STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Office of Health Care Quality
Spring Grove Center • Bland Bryant Building
55 Wade Avenue • Catonsville, Maryland 21228-4663
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

March 1, 2010

Mr. Alexander Neustadter
1111 University Blvd. West
Apt. 405
Silver Spring, Maryland 20902

Dear Mr. Neustadter,

Below please find a chronology of the Office of Health Care Quality's efforts to address the concerns you have raised regarding the care your father, Israel Neustadter, received while a patient at the Holy Cross Hospital during March of 2003:

- On December 19, 2006, you personally visited the Office of Health Care Quality (OHCQ) and met with the Assistant Director and a nurse surveyor of the hospital unit. During this two-hour meeting, you alleged that the physicians caring for your father failed to provide intubation when his condition deteriorated. You also alleged that the physicians acted unethically in the treatment of your father.

- Between December of 2006 and April of 2007, the nurse surveyor conducted an investigation into your complaints. As part of this investigation the surveyor reviewed various documents, including but not limited, to your father's medical record, hospital policies and procedures, and related peer review material. It was noted that even before OHCQ investigated your concerns the hospital itself, based on complaints you made directly to them, had conducted an external peer review of your father's care which concluded that the care provided to him was appropriate. The surveyor also conducted various interviews involving physicians, the hospital's Chief of Staff and the hospital's risk manager. The surveyor reviewed the findings of her investigation on an ongoing basis with OHCQ's Medical Director who also had numerous conversations with the hospital staff regarding your father's care. During this period the nurse surveyor remained in contact with you and you provided additional information and made further allegations of inadequate care. The surveyor, as well as OHCQ's Medical Director, reviewed the additional information you supplied and investigated each additional concern raised by you. As a result of OHCQ's investigation, Holy Cross Hospital received a deficiency which centered on the failure of the physicians to complete a "certification of condition" form when your father was made a DNR*(do not

* But no investigation into ***why*** or ***how*** he was made a DNR, when Drs. Nawaz (admitting), Shamim (attending), Kariya (pulmonologist) and the surrogate *all* say he was full-code. This unauthorized and expired DNR, absent from original medical records, made my father a "candidate for intubation." Why wasn't he intubated?

resuscitate). The nurse surveyor and Assistant Director of OHCQ's hospital unit discussed the investigation with you and provided you with a copy of the cited deficiency. Additionally, they explained to you why they were unable to substantiate the numerous other allegations of inadequate care that you had made.

- On December 7, 2007, you contacted the Director of the Office of Health Care Quality and asked that your complaints against Holy Cross Hospital be re-investigated in light of new information you obtained via a civil action against the hospital. Your request was forwarded to the Chief Nurse of the Office of Health Care Quality who met with you on December 27, 2007. During this two-hour meeting, you expanded your allegations of inadequate care to include areas such as nutrition, medication management, medical records, physician judgment and physician communication. During and subsequent to this meeting, you supplied the Chief Nurse with various documents including electronic links to files of depositions obtained during the discovery phase of your civil litigation. Ultimately you supplied the Chief Nurse with similar electronic links to the transcripts of the civil trial which included over 1,100 pages of documents. All documents provided by you were reviewed extensively by the Chief Nurse as well as a second nurse surveyor who had recent acute care hospital experience. The new Medical Director of the Office of Health Care Quality was consulted and also reviewed the care provided to your father by the physicians at Holy Cross Hospital. This exhaustive review, conducted between January and August of 2008, , did not result in the finding of any additional deficiencies. However, OHCQ determined that an unannounced survey would be conducted at Holy Cross Hospital to determine current compliance with regulations related to healthcare decision making. You were notified of this decision via e-mail on September 9, 2008. It should be noted that there was regular communication between the Chief Nurse and yourself between January, 2008 and September, 2008, including a second meeting with you in August of 2008.

- On September 17, 2008, the OHCQ's Medical Director and Chief Nurse conducted an unannounced survey of Holy Cross Hospital. The care of current patients in the intensive care units of the hospital was reviewed as well as several medical records of recently discharged patients. Deficiencies related to the hospital's failure to comply with Maryland's Health Care Decisions Act were cited and shared with you along with the hospital plan of correction. Additional a medical records deficiency related to your father's discharge summary was cited as well. Once you were supplied with these deficiencies you had numerous questions related to them which were answered in multiple e-mails by the Chief Nurse.

- In December of 2008, you made a request to both the Chief Nurse and the Director of the Office of Health Care Quality that your father's care once again be re-investigated. Given the extent of the previous investigations your request was respectfully declined.

- During the summer of 2009, the Office of Heath Care Quality was contacted by a representative of Senator Mike Lenett's office. The Senator had received a complaint from you that the Office of Health Care Quality had failed to adequately investigate the care provided to your father at Holy Cross Hospital in 2003. The staff at OHCQ spent several hours explaining to the Senator's representative the steps involved in responding to your initial and subsequent complaints.

- On January 29, 2010, you contacted me as the new Director of the Office of Health Care Quality and asked me to reopen the investigation into your father's care at Holy Cross Hospital in 2003. I met with the Medical Director, Chief Nurse and Assistant Director of the hospital unit and reviewed what actions had been taken to date to address your concerns. I then informed you that your complaint had already been thoroughly investigated and no further action would be taken by OHCQ.

In February of 2010, the Office of Health Care Quality was contacted by a representative of the Governor's Office as a result of a complaint by you that OHCQ had not thoroughly investigated the care your father received at Holy Cross Hospital in 2003. You specifically alleged that your recent request to me as the new Director of the Office of Health Care Quality to reinvestigate your complaint was denied without an explanation , when, in fact, I corresponded with you via email, stating I had fully assessed OHCQ's internal review of your complaint and the final outcome of that review. I reiterated to you that the initial and subsequent evaluations were thoroughly performed and completed utilizing a significant number of resources and personnel, which included the expertise of two medical directors, several surveyor staff, which included two nurse surveyors, two Directors of OHCQ and an Assistant Director, as well as our Chief Nurse. I also informed you that I found "our investigation to be complete and no reason to re-open the case".

Lastly, you have expressed a repeated concern that the issue of physician communication (you describe as the "hand off" issue) regarding your father's care was never fully explored or explained by the staff at the Office of Health Care Quality. During the course of your civil litigation, one of the physicians caring for your father could not recall a specific communication between him and another physician who was also involved in your father's care. Put in the context of the overall care you father received, this single episode, based on the memory of a physician several years after the event, does not rise to the level of a citable deficiency.* The Maryland Board of Physicians has also completed their investigation into the two physicians that you reported to them. They found no actions against either physician and have declined to reopen the investigations as well.

To date, OHCQ has spent approximately 200 hours investigating your father's care at Holy Cross Hospital. Despite our best efforts and multiple attempts to explain our rationale, we are sorry that you do not agree with our findings.

Sincerely,

Nancy Grimm

Nancy Grimm, RN, JD
Director,
Office of Health Care Quality

cc: Peggy Watson
Yolanda Winkler
Office of the Governor

* The *single episode* that does not rise to the level of a citable deficiency: Dr. Jay Weiner testified that he did not recall talking with attending physician Dr. Shahid Shamim the night before my father died. Dr. Shamim however, clearly remembers turning over all care of my rapidly degrading father to Dr. Weiner and leaving the hospital. Dr. Shamim's testimony substantiates the crux of my original complaint to OHCQ: that he falsified his progress notes to omit Dr. Weiner's presence, and that Dr. Weiner and Dr. Shamim abandoned my dying father. OHCQ deemed this unworthy of investigation, never even contacting the principals involved.