HolyCrossHealth.com

Annotated records with complete physician progress notes

CONTINUATION SHEET

2.27.13 Neustadter, Israel 4.14.41 New Patient ____ Established Patient ____

Date Name DOB

Family/Social History: see initial visit

Subjective: CC leg weakness cold

- family noticed that pt more lethargic recently started on Dyazide

Medications: see medicine list

Objective:

Vitals: wgt. ht. BP 140/70 P 76 Temp. 96.5

	Nml.	Abnl.	Abnormal Findings
General			
HEENT			- N.C.A.T., oral mucous membranes dry
Lungs			- CTA
Heart			- RRR
Breast			
Abd			- soft, nontender
Genital/Rectal/Prostate			
Muskoskelatol/Extremities			- 4 ECHE
Skin			
Neuro			

Assessment: see problem list

- start BMP. R/O hyponatremia also start CBC.

Plan: continue prior medications

- Hold on diuretic

- cont other meds

2/27/13

Doctor Signature or Initials _____ **Date** _____

Eleven days prior to admission:
Symptomatic patient with hyponatremia and elevated white count of 14.3 with neutrophil predominance.
Isn't follow-up warranted?

Holy Cross Hospital
Fri Feb 28, 2003 01:23 am
Outpatient Summary Report-General Lab Studies

Pat Name: NEUSTADTER,ISRAEL Page: 1
Unit #/Acct #: 815510/M0305800320
Loc: LAB 02/27/03
Phys-Service: NAWAZ,AHMED - MEDICAL

****

In: 02/27/03 1856
Out: 02/27/03 1929
Coll Time: 02/27/03 1813
Order Phys: NAWAZ,AHMED

BASIC METABOLIC PANEL

Spec: Blood
Techs: V8491 T499

[M0305800320/5440005]

*STAT*STAT*STAT*

Result Name	Result	Normal Range
Sodium(mmol/L):	125. L	135-145
Potassium(mmol/L):	3.8	3.8-5.2
Chloride(mmol/L):	88. L	96-112
Carbon Dioxide(mmol/L):	25.	22-30
Glucose(mg/dl):	83.	70-110 <140=Gestational
Urea Nitrogen(mg/dl):	18.	7-22
Creatinine(mg/dl):	.8	0.5-1.2
Calcium(mg/dl):	8.2 L	8.7-10.7

In: 02/27/03 1856
Out: 02/27/03 2240
Coll Time: 02/27/03 1813
Order Phys: NAWAZ,AHMED

CBC,AUTOMATED DIFF

Spec: Blood
Techs: V8491 T10636

[M0305800320/5440005]

*STAT*STAT*STAT*

Result Name	Result	Normal Range
WBC(K/mm3):	14.3 H	3.6-10.8
Red Blood Cells(M/mm3):	3.36 L	4.73-5.61
Hemoglobin(gm/dl):	11.5 L	13.0-16.9
Hct(%):	32.0 L	42.2-48.6
MCV(fl):	95.5	84.0-97.6
MCH(pg):	34.2	27.3-34.3
MCHC(%):	35.8	33.0-36.1
RDW:	11.5	11.5-14.5
Platelet,Auto(K/mm3):	227	140-440
MPV(fl):	8.29	8.0-12.0
Auto-Lymphocytes(%):	10.3 L	23.6-57.9
Auto-Monocytes(%):	8.64	2.0-10.0
Auto-Neutrophils(%):	79.2 H	42.0-75.0
Auto-Eosinophils(%):	1.63	0.0-10.0
Auto-Basophils(%):	.229 L	0.5-2.0

End of Report - 02/28/03 01:23am

L=LOW H=HIGH P=PANIC &=ADDENDUM C=CORRECTED

NEUSTADTER,ISRAEL
815510/M0305800320
LAB 02/27/03
(M-04/14/11)
Dr. NAWAZ,AHMED

Absolute Neutrophil Count of 11.3, more than double patient's 10-year baseline; even more suspicious for bacterial infection than bandemia (left-shift).

Holy Cross Hospital
Fri Feb 28, 2003 07:25 pm
Outpatient Summary Report-General Lab Studies

Pat Name: NEUSTADTER,ISRAEL Page: 1
Unit #/Acct #: 815510/M0305800320
Loc: LAB 02/27/03
Phys-Service: NAWAZ,AHMED - MEDICAL

****

In: 02/27/03 1856
Out: 02/27/03 2240
Coll Time: 02/27/03 1813
Order Phys: NAWAZ,AHMED

CBC,AUTOMATED DIFF

Spec: Blood
Techs: V8491 T10636,10507
[M0305800320/5440005]

*STAT*STAT*STAT*

Result Name	Result	Normal Range
WBC(K/mm3):	14.3 H	3.6-10.8
Red Blood Cells(M/mm3):	3.36 L	4.73-5.61
Hemoglobin(gm/dl):	11.5 L	13.0-16.9
Hct(%):	32.0 L	42.2-48.6
MCV(fl):	95.5	84.0-97.6
MCH(pg):	34.2	27.3-34.3
MCHC(%):	35.8	33.0-36.1
RDW:	11.5	11.5-14.5
Platelet,Auto(K/mm3):	227	140-440
MPV(fl):	8.29	8.0-12.0
Auto-Lymphocytes(%):	10.3 L	23.6-57.9
Auto-Monocytes(%):	8.64	2.0-10.0
Auto-Neutrophils(%):	79.2 H	42.0-75.0
Auto-Eosinophils(%):	1.63	0.0-10.0
Auto-Basophils(%):	.229 L	0.5-2.0
Auto-Lymphocyte(K/mm3):	1.48 &	1.2-3.4
Auto-Monocytes(K/mm3):	1.23 &H	0.2-1.0
Auto-Neutrophils(K/mm3):	11.3 &H	1.4-6.5
Auto-Eosinophils(K/mm3):	.233 &	0.0-0.7
Auto-Basophils(K/mm3):	.033 &	0.0-0.2

End of Report - 02/28/03 07:25pm

L=LOW H=HIGH P=PANIC &=ADDENDUM C=CORRECTED

Five days prior to admission:
Shouldn't white count be rechecked with BMP?
Shouldn't still-symptomatic patient be seen in office?

Holy Cross Hospital
Wed Mar 05, 2003 11:12 pm
Outpatient Summary Report-General Lab Studies

Pat Name: NEUSTADTER,ISRAEL Page: 1
Unit #/Acct #: 815510/M0306400169
Loc: LAB
Phys-Service: ALTSCHULER,MORTON - MEDICAL

****

In: 03/05/03 1225
Out: 03/05/03 1246
Coll Time: 03/05/03 1215

BASIC METABOLIC PANEL

Spec: Blood
Techs: V1984 T507

Order Phys: ALTSCHULER,MORTON [M0306400169/5448621]

*STAT*STAT*STAT*

Result Name	Result	Normal Range
Sodium(mmol/L):	132 L	135-145
Potassium(mmol/L):	4.3	3.8-5.2
Chloride(mmol/L):	98.	96-112
Carbon Dioxide(mmol/L):	28.	22-30
Glucose(mg/dl):	73.	70-110 <140=Gestational
Urea Nitrogen(mg/dl):	9.	7-22
Creatinine(mg/dl):	.7	0.5-1.2
Calcium(mg/dl):	8.4 L	8.7-10.7

End of Report - 03/05/03 11:12pm

Ordering Phys: ALTSCHULER,MORTON 815510

pec. Type: Blood Collected: 03/05/03 1215 [5448621]

esult name	Result	Normal Range
odium(mmol/L):	132. L	135-145
otassium(mmol/L):	4.3	3.8-5.2
hloride(mmol/L):	98.	96-112
arbon Dioxide(mmol/L):	28.	22-30
lucose(mg/dl):	73.	70-110 <140=Gestational
rea Nitrogen(mg/dl):	9.	7-22
reatinine(mg/dl):	.7	0.5-1.2
alcium(mg/dl):	8.4 L	8.7-10.7

End of Report!

STAT* A/Date: 03/05/03 1225 Mar 05,2003 1503 (04/14/1911) 1
DUPLICATE BASIC METABOLIC PANE M0306400169 LAB
EST STATUS: Done NEUSTADTER,ISRA

TOTAL P.01

CONTINUATION SHEET

3/10/03 Neustetter, Israel 4/14/11 New Patient ___ Established Patient /
Date Name DOB

Family/Social History: see initial visit

Subjective: ~~pt~~ fell
- pt fell at home, feeling tired. also not responding the way he does. he also hit his head.

Medications: see medicine list

Objective:

Vitals: wgt. ht. BP 70/palp P 100 Temp. 98.9

	Nml.	Abnl.	Abnormal Findings
General			
HEENT			
Lungs			bibasalar rales.
Heart			rr.
Breast			
Abd			Soft, nontender.
Genital/Rectal/Prostate			
Muskoskelatol/Extremities			↓ edema.
Skin			
Neuro			

Assessment: see problem list
- sepsis v/s Subdural hematoma.

Plan: continue prior medications
- 911 called, pt has been taken to Mollycaos hospital
- spoke ē ER physician

Doctor Signature or Initials [signature] Date 3/2/03

HOLY CROSS HOSPITAL
A Member of Holy Cross Health System
1500 Forest Glen Road • Silver Spring, Maryland 20910-1484 • (301) 754-7500

Patient: JSTADTER, ISRAEL
Medical Record #: 815510
Account #: 0306900162
Visit Date: 3/10/2003
Age: 91 *Sex:* M
DOB: 4/14/1911

EMERGENCY DEPARTMENT RECORD

*BP: 90/50 mm. Hg Sitting 12:02
BP: 130/53 mm. Hg Supine 14:07
P: 62 /min. 12:02
Resp: 18 /min. 12:02
Temp: 98.3 F Oral 12:02
PulseOX: 98 % Room Air 12:04

MEDICATIONS: Medication list reviewed - see list. (KRM)

Medication list is lost. Hospital fails to administer Synthroid, Cosopt, Betagan.

CONCISE SUMMARY: [Pts. son states that his father fell at home 2 nights ago. Pt. lives with the son in his apartment. Pts. son states that pt. has gradually become disoriented since the fall. Pt. normally carries on a conversation and responds sponateously to questions but since the fall the pts. son states that the pts. mental status has progressively become worse. Pt. was in to see Dr. Nawaz today and was sent to the ER.] (KRM)

HISTORY:
12:02 The onset of the presenting problem began [3] days ago.The patient's son supplied some of the history. Overall the history seems quite reliable.

Problem #1 Fall: The patient lost their balance and fell.

Problem #2 Decreased level of consciousness: Presents with an altered level of consciousness.Patient has had gradual change in LOC over a period of days. Patient lives with family. Baseline mental status is consistent with mild dementia. The patient seems confused to observers. Has had a significant decrease in normal activity. Patient is poorly responsive.

Problem #3 Head trauma: Patient remains poorly arousable.Other symptoms associated with this injury include [unable to evaluate symptoms due to pts. condition.].

General History and Problem specific ROS: Injury can be coded as occurring in home environs. These symptoms are slowly getting worse. Has become gradually less responsive over a period of time. Positive history for head injury. Currently symptoms seem to be deteriorating. No history suggestive of syncope. No history of acquired or congenital bleeding diathesis. No history of pre-existing CNS pathology. Denies drugs or alcohol use. No history to suggest dehydration, sepsis, or diabetes. Patient is non verbal and unable to give reliable history.

PMH/ROS: Patient has elevated lipid profile History of hypertension. Has thyroid problems. There is a prior history of known coronary artery disease. Except as noted the remainder of the Past Medical History and Review of Systems are all negative. Patient has underlying mild Alzheimer's dementia. (KRM)

SH: Lives in a family situation. Lives in a home environment. Currently retired from work force. Denies significant ETOH intake. Nonsmoker. Widowed.

EMERGENCY DEPARTMENT

RECORD

Patient: NEUSTADTER, ISRAEL
Medical Record #: 815510
Account #: 0306900162
Visit Date: 3/10/2003
Age: 91 *Sex:* M
DOB: 4/14/1911

My father arrived with clear lungs, a normal heart rate, no pain or disress and not appearing acutely ill - but with a panic-level white count. He got there on time, but needed careful attention to antibiotics, not DNR status.

PHYSICAL EXAM:
GENERAL PRESENTATION: Denies acute pain and is in no apparent distress. Patient does not appear acutely ill. Patient appears to be stated age. Skin is warm and dry with good color. This patient is quite elderly and frail. The patient is confused and a poor historian. Well hydrated with moist mucous membranes. Appears to be demented and a poor historian.
OPTHAMOLOGIC EXAM: Conjunctivae clear. Sclerae nonicteric. The pupils are equal and reactive to light. EOM's are intact.
ENT EXAM: Oropharynx is clear and moist. Nasal mucosa clear. TM's and EAC's are normal. The neck is supple without meningismus or significant adenopathy. The trachea is midline without thyromegaly. Has a local ecchymotic contusion over the upper lip. Exam and studies are consistent with an acute maxillary sinusitis.
PULMONARY EXAM: Lungs are clear without wheezes, crackles or rhonchi. Respirations are nonlabored without accessory muscle use.
CARDIOVASCULAR EXAM: Regular cardiac rate without significant murmur, rub or gallop.
ABDOMEN AND FLANK EXAM: Abdomen is soft, nontender, and nondistended. Normoactive bowel sounds present. No hepatosplenomegaly noted. Flanks nontender.
NEUROLOGIC EXAM: Responds to voice. Non verbal - responds with groans. A reliable exam was not possible due to the patient's acuity and mental status. A reliable exam was not possible due to the patient's acuity and mental status. A reliable exam was not possible due to the patient's acuity and mental status.
DERMATOLOGIC EXAM: Local ecchymotic contusion noted over the posterior occipital scalp. The area of the posterior occipital scalp is contused.
PSYCHIATRIC AND MENTAL STATUS: This patient is essentially non communicative during the exam. Unable to reliably assess patient's judgment. Unable to reliably evaluate orientation at this point. Cannot adequately evaluate memory at this point. Attention span not evaluated at this time. Unable to evaluate language use at this time.

1) Altere

PROGRESS NOTES:
14:23 The patient's PMD, Dr. Nawaz, was contacted. He will admit the pt. (KRM)

INTERPRETATION OF TESTS:
12:41 CT of head without contrast - radiology report reviewed. Diffuse small vessel disease noted on brain CT. Evidence of sinusitis noted on brain CT. No evidence of skull fracture. Atrophy noted on CT. No evidence of blood in the ventricles. No evidence of mass lesions or midline shift.
12:50 EKG has a left axis deviation. EKG axis and voltage consistent with a left ventricular strain pattern. First degree heart block.
12:51 Sodium (132 mEq/L). Normal serum potasium. Serum bicarbonate is OK. Serum Chloride is normal. Serum calcium is WNL. Glucose - Routine (122 mg%). The blood sugar is normal. Creatinine is OK. BUN (24 mg%). The BUN is mildly elevated.
12:52 Hematocrit (30.6 %). Patient is anemic. Hemoglobin (10.7 mg%). Patient is anemic. WBC (38500 /cu mm). The patient has a very significantly elevated wbc count. Platelets OK
13:11 Normal CPK CPK cardiac isoenzymes WNL. CPK - MB INDEX (Ratio of CK/MB to CK) (.05). Troponin (.6 U).
14:08 X-ray 2 view of chest - radiology report reviewed. Has radiographic cardiomegaly. X-ray shows diffuse increase in interstitial markings consistent with congestive heart failure and pulmonary edema. (KRM)
Primary Diagnosis 1) Altered level of consciousness 2) Dehydration, Sepsis

SYMPTOM AND PROBLEM LIST:: Altered level of consciousness Major concussion with LOC Congestive heart failure Free Text DX: Dehydration, Sepsis Head injury Confusion on arrival in department Dense aphasia Diffuse CNS small vessel disease Moderate hyponatremia Marked leukocytosis Hx of hyperlipidemia Hx of hypertension Hypertension ASCVD Dementia Chronic dementia Alzheimer dementia Dementia associated with Alzheimer Acute maxillary sinusitis Left axis deviation Left ventricular strain pattern First degree heart block Moderate anemia Systolic hypotension (This visit) Old age debility Contusion posterior occipital scalp Injury to posterior occipital scalp Injury to upper lip Cerebral atrophy Borderline elevated BUN Injury at home/environs Fall on level ground

CT found Acute Maxillary Sinusitis.
No findings of pneumonia.

HOLY CROSS HOSPITAL
A Member of Holy Cross Health System
1500 Forest Glen Road • Silver Spring, Maryland 20910-1484 • (301) 754-7500

Patient: NEUSTADTER, ISRAEL
Medical Record #: 815510
Account #: 0306900162
Visit Date: 3/10/2003
Age: 91 *Sex:* M
DOB: 4/14/1911

EMERGENCY DEPARTMENT RECORD

Repetitive and overlapping diagnostic codes, but failure to find pacemaker placement or pneumonia.

PHYSICIAN DISPOSITION:
14:23 [Explained importance of pts. admission including sepsis, Dehydration and the need of IV antibiotics.]
14:26 [Urine is pending.] (KRM) Condition: Stable.
14:27 Admit to regular bed.
14:27 Case discussed with Dr. [Nawaz] who will admit to their service. I have reviewed the contents of this record, and my electronic signature confirms its accuracy. (HCC)

ICD-9

E849.0	Injury at home/environs
E885.9	Fall on level ground
331.9	Cerebral atrophy
429.3	Radiographic cardiomegaly
458.9	Systolic hypotension (This visit)
790.6	Borderline elevated BUN
797	Old age debility
920	Contusion posterior occipital scalp
	Contusion upper lip
959.01	Injury to posterior occipital scalp
959.09	Injury to upper lip
272.4	Hx of hyperlipidemia
285.9	Moderate anemia
290.0	Dementia associated with Alzheimer
294.8	Chronic dementia
294.9	Dementia
331.0	Alzheimer dementia
401.9	Hx of hypertension
426.11	First degree heart block
426.2	Left axis deviation
429.2	ASCVD
429.3	Left ventricular strain pattern
461.0	Acute maxillary sinusitis
V12.59	Hypertension
	ASCVD
276.1	Moderate hyponatremia
288.8	Marked leukocytosis
443.9	Diffuse CNS small vessel disease
780.02	Confusion on arrival in department
784.3	Dense aphasia
854.00	Head injury
428.0	Congestive heart failure
780.09	Altered level of consciousness
850.2	Major concussion with LOC
999.99	Free Text DX: Dehydration, Sepsis

Erroneous coding: There was no diagnosis of CHF, no altered level of consciousness, no loss of consciousness at any time.

HOLY CROSS HOSPITAL
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Patient: NEUSTADTER, ISRAEL
Medical Record #: 815510
Account #: 0306900162
Visit Date: 3/10/2003
Age: 91 *Sex:* M
DOB: 4/14/1911

EMERGENCY DEPARTMENT

RECORD

CPT

70450-52
71020-52
93010
93042
94760
99285

Henry C. Chu MD: _____

Electronic Signatures derived from a single controlled password

Kevin R Mull PA (KRM)
Henry C. Chu MD (HCC)

HOLY CROSS HOSPITAL

PHYSICIAN ORDER FORM

Admit to
Dx - Pneumonia, Sepsis, hypertension, dementia
Reg diet (2)
D5½NS at 100cc/hr (3)
Zosyn 3.375mg IV q6h standard
Ciprofloxacin 400mg IV q12h
Diflucan 200mg PO q24h
MOM 30cc PO q6h prn
BMP, CBC in am (4)
DNR (11)

PHYSICIAN SIGNATURE | PHYSICIAN NAME (PRINT)/PAGER# | TIME | DATE

2L NC O2
Ativan 1mg IV q 2-4h prn agitation
T.O. Dr Nawaz/Bozkurt, PA

PHYSICIAN SIGNATURE | PHYSICIAN NAME (PRINT)/PAGER# | 1510 TIME | 3/10/03 DATE

Abdominal Xray
R/O Mass (16)

T.O. Dr Nawaz/Smith, Bangalore PA

PHYSICIAN SIGNATURE | PHYSICIAN NAME (PRINT)/PAGER# | 6:15 TIME | 3/10 DATE

Form No. DRS-001 Physician Order Form — WHITE - CHART COPY — YELLOW - DEPT.

According to Dalmarva Foundation Quality Concern Inquiry, it is "not clear...why the orders on 3/10/03 included "DNR," in **opposition to the son's wishes for this patient**."

Unauthorized 'DNR' order written in ER absent any discussion. Is this Holy Cross's tacit code status for the "demented elderly"?

HOLY CROSS HOSPITAL

PHYSICIAN ORDER FORM

NEUSTADTER, ISRAEL 91Y
03/10/03 0306900112
3127 NAWAZ, AHMED
CD I/P 815510
1111 UNIV BLVD WEST
SILVER SPRING MD 20902
301 649-1319

Transplant to IMCU
Rocephin 1gm Q24° ✓
Levaquin 250mg i/v Q24° ✓
D5NS at 75cc/hr #2
Tylenol ½ PO Q4° PRN
Mom 30cc PO Q6° PRN ✓
Ativan 1mg i/v Q4-6° PRN for agitation
Resp. on p/ease
Regular meals
Full Code #19

PHYSICIAN SIGNATURE | PHYSICIAN NAME (PRINT)/PAGER# | TIME 3/10/03 DATE

Why is Levaquin cut to 250mg? There is no geriatric Levaquin dose and patient's renal function is superb. Isn't resolution of 38k leukocytosis most dependent on antibiotics?

Why do Kardex & progress notes show Levaquin 500 for 3 more days? Doesn't this order mean it was changed to 250mg upon transfer from ER on day one?

Physicians Order Forms and medication list show gap in antibiotic coverage for period of March 17 to March 20.

Pharmacy printout obtained by court order shows 40% of prescribed abx doses were never dispensed by hospital pharmacy.

High WBC tolorated throughout 17-day hospitalization without infectious disease consult or attention to antibiotics. White count finally jumps to 43k and my father goes into acute respiratory distress.

NEUSTADTER, ISRAEL 91Y
03/10/03 0306900112
3127 NAWAZ, AHMED
CD I/P 815510
1111 UNIV BLVD WEST
SILVER SPRING MD 20902
301 649-1319

Ok to change #

PHYSICIAN SIGNATURE | PHY... | 3/10/03 ME DATE

NEUSTADTER, ISRAEL 91Y
03/10/03 0306900112
3127 NAWAZ, AHMED
CD I/P 815510
1111 UNIV BLVD WEST
SILVER SPRING MD 20902
301 649-1319

3/10/03 2111

- BNP level now

T.O. Dr Nawaz | [illegible], RN

3/10/03 2246

PHYSICIAN SIGNATURE | PHYSICIAN NAME (PRINT)/PAGER# | TIME 3/10/03 DATE

Nurses Kardex conflicts with physician order form, which changed dosage to 250mg. What dosage did my father actually receive?

HOLY CROSS HOSPITAL

MEDICATION ADMINISTRATION RECORD

DATES GIVEN

Order Date	Re-newal Date	MEDICATION, DOSE, FREQUENCY	HR.	3/10	11	12	13	14	15	16	17	18	19	20	21	22	23
3/10		Levaquin 500mg IV QD	3P	→ 9													
3/10		Rocephin 1 gm IV QD	4P	→													
3/10		Rocephin 1 gm IV QD	3P	→													
3/12		Heparin 5000u SQ BID	10A	→		10											
			10P	→													

ADDRESSOGRAPH BELOW

Sulfa

ALLERGIC TO

DATE & TYPE OF SURGERY

DIAGNOSIS

SECOND PAGE IN USE ☐

6107-2

ROOM NAME ~~4C3-2~~ Neustadter

STOCK-204 (Rev. 7/99) MEDICATION ADMINISTRATION RECORD

HOLY C

Patient Ca
Progress Notes

In cardiac monitoring area pending admission at 3:30 pm.

Still no pneumonia.

Neustadter, Israel 91Y
NEUSTADTER, ISRAEL 03/10/03 0306900162
3127 NAWAZ, AHMED
CO I/P 815510
1111 UNIV BLVD WEST
SILVER SPRING MD 20902
301 649-1319

DATE	TIME	COMMENTS AND OBSERVATION	TITLE & SIGNATURE
3/10/03	1530	Alert + oriented XO. Pt has history of dementia. Does not follow Commands, ~~does not~~ to verbal Commands. Moves arms + legs at will. Little speech to questions. Monitor shows SR. Pt appears agitated, repeatedly asking for SEX. Digs his rectum + attempts to remove monitor. All pulses palpable. LS clear to all fields, Sats 98% on room air. Lt hand IV infusing 100 cc/o D5NS w/ difficulty. BS active to all quadrants. Foley intact, draining mod Amt clear yellow urine. Monitor d/c'd after strip obtained. Pt quiet + less agitated once Lorazepam. Continue to monitor closely	Caseley RN

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

[illegible] ISRAEL 91
03/10/03 0305500162
3127 NAWAZ, AHM
CO I/P 815510
- 11/ [illegible] S. ISRAEL
SILVER SPRN MD 20902
301 649-1319

Monday afternoon, March 10

- Dr. Ahmed Nawaz, admitting & attending physician.

Admission notes state "possible aspiration pneumonia," making no mention of Community Acquired Pneumonia.

DATE	TIME	
3/10/03		medsi:- (dictated).
		impression:-
		① Community acquired pneumonia.
		② Sepsis.
		③ Renal Azotemia.
		④ Dementia.
		⑤ reducible umbical hernia.
		A/P:-
		- Admit to regular floor.
		- IVF.
		- I/V ABX.
		- foley catheter, for bladder distention
		- I/V Ativan for agitation
		- labs in AM
		- Pt is full Code.
		d/w family members.
		- H/O on B/P meds
3/11/03		medicine:-
		- Doing better, more alert.
		vs:- B.P - 110/57 RR - 16 Hr - 76.
		Chest:- bibasilar rhonchi
		abd:- soft, non tender.
		CVS:- RRR. S1 S2 heard.
		Ext:- edema
		A/P:- - DIC - foley
		- PT consult
		- WBC ↓ 20000
		- family meeting in afternoon at

I made it clear that my father was full code yet was questioned about it repeatedly. My answer was always the same.

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

March 11, Tuesday morning

- Consult with Dr. Jay Weiner, head of pulmonology practice under hospital contract.

If aspiration pneumonia, why aren't antibiotics with anaerobic coverage like clindamycin or Zosyn used?

Why is patient continuing to be fed orally prior to swallowing study and with increasing hypoxemia? Dr. Weiner testified that **patient was too sick to eat and that any food would have made him worse**.

DATE	TIME	
		- Son feels that he can also breathe - pulmonary consult obtained.
		A.N.
3/11/07		Pulm Consult (Full note below)
		Imp ① Asp pneumonia ± sepsis — ? ± Zosyn's ② Dementia ± septic encephalopathy ③ ↳ HTN ④ recent hyponatremia 2° ↳ Diuretic
		Rec IV Rocephin/Flagyl IV Lyrica Allow cook wife to bring him food if she will consult to Rds: Discuss swallow eval with MD
3/11 5:30p	ARNP	DEMENTED OLDER BABBLING Ø IN NAD ± ANXIOUS SON @ BEDSIDE. ON 1SL/MIN VIA NRPM, RA SAT 93-98% + SCATTERED ⑧ RALES. ABD BSX4 CNV UMBILICAL + ⑤ INGUINAL HERNIA TM 100.4
		TRIED TO EXPLAIN TO SON LIMITED PROSPECTS FOR TOTAL RECOVERY, SON MAY REQ VIDEO EVAL IN AM /Sig — KARIYA

- Doctor Steven Kariya, pulmonologist in Dr. Weiner's practice.

"Demented older babbling male," is Dr. Kariya's tender portrayal of my dear father, speaking in Yiddish to his son at bedside.

Doctor Kariya's goals already at odds with family.

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

HOLUSTACTER, ISRAEL 91Y
03/10/03 0306900162
3127 NAWAZ, AHMED
CC I/P 815510
1111 UNIV BLVD W ST
SILVER SPRING MD 20902
301 649-1319

DATE	TIME	
3/11		Rolin 2nd opinion
		Imp - ① Falling 2° HBP
		② HBP [illegible]
		③ Sepsis 2° pneumonia c/f dementia.
		④ Hypoxemia - developing pneumonia, LLL (Bronchial BS)? R/o CHF 2° IVF
		⑤ Pneumonia? - aspiration (recent UNa, Cory stanley Zeeker's)
		⑥ Underlying dementia, but good quality of life.
		Plan ① IVF, Abx, high flow O2
		② Intubate if necessary - after long talk c son. He will think about DNR, but tends against it for religious reasons.

Ahmed

March 11

"I discussed with son code status, patient is full code, will intubate and transfer to ICU if needed."

- Dr. Libuse Heinz, pulmonologist in Dr. Weiner's practice.

Dr. Heinz's notations were complete and accurate on each of her 3 visits with my father.

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

DATE	TIME	
03/11/2003 8:00 pm		PULMONARY / CRITICAL CARE
		I was called by nurse after son's request to see patient. Patient is confused. ABG on FiO2 2 50% - 80% :- 7.37 / 34 / 44 / 90% BP: 129/53 P: 86 R: 18 T: 99.8 Vent 36% 42 l/min CO_2 O_2
		LUNGS: Bronchial breath sounds (+) Rales, rhonchi, inspiratory crackles
		HEART: Regular
		ABDOMEN: Benign
		EXTREMITIES: No edema
		CXR 3/10/03 : Focal infiltrate in LLL
		ASSESSMENT / PLAN:
		1.) CXR STAT ; continue antibiotics
		2.) Will Δ FiO2 to 100% via non rebreather if sats O_2 sat <92%
		3.) I D/W son code status, patient is full code, will intubate and transfer to ICU if needed.
		5.) D/W house staff
		Dr. Libuse Heinz, Pulmonology

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

[illegible] ISRAEL 91Y
03/10/03 [illegible]
3127 NAWAZ, AHMED
[illegible] I/P [illegible]
1111 UNIV BLVD W #31
SILVER SPRING MD 20902
301 649-1310

Conflicts with physician order form which changed dosage to 250mg. What dosage did my father receive?

DATE	TIME	
3/11/03	2100	**Medicine Accept Note**
		HPI: 91 yo ♂ in USOH until 3d pta, when he fell @ home + hit his head. Pt. developed progressive weakness over next 2d. ⊕F of 101 1d pta. On admission (day of) pt. was hypotensive, BP of 60 systolic in Dr. Nawaz's office + sent to ED. CXR on arrival to hospital showed ⓛ LL infiltrate, small pleural effusion blunting of ⓡ costophrenic angle. Initial WBC - 38,000. PMH significant for dementia, HTN + Zenckers diverticulum. Recently placed on Diazide causing severe ↓Na, which responded to subsequent removal of drug. Hx of pacemaker placement. Hospital course: Pt. was admitted 3/10/03 + started on IV Abx + hydrated. Possible ⓛ inguinal hernia. Pt. became agitated on HD#2 c ↓ pulse ox to low 80's + ABG demonstrating severe hypoxemia. Pt. was agitated + given haldol, to which he responded. Lung exam demonstrated rales. PCXR demonstrated ⓑ pleural effusions - increased from admission. As pt. was Lasix naive, he was given 20mg IV. Pt. is currently DNR. Pt. is currently stable.
Meds		
evaquin 500mg IVQD		
rocephin 1gm IV qd		
lasix 20g IV x1		
KCl 10 Meq in 100cc NS over 1°		

3rd-year medical student sees 'DNR' on first Physician Order Form and wrongfully assumes patient is DNR.

O: Vitals: T 100.3 P 89 (67-102) R (21-32)
BP 103/40 ($\frac{103-136}{33-64}$) 93% 100% O_2 NRB

Exam: GEN - in obvious distress, on 100% NRB
Neck - ∅ JVD
CV - S_1S_2
Pulm - ~~bibasilar~~ crackles c bronchial lung sounds ½ the lung fields
Abd - benign
Ext - ~~∅~~ EN edema 1+ ⓑ

Elyse Nimss
NILES

11/91

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTAETER, ISRAEL 91Y
03/10/03 03069001L2
3127 NAWAZ, AHM.G
CO I/P #15510
1111 UNIV BLVD W.ST
SILVER SPRING MD 20902
301 649-1319

DATE	TIME	
3/11/03	2100	Medicine Accept Note (cont'd)

Labs: 20.7 / 10.4 / 29.6 < 211 L 1.96 M 1.13 N 96.3 E .180 B .388

ABG: 100%/7.379/34.9/44.9/80.4/20.1/-4.2

132 | 100 | 29 < 114

A/P: 91 yo ♂ c aspiration pneumonia ~~+ sepsis~~ EN, now c hypoxia

Was my father septic or not?

1. aspiration pneumonia ~~/sepsis~~ EN and hypoxia - called to evaluate pt. due to concerns about respiratory status
   - evaluated pt + reviewed chart
   - pt on NRB, pulse ox ~ 89%
   - CXR b/c physical exam revealed (B) crackles
   - pt seemed clinically overloaded, ordered lasix 20mg IVX1
   - pt. also seemed agitated, but was calmed c ~~H~~aldol 1mg IV X1 → improvement in resp fxn
   - pt placed on humidified NC @ 100% for pt's comfort
   - foley placed to accurately assess I/O's.
   - CXR showed (B) interstitial lung markings - fluid?
   - responded to lasix, good UOP > 250cc's, Pulse Ox @ 95%
   - will monitor closely overnight.
   - will continue IV Abx

Agree c above

Elyssa MS3 / NILES

MD 1691

Resident Addendum.

Pt resp'd well. Very anxious son @ bedside. Have tried to reassure him + the pt. Will watch closely.

Needed IV Lasix

N. Swati

IHC

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 0306900162
2127 NAWAZ, AHM..S
C.. I/P 815510
1111 UNIV BLVD W.ST
SI... Neustadter, Israel
3...

DATE	TIME	
3/12/03	1300	Cardiology (Social Visit) Lengthy d/w son regarding all issues. I advised against mechanical ventilation should this become an issue given advanced age, dementia and expected debilitation. SCHNEIDER

Form No. STK-028 (Rev. 5/99) Progress Notes

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

[illegible] ISRAEL 91Y
03/10/03 0306900162
3127 NAWAZ, AHMED
GS I/P 815510
1111 [illegible] BLVD WEST
SILVER SPRING MD 20902
301 649-1310

Conflicts with physician order form which changed dosage to 250mg. What dosage did my father receive?

DATE	TIME	
3/12/03	1500	MSB PN

S: Pt sating 94-96% on vapotherm overnight. Given Haldol to improve restlessness & pt. was more calm overnight. No acute events overnight.

Meds
- eviaquin 500mg IVqd (D#3)
- xephim 1gm IV qd (D#3)
- prn
  - Ativan 1mg IV Q2-4 prn agitation
  - Nam @ 30cc PO
  - Tylenol
  - Haldol 1mg IMq8°

O: Vitals: Tm 100.3 (3/11@2000) Tc 97 HR 65 (65-102) R 20 (20-32)
BP 138/54 ($\frac{108-138}{33-50}$) FS 114 @ 3/11/03 0600:35 Pulse Ox - 92-94%
I/O: 1095/950 (S) IVF: 975cc O: 120cc UOP: 970 + 500cc in foley bag
Exam: GEN: Resting, mild distress
Pulm: (B) crackles in 1/2 lung fields
CV: S_1S_2
Abd: ND (+)BS / soft / nontender, raised soft protrusion to (R) of umb
Ext: ø edema
Neck: ø JVD

Labs: 17.2 / 10.3 / 29.0 < 200 L 3.14 M 6.31 N 89.2 E .245 B 1.07
136 | 104 | 23 / 3 | 23 | 08 < 124 Mg 2 Ca 7.5
UCx: NGTD BCx - (P)

A/P: 91 yo ♂ c aspiration pneumonia & hypoxia.
1. Aspiration Pneumonia - Continue IV levaquin 500mg IVqd & Rocephin 1g IV qd. Aspiration precautions. DVT prophylaxis - Sq heparin - not yet resolved,
2. Hypoxia - Sat's stable on vapotherm - continue. Will monitor Pox & labs closely.
3. ~~Hypervolemia~~ Pulmonary Edema - very good UOP - resolving. Will continue to monitor c UOP & lung exam. Will get repeat CXR today.

Elyahu MS3 / NILES

Agree c above. K is 3. Will replete c KCl runs & monitor for arrhythmia

MD 1691

MD 1691

Form No. STK-028 (Rev. 5/99) Progress Notes

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 0306900162
3127 NAWAZ, AHMED
CO I/P 815510
1111 UNIV BLVD W ST
SILVER SPRIN MD 20902
301 649-1319

DATE	TIME	
3/12	12N	RUU LOOKS BETTER. PT/SON HAD "STORMY" NIGHT ↓↑ BP ↑↑↓ HR BUT TODAY PT BASELINE DEMENTIA, SITTING IN CHAIR, COUGHING? CHOKING ☹ CLEAR LIQUIDS (SON REPORTS THIS SWALLOWING BEHAVIOR IS BASELINE FOR 10-20 YRS). AFEBRILE HR 67-87 R20-28 BP 121/50 - 171/68 RA 94% ON VAPOTHERM @ 20L/M, 100% SCHEDULED RHINITIS/CONGESTION ☺ COR/HSD QLV 124 K 3.0 WBC 17.2 IMP: OVERALL SL IMPROVEMENT FROM PROB ASP PNEUMONIA. SON WANTS FULL CODE BUT NO HD - I TRIED TO POINT OUT THAT THOSE DECISIONS MAY NOT LOGICALLY FLOW. HAVE REF TO SON LIMITS TO RESUSCITATION WILL ✓ SWALLOW EVAL TOMORROW - PT AT RISK B/O KNOWN ZENKER'S DIVERTICULUM ② PROG DEMENTIA ③ SON (UNMARRIED, ONLY FAMILY MEMBER) REMAINS HOPEFUL, PERHAPS UNREALISTICALLY SO. D/W SON, HO, DR NAWAZ

"My mother died about a year ago in the next room. No, it was 2 rooms down. It was so peaceful."

- Dr. Steven Kariya

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 0306500112
3127 NAWAZ,AHM
CO I/P 815810
1111 UNIV BLVD WEST
SILVER SPRIN MD 20902
301 [illegible]

DATE	TIME	
3/12/03		meds:-.
		-. Pt more alert, yesterday went into respiratory distress and was placed on 100% Ox.
		Hyst- B.P- 126/70 RR-20 HR-86.
		T- 99.7.
		Chest:- bi basalar rales & rhonchi
		Cvs:- RRR, Abd:- soft, nontender
		Ext:- 4+ LE edema
		Mg p:- K+ ↓ - will be replaced.
		-. D/C IVF
		-. Get 2D echo.
		-. Pts son did call 2nd opinion by Dr. Chandler. he agrees with same management.
		-. Case discussed with staff & Dr. Kenn
		A. Nawaz

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 03086001.2
3127 NAWAZ, AHM.
CC I/P 8J5210
1111 UNIV BLVD WEST
SILVER SPRIN MD 20902
301 649-1319

Conflicts with physician order form which changed dosage to 250mg. What dosage did my father receive?

DATE	TIME	
3/13/03	9:15	MSB PN

muds
epaarin 5000u sqBID
evaquin 500mg IVqD (D#4)
Rocephin 1g IVqd (D#4)
prn
Ativan
MoM
Haldol
tylenol

S: Pt. agitated last night + pulling off O_2 - sats down to 80%. Soft wrist restraints put on + pt. given Ativan. Pt. calm after this c no other issues. Son @ bedside this am. Pt seen by med atting, pulm + cardiology yesterday. Nutrition note - cont. diet + supplement c boos

O: vitals - T_m 100^2 T_c 100^2 92(65-92) 30(20-38) 129/63 (121-152/50-71)
Sat - 92% on vapotherm FS: 124 @ 6:35
I/O: 3/12/03 340/2700 (s) crystalloid: 260 O: 80 UOP: 2700
3/13/03 0/801 UOP: 800 stool 1
Exam: GEN - mild distress, responsive to voice
CV - rrr, S_1S_2
Pulm - Ø crackles, Ⓟ bronchial breath sounds
Abd - benign
ext - Ø edema
labs: am labs Ⓟ
Radiology: CXR (3/12) - overall worsening in Ⓑ infiltrates

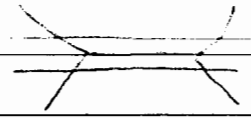
A/P: 91 yo ♂ c aspiration pneumonia + hypoxia

- Aspiration Pneumonia - not yet resolved, worsening on CXR. Will continue IV levaquin + Rocephin. Will repeat CXR today
- Hypoxia - Sats remain stable on vapotherm. Sats ↓ when pt. agitated + pulls out NC. Will continue prn Ativan for agitation
- Pulmonary edema - will get 2D echo today as per atting to evaluate LVEF.
- Nutrition - needs assistance c PO intake, Zencker's Diverticulum. Will cont. current diet + supplement c boost. ~~Swallow study today~~ EN. Will need to discuss aggressiveness of plan c atting + SO. Pt

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

[illegible],ISRAEL 91Y
03/10/03 0306900162
3127 NAWAZ,AHM.D
00 I/P 815510
1111 UNIV BLVD W.ST
SILVER SPRIN MD 20902
301 [illegible]

DATE	TIME	
		MS3 PN (cont'd)
		will need aggressive electrolyte repletion. ? central line. Pt. remai
		full code but son's wishes for Tx seem to Δ daily. Elyahu MS3 NILES / Neeraj N. SHAH PGY II
3/13/03	1015	MS3 lab addendum
		140 / 105 / 3 ; 2.8 / 23 / 0.7 ; 128 / 8.2 ; Mg 2.0
		
		B(x2-NGTD ; 21.8 / 35.5 / 11.7 / 235 ; L 3.43 M 6.3 N 89.8 E .137 B .346
		Plan- will place central line for aggressive electrolyte repletion.
		Elyahu MS3 / Neeraj N SHAH X1047 NILES

3rd-year medical student sees numerous 'Full Code' notations alongside 'DNR' (absent dnr form) and wrongfully assumes "son's wishes seem to change." This med student never spoke with me.

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
Neustadter, Israel

"Looks Septic... Will need vent with any further deterioration if aggressive treatment is desired. Given his age I doubt it will change ultimate outcome."

- Dr. Weiner

DATE	TIME	
3/13/03		Pulm
9:20	A	Pt long term nursing SNF c h/o gram neg pneumonia, COPD on 100% O2 via trach collar. Cardiac
10:00	A	hx c/b septic emboli s/p CVA c R sided weakness, AFib not on coumadin, DM2 diet controlled, CRF baseline Cr 1.5, BUN/Cr 40/1.5, anemia baseline Hct 30s, HTN, PVD s/p R fem-pop bypass 1999, s/p PEG tube placement 2001, h/o DVT/PE not on anticoagulation, h/o GI bleed, h/o C. diff colitis, h/o pressure ulcers, h/o trach placement 2001, h/o recurrent aspiration pneumonia, h/o respiratory failure requiring intubation, h/o hypokalemia, h/o hypomagnesemia, h/o hypophosphatemia, h/o hypocalcemia, h/o hypoalbuminemia, h/o anemia of chronic disease, h/o thrombocytosis, h/o leukocytosis, h/o hyperglycemia, h/o hyponatremia, h/o hypochloremia, h/o metabolic acidosis, h/o hypercapnia, h/o hypoxia, h/o hypothermia, h/o hypotension, h/o bradycardia, h/o tachycardia, h/o atrial fibrillation, h/o ventricular tachycardia, h/o cardiac arrest, h/o sepsis, h/o septic shock, h/o multiple organ dysfunction syndrome, h/o acute renal failure, h/o acute respiratory distress syndrome, h/o disseminated intravascular coagulation, h/o thrombotic thrombocytopenic purpura, h/o hemolytic uremic syndrome, h/o thrombotic microangiopathy, h/o heparin induced thrombocytopenia, h/o warfarin induced skin necrosis, h/o antiphospholipid antibody syndrome, h/o lupus anticoagulant, h/o factor V Leiden mutation, h/o prothrombin gene mutation, h/o protein C deficiency, h/o protein S deficiency, h/o antithrombin III deficiency, h/o hyperhomocysteinemia, h/o MTHFR mutation, h/o elevated lipoprotein(a), h/o elevated factor VIII, h/o elevated factor IX, h/o elevated factor XI, h/o elevated factor XII, h/o elevated prekallikrein, h/o elevated high molecular weight kininogen, h/o elevated fibrinogen, h/o elevated D-dimer, h/o elevated fibrin degradation products, h/o elevated plasminogen activator inhibitor-1, h/o elevated tissue plasminogen activator, h/o elevated urokinase plasminogen activator, h/o elevated plasminogen activator inhibitor-2, h/o elevated protein C, h/o elevated protein S, h/o elevated antithrombin III, h/o elevated heparin cofactor II, h/o elevated alpha-2-macroglobulin, h/o elevated alpha-1-antitrypsin, h/o elevated alpha-1-antichymotrypsin, h/o elevated C1-inhibitor, h/o elevated C4b-binding protein, h/o elevated beta-2-glycoprotein I, h/o elevated prothrombin, h/o elevated factor II, h/o elevated factor V, h/o elevated factor VII, h/o elevated factor X, h/o elevated factor XIII, h/o elevated fibrin stabilizing factor, h/o elevated transglutaminase, h/o elevated tissue factor, h/o elevated tissue factor pathway inhibitor, h/o elevated endothelial protein C receptor, h/o elevated thrombomodulin, h/o elevated endothelial cell protein C receptor, h/o elevated endothelial cell thrombomodulin, h/o elevated endothelial cell tissue factor pathway inhibitor, h/o elevated endothelial cell tissue factor, h/o elevated endothelial cell factor VII, h/o elevated endothelial cell factor X, h/o elevated endothelial cell factor XIII, h/o elevated endothelial cell fibrin stabilizing factor, h/o elevated endothelial cell transglutaminase, h/o elevated endothelial cell fibrinogen, h/o elevated endothelial cell D-dimer, h/o elevated endothelial cell fibrin degradation products, h/o elevated endothelial cell plasminogen activator inhibitor-1, h/o elevated endothelial cell tissue plasminogen activator, h/o elevated endothelial cell urokinase plasminogen activator, h/o elevated endothelial cell plasminogen activator inhibitor-2, h/o elevated endothelial cell protein C, h/o elevated endothelial cell protein S, h/o elevated endothelial cell antithrombin III, h/o elevated endothelial cell heparin cofactor II, h/o elevated endothelial cell alpha-2-macroglobulin, h/o elevated endothelial cell alpha-1-antitrypsin, h/o elevated endothelial cell alpha-1-antichymotrypsin, h/o elevated endothelial cell C1-inhibitor, h/o elevated endothelial cell C4b-binding protein, h/o elevated endothelial cell beta-2-glycoprotein I, h/o elevated endothelial cell prothrombin, h/o elevated endothelial cell factor II, h/o elevated endothelial cell factor V, h/o elevated endothelial cell factor VII, h/o elevated endothelial cell factor X, h/o elevated endothelial cell factor XIII, h/o elevated endothelial cell fibrin stabilizing factor, h/o elevated endothelial cell transglutaminase, h/o elevated endothelial cell tissue factor, h/o elevated endothelial cell tissue factor pathway inhibitor, h/o elevated endothelial cell endothelial protein C receptor, h/o elevated endothelial cell thrombomodulin, h/o elevated endothelial cell endothelial cell protein C receptor, h/o elevated endothelial cell endothelial cell thrombomodulin, h/o elevated endothelial cell endothelial cell tissue factor pathway inhibitor, h/o elevated endothelial cell endothelial cell tissue factor, h/o elevated endothelial cell endothelial cell factor VII, h/o elevated endothelial cell endothelial cell factor X, h/o elevated endothelial cell endothelial cell factor XIII, h/o elevated endothelial cell 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alpha-1-antitrypsin, h/o elevated endothelial cell endothelial cell alpha-1-antichymotrypsin, h/o elevated endothelial cell endothelial cell C1-inhibitor, h/o elevated endothelial cell endothelial cell C4b-binding protein, h/o elevated endothelial cell endothelial cell beta-2-glycoprotein I, h/o elevated endothelial cell endothelial cell prothrombin, h/o elevated endothelial cell endothelial cell factor II, h/o elevated endothelial cell endothelial cell factor V, h/o elevated endothelial cell endothelial cell factor VII, h/o elevated endothelial cell endothelial cell factor X, h/o elevated endothelial cell endothelial cell factor XIII, h/o elevated endothelial cell endothelial cell fibrin stabilizing factor, h/o elevated endothelial cell endothelial cell transglutaminase, h/o elevated endothelial cell endothelial cell tissue factor, h/o elevated endothelial cell endothelial cell tissue factor pathway inhibitor, h/o elevated endothelial cell endothelial cell endothelial protein C 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HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 [illegible]
Veinstadter, Israel
[illegible] I/P 815810.
1111 UNIV BLVD W ST
SILVER SPRIN MD 20902
301 649 1319

DATE	TIME	
3/13/03		medicine:-
		- Pt is in respiratory distress. and only responding to painful [illegible]
		V/S:- RR - 30-35 B.P - 160/80
		HR - 98. T - 100.6.
		Chest:- B/L exp wheezing & rhonchi
		CVS:- RRR, S1 S2 normal
		abd:- soft, non tender
		A/P:-
		- Pt needs to be intubated will d/w Dr; mmm.
		- Had long conversation w Pts son.
		- Pt will be replaced.
		- femoral line was attempted but not successful.
		Z A'Nawaz
3/13		Anesth. Pt in resp distress. DL x + 1 MAC 3.0, 8.5 ETT via through VCs, + ETCO2, + BBS. Taped.
3/13	545	RUL ATTEMPTED NG & SUCCESS/SZ

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 [illegible] 900162
[illegible] 81510
[illegible] GEORGIA BLVD WEST
SILVER SPRING MD 20902
[illegible] 949-1319

DATE	TIME	
3/14/03	0900	MSB PN - ICU
		S: Pt. intubated + sedated c propofol. No acute events overnight. Son concerned about nutrition status - UOP dropped to 30/o as per RN + cracke heard on lung exam. Pt was given lasix + UOP improved but remains marginal. K 3.1 to 4.4 after repletion but ↓ after lasix given to 3.7. RN disimpacted large amt of stool. No other issues.
meds		
ceftriaxone 1g IVq24 D#5		
avequin 250mg IVq24° D#5		
heparin 5000 U SQ BID		
Propofol prn		
valdol		O: vitals - T_m 100² T_c 98¹ 71 (70-100) 99/45 (90-150 / 40-75) 19 (18-30)
		Vent settings: CMV / 500cc / F_iO_2 100% / PEEP 5 / RR 12 Sat - 100%
		Exam - GEN - sedated, on vent
		CV - S_1S_2
		lungs - ↓ BS @ (B) bases, Ø W/R/R
		Abd - benign
		Ext - Ø edema
		labs: 23.3 / 10.0 / 30.3 \ 243 L 4.33 m 8.2 N 86.3 E 186 B .967 — 137 | 106 | 28 / 3.7 | 23 | 1.0 \ Ca - 7.9, 101, Mg 2.2
		ABG: 7.49 / 29.7 / 95.9 / 97.5%
		A/P: 91 yo ♂ c aspiration pneumonia + hypoxia. Now on vent.
		Neuro - Pt. intubated + sedated, but currently not on pain meds. Will consider pain meds + discuss c intensivist. Cont propofol for sedatio
		Pulm - Aspiration Pneumonia - will cont. IV Abx.
		• Continue current vent settings
		CV - Will monitor BP, running a little low. Will consider pain med to titrate down propofol drip
		GI - Nutrition consult for ppn vs. tube feeds
		GU - UOP responding to lasix. Will cont. to monitor

MD

→

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 0000590162
PCP NAWAZ, AFM.D
A/C I/P 815510
1111 UNIV BLVD WEST
SILVER SPRIN MD 20902
301 649-1319

DATE	TIME	
3/14/03	0900	MS3 PN

ID- BCx's NGTD- will monitor + cont Abx.
Heme- DVT prophylaxis ☐ Heparin 5000U sq- continue
Pulm- [illegible]

Elyan MS3
NILES

Agree ☐ above. MD
D/W attending - pt's ABG 1691
demonstrates severe dz as PO_2 on 100% is only 97
- F_iO_2 ↓ to 75% - PEEP ↑ to 8
- Will d/c diprovan gtt to improve labile BP
- will start combo of MSO4 - Versed for pain control
- NGT for suction
- Would hold off on nutrition consult for now as pt is only Day 1 in ICU

MD
FADL 1691

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03
SILVER SPRING MD 20902
301 649-1319

DATE	TIME	
3/14/03		CCL
	8:56 P	Pt seized in the vent. BP ~ 100 systolic. Requiring increased
	9:25 P	FiO_2. NG could not be placed probably d/t tortuous [illegible] 100
		cc's residual thick [illegible] FiO_2. ABG with [illegible]
		CXR shows infiltrates worse in RUL [illegible]
		WBC 23.3 Hct 36 Na+ 137 K+ 5.7
		ABG 45/129/7.48 on FiO_2 [illegible]
		Imp ① Pneumonia and sepsis
		② Gas exchange poor 2 large shunt
		③ Dehydration
		Rec ① Start IV Ringers lactate [illegible]
		to maintain MAP
		② ↓ FiO_2 to 50% - keep pO_2 ~ 65-70
		③ Antibiotics
		④ Continue antibiotics

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

[illegible] Neustadter - Cleared
[illegible] NAHAZ, ARNIE
I/P 815510
1111 UNIV BLVD W ST
SILVER SPRING MD 20902
301 649-1319

DATE	TIME	
3/14/03		GE Consult (Dictated) Pl: 1. aspiration pneumonia - intubated 2. R/O Dobhoff placement - Trial of NG 3. R/O ileus 4. need volume depletion Pl: 1. NPO after 0 at MOT - Could only be done in X-ray at reasonable cost 2. no TPN 3. Continue motility support c ranitidine/Reglan - D/W PCP/ Dr. Nancy Will get to follow in am Thanks

March 14, Friday Morning, 9:30 am

Nutritional Consult (no food consumed since Tuesday).

- Will not personally attempt NG tube insertion (unlikely to succeed).
- Will not order NG tube insertion under x-ray guidance (grossly inappropriate elective procedure).
- Will not order a PICC line for TPN (unreasonable given bother and expense).
- **Will order PPN immediately as a "fair compromise."**

"Mr. Neustadter, may I be frank with you? I want to do as little as possible for your father because I don't want to hurt him."

- Dr. Milton Koch, gastroenterologist -- **Fails to order promised PPN nutritional support**.

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTAETER, ISRAEL 91Y
03/10/03 [illegible] 00162
[illegible] I/P [illegible]
[illegible] GLEN DALE BLVD W-ST
SILVER SPRING MD 20902
[illegible]

DATE	TIME	
3/14/03		medicine :-
		-· Pt is on vent, resting comfortably
		vysi- B.P - 130/70 RR - 16 HR - 90
		Chest :- bilateral rhonchi.
		CVS :- RRR, S1S2 (+).
		Abd :- soft, non tender.
		A/P :-
		·. Pneumonia — cont vent support.
		cont I/V ABX.
		·. Sepsis — stable.
		-. Resp failure — Oxygenation improved.
		will cont weaning off vent
		·. NJT difficult to place because
		of Zenkers diverticulum.
		might need lipid TPN
		-. Labs in AM

March 14, Friday afternoon
Dr. Nawaz **fails to order nutritional support.**

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 0705900162
3127 NAWAZ,ALI
I/P 815510
1111 UNIV BLVD W_ST
SILVER SPRIN MD 20902
301 649-1319

DATE	TIME	X Cover note
3/14/03	7pm	[S] called by nurse to evaluate pt's sedation and to answer son's questions. Son asked why the Lopressor was d/c'd in favor of versed.
		[O] VSS pt resting comfortably son appears anxious Progress note reviewed discussed case w Dr Dyer
		[A/P] decided to con't current regimen of versed and MSO4 Both pt w NS explained the difference b/w sedation and general goals of intubation. Explained that the pt appeared in my judgement to be stable and comfortable. The son did not accept this information and said he would call the attending which I said was okay. D. Fuchs Fellow 1005

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 [illegible]
[illegible] NAWAZ, [illegible]
[illegible] I/P [illegible]
[illegible] [illegible] BLVD WEST
SILVER SPRING MD 20902
301 649-1319

DATE	TIME	
3/15/03		medicine:-
		-. PI- restless, comfortable
		Tmax 98.6 RR-16-30 Htr- 97-103
		B.P- 151/82
		Const:- B/L rhonchi
		Cvs:- RRR, SEM++.
		abd: soft, nontender.
		(9) 10.3 / 31.5 (265 — 139 / 110 / 41 (RR — 4 / 19 / 1.0 —
		7.41 | 31 | 62 | 93 |
		MP:-
		- Pneumonia — on vanc, cont i/v Rbx - cont i.v.
		-. cont other meds.
		-. might need to start tpn on pre-albumin & lipids.

March 15, Saturday

Dr. Nawaz, one day later, **again fails to order this nutritional support**. My father now 5 days without food!

3

March 15, Saturday afternoon

- Dr. Ball, on-call pulmonologist in Dr. Weiner's practice, cannot account for lack of nutritional support but promises peripheral nutrition will be delivered by evening.

- Hospital fails to process order for peripheral nutrition causing an additional 24 hour delay.

PPN doesn't arrive until Sunday night at 8:00 pm - 58 hours after first recommended. *Prealbumin sinks to 3.8 mg/dl (reference=20-40 mg/dl) indicative of starvation.*

HOLY CROSS H

PHYSI
PROGRES

R, ISRAEL 91Y
C20h900162
AWAY, APT. C
81550
BLVD WEST
IN MD 20902
919

DATE	TIME	
3/14/03		GT - Pt. doesn't want to have ? w. sustained stones. Unable to do femoral access. PICC line x failed since pt would require intra xray manipulation (apnuria). Will defer to IR for now. Check pt for further progress in regaining renal status, UO reduction, etc. D/W Dr. Thomas IR & pt'd for
3/15/03		Pulm/Cons PA Sedated. 101-160/52-75 80-100 AF 1/0 927/981 News - arousable but not following commands OUS RRR on Ant atnd Ext edema 7.41/32/63 4x7 12.1/520 139/110/41/112 20/10/31.5/19.2 4.3/19/1.3 CXR - improved RML infiltrate 1) Resp failure w/ pneumonia - CAP 2) Anemia 3) Renal failure - IVF hydration - unable to pass NGT or OGT ∴ will start pressors - start Rx blockers. - D/W Son & friends x 20 min BAL

Dr. Ball, in the presence of my friends, urges me to consider the emotional impact that treating an elderly man like my father has on staff morale.

Dr. Ball writes unauthorized DNR the next day.

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 [illegible]
[illegible] NAME [illegible]
[illegible] I/P 815[illegible]
1111 UNIV BLVD W[illegible]
SILVER SPRIN MD 20902
301 649-1310

DATE	TIME	
3/15/03		MS3 ICU Note
		S: No acute events overnight. Pt. intubated & sedated
Meds		O: Vitals T_m 98.6 T_c 98° BP 157/82 (150s/80s) HR 97-103 R 16-35
ftriaxone 1g IVq24° (D#6)		Sat - 99%
		Vent settings: 500cc / 8 / 12 / 45%
vaguin 2~~5~~mg IVq24° (D#6)		~~I/O~~ I/O: 560/250 (s)
eparin 5000U SqBID		Exam: Gen - NAD, intubated & sedated
		Lungs - ↓ breath sounds @ bases (B), Ø crackles
prn		CV - S_1S_2
ersed 1-2mg IVq1-2°		Abd - benign
aldol 2mg IV/IMq4°		Ext - Ø edema
orphine 2-5mg IV q1-2°		Labs - 19 / 10³ / 315 / 265 ; 139 | 110 | 41 ; 4 | 14 | 1.0 ; 8.3 / 112 / 2.5
		Sputum Cx: many budding yeast + fungal elements, many WBC's, no epith cells
		ABG: 7.41 / 31 / 62.7/92
		BCx's - NGTD

A/P: 91 yo ♂ c aspiration pneumania + hypoxia. Now on vent.
- P/c'd dipridan drip due to low blood pressures.
- Neuro - will continue Versed / Morphine / Haldol for pain + agitation.
- ~~Resp~~ - Aspiration pneumania - cont IV Abx (currently D#6)
  - Resp failure on vent - oxygenation improved. Cont. weaning
- CV - episodes of hypotension - will continue to monitor BP. Responds to fluid bolus
- GI - Unable to place NGT. Consider nutritional support c procalamine as per GI attng
- GU - will cont to monitor UOP. Currently stable. BUN/cr increasing - may be slightly intravascularly depleted
- ID - BCx's still NGTD. Will continue to follow WBC + T.
- FEN - replete lytes prn
- heme - cont. DVT prophylaxis c Sq heparin

[illegible] MS3 / [illegible] MD
NICES
1641

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

03/10/03 [illegible]
[illegible] MANAGED CARE
I/P 815510
[illegible] UNIV BLVD WEST
SILVER SPRING MD 20902
301 649-1319

DATE	TIME	
		Agree c above Reviewed CXR - continued RUL infiltra
		Much improved from 3/12 CXR

Form No. STK-028 (Rev. 5/99) Progress Notes

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 0306900162
3127 NAWAZ, AFM_D
CC I/P 815510
1111 UNIV BLVD WEST
SILVER SPRN MD 20902
301 649-1319

DATE	TIME	
3/16/08	0900	MSB ICU Note

S: NGT attempted multiple times c no success, MC discussed to Zenker's. Son wishes to be aggressive in care and is very worried about pt. not eating. No acute events overnight.

O: Vitals - Tm 98° Tc 97.8 BP 131/48 (117-181/48-56) RR 13-41 HR 95 SpO2 Sat: 96% Vent settings: 500cc/Peep 8/R 12/45%

I/O: 1080/565 (S) IVF: 1080 (125 c/o NS) UOP: 565

Exam: GEN - Intubated & sedated
Lungs - ↓ BS @ (13) bases. Ø crackles
CV - S1S2
Abd - benign
Ext: Ø edema

Lab:

19	10^3	265	146 or 139	116	31
	31.5		3.6	25	.9

8.2 / 101 / 2.5

A/P: 91 yo ♂ c aspiration pneumonia + hypoxia. Now on Vent.

- Neuro - cont sedation c versed. MSO4
- Resp - Aspiration Pneumonia - temp + WBC ↓'ng → improving ~~resolving~~. Will cont. IV Abx; Resp failure - oxygenation stable on vent - will cont. to wean
- CV - will continue to monitor BP for episodes of hypotension
- GI - unable to place NGT. Pt. will have it placed under flouroscopy as per attng.
- GU - UOP stable. ↑'d BUN/Cr - may be intravascularly depleted. Will continue to monitor UOP
- ID - WBC + T decreasing & BCx's NGTD. Will continue to monitor

meds
- ertapenem 1g IVq24° (D#7)
- Levaquin 250mg IVqD (D#7)
- Heparin 5000u SQBID
- Pepcid 20mg IVqD
- Vit. K 10mg SQ q Monday

prn
- versed 1-2mg IVq1-2°
- Ativan 2mg IV/IMq4
- Morphine 2-5mg IVq1-2

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 0306900162
3127 NAWAZ, AHMED
GG I/P 815510
9111 UNIV BLVD WEST
SILVER SPRIN MD 20902
301 649-1319

DATE	TIME	
3/16/03	0900	MS3 ICU NOTE (cont'd) A/P (cont'd) FEN - ↓ K^+ this am. Will replete ē IV runs. Rena - [illegible]. DVT prophylaxis - Sq heparin MD/1691 FADVL

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 [illegible]00162
[illegible] NAWAZ, FAHAD
[illegible] I/P [illegible]
[illegible] GEORGIA AVE. WEST
SILVER SPRING MD 20902
301 [illegible]

DATE	TIME	
3/16/03		meds:-
		-Pt resting comfortably on vent
		V/S:- Tmax - 99.6 Hr - 82 RR - 16-30
		B.P - 101/70
		Cust:- bibasilar rhonchi
		Cus:- non-productive
		abd:- soft, non-tender
		Labs:-
		17.3 / 9.7 / 29.6 (293
		116 / 116 / 31 (101
		3.6 / 25 / 0.9
		A/P:-
		- Pneumonia & Resp failure —
		- on vent, cont I/O HOR.
		cont I/V fluids
		- Feeding issue — spoke to Radiology
		will try under fluoroscopy
		- cont other meds.
		- case d/w nurse staff

Dr. Nawaz fails to renew antibiotics

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 0306900162
3127 NAWAZ, AFM
I/P 8155 0
1111 UNIV BLVD W ST
SILVER SPRIN
301 649-1319

DATE	TIME	
3/16/03		Rad Unable to place NGT under fluro guidance Able to pass Dobhoff to GE junx but not beyond. JK(kw) MD
3/16/03 SJ		Dsin/ccm VS 124/42 60 22 16-20 1/0 1581/1200 Lungs CTA B CVS RRR no m Abd ntnsnt Extr edema 293/9.7/17.3 (29.4) 146/114/31 (N) 3.4/25/9 CTR RML infilt (1) Asp pneumonia w/ Resp failure (2) Leukocytosis both (3) new-onset Atrial fib/flutter (4) h/o tumor distal colon (5) Agitation - Trial of CPAP/BiPAP in AM - d/c Restraints - Trial of Scheduled Haldol - needs PICC line - consult SW Ball

Dr. Ball orders megadose of Haldol for agitation but fails to renew antibiotics.

PICC line placement ordered for TPN nutrition, but PA on call has no PICC line insertion experience. Procedure delayed until Monday!

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 0306900162
3127 NAWAZ, AHM D
CC I/P 815510
1111 UNIV BLVD W ST
SILVER SPRIN
301 649-1319

DATE	TIME	
3/16/03		CC'd c/A Sons wishes No CPR Ball

Responding to weekend on-call doctor's questioning, I explain that in cases of clearly terminal illness Jewish law might not require a life-sustaining procedure that cracks ribs - but that each situation is unique and must be evaluated in consultation with one's rabbi.

Without informing family or admitting physician, Dr. Ball writes DNR order on the basis of this conversation.

Under PRE ARREST ORDERS patient is listed as a "candidate for intubation," whatever that means.

3/17/03 0810 IPN

Dubhoff tube was *never* placed.

Dopheff placed yesterday per radiology.

VS: T_m = 100 T_c = 98.3 BP = 142/57 P = 85 R = 24

Vent Settings: CMV

POx = 98%

Rate = 12

V_T = 500

FiO_2 = 45%

ABG - 7.47/33/113/98.4%

Alb - 2.0 AST - 27

A Phos - 145 ALT - 22

T Prot - 5.1 Trig - 137

T Bili - 3

143 111 23 / 7.7 / 122

3.5 23 .7 / 2.3

D/W attending. Due to myriad of consultants + multiple issues managed by each, will have teaching service sign off for now. Please call us if needed further

MD

1691 FADIL

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 03060900162
3127 NAWAZ, AHM
I/P 8155
1111 UNIV BLVD W.
SILVER SPRIN MD
301 649-1319

DATE	TIME	
3/17/03		P.M / CCM
4U Units		120-180/60-80 HR 80-100 T 100.3 336 4/132/
		lungs CTA w/ Scattered rhonchi
		CVS RRR soft
		Abd +BS NT ND
		Ext edema
		7.46/33/113 140/117/23/122 3.0 27 .7
		CXR: RML i-f.lt
		(1) Resp failure w/ RML pneumonia
		(2) HTN
		(3) ↓ Albumin
		(4) Agitation
		(5) h+/o tuberculosis
		- Dc'd line
		- TPN
		- Trend of CBC/Lytes
		- start lopressor for HTN
		- [illegible]
		- D/W SON & Dr. Nawaz & Nursing
		B-11

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER,
03/10/03
3127 NAW
O I/P
1111 UNIV B
SILVER SPRIN
301 649-1319

March 17, Monday

"Doing fine. Blood gases look better. More alert. Will try to wean him."

- Dr. Nawaz

DATE	TIME	
3/17/03		CCL
10AM		Case discussed with Dr Nawaz. Please see his note for details. ? Holdup at Ed-Jacksn, ? due to mental illness. Pulm status improved. We will continue trial on PSV for now. Hopefully extubate this week and advance pt diet. Please call if we can assist further. Jamal.
3/17		meds:.
		↑ Doing fine, resting on vent
		v/s:- BP-130/80 RR-15. Hr-107
		Lungs:- BIL rhonchi.
		CVS:- RRR, SEM ↑ABD:- soft, nontender
		A/P:-
		1. - Blood gases look better more alert will try to wean him.
		- cont current meds
		- Long conversation ↑ son to d/c ↑ off on RUT
		- Pic line under flow

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March 17, Monday, approximately 4:00 pm

Just prior to extubation, Dr. Weiner waved his finger in my face and raised his voice in anger:

"Remember what I told you. (He'll go) On-again, off-again, on-again, off-again until you tell us to stop. Has he woken up? Has he tried to talk to you?"

I contacted Caroline Williams of Patient Relations to file a complaint immediately after this encounter.

Dr. Weiner denies seeing my father or me on March 17, but a Verbal Order to extubate proves he was present.

March 18, Tuesday

(Extubated Monday afternoon, TPN started Monday night.)

"Patient lethargic but opens eyes to stimuli."

"Aspiration pneumonia improving. Neuropathy of critical illness. Dementia."

- Dr. Weiner

DATE

3/17/03 11:15a

PROCEDURE NOTE

Double lumen PICC placed in (L) brachial vein under US guidance to 49 cm. STAT PCXR ordered for PICC placement

3/17/03 1410

Surgical PA

PICC line Tip in SVC. May use for med - compatible but flushed.

3/18

Pt lethargic but opens eyes to stimuli. T 100.3 HR 110 RR 22, BP 117/64 RA 94%

K+ 3.1 N+ 138 BUN 30 / Cr 0.7 -- 40 ...

Impression:

Neuropathy of critical illness

~~Pneumonia~~ Dementia

Rec 4 weeks

total IV

antibiotics

D/C steroids in 3 days

speech path eval

Form No STK-028 (Rev 5/99) Progress Notes

March 18, Tuesday

"Groggy but opening eyes and (following) commands."

- Dr. Nawaz

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

AEL 91Y
00162
APM
1111 UNIV BLVD W.
SILVER SPRIN
301 A10-1319

DATE	TIME	
3/18/03		meds:-
		- Pt been extubated.
		VS:- 182/72. R - 26 Hr - 82.
		Chest :- B/L rhonchi.
		Cvs - S1 S2 reg.
		Abd :- soft, non tender
		Labs :- 138 / 104 / 17 (180 ; 3.1 / 28 / 0.6 ; 17.1 / 9.5 / 29.0 / (316
		7.51 / 33.8 / 74.4 / 96.2
		AP :-
		- Been extubated
		- Groggy but opening eye & command.
		- cont chest cons
		-
		- Labs in Am.
		- Spoke to son and discussed about reintubation issue, he is going to talk to his friends and Rabbi and let me know.

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 0306900162
8127 NAWAZ, AHM
O I/P 8155
1111 UNIV BLVD W
SILVER SPRIN
301 [illegible]-1310

DATE	TIME	
3/19/03		meds :-
		-. Pt alert more responsive.
		VS :- B.P - 169/70 RR - 16 HR 82
		Chest :- bibasalar rhonchi.
		Cvs :- RRR, S1S2
		abd :- Soft, non tender
		+ bag reflexes
		ABG :- 7.52 | 34.6 | 66.1 | 95%
		20.5) 10.4 (38%
		32.3
		139 | 103 | 17 (186
		3.4 | 29 | 0.6
		-. Get speech eval.
		-. might need PEG
		- Get aggressive pulmonary toilet
		-. Check mi Am
		-. K+ wnl so replace
3/20/03		Pt lethargic Afebrile No sig events
		Lyte stable Creat 0.5 WBC stable
		I=O WBC 20.5 N. +134 K+ 3.4
		ABG 66/34/7.52 - 35%
		CXR

March 20, Thursday

- The same day Dr. Weiner writes "failure to thrive" & "long term very grim," a nurse writes: "More alert and active. Reaching and trying to talk. Breathing more relaxed."

- Physical therapist Laura Heughens writes: "Sitting at edge of bed, able to dangle 10-15 minutes. Rehab potential is fair."

Meanwhile, continued high WBC and "copious amounts of thick, creamy, tenacious secretions" noted by nurses and respiratory therapists are completely ignored. Physicians Order Forms show no antibiotics ordered for period of March 17 to March 20. Pharmacy printout shows 40% of prescribed doses were never dispensed by hospital pharmacy.

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

DATE	TIME	
3/19		Pulm c.f. / Eval for Pneumonia ② Swallowing dysfunction / Zenker's ③ Neurologically at baseline ④ Dementia P: ① Leave NGT speech pulm eval PT OT TPN will eventually need PEG at some point
3/20/03		Pulm Pt lethargic, unable to swallow. Afebrile Very weak. Lungs: coarse rhonchi throughout Eval for pneumonia Swallowing dysfunction Dementia weakness failure to thrive P: Pt/fam wishes will plan for PEG and home care. Prognosis long term very grim. Discussed prognosis

Form No. STK-028 (Rev. 5/99) Progress Notes

From Nurses Notes

Holy Cross Hospital

From: 10-Mar-2003 at 13:55
To: 27-Mar-2003 at 18:51

Printed: 06-May-2003 at 09:33

Progress Notes

03/18 13:45 — MD — Susan L. Snyder, RN

Seen by Dr.Nawaz, who spoke, at length, with son.

03/19 01:14 — Cough — susan d. willoughby

Problem: Impaired Airway Clearance

received pt.awake,mental state unchanged. patient's son remains @ bedside. pt. coughs frequently however unproductive. deep oral suctioning tried x 2 using suction kit unable to pull out sufficient amt. pt. son voiced his concern and disapointment re. lack of precribed respiratory therapy, states he will speak with md. regarding options. pt. has been turned from side to side and given cpt x1. .40 02 remains in use via hhfm.observed no resp. distress or symptoms of pain, morphine given x 1 for restlessness.

Son wants aggressive treatment for his recovering father.

03:00 — Respiratory — susan d. willoughby

pt. cont. to sound coarse with unproductive cough. resp. notified to replace 02 humidification. therapist N/T suctioned pt. pulling out large amt. of thick creamy tanish secretion. pt. sounds much better and coughing has stopped.

16:23 — Case Mgmt-Progress Note — Stella R. Ross, RN/CM

Problem: Potential Need for Post Acute Care

Chart reviewed. Pt remains in ICU/extubated,, son at bedside. Pending PT consult. Continue with currentplan of care. CMC will continue to follow.

03/20 02:58 — Mentation — susan d. willoughby

received pt.awake in bed,son at bed side. pt. appears more alert and active today; reaching and trying to talk. his breathing is more relaxed with the nc,he continues to sat. in mid./high 90"s. nt suctioning is effective for airway clearance. pt. was given 2mg morphine x1 @ approx. midnight. for restlessness and removing his nc. lopressor was held at 2000 due to low bp and hr.

Patient apparently not terminally ill. Why was treatment withheld?

07:30 — OT Evaluation — Richard J. Holley, OT

Problem: Impaired Functional Mobility

This patient is referred to OT for Evaluation/treatment and discharge planning

Diagnosis: Septicemia NOS

Precautions: Fall, aspsiartion

Unauthorized, expired DNR. Patient was Full Code.

Noted: DNR, Physician Cert. of Incapacity

PMHX: Demantia, Macular Degeneration, Anemia, HTN, Zenkes Diveticular, CAD, S/P ACID, H/O Pneumonia, H/O Sepsis

Prior to this admission, the patients level of function in ADLs was with minimal assist of family/ caregiver
- used cane during ambualtion
- dependent: transportation

Prior Rehab: The pt has not received OT in the past

EVALUATION
Upon evaluation the patient demonstrates the following:
Feeding: NPO

-- Continued on next page --

From Nurses Notes

Holy Cross Hospital

From: 10-Mar-2003 at 13:55
To: 27-Mar-2003 at 18:51

Printed: 06-May-2003 at 09:33
Page 12 of 17

Progress Notes

03/20 07:30

-- Continued from previous page -

education will include patient/family/caretaker/staff education, exercise program, ADL's/self-care training, functional activities/exercises, cognitive training, adaptive equipment training, balance & gross coordination activities, compensatory techniques, energy conservation, discharge planning, joint protection, positioning, ROM exercises/activities, strengthening exercises/activites, safety screening, functional mobility training, fine motor training

Patient will be seen 4-6 times a week for OT treatment.

If pt is discharged from HCH causing STGs not to be met, defer unmet goal achievement to follow up care/facility.

Thank you for this referral

08:55

PT Re-eval Laura R. Heughens, PT, 20326

Problem: Impaired Functional Mobility

Database:Pt evaluated by PT on 3-11-03. Pt placed on hold on 3-14-03 for a change in medical status. Pt transfered fo ICU for respiratory distress. Pt intubated then extubated on . Please refer to initial eval for further info.
S: Pt is non verbal but does opens eyes to commands & tactile stimuli.
O:ROM:BUE:less than 1/4 AROM at shoulders, 1/2 AROM at elbows and 3/4 AROM at hands. PROM:shoulder flex=90deg B, elbow and hand WFL B. Increased resistance noted during all PROM at B UEs.
BLe:1/2 AROM at hip and knees, <1/4 AROM at ankles.
PROM: WFL overall.

Bed mobility:rolling to L & R maxA. sup-sit, sit-sup maxA.

Balance: sitting at edge of bed c BUE support minA.
Pt abe to dangle ~10-15min.

Rx: BUE & BLE:PROM/AAROM in all planes 10x.

A:Pt presents to PT c impaired functional mobility, decreased strength, endurance and balance. Pt would benefit from cont PT to work on above functional problems. Pt demonstrates ability to participate in PT. Pt's rehab potential is fair.
Currently reccommend STNH for cont PT.
STGs:5-6 sessions:
1. Pt will perform sup-sit c modA.
2. Pt will transfer sit-stand c RW modA.
3. Pt will transfer from bed-chair c modA.
4. Pt will participate in ther exs program, AAROM > PROM.
LTGs:12 sessiosn:
1. Pt will perform sup-sit c minA.
2. Pt will transfer sit-stand c RW minA.
3. Pt will amb 15 ft x2 c RW minA.

P: Pt to be seen by PT 4-6 x per week for functional mobility/transfers, balance, bed mobility, ther exs, eduction and ongoing assessment.

09:28

assessment Irene C. Wosu-Asuru, RN

Problem: Potential Need for Post Acute Care

pt awake, non-verbal and unable to follow instructions. lung sounds clear and improved , no respiratory distress noted. o2 sat at 98% on 6 liters of o2. afebril, vital signs stable, less than 50% paced on the telemonitor. TPN infusing at 83cc/hr, IV NS at kVO. full bath given , skin and oral care done. will continue to monitor pt's status. plan of care continues.

Patient apparently not terminally ill.
Why was treatment withheld?

0000815510 M 14-Apr-1911 Age: 91

I MT

NEUSTADTER, ISRAEL Wt: 61.900Kg

Admit Physician: NAWAZ AHMED MD Attending: NAWAZ AHMED MD

Holy Cross Hospital

Progress Notes

Chart Copy

Requested by:
WHITLV

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 [illegible]00162
3127 NAWAZ, AHM[illegible]
[illegible] I/P 815[illegible]
[illegible] UNIV BLVD W
SILVER SPRIN[illegible]
301 [illegible]

DATE	TIME	
3/20/03		medicine f/u
		-, more responsive
		VS:- B.P.- 170/60 RR - 16, Hr - 82.
		Const:- Bibasilar rhonchi
		Abd:- soft, NT, ND, BS+
		19 > 9.8 / 30.8 < 396 ; 138 / 3.6 | 104 / 28 | 24 / 0.7 < 196
		-. Card Comm management.
		-. failed SBT secondary resp.
		-. Pt will take 12h Diamox for possible PEG.
3/20/03		CE
9AM		Patient seen for PEG -
		PEG, RISKS/benefits discussed with SON. -
		SON wishes to proceed tomorrow.
		Pt will need anesthesia for sedation.
		Patient on antibiotics.
		He has hx of rigidity, - ? SE of Haldol,
		Consider D/C Haldol.

High dose of Haldol (5 mg every 8 hours) started on 3/16/03 while on vent is not cancelled until elevated liver functions found on 3/24/03.

Significant muscle rigidity and the discontinue recommendation noted here are ignored.

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 0306900162
3127 NAWAZ, ARM
I/P 8155
8111 UNIV BLVD W
SILVER SPRIN
301 879-1310

DATE	TIME	
3/21		PCI Pt w/ known Afib w/ CHF & ETOH abuse c/o SOB, DOE x 1 mo, NYHA class 2b No CP x 13Y Risk factors reviewed, pt counseled re: smoking cessation program Rec. PCI Transfer to shpd unit Echo, ASA, Plavix, Lipitor, Lopressor, Lasix, Imdur, Nitro SL PRN, Ace-I, Heparin gtt, Integrilin gtt, Cath in AM Risks, benefits, alternatives discussed with pt, pt agrees to proceed

Form No. STK-028 (Rev. 5/99) Progress Notes

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 0306900162
3127 NAWAZ, AMM
I/P 8155
1111 UNIV BLVD W
SILVER SPRIN
301 649-1319

DATE	TIME	
3/21/03	4PM	Procedure EGD / PEG Large Tumor prox Esoph / GES. ? Post Bulb Stricture N duodenal deformity. No gastric outlet obst. Right LES # 20 F Mic-O-Vasive PEG placed Complications Large duct Debris suctioned Dry post pharynx. Recommend Tube feed in AM. Dr. [illegible]

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

March 22, Saturday

(Peg tube feeding not yet started.)

"Doing same. Having eye contact. Following commands."

- Dr. Nawaz, admitting & attending physician.

91Y F 00162

DATE	TIME	
3/21/03		medo:-
		-. Pt- is Same.
		Vys:- 130/70 RR-20 HR-93.
		Chest:- bibasalar rochi.
		Cvs:- RR, SEmôni.
		abd:- Soft, nontender.
		20.4 > 10.1 < 409.
		30.4.
		Mp:-
		-. cont current meds.
		-. PEG tube placement.
		-. can be discharged to incell
		-. wbc ↑.
		3 3 A.Nawaz
3/22/03		medicine:-
		- Doing Same. having eyecontact. following commands
		Vys:- B.P- 120/70 RR-20 HR-90.
		Chest:- bibasalar roncchi.
		Cvs:- RRR. abd:- PEG tube in place.
		Ext:- ΦCLE

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 0306900162
3127 NAWAZ, AHM
I/P 8155
SILVER SPRIN
301 [illegible]-1310

DATE	TIME	
		9.8 / 29.6 — 9.8 — 140 / 4.1 — 105 / 30 — 24 / 0.7 — 131.
		-A/P:-
		-. Transfer to incu.
		-. Aspiration precautions
		-. will start TF.
		-. D/C TPN.
		-. Labs in AM.
		-. Tcc consult.
		A. Nawaz
3/24/03		OE
3pm		Progress OK; ABG soft begin. will start tube feeds now.
		Resp status stable secretion & throat removal problem. Continue to monitor for aspiration & dysphagia and Evaluate Antibiotics. Requires freq suctioning.
		Stop TPN today.

Progress notes show experts recommending treatment; no intention of letting my father die.

March 22, Saturday night

(Tube feeding just started.)

"Lethargic but easily arousable." "From a pulmonary standpoint continue antibiotics for aspiration pneumonia."

- Dr. Heinz, pulmonologist in Dr. Weiner's practice.

March 23, Sunday

"Patient is alert following commands."

"Social Services consult for placement."

- Dr. Nawaz, admitting & attending physician.

Are these assessments consistent with a terminal patient for whom no further treatment is planned?

Why was treatment withheld on March 25?

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

DATE	TIME	
03/22/03 9:40 PM		PULMONARY / CRITICAL CARE PEG tube was inserted yesterday. Patient is extubated. Lethargic but easily arousable BP: 144/53 P: 93 T: 97.3 R: 17 Vent: 100%/8 4L/min via O2 LUNGS: B/L inspiratory crackles HEART: RRR ABDOMEN: soft, nontender, BS (+) EXTREMITIES: No edema From pulmonary stand point continue antibiotics for aspiration pneumonia, titrate ↓ FIO2 for O2 sat ≥ 92%. Agree with PT consult D. Feinstein - Monitor ✓.
3/23.		meds: - Pt is alert following commands VS:- B.P - 155/70 RR - 20 HR - 90 chest:- bibasilar rhonchi Cor:- RRR, SEM heard. abd:- soft, nontend., ABG: 7.38 / 41.0 / 29.4 / 4.90 — 9.8 139 / 105 / 26 / 4.2 / 30 / 0.7 — 119 - Pneumonia - stable - cont suctioning - use ↓. - SS consult for placement. - cont TF.

March 23, Sunday afternoon

"Tolerating tube feeds. Oral hygiene improved. I discussed Peg care with son. If improves, may have speech reevaluated for comfort foods. If improves substantially, may have surgery evaluation for Zenkers."

- Dr. Diamond, gastroenterologist.

March 23, Sunday evening

"Patient is more awake today." "Tolerates tube feeding." "From pulmonary standpoint will need to complete 2-week antibiotic course. Will need to repeat chest x-ray in 4 weeks."

- Dr. Heinz, pulmonologist in Dr. Weiner's practice.

Are these assessments consistent with a terminal patient for whom no further treatment is planned?

Why was treatment withheld on March 25?

I/P 815510
111 UNIV BLVD W.

DATE	TIME	
3/23/03 12 pm.		CE Peg site OK. tolerating tube feeds. Oral hygeine improved. I discussed peg care with son. If improves, may have speech reeval for comfort foods. If improves substantially, may have surgery eval Rx Zenkers. Please call if we can assist further [signature]
03/23/2003 6:40 pm		PULMONARY / CRITICAL CARE Patient is more awake today. Is SOB. Tolerates tube feeding. BP: 151/99 PC 82 T: 38.3 R: 15 Oxsat: 95% 4L/nc LUNGS: B/L inspiratory crackles HEART: Regular rate and rhythm ABDOMEN: Soft, nontender, B/S, PEG in place EXTREMITIES: No edema From pulmonary standpoint will need to complete 2 week antibiotic course. Will need to repeat CXR in 4 weeks. Will hyper ↓ FIO2 for O2 sat 92%. D/W son. Dr. Heinz-Pulmonology

Form No. STK-028 (Rev. 5/99) Progress Notes

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTAETER, ISRAEL 91Y
03/10/03 0306900162
3127 NAWAZ,AHMED
I/P 81551A
1111 UNIV BLVD W
SILVER SPRING
301 449-1310

DATE	TIME	
3/24/03		meds :- -- Pts condition is same. Vit:- T. 97.6 HR-82 B.P. 154/70 Chest :- bibasalar ronchi. CVS :- nl. abd:- soft, nontender Labs:- 139 / 105 / 23 (97) 4.3 / 26 / 0.7 alkPO4 - 391 AST - 235 ALT - 116 -- ↑ LFT - due to haldol V/S long term TPN gall bladder problem. - get gall bladder U/S. -- D/C haldol. -- Cont other meds -- Labs in am. - Case d/w family in details. -- Case d/w Dr. Kariya
3/24 12 NAWM		NOT CONSCIOUS TO ME, OBVIOUS GURGLING AFEBRILE HR79-96 R10-44 BP135/57 PO x 98-10% SWOLLEN LIPS (-) COR BUN 24 WBC 12.9 S90723 HE MAY BE SLOWLY IMPROVING RE ASP PN + RECENT EXTUBATION, LONG D/W SON RE LIMITED GOALS

High dose of Haldol (5 mg every 8 hours) started on 3/16/03 while on vent. Muscle rigidity noted on 3/20/03, but Haldol not discontinued until elevated liver functions found here.

Antibiotics never revisited despite persistently high WBC throughout hospitalization.

If patient is aspirating, isn't Dr. Kariya obligated to offer tracheotomy or intubation?

From Nurses Notes

Holy Cross Hospital

From: 10-Mar-2003 at 13:55
To: 27-Mar-2003 at 18:51

Printed: 06-May-2003 at 09:33

Progress Notes

03/21	16:00	Miscellaneous	Anita A. Clark, RN
		Recieved report assumed care of patient.	
	21:56	assessment	Luciana Delca, RN
		Assumed pt. care at 19.30. Assessed per unit standards (see assessment flowshet). Alert, doesn't folow commands, nonverbal, resists turning and repositioning. Afebrile, VSS. PEG site: no bleeding or drainage, TPN infusing. Will cont. to monitor.	
03/22	12:31	Secretions	Karen R. Becraft, RN
		Suctioned down nares approx q 4hrs for large amount of upper airway thick creamy secretions.	
	16:00	Tube Feeds	Karen R. Becraft, RN
		Tube feeds isosource 30cc's initiated via peg tube. Pt tol well. TPN to be d/ced after present bottle infused.	
	20:38	Tx to IMC	Karen R. Becraft, RN
		Report given to IMC. Pt tx to 6231 via bed. Son in attendance.	
	21:00	Admission Note	Kathy A. Butler, RN
		Received pt. from ICU in stable condition. VS stable. Pt. sleeping when not disturbed. Tube feeding increased to 50 cc/hr as ordered.	
03/23	12:27	Assessment	Wanda C. Caesar, RN
		Assumed care of Patient, all treatment plan explained to Patient family prior to intervention. Physical assessment completed (see flow sheet). Telemetry display 100% paced. Nasal suction done by resp. therapist, sputum sent for culture, neb tx. albuterol 2.5mg given as per MD order. HOB elevated, pulse ox 97% on 3LNC. Family member at bedside, will continue with plan of care.	
	20:09	Secretions	Ronald L. Gibbs, rn
		Problem: Impaired Airway Clearance Pt. has weak, non-productive cough. Noted to be desaturating from 98% to 86% on 4L O2/NC. Using flrxible suction catheter suctioned posterior oropharynx deeply with moderate amount of yellow/tan, thick secretions returned. Saturations returned to above 96% after suctioning. Pt. noted to have poor gag reflex.	
03/24	09:30	TUBE FEED	Irene C. Wosu-Asuru, RN
		pt on isosource tube feeding , rate at 60cc/hr. am residual >100. held feeding for 1hr and restarted feeding after 1hr with same rate. abdomen soft with positive bowel sounds.	
	12:13	Case Mgmt-Progress Note	Charleen Brand, SW/CM
		Have faxed a referra; to the Hebrew Home and TCC and gave son Cheryl"s name and no. at the Hebrew Home (admissions). 301-770-8476. SW will follow at beeper 1440. Charleen Brand, ACSW-PRN	
	17:48	nursing note	Irene C. Wosu-Asuru, RN
		Problem: Potential Need for Post Acute Care total care, calm, alert and oriented x1. son at the bedside. no distress noted with pt. afebril, vital signs stable. continued to	
		-- Continued on next page --	

March 23, Sunday, 8:00 pm

I inform Nurse Gibbs that my father received no Levaquin on Sunday. After attempting to contact previous nurse and after checking with pharmacy, Levaquin is started at 8:30 pm, more than 6 hours late.

Gibbs tells me he will chart the late delivery in order to allow for later administration of next dose on Monday.

Gibbs fails to note anything amiss. Kardex shows Levaquin administered at usual time of 2:00 pm.

March 24, Monday, 5:40 pm

Just 5 hours after Dr. Kariya remarking "not conscious to me" a nurse writes: "Calm, alert and oriented X1, son at the bedside. No distress noted with patient. No fever, vital signs stable, no respiratory distress noted."

Daily Vital Signs show orientation for Monday night and Tuesday as X2 (alert and oriented to person and place).

0000815510 M 14-Apr-1911 Age: 91

I MT

NEUSTADTER, ISRAEL Wt: 61.900Kg

Admit Physician: NAWAZ AHMED MD Attending: NAWAZ AHMED MD

Holy Cross Hospital

Progress Notes

Chart Copy

Requested by:
WHITLV

From Nurses Notes

Holy Cross Hospital

From: 10-Mar-2003 at 13:55
To: 27-Mar-2003 at 18:51

Printed: 06-May-2003 at 09:33
Page 16 of 17

Progress Notes

03/24 17:48

-- Continued from previous page -

tolerate tube feeding well with minimal residual. maintained up and elevated in bed to minimize potential for aspiration. turned and repostioned for comfort every 2hrs. no respiratory distress noted with pt, continued to receive respiratory treatment as ordered. will continue to monitor pt's status. plan of care continues.

March 24, Monday evening
Patient doing very well.

19:40 Pastoral Care — Susan C. Mitchell

followup visit with pt and son, whom I had met earlier;son continues to be very anxious about care; he is working thru many personal issues; son and pt both are very observant Jews, and being able to practice is important to them;provided a listening presence, prayer, and pastoral care; encouraged him to call pastoral care prn; Chaplain Susan Mitchell

"Son continues to be very anxious about care."
"Son and patient are very observant Jews, and being able to practice is important to them."

03/25 07:21 nursing note — pat a. chandler, rn

Problem: Impaired Gas Exchange
Sytems assessed unchanged during shift. Turned and positioned for confort. Son state that this is the first rested night he has had since dad in hospital. Complimented caregiver on "how good he looks. He looks so restfull, his sat is 100%".

Corrected

nursing note — pat a. chandler, rn

Problem: Impaired Gas Exchange
Sytems assessed unchanged during shift. Turned and positioned for confort. Blood specimen for am lab collected results pending. Son state that this is the first rested night he has had since dad in hospital. Complimented caregiver on "how good he looks. He looks so restfull, his sat is 100%".

March 25, Tuesday morning
Patient continues to do very well.

13:00 Pastoral Care — Ellen K. Radday

Follow-up visit per night chaplain's requesfor pastoral support to son. Son very appreciative.

13:32 Nutrition Progress Note — Chitua A. Okoh, RDLDN,PHD

DIET: Isosource @ 60cc/h
Assessment/pxs:
1. TF on hold this pm probably due to scheduled sonogram
2. Elevated liver enzymes noted on 3/24
3. Continues to use O2; possible transfer this pm
PLAN:
1. May restart TF post sonogram, goal 60cc/h
2. RD will continue to f/u

17:05 Respiratory — Christina E. Canfield, RN

pulse ox desat in the 80s. son by side and very anxious.son touching oxygen equipment and suction equipment. son stated that he had given patient apple juice and ice. resp called and 100% mask applied . suction xl small amount of secretions noted. 15min later pulse ox 94-98%. DRkayixa aware. will continue to monitor. son stated i take the responsiblity of this ,my father was finally awake and was hungry. tube feeding held at this time. patient comfortable at this time. will follow plan of care.

After writing, "Son stated that he had given patient apple juice and ice," Nurse Canfield purportedly calls Patient Relations *the next morning* to add that she *observed* him pushing ice chips down his father's throat.

March 25, Tuesday, 5:00 pm

Respiratory distress suddenly sets in.
Withholding of treatment (forced euthanasia) begins.

- Peg feeding started just 72 hours ago.
- "Father was finally awake and hungry."
- No history of serious medical problems.
- Ambulatory, excellent quality of life.

What son could deny such a father ventilation?
What doctor would deny such a patient ventilation?
What hospital would allow it?

19:50 Respiratory — Christina E. Canfield, RN

patient restlesss and taking off mask with son present. o2 mask 4liters attempted but not able to tolerate. 50%venti mask on and abgs done. pulse ox 96-97. hob remains elevated. gtube feeding off at this time. son remains at bedside. no further episodes of son giving patient ice or fluids of any kind. patient remains npo.

-- Continued on next page --

0000815510 M 14-Apr-1911 Age: 91

I MT

NEUSTADTER, ISRAEL Wt: 61.900Kg

Admit Physician: NAWAZ AHMED MD Attending: NAWAZ AHMED MD

Holy Cross Hospital

Progress Notes

Chart Copy

Requested by:
WHITLV

March 25, Tuesday afternoon

Approximately 1 hour before rapid onset of breathing difficulty.

Dr. Shamim talked with him and watched him suck on foam lollipop, remarking "great, you can swallow."

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

DATE	TIME	
3/25/06		Medicine (Co-Covering Dr. Nawaz) 1. (B) Pneumonia 2. Dysphagia 3. PEG Tube placement 4. Mod LFTs & alk Phosp. 5. HTN 6. Hx of Resp failure V/S - 142/67 99% pulse 95 T5/min 98.2 142 / 4.3 | 109 / 28 | 30 / 0.8 ↓ (18.1) | 10.3 / 32.1 | 525 AST = (241) ↑ alk Phos = (623) ALT = (234) albumin = 23/5.9 Cont RRR Sys ↓ S3 Chest: Bilateral Crackles Abd: PEG tube (+) BS Ext: Edema A/P. 1) Cont IV Abx 2) ✓ U/S liver / gall bladder 3) prognosis, guarded 4) Placement → Rehab S. Shamim

Dr. Shamim fails to renew antibiotics

March 25, Tuesday night

6:00 pm - Dr. Kariya is first to observe emergent situation. He writes, "Breathing tenuous, pulse oximetry down...Patient remains tenuous and son remains unrealistic. No new suggestions."

- Isn't Dr. Kariya obligated to "suggest" intubation or tracheotomy for the tenuous breathing? Instead, Dr. Kariya disappears. Can he do that?

8:30 pm - Previously uninvolved resident called in by me.
Spoke with Rabbi Anemer who told him Jewish law mandated intubation.

- Why did I call resident into the room?
- Why did resident call Rabbi Anemer?
- WHY NO INTUBATION?

NEUSTADTER, ISRAEL 91Y
03/10/03 [redacted]0306900[redacted]
3127 NAWAZ, AHMED
I/P 815.1N
[illegible] UNIV BLVD W
SILV[illegible] SPRIN [illegible]

Patient abandonment
Dr. Kariya finds full-code patient in respiratory distress.

He documents irreconcilable difference with family, yet fails to provide needed life-sustaining treatment, or to withhold it as medically ineffective pursuant to state law and hospital policy. He simply walks away!

3/25 6PM BREATHING TENUOUS, ↓POX WHEN SON GAVE HIM ICE CHIPS
AFEBRILE HR 68-94 RR 20-26 BP 129/60 [illegible]9/79 POX 92-94% 2L 1.7/1.5
SCATTERED RHONCHI THROUGHOUT
BUN 30 WBC 18.1 H 9.2 A 87.2 L 1.2 A 2.3 L
PT REMAINS TENUOUS & SON REMAINS UNREALISTIC
NO NEW SUGGESTIONS

Dr. Kariya fails to return as my father's condition is worsening. I see a resident entering an elevator and plead for help.

"Contacted Dr. Shamim and discussed possibility of intubation. ICU doctor covering & Dr. Kariya was also consulted and agrees at this point will readdress code status (due to poor prognosis). Will also keep patient on 100% NRB and suction PRN."

- What did these doctors agree to?
- Was code status readdressed?
- Who readdressed it?
- What *was* Israel Neustadter's code status?
- What about inbutation for respiratory distress?

25 8:30 PM INTERN - MEDICINE X COVER.
DR WAS CALLED BY NURSING STAFF/PT HIMSELF TO EVAL PT FOR LOW POX. PT'S POX WAS (83)% ON 6LNC UPON ENTERING ROOM, HIS HR (113), BP 120/67 AND RR 36, STAT ABG, POX EKG WERE ORDERED AND 100% NRB PLACED ON PT. PE REVEALED RONCHI'S BIL & RR, HS TACHYCARDIC & MILD SOB.
STAT ABG 7.50 / 32.9 / 58.5 / 93% ON 100% NRB.
CONTACTED DR. SHAMIN AND DISCUSSED POSS. OF INTUB. ICU DR COVERING & DR. KARIYA WAS ALSO CONSULTED, AND AGREED @ THIS POINT WILL READDRESS CODE STATUS (2° TO POOR PROGNOSIS). WILL ALSO KEEP PT ON 100% NRB ON SUCTION PRN.

Never "expressed."
Expressed repeatedly, resulting in resident's call to rabbi Anemer.

PT'S SON EXPRESSED HE DOES NOT WANT RE-INTUBATION BUT IS BOUND BY STRICT JEWISH LAW. ASKED IF WE CAN SPEAK TO RABBI ANEMER TO READDRESS CODE STATUS.

Rabbi Anemer testified he told doctor that Jewish law required intubation to prolong life as much as possible, and **it is what my father would want** as well. The doctor said he understood.

#1672

HOLY CROSS HOSPITAL

March 26, Wednesday morning

Dr. Kariya writes, "Called stat to see patient in respiratory distress by son."

Why did I call Dr. Kariya into the room?

Dr. Kariya testified that he didn't think intubation would be curative, and he thought that by suctioning the patient "he *did not require* intubation at that time." (!)

Dr. Kariya testified that he knew patient's status was full-code.

PR

DATE	TIME	
3/26	11AM	RWW

CALLED STAT TO SEE PT IN RESP DISTRESS BY SON.
TM 100.3 HR 95 +11 R 24-31 BP 113/46 -173/73 POX 89-96% FIO2 1.1/1.0
SUCTIONED RHONCHI. INT RESP DISTRESS. ⊖ COR. ⊖ CHEST PT/LLL POSITIONING,
I SUCTIONED HIM ORALLY (UNABLE TO PASS NT TUBE VIA NARIS
RUMPTED) FOR MOD AMOUNT YELLOW GREEN TENACIOUS SECRETIONS
GLU 147 NA 148 CA 8.5 WBC 37.6 HCT 36 AST 100 ALT 164
IMP (1) RWW HE WILL RECURRENTLY ASPIRATE AND IS SO WEAK HE CANNOT
CONTROL/ELIMINATE HIS SECRETIONS. ~~HIS IMPROV~~ ANY IMPROVEMENT
FROM A RESP STANDPOINT IS LIKELY ONLY TO BE TEMPORARY. I
SPENT A LONG TIME @ PT CARE @ BEDSIDE D/W SON THE PT'S
POOR SITUATION. I HOPE THE PT'S FINAL DAYS ARE PEACEFUL,
AS OPPOSED TO BEING SUCTIONED/INTUBATED OR GETTING CPT.
SON HAS D/W ME PT'S PAST ILLNESSES, BUT HAS
(I THINK) ONLY CONSIDERED THEM IN THE ABSTRACT.

1 HR SPENT ON PT CARE

SY

Dr. Kariya writes, "I hope the patient's final days are peaceful, as opposed to being suctioned/intubated or getting CPT."

- Touching sentiment, but with yellow-green tenacious secretions and a white count of 37.6 how about some antibiotic? The patient is not dead yet.

- If aspiration suspected why isn't tracheotomy suggested?

- No conversation whatsoever with family about intubation.*

Dr. Kariya is clearly aware of chasm between *his hopes* and *family's wishes* for treatment, yet fails to honor family's wishes.

According to Delmarva Foundation Quality Concern Inquiry, it is "unclear" if it was actually the *son's* choice not to suction or intubate.

* According to Holy Cross Hospital brief neither Dr.Kariya nor Dr. Weiner believed reintubation was in Israel Neustadter's "best interests" and accordingly "never recommended" this course of treatment for him (in other words they made the decision to euthanize without the informed consent of family).

March 26, Wednesday, late afternoon

Falsified record
Dr. Shamim writes, "Called Dr. Kariya," when in truth he handed patient off to Dr. Weiner - of whom there is no record. Dr. Weiner refused my plea for intubation, telling me that my father was "dead the day he got here" as the two of them walked away. Can the doctors really get away with this?

Full-code patient in acute respiratory distress. ICU consult and ABG test suggest intubation was under consideration. What became of the consult and the test? No nursing notes of substance. Why wasn't my father intubated? Can the hospital really get away with this?

Patient abandonment
Dr. Weiner's presence and his abandonment of my father confirmed by trial testimony. Dr. Shamim admits to handing over all care to Dr. Weiner.

Why are final 3 pages of physician progress notes missing the hospital identification stamp? Could they have been rewritten to hide Dr. Weiner's presence on March 26 and to cover up the withholding of treatment? With this hospital anything is possible!

New Ashdod, Israel.

3/26/05 Medicine

S. Events of last night noted. Appreciate hosp staff & Dr Mayo's input.

What was Dr. Mayo's input?

Hypoxemic & recurrent aspiration.

O. V/S 156/63 98 95 160'4.

Labs 37.6 | 10.9/60.9/35.7 | 148/110/29 | 4.2/28/0.9

SGOT/SGPT 100/164

*U/S abd. – gall bladder sludge
– Renal Cyst

* CXR: (R) UL infiltrate

S. Pt. in acute resp distress on 100% Non Rebreather

Ted resp rate, / Os 790%

O: (R) crackles

tachy

Abd: Soft, NT, (+)BS

Ext: edema

A/P: 1) Discussed w son

Falsified record
Dr. Shamim testified that he did not discuss code status or the issue of intubation with son.

2) Start Zosyn + levaquin

3) Suction q 4-6 Hrs prn

4) Called Dr. Kanya. ICU Consult

S. Shamim

Form No. STK-028 (Rev. 5/99) Progress Notes

HOLY CROSS HOSPITAL

PHYSICIAN ORDER FORM

(1) ABGs - stat
Call results to Dr. Weiner
or Dr. Steve Kariya (Start)

March 26, Wednesday, late afternoon

Falsified record
Dr. Shamim writes, "Call results to Dr. Weiner or Dr. Steve Kariya," when Dr. Weiner was with him the entire time and was handed the results in his presence. There were no calls to anyone.

Arterial blood gas test shows acute lung failure, impending respiratory collapse, yet no intubation.

noted ABGs 3:51P 3/26

PHYSICIAN SIGNATURE	PHYSICIAN NAME (PRINT)/PAGER#	TIME	DATE
	S. Shamim		

(1) CXR, CBC, CMP in am
(2) IVFT. D5 .45 NS @ 50cc/hr
+ 20 KCl

noted 12 hour 3/27/03

PHYSICIAN SIGNATURE	PHYSICIAN NAME (PRINT)/PAGER#	TIME	DATE
	S. Shamim		

Morphine 1-3 mg IV q 1-3 hr prn SOB

N.O. Dr. Weiner
T.C. Elsewhere

03 27 03

PHYSICIAN SIGNATURE	PHYSICIAN NAME (PRINT)/PAGER#	TIME	DATE

Form No. DRS-001 Physician Order Form — WHITE - CHART COPY — YELLOW - DEPT.

From Nurses Notes

Holy Cross Hospital

From: 10-Mar-2003 at 13:55
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Printed: 06-May-2003 at 09:33
Page 17 of 17

Progress Notes

03/25 19:50 -- Continued from previous page -
will follow plan of care.

What *was* the plan of care? When did it change?

03/26 11:29 Pastoral Care — Y. Louis Hicks, Chaplain

Follow up visit with son. He was concerned about the need for his father to be suctioned. Passed information on to Nurse and Social Worker handling patient's care. Offered words of encouragement and support for son.

13:03 Secretions — John Robinson, RN

Problem: Impaired Gas Exchange

pt suctiond prn with litt1e results. pt placed on 100% nonrebreathing mask and is sating >94%. pt's son informed that the secretions are to deep to suction and pt needs to cough to bring secretions up further.

03/27 09:30 Tests/Procedures — Denise L. Johnston, RN

Precise time was 9:50 am

pt ordered labs and xray. son refused any treatment. Dr. Weiner on floor and made aware. Dr. Weiner in to see pt and was asked to leave by pt son. orders to stop all treatment and to give morphine only for comfort witnessed by 2 nurses Denise Johnston and Elaine Warren. cont to monitor

13:08 Rhythm & Character — Elaine Warren, R.N

Problem: Impaired Airway Clearance

resp labored entire shift but 02 sat wnl 02 sat began decreasing as charted sx. o2 checked and dr. aware and present at the time. pt. refused cxr and all preventative care. statement via son verified c another team member.pt.s son refused all care not pt as stated above. dr. notified and pallitive care started stat morphine 3mgm. admin s.q as ordered. son acting very bizzare and confused stating dont do anything else for my father. then later stating no call anew dr. i want everything done . pastoral c. called forsupport,psych nurse. h.o spoke c son and made comfort. as poss. pt. made comf. as poss. also . care and v/s as charted.

Palliative care started < 1 hour before death. What was the level of care prior to this time?

14:00 Summary — Denise L. Johnston, RN

pt dying and son in room at bedside with caregiver. son refused any treatment for pt. witnessed by Elaine Warren RN and Denise Johnston RN. pt expired and pronounced by Dr. Fadul at 215 pm pastoral care notified and went to room. Dr. Fadul to notify attending

18:19 Discharge Note — Wullaimatu Kamara, RN

Pt expired today.Body picked up by Torchinsky morgue company.Son remained at the bedside till pick up arrived.Wrapped in a plain sheet of cloth per Jewish laws.

March 26, Wednesday

No nursing notes of substance on day when:

- Full-code patient develops acute respiratory distress and status degrades to critical.
- Attending physician turns care over to a "nonexistent" pulmonologist and leaves hospital.
- Surrogate purportedly decides to withhold treatment from his previously recovering father.

Refused what sort of preventative care?
Without intubation what care was being offered?
Without intubation what outcome was being prevented?

10:15 am

Nurse Elaine Warren and Nomeda witness Dr. Weiner's refusal to return to room.

Hospital manager Elise Reilly and chaplain Susan Mitchell "try" to get any other doctor available into room but "can't find one."

Refused what kind of treatment?
Without intubation what treatment was on the table?
Why wasn't patient intubaed 24 hours earlier?

0000815510 M 14-Apr-1911 Age: 91

I MT

NEUSTADTER, ISRAEL Wt: 61.900Kg

Admit Physician: NAWAZ AHMED MD Attending: NAWAZ AHMED MD

Holy Cross Hospital

Progress Notes

Chart Copy

Requested by:
WHITLV

March 27, Thursday, 8:50 am

Breathing collapses, pulse oximetry alarms. I am praying, holding my father's hand, Nomeda holds his feet. Nobody comes to help us despite repeated calls to nurses station.

According to the Medical Director of Critical Care, Nursing *probably knew* that additional life support measures were *not planned* for my father!

Portable X-Ray enters at exactly 9:50 am, followed by Dr. Weiner.

Falsified Record
Dr. Weiner writes, "Case discussed with son. He does not wish any other treatment (x-rays, vent etc.) He wishes to be alone with his father while he dies."

Dr. Weiner fails to reference his undocumented visit the previous afternoon - during which he categorically *refused my wish* that my father be placed on a ventilator, explaining "We don't just intubate any time somebody asks."

DATE

3/27 RVL

Pt is very poorly. Appears terminal. Case discussed c son. He does not wish any other tx (x-rays, vent etc) He wishes to be alone c his father while he dies. He understands he is terminal

3/27/05 Medicine

12:10 p.m. S: Appears in resp distress. Terminal
Above approached by Dr. Jay Weiner
O. V/S. 121 tachy 37/min R.R q8 15
Lower tachy
Chest (R) Crackles
Abd. Soft NT.
Ext Edema

Labs

43	10.5	521	152	112	29
	32.9		4.0	28	1.0

A/P 1) Terminal
2) Resp failure impending
3) INR. / Electrolyte abn
4) Discussed c Son

12:00 pm (actual time was 10:00 am)

Patient Abandonment
"Patient's son requested to talk to PMD & discuss further DNR considerations. He stated that he felt he was unclear in his request and that he wanted more done for his father."

- Previously recovering patient still very much alive.

- No doctor ever returns to "clarify" matters with son.

- Patient allowed to die despite designation as a "candidate for intubation," despite lack of Certificate of Condition authorizing withholding of treatment, and despite obvious indication that family is not on-board with "plan of care."

IHC

ISRAEL

4-14-11

NSG.

DATE	TIME	
27-03	1200	Pt son requested pt care initiated. PT son requested to talk to PMD + discuss further DNR considerations. He stated that he felt he was unclear in his request and that he wanted more done for his father. @ 1230 Postural care + Pt liason in Room with son. RN Bethany explained how the DNR program operated + what his decision met. if his father was to stop breathing + heart was to stop. Son stated that he was clear ē the program.
	1300	In Room ē assistant + Son Repositioned pt. for comfort. PT stated he was comfortable inhibited ē postural care JB.
	1400	Post postural care + med Resident. Pt cont. Apneic + asystolic (2-leads) Removed NRB + B/p cuff family @ bedside JB.
27	~~1400~~ 1420	Intern K-Correa Called ē presence of pt had been found to be apneic + asystolic. Pt did not respond to verbal or painful stimuli. Pupils were fixed + dilated. No heart sounds or breath sounds heard on auscultation. No palpable pulses. Son was at bedside. Pt pronounced on Thursday March 27 2003 @ 2:15 pm. Attending notified. MD 11691

VALID ONLY WITH IMPRESSED SEAL

I HEREBY CERTIFY THAT THE ATTACHED IS A TRUE COPY OF A RECORD ON FILE IN THE DIVISION OF VITAL RECORDS.

DATE ISSUED: March 31, 2003

Geneva G. Sparks
STATE REGISTRAR OF VITAL RECORDS

1- For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Israel Reuven NEUSTADTER	March 27, 2003	2:15 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
053-24-7926	1 [X] M 2 [ ] F	91 Yrs.			April 14, 1911	Czechoslovakia

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1 [ ] Yes 2 [X] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1111 University Blvd., W. #405	20902	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	4	Woodworker	Lumber

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Alexander Neustadter	Mantsu (unknown)

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Alexander Neustadter, Son	1111 University Blvd., W #405, Silver Spring, MD 20902

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)	Eretz Hachaim Cemetery	03/30/03	Bet Shemesh, Israel

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
	Torchinsky Hebrew Funeral Home, Inc. 254 Carroll St. NW, Washington, DC 20012

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Aspiration Pneumonia	
Due to (or as a consequence of):	b. Respiratory Failure	
Due to (or as a consequence of):	c. Dysphagia	
Due to (or as a consequence of):	d. Dementia	

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown	23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) _____ 9 [ ] Unknown	23d. Date of delivery Month Day Year

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No	24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No	26. Place of Death (Check only one) Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] Yes 2 [ ] No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0036

29a. Certifier (Check only one)	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	S. SHAMIM, MD	D 59284	March 27, 2003

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
S. Shamim, M.D. 1299 Lamberton Drive, Silver Spring, MD 20902

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
MAR 31 2003	Geneva G. Sparks

DHMH 17 Rev 1/2001

High wbc throughout hospitalization elicits no concern for underdosing, no infectious disease consult. It finally jumps to 43k and my father goes into acute respiratory distress.

Holy Cross Hospital
Mon Mar 17, 2003 11:20 am
Cumulative Trend Report from 03/05/03 1215 to 03/17/03 0640

Patient Name: NEUSTADTER,ISRAEL — Hematology-Page 5
Unit #: 815510 — Adm: 03/10/03
Location: ICU ICU 07
Phys-Service: NAWAZ,AHMED-MEDICAL
Acct #: M0306900162 — Previous Accounts Included

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H E M A T O L O G Y P R O F I L E (Cont)

Date:	03/11	03/10	Normal Range	
Time:	0635	1204		
WBC	20.7 H	38.5 HP	3.6-10.8	(K/mm3)
RBC	3.01 L	3.14 L	4.73-5.61	(M/mm3)
Hemoglobin	10.4 L	10.7 L	13.0-16.9	(gm/dl)
Hct	29.6 L	30.6 L	38.0-48.6	(%)
MCV	98.2 H	97.4	80.5-97.6	(fl)
MCH	34.5 H	34.2	27.3-34.3	(pg)
MCHC	35.2	35.1	33.0-36.1	(%)
RDW	12.3	11.6	11.5-14.5	
Platelet,Auto	211.	311	140-440	(K/mm3)
MPV	8.34	7.3 L	8.0-12.0	(fl)
AUTO DIFF				
Lymph %	1.96 L	2.96 L	23.6-57.9	(%)
Mono %	1.13 L	6.43	2.0-10.0	(%)
Neut %	96.3 H	89.6 H	42.0-75.0	(%)
Eos %	.180	.319	0.0-10.0	(%)
Baso %	.388 L	.726	0.5-2.0	(%)
Lymphocytes	.406 L	1.14 L	1.2-3.4	(K/mm3)
Monocytes	.235	2.47 H	0.11-0.59	(K/mm3)
Neutrophils	20.0 H	34.5 H	1.4-6.5	(K/mm3)
Eosinophils	.037	.123	0.0-0.7	(K/mm3)
Basophils	.080	.279 H	0.0-0.2	(K/mm3)
MANUAL DIFF				
Bands	23 &H	18 &H	0-8	(%)
Segs	72 &H	75 &H	35-65	(%)
Lymphs	2 &L	3 &L	25-45	(%)
Mono	1 &	4 &	0-8	(%)
Meta	2 &			(%)
CELL MORPH				
RBC Morp	# &	# &		
Plt Est	# &	# &		

- - - - - - - - - - - - - - - - - - Specific Comments - - - - - - - - - - - - - - - - -

03/16/03 0345	CBC,AUTOMATED DIFF-RBC Morp: Normal *&*
03/16/03 0345	CBC,AUTOMATED DIFF-Plt Est: Consistent with instrument count *&*
03/15/03 0345	CBC,AUTOMATED DIFF-RBC Morp: Slight Anisocytosis, Poikilocytosis *&*
03/15/03 0345	CBC,AUTOMATED DIFF-Plt Est: Consistent with instrument count *&*

Continued next page

Holy Cross Hospital
Mon Mar 17, 2003 11:20 am
Cumulative Trend Report from 03/05/03 1215 to 03/17/03 0640

Patient Name: NEUSTADTER,ISRAEL — Hematology-Page 4
Unit #: 815510 — Adm: 03/10/03
Location: ICU ICU 07
Phys-Service: NAWAZ,AHMED-MEDICAL
Acct #: M0306900162 — Previous Accounts Included

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H E M A T O L O G Y P R O F I L E

Date:	03/16	03/15	03/14	03/13	03/12		
Time:	0345	0345	0340	0640	0635	Normal Range	
WBC	17.3 H	19.8 H	23.3 H	21.8 H	17.2 H	3.6-10.8	(K/mm3)
RBC	2.99 L	3.19 L	3.09 L	3.61 L	2.97 L	4.73-5.61	(M/mm3)
Hemoglobin	9.70 L	10.3 L	10.0 L	11.7 L	10.3 L	13.0-16.9	(gm/dl)
Hct	29.6 L	31.5 L	30.3 L	35.5 L	29.0 L	38.0-48.6	(%)
MCV	99.2 H	98.6 H	98.0 H	98.3 H	97.9 H	80.5-97.6	(fl)
MCH	32.5	32.1	32.4	32.3	34.7 H	27.3-34.3	(pg)
MCHC	32.7 L	32.6 L	33.1	32.9 L	35.5	33.0-36.1	(%)
RDW	13.2	13.4	13.3	12.3	11.8	11.5-14.5	
Platelet,Auto	293.	265.	243.	235	200.	140-440	(K/mm3)
MPV	8.26	8.56	8.59	8.18	8.54	8.0-12.0	(fl)
AUTO DIFF							
Lymph %	6.43 L	7.60 L	4.33 L	3.43 L	3.14 L	23.6-57.9	(%)
Mono %	10.6 H	9.73	8.20	6.30	6.31	2.0-10.0	(%)
Neut %	81.4 H	81.6 H	86.3 H	89.8 H	89.2 H	42.0-75.0	(%)
Eos %	1.55	1.10	.186	.137	.245	0.0-10.0	(%)
Baso %	.081 L	0.00 L	.967	.346 L	1.07	0.5-2.0	(%)
Lymphocytes	1.11 L	1.51	1.01 L	.747 L	.539 L	1.2-3.4	(K/mm3)
Monocytes	1.83 H	1.93 H	1.91 H	1.37 H	1.08 H	0.11-0.59	(K/mm3)
Neutrophils	14.1 H	16.2 H	20.1 H	19.6 H	15.3 H	1.4-6.5	(K/mm3)
Eosinophils	.269	.217	.043	.030	.042	0.0-0.7	(K/mm3)
Basophils	.014	0.00	.226 H	.076	.184	0.0-0.2	(K/mm3)
MANUAL DIFF							
Bands			5 &	10 &H	18 &H	0-8	(%)
Segs	86 &H	82 &H	80 &H	79 &H	71 &H	35-65	(%)
Lymphs	4 &L	9 &L	12 &L	7 &L	7 &L	25-45	(%)
Mono	6 &	6 &	3 &	4 &	4 &	0-8	(%)
Eosinophils	4 &	2 &				0-10	(%)
Myelocyte		1 &					(%)
CELL MORPH							
RBC Morp	# &	# &	# &	# &	# &		
Plt Est	# &	# &	# &	# &	# &		

Continued next page

Holy Cross Hospital
Mon Mar 24, 2003 11:15 am
Cumulative Trend Report from 03/10/03 2120 to 03/24/03 0500

Patient Name: NEUSTADTER,ISRAEL — Hematology-Page 4
Unit #: 815510 — Adm: 03/10/03
Location: IMC 6231 02
Phys-Service: NAWAZ,AHMED-MEDICAL
Acct #: M0306900162 — Previous Accounts Included

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H E M A T O L O G Y P R O F I L E (Cont)

No hematology on 3/17

	Date: 03/19 Time: 0405	03/18 0330	Normal Range	
WBC	20.5 H	17.1 H	3.6-10.8	(K/mm3)
RBC	3.29 L	2.94 L	4.73-5.61	(M/mm3)
Hemoglobin	10.4 L	9.50 L	13.0-16.9	(gm/dl)
Hct	32.3 L	29.0 L	38.0-48.6	(%)
MCV	98.2 H	98.5 H	80.5-97.6	(fl)
MCH	31.7	32.3	27.3-34.3	(pg)
MCHC	32.3 L	32.8 L	33.0-36.1	(%)
RDW	12.2	12.3	11.5-14.5	
Platelet,Auto	389.	316.	140-440	(K/mm3)
MPV	8.36	7.96 L	8.0-12.0	(fl)
AUTO DIFF				
Lymph %	7.36 L	9.14 L	23.6-57.9	(%)
Mono %	10.5 H	9.65	2.0-10.0	(%)
Neut %	79.8 H	79.3 H	42.0-75.0	(%)
Eos %	2.28	1.92	0.0-10.0	(%)
Baso %	.047 L	0.00 L	0.5-2.0	(%)
Lymphocytes	1.51	1.56	1.2-3.4	(K/mm3)
Monocytes	2.15 H	1.65 H	0.11-0.59	(K/mm3)
Neutrophils	16.4 H	13.6 H	1.4-6.5	(K/mm3)
Eosinophils	.467	.329	0.0-0.7	(K/mm3)
Basophils	.010	0.00	0.0-0.2	(K/mm3)
MANUAL DIFF				
Bands	6 &	9 &H	0-8	(%)
Segs	75 &H	68 &H	35-65	(%)
Lymphs	10 &L	12 &L	25-45	(%)
Mono	5 &	9 &H	0-8	(%)
Eosinophils	1 &	2 &	0-10	(%)
Meta	3 &			(%)
CELL MORPH				
RBC Morp	# &	# &		
WBC Morp	# &	# &		
Plt Est	# &	# &		

- - - - - - - - - - - - - - - - - - Specific Comments - - - - - - - - - - - - - - - - -

03/24/03 0500	CBC,AUTOMATED DIFF-RBC Morp: Normal *&*
03/24/03 0500	CBC,AUTOMATED DIFF-Plt Est: Consistent with instrument count *&*
03/22/03 0315	CBC,AUTOMATED DIFF-RBC Morp: Normal *&*

Continued next page

Holy Cross Hospital
Mon Mar 24, 2003 11:15 am
Cumulative Trend Report from 03/10/03 2120 to 03/24/03 0500

Patient Name: NEUSTADTER,ISRAEL — Hematology-Page 3
Unit #: 815510 — Adm: 03/10/03
Location: IMC 6231 02
Phys-Service: NAWAZ,AHMED-MEDICAL
Acct #: M0306900162 — Previous Accounts Included

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H E M A T O L O G Y P R O F I L E

Date: / Time:	03/24 0500	03/23 0449	03/22 0315	03/21 0320	03/20 0345	Normal Range	
WBC	21.9 H	16.0 H	19.8 H	20.4 H	19.0 H	3.6-10.8	(K/mm3)
RBC	3.34 L	2.99 L	3.02 L	3.11 L	3.12 L	4.73-5.61	(M/mm3)
Hemoglobin	10.7 L	9.85 L	9.86 L	10.1 L	9.81 L	13.0-16.9	(gm/dl)
Hct	32.4 L	29.4 L	29.6 L	30.4 L	30.8 L	38.0-48.6	(%)
MCV	97.1	98.3 H	98.0 H	97.6	98.7 H	80.5-97.6	(fl)
MCH	32.0	33.0	32.7	32.5	31.5	27.3-34.3	(pg)
MCHC	32.9 L	33.6	33.3	33.3	31.9 L	33.0-36.1	(%)
RDW	13.6	13.5	13.5	13.3	12.2	11.5-14.5	
Platelet,Auto	481. H	400.	418.	409.	396.	140-440	(K/mm3)
MPV	8.68	8.23	8.48	7.93 L	8.35	8.0-12.0	(fl)
AUTO DIFF							
Lymph %	10.9 L	9.85 L	10.1 L	8.50 L	7.60 L	23.6-57.9	(%)
Mono %	11.3 H	11.7 H	11.3 H	10.6 H	9.47	2.0-10.0	(%)
Neut %	76.9 H	75.3 H	75.9 H	78.0 H	80.6 H	42.0-75.0	(%)
Eos %	.883	2.98	2.56	2.76	2.17	0.0-10.0	(%)
Baso %	.056 L	.223 L	.184 L	.090 L	.140 L	0.5-2.0	(%)
Lymphocytes	2.38	1.58	2.00	1.74	1.45	1.2-3.4	(K/mm3)
Monocytes	2.49 H	1.87 H	2.23 H	2.17 H	1.80 H	0.11-0.59	(K/mm3)
Neutrophils	16.8 H	12.0 H	15.0 H	16.0 H	15.4 H	1.4-6.5	(K/mm3)
Eosinophils	.193	.476	.506	.564	.414	0.0-0.7	(K/mm3)
Basophils	.012	.036	.036	.018	.027	0.0-0.2	(K/mm3)
MANUAL DIFF							
Bands	5 &		3 &	10 &H	3 &	0-8	(%)
Segs	73 &H		78 &H	64 &	82 &H	35-65	(%)
Lymphs	7 &L		8 &L	7 &L	6 &L	25-45	(%)
Mono	11 &H		6 &	10 &H	5 &	0-8	(%)
Eosinophils	2 &		2 &	5 &	3 &	0-10	(%)
Meta				3 &	1 &		(%)
Myelocyte	2 &		3 &	1 &			(%)
CELL MORPH							
RBC Morp	# &		# &	# &	# &		
WBC Morp				# &	# &		
Plt Est	# &		# &	# &	# &		

Continued next page

Holy Cross Hospital
Thu Mar 27, 2003 10:04 pm
Discharge Cumulative Trend Report from 03/23/03 1145 to 03/27/03 0530

Patient Name: NEUSTADTER,ISRAEL
Med Rec #: 815510
Dis Date 03/27/03
Phys-Service: NAWAZ,AHMED - MEDICAL

Adm: 03/10/03

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H E M A T O L O G Y P R O F I L E

Date:	03/27	03/26	03/25	Normal Range	
Time:	0530	0650	0615		
WBC	43.1 HP	37.6 HP	18.1 H	3.6-10.8	(K/mm3)
RBC	3.28 L	3.67 L	3.29 L	4.73-5.61	(M/mm3)
Hemoglobin	10.5 L	10.9 L	10.3 L	13.0-16.9	(gm/dl)
Hct	32.9 L	35.7 L	32.1 L	38.0-48.6	(%)
MCV	100. H	97.2	97.7 H	80.5-97.6	(fl)
MCH	32.0	29.9	31.2	27.3-34.3	(pg)
MCHC	31.9 L	30.7 L	32.0 L	33.0-36.1	(%)
RDW	14.0	12.6	12.6	11.5-14.5	
Platelet,Auto	521. H	609. H	525. H	140-440	(K/mm3)
MPV	9.18	8.92	8.92	8.0-12.0	(fl)
AUTO DIFF					
Lymph %	5.53 L	6.85 L	12.5 L	23.6-57.9	(%)
Mono %	7.59	5.95	12.2 H	2.0-10.0	(%)
Neut %	86.8 H	86.6 H	72.3	42.0-75.0	(%)
Eos %	.069	.382	2.65	0.0-10.0	(%)
Baso %	.042 L	.191 L	.355 L	0.5-2.0	(%)
Lymphocytes	2.38	2.57	2.27	1.2-3.4	(K/mm3)
Monocytes	3.27 H	2.24 H	2.20 H	0.11-0.59	(K/mm3)
Neutrophils	37.4 H	32.5 H	13.1 H	1.4-6.5	(K/mm3)
Eosinophils	.030	.143	.480	0.0-0.7	(K/mm3)
Basophils	.018	.072	.064	0.0-0.2	(K/mm3)
MANUAL DIFF					
Bands	17 &H	17 &H		0-8	(%)
Segs	73 &H	69 &H		35-65	(%)
Lymphs	2 &L	10 &L		25-45	(%)
Mono	7 &	4 &		0-8	(%)
Myelocyte	1 &				(%)
CELL MORPH					
RBC Morp	# &	# &			
WBC Morp		# &			
Plt Est	# &	# &			

Specific Comments

03/27/03 0530	CBC,AUTOMATED DIFF-RBC Morp: Normal *&*
03/27/03 0530	CBC,AUTOMATED DIFF-Plt Est: Consistent with instrument count *&*
03/26/03 0650	CBC,AUTOMATED DIFF-RBC Morp: Slight Hypochromia, Moderate

Continued next page

Holy Cross Hospital
Mon Mar 17, 2003 11:20 am
Cumulative Trend Report from 03/05/03 1215 to 03/17/03 0640

Patient Name: NEUSTADTER,ISRAEL — General Chemistry-Page 1
Unit #: 815510 — Adm: 03/10/03
Location: ICU ICU 07
Phys-Service: NAWAZ,AHMED-MEDICAL
Acct #: M0306900162 — Previous Accounts Included

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C H E M I S T R Y P R O F I L E S B L O O D

Date: / Time:	03/17 0400	03/17 0400	03/16 0345	03/15 0345	03/14 0340	Normal Range	
Sodium	143.		146. H	139.	137.	135-145	(mmol/L)
Potassium	3.5 L		3.6 L	4.0	3.7 L	3.8-5.2	(mmol/L)
Chloride	111.		116. H	110.	106.	96-112	(mmol/L)
CO2	23.		25.	19. L	23.	22-30	(mmol/L)
Glucose	122. H		101.	112. H	101.	70-110	(mg/dl)
Urea Nitrogen	23. H		31. H	41. H	28. H	7-22	(mg/dl)
Creatinine	.7		.9	1.0	1.0	0.5-1.2	(mg/dl)
Calcium	7.7 L		8.2 L	8.3 L	7.9 L	8.7-10.7	(mg/dl)
Alk Phos	145. H					38-126	(U/L)
TotBili	.3					0.3-1.2	(mg/dl)
SGOT/AST	27.					12-45	(U/L)
SGPT/ALT	22.					11-66	(U/L)
Albumin	2.0 L					3.4-4.9	(gm/dl)
Total Protein	5.1 L					6.3-8.5	(gm/dl)
Tot Glob	3.1 H					2.5-2.9	(gm/dl)
A/G Ratio	0.6 L					1.4-1.9	
Magnesium		2.3	2.5 H	2.5 H	2.2	1.6-2.4	(mg/dl)
Triglycerides	137.					<200	(mg/dl)

C H E M I S T R Y P R O F I L E S B L O O D

Date: / Time:	03/13 2255	03/13 0640	03/12 0635	03/11 0635	03/10 1204	Normal Range	
Sodium	137.	140.	136.	132. L	132. L	135-145	(mmol/L)
Potassium	4.4	2.8 LP	3.0 L	3.4 L	3.8	3.8-5.2	(mmol/L)
Chloride	107.	105.	104.	100.	96.	96-112	(mmol/L)
CO2	22.	23.	23.	22.	25.	22-30	(mmol/L)
Glucose	115. H	128. H	124. H	114. H	122. H	70-110	(mg/dl)
Urea Nitrogen	25. H	15.	23. H	29. H	24. H	7-22	(mg/dl)
Creatinine	.9	.7	.8	1.2	1.1	0.5-1.2	(mg/dl)
Calcium	7.9 L	8.2 L	7.8 L	7.6 L	8.5 L	8.7-10.7	(mg/dl)
Magnesium		2.0	2.0			1.6-2.4	(mg/dl)

Continued next page

Holy Cross Hospital
Mon Mar 24, 2003 11:15 am
Cumulative Trend Report from 03/10/03 2120 to 03/24/03 0500

Patient Name: NEUSTADTER,ISRAEL — General Chemistry-Page 1
Unit #: 815510 — Adm: 03/10/03
Location: IMC 6231 02
Phys-Service: NAWAZ,AHMED-MEDICAL
Acct #: M0306900162 — Previous Accounts Included

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C H E M I S T R Y P R O F I L E S B L O O D

Date: / Time:	03/24 0500	03/24 0343	03/23 0449	03/22 0315	03/21 0320	Normal Range	
Sodium	141.	139.	139.	140.	138.	135-145	(mmol/L)
Potassium	4.3	4.3	4.2	4.1	3.9	3.8-5.2	(mmol/L)
Chloride	105.	105.	105.	105.	105.	96-112	(mmol/L)
CO2	30.	26.	30.	30.	29.	22-30	(mmol/L)
Glucose	98.	97.	119. H	131. H	162. H	70-110	(mg/dl)
Urea Nitrogen	24. H	23. H	26. H	24. H	21.	7-22	(mg/dl)
Creatinine	.7	.7	.7	.7	.6	0.5-1.2	(mg/dl)
Calcium	8.1 L	8.6 L	7.8 L	7.5 L	7.6 L	8.7-10.7	(mg/dl)
Alk Phos		391. H		176. H		38-126	(U/L)
TotBili		.8		.1 L		0.3-1.2	(mg/dl)
SGOT/AST		231. H		83. H		12-45	(U/L)
SGPT/ALT		116. H		66.		11-66	(U/L)
Albumin		2.3 L		2.0 L		3.4-4.9	(gm/dl)
Total Protein		5.8 L		5.2 L		6.3-8.5	(gm/dl)
Tot Glob		3.5 H		3.2 H		2.5-2.9	(gm/dl)
A/G Ratio		0.7 L		0.6 L		1.4-1.9	
Magnesium		2.2				1.6-2.4	(mg/dl)
Triglycerides		90.				<200	(mg/dl)

C H E M I S T R Y P R O F I L E S B L O O D

Date: / Time:	03/20 0345	03/19 0405	03/18 0330	Normal Range	
Sodium	138.	139.	138.	135-145	(mmol/L)
Potassium	3.6 L	3.4 L	3.1 L	3.8-5.2	(mmol/L)
Chloride	104.	103.	104.	96-112	(mmol/L)
CO2	28.	29.	28.	22-30	(mmol/L)
Glucose	196. H	186. H	180. H	70-110	(mg/dl)
Urea Nitrogen	24. H	17.	17.	7-22	(mg/dl)
Creatinine	.7	.6	.6	0.5-1.2	(mg/dl)
Calcium	7.6 L	7.8 L	7.6 L	8.7-10.7	(mg/dl)
Alk Phos	146. H			38-126	(U/L)
TotBili	.2 L			0.3-1.2	(mg/dl)

Continued next page

Holy Cross Hospital
Thu Mar 27, 2003 10:04 pm
Discharge Cumulative Trend Report from 03/23/03 1145 to 03/27/03 0530

Patient Name: NEUSTADTER,ISRAEL
Med Rec #: 815510
Dis Date 03/27/03
Phys-Service: NAWAZ,AHMED - MEDICAL

General Chemistry-Page 1
Adm: 03/10/03

****

C H E M I S T R Y P R O F I L E S B L O O D

	Date: 03/27 Time: 0530	03/26 0650	03/25 0615	Normal Range	
Sodium	152. H	148. H	142.	135-145	(mmol/L)
Potassium	4.0	4.2	4.3	3.8-5.2	(mmol/L)
Chloride	112.	110.	109.	96-112	(mmol/L)
CO2	28.	28.	28.	22-30	(mmol/L)
Glucose	223. H	147. H	101.	70-110	(mg/dl)
Urea Nitrogen	29. H	29. H	30. H	7-22	(mg/dl)
Creatinine	1.0	.9	.8	0.5-1.2	(mg/dl)
Calcium	8.1 L	8.5 L	8.2 L	8.7-10.7	(mg/dl)
Alk Phos	472. H	600. H	623. H	38-126	(U/L)
TotBili	.5	.5	.4	0.3-1.2	(mg/dl)
SGOT/AST	58. H	100. H	241. H	12-45	(U/L)
SGPT/ALT	104. H	164. H	234. H	11-66	(U/L)
Albumin	2.5 L	2.6 L	2.3 L	3.4-4.9	(gm/dl)
Total Protein	6.5	6.4	5.9 L	6.3-8.5	(gm/dl)
Tot Glob	4.0 H	3.8 H	3.6 H	2.5-2.9	(gm/dl)
A/G Ratio	0.6 L	0.7 L	0.6 L	1.4-1.9	

Nutrition recommended at March 14 consult is not delivered for almost 3 more days. Prealbumin sinks to 3.8 mg/dl, indicative of starvation.

Holy Cross Hospital
Mon Mar 24, 2003 11:15 am
Cumulative Trend Report from 03/10/03 2120 to 03/24/03 0500

Patient Name: NEUSTADTER,ISRAEL — Send Outs-Page 8
Unit #: 815510 — Adm: 03/10/03
Location: IMC 6231 02
Phys-Service: NAWAZ,AHMED-MEDICAL
Acct #: M0306900162 — Previous Accounts Included

****

In: 03/20/03 0531
Out: 03/23/03 1017
Coll Time: 03/20/03 0345
Order Phys: NAWAZ,AHMED

PREALBUMIN(TRANSTHYRETIN)

Spec: Blood
Techs: V14796 T6248
[M0306900162/5470119]

Result Name	Result	Reference Range
Prealbumin,serum(mg/dl):	7.5 L	20.0-40.0

Referred to: ARUP (1507)
500 Chipeta Way
Salt Lake City, Utah 84108

In: 03/17/03 0623
Out: 03/19/03 0611
Coll Time: 03/17/03 0400
Order Phys: NAWAZ,AHMED

PREALBUMIN(TRANSTHYRETIN)

Spec: Blood
Techs: VRN T3155
[M0306900162/5466226]

Result Name	Result	Reference Range
Prealbumin,serum(mg/dl):	3.8 L	20.0-40.0

Referred to: ARUP (1507)
500 Chipeta Way
Salt Lake City, Utah 84108

In: 03/10/03 2202
Out: 03/24/03 0657
Coll Time: 03/10/03 2120
Order Phys: NAWAZ,AHMED

MISC SEND OUT

Spec: Blood
Techs: V12270 T507
[M0306900162/5456765]

*STAT*STAT*STAT*

Result Name	Result
Test Name:	Brain Natriuretic Peptide
Result:	321 pg/mL
Normal Range:	29 or less pg/mL

Referred to: American Medical Laboratory
14225 Newbrook Drive
Chantilly, Virginia 22021

Holy Cross Hospital
Thu Mar 27, 2003 10:04 pm
Discharge Cumulative Trend Report from 03/23/03 1145 to 03/27/03 0530

Patient Name: NEUSTADTER,ISRAEL
Med Rec #: 815510
Dis Date 03/27/03
Phys-Service: NAWAZ,AHMED - MEDICAL

Adm: 03/10/03

****

In: 03/24/03 0401
Out: 03/26/03 0626
Coll Time: 03/24/03 0343

PREALBUMIN(TRANSTHYRETIN)

Spec: Blood
Techs: V14166 T507

Order Phys: NAWAZ,AHMED [M0306900162/5476696]

Result Name	Result	Reference Range
Prealbumin,serum(mg/dl):	11.5 L	20.0-40.0

Referred to: ARUP (1507)
500 Chipeta Way
Salt Lake City, Utah 84108

Holy Cross Hospital
Mon Mar 17, 2003 11:20 am
Cumulative Trend Report from 03/05/03 1215 to 03/17/03 0640

Patient Name: NEUSTADTER,ISRAEL — Urinalysis-Page 11
Unit #: 815510 — Adm: 03/10/03
Location: ICU ICU 07
Phys-Service: NAWAZ,AHMED-MEDICAL
Acct #: M0306900162 — Previous Accounts Included

****

U R I N A L Y S I S P R O F I L E

	Date: 03/10 Time: 1434	Normal Range	
Amount	25		(ml)
Color	Amber		
Appearance	Clear		
Glucose	negative	Negative	(mg/dl)
Bilirubin	negative	Negative	(mg/dl)
Ketone	trace	Negative	(mg/dl)
Spec Gravity	1.025	See Below	
Occult blood	small	Negative	
pH	6.0	5.0-8.0	
Protein	100	Negative	(mg/dl)
Urobilinogen	0.2	0.2-1.0	(EU/dl)
Nitrite	negative	Negative	
Leuk Est	negative	Negative	
MICROSCOPIC			
WBCs	0-2	0-2	(/HPF)
RBCs	0	0-2	(/HPF)
Casts	None	None	(/LPF)
Crystals	None	None	(/LPF)
Epith	None	Few	
Bacteria	Few	Rare	
Mucus	Absent	Few	

General Comments

03/10/03 1434	URINALYSIS ROUTINE-Comment: Specific gravity, the range 1.016-1.022, assumes an adult on normal fluid intake. Specific gravity can range from 1.003-1.029. S.G. is considered "increased" if >1.020 and "decreased" if <1.009.

Holy Cross Hospital
Mon Mar 17, 2003 11:20 am
Cumulative Trend Report from 03/05/03 1215 to 03/17/03 0640

Patient Name: NEUSTADTER,ISRAEL Microbiology-Page 10
Unit #: 815510 Adm: 03/10/03
Location: ICU ICU 07
Phys-Service: NAWAZ,AHMED-MEDICAL
Acct #: M0306900162 Previous Accounts Included

****

>> CULTURE,URINE W/COLONY COUNT <<
Source: Urine Clean Catch

Coll. Time: 03/10/03 1430 In at: 03/10/03 1500 Acct #: M0306900162
Order Phys: MULL,KEVIN R Techs : V-14864

- -

Out at: 03/12/03 1046 Final [5456175] Techs: T13397*,9393

No Growth <1,000 cfu/ml

Holy Cross Hospital
Mon Mar 17, 2003 11:20 am
Cumulative Trend Report from 03/05/03 1215 to 03/17/03 0640

Patient Name: NEUSTADTER,ISRAEL Microbiology-Page 9
Unit #: 815510 Adm: 03/10/03
Location: ICU ICU 07
Phys-Service: NAWAZ,AHMED-MEDICAL
Acct #: M0306900162 Previous Accounts Included

****

>> CULTURE,BLOOD SET AER/ANAER <<
Source: Blood

Coll. Time: 03/10/03 1430 In at: 03/10/03 1504 Acct #: M0306900162
Order Phys: ULL,KEVIN R Techs : V-14864

Out at: 03/16/03 0820 Final [5456170] Techs: T10454*

No growth to date

>> CULTURE,BLOOD SET AER/ANAER <<
Source: Blood

Coll. Time: 03/10/03 1430 In at: 03/10/03 1505 Acct #: M0306900162
Order Phys: MULL,KEVIN R Techs : V-14864

Out at: 03/12/03 1439 Preliminary 1 [5456172] Techs: T11979*

No growth to date

Out at: 03/16/03 0820 Final [5456172] Techs: T10454*

No growth to date

>> CULTURE,URINE W/COLONY COUNT <<
Source: Urine Clean Catch

Coll. Time: 03/10/03 1430 In at: 03/10/03 1500 Acct #: M0306900162
Order Phys: MULL,KEVIN R Techs : V-14864

Out at: 03/11/03 0837 Preliminary 1 [5456175] Techs: T13397*,11979

No Growth <1,000 cfu/ml

Holy Cross Hospital
Mon Mar 17, 2003 11:20 am
Cumulative Trend Report from 03/05/03 1215 to 03/17/03 0640

Patient Name: NEUSTADTER,ISRAEL Microbiology Page 8
Unit #: 815510 Adm: 03/10/03
Location: ICU ICU 07
Phys-Service: NAWAZ,AHMED-MEDICAL
Acct #: M0306900162 Previous Accounts Included

****

>> CULTURE,SPUTUM W/SMEAR <<
Source: Sputum

Coll. Time: 03/13/03 1400 In at: 03/13/03 1452 Acct #: M0306900162
Order Phys: NAWAZ,AHMED Techs : V1127

Out at: 03/13/03 1654 Gram Stain [5461904] Techs: T9393*

Many budding yeast and fungal elements
Many Wbc's
Type 3 Sputum (Many WBCs with rare epith cells/LPF)
Few gram positive rods
No epithelial cells
Referred to: American Med Lab (Micro)

Out at: 03/14/03 1356 Preliminary 1 [5461904] Techs: T11889**,10454,

Moderate Yeast

Yeast
ID to follow Referred to: American Med Lab (Micro)

>> CULTURE,BLOOD SET AER/ANAER <<
Source: Blood

Coll. Time: 03/10/03 1430 In at: 03/10/03 1504 Acct #: M0306900162
Order Phys: MULL,KEVIN R Techs : V-14864

Out at: 03/12/03 1439 Preliminary 1 [5456170] Techs: T11979*

No growth to date

Holy Cross Hospital
Mon Mar 24, 2003 11:15 am
Cumulative Trend Report from 03/10/03 2120 to 03/24/03 0500

Patient Name: NEUSTADTER,ISRAEL Microbiology-Page 7
Unit #: 815510 Adm: 03/10/03
Location: IMC 6231 02
Phys-Service: NAWAZ,AHMED-MEDICAL
Acct #: M0306900162 Previous Accounts Included

****

>> CULTURE,SPUTUM W/SMEAR <<
Source: Sputum

Coll. Time: 03/13/03 1400 In at: 03/13/03 1452 Acct #: M0306900162
Order Phys: NAWAZ,AHMED Techs : V1127

Out at: 03/14/03 1356 Preliminary 1 [5461904] Techs: T11889**,10454,

Moderate Yeast

Yeast
ID to follow Referred to: American Med Lab (Micro)

Out at: 03/23/03 1507 Final [5461904] Techs: T11889*,11979

Moderate Candida albicans

Candida albicans Referred to: American Med Lab (Micro)

Holy Cross Hospital
Mon Mar 24, 2003 11:15 am
Cumulative Trend Report from 03/10/03 2120 to 03/24/03 0500

Patient Name: NEUSTADTER,ISRAEL Microbiology-Page 6
Unit #: 815510 Adm: 03/10/03
Location: IMC 6231 02
Phys-Service: NAWAZ,AHMED-MEDICAL
Acct #: M0306900162 Previous Accounts Included

****

>> CULTURE,SPUTUM W/SMEAR <<
Source: Sputum Expectorated

Coll. Time: 03/23/03 1145 In at: 03/23/03 1217 Acct #: M0306900162
Order Phys: NAWAZ,AHMED Techs : VRN

Out at: 03/23/03 1610 Gram Stain [5477277] Techs: T8403*,11979

Moderate Wbc's
Few epithelial cells
Few gram positive rods
Few gram negative rods
Rare gram positive cocci in pairs
Rare budding yeast

Out at: 03/24/03 0951 Preliminary 1 [5477277] Techs: T11889*,11979

Few normal flora for site

>> CULTURE,SPUTUM W/SMEAR <<
Source: Sputum

Coll. Time: 03/13/03 1400 In at: 03/13/03 1452 Acct #: M0306900162
Order Phys: NAWAZ,AHMED Techs : V1127

Out at: 03/13/03 1654 Gram Stain [5461904] Techs: T9393*

Many budding yeast and fungal elements
Many Wbc's
Type 3 Sputum (Many WBCs with rare epith cells/LPF)
Few gram positive rods
No epithelial cells

Referred to: American Med Lab (Micro)

Holy Cross Hospital
Thu Mar 27, 2003 10:04 pm
Discharge Cumulative Trend Report from 03/23/03 1145 to 03/27/03 0530

Patient Name: NEUSTADTER,ISRAEL Microbiology-Page 4
Med Rec #: 815510 Adm: 03/10/03
Dis Date 03/27/03
Phys-Service: NAWAZ,AHMED - MEDICAL

****

>> CULTURE,SPUTUM W/SMEAR <<
Source: Sputum Expectorated

Coll. Time: 03/23/03 1145 In at: 03/23/03 1217 Acct #: M0306900162
Order Phys: NAWAZ,AHMED Techs : VRN

Out at: 03/23/03 1610 Gram Stain [5477277] Techs: T8403*,11979

Moderate Wbc's
Few epithelial cells
Few gram positive rods
Few gram negative rods
Rare gram positive cocci in pairs
Rare budding yeast
Referred to: American Med Lab (Micro)

Out at: 03/24/03 0951 Preliminary 1 [5477277] Techs: T11889*,11979

Few normal flora for site
Referred to: American Med Lab (Micro)

Out at: 03/25/03 1617 Preliminary 2 [5477277] Techs: T11889**,11979,

Few normal flora for site
Few Yeast

Yeast
ID to follow Referred to: American Med Lab (Micro)

Holy Cross Hospital
Mon Mar 17, 2003 11:20 am
Cumulative Trend Report from 03/05/03 1215 to 03/17/03 0640

Patient Name: NEUSTADTER,ISRAEL — Respiratory Care-Page 12
Unit #: 815510 — Adm: 03/10/03
Location: ICU ICU 07
Phys-Service: NAWAZ,AHMED-MEDICAL
Acct #: M0306900162 — Previous Accounts Included

****

B L O O D G A S

Date:	03/17	03/15	03/14	03/14	03/13	Normal Range	
Time:	0640	0633	1705	1317	1435		
Time Drawn	0630	0600	1655	1310	1435		
Mode	A/C	A/C	A/C	CMV	A/C		
FIO2	45.0	45.0	45.0	60.0	100.0		
pH	7.465 H	7.409	7.445	7.465 H	7.485 H	7.35-7.45	(pH Unit
PCO2	32.9 L	31.8 L	30.8 L	30.4 L	29.7 L	35-45	(mm Hg)
PO2	113.4 H	62.7 L	88.4 H	165.9 H	95.9 H	80-100	(mm Hg)
O2 Saturation	98.4	92.5	97.2	99.2	97.8		(%)
HCO3	23.1	19.7 L	20.7 L	21.4 L	21.9 L	22-26	(mEq/L)
Base Excess	0.2	-3.9	-2.2	-1.2	-0.4	-2 - +2	(mEq/L)
Sample Type	Arterial	Arterial	Arterial	Arterial	Arterial		
Sample Site	RR	RR	LR	LB	RB		
PEEP/CPAP	8	8	8	8	5		
Tidal Volume	500	500	500	500	500		(ml)
RR	12	12	12	12	12		(vent/to
Bar Pres	753	764	764	766	754		

B L O O D G A S

Date:	03/11	Normal Range	
Time:	1825		
Time Drawn	1823		
Mode	NRM		
FIO2	100.0		
pH	7.379	7.35-7.45	(pH Unit
PCO2	34.9 L	35-45	(mm Hg)
PO2	44.9 LP	80-100	(mm Hg)
O2 Saturation	80.4		(%)
HCO3	20.1 L	22-26	(mEq/L)
Base Excess	-4.2	-2 - +2	(mEq/L)
Sample Type	Arterial		
Sample Site	RR		
Bar Pres	760		

End of Report

Holy Cross Hospital
Mon Mar 24, 2003 11:15 am
Cumulative Trend Report from 03/10/03 2120 to 03/24/03 0500

Patient Name: NEUSTADTER,ISRAEL
Unit #: 815510
Location: IMC 6231 02
Phys-Service: NAWAZ,AHMED-MEDICAL
Acct #: M0306900162

Adm: 03/10/03
Previous Accounts Included

****

B L O O D G A S

Date:	03/19	03/18	03/17	Normal Range	
Time:	0629	0514	1437		
Time Drawn	0600	0512	1435		
Mode	HHFM	HHFM	CPAP		
FIO2	35.0	40.0	40.0		
pH	7.520 H	7.510 H	7.487 H	7.35-7.45	(pH Unit
PCO2	34.6 L	33.8 L	32.9 L	35-45	(mm Hg)
PO2	66.1 L	74.4 L	98.3 H	80-100	(mm Hg)
O2 Saturation	95.0	96.2	97.9		(%)
HCO3	27.6 H	26.4 H	24.3	22-26	(mEq/L)
Base Excess	5.0	3.8	1.6	-2 - +2	(mEq/L)
Sample Type	Arterial	Arterial	Arterial		
Sample Site	RB	RR	LR		
PEEP/CPAP			5		
Prsr Sup			10		
Tidal Volume			.460		(ml)
RR			15		(vent/to
Min Vol			10.3		(tot)
Bar Pres	761	751	752		
Pt Temp			37		('C)

End of Report

Holy Cross Hospital
Thu Mar 27, 2003 10:04 pm
Discharge Cumulative Trend Report from 03/23/03 1145 to 03/27/03 0530

Patient Name: NEUSTADTER,ISRAEL
Med Rec #: 815510
Dis Date 03/27/03
Phys-Service: NAWAZ,AHMED - MEDICAL

Adm: 03/10/03

****

B L O O D G A S

Date:	03/26	03/25		
Time:	1600	1946	Normal Range	
Time Drawn	1558	1948		
Mode	NRM	NRM		
FIO2	100.0	100.0		
pH	7.500 H	7.504 H	7.35-7.45	(pH Unit
PCO2	31.1 L	32.9 L	35-45	(mm Hg)
PO2	68.8 L	58.5 L	80-100	(mm Hg)
O2 Saturation	95.3	92.8		(%)
HCO3	23.7	25.3	22-26	(mEq/L)
Base Excess	1.4	2.8	-2 - +2	(mEq/L)
Sample Type	Arterial	Arterial		
Sample Site	LR	RR		
Bar Pres	754	755		
Pt Temp		37.0		('C)

End of Report

Friday, March 14
- Dr. Nawaz fails to order nutrition per consult recommendation.
- Nurses fail to note lack of nutrition. Patient provided no food since March 11.

Saturday, March 15
- Hospital fails to submit this PPN order, resulting in an additional 24-hour delay.

Sunday, March 16
- PICC line placement ordered for Central TPN, but PA on call has no PICC line insertion experience so procedure delayed until Monday.
- Hospital **alters date on this Saturday PPN order from 3/15 to 3/16** and submits.

- PPN doesn't arrive until Sunday night at 8:00 pm, 58 hours after first recommended.
- TPN doesn't arrive until Monday night at 8:00 pm. **Six days without food.**
Prealbumin sinks to 3.8 mg/dl (reference=20-40 mg/dl) indicative of starvation.

HOLY CROSS HOSPI

PARENTERAL NUT
TWENTY FOUR H
ADULT

INSTRUCTIONS:
Check boxes for all orders that apply. Fill-in all blank spaces of all checked orders. Write signature and print name, time and date at bottom of each form

ALL ORDERS MUST BE RECEIVED BY THE I.V. PHARMACY by 2 PM DAILY

VASCULAR ACCESS ☐ Central ☒ Peripheral
DOES PT. TOLERATE ORAL/ENTERAL INTAKE? ☐ Yes ☐ No

Time TPN started:
RN Signature

24 hr. bottle number:

BASE SOLUTION CHECK ONE BOX	☐ STANDARD CENTRAL 1000/kCal/Liter	☒ STANDARD PERIPHERAL 500/kCal/Liter	☐ Non-STANDARD-for 24 hours (fill in)
	Protein 50gm(200kCal)/Liter	Protein 35gm(140kCal)/Liter	Protein gm/ 24 hr
	Dextrose 147gm(500kCal)/Liter	Dextrose 47gm(160kCal)/Liter	Dextrose kCal/ 24 hr
	Lipids 30gm(300kCal)/Liter	Lipids 20gm(200kCal)/Liter	Lipids kCal/ 24 hr

Sources: protein (Aminosyn 15%)=4 kCal/gm; dextrose 70%=3.4 kCal/gm; fat 20% =10 kCal/gm

VOLUME & RATE CHECK ONE BOX

☐ 1 Liter/DAY @ 42 mL/hr ☐ 1.5 Liters/DAY @ 63 mL/hr ☒ 2 Liters/DAY @ 83 mL/hr ☐ 2.5 Liters/DAY @ 104 mL/hr ☐ 3 Liters/DAY @ 125 mL/h ☐ ____ Liters/DAY @ ____ mL/hr ☐ CYCLE ____Liter x ___ hrs

MICRO NUTRIENTS
CHECK ONE BOX

ONE DAY (24 hr) QUANTITIES
---This is **NOT** per Liter---

☐ **Standard**—Central line ONLY	☒ **LOW Standard**—Central or Peripheral	☐ **NON-Standard** (for 24 hrs) Fill in
Sodium . . . . . 95 mEq	Sodium . . . . . 56 mEq	Sodium Chloride. . . . _____ mEq
Potassium . . . . . 60 mEq	Potassium . . . . . 40 mEq	Sodium Acetate . . . . _____ mEq
Calcium . . . . . 15 mEq	Calcium . . . . . 10 mEq	Sodium Phosphate** _____ mM
Magnesium . . . . . 15 mEq	Magnesium . . . . . 10 mEq	Potassium Chloride. . _____ mEq
Phosphate . . . . . 15 mM	Phosphate . . . . . 5 mM	Potassium Acetate. . . _____ mEq
Chloride . . . . . 90 mEq	Chloride . . . . . 60 mEq	Potassium Phosphate* _____ mM
Acetate . . . . . 90 mEq	Acetate . . . . . 60 mEq	Calcium Gluconate. . . _____ mEq
		Magnesium Sulfate. . _____ mEq
Trace Elements . . . . . standard	Trace Elements . . . . . standard	Trace Elements . . . . . standard
Multivitamins . . . . . standard	Multivitamins . . . . . standard	Multivitamins . . . . . standard

*K Phosphate= 4.4 mEq K & 3 mM Phosphorous /mL
**Na Phosphate= 4 mEq Na & 3 mM Phosphorous /mL

ADDITIONS for 24 hrs [**NO Vitamin K (Phytonadione), Albumin, or Meds**]

☐ Insulin, Reg. Human _____ Units
☐
☐
☐
☐
☐

CHECK IF APPLICABLE
☐ Omit Multivitamins
☐ Omit Trace Elements

STANDING ORDERS:
☑ Baseline, then every Monday and Thursday: Metabolic-basic, Metabolic-comprehensive, and Pre-albumin
☑ Baseline, then every Monday: albumin, Magnesium, and triglycerides
☑ Vitamin K 10 mg subcutaneously every Monday
☑ Weigh patient every Monday and Thursday

☑ START and CHANGE TPN SOLUTIONS DAILY at 8 PM.
☑ IF TPN is DISCONTINUED TEMPORARILY for ANY REASON start D10%W in ITS PLACE at the SAME RATE.
☑ Discontinue standing orders when TPN is discontinued.

If you have any questions, please contact the IV Pharmacist x7309 or unit Dietitian (x7724)

PHYSICIAN SIGNATURE	PHYSICIAN NAME (PRINT)/PAGER #	TIME	DATE
		1733	3/16/13

WHITE - CHART YELLOW - PHARMACY

Form No DRS-068(Rev 3/99) Parenteral Nutrition Twenty Four Hour Adult

Undated order likely placed on Monday, March 17, when central line access was finally provided after 6 days without food.

HOLY CROSS HOSPITAL

Scanned 11-24-AM

PARENTERAL NUTRITION TWENTY FOUR HOUR ADULT

WEINSTEIN, ISRAEL 9 M
03/10/03 0306500162
3127 NAWAZ, AHM
ID I/P 8155
1111 UNIV BLVD W,
SILVER SPRIN
301 649-1319

INSTRUCTIONS:
Check boxes for all orders that apply. Fill-in all blank spaces of all checked orders. Write signature and print name, time and date at bottom of each form

ALL ORDERS MUST BE RECEIVED BY THE I.V. PHARMACY by 2 PM DAILY

VASCULAR ACCESS ☒ Central ☐ Peripheral
DOES PT. TOLERATE ORAL/ENTERAL INTAKE? ☐ Yes ☐ No

Time TPN started:
RN Signature

24 hr. bottle number:

BASE SOLUTION CHECK ONE BOX	☒ STANDARD CENTRAL 1000/kCal/Liter		☐ STANDARD PERIPHERAL 500/kCal/Liter		☐ Non-STANDARD-for 24 hours (fill in)	
	Protein	50gm(200kCal)/Liter	Protein	35gm(140kCal)/Liter	Protein	gm/ 24 hr
	Dextrose	147gm(500kCal)/Liter	Dextrose	47gm(160kCal)/Liter	Dextrose	kCal/ 24 hr
	Lipids	30gm(300kCal)/Liter	Lipids	20gm(200kCal)/Liter	Lipids	kCal/ 24 hr

Sources: protein (Aminosyn 15%)=4 kCal/gm; dextrose 70%=3.4 kCal/gm; fat 20% =10 kCal/gm

VOLUME & RATE CHECK ONE BOX

☐ 1 Liter/DAY @ 42 mL/hr ☒ ~~1.5 Liters/DAY @ 63 mL/hr~~ ☒ 2 Liters/DAY @ 83 mL/hr ☐ 2.5 Liters/DAY @ 104 mL/hr ☐ 3 Liters/DAY @ 125 mL/h ☐ ____ Liters/DAY @ ____ mL/hr ☐ CYCLE ____Liter x ___ hrs

MICRO NUTRIENTS CHECK ONE BOX

ONE DAY (24 hr) QUANTITIES
---This is **NOT** per Liter---

☒ **Standard**—Central line ONLY		☐ **LOW Standard**—Central or Peripheral		☐ **NON-Standard** (for 24 hrs) Fill in	
Sodium	95 mEq	Sodium	56 mEq	Sodium Chloride	_____ mEq
Potassium	60 mEq	Potassium	40 mEq	Sodium Acetate	_____ mEq
Calcium	15 mEq	Calcium	10 mEq	Sodium Phosphate**	_____ mM
Magnesium	15 mEq	Magnesium	10 mEq	Potassium Chloride	_____ mEq
Phosphate	15 mM	Phosphate	5 mM	Potassium Acetate	_____ mEq
Chloride	90 mEq	Chloride	60 mEq	Potassium Phosphate*	_____ mM
Acetate	90 mEq	Acetate	60 mEq	Calcium Gluconate	_____ mEq
				Magnesium Sulfate	_____ mEq
Trace Elements	standard	Trace Elements	standard	Trace Elements	standard
Multivitamins	standard	Multivitamins	standard	Multivitamins	standard

*K Phosphate= 4.4 mEq K & 3 mM Phosphorous /mL
**Na Phosphate= 4 mEq Na & 3 mM Phosphorous /ml

ADDITIONS for 24 hrs [NO Vitamin K (Phytonadione), Albumin, or Meds]

☐ Insulin, Reg. Human _____ Units
☐
☐
☐
☐
☐

CHECK IF APPLICABLE
☐ Omit Multivitamins
☐ Omit Trace Elements

STANDING ORDERS:

☑ Baseline, then every Monday and Thursday: Metabolic-basic, Metabolic-comprehensive, and Pre-albumin
☑ Baseline, then every Monday: albumin, Magnesium, and triglycerides
☑ Vitamin K 10 mg subcutaneously every Monday
☑ Weigh patient every Monday and Thursday
☑ START and CHANGE TPN SOLUTIONS DAILY at 8 PM.
☑ IF TPN is DISCONTINUED TEMPORARILY for ANY REASON start D10%W in IT'S PLACE at the SAME RATE.
☑ Discontinue standing orders when TPN is discontinued.

If you have any questions, please contact the IV Pharmacist x7309 or unit Dietitian (x7724)

PHYSICIAN SIGNATURE	PHYSICIAN NAME (PRINT)/PAGER #	TIME	DATE
Joel A Boll	Joel A Boll	RM	

WHITE - CHART YELLOW - PHARMACY

HOLY CROSS HOSPITAL

PATIENT: Neustadter, Israel
ACCOUNT #: 0306900162
CONSULTANT: Jay H Weiner, MD
ATTENDING: Ahmed Nawaz, MD

MR #: 00815510
PT TYPE: I/P
ROOM: ~~IMC610702~~ ICU-07
DISCH DATE:

PULMONARY CONSULTATION REPORT

DATE OF ADMISSION: 03/10/2003

DATE OF CONSULTATION: 03/11/2003

This patient is a 91-year-old male who was last in his normal state of health three days prior to admission. At that time he fell at home, striking his head. Over the next two days, he began to have increasing weakness. On the day prior to admission he had a fever or 101. On the day of admission he was found to be hypotensive, with a blood pressure of 60 systolic in Dr. Nawaz's office and he was sent to the emergency room.

On arrival to the hospital, his chest x-ray has shown left lower lobe infiltrate and a small pleural effusion, blunting of the right costophrenic angle. His initial white count was 38,000, and I have been asked to evaluate.

The patient's past medical history is significant for dementia. He has hypertension and has a Zenker's diverticulum. He has recently been placed on Dyazide, which has caused severe hyponatremia, but this responded with removal of the Dyazide. He also has a history of pacemaker placement.

PHYSICAL EXAMINATION: On physical examination, he is a well-developed, well-nourished male, who is lethargic and confused. Head, ears, eyes, nose and throat examination is within normal limits. There is no palpable lymphadenopathy or subcutaneous emphysema. His lungs revealed some crackles at the left base. Cardiac examination was without an S3 or rub. His abdomen was without organomegaly or masses and soft. His extremities were without edema.

His sodium was 132, potassium 3.4, initial white count was 38,000 and repeat was 20,700, hematocrit 29.6.

IMPRESSION:
This patient presents with aspiration pneumonia and sepsis. He has a Zenker's diverticulum and this is probably the cause of his aspiration. He does have dementia that has worsened by septic encephalopathy, history of hypertension, history of pacemaker placement and recent hyponatremia, secondary to Dyazide.

Neustadter, Israel MR #: 00815510

CONSULTATION REPORT

At this time, I recommend giving him intravenous Levaquin and Rocephin. He will need intravenous hydration.

I have addressed his "code status" with his son for a lengthy period of time. His son will consult his rabbi to help him make a decision.

He will need a barium swallow when he stabilizes.

Signed
Jay H Weiner, MD 03/20/2003 12:35

Jay H Weiner, MD

D: 03/11/2003
T: 03/11/2003 4:07 P
JHW/ksw
Doc #: 337000
cc: Ahmed Nawaz, MD
Jay H Weiner, MD

PATIENT: Neustadter, Israel
ACCOUNT #: 0306900162
CONSULTANT: Alan S Chanales, MD
ATTENDING: Ahmed Nawaz, MD

MR #: 00815510
PT TYPE: I/P
ROOM: IMC610702
DISCH DATE: 03/11/2003

SECOND-OPINION PULMONARY CONSULTATION REPORT

DATE OF ADMISSION: 03/10/2003

DATE OF CONSULTATION: 03/11/2003

I was asked to render a second pulmonary opinion on this patient, who was admitted yesterday.

He is a 91-year-old demented patient, who is confused at home, but who goes to synagogue twice a day and carries long conversations and walks independently. Sometime ago, the patient developed an increase in his blood pressure and Vasotec was increased to 10 mg and he began having tightness in his chest, diagnosed in the emergency room as angioedema reaction and the Vasotec was stopped and he was placed on some Dyazide, which in the past caused hyponatremia. Indeed, the patient became rather profoundly hyponatremic, but was not hospitalized at the time, was taken off the Dyazide, was given an increase in his Cardura, which he was taking for prostatism. It was some time after that that the patient displayed some degree of confusion, got up in the middle of the night and started walking around and fell down striking his lip and his head, but without apparent injury, although he was somewhat more confused than usual.

When he was brought into Dr. Nawaz's office, he was found to have a systolic blood pressure of about 60 and was sent to the hospital. By the time they lay him down and gave him some fluids, his blood pressure came up to around 100, but the patient was still admitted. He was found to have a sodium of 132, potassium 3.4, blood urea nitrogen 29 and creatinine 1.2 and the white blood count reportedly was 40,000, but I can not find that result in the chart or on the computer. Urinalysis was unremarkable, with 0-2 white cells.

The son seemed to get some degree of different opinions about the patient's status from Dr. Nawaz and Dr. Weiner, with the latter being more pessimistic about his chances of recovery, and he wanted some corroborating opinion.

In the interim, the patient has been hydrated, with the blood urea nitrogen going down to 9, and his white count today was 20,000 with a hemoglobin of about 10, and the patient does run a chronic anemia. Blood pressure was running about 125/70. His temperature was only about 100 degrees today. On two liters, his oxygen saturation was about 98 earlier, but this evening his oxygen saturation went down low into the 80s and a blood gas showed a pO2 of

CONSULTATION REPORT

44 on 100% nonrebreather mask. He was switched to a high-flow oxygen cannula at 100% and his oxygen saturations were in the 88 to 92% range.

Also of note is that the patient has had a Zenker's diverticulum for many years, but does not seem to have much trouble from it.

ALLERGIES: Sulfa.

PAST MEDICAL HISTORY: Dementia, hypertension, Zenker's diverticulum, prostatism and pacemaker placement.

SOCIAL HISTORY: Nonsmoker and nondrinker. He lives with his son. He has not been hospitalized before.

REVIEW OF SYSTEMS: Unobtainable from the patient.

PHYSICAL EXAMINATION: Vital signs are as above. The patient is awake and responsive, although confused. Mucous membranes and skin are dry. No neck vein distention at 30 degrees, thyromegaly or bruits. Lungs: There is bronchophony at the left lower base posteriorly, but no wheezes or rhonchi are heard. The patient was not coughing during my attendance on the patient. Heart: No murmur, rub, gallop or click. Abdomen: Normal bowel sounds, soft, nontender; no hepatosplenomegaly, masses or bruits. Extremities: No clubbing, cyanosis, edema, tenderness, redness or cords.

IMPRESSION:

1. Falling episode secondary to hypotension.
2. Hypotension, secondary to dehydration from recent Dyazide as well as possible development of sepsis.
3. Sepsis, could be coming from an aspiration pneumonia or from possible sinusitis as seen on the CT of the head, which was otherwise unremarkable for trauma-related issues.
4. Hypoxemia, secondary to developing pneumonia in the left lower lobe, to be confirmed on chest x-ray. Another consideration would be the development of fluid overload from the patient's fluid resuscitation.
5. Pneumonia, certainly could be aspiration secondary to his recent change in mental status with hyponatremia, in conjunction with his long-standing Zenker's diverticulum.
6. Underlying dementia, but a reasonable quality of life for the patient and without any really serious medical problems.

Neustadter, Israel MR #: 00815510

CONSULTATION REPORT

PLAN:

1. Intravenous fluids to be adjusted now that the patient has been rehydrated.
2. Antibiotics as ordered, Levaquin and Rocephin.
3. High-flow oxygen.
4. If necessary, the patient will be intubated and put on mechanical ventilation according to the son's wishes as well as the instructions of his rabbi. We had a long discussion about the issues involved in making this decision, including – but not limited to – the multiple complications that often care in elderly patients placed on the ventilator, leading to an insoluble situation, with the patient stuck on the ventilator.
5. The issue of resuscitation was discussed with the son, who for the moment will press ahead with a "full code" situation, even though I told him that the result of such therapeutic action is often death or, worse, vegetative state.

Alan S Chanales, MD

D: 03/11/2003
T: 03/11/2003 8:54 P
ASC/ksw
Doc #: 337039
cc: Alan S Chanales, MD
Ahmed Nawaz, MD
Jay H Weiner, MD

HOLY CROSS HOSPITAL

PATIENT: Neustadter, Israel
ACCOUNT #: 0306900162
CONSULTANT: Milton J Koch, MD
ATTENDING: Ahmed Nawaz, MD

MR #: 00815510
PT TYPE: I/P
ROOM: ICUICU 07
DISCH DATE:

CONSULTATION REPORT/GI

DATE OF ADMISSION: 03/10/2003

DATE OF CONSULTATION: 03/14/2003

REASON FOR CONSULTATION: Evaluation for nutritional support in this intubated, sedated, 91-year-old gentleman.

The history is obtained from the record as well as discussions with Dr. Nawaz, the house staff, and the patient's son at the bedside since the patient is on a propofol drip.

The patient was admitted on 3/10/03 following significant volume depletion because of labile responses to antihypertensive medications which resulted in a fall and an injury. He was fluid resuscitated and over the next several days in the hospital was noted to have a probable pneumonic process and was given intravenous antibiotics with oxygen support but he became progressively and acutely hypoxic requiring intubation. In addition he was quite agitated when attempting to insert a central line through the femoral which was therefore not done.

Of significance in terms of any nutritional evaluation is the fact that the son states that he has a long history of Zenker's diverticulum which was recognized many years ago. Reportedly an esophagogram was done within the last several years but the patient's son does not remember where other than confirming the Zenker's. In addition, Dr. Barry Rubin reportedly endoscoped him for a possible GI bleed about four years ago and prior to the endoscopy was not aware of the Zenker's according to the son and Dr. Rubin admitted that the endoscopy was quite difficult. Thereafter he was told of the Zenker's and understood why. The patient was started on a proton pump inhibitor in the last couple of years and some of his swallowing difficulties improved but were still transiently problematic with liquid regurgitation spontaneously in the midst of a meal on occasions.

PAST MEDICAL HISTORY: Mild dementia, but he was going to synagogue daily and was able to be independent otherwise. Pacemaker placement.

MEDICATIONS: Medications have included Dyazide which resulted in hyponatremia, Vasotec which resulted in an allergic reaction, Cardura which he was using for BPH.

CONSULTATION REPORT

ALLERGIES: Sulfa drugs.

SOCIAL HISTORY: Nonsmoker, nondrinker, living with his son.

REVIEW OF SYSTEMS: Not available whatsoever.

PHYSICAL EXAMINATION: The patient is an intubated gentleman on a Diprivan drip with vital signs stable and no other significant findings.

LABORATORY DATA: White blood cell count elevated to 40,000 initially, has come down to about 20,000. Chest x-ray has shown abnormalities with infiltrates. Electrolytes are remarkable for hyponatremia corrected. Electrocardiogram showed pacemaker artifact controlling his rhythm.

IMPRESSION:

1. Aspiration pneumonia – intubated on Diprivan.
2. History of Zenker's diverticulum, resulting in increased risk of #1.
3. History of dementia.
4. Recent volume depletion.
5. Electrolyte abnormality.
6. Pacemaker insertion.
7. Prostatism.

PLAN:

1. At the bedside I had a very lengthy discussion with the patient's son regarding his nutritional status which was the main reason for my consultation.
2. I explained to the son that for the short term, nutritional compromise is not relevant but not knowing how long the patient would be intubated, an intermediary step would be appropriate.
3. Although I explained to the son that using the GI tract was the primary goal in all patients who have a functioning gut, given the difficulty with the Zenker's tube (and the failed attempt by nurses on a couple of occasions yesterday to place an NG tube – understandably so), no reasonable attempt should be made by me. The patient questioned why I could not do it and I explained to him that with the presence of known Zenker's and the attendant cricopharyngeal achalasia, my expertise would not improve any possibility of passing this tube safely. The only recommended approach would be to have the patient go to X-Ray and have a guidewire-assisted passage. I felt that this was

March 14, Friday morning

Recommended nutrition was not delivered for almost 3 more days. My father's prealbumin sank to 3.8 mg/dl, indicative of starvation.

Was it *really* a fair compromise?

Neustadter, Israel

CONSULTATION REPORT

grossly inappropriate given the fact that this would be an "elective" procedure in a patient who is intubated on a Diprivan drip to require sedation for adequate ventilator support.

4. I did not think that TPN was reasonable at this early stage of his hospitalization given its need to closely monitor electrolytes and its expense.
5. I thought a fair compromise, if he was to have a central line, was to use Procalamine and Intralipid – this was discussed with the house officer as well. Therefore, this is my recommendation.

We will continue to monitor with you for support and further decisions as appropriate.

Thank you once again.

Milton J Koch, MD

D: 03/14/2003
T: 03/15/2003 7:36 A
MJK/mkn
Doc #: 337661
cc: Alan S Chanales, MD
Milton J Koch, MD
Ahmed Nawaz, MD
Jay H Weiner, MD

What son would request such a procedure, only to refuse his father ventilation 5 days later?

What hospital would permit such a contradictory act without an ethics consult?

HOLY CROSS HOSPITAL

PATIENT: Neustadter, Israel
ACCOUNT #: 0306900162
SURGEON: Alan Diamond, MD
ASSISTANT:

MR #: 00815510
PT TYPE: I/P
ROOM: IMC623102
DISCH DATE:

OPERATIVE REPORT

DATE OF PROCEDURE: 03/21/2003

PROCEDURE PERFORMED: Esophagogastroduodenoscopy with percutaneous endoscopic gastrostomy.

PREOPERATIVE DIAGNOSIS: Pharyngeal dysphagia, Zenker's diverticula and pulmonary aspiration.

POSTOPERATIVE DIAGNOSIS: Pharyngeal dysphagia, Zenker's diverticula and pulmonary aspiration with possible choledochoduodenostomy.

INDICATIONS FOR PROCEDURE: Endoscopy with percutaneous endoscopic gastrostomy placement was performed at the son's request because of the patient's recurring aspiration pneumonia and inability to swallow food safely.* Nutritional support has been difficult because of a large Zenker's diverticulum which lessened the ability to pass a NG feeding tube.

DESCRIPTION OF PROCEDURE: The patient was sedated by the anesthesiologist. No oropharyngeal sedation was given. The Olympus videoscope was used. Blood pressure, electrocardiogram and pulse oximetry were monitored throughout.

The endoscopy revealed a lot of thick debris encrustation in the posterior pharynx and upper esophagus. The endoscopy was extremely difficult, initial intubation passed the scope into the Zenker's diverticulum which was filled with old food debris. Subsequently, a large amount of adherent debris was suctioned from the oropharynx. Respirations improved after doing so. After multiple attempts, the scope was passed under visual guidance down into the esophageal lumen which was opening towards the right side of the posterior pharynx. The Zenker's seemed to open more so on the left. The opening to the Zenker's was relatively large. Once traversing the upper sphincter, the scope passed easily into the distal esophagus. Interestingly, the LAS was rather tight but the scope popped through without great difficulty. Retroflexed view of the gastroesophageal junction was normal. The stomach appeared entirely normal. The pylorus was normal. The duodenal bulb appeared normal. In the posterior bulb, there was a small opening through which the scope would not pass. There was also angulation in that area and I couldn't pass the scope further. It was unclear to me if this was a surgical defect of possible choledochoduodenostomy or if there was a post-bulbar

*This was patient's first and only pneumonia.

Neustadter, Israel MR #: 00815510

OPERATIVE REPORT

stricture. There was no evidence of obstructive changes and no significant secretions in the stomach.

Following the endoscopy, a percutaneous endoscopic gastrostomy was placed. The abdomen was prepped with Betadine. 1% Lidocaine was injected into the site selected in the midline. A 1 centimeter incision was made with a #11 blade. A trocar was passed into the gastric lumen. The guide wire was passed through the trocar and was grasped endoscopically with a snare and pulled out through the mouth. A #20 French microinvasive percutaneous endoscopic gastrostomy tube was then passed over the guide wire and pulled out through the anterior abdominal wall. The tube was pulled until the mushroom portion was firmly snug against the anterior gastric wall. T-bar was placed externally to hold it securely in place. The patient tolerated the procedure reasonably well without complications. The patient is presently on antibiotic coverage. Tube feedings will begin tomorrow.

Alan Diamond, MD

D: 03/21/2003
T: 03/23/2003 8:41 A
AD/ccd
Doc #: 338896
cc: Alan Diamond, MD
Ahmed Nawaz, MD

HOLY CROSS HOSPITAL

PATIENT: Neustadter, Israel
ACCOUNT #: 0306900162
ATTENDING: Ahmed Nawaz, MD
DICTATED BY: Ahmed Nawaz, MD

MR #: 00815510
PT TYPE: I/P
ROOM:

DISCHARGE SUMMARY

DATE OF ADMISSION: 03/10/2003

DATE OF DISCHARGE: 03/27/2003

FINAL DIAGNOSES: Aspiration pneumonia; Sepsis; Multiple electrolyte imbalance; Difficulty swallowing; Large Zenker's diverticulum; Status post percutaneous endoscopic gastrostomy tube placement; Respiratory insufficiency leading to failure on ventilator for quite some time during his stay in the hospital. Mild to moderate dementia; Degenerative arthritis; Status post permanent pacemaker placement; Hypothyroidism

CONSULTATION: Dr. Jay Weiner, pulmonary and critical care, Dr. Milton Koch, gastrointestinal, Dr. Chanales second opinion for pulmonary and critical care, Dr. Herman Segal cardiology

HISTORY OF PRESENT ILLNESS: The detailed history and physical have already been dictated and will not be repeated here.

This elderly gentleman was admitted to the hospital with suspected aspiration pneumonia and sepsis. He was initially kept in the telemetry unit. He was started on intravenous antibiotics along with minimal intravenous fluid support. We continued the other medications on this patient except for the blood pressure mediations which he was taking at home because of hypotension. The very next day, the patient's condition got worse and his respiratory status became decompensated. Pulmonary, who was already on the case, spoke with the patient's son about the code status standpoint because the patient was developing respiratory failure. He was intubated and was transferred to the Intensive Care Unit for further management.

His antibiotics were changed on numerous different occasions. We had a second opinion from Dr. Chanales who also had a long conversation with the patient's son about the patient's condition. The son's wishes were to continue the aggressive measures on him. The patient was volume resuscitated. Aggressive suctioning was done in the Intensive Care Unit on this patient and secretions were suctioned on different occasions. The patient did

A Nawaz 4/3/03

Medical Records Department
EXTRA COPY

error
See the attached Hospital course.

Neustadter, Israel MR #: 00815510

DISCHARGE SUMMARY

respond to a certain extent and was successfully extubated some times. The patient's swallowing was very poor. He failed the swallowing evaluation. We had a conversation with the patient's son again and he wishes to pursue with a percutaneous endoscopic gastrostomy tube. The patient was on a nasogastric tube at the time. Finally, gastroenterology was consulted and with some difficulty, the percutaneous endoscopic gastrostomy tube was placed.

The patient stayed in the Intensive Care Unit for a couple of weeks and was transferred down to the CIC where the patient again developed aspiration and went into respiratory distress. The case was discussed with the patient's son by Dr. Shamim, by Dr. Kariya on numerous different occasions. At that time, the decision was made to continue the aggressive medical therapy but do not reintubate the patient again. We honored the patient's family wishes and on the 27th of March, the patient was found to be unresponsive without any breathing, no pulse, no blood pressure and he was pronounced by the house staff. The patient expired due to respiratory failure because of aspiration pneumonia and multiple other medical problems with sepsis.

A. Nawaz 7/3/03

Signed
Ahmed Nawaz, MD 06/29/2003 11:28

Erroneous date. I retrieved these records on 7/2/03.

_____
Ahmed Nawaz, MD

D: 06/19/2003
T: 06/19/2003 4:24 P
AN/cn
Doc #: 353992
cc: Ahmed Nawaz, MD

Dr. Nawaz writes error-laden and falsified summary 3 months after my father's death, when privileges are suspended for failure to submit.

HOLY CROSS HOSPITAL

PATIENT: Neustadter, Israel
ACCOUNT #: 0306900162
ATTENDING: Ahmed Nawaz, MD
DICTATED BY: Ahmed Nawaz, MD

MR #: 00815510
PT TYPE: I/P
ROOM:

DEATH SUMMARY

DATE OF ADMISSION: 03/10/2003

DATE OF DEATH: 03/27/2003

Detailed history and physical has already been dictated, is part of the chart and will not be repeated here.[1]

This elderly gentleman was admitted to the hospital with aspiration pneumonia and with septicemia.[2] He was started on intravenous antibiotics along with intravenous fluid support. The very next day the patient's respiratory condition became decompensated. Dr. Jay Weiner, who was already on the case, discussed with the patient at length the DNR status.[3] The patient's son wanted to continue the aggressive measures and wanted to buy some time to talk with the rabbi. We honored the patient's family's wishes and the patient was intubated and was transferred to the Intensive Care Unit.

The patient remained intubated for a few weeks.[4] Aggressive suctioning was done. Multiple antibiotics were changed during the patient's stay in the Intensive Care Unit.[5] Intravenous fluid resuscitation was given to the patient. Electrolyte imbalance was corrected during his stay in the Intensive Care Unit.

The patient's nutritional status was poor. He was placed on total parenteral nutrition for a short term because it was hard for us to put in the nasogastric tube due to large Zenker's diverticulum.[6] We had a conversation with the patient's son about placing a PEG tube, which he considered to be done. Gastroenterology consultation was obtained from Dr. Milton Koch, who also had a conversation with the son at length about the patient's prognosis. Finally, decision was made to proceed with the PEG tube, which was done and PEG tube feedings were started.

Eventually the patient was successfully extubated. Electrolytes seemed to be stable, but his swallowing evaluation was still not adequate. He was later transferred down to the CIC and slowly and gradually was started feeding and he was tolerating this relatively well.[7] At the CIC, the patient again developed aspiration pneumonia and respiratory-wise became

1. History and Physical was *not* part of chart; it was dictated on 6/19/2003, almost 3 months after my father's death.
2. My father was admitted with community acquired pneumonia, not aspiration pneumonia. No evidence of septicemia.
3. Why no mention of actual DNR status? My father was unambiguously Full Code.
4. My father was intubated for 4 days.
5. No antibiotics were changed during my father's stay in ICU and throughout hospitalization, despite unrelentingly high white count.
6. My father was placed on *peripheral* parenteral nutrition after 5 days of starvation.
7. My father was never transferred down to the CIC; he was moved to the IMCU adjacent to the ICU, where life-sustaining treatment was withheld and he was allowed to die against his will.

Neustadter, Israel MR #: 00815510

DISCHARGE SUMMARY

decompensated again. Dr. Shamim and Dr. Kariya had a long conversation with the son again for further management because the patient needed intubation at the time. The family decided not to intubate the patient and continue the aggressive medical therapy with suctioning. The care was provided, but on March 27, 2003, the patient was found to be unresponsive, without any breathing, no pulse, no blood pressure and he was pronounced by the house staff. The patient expired due to respiratory failure, because of aspiration pneumonia and multiple other medical problems with sepsis.

Signed
Ahmed Nawaz, MD 06/29/2003 11:28

_____
Ahmed Nawaz, MD*

D: 06/25/2003
T: 06/25/2003 9:12 A
AN/ksw
Doc #: 354855
cc: Ahmed Nawaz, MD

Falsified Record
- 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).

*Dr. Nawaz became Holy Cross Hospital's Chief Hospitalist in 2003 and was appointed in 2012 to the Maryland Board of Physicians.
Dr. Nawaz pleaded guilty in 2012 to a charge of failing to control vehicle speed contributing to accident and injury.
Dr. Nawaz pleaded guilty in 2013 to a charge of driving under the influence of alcohol.

HOLY CROSS HOSPITAL

Medical Records Department
Phone: (301) 754-7180 Fax: (301) 754-7175

July 14, 2003

Alexander Neustadter
1111 University Blvd. W.
Apt. 405
Silver Spring, MD 20902

Pharmacy printout obtained by court order shows 40% of prescribed abx doses were never dispensed by hospital pharmacy.

Re: Israel Neustadter
DOB: 4/14/1911
Rec #: 815510

Dear Mr. Neustadter:

On July 7, 2003 you requested a copy of a detailed pharmacy printout of all dispensed medications on patient Israel Neustadter, medical record number 815510. This type of report is not considered part of the medical record therefore; we are not able to honor your request. Attached you will find a copy of the Maryland Code, Health-General, 4-301, which defines the contents of a medical record.

The type, dose, mode, and time of dispensed medications during a patients stay at the hospital can be located in the Medication Administration Record also known as the Kardex. This document can be found in the patient's medical record, copies of which were given to you on May 6, 2003.

If you have any questions regarding the above matter, please call Sarah Shulman at the General Counsel's Office at (301) 754-7464.

Sincerely,

Ileana Sosa Urgell, MS, RHIA
Records Control Manager
Medical Records Department

HOLY CROSS HOSPITAL

1500 Forest Glen Road
Silver Spring, MD
20910-1484
(301) 754-7000
www.holycrosshealth.org

March 30, 2004

Mr. Alexander Neustadter
1111 University Boulevard, West
Silver Spring, MD 20902

Dear Mr. Neustadter:

I am writing to you in follow-up to our meeting on March 16, 2004 during which you expressed your concerns about the circumstances involving your father's death at Holy Cross Hospital in March of 2003. First, let me tell you again how sorry I am that your father had died. He was clearly a very much-loved man and I am sure that he is sorely missed.

We have referred your concerns about the physician care provided your father during that admission to the Internal Medicine Peer Review Committee. This committee of the medical staff is composed of internal medicine physicians who review the medical record and other available documentation to determine if appropriate care was rendered. Most often they have questions that require investigation, and may take several weeks before they can reach a conclusion about the care provided. In addition, review by independent physicians outside the Holy Cross Medical Staff may be requested. Any recommendations made by the peer review committee concerning a physician are taken under consideration by the Department of Medicine leadership, and possibly the Medical Executive Committee (leadership committee of the medical staff) and the Board of Trustees.

I also want you to know that end-of-life care is an ongoing focus of the hospital Ethics Committee. I believe that the issues you have raised will help to inform those discussions. I am hopeful that this will result in improvements involving the care of critically ill elderly patients at Holy Cross and our communication with those patients and their families.

Again, please accept my sympathy over your loss. Voicing your concerns about your father's care has added significantly to this important discussion and may yet yield improvement in this vital area.

Sincerely,

Blair M. Eig, M.D.
Senior Vice President, Medical Affairs

BME:jhk

1111 University Blvd West
Silver Spring, MD 20902

April 5, 2004

Doctor Blair M. Eig
Holy Cross Hospital
1500 Forest Glen Road
Silver Spring, MD 20910

Dear Dr. Eig,

Thank you for your letter and your kind words about my father. He was indeed very much loved but gave infinitely more than he received.

While I am gratified that end-of-life care is important to your hospital's ethics committee, I fail to understand how or why this would relate to my father. Indeed it is my fear that the hospital went into an "end-of-life mode" with my father based solely on his age, with little regard to his medical status or his wishes. I brought my father to your hospital for treatment of an infectious disease. He was ambulatory, suffered from no additional serious illnesses and had an excellent quality-of-life. As such, he wanted and required the most aggressive treatment in the hope of recovering and returning to that life. Anyone in his position, enjoying his good heath, would have opted for the same regardless of religious orientation and very likely regardless of age.

As I conveyed to Ms. Williams, I believe the more serious issues we raised at our March 16th meeting go beyond the scope and purview of a confidential medical peer review process. They call into question, in a compelling and credible way, the accuracy of the medical records and the veracity of the doctors who treated my father. I trust they will be investigated in the thorough, open and transparent manner that such serious allegations mandate.

Dr. Eig, the unthinkable did happen in your hospital: Doctors surreptitiously wrested control of a patient's care from the patient and his family. An "unrealistic son" was left to stand and watch his father go from good to bad to critical without being apprised of readily-available treatment options. He was subsequently denied those options. As a result the patient's life ended prematurely, possibly very prematurely. By our Judeo-Christian standards this was essentially a murder.

We would appreciate if you could give us a timeframe by which we can expect to hear back from you. If you have any questions please feel free to contact me.

Rabbi Anemer, Dr. Cooper and I are awaiting with great interest your response.

Alexander H. Neustadter

HOLY CROSS HOSPITAL

1500 Forest Glen Road
Silver Spring, MD
20910-1484
(301) 754-7000
www.holycrosshealth.org

April 14, 2004

Mr. Alexander Neustadter
1111 University Boulevard, West
Apt. #405
Silver Spring, MD 20902

Dear Mr. Neustadter:

I am responding to your letter of April 5, 2004 in which you requested a timeframe by which you could expect to hear from me concerning the outcome of our review of your father's medical care prior to his death at Holy Cross Hospital in March 2003. As you are well aware, you brought these concerns to us after almost one year, based on your review of the medical record and your recollections of the events surrounding your father's death. Please try to understand that that we will move as quickly as possible consistent with a thorough, open and fair inquiry. As I suggested we might do in my previous letter, we have sent the case for outside physician review and must await that and any further analysis we feel appropriate following it.

In truth, Dr. Eig's office was aware of my concerns *while my father was still alive.*

Based on your letter I am concerned that any resolution we achieve that does not completely agree with your conclusions will fail to satisfy you. It appears that you have irrevocably decided what outcome we should reach. I am especially concerned and distressed with your injudicious use of the word "murder" in your recent letter. I assure you that we will work to reach a conclusion that is based on facts and is fair to all concerned.

I hope to report back to you within the next 30 days.

Sincerely,

Blair M. Eig, M.D.
Senior Vice President, Medical Affairs

BME:jhk

cc: Customer Relations Department

Customer Relations Manager noted my concerns about Dr. Weiner 2 days prior to my father's death, testifying that she considered them very serious and that she *promptly notified the Medical Affairs office of Dr. Blair Eig*. Eig's office failed to take any action.

1111 University Blvd West
Silver Spring, MD 20902

April 19, 2004

Doctor Blair M. Eig
Holy Cross Hospital
1500 Forest Glen Road
Silver Spring, MD 20910

Dear Dr. Eig,

Thank you for providing me the timeframe information I requested.

Please know that I came to you in good faith and with the understanding that there will be views other than my own for us to consider. I am eager to hear those views. I will keep an open mind to whatever your inquiry finds. I am also gratified that you have sought outside review.

Thank you for your help and for the time you are devoting to this.

Sincerely,

Alexander H. Neustadter

HOLY CROSS HOSPITAL

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July 2, 2004

Mr. Alexander Neustadter
1111 University Boulevard, West
Apt. #405
Silver Spring, MD 20902

Dear Mr. Neustadter:

I wanted to keep you informed about my efforts to help resolve the issues you have raised concerning your father's death.

In the three weeks since our last meeting, I have had discussions with some of the physicians directly involved in your father's care. I hope to arrange a meeting for you with them in the near future.

This entire process has taken a long time, but I have come to realize that slow, deliberate progress toward a resolution is much better than no resolution at all. I will let you know what I have accomplished towards that end soon.

Sincerely,

Blair M. Eig, M.D.
Senior Vice President, Medical Affairs

BME:jhk

1111 University Blvd West
Silver Spring, MD 20902

July 18, 2004

Doctor Blair M. Eig
Holy Cross Hospital
1500 Forest Glen Road
Silver Spring, MD 20910

Dear Dr. Eig,

Thank you for your efforts in facilitating a meeting with the doctors involved in my father's treatment. I also appreciate your keeping me informed.

I would like to ask you to look into a few important aspects of my father's care as we await our meeting. I think they pale only in comparison to the more serious issues we discussed. As you have indicated to me that your primary responsibility is to the patient and family, I urge you to further investigate and make determinations regarding:

1. Levaquin dosing: I can't stress enough the importance to me of knowing definitively how much levaquin my father received. On July 7, 2003 I requested a pharmacy record of all dispensed medications. Records Manager Ileana Sosa informed me that this type of information is not considered part of the record and therefore my request would not be honored. I ask you to please obtain these records for me.

2. PPN delivery: Dr. Milton Koch ordered PPN for my father on Friday morning, March 14, 2003. This PPN did not arrive until Sunday evening, some 59 hours later. My father's prealbumin sank to 3.8 mg/dl (reference=20-40.) He didn't have any food from the time he entered the hospital on Monday, March 10. I think it is fair to say he was starving. What happened?

3. On Thursday, March 27, 2003, at 8:50 am, I was in my father's room together with his home-care assistant, Nomeda. We both witnessed my father's breathing suddenly collapse. We saw the respiration rate and the pulse oxygen level on the monitor begin blinking and alarming, my father gasping for air. Nobody entered the room for an entire hour, despite my calls to the nurse's station. I think it is reasonable to assume that my father suffered injury during that time, and I will not dwell on the pain he must have experienced. What happened? Why did no one come into the room with the telemetry alarming?

I'm sure you can empathize with how the mere thought of these events still sends chills through me. Please try to imagine seeing this happen to your father and how you might react.

I recall it mentioned during our last meeting that Holy Cross has rules regarding what doctors must do in following patient and surrogate desires for treatment. I'd be most appreciative if you could send me a copy of these guidelines.

Thanks again,

Message-ID: <4107D4D9.E81EF4C9@ibb.gov>
Date: Wed, 28 Jul 2004 12:31:21 -0400
From: Alexander Neustadter <an@ibb.gov>
Organization: U.S. International Broadcasting Bureau
X-Mailer: Mozilla 4.8 [en]C-IBB 20-Sep-02 (Windows NT 5.0; U)
X-Accept-Language: en
MIME-Version: 1.0
To: Blair Eig <EIGB@holycrosshealth.org>
Subject: Looking Into My Father Treatment
Content-Type: text/plain; charset=us-ascii
Content-Transfer-Encoding: 7bit

Dear Dr. Eig,

Thank you for your attention to the concerns I expressed in my letter of July 18.

I completely agree with you that it's important for me to speak directly with the physicians involved in my father's care, particularly Drs. Weiner, Kariya, Shamim and Nawaz. I am grateful for your efforts to try to arrange such a meeting.

I too, have no easy answers to account for what I report occurred with my father, but there it is:

- Records show a patient in sudden respiratory distress and in need of mechanical ventilation to attempt to save his life.

- Records show a senior pulmonologist (and Board of Trustees member, no less) bemoaning his differences with the patient's family regarding prognosis and desired life-sustaining treatment instead of providing them with options.

- Records show family repeatedly summoning doctors to patient's room, asking for help with patient's respiratory distress.

- Progress notes show no indication that doctors ever offered or that family ever refused ventilation. Records contain no DNR or Do Not Ventilate orders.

If those points do not confirm what I have told you they must surely arouse your suspicion that something not kosher was going on. And we haven't even mentioned my undocumented interaction with Dr. Weiner on 3/26/03, the afternoon before my father's demise. Speaking of that interaction, what became of the ABG test and ICU consult Dr. Shamim ordered at that time? Those tests suggest intubation was being

considered.

What I have conveyed to you may represent an aberration or may be indicative of a Futile Care Theory practice in your hospital that you are unaware of. In either case I think it mandates a thorough investigation into the manner in which other critically ill elderly patients have been treated by this pulmonological practice and how such treatment or lack-thereof was documented. An analysis should be done of what their records contain in the way of informed consent, family instructions and agreements or disagreements between these doctors and the families. I hope you concur that where life-or-death matters are concerned there must be a zero-tolerance policy for failure to document and follow the decision-makers' wishes. Let's see how other records compare with my father's.

It occurs to me that while you may be doing everything in your power, I may be asking for more than you can reasonably accomplish given your closeness to these well-respected doctors and Dr. Kariya's membership on the Holy Cross Hospital Board. In all seriousness, perhaps your job would be made easier if I were to contact Kevin Sexton or the management of Trinity Health to try to bring extrinsic pressure on the people involved.

Doctor, I wish for you to know that I harbor no illusions of achieving the "Perry Mason-like" outcome you expressed concern about. I understand that even if I were to take this matter to court and prevail I am unlikely to see that happen. But posthumous respect for my father, my ability to come to terms with this, and future deterrence - make it imperative that the true nature of what happened be brought to light. Please help me make that happen. If it were your father, could you settle for less?

Al Neustadter

> ----------
>
> Subject: Re: My Father's Treatment
> Date: Fri, 23 Jul 2004 14:34:51 -0400
> From: Blair Eig <EIGB@holycrosshealth.org>
> To: an@IBB.GOV
>
> Mr. Neustadter:
>
> I received your letter of July 18 yesterday, and I've asked Dr. Schwab
> to assist me in answering the questions you have raised in it. As to
> the linked article you reference in your email, I want to refer back

> to what Dr. Schwab, Sister Rachel and I have discussed with you
> several times in our meetings. We have often seen what we (as
> clinicians and members of the ethics committee) consider to be futile
> patient care delivered in this hospital. However, we always abide by
> the patient's or family's wishes in terms of the care provided in
> these cases. That is why we have no easy answer for what you report
> occurred with your father. I still believe it is most important for
> you to speak directly with the physicians that were involved in your
> father's care, and I am trying to set that up. I think Dr. Kariya is
> willing to meet with you, but it may not occur till later this
> summer. I will keep you informed.
>
> Blair Eig
>
> >>> "Alexander Neustadter" <an@ibb.gov> 7/22/2004 6:58:55 PM >>>
> Dear Dr. Eig,
>
> When I came upon this article it sent chills through me. I hope
> something similar is not happening at Holy Cross.
>
> http://216.247.220.66/archives/miscellaneous/futile.htm
>
> The more I consider what transpired at your hospital the less sense it
> seems to make. My father's records indicate that PEG feeding started
> just 3 days before he went into respiratory distress. I am quoted as
> saying "my father is finally awake and hungry." The records indicate
> a good quality of life. What son could deny such a father ventilation?
> What doctor would deny such a patient ventilation?
>
> Unless my father was being treated against a backdrop of terminal
> cancer, heart failure or stroke, one would think that even if the
> family asked that he not be ventilated or that new antibiotics not be tried,
> a Catholic hospital would caution against and even refuse such a request
> as being unwarranted and unethical.
>
> Certainly without major comorbidity and with a family request to
> ventilate if indicated, the unwillingness to do so suggests that your
> hospital subscribes to "futilitarianism" (see hyperlinked article.)
> As Dr. Schwab stated at our recent meeting, perhaps Drs. Weiner and
> Kariya "gave up"; the patient and family didn't.
>
> When my father and I crossed your hospital doors there was an implicit
> pact that you would do what you must to properly treat him; that the
> goal was to make him well, barring the unforeseen. That was never
> supposed to change. What happened is stunning and the ball is now in
> your court. I remember what you said your mother used to tell you,

> and I pray you will keep it in mind.
>
> Sincerely,
> Al Neustadter
>
> Al Neustadter
> Office of Internet Services
> 202-260-2454
>
>

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Al Neustadter
Office of Internet Services
202-260-2454

HOLY CROSS HOSPITAL

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www.holycrosshealth.org

September 27, 2004

Mr. Alexander Neustadter
1111 University Boulevard, West
Apt. #405
Silver Spring, MD 20902

Dear Mr. Neustadter:

We are sorry to have taken an extended time to respond to your questions concerning the events around your father's admission to Holy Cross Hospital. Hopefully, these answers will at least in part respond to your concerns.

You have asked to see the pharmacy record of dispensed medications. As we previously explained to you, the official record of what medication the patient actually received is the medication Kardex that you have. All other information is subordinate to the Kardex. This is what the nurse who administered the drug says was given to the patient. I don't believe there is any reason to waste time and effort dredging up less reliable information* By the way, the 750mg dose of Levaquin for community-acquired pneumonia was not approved by the FDA until Oct. 24, 2003. The 750mg dose was clearly not standard medical therapy at the time of your father's hospitalization.

I trust your word that nutrition was not started for 59 hours after you and Dr. Koch spoke. Dr. Koch did recommend procalamine and lipids as a stopgap measure in his consult of 3/14. He did not write an order for procalamine and lipids. Another physician wrote an order for peripheral parenteral nutrition on 3/16. There was also an order sheet for central parenteral nutrition that is undated. His physicians were clearly hoping to use his gut for nutrition rather than the IV route, as the enteral route is much preferred for safety and effectiveness. Multiple attempts at placing a feeding tube failed because of his Zenker's diverticulum and this clearly contributed to a delay in providing nutrition. I can easily surmise that the physicians assumed a feeding tube would be successfully placed by GI or radiology and saw no reason to start IV nutrition when tube feedings would be started shortly. It really is very unusual that we are unable to place a feeding tube.

Holy Cross Hospital does not prepare its own parenteral nutrition solutions. They are made by an outside service to insure the highest quality. Orders must be submitted by 2 pm in order for the outside pharmacy to prepare and deliver the product by the next morning. Thus if orders are submitted after 2 pm, the parenteral nutrition solution will not be ready until the morning of the second day after the order is submitted. This is acceptable as parenteral nutrition is not considered an emergency or urgent intervention. All the above factors likely contributed to the delay in initiation of nutritional support.

*Pharmacy record obtained by court order shows 40% of prescribed antibiotic doses were never dispensed.

There are many controversies in the field of nutrition. While it is obvious that we can't live without nutrition, the timing for initiation of feeding during acute illness is controversial (as long as fluids and electrolytes are managed appropriately). Acutely ill patients are generally not hungry and do not feel like they are starving.

I have asked Susan King, the Director of Critical Care, to respond to your questions concerning care provided by that unit. Her response follows:

"I am saddened that your experience on the morning of March 27, 2003 was not found to be supportive of the dying process for both you and your father.* I apologize for any additional pain you must have felt during this most difficult time. I have researched the call response times on the date in question and would be happy to review that information with you.

Your comments about no one responding to the alarms brings up the much broader question of the appropriateness of using monitoring devices on dying patients. These devices can be very intrusive and distracting with little to offer in the setting of an actively dying patient when additional life support measures are not planned. Nursing probably knew 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. One could argue that such monitoring only serves to make family at the bedside more anxious and distract them from paying full attention to their dying loved one. Therefore, many believe that such monitoring is inappropriate in this setting and should be discontinued."

You may reach Susan King at 301-754-7521. As I stated above, I hope that these answers will help resolve some of the issues lingering since your father's death. I wish you health and hopefully more happiness in the new year.

Sincerely,

Lee Schwab, M.D.
Medical Director, Critical Care

LS:jk

* Why *was* there a dying process for me and my father? Why were life support measures *not planned*, when patient wasn't terminal and when admitting doctor, attending doctor, pulmonologist and surrogate *all say* patient was full-code?

1111 University Blvd West
Silver Spring, MD 20902

October 25, 2004

Doctor Lee Schwab
Holy Cross Hospital
1500 Forest Glen Road
Silver Spring, MD 20910

Dear Dr. Schwab,

I have a few additional questions on the last part of your letter of September 27 and am hoping you can provide clarification.

Precisely when did my father transition from a full-code aggressively treated patient who was improving, to an actively dying patient for whom additional life support measures were not planned? Please, make a determination as to when this occurred. Does Holy Cross Hospital have any documentation requirements or forms to be filled out that would identify a patient in whom life support will not be employed? If hospital regulations address this subject I would be grateful if you would send me a copy. Was there proper documentation in my father's case?

I appreciate your assistance with this and look forward to your timely reply.*

Sincerely,

Alexander H. Neustadter

* No reply ever received

HC
HOLY CROSS HOSPITAL

DO NOT RESUSCITATE PHYSICIAN ORDER FORM

[redacted]

IMPORTANT

* If Patient is not competent to make his/her own decisions, see administrative policy "CONSENT TO WITHHOLD OR WITHDRAWAL TREATMENT". Completion of other forms is required.

* See reverse side for guidelines for completion of this form.

SECTION I DO NOT RESUSCITATE

I have discussed the decision to withhold cardiopulmonary resuscitation from [redacted] (PATIENT NAME)
with [redacted] (RELATIONSHIP TO PATIENT)

On the basis of this discussion or on the basis of an advance directive, if a cardiopulmonary arrest occurs, NO resuscitative measures are to be performed.

PHYSICIAN SIGNATURE: [redacted] DATE: 3/16/03 TIME: _____

SECTION II PRE-ARREST ORDERS

Before cardiopulmonary arrest occurs, the patient is a candidate for the following:

- ☒ Intubation
- ☐ Lab/Diagnostics
- ☒ IV Pressor Therapy
- ☒ Defibrillation
- ☒ IV Antiarrhythmic Therapy
- ☒ Cardioversion
- ☐ Other NO CPR
- ☐ No to all of the above

PHYSICIAN SIGNATURE: [redacted] DATE: 3/16/03 TIME: 1915

SECTION III CHANGE - IN - STATUS ORDERS

1. ☐ DNR ORDER RESCINDED

PHYSICIAN SIGNATURE: _____

2. ☐ SEE UPDATED DNR ORDERS

PHYSICIAN SIGNATURE: _____

DNR form, obtained from general counsel on May 25, 2006.

Why wasn't this form found in the patient records file?

- Form written on March 16, 2003 by weekend on-call doctor without admitting physician's or surrogate's knowledge.
- Form expired on March 17, 2003 upon Dr. Ball's final visit.
- Form was in any case void upon patient's transfer out of ICU.
- Admitting doctor, attending doctor and pulmonologist all say patient was full-code after leaving ICU.
- Form made patient a "candidate for intubation."

Why wasn't patient intubated when intubation was needed?

DO NOT RESUSCITATE FORM

GUIDELINES FOR COMPLETION OF FORM

1. The DNR order is discussed with the patient or responsible decision-maker prior to writing the order (See administrative policy "Consent to Withhold or Withdrawal Treatment")

   Discussion includes:

   a. The fundamental understanding of resuscitation therapy.
   b. The appropriate use of this therapy.
   c. Conditions which would include or preclude the patient as a candidate for this therapy.
   d. The physician's recommendation regarding the therapy for this individual patient.

2. Patient or responsible decision-maker, in conjunction with the attending physician, makes the decision regarding the DNR status. If there is a conflict, refer to the policy concerning withholding of treatment.

3. If the decision is to write the DNR order, the procedure is as follows:

   a. The attending physician is responsible for completion of the DNR order form within 24 hours of order. (Forms available at Nursing Unit)

      Section I - DO NOT RESUSCITATE ORDER

      1. Indicate name of patient and other if discussed with other than patient.

      2. Sign and indicate date and time.

      Section II - PRE-ARREST ORDERS

      1. Determine and check appropriate treatments for this patient to receive previous to any arrest.

      2. Sign and indicate date and time.

      Section III - CHANGE - IN - STATUS ORDERS

      This section is to be used only when the

      1. DNR order is rescinded, or

      2. A new DNR order form has been completed.

   b. Once completed, the newly written DNR form is placed IN FRONT of the physician orders section of the patient chart by the physician. The unit secretary or RN will transcribe the DNR orders to the patient care profile (PCP) and transfer the DNR form to the front of the chart. The "ACTIVE" DNR form will remain in the front of the chart and is not to be thinned. "INACTIVE" DNR orders are placed in the "MISCELLANEOUS" section of the chart. "INACTIVE" DNR orders will not be thinned from the "MISCELLANEOUS" section.

   c. The DNR order must be reconsidered when the patient is transferred to or from a critical care unit, the operating room or at change of attending physician.

Pharmacy record obtained by court order May 25, 2007

Assuming "IV MEDS FROM PHARMACY" are antibiotics, **40% of prescribed doses were never dispensed by hospital pharmacy**. Perhaps that is why Holy Cross Hospital refused to release this document.

PtID	TxDate	TxTime	Station	GenMedName	Dosage	Strength	UnitsM	Volume	InfusM	RxType	Amt
0306900162	03/10/2003	15:09:45	ER1	Levofloxin 500mg IV/D5W	Infusion	0		100	ml	WITHDRAWN	1
0306900162	03/10/2003	18:21:49	4NW	LORAZEPAM	Vial	2	mg	1	ml	WITHDRAWN	1
0306900162	03/10/2003	21:04:00	4SW	IV MEDS FROM PHARMACY	Infusion	0		0		WITHDRAWN	1
0306900162	03/10/2003	22:35:08	IMC	LORAZEPAM	Vial	2	mg	1	ml	WITHDRAWN	1
0306900162	03/11/2003	09:37:55	IMC	LORAZEPAM	Vial	2	mg	1	ml	WITHDRAWN	1
0306900162	03/11/2003	12:10:51	IMC	IV MEDS FROM PHARMACY	Infusion	0		0		WITHDRAWN	1
0306900162	03/11/2003	13:09:48	IMC	IV MEDS FROM PHARMACY	Infusion	0		0		WITHDRAWN	1
0306900162	03/11/2003	14:04:22	IMC	Potassium Cl Run	Bag	0		0		WITHDRAWN	1
0306900162	03/11/2003	17:57:18	IMC	HALOPERIDOL	Vial	5	mg	1	ml	WITHDRAWN	1
0306900162	03/11/2003	20:40:17	IMC	FUROSEMIDE	Vial	20	mg	2	ml	WITHDRAWN	1
0306900162	03/12/2003	01:49:27	IMC	HALOPERIDOL	Vial	5	mg	1	ml	WITHDRAWN	1
0306900162	03/12/2003	03:35:23	IMC	LORAZEPAM	Vial	2	mg	1	ml	WITHDRAWN	1
0306900162	03/12/2003	10:54:48	IMC	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/12/2003	11:02:47	IMC	FUROSEMIDE	Vial	20	mg	2	ml	WITHDRAWN	1
0306900162	03/12/2003	15:32:55	IMC	IV MEDS FROM PHARMACY	Infusion	0		0		WITHDRAWN	1
0306900162	03/12/2003	16:39:47	IMC	POTASSIUM CL POWDER	Package	20	mEq	0		WITHDRAWN	4
0306900162	03/12/2003	17:38:21	IMC	LORAZEPAM	Vial	2	mg	1	ml	WITHDRAWN	1
0306900162	03/12/2003	20:05:30	IMC	LORAZEPAM	Vial	2	mg	1	ml	WITHDRAWN	1
0306900162	03/12/2003	22:05:29	IMC	HALOPERIDOL	Vial	5	mg	1	ml	WITHDRAWN	1
0306900162	03/12/2003	22:05:40	IMC	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/12/2003	23:00:15	IMC	LORAZEPAM	Vial	2	mg	1	ml	WITHDRAWN	1
0306900162	03/13/2003	09:32:32	IMC	Potassium Cl Run	Bag	0		0		WITHDRAWN	1
0306900162	03/13/2003	09:32:59	IMC	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	2
0306900162	03/13/2003	11:12:43	IMC	HALOPERIDOL	Vial	5	mg	1	ml	WITHDRAWN	1
0306900162	03/13/2003	15:26:16	ICU	Potassium Cl Run	Bag	0		1	ml	WITHDRAWN	1
0306900162	03/13/2003	17:09:01	ICU	PROPOFOL INJ 100ML	Bottle	10	mg	1	ml	WITHDRAWN	2
0306900162	03/13/2003	18:34:51	ICU	Potassium Cl Run	Bag	0		30	GM	WITHDRAWN	1
0306900162	03/13/2003	18:34:56	ICU	VASELINE (PETROLATUM)	Tube	0		0		WITHDRAWN	1
0306900162	03/13/2003	19:42:35	ICU	Potassium Cl Run	Bag	0		0		WITHDRAWN	1
0306900162	03/13/2003	20:33:06	ICU	Potassium Cl Run	Bag	0		0		WITHDRAWN	1
0306900162	03/13/2003	21:46:19	ICU	Potassium Cl Run	Bag	0		0		WITHDRAWN	1
0306900162	03/13/2003	21:51:10	ICU	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/14/2003	00:00:15	ICU	FUROSEMIDE	Vial	20	mg	2	ml	WITHDRAWN	1
0306900162	03/14/2003	03:07:38	ICU	PROPOFOL INJ 100ML	Bottle	10	mg	1	ml	WITHDRAWN	1
0306900162	03/14/2003	10:02:05	ICU	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/14/2003	10:02:26	ICU	IV MEDS FROM PHARMACY	Infusion	0		0		WITHDRAWN	1
0306900162	03/14/2003	12:15:23	ICU	Potassium Cl Run	Bag	0		0		WITHDRAWN	2

Only 19 of the 32 doses needed are accounted for in this record.

0306900162	03/14/2003	15:36:47	ICU	IV MEDS FROM PHARMACY	Infusion	0		0		WITHDRAWN	1
0306900162	03/14/2003	17:33:30	ICU	MORPHINE TUBEX	Syringe	2	mg	0		WITHDRAWN	1
0306900162	03/14/2003	20:18:41	ICU	Midazolam (versed)	Vial	2	mg	2	ml	WITHDRAWN	1
0306900162	03/14/2003	22:51:22	ICU	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/14/2003	22:51:58	ICU	Midazolam (versed)	Vial	2	mg	2	ml	WITHDRAWN	1
0306900162	03/14/2003	23:43:06	ICU	MORPHINE TUBEX	Syringe	2	mg	0		WITHDRAWN	1
0306900162	03/15/2003	03:38:01	ICU	Midazolam (versed)	Vial	2	mg	2	ml	WITHDRAWN	1
0306900162	03/15/2003	05:11:58	ICU	Midazolam (versed)	Vial	2	mg	2	ml	WITHDRAWN	1
0306900162	03/15/2003	09:29:22	ICU	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/15/2003	09:32:46	ICU	Midazolam (versed)	Vial	2	mg	2	ml	WITHDRAWN	1
0306900162	03/15/2003	09:44:21	ICU	IV MEDS FROM PHARMACY	Infusion	0		0		WITHDRAWN	1
0306900162	03/15/2003	11:13:10	ICU	MORPHINE TUBEX	Syringe	2	mg	0		WITHDRAWN	1
0306900162	03/15/2003	13:02:07	ICU	Midazolam (versed)	Vial	2	mg	2	ml	WITHDRAWN	1
0306900162	03/15/2003	13:31:12	ICU	IV MEDS FROM PHARMACY	Infusion	0		0		WITHDRAWN	1
0306900162	03/15/2003	15:13:43	ICU	Midazolam (versed)	Vial	2	mg	2	ml	WITHDRAWN	1
0306900162	03/15/2003	15:14:18	ICU	MORPHINE TUBEX	Syringe	2	mg	0		WITHDRAWN	1
0306900162	03/15/2003	16:51:57	ICU	LIDOCAINE 2% JELLY	Tube	2	%	5	ml	WITHDRAWN	1
0306900162	03/15/2003	16:56:02	ICU	Midazolam (versed)	Vial	2	mg	2	ml	WITHDRAWN	1
0306900162	03/15/2003	17:00:21	ICU	MORPHINE TUBEX	Syringe	2	mg	0		WITHDRAWN	2
0306900162	03/15/2003	18:47:05	ICU	FAMOTODINE	Vial	20	mg	2	ml	WITHDRAWN	1
0306900162	03/15/2003	22:40:49	ICU	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/16/2003	02:39:16	ICU	Midazolam (versed)	Vial	2	mg	2	ml	WITHDRAWN	1
0306900162	03/16/2003	02:39:38	ICU	MORPHINE TUBEX	Syringe	10	mg	0		WITHDRAWN	1
0306900162	03/16/2003	05:56:43	ICU	IV MEDS FROM PHARMACY	Infusion	0		0		WITHDRAWN	1
0306900162	03/16/2003	09:47:57	ICU	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/16/2003	09:48:24	ICU	IV MEDS FROM PHARMACY	Infusion	0		0		WITHDRAWN	1
0306900162	03/16/2003	10:19:30	ICU	Midazolam (versed)	Vial	2	mg	2	ml	WITHDRAWN	1
0306900162	03/16/2003	10:23:54	ICU	MORPHINE TUBEX	Syringe	10	mg	0		WITHDRAWN	1
0306900162	03/16/2003	12:40:48	ICU	Midazolam (versed)	Vial	2	mg	2	ml	WITHDRAWN	1
0306900162	03/16/2003	14:34:25	ICU	Potassium Cl Run	Bag	0		0		WITHDRAWN	1
0306900162	03/16/2003	16:55:37	ICU	FAMOTODINE	Vial	20	mg	2	ml	WITHDRAWN	1
0306900162	03/16/2003	16:56:06	ICU	Potassium Cl Run	Bag	0		0		WITHDRAWN	2
0306900162	03/16/2003	17:33:57	ICU	HALOPERIDOL	Vial	5	mg	1	ml	WITHDRAWN	1
0306900162	03/17/2003	01:27:35	ICU	HALOPERIDOL	Vial	5	mg	1	ml	WITHDRAWN	1
0306900162	03/17/2003	03:40:23	ICU	CEPACOL MOUTHWASH	Bottle	0		120	ml	WITHDRAWN	1
0306900162	03/17/2003	07:05:56	ICU	Potassium Cl Run	Bag	0		0		WITHDRAWN	3
0306900162	03/17/2003	10:21:14	ICU	HALOPERIDOL	Vial	5	mg	1	ml	WITHDRAWN	1
0306900162	03/17/2003	10:21:24	ICU	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1

0306900162	03/17/2003	10:21:32	ICU	PHYTONADIONE (VITAMIN K)	Ampule	10	mg	1	ml	WITHDRAWN	1
0306900162	03/17/2003	10:21:50	ICU	IV MEDS FROM PHARMACY	Infusion	0		0		WITHDRAWN	1
0306900162	03/17/2003	10:51:45	ICU	Midazolam (versed)	Vial	2	mg	2	ml	WITHDRAWN	1
0306900162	03/17/2003	12:54:06	ICU	METOPROLOL INJ	Ampule	5	mg	5	ml	WITHDRAWN	2
0306900162	03/17/2003	18:10:59	ICU	FAMOTODINE	Vial	20	mg	2	ml	WITHDRAWN	1
0306900162	03/17/2003	18:11:15	ICU	HALOPERIDOL	Vial	5	mg	1	ml	WITHDRAWN	1
0306900162	03/17/2003	18:11:48	ICU	METOPROLOL INJ	Ampule	5	mg	5	ml	WITHDRAWN	1
0306900162	03/17/2003	22:37:54	ICU	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/18/2003	00:58:24	ICU	METOPROLOL INJ	Ampule	5	mg	5	ml	WITHDRAWN	2
0306900162	03/18/2003	01:01:19	ICU	HALOPERIDOL	Vial	5	mg	1	ml	WITHDRAWN	1
0306900162	03/18/2003	05:47:14	ICU	METOPROLOL INJ	Ampule	5	mg	5	ml	WITHDRAWN	2
0306900162	03/18/2003	08:10:50	ICU	MORPHINE TUBEX	Syringe	2	mg	0		WITHDRAWN	1
0306900162	03/18/2003	09:25:14	ICU	Potassium Cl Run 20mEq/50ml	Bag	0		0		WITHDRAWN	2
0306900162	03/18/2003	10:05:37	ICU	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/18/2003	10:05:46	ICU	HALOPERIDOL	Vial	5	mg	1	ml	WITHDRAWN	1
0306900162	03/18/2003	10:06:08	ICU	IV MEDS FROM PHARMACY	Infusion	0		0		WITHDRAWN	1
0306900162	03/18/2003	12:04:02	ICU	METOPROLOL INJ	Ampule	5	mg	5	ml	WITHDRAWN	1
0306900162	03/18/2003	12:10:54	ICU	METOPROLOL INJ	Ampule	5	mg	5	ml	WITHDRAWN	1
0306900162	03/18/2003	14:06:53	ICU	MORPHINE TUBEX	Syringe	2	mg	0		WITHDRAWN	1
0306900162	03/18/2003	17:23:38	ICU	FAMOTODINE	Vial	20	mg	2	ml	WITHDRAWN	1
0306900162	03/18/2003	17:23:52	ICU	HALOPERIDOL	Vial	5	mg	1	ml	WITHDRAWN	1
0306900162	03/18/2003	17:23:57	ICU	METOPROLOL INJ	Ampule	5	mg	5	ml	WITHDRAWN	2
0306900162	03/18/2003	20:48:47	ICU	MORPHINE TUBEX	Syringe	2	mg	0		WITHDRAWN	1
0306900162	03/18/2003	21:50:03	ICU	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/18/2003	23:59:35	ICU	METOPROLOL INJ	Ampule	5	mg	5	ml	WITHDRAWN	2
0306900162	03/19/2003	03:53:08	ICU	HALOPERIDOL	Vial	5	mg	1	ml	WITHDRAWN	1
0306900162	03/19/2003	06:38:45	ICU	METOPROLOL INJ	Ampule	5	mg	5	ml	WITHDRAWN	2
0306900162	03/19/2003	10:16:55	ICU	HALOPERIDOL	Vial	5	mg	1	ml	WITHDRAWN	1
0306900162	03/19/2003	10:17:05	ICU	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/19/2003	10:18:27	ICU	Potassium Cl Run	Bag	0		0		WITHDRAWN	3
0306900162	03/19/2003	12:35:33	ICU	METOPROLOL INJ	Ampule	5	mg	5	ml	WITHDRAWN	2
0306900162	03/19/2003	18:12:13	ICU	FAMOTODINE	Vial	20	mg	2	ml	WITHDRAWN	1
0306900162	03/19/2003	18:12:27	ICU	HALOPERIDOL	Vial	5	mg	1	ml	WITHDRAWN	1
0306900162	03/19/2003	19:02:12	ICU	MORPHINE TUBEX	Syringe	2	mg	0		WITHDRAWN	1
0306900162	03/19/2003	20:11:06	ICU	METOPROLOL INJ	Ampule	5	mg	5	ml	WITHDRAWN	1
0306900162	03/19/2003	23:42:10	ICU	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/20/2003	00:49:06	ICU	HALOPERIDOL	Vial	5	mg	1	ml	WITHDRAWN	1
0306900162	03/20/2003	02:21:08	ICU	MORPHINE TUBEX	Syringe	2	mg	0		WITHDRAWN	1

0306900162	03/20/2003	10:00:55	ICU	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/20/2003	10:01:02	ICU	HALOPERIDOL	Vial	5	mg	1	ml	WITHDRAWN	1
0306900162	03/20/2003	10:01:46	ICU	IV MEDS FROM PHARMACY	Infusion	0		0		WITHDRAWN	1
0306900162	03/20/2003	10:27:27	ICU	METOPROLOL INJ	Ampule	5	mg	5	ml	WITHDRAWN	2
0306900162	03/20/2003	12:27:23	ICU	IV MEDS FROM PHARMACY	Infusion	0		0		WITHDRAWN	1
0306900162	03/20/2003	13:37:27	ICU	Potassium Cl Run	Bag	0		0		WITHDRAWN	3
0306900162	03/20/2003	17:52:53	ICU	HALOPERIDOL	Vial	5	mg	1	ml	WITHDRAWN	1
0306900162	03/20/2003	17:53:01	ICU	FAMOTODINE	Vial	20	mg	2	ml	WITHDRAWN	1
0306900162	03/20/2003	18:24:22	ICU	MORPHINE TUBEX	Syringe	2	mg	0		WITHDRAWN	1
0306900162	03/20/2003	22:00:31	ICU	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/21/2003	03:01:19	ICU	HALOPERIDOL	Vial	5	mg	1	ml	WITHDRAWN	1
0306900162	03/21/2003	03:01:28	ICU	METOPROLOL INJ	Ampule	5	mg	5	ml	WITHDRAWN	2
0306900162	03/21/2003	05:37:35	ICU	MORPHINE TUBEX	Syringe	2	mg	0		WITHDRAWN	1
0306900162	03/21/2003	06:05:13	ICU	MORPHINE TUBEX	Syringe	2	mg	0		WITHDRAWN	1
0306900162	03/21/2003	08:15:29	ICU	HALOPERIDOL	Vial	5	mg	1	ml	WITHDRAWN	1
0306900162	03/21/2003	08:15:40	ICU	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/21/2003	08:15:57	ICU	IV MEDS FROM PHARMACY	Infusion	0		0		WITHDRAWN	1
0306900162	03/21/2003	13:34:48	ICU	MORPHINE TUBEX	Syringe	10	mg	0		WITHDRAWN	1
0306900162	03/21/2003	13:56:43	ICU	METOPROLOL INJ	Ampule	5	mg	5	ml	WITHDRAWN	2
0306900162	03/21/2003	18:27:03	ICU	FAMOTODINE	Vial	20	mg	2	ml	WITHDRAWN	1
0306900162	03/21/2003	18:27:11	ICU	HALOPERIDOL	Vial	5	mg	1	ml	WITHDRAWN	1
0306900162	03/22/2003	00:03:25	ICU	MORPHINE TUBEX	Syringe	2	mg	0		WITHDRAWN	1
0306900162	03/22/2003	01:59:20	ICU	HALOPERIDOL	Vial	5	mg	1	ml	WITHDRAWN	1
0306900162	03/22/2003	04:23:13	ICU	METOPROLOL INJ	Ampule	5	mg	5	ml	WITHDRAWN	2
0306900162	03/22/2003	08:07:20	ICU	HALOPERIDOL	Vial	5	mg	1	ml	WITHDRAWN	1
0306900162	03/22/2003	08:07:38	ICU	IV MEDS FROM PHARMACY	Infusion	0		0		WITHDRAWN	1
0306900162	03/22/2003	11:47:35	ICU	METOPROLOL INJ	Ampule	5	mg	5	ml	WITHDRAWN	2
0306900162	03/22/2003	17:35:51	ICU	FAMOTODINE	Vial	20	mg	2	ml	WITHDRAWN	1
0306900162	03/22/2003	17:35:59	ICU	HALOPERIDOL	Vial	5	mg	1	ml	WITHDRAWN	1
0306900162	03/22/2003	18:44:55	ICU	MORPHINE TUBEX	Syringe	2	mg	0		WITHDRAWN	1
0306900162	03/22/2003	19:51:57	ICU	METOPROLOL	Tablet	25	mg	0		WITHDRAWN	1
0306900162	03/22/2003	20:05:32	ICU	MORPHINE TUBEX	Syringe	2	mg	0		WITHDRAWN	1
0306900162	03/22/2003	21:59:51	IMC	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/23/2003	04:29:02	IMC	HEP LOCK FLUSH 10ML	Vial	10	units	1	ml	WITHDRAWN	1
0306900162	03/23/2003	08:58:48	IMC	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/23/2003	08:58:59	IMC	METOPROLOL	Tablet	25	mg	0		WITHDRAWN	1
0306900162	03/23/2003	11:22:01	IMC	ALBUTEROL INHALANT	UD Inh.	2.5	mg	3	ml	WITHDRAWN	1
0306900162	03/23/2003	12:51:15	IMC	VASELINE (PETROLATUM)	Tube	0		30	GM	WITHDRAWN	1

0306900162	03/23/2003	16:23:48	IMC	IV MEDS FROM PHARMACY	Infusion	0		0		WITHDRAWN	1
0306900162	03/23/2003	19:38:57	IMC	LEVALBUTEROL 1.25MG/3ML	DOSE	1.25	mg	3	ml	WITHDRAWN	2
0306900162	03/23/2003	20:31:57	IMC	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/23/2003	20:32:16	IMC	METOPROLOL	Tablet	25	mg	0		WITHDRAWN	1
0306900162	03/23/2003	20:34:13	IMC	FAMOTODINE	Vial	20	mg	2	ml	WITHDRAWN	1
0306900162	03/24/2003	04:43:28	IMC	ALBUTEROL INHALANT	UD Inh.	2.5	mg	3	ml	WITHDRAWN	2
0306900162	03/24/2003	07:52:35	IMC	METOPROLOL	Tablet	25	mg	0		WITHDRAWN	1
0306900162	03/24/2003	10:08:58	IMC	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/24/2003	10:09:11	IMC	FAMOTODINE	Vial	20	mg	2	ml	WITHDRAWN	1
0306900162	03/24/2003	12:34:01	IMC	ALBUTEROL INHALANT	UD Inh.	2.5	mg	3	ml	WITHDRAWN	2
0306900162	03/24/2003	15:22:39	IMC	IV MEDS FROM PHARMACY	Infusion	0		0		WITHDRAWN	1
0306900162	03/24/2003	21:31:20	IMC	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/24/2003	21:31:35	IMC	METOPROLOL	Tablet	25	mg	0		WITHDRAWN	1
0306900162	03/25/2003	09:38:55	IMC	FAMOTIDINE	Tablet	20	mg	0		WITHDRAWN	1
0306900162	03/25/2003	09:39:05	IMC	METOPROLOL	Tablet	25	mg	0		WITHDRAWN	1
0306900162	03/25/2003	13:34:41	IMC	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/25/2003	14:11:30	IMC	ALBUTEROL INHALANT	UD Inh.	2.5	mg	3	ml	WITHDRAWN	1
0306900162	03/25/2003	19:48:42	IMC	ALBUTEROL INHALANT	UD Inh.	2.5	mg	3	ml	WITHDRAWN	1
0306900162	03/25/2003	20:04:43	IMC	IV MEDS FROM PHARMACY	Infusion	0		0		WITHDRAWN	1
0306900162	03/25/2003	20:24:47	IMC	METOPROLOL	Tablet	25	mg	0		WITHDRAWN	1
0306900162	03/25/2003	22:38:28	IMC	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/26/2003	01:47:34	IMC	ALBUTEROL INHALANT	UD Inh.	2.5	mg	3	ml	WITHDRAWN	1
0306900162	03/26/2003	08:37:23	IMC	METOPROLOL	Tablet	25	mg	0		WITHDRAWN	1
0306900162	03/26/2003	09:31:23	IMC	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/26/2003	09:31:34	IMC	FAMOTIDINE	Tablet	20	mg	0		WITHDRAWN	1
0306900162	03/26/2003	11:57:34	IMC	ACETAMINOPHEN	UD Cup	650	mg	20	ml	WITHDRAWN	1
0306900162	03/26/2003	12:35:36	IMC	ALBUTEROL INHALANT	UD Inh.	2.5	mg	3	ml	WITHDRAWN	2
0306900162	03/26/2003	20:10:19	IMC	METOPROLOL	Tablet	25	mg	0		WITHDRAWN	1
0306900162	03/26/2003	22:16:38	IMC	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/27/2003	02:40:48	IMC	ALBUTEROL INHALANT	UD Inh.	2.5	mg	3	ml	WITHDRAWN	1
0306900162	03/27/2003	08:23:29	IMC	HEPARIN 5000 UNITS/ML	Vial	5000	units	1	ml	WITHDRAWN	1
0306900162	03/27/2003	08:23:37	IMC	FAMOTIDINE	Tablet	20	mg	0		WITHDRAWN	1
0306900162	03/27/2003	08:23:43	IMC	METOPROLOL	Tablet	25	mg	0		WITHDRAWN	1
0306900162	03/27/2003	10:21:57	IMC	MORPHINE TUBEX	Syringe	10	mg	0		WITHDRAWN	1
0306900162	03/27/2003	15:44:14	IMC	ALBUTEROL INHALANT	UD Inh.	2.5	mg	3	ml	WITHDRAWN	1

10:20 AM

PATIENT RELATIONS WORKSHEET
For Facility: M

MRN: 815510 NEUSTADTER,ISRAEL 91Y M

Obtained by court order July 31, 2007

========== ENCOUNTER DATA ==========

Start Date: 3/10/2003 Acct. No.: 0306900162

Admit Phys: NAWAZ,AHMED Attend Phys: NAWAZ,AHMED

Complaint: A--038.9--SEPTICEMIA NOS

End Date: 3/27/2003 Disch Dx:

========== INCIDENT DATA ==========

Date Received: 3/25/2003 Information Source: CUST RELATIONS FAMILY VIS

No: 03-118 Facility: HOLY CROSS HOSPITAL

Date: 3/24/2003 Time: Shift:

Loc: IMC - INTERMEDIATE CARE UNIT Room No: 6231-2

Depts: INTERMEDIATE CARE UN Empls:

Phys Notified: (N) Risk Mgmt Notified: (N) Physician: WEINER,JAY H

Inc Types:		Quantities:
	PROCEDURE/TREATMENT - DELAY	1
	MISCOMMUNICATION	1
	BEHAVIORAL - PHYS. RELATED	1

Outcomes:

Significance: PROCESS IMP ISSUES ID-PR,QI,RM Parameters:

Treatment:

Comment:

Status: PENDING

Comments/Abstract: SON - AL NEUSTADTER CALLED WITH CONCERNS REGARDING A LIVER SONOGRAM STUDY FOR HIS FATHER. DR. NAWAZ TOLD SON @ 10AM ON 3-24-03 HE WAS ORDERING A SONOGRAM OF THE LIVER ON HIS FATHER B/C THE TEST RESULTS WERE 4X HIGHER THAN NORMAL. THE CHARGE NURSE (LIZ) ON THE NIGHT SHIFT (3/24/03) TOLD HIM THAT THE TEST WOULD BE DONE ON 3-25-03. THE DAY OF THE STUDY THE STAFF TOLD HIM THAT THERE WAS NO RECORD OF THE TEST BEING ORDRED.

THE SON MADE THE FOLLOWING ADDED REQUESTS:
1. FATHER WAS ON TEACHING SVS B/C DURING ICU ADMISSION, SON WOULD LIKE TO HAVE FATHER BACK ON TEACHING SVS. SON ALSO CALLED MD OFFICE TO MAKE THE SAME REQUEST.

2. SON WOULD LIKE TO BE INFORMED OF PROBLEMS W/ HIS FATHER'S LIVER FUNCTIONS & RESULTS OF THE SONOGRAM.

3. SON WANTS FATHER SUCTIONED FREQUENTLY.

4. SON FEELS DR. WEINER DISPLAYED INAPPROPRIATE BEHAVIOR WITH

Son clearly rejects end-of-life care, conveying to hospital desire for aggressive treatment and concern about behavior of Dr. Weiner.

10:20 AM

PATIENT RELATIONS WORKSHEET

For Facility

Hospital made aware of openly hostile doctor who does not want patient to survive, yet fails to intervene. Two days later patient is euthanized by the withholding of treatment.

MRN: 815510 NEUSTADTER, ISRAEL 91Y M

Comments/Abstract: (Continued)

RESPECT TO THE CARE & TREATMENT OF HIS FATHER. STATES DR. WEINER VERBALLY EXPRESSED HOSTILITY TO NOTION OF HIS DAD'S SURVIVAL. CONVERSATION WAS HELD AT THE BEDSIDE WHERE HIS FATHER COULD HEAR. SON FELT DR. WEINER'S MANNERISM LACKED CARE & COMPASSION. SON WANTED TO HAVE ANOTHER PULOMNOLOGIST CARE FOR HIS DAD, BUT IT WAS NOT DONE AT DR. NAWAZ'S RECOMMENDATION.

Son literally pleads for better care in the hope of saving his father's life.

5. SON ASKED ABOUT HEPARIN INJ. NURSE CHRISTINE SAID NOT ON LIST OF THINGS TO GIVE. SON CHECKED WITH CHARGE NURSE DEBBIE. MED DAD SHOULD HAVE GOTTEN IN THE MORNING WAS NOT GIVEN UNTIL 2 PM. SON QUESTIONS WHAT WOULD HAVE HAPPENED IF HE WASN'T AT HOSPITAL TO CHECK.

6. SUNDAY DAD DID NOT GET LEVAQUIN. SUPPOSE TO GET Q24 HOURS. NURSE CONFIRMED SHE WAS CHECKING WITH PREVIOUS NURSE TO SEE IF SHE GAVE THE MED. WHEN EVENING NURSE RON GIBB (EXCELLENT NURSE) ARRIVED @ 7 OR 7:15 PM HE SAID, 'YES, WERE STILL WAITING TO HEAR BACK FROM THE NURSE ABOUT WHETHER SHE GAVE THE MED." MED WASN'T GIVEN UNTIL 10 PM AFTER Rx MADE DETERMINATION BASED ON COUNTING DOSES THAT MED WAS NOT GIVEN EARLIER. SON VERY CONCERNED THAT MISSED DOSE WOULD ADVERSELY AFFECT HIS DAD'S ABILITY TO GET BETTER.

7. PT CAME TO TREAT DAD. DAD WAS SLEEPING THERAPIST LEFT. LATER, SON ASKED NURSE TO HAVE THERAPIST COME BACK. THERAPIST SAID SHE COULDN'T B/C SHE WAS TOO BUSY. SON FELT SOMEONE FROM THE DEPARTMENT COULD HAVE COME BACK TO RENDER THERAPY.

SON WANTS TO SEE STAFF GIVING GOOD CARE - STAYING ON TOP OF THINGS. MISSING ANTIBIOTICS, HEPARIN SHOTS, PT APPOINTMENTS & SONOGRAM STUDIES IS NOT HIS IDEA OF GOOD CARE.

MARCH 27, 2003

SON CALLED CUSTOMER RELATIONS @ 11:36 AM REQUESTING ASSISTANCE IN CONTACTING DR. WEINER. HE WANTED TO GET CLARIFICATION REGARDING HIS FATHER'S STATUS. SON STATED HE TOLD DR. WEINER HE WANTED "NO FURTHER TREATMENT" & THEN TOLD DR. WEINER TO "LEAVE THE ROOM". DR. WEINER ASKED THE SON, IF HE WANTED ANOTHER DOCTOR, SON REPEATED, "PLEASE LEAVE THE ROOM." DR. WEINER ASKED AGAIN, "DO YOU WANT ANOTHER DOCTOR?" SON SAID, "NO YOU'RE MY FATHER'S DOCTOR!" SON SAID, HE DIDN'T REALIZE WHAT HE WAS SAYING AT THE TIME WHEN HE TOLD DR. WEINER NO FURTHER TREATMENT. HE MEANT NO RESUSCITATION, NO INTUBATION, BUT HE WANTED EVERYTHING ELSE POSSIBLE TO BE DONE.

SON STATES HE CAME OUT TO TALK WITH DR. WEINER TO CLARIFY & EXPLAIN HIS COMMENTS, BUT DR. WEINER WAS ON THE PHONE & DID NOT ACKNOWLEDGE HIM. SON WANTED TO CLARIFY THE COMMENTS HE MADE TO DR. WEINER B/C HE FEELS THERE MAY HAVE BEEN A MISUNDERSTANDING BTWN HIM & DR. WEINER.

REFERRAL DATA

Referred To: PERFORMACE DEVELOPMENT Person: BRENDA RUSSO, R.N./LINDA PAESE, R.N

MRN: 815510 NEUSTADTER, ISRAEL 91Y M

Ref Date: 3/31/2003 Resp Expected: 3/31/2003 Resp Received: 3/31/2003

Action: CALL/LETTER TO PATIENT/FAMILY Disposition: SENT TO QUALITY IMPROVEMENT

Reason: FOR YOUR INFORMATION ONLY - NO RESPONSE NEEDED.
Comment: NO RESPONSE NEEDED

Referred To: INTERMEDIATE CARE UNIT Person: SUSAN KING, R.N., NURSE MANAGER

Ref Date: 3/31/2003 Resp Expected: 3/31/2003 Resp Received: 3/31/2003

Action: ISSUES IDENTIFIED Disposition:

Reason: FOR YOUR INFORMATION
Comment: ON GOING MEETINGS WERE CONDUCTED WITH SON.

Referred To: MEDICAL AFFAIRS Person: DR. BLAIR EIG, M.D.

Ref Date: 3/31/2003 Resp Expected: 3/31/2003 Resp Received: 3/31/2003

Action: ISSUES IDENTIFIED Disposition: SENT TO QUALITY IMPROVEMENT

Reason: FOR REVIEW
Comment: DR. ELISE REILLY MET WITH THE SON ON 3/27/03 FROM 12:30 PM - 1:10 PM TO CLARIFY ISSUES REGARDING HIS FATHER'S STATUS. SHE INFORMED THE SON SHE WOULD CALL DR. WEINER TO NOTIFY HIM OF HIS CONCERNS & DESIRE TO SEE HIM. DR. WEINER'S OFFICE WAS CALLED PRIOR TO MEETING WITH SON. MESSAGE LEFT WITH OFFICE FOR DR. WEINER TO CONTACT DR. REILLY ON HER PAGER. DR. REILLY QUESTIONED SON ABOUT SUPPORT SYSTEM FOR HIM & SUGGESTED PALLIATIVE CARECONSULT. SON AGREED. DR. REILLY SAID SHE WOULD GET AN ORDER FOR THE CONSULT.

Patient still alive. Son states there was a misunderstanding and urgently requests clarification of his father's status, of Dr. Weiner's refusal to intubate the previous night and of the options still available. Son has plainly not signed off on "plan of care" to withhold treatment and to allow his full-code, non-terminal father to die.

Hospital fails to offer intubation pending resolution of status, fails to locate Weiner or covering doctor, "questions son about support system" and finally "suggests a palliative consult" one hour before death.

INTERVIEW DATA

Date	Time	Person Interviewed	Location
3/26/2003	8:30A	CHRIS CAMFIELD, R.N.	UNABLE TO DETERMINE

Notes: CHRIS CALLED THE CUSTOMER RELATIONS OFFICE TO F/U A DISCUSSION REGARDING MR. AL NEUSTADTER'S BEHAVIOR ON 3/25/03. SHE SAID MR. NEUSTADTER HAD GIVEN HIS FATHER ICE CHIPS, APPLE JUICE & H20. CHRIS OBSERVED HIM PUSHING ICE CHIPS DOWN HIS FATHER'S THROAT* DAD HAS A FEEDING TUBE. SON WAS ALSO NOTED ADJUSTNG HIS DAD'S OXYGEN.

3/25/03 CRC PRESENT DURING DISCUSSION BTWN CHRIS & AL NEUSTADTER. CHRIS ASKED SON, FROM THIS POINT FORWARD NOT TO TOUCH THE EQUIPMENT AT HIS FATHER'S BEDSIDE OR TO FEED HIS FATHER ANYTHING. CHRIS PROMISED THE SON THAT THE STAFF WOULD PROMPTLY RESPOND TO ANY REQUESTS HE MADE FOR HELP WITH HIS DAD & THE SON PROMISED CHRIS HE WOULD NOT

Falsified record
Implausible next-day phone call from Nurse Canfield to inform Patient Relations that she witnessed son "pushing ice chips down his father's throat" the previous day.

This was likely inserted to demonstrate contributory negligence for legal purposes. My father was never given ice at any time.

Can a hospital falsify records with impunity?

*Nurse Canfield testified that she did not recall the incident or the patient, but that if she had witnessed such behavior she would have documented it contemporaneously rather than calling to report it the following day.

10:20 AM PATIENT RELATIONS WORKSHEET
For Facility: M

MRN: 815510 NEUSTADTER,ISRAEL 91Y M

Date	Time	Person Interviewed	Location (Continued)

ATTEMPT TO CARE FOR HIS DAD, BUT WOULD RATHER WAIT FOR THE NURSE TO RESPOND.

Date	Time	Person Interviewed	Location
3/27/2003	11:30A	REV. Y. LOUISE HICKS, CHAPLIN	IMC - INTERMEDIATE CARE UNIT

Notes: MET WITH SON TO LISTEN TO HIS CONCERNS REGARDING CONVERSATION WITH DR. WEINER, DNR/DNRI ORDER* & DESIRE NOT TO HAVE FATHER RESUSCITATED & INTUBATED.

Patient still alive. No action taken on son's concerns regarding conversation with Dr. Weiner and the purported decisions that were made.

* No such order ever written.

Date	Time	Person Interviewed	Location
3/27/2003	12:00P	DENISE JOHNSTON, R.N., CHARGE	IMC - INTERMEDIATE CARE UNIT

Notes: DENISE JOHNSTON & ELAINE THE PATIENT'S NURSE FROM THE NIGHT SHIFT MET WITH SON TO VERIFY HIS REQUEST MADE TO DR. WEINER OF NO FURTHER TREATMENT. DENISE STATED THAT THE SON TOLD THEM HE WANTED NO FURTHER TREATMENT.