care to provide, but clinical staff consistently counseling him as to the futility of all the interventions that exist in hospitals to offer to sick people.

i. Nawaz, both pulmonologists, the cardiologist (alleging that he is just making social call), and nursing staff all participated in this biased counseling. They treated Mr. N's death on this admission as a foregone conclusion.

19. Conflicting values: He was ordered DNR and this admission order never formally reversed, despite many notes documenting full code status. RN's and MD's allowed him to die on 3/27 without clarification of DNR status. If not DNR, he should have been resuscitated, including intubation and associated intensive care. It was duty of RN's and MD's to ensure that code status was clarified, transparent, in alignment with family's wishes and values, and clearly documented. It seems that they just decided to withhold care on 3/27 (intubation, pulm toilet, care of infection, etc.)

a. Son's wishes not respected and clarification never sought in transparent and effective manner.

i. Clinical staff needed to communicate to the son Mr. N's clinical status, the range of interventions that were possible – and then they needed to listen. It was clinical staff's duty to seek alignment based on common understanding of issues and options for Mr. N.

ii. This deviation from standard of care was on the part of the MD's, the nurses and the hospital.

b. It doesn't seem that provision of basic interventions such as those listed should have violated the ethics and professional judgment of the caregivers, except that Mr. N. was 91.

i. (I mention this because there is no duty to provide medical interventions that are futile. An example of this would be Hemodialysis in a brain-dead patient.) Mr. N. did not qualify as a futile case.

c. The goals and direction of medical care were unclear and there was mismatch between understanding of son and that of the care givers. This is salient.

i. Although mildly demented, Mr. N. had a good quality of life at home with his son and there was no indication that he had end-stage neurologic disease, cardiopulmonary disease, cancer, renal disease or other reason why this should have been his terminal admission.

1. He was treated as if it were self-evident that this should be his final admission and that his death was pre-ordained at admission.

d. The goals of the son and of the care team should have been formally reconciled. There is a defined process for this.

i. The son felt that his father would get better and come home, but the doctors and nurses seemed to sign off on him at admission, not even providing adequate history, treatment for admitting dx's and basic care such as nutrition.

ii. Since there was obvious disagreement about whether son's goals were realistic, providers had a duty to effectively convey or demonstrate to son that situation was hopeless. There is a process for this.

iii. Clinical situation wasn't hopeless, however. When son lobbied for more and better care, and at the times when his father received it, the son saw some improvements.

e. If the son's desires for interventions were unrealistic, MD's are not required to offer care, but this was not the case.

i. There was a good chance that Mr. N would have recovered sufficiently to go home if treated aggressively and this is how the son wanted him treated. Yet the MD's and RN's never bothered to correct the DNR order – and they were passive and did as little as possible to treat infection, prevent aspiration, provide nutrition, etc.)

f. Son's right to informed consent to strategy of care was violated, including DNR, intubation, nutrition, thyroid and other aspects of care including giving him a realistic appraisal of risks of intervention and risks of not providing the intervention. It seems that son was more realistic about the risks of withholding care than the doctors and nurses.

g. They didn't listen to son, but wrote him off as unrealistic (?just as they wrote off the father because of his age.)

h. In the end his decline and death were handled as if he had been made DNR when this was not the case.

20. It was inappropriate to ignore the son's right to autonomy in decision-making in this case. The son was the clear surrogate decision maker since father was incapacitated. This gave him specific rights to information and to input about direction of care. The care givers had a duty to align decisions with his wishes.

a. Through their actions and words the care-givers decided that Mr. N's life was not worth trying to save.

b. **Yet there was competent surrogate who disagreed.**
    i. **The surrogate's opinions were not unrealistic or irrelevant.**

21. **The hospital, including its agents such as heads of ICU, RN's and others have duty to have in place a formal system and PNP for ensuring that ethical and sound decisions are made on behalf of patients. If there is disagreement, the institution must make resources available to care team and to patient or surrogate to resolve disagreements about treatment goals, issues of futility, etc.**

    a. **This is where the ethics committee would have been needed – or a family meeting with rabbi. The meeting should have put all cards on the table so that information could be openly shared - & alignment on goals and action plan could be defined.**

22. **The doctors, nurses and hospital were at fault for withholding care (not treating the treatable) in the form of antibiotics, nutritional support, airway protection, thyroid replacement and in failing to make attempts to prevent the preventable (eg, passively allowing starvation, aspiration, under-treatment.)**

References consulted in Neustadter review:

Schweikert, et al. Informed Consent in the Intensive Care Unit: Enduring Understanding in a Complex Environment. Current Opinion in Critical Care 2000; 11: 624.

• American Thoracic Society -ATS Guidelines: Withholding and Withdrawing life-Sustaining Therapy. Am. Rev Respiratory Diseases 1991;
144: 726.

American Gastroenterological Association (AGA) -AGA Guideline: Oropharyngeal Dysphagia. Gastroenterology 1999; 116: 452.

Principles and Practice of Infectious Diseases. Mandell, Gerald L., Bennett, John E., Dolin, Raphael 6th ed., 2005. (MD Consult : Churchill Livingstone)

i. Pneumonia Syndromes

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