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 Bystolic

Medications: see medicine list

Objective:

Vitals: wgt. ht. BP 140/70 P 76 Temp. 98.5

	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 | BASIC METABOLIC PANEL | Spec: Blood
Out: 02/27/03 1929 Techs: V8491 T499
Coll Time: 02/27/03 1813
Order Phys: NAWAZ,AHMED [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 | CBC,AUTOMATED DIFF | Spec: Blood
Out: 02/27/03 2240 Techs: V8491 T10636
Coll Time: 02/27/03 1813
Order Phys: NAWAZ,AHMED [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

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
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

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

NEUSTADTER,ISRAEL
815510/M0306400169
LAB
(M-04/14/11)
Dr ALTSCHULER,MORTON

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!

5

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: fall
- 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

7

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.

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
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

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)
D5 NS at 100cc/hr (3)
Zosyn 3.375 mg IV q6 started
Ancef 1 gm IV q8
Diflucan 2 tabs q 60 pm
MOM 30 cc po q 6° pm
BMP, CBC in am (4)
DNR (11)

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"?

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

2L NC O2
Ativan 1 mg IV q 2-4 pm dystonia
T.O. Dr Nawaz/Bozkurt, RN

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

Abdominal Xray
R/O Mass (16)

T.O. Dr Nawaz/Smith, RN

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

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

HOLY CROSS HOSPITAL

PHYSICIAN ORDER FORM

NEUSTADTER, ISRAEL 91Y
03/10/03 03006900112
3127 NAWAZ, AHMED
CO 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
Pessy on phone
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 03006900112
3127 NAWAZ, AHMED
CO I/P 815510
1111 UNIV BLVD WEST
SILVER SPRING MD 20902
301 649-1319

Ok Levaquin

PHYSICIAN SIGNATURE | PHY[illegible] | 3/10/03 ME DATE

NEUSTADTER, ISRAEL 91Y
03/10/03 03006900112
3127 NAWAZ, AHMED
CO 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# | 3/10/03 TIME DATE

Form No. DB8-001 Physician Order Form WHITE - CHART COPY YELLOW - DEPT.

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

NEUSTADTER, ISRAEL
0=0[illegible]0162
NAHAZ, AHM[illegible]
8155 10
111 UNIV BLVD WEST
SILVER SPRING MD 20902
301 649-1319

HOLY CROSS HOSPITAL

MEDICATION ADMINISTRATION RECORD

Order Date	Renewal Date	MEDICATION, DOSE, FREQUENCY	HR.	DATES GIVEN 3/10 11 12 13 14 15 16 17 18 19 20 21 22 23
3/10		Levaquin 500mg IV QD	3P	→ 9a
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 4[illegible]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 0306900162
03/10/03 NAWAZ, AHMED
3127 815510
CO I/P
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 BRP. 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 wires removed. Continue to monitor closely	Cassidy RN

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADT, ISRAEL 91
03/10/03 03059001162
3127 NAWAZ, AHM
CO I/P 815510
- 11/ Neustadt, S. ISRAEL
SILVER SPRI 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		meds:- (dictated).
		impression:
		① Community acquired pneumonia. ✓
		② Sepsis. ✓
		③ Renal Azotemia. ✓
		④ Dementia. ✓
		⑤ reducible umbilical 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.
		I made it clear that my father was full code yet was questioned about it repeatedly. My answer was always the same.
		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 2+
		A/P:- - DIC Foley
		- PT comfort
		- WBC ↓ 20000
		- Family very much in favor of

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 Allows coop sips - Ld long talk ± sips He will consult Lo Reds: Dietician swallow eval/SLP
3/11 5:30p	ARNP	DEMENTED OLDER BABBLING O/ IN NAD ± ANXIOUS SON @ BEDSIDE. ON 1SL/MIN VIA NRPM, RA SPO2 93-98% + SCATTERED ⑧ RALES. ABD BSX4 CNW 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

MUSTACHER, ISRAEL 91Y
03/10/03 0306900162
3127 NAWAZ, AHMED
GS 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° ↓BP
		② HBP - ? likely due to recent hypotensive episode
		③ Sepsis 2° pneumonia c/n semesters.
		④ Hypoxemia - developing pneumonia, LLL (Bronchial BS) ? R/o CHF 2° IVF
		⑤ Pneumonia ? - aspiration (recent UNa, Coxy stenting Zenker'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.

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

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		PULMONARY / CRITICAL CARE
8:00 PM		
		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, titrate O2 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 301
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 day of admission 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.

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

Meds
evaquin 500mg IVQD
rocephin 1gm IVqd
lasix 20g IV x 1
KCl 10 Meq in 100cc NS over 1°

O: Vitals: T 100.3 P 89 (67-102) R (21-32)
BP 103/40 (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 Niles MS3

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

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PHYSICIAN PROGRESS NOTES

NEUSTAETER, ISRAEL 91Y
03/10/03 03069001L2 20
3127 NAWAZ, AHM.G
CO I/P A15510
1111 UNIV BLVD W.ST
SILVER SPRIN 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 / MD 1691

NILES

Resident Addendum.

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

Needed it - N. Swati

IHC HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 0306900162
3127 NAWAZ, AHM..S
CC I/P 815510
1111 UNIV BLVD W.ST
SI Neustadter, Israel
3[illegible]

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

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PHYSICIAN PROGRESS NOTES

[illegible] ISRAEL 91Y
03/10/03 0306900162
3127 NAWAZ, AHMED
[illegible] 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	0915	MSB PN
Meds		S: Pt sating 94-96% on Vapotherm overnight. Given Haldol to improve restlessness & pt. was more calm overnight. No acute events overnight.
Avelox 500mg IV qd (D#3)		O: Vitals: Tm 100^3 (3/11@2000) Tc 97^7 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%
Zephrin 1gm IV qd (D#3)		I/O: 1095/950 (S) IVF: 975cc O: 120cc UOP: 970 + 500cc in foley bag
PRN		Exam: GEN: Resting, mild distress
Ativan 1mg IV Q2-4 prn agitation		Pulm: (B) crackles in 1/2 lung fields
		CV: S_1S_2
Nam @ 30cc PO		Abd: ND (+)BS / soft / nontender, raised soft protrusion to (R) of umb
Tylenol		Ext: ø edema
Haldol 1mg IM q8°		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 / 3 | 104 / 23 | 23 / 0.8 | Mg 2 / 124 / Ca 7.5
		UCx: NGTD BCx - (P)
		A/P: 91 yo ♂ c aspiration pneumonia & hypoxia. - not yet resolved,
		1. Aspiration Pneumonia - Continue IV Levaquin 500mg qd & Rocephin 1g IV qd. Aspiration precautions. DVT prophylaxis - Sq heparin
		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.
		Elyahi MS3 / NILES / MD 1691
		Agree c above. K is 3. Will replete c KCl runs & monitor for arrhythmia
		MD 1691

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PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 0306900162
3127 NAWAZ, AHMED
CO I/P 815510
1111 UNIV BLVD WEST
SILVER SPRING 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 c 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 RESPIRATORY CARE/HSD QLV 124 K 3.0 WBC 17.2 IMP: RUU 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 REC 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

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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. Vs:- B.P- 126/70 RR-20 HR-86. T- 99.7. Chest:- bi basalar rales & rhonchi Cvs:- RRR, Abd:- soft, non tender Ext:- 4+ LE edema Mg p:- K+ ↓ - will be replaced. -. D/C IVF -. Get 2D echo. -. Pts son did call 2nd opinion by Dr. Chandra. He agrees with same management. -. Case d/w house staff & Dr. Kenn A. Nawaz

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PHYSICIAN PROGRESS NOTES

NUSTADTER, ISRAEL MIY
03/10/03 0308500112
3127 NAWAZ, AHM.
CC I/P 8J5510
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

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 & no other issues. Son @ bedside this am. Pt seen by med atting, pulm & cardiology yesterday. Nutrition note - cont. diet & supplement & boost

meds
epar inn 5000u sc q12
evaquin 500mg IVq D (D#4)
Rocephin 1g IVqd (D#4)
prn
Ativan
MoM
Haldol
tylenol

O: vitals - T_m 100² T_c 100² 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, $S_1 S_2$
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

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PHYSICIAN PROGRESS NOTES

DATE	TIME	
		MS3 PN (cont'd)
		will need aggressive electrolyte repletion. ? central line. Pt. remains 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 / 13 ; 2.8 / 23 / 0.7 ; 128 / 8.2 ; Mg 2.0 ; 21.8 / 35.5 / 11.7 ; 235 ; L 3.43 M 6.3 N 89.8 E .137 B .346 ; t.N
		B(x x 2 - NGTD
		Plan - will place central line for aggressive electrolyte repletion.
		Elyahu MS3 / Neeraj N SHAH #1047 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.

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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 nurse. Still c low grade temp. Probably
10:00	A	hypoxic c O2 sat 89 on 100% ventilator. Cellulitis
		looks septic. Labs c WBC c shift c/w c/s, ABG
		distended. Ext c edema c CXR yesterday with small infiltrates
		flow out. K+ 2.8 WBC c 21.8 BUN c creat 0.7
		DC NG flow for
		Imp ① Sepsis pneumonia c resp failure - worsening
		② hypokalemia
		Rec ① Broad spectrum antibiotics c goal of Lactate clearance
		Pt will need vent c any further deterioration if
		aggressive tx desired. Given his age I doubt it will
		d ultimate outcome. TLC was will decide after consultation
		c his family if he needs vent
		② central line - replace KLI
		[illegible]
3/13/03		Procedure Note
12PM		Attempted TLC verses line @ (R) groin. Pt continuously
		moving, gave Haldol, ø more Ativan due to resp
		status. No success @ line after multiple
		attempts. NO complications D/W Dr. Neuwaver.
		Meredith

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PHYSICIAN PROGRESS NOTES

DATE	TIME	
3/13/03		Medicine:-
		- Pt is in respiratory distress. and only responding to painful
		U/S:- Ht - 30-35 B.P - 160/80
		Hr - 98. T - 100.6.
		Chest:- B/L exp wheezing & rhonchi
		CVS:- Reg, S1 S2 normal
		abd:- soft, non tender
		MP:-
		- Pt needs to be intubated will d/w Dr; mmm.
		- Had long communication 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	5:45	RUJ ATTEMPTED NG & SUCCESS/SZ

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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	MS3 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 + crackle. heard on lung exam. Pt was given lasix + UOP improved but remains marginal. K 4.1 to 4.4 after repletion but ↓ after lasix given to 3.7. RN disimpacted large amt of stool. No other issues.
		O: Vitals- T_m 100.2 T_c 98.1 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

meds
ceftriaxone 1g IVq24 D#5
avaquin 250mg IVq24° D#5
heparin 5000U SQ BID
Propofol
prn
valdol

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

MD →

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PHYSICIAN PROGRESS NOTES

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

30

DATE	TIME	
3/14/03	0900	MS3 PN

ID- BCx's NGTD- will monitor + cont Abx.
Heme- DVT prophylaxis ☐ Heparin 5000U sq - continue
Pulm- ABG's/CXR - wean, replete ☐ 2 units of RCL

Elyan MS3
NILES

MD
1691

Agree ☐ above.
D/W attending - pt's ABG 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

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

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PHYSICIAN PROGRESS NOTES

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

DATE	TIME	
3/14/03		CCL
	8:56 A	Pt seized in the vent. BP ~ 100 systolic. Requiring increased
	9:25 A	FiO_2. NG could not be placed probably d/t varices. Time 100
		Lyte is sent and pharmacy to fill. ABG sent from
		CVL still infiltrates noted in RUL. T ≥ 0
		WBC 23.3 Hct 31 Na+ 137 K+ 3.7
		ABG 45/129/7.42 on FiO_2 100% on 12 rate of
		Imp ① Pneumonia and sepsis
		② Gas exchange poor d/t large shunt
		③ Dehydration
		Rec ① Vent. Pt. Pressure support control
		to meet ordered PaO
		② ↓ FiO_2 to 50% - keep SpO_2 ~ 95-98
		③ Antibiotics
		④ Continue antibiotics A

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PHYSICIAN PROGRESS NOTES

NEUSTADTER, ALEXANDER
NAVAZ, ARIFA
I/P 815510
1111 UNIV BLVD W ST
SILVER SPRING MD 20902
301 649-1319

DATE	TIME
3/14/03	

GE Consult (Dictated)
1. aspiration pneumonia - intubated
2. s/p b/l basilar thoracentesis - Tube # x4
3. s/p apnea
4. need volume depletion
Plan: 1. NO attempt at NGT - Could only be done in x-ray & not reasonable way
2. no TPN
3. Continue nutritional support c moderate/ic - D5W 40/ Dr. Navaz
Will call 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**.

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PHYSICIAN PROGRESS NOTES

DATE	TIME	
3/14/03		medicine :-
		-. Pt is on vent, resting comfortably
		vysi- B.P - 130/70 RR - 16 Htr - 90
		Chest :- bilateral rhonchi.
		Cvs :- RRR, SEM Grade.
		Abdn 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 lap procedure
		-. Labs as ordered

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

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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

34

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. Neustadter Fellow 1005

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PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
(3/10/03 [illegible]
[illegible] NAWAZ, [illegible]
[illegible] I/P 815510
[illegible] GEORGIA AVE 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
		Chest:- B/L rhonchi
		Cvs:- RRR, SEM++.
		abd: soft, nontender.
		(9) 10.3 / 31.5 (265 — 139 / 110 / 41 (R2 — 4 / 19 / 1.0 —
		7.41 | 31 | 62 | 93 |
		MP:-
		- Pneumonia — on vent, cont i/v Rbx - cont i.v.
		-. cont other meds.
		-. might need to start tube on prednisone q lipids.

March 15, Saturday

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

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. does not talk spont ? w. sedation stores. Unable to do femoral access. PICC line x failure since it would require intra xray manipulation (apnea) ; will defer for now, check pt further progress in weaning sedation, LV function, etc. D/w Dr. Thomas PCP & pt's son
3/15/03		Pulm/CCM PA Sedated. 101-160/52 75 SV - 100 AF 1/0 927/981 Neuro - arousable but not following commands OUS RRR ext Ext edema 7.41/32/63 4y 12/500 139/110/41/112 20 10 19.2 4.3/19/1.3 CXR - improved RML infiltrate 1) Resp failure w/ pneumonia - CAP 2) Anemia 3) Perirenal hematoma - IVF hydration - unable to PASS NGT ? OG ∴ will start pneumonia - start Hz blocker. - D/w Son & friends x 20 min BAll

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
I/P
1111 UNIV BLVD W
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 2.5mg IVq24° (D#6)		~~ERG~~ 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 - 14 / 10³ / 265 / 31⁵ ; 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 / 62.7/12
		BCx's - NGTD

A/P: 91 yo ♂ c aspiration pneumania + hypoxia. Now on vent.
- P/c'd dipervan 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 intravascular depleted
- ID - BCx's still NGTD. Will continue to follow WBC + T.
- FEN - replete lytes prn
- heme - cont. DVT prophylaxis c Sq heparin

MS3 NICES / MD 1641

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

03/10/03 [illegible]
[illegible] MANAGED CARE
I/P 815510
1111 UNIV BLVD WEST
SILVER SPRIN MD 20902
301 649-1319

38

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

HC HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 0306900162
3127 NAWAZ, AHM_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 HR95SR
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°
- valium 2mg IV/im q4
- morphine 2-5mg IVq1-2

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 0306900162 40
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
FADUL

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-sanguinous
		abd:- soft, non-tender
		Labs:-
		17.3 | 9.7 | 293 / 29.6.
		116 | 116 | 31 / 3.6 | 25 | 0.9. (101
		A/P:-
		-Pneumonia & Resp failure —
		-on vent, cont i/v Abx.
		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		Dvir/ccm VS 124/42 60 22 16-20 1/0 1581/1200 Lungs CTA BD CVS RRR no m Abd NT ND NT Extr edema 293/9.7/17.3 (29.4) 146/114/31 (N) 3.4/25/.9 CTR BML infilt (1) Asp pneumonia w/ Resp failure (2) Leukocytosis both (3) Re-start Acetazolamide improving (4) h+/o tumor discontinued (5) Agitation — Dr. Ball orders megadose of Haldol for agitation but fails to renew antibiotics. - Trial of CPAP/BiPAP in AM - d/c Antibiotics - Trial of Scheduled Haldol - needs PICC line — PICC line placement ordered for TPN nutrition, but PA on call has no PICC line insertion experience. Procedure delayed until Monday! - Im-fus SON Ball

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

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

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

43

DATE	TIME	
3/16/03		CC meeting 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.

Dophoff 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
		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 Lines
		- TPN
		- Trial of CPAP/BiPAP
		- start lorazepam for agitation
		- Progress Summary
		- D/W Son & Dr. Nawaz & Nursing
		B-11

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER,
03/10/03
3127 NAW
I/P
1111 UNIV BLVD W.
SILVER SPRIN
301 649-1319

March 17, Monday

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

- Dr. Nawaz

DATE	TIME	
3/17/03		CC
10AM		Case discussed with Dr Nawaz. Patient doing well. No acute events. ? Holidays at EG - Tuesday, ? 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.
3/17		subj:
		• Doing fair, resting on vent
		o/s:- BP - 130/80 RR - 15. Temp - 107
		Gen:- 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 ? Soon to d/c ? off on XMT
		- Pic line under flow

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

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

03/10/03

DATE

DATE	
	PROCEDURE NOTE
3/17/03 11:15am	Double lumen PICC placed in (L) ~~[illegible]~~ brachial vein under US guidance to 49 cm. STAT PCXR ordered for PICC placement
	[signature]
3/17/03 1:40 P	Surgical PA
	PICC line Tip in SVC. will use for med - [illegible] have pulled line flushed. [signature] PA
3/18	[illegible] Pt lethargic but opens eyes to stimuli. [illegible] [illegible]
	K+ 3.1 Na+ 138 [illegible]
	Imp Asp pneumonia improving Neuropathy of critical illness ~~[illegible]~~ Dementia Rec [illegible] [illegible] [illegible] [illegible] speech path eval [signature]

March 18, Tuesday

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

- Dr. Nawaz

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

AEL 91Y
0900162
AHM
1111 UNIV BLVD W.
SILVER SPRIN
301 A10-1310

DATE	TIME	
3/18/03		meds:-

.. Pt been extubated.

VS:- 182/72. RR-26 HR- 82.

Chest :- B/L rhonchi

CVS :- S1 S2 heard.

Abd :- soft, non tender

Labs :- 138 | 104 | 17 (180 — 9.5 (316

3.1 | 28 | 0.6 — 17.17 — 29.0

7.51/33.8/74.4/96.2

AP :-

- Been extubated
- Groggy but opening eye & command.
- cont chest care
- xplain
- 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
2127 NAWAZ, AHM
O I/P 8155
111 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:- bibasilar rhonchi.
		Cvs:- RRR, S1S2
		abd:- Soft, nontender
		+ 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 Ab
		-. K+ will be replaced
3/20/03		Pt lethargic Afebrile No sig events
		Lytes stable Creat 0.5 WBC stable
		I=O WBC 20.5 N. +39 K=3.4
		ABG 66/34/7.52 - 35%

CONT

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 ① swallowing dysfunction / Zenker's ② Neurologically at baseline ③ Dementia Plan ① Consult ENT speech path eval PT OT TPN will eventually need PEG at some point
3/20/13		Pulm Pt lethargic but awakens after drink Very weak. Lungs c rare rhonchi clearing Eval c/s pneumonia swallowing dysfunction Dementia weakness failure to thrive Plan per family wishes will refer for PEG and home care Prognosis long term very grim Discussed prognosis

From Nurses Notes

50

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 10 of 17

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.
	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.
	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 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 --

Son wants aggressive treatment for his recovering father.

Patient apparently not terminally ill. Why was treatment withheld?

Unauthorized, expired DNR. Patient was Full Code.

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 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?

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 -, now responsive VS:- B.P.- 170/60 RR - 16, Hr - 82. Cont:- Bibasal rales Ab:- nl, and:- NT, normoactive Lab: 9.8 / 30.8 / 396 ; 138 / 3.6 / 104 / 28 / 24 / 0.7 / 196 -. Cont current management. -. failed swallowing eval. -. Q will take D/c Diamox for possible PEG.
3/20/03	CE	
AUSTIN	Patient seen for PEG -	
	PEG, RISKS/benefits discussed with SON. -	
	SON wishes to proceed tomorrow.	
	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
SILVER SPRIN
301 879-1310

DATE	TIME	
3/21		PCL Pt [illegible] Atelectasis [illegible] & ett ara check cir SS, Ett Tube JDC 20.4 No: 13Y Rf Appreciate neurosurgery, critical Mgmt - Progress very gra Re. PEC Transfer to step down enhance supportive R

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

NEUSTADTER, ISRAEL 91Y
03/10/03 03069900162
3127 NAWAZ, AHM
I/P 8155
11111 UNIV BLVD W
SILVER SPRIN
301 649-1319

DATE	TIME	
3/21/03		Procedure
	4PM	EGD / PEG

Large tumor prox Esoph / GES.
? Post Bulb Stricture N Obstructed duodenum.
No gastric outlet obst.
Right LES.

20 F Mic-O-Vasive PEG placed

Complete RME
Large dose Depo Medrol
Amp post pharynx.

Recommend Tube feed in AM.

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 55

DATE	TIME	
3/21/03		medo:-
		-. PT- is Dame.
		Ufs:- 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 discussed to incr
		-. tube ↑.
		3 3 A.Nawaz
3/22/03		medicine:-
		- Doing same. having eyecontact.
		following commands
		Ufs:- B.P- 120/70 RR-20 HR-90.
		Chest:- bibasalar roncchi.
		Cvs:- RRR. abd:- PEG tube in place.
		Ext:- ¢ c/c/c

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
		-. mild stmt TF.
		-. D/C TPN.
		-. Labs in AM.
		-. Tcc consult.
		A. Nawaz
3/24/03		OE
3pm		Pt sitting OK; ABG soft bugs. Will start tube feeds now.
		Resp status stable secretions w throat sensory problem. Continue TF ? oropharyngeal dysphagia and ? vocal cord dysfunction. 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.

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

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

Why was treatment withheld on March 25?

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 Accu-Chek: 135/8 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 to FIO2 for O2 sat > 92%. Agree with PT consult H. Feinstein - Monitor v.
3/23.		meds: - Pt is alert following commands VS:- B.P - 155/70 RR - 20 HR - 90 chest:- bibasilar rhonchi Cvs:- RRR, SEM heard. abd:- soft, nontend., Apr (.1610) 9.8 / 29.4 (4.90) 139 / 105 / 26 / 119 4.2 / 30 / 0.7 - Pneumonia - stable - cont suctioning - wbc ↓. - 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.

I/P 815510

111 UNIV BLVD W.

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

Why was treatment withheld on March 25?

DATE	TIME	
3/23/03 12 pm.		CC 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 for 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/m 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

HOLY CROSS HOSPITAL

PHYSICIAN PROGRESS NOTES

DATE	TIME	
3/24/03		meds :- -- Pts condition is same. VS:- 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

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).

From Nurses Notes

Holy Cross Hospital

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

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) Hx LFTs & alk Phosp.
		(5) HTN
		(6). Hx of Resp failure
		V/S - 142/67 99% pulse on TS/mist 98.2
		142 / 4.3 | 109 / 28 | 30 / 0.8 ↓ (18.1) | 10.3 / 32.1 | 525
		AST = (241) ↑ alk Phos = (623)
		ALT = (274) albumin = 23/5.9
		Cont RRR Sys Sx Ø Sz
		Chest: Bilateral Crackles
		Abd: PEG tube (+) BS
		Ext. Edema
		Dr. Shamim fails to renew antibiotics
		A/P. 1) Cont IV Abx
		2) ✓ U/S liver / gall bladder
		3) prognosis, guarded
		4) Placement → Rehab
		S. Shamim

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?

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 PULM BREATHING TENUOUS, ↓POX WHEN SON GAVE HIM ICE CHIPS
AFEBRILE HR 68-94 RR 20-26 BP 129/60 79/79 POX 92-94% 2L 1.7/1.5
SCATTERED RHONCHI THROUGHOUT CXR
BUN 30 WBC 18.1 H 9.2 A 87.2 L 7.2 A
PT REMAINS TENUOUS & SON REMAINS UNREALISTIC
NO NEW SUGGESTIONS

"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?

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

25 8:30 PM INTERN - MEDICINE X COVER.
PT 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. PT ALERT NONDIAPHORETIC WAS T&RR, HS TACHYCARDIC & MILDLY
STAT ABG 7.50/32.9/58.5/93% ON 100% NRB.
CONTACTED DR. SHAMIM AND DISCUSSED POSS. OF WITNESS ICU DR COVERING FOR DR. KARIYA WAS ALSO CONSULTED, AND AGREED AT THIS POINT WILL READDRESS CODE STATUS (2° TO POOR PROGNOSIS). WILL ALSO KEEP PT ON 100% NRB ON SUCTION PRN.

Never "expressed."
PT'S SON EXPRESSED HE DOES NOT WANT RE-INTUBATION

Stated repeatedly, resulting in resident's request to call rabbi.
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

PR

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.

DATE	TIME	
3/26	11AM	RWW

CALLED STAT TO SEE PT IN RESP DISTRESS BY SON.
TM100.3 HR95+11 R24-31 BP113/46 -/73/73 POX89-96% 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 NASAL
PUMPED) FOR MOD AMOUNT YELLOW GREEN TENACIOUS SECRETIONS
GLU147 NA148 CA8.5 WBC 37.6 HCT36 AST100 ALT164
IMP ① RWW HE WILL RECURRENTLY ASPIRATE AND IS SO WEAK HE CANNOT
CONTROL/ELIMINATE HIS SECRETIONS. ~~HIS IMPROVEMENT~~ ANY IMPROVEMENT
FROM A RESP STANDPOINT IS UNLIKELY 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 PRIOR ADVANCE DIRECTIVES, BUT HAS
(I THINK) ONLY CONSIDERED THEM IN THE ABSTRACT.

1 HR SPENT ON PT CARE
/S7

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? Were they rewritten to hide Dr. Weiner's presence on March 26 and to cover up the withholding of treatment?

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 95 100.4

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 - q 3h x 3
Call results to Dr. Weiner
or Dr. Steve Kariya (Start 3/26 3:15P)

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.

noted 3/26 3:15P

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

(1) CXR, CBC, CMP in am 3/27
(2) IVFT. DS. 4 1/2 NS @ 50cc/hr + 20 KCl

3/27

3/27

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

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

V.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
To: 27-Mar-2003 at 18:51

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.

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.

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.

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

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

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."

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

Refused what kind of treatment?
Without intubation what treatment was on the table?

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.

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.

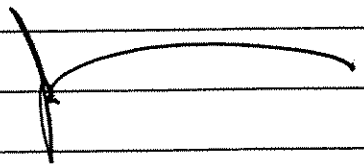
Falsified Record
Dr. Weiner writes, "Case discussed with son. He does not wish any other treatment (x-rays, vent etc.) He wishes to be alone with his father while he dies."

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 RUL

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.

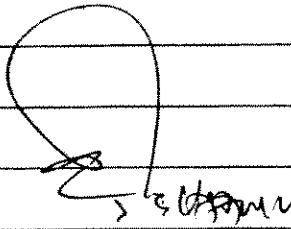
S: Appears in resp distress. Terminal
Above approached by Dr. Jay Weiner

O. V/S. 121 tachy 87/min R.R q8 15
Lungs tachy Resp Sx
Chest (R) Crackles
Abd. Soft NT.
Ext Edema

Labs

43	10.5 / 32.9	521	152	112	29
			4.0	28	1.0

A/P: 1) Terminal
2) Resp failure impending
3) IVF's / 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."

HC

ISRAEL

4-14-11

NSG.

DATE	TIME	
27-03	1200	Report received at 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 Postnatal care + Pt liaison 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 ~ the program.
	1300	In Room ~ assistant + Son Resisting at. for comfort Pt stated he was comfortable + inhibited ~ postnatal care JB.
	1400	Paged postnatal care + med Resident. Pt conh. Apneic + asystole (2-leads) Removed NRB + B/p cuff family @ bedside JB.
27	~~1420~~ 1420	Intern K-Correa Called to pronounce Pt at bedside. Pt 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

DATE ISSUED: March 31, 2003

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

Geneva G. Sparks
STATE REGISTRAR OF VITAL RECORDS

70

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

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+)	Woodworker	Lumber
	4		

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

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):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Respiratory Failure	
	Due to (or as a consequence of):	
	c. Dysphagia	
	Due to (or as a consequence of):	
	d. Dementia	

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)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one) 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.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
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

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

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.**

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

Division of Vital Records, P.O. Box 68760,

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
Unit #: 815510
Location: ICU ICU 07
Phys-Service: NAWAZ,AHMED-MEDICAL
Acct #: M0306900162

Adm: 03/10/03
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 Time: 0635	03/10 1204	Normal Range	
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
Unit #: 815510
Location: ICU ICU 07
Phys-Service: NAWAZ,AHMED-MEDICAL
Acct #: M0306900162

Hematology-Page 4
Adm: 03/10/03
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	03/18	Normal Range	
Time:	0405	0330		
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

Hematology-Page 2
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:	03/17	03/17	03/16	03/15	03/14		
Time:	0400	0400	0345	0345	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:	03/13	03/13	03/12	03/11	03/10		
Time:	2255	0640	0635	0635	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

****

CHEMISTRY PROFILES BLOOD

Date:	03/27	03/26	03/25	Normal Range	
Time:	0530	0650	0615		
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 Send Outs-Page 5
Med Rec #: 815510 Adm: 03/10/03
Dis Date 03/27/03
Phys-Service: NAWAZ,AHMED - MEDICAL

****

In: 03/24/03 0401 | PREALBUMIN(TRANSTHYRETIN) | Spec: Blood
Out: 03/26/03 0626 | Techs: V14166 T507
Coll Time: 03/24/03 0343
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
Unit #: 815510
Location: ICU ICU 07
Phys-Service: NAWAZ,AHMED-MEDICAL
Acct #: M0306900162

Adm: 03/10/03
Previous Accounts Included

****

B L O O D G A S

Date:	03/17	03/15	03/14	03/14	03/13	
Time:	0640	0633	1705	1317	1435	Normal Range
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	
Time:	1825	Normal Range
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	3/16/03

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
Joan A Boll	Joan A Boll	RN	

WHITE - CHART YELLOW - PHARMACY

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

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.

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.

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?

100

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.

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
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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

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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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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

These questions, along with annotated records, were left with Drs. Eig, Schwab, Sister Rachel and Caroline Williams on March 16, 2004. A couple of months later Dr. Eig provided the results of his peer review: "Although there are inconsistencies, the records describe adequate care given to your father."

My father was counting on me to protect him. He was healthy and he desperately wanted to live. Did I place him in jeopardy by taking him to a hospital that was certain he had come to die?

A little bit about my pops: He would get up each morning, shower and dress himself and come into the kitchen for coffee and cereal. I would leave him with a homecare assistant during the day, and she would walk with him around the parking lot of our apartment complex for exercise. If I would say "you're walking like an old man" he would sprint ahead and retort "Is this what you want?" My father lived to interact with people.

My father used a cane. He had mild dementia. In March '03 he couldn't have told you that we were about to go to war in a futile search for weapons of mass destruction, but he could have said "I can't sit anymore, let's go out," or "isn't it time for Synagogue?" or "I love you." He was very affectionate. He had a voracious appetite; definitely not "frail elderly." He was a non-smoker, no history of heart attack, stroke, cancer, diabetes or COPD. He had a 30-year-old Zenker's diverticulum which gave him no trouble. Did the doctors appreciate the quality and joy in his life, or was he just another 90+ year-old in a hospital gown lying on his back with pneumonia?

On the first day of my father's hospitalization the pulmonologist, Dr Weiner, asked me how long I thought people live. 2 ½ weeks later at my father's bedside he looked me in the eye and said that my father was "dead the day he got here," as he refused my impassioned plea for intubation (no record of him even seeing my father on that day). Was there a nexus between the two remarks? Should I be concerned that my father may have been written off from the start and treated accordingly? Did he get caught in a trap that even a young man might not pull out of?

More than three months after my father's "passing," a Discharge Summery was entered into his medical record. Had his treatment indeed been as depicted in this clumsily written document, might he still be walking around our apartment complex wearing his big smile?

WHERE WERE THE ANTIBIOTICS? WHERE WAS THE FOOD?

- I read that when treating pneumonia you "hit hard and fast:" The antibiotics must kill the bug quickly and completely, must not drive resistance and must not create the emergence of other pathogens; that underdosing is a significant risk factor for the development of resistance; that careful evaluation of the patient's response to therapy is essential. If there is no improvement within 72 hours you must suspect non-covered organisms, unusual pathogens, drug resistance or dosing error. Are these things true? If so, was my father's pneumonia treated in such a manner?

- The nurse's Kardex indicates that a daily dose of 500mg of the antibiotic Levaquin was given for the first 3 days, while the physician order forms indicate that 500mg was ordered for only one day before being cut to 250mg. Which is correct and what accounts for the discrepancy? Why was the dose *ever* cut to 250mg? Ortho-McNeil recommends 500mg for the treatment of CAP and 750mg for nosocomial or complicated CAP, with no dosage reduction required in the elderly or even in those with mild renal impairment. My father's white count improved from 40k to 20k within 16 hours of one 500mg dose of Levaquin. His bands quickly started reverting to normal - a positive prognostic indicator. It would be regrettable if the dosage was erroneously or negligently cut; in a prejudicial environment where a poor response will be used against him he could ill-afford such a mistake.

- Physician order forms show a 3-day gap in antibiotics, from March 17 to March 20. When one is hospitalized for pneumonia without concomitant illness, doesn't the focus have to remain on antibiotics and the patient's response? Did Dr. Weiner have the medical option of noting "failure to thrive, situation grim" on March 20 - ten days into the hospitalization, without re-assessing his treatment of the infectious disease? Wasn't he obligated to recognize *failure to thrive*, an unrelentingly high white count and copious secretions as signs of possible continuing infection?

- Why did a full week go by before my father received any nutritional support? Why did 58 hours elapse between his nutritional consult and the delivery of PPN? His prealbumin level went as low as 3.8 before PPN/TPN started; he was starving. It climbed to 7.5 on March 20 - when my father was sitting at the side of the bed, dangling his feet and doing physical therapy for 15 minutes. Is sitting up and doing physical therapy under such conditions consistent with *failure to thrive*?

- For 8 days after his extubation my father was breathing independently with no respiratory distress noted. Almost immediately after gastric feeding began on March 22, ever-increasing periods of alertness were documented. He was improving each day except for the WBC and the secretions. Wasn't it just a matter of time before resistant bacteria came roaring back with a vengeance?

DON'T ASK DON'T TELL DON'T TREAT

From the final Tuesday evening when my father suddenly went into respiratory distress, was there a tacit understanding among the doctors and staff that he was being "taken down" by withholding treatment because of his age? That intubation was to be avoided at all costs?

- Did Dr. Kariya have the legal option of noting on Tuesday, March 25, "breathing tenuous…son unrealistic, no new suggestions" without invoking the *Maryland Health Care Decisions Act* or informing me that intubation was medically necessary? Did he have the option of leaving my father in a life-threatening situation without offering medical assistance; without explaining what our choices were and soliciting my instructions; without so much as taking a blood test to check the white count? Was my father now somehow deemed unworthy of the treatment he needed and wanted? Is there any indication that I, God forbid, declined to have my father intubated?

- A resident I called in later Tuesday evening found my father to be in respiratory distress and in need of intubation. I told him he must intubate. Rabbi Anemer spoke with him and informed him that Jewish law mandated intubation. Did he have the option of leaving without doing so, giving my father oxygen instead? Is there any indication that I declined to have my father intubated?

- Did Dr. Kariya have the medical / legal option of noting on Wednesday morning, March 26, "Patient in respiratory distress…white count 37.6…I hope the patient's final days are peaceful as opposed to being suctioned/intubated" without informing me that intubation was necessary and without even revisiting the antibiotics? Is there any indication that I declined intubation?

- Did Drs. Weiner and Shamim have the option of refusing my direct request for intubation during their lengthy visit on Wednesday afternoon? Can such decisions be made absent any documentation? What was the purpose of changing one antibiotic Wednesday night at 10 pm?

- Why didn't the staff respond to my repeated calls to the nurse's station for help on Thursday morning? Didn't their telemetry display the same things Nomeda and I were witnessing – respiratory and sat rates both alarming -- my father choking to death?

WAS AN *AGE* TREATED RATHER THAN A PATIENT?

Did this dear father pay the ultimate price because a group of doctors led by a dogmatic pulmonologist decided they'd seen enough 90-year-olds on vents – ethical, religious and patient-specific considerations aside? Our faith teaches that a doctor is but an agent through whom God affects his cures, and who has no leeway to make godly decisions. As long as his patient is alive the doctor is obligated to do everything in his power for him. Why did the doctors dishonor this dignified and gentle man's deeply-held religious beliefs?

Are all patients equal in the eyes of Holy Cross Hospital? If Ronald Reagan had been admitted with pneumonia and Nancy Reagan requested that "everything" be done, would you have hesitated to do so, much less confront or deceive her? For all of Dr. Weiner and colleagues' professed desire not to cause suffering to a person who has lived a full life, shouldn't they stand up for their "principles" rather than hide behind falsified records?

Do my father's medical records appear accurate or logical? Would a son described as "deeply religious" and "unrealistic," and quoted as saying "my father was finally awake and hungry" refuse ventilation for a parent who was independent and healthy prior to hospitalization, had just received a peg tube and was last charted as "alert and oriented X2, resting comfortably, no respiratory distress noted"? Why is there no documentation of such refusal?

Did these arrogant doctors see a vulnerable son whose obstinance they resented and take advantage of him? Of much greater concern, is there a possibility that my father's illness was curable? Did their prejudice of ageism blind them to the basics of infectious disease management, condemning this robust man to certain death - by predictable bacterial resistance and callous refusal to treat?

Written when I arose from *Shiva* at the urging of friends who visited during the mourning period.

Background: In early February, 2003, Dr. Nawaz put my father on a trial of dyazide for better control of hypertension. On February 27 I took him to the doctor because he'd been feeling weak for a few days; less than normal energy & orientation and a cold. Dr. Nawaz ordered a stat BMP & CBC which showed my father to be hyponatremic (Sodium=125 Chloride=88) and revealed a WBC of 14.3 with left shift. Dr. Nawaz asked me to discontinue the dyazide but made no mention of the elevated WBC. One week later (March 5) a repeat BMP showed sodium and chloride back to normal range. No repeat CBC was ordered. When informed of the results by phone I told Dr. Nawaz that my father's weakness and cold were not improving; that he was not his usual self. (I recall his homecare assistant, Nomeda, postponing his haircut each day that week, telling me he was still sick.) Dr. Nawaz replied "Well, his sodium level has come back so everything is OK."

My father fell in the living room early **Friday morning (March 7)**. He suffered a bruise on his head and lip but appeared otherwise to be unhurt. (He didn't trip over anything, saying he just had a dizzy-spell.) Over the weekend he appeared to be even less energetic, able to complete only half his walk around the building on Sunday. That evening I found he was running a fever of 101.4.

He seemed himself again on **Monday (March 10)** morning taking his shower as usual, eating a normal breakfast and his temperature normal. As a precaution I decided I would take him to the doctor before I go to work. I would also take him to have his glasses adjusted. Dr. Nawaz checked my father's blood pressure and measured a systolic of around 65. He immediately called for an ambulance. He checked the BP with 2 other cuffs and found the pressure to be normal but was nevertheless concerned about the first reading. He advised me to let the ambulance take my father to the ER for an evaluation. I agreed.

At the ER I'm told by Dr. Chu that my father has a white count of 38,000, indicative of infection somewhere. Soon afterward I'm told he has pneumonia in the lower left lobe. I speak with Dr. Nawaz by phone. He explains that although he could release my father and treat him with oral antibiotics he'd strongly recommend that we keep him in the hospital for 24 hours so he can be given antibiotics by IV. I agree. A Foley catheter is inserted. I watch the nurses take blood culture tests. My father was moved to the 1st floor chest pain observation area as a holding place until a room would become available in approx. 6 hours.

He was first admitted to the 4th floor. His nurse was a lady named Ginta. A bag of levaquin 500 was hanging from his IV. When I entered the room I saw his hands were shaking and he had the chills. I had never seen him like this. He was in great pain. Something was wrong with the catheter area. The bladder was swollen and his naval hernia was bulging outward. Four nurses were standing over him looking and examining the bladder area. They were asking each other, "is that where his bladder would be or is that a hernia?" The problem subsided just as Dr. Nawaz came by. He ordered my father moved to the 6th floor where telemetry was available. My father missed dinner and had no food all day.

On **Tuesday Morning (March 11)** Dr. Nawaz says my father looks better and the white count is down to 20,000. The foley can be removed. Dr. Nawaz will come by later in the afternoon and will aim for an evening release. I leave my father with Nomeda to go home to bring some soup in a thermos. Almost as soon as I arrive Dr. Weiner calls and introduces himself. He asks if my father has an advance directive and inquires about my wishes re code and resuscitation. I tell him that we adhere to Orthodox Jewish law (*Halacha*) and that I hope to be taking him home that evening. He asks me what I'm talking about, saying my father is very sick. "He is septic and if the sepsis is refractory to treatment death is imminent," he tells me. "He may recover," he says, "but I've been doing this a long time. Let me ask you - how long do you think people live? How many 105-year-olds do you know? How many 100 year-olds? Have you ever asked yourself why?" I am simply stunned.

I drove to Dr Nawaz's office and asked that he call me ASAP. I went to the hospital and found Dr. Weiner at the nurse's station. He told me that people as old as my father usually don't overcome pneumonia. He asked me if I remembered the anthrax attacks. "We know that antibiotics kill anthrax, so why did so many people die anyway? Because it's not the bacteria, but the cascading sets of inflammatory and immune responses that once started cannot be overcome. If your father would be a tennis player or would jog 5 miles every day that would be different, but he isn't." I reiterate that my father is in very good health, and he says, "Let's see what the antibiotics will do. We'll know in a day or so."

Dr. Nawaz called me later in the afternoon and reassured me. He told me that Dr. Weiner was merely painting a worst-case scenario and not to worry. I should think of this as a wake-up call that my father is "not getting any younger." He would like to keep my father in the hospital another day. My father had a dinner of roast beef and mashed potatoes as my friend Gary was visiting.

Rabbi Anemer had suggested I call Dr. Chanales for a second opinion, and Dr. Chanales visits my father that evening. He tells me that if it were his dad he wouldn't put him on a ventilator should the need arise, although it's not a "totally unreasonable" thing to do." He says he has cases where he walks out of the hospital room shaking his head and wondering "what are they thinking?" My father's case is not like that, but still no rabbi should render an Halachic opinion without living with the family and witnessing the hardships that result. He observes that if I were to consult Rabbi Breitowitz I might get a different opinion than that of Rabbi Anemer.

My father's pulse O2 is in the upper 80's. He's put on "vapotherm," allowing 100% oxygen through a canula right after Dr. Chanales leaves. His O2 goes up to 92.

Wednesday morning (March 12): Dr. Nawaz visits. He shows me X-rays and says "let's give the pneumonia time to resolve." White count is 18,000. I watch Laura do physical therapy. She remarks on "how strong my father's legs are." At my suggestion they help my father off the bed to a portable toilet. I see how weak he has become. Dr. Schneider comes by to talk with me. He also recommends against intubation should it be needed. "Wasn't your father diagnosed with Alzheimer's?" he asks. "It usually doesn't have more than a 5-year course. Age itself is a major killer. I lost two people in the ER just last week. F___ Halacha. No, I take that back but if you put him on a respirator you'll be stuck halachically. Just promise me you'll know when to take him off."

Dr. Kariya introduces himself and talks with me about a peg tube for my father. I express surprise that he would need one; he's been eating and drinking with no problems. Dr. Kariya says "think about it, you don't have to make a decision yet." He suddenly changes the subject, telling me that his mother "died in the next room, no, it was two rooms down. It was so peaceful." This struck me as odd and out of place. In the evening Dr. Shah (a resident) put the Foley back in, saying it would help keep accurate track of urine flow. My father had no food this day other than a half can of Boost in the morning that a nutritionist watched him drink.

Thursday (March 13): Discussion in the morning with Dr. Weiner about respirators and Jewish law. Rabbi Anemer tells me to ask him if there is any unusual pain an elderly person would suffer as a result of intubation. Dr. Weiner replies that if you have to put an elderly person back on a respirator every 3 days until the end, then yes, there is more total pain for an elderly person. This does not satisfy Rabbi Anemer. I call Rabbi Anemer more than once going back and forth with Dr. Weiner. I ask Dr. Weiner if he would want to speak to Rabbi Anemer directly and he says no. My mind on this matter is completely made up. Even aside from Halacha it simply makes no sense not to aggressively treat a man who has no cardio-pulmonary disease or cancer, is ambulatory and very happy to be alive.

Dr. Shah wants a central line inserted for enzyme replenishment and faster administration of medication. He explains risks/benefits. (Risks = infection, bleeding) Says no discomfort is involved as Novocain is used. Female intern comes out of room and tells me "everything went fine, they're just cleaning up." I'm with Dr. Nawaz in hallway when Dr. Shah comes out and tells him "I couldn't get it in. Tried twice and didn't want to risk inserting a dirty line. He was moving around too much from the pain." I enter the room to find my father breathing heavily and his O2 level in the mid 80s. Dr. Nawaz tells me they will have to intubate soon. "It is time to make a decision," he says. I tell him the decision was already made. Denise walks in carrying a plastic tub and tells me and Nomeda "you'll have to leave." I ask her what she was going to do. "You said you wanted him intubated, didn't you?" she replies, with unmistakable annoyance. I suddenly feel a chill, realizing that she would have preferred my father die at that time. What kind of hospital is this?

Nomeda and I sit in the waiting area. Nomeda says to me "I take care of…I be with…many older people…but never like your father." They allow us into the ICU to see my father. He is resting very comfortably. What an amazing relief compared to the way he looked before the intubation.

When I get back to the ICU waiting area before the 6:00 pm visiting hours I meet med student Horde in the waiting area. He inquires of my wellbeing and tells me that without question I did the right thing to intubate my father. He says "if it were me who had the choice of suffering the way your father was suffering today or the way he is resting now I would take this without question. I want you to do something – when your father wakes up just whisper in his ear to breath with the machine – in, out. Don't fight the machine."

Once inside the ICU I see Dr. Kermaier and introduce myself. I tell him that my father is 91 years old and I put him on a respirator; I hope I did the right thing. He asks me why my father is here. "Did he have a stroke?" I say no. "How is his quality of life? Is he in a nursing home?" I answer no, explaining that while my father does have some dementia, he is happy, healthy and walks to shul with me on Shabbos. He gives me a puzzled look and says "well then I'm not sure what your question is." He peeks in on my father and says "he should have a *Refuah Shlaima*" (complete recovery.)

My colleagues Richard and Natalia come from work to visit me. While I'm talking with them in the waiting room ICU nurse Sue (wears long hair braid in front) comes over on her way out. She tells me she tried to insert NG tube but it would not go down. She is unwilling to try again. Tells me a GI consult is set up for Friday morning. My father is resting comfortably. He had no food on at all on Thursday.

Friday morning (March 14): When I arrived at the ICU I found Dr. Milton Koch already there to address the nutritional issue. He inquired as to the history of the Zenkers. I told him it was at least 25 years old and my father wasn't having trouble with it. Some swallowing difficulty that he started complaining about 2 years ago disappeared when he was put on prevacid. I asked him if he would try to insert the NG tube that the nurses were unable to. He refused, saying that there was nothing about his expertise that would allow him to be more successful. "The only way to insert the tube would be under X-ray guidance," he told me, "requiring a lot of expensive labor. It would take perhaps 6 people to vent him and get him down the elevator to radiology." He asked us (Ruthie & Nomeda were with me) to wait with my father while he goes to the nurse's station to write his orders. He would order a form of light nutrients through the regular IV line for now. No questions for him other than nutrition.

I walked over to Dr. Koch and related how some 8 years ago after doing an endoscopy to check for ulcers (dx helicobacter) Dr. Barry Rubin told me what a difficult time he had getting the scope down until he remembered about the Zenkers. Then he just guided the scope visually until he found the esophagus again. I asked him if perhaps he might use an endoscope to get the NG tube down. Dr. Koch replied, "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." His hostility was palpable. I felt a sudden chill as I looked at my father through the glass window with my friends near him. I was scared. What am I going to do now?

Friday afternoon I see Dr. Weiner in the waiting area where I am sitting with Nomeda and Katrine. I ask him how soon he would contemplate removing the tube. "Some time next week," he replied. "He's not ready yet. I know it when I see it and he's not there."

Right before Sabbath I return to the hospital to find my friend Hakki waiting for me, giving me encouragement. Later that evening my father is switched from propofol to atavan / morphine as needed. He begins to get restless and shift in the bed. Resident says they may extubate on Saturday then comes back and says "don't quote me on that. All decisions are made in conjunction with teaching staff." No food today, only sodium chloride drip. Nobody can answer me as to the plan for nutrition or why no nutrition has come today.

Saturday (March 15): I contact Dr. Ball (on-call pulmonologist with Weiner/Kariya group) in the morning to express concern about nutrition. My father hasn't had food since Tuesday. Ruthie walks to the hospital with me. Dr. Ball does rounds later in the afternoon. He tried to pass the NG tube without success and comes out to talk with me. He urges me to "keep focused on whole picture – pneumonia getting better; no fever; ordering light nutrients to be given through the regular IV tonight; he may be extubated soon, - so the trend is positive." Katrine and Ruthie are with me. Katrine asks Dr. Ball who I can count on to be my contact tomorrow. He says he will get back to me. I thank him but reiterate how aggravated I am about the nutrition. "Every little part of the picture adds to the overall outcome," I told him, "and you never know if getting real food sooner rather than later won't make the difference." Dr. Ball responds, "I can't disagree with you."

We meet evening nurse Luciana and I leave after 9:00 pm closing time. I just miss Anita & Ken who call me from their car and tell me that my father looks comfortable with 40% oxygen. No nutrition yet delivered! I try to reassure myself that the ICU staff and the doctors must know what they are doing.

Sunday morning (March 16): I call Luciana and ask about IV nutrition. She says it never came and she was concerned about that too. I contact Dr. Ray White at Bethesda Naval expressing my alarm about nutrition; no food at all since Tuesday evening dinner. He says he'll stop by soon and see what he can do. I find Dr. White in the room with my dad when I arrive at 7:20 am and he stays next to my father for 2 hours trying to pass an NG tube. Dr. Nawaz joins him. He comes out looking exhausted saying "It just wouldn't go. I'm convinced I got it past the pharynx but it just wouldn't go further. I hope you have a better day."

Later Sunday morning they try to insert the PICC line and fail. I'm told this will have to be attempted again tomorrow under ultrasound guidance; there is nobody on the weekend staff with that kind of experience. Later still they try to insert an NG tube under radiological guidance and fail. Sunday evening at 8:00 pm the light IV nutrition (PPN) Dr. Koch was talking about on Friday morning and Dr. Ball was telling me about on Saturday arrives and is hooked to the IV.

Monday (March 17): PICC line is successfully inserted under ultrasound guidance. Better TPN ordered for Monday night. Dr. Nawaz says white count is 17,000. Says X-rays look better. Respirator placed in passive mode for 5 hours. Dr. Weiner comes in late afternoon and says he will pull the tube. He raises his voice and wags his finger at me as he says "Remember what I told you: On again off again, on again off again, on again off again until you tell us to stop. Has he tried talking to you? Has he opened his eyes?" He waves his arm and walks to the nurse's desk.

I'm asked to step out and when I return my father is resting comfortably without the tube. PICC line TPN is started at 8:00 pm. I speak with Anita who tells me that in terms of nutrition TPN is as good as stomach feeding – so the nutritional issue has now been addressed.

It is Purim night and I run home to get my father's Megilla. I read it to him so loudly that the nurses close ICU-7's sliding glass door.

Tuesday (March 18): In morning phone conversation Ruthie suggests I find a new pulmonologist; a doctor that is not "hostile to the idea of my father recovering." In the ICU Dr. Nawaz is near my father who is sitting up in bed and looking all around the room. He tells him to "open your mouth" and sticks an object into his throat. My father lets out a yell and says "no!" Dr. Nawaz gently says "I'm sorry Mr. Neustadter, I was just testing your gag reflex. I won't do that again." Speech pathologist evaluates and says for now he cannot safely swallow food, but she shows me how I can wet his mouth and lips with a foam lollipop dipped in cold water.

On or about this day I started leaving messages to talk with IMCU / ICU head nurse Susan King. I wanted to tell her about Dr. Weiner and get her recommendation for another doctor. I also called customer relations and was put in touch with Carolyn Williams, who told me she would get back to meet with me to hear what happened.

My father is in a light sleep the rest of the day, but he mouths amen when I'm davening mincha.

Wednesday (March 19) around 9:00 am the door to the ICU is stuck in the open position and I witness my father sitting on the side of the bed (his face away from me, toward the window.) He is with Laura, the physical therapist. Sue (charge nurse that shift, has British accent) comes to the door and says "that's your father over there, sitting up. I have to tell you he's a lot stronger than I gave him credit for." [I remember this as occurring on Wednesday. Nurse's flowchart appears to indicate Thursday.]

I ask Sue if it would be possible for me to come in now just to see him and be with him. She leads me into Susan King's office where Susan explains the importance of ICU discipline. I tell her I understand, and would like to talk with her about another matter. She promises she'll get back to me within an hour.

I asked Laura what made her decide to get my father sitting up on the side. "He just looked like he wanted to get up," she said.

During the afternoon I bring Rabbi Kawior to see my father, who is now fast asleep.

Thursday (March 20): It was on or about Thursday morning that I go to the ER to ask Dr. White if he know of any pulmonologists who could replace Dr. Weiner. He gives me a few names. I call Dr. Ira Tauber from the Baha group and am told he is at the hospital on rounds and would be paged. I hear the overhead page. Dr. Nawaz is in the ICU and I inform him that I want Dr. Weiner replaced. I explain that I need a doctor who isn't "hostile to the idea of my father recovering," using Ruthie's words. He asks me to please not bring in another group because it will "sour the relationship." If I feel it is really necessary I should call Dr. Chanales back for another consultation, but not a new group. It will "sour the relationship" he repeated. "Look," he told me, "say what you will Dr. Weiner is a good doctor. He did exactly as you asked. He is treating your father as any pulmonologist would."

Dr. Alan Diamond comes late in the evening to evaluate for a peg tube. He examines my father and describes the procedure and its' risks; if he punctures the Zenkers the results will be catastrophic. I tell him I'm scared; what does he think? He replies "look around you. You've been here long enough to see that everyone in this room is pretty sick. But I've been watching you from a distance. You decided to

treat your father aggressively and it looks like he may have turned the corner. As I see it you now have two choices. You can either give him ice chips for comfort until the end or you do this surgery and continue the aggressive path." I sign the paperwork immediately.

I recall "getting into trouble" with charge nurse Ian for staying with my father past ICU hours. He told me early Friday morning that he had called security to come and escort me out just as I was leaving. He will be "reporting" me to Susan King.

Friday (March 21): My father is asleep all day. Katrine, Ruthie, Nomeda are with me in the waiting room late in the afternoon while the peg surgery takes place in the ICU. I stand against the wall saying Tehilim. Dr. Diamond comes out and tells me that it went very well. "The endoscope naturally went right into the Zenkers. I had to fiddle around a bit to find my way out but once I did the surgery was uneventful. I removed a huge chunk of matter from your father's Zenkers and he's in fact breathing easier than ever now." I thank Hashem. I wonder to myself why they couldn't try to pass the NG tube with the aid of an endoscope one week earlier. Eight extra days without food!

With an hour before Shabbos I ran home to shower and come back. My father's eyes are open the entire evening I am there with Katrine. I caress him and kiss him. He repeatedly brings my arm to him for a kiss. At the end of visiting hours I move away from his visual range so he should fall asleep.

Luciana is the overnight nurse. Katrine takes me to the Hecht Co to buy coffee for the ICU and chocolate for Luciana.

I walk to hospital early **Saturday (March 22)** morning and stay the entire day. My father is less alert, asleep most of the day but resting comfortably. Seems to me the bag of levaquin hasn't been changed in the past day or two, only the Rocephin. I realize however that I am not in the ICU for much of the day and night. Still, it looks like it hasn't been touched.

Day Nurse (Karen) tells me my father is to be transferred out of ICU to the regular floor. Toward the end of the afternoon Dr. Diamond comes to me in waiting room and tells me he is now starting the stomach feeding. Peg looks good.

Saturday night: Discharge from ICU to room 6107. It's around 10:00 pm. My father is asleep.

Sunday (March 23) morning: My father is a little bit alert and affectionate. Dr. Diamond comes in to examine him one last time. He shows me how to clean my father's mouth and gums; says it's important to keep mouth free of bacteria. He tells me if my father gets stronger he'd be happy to operate on the Zenkers and remove the peg. He recalls doing just that to a woman in her late 80s.

Soon after he leaves Dr. Nawaz comes in and sees my father awake and alert. He tells me he will be taking his son on a vacation this week so Monday will be the last day I will see him. Dr. Shamim will cover. He is putting in an order to evaluate my father for physical therapy on the top floor. If my father "passes inspection" Medicare will cover it. It will "buy him a great week here. Go up and take a look at the physical therapy unit. You'll be impressed."

My friends from work Bernie & Melissa visit around noontime and during their visit Anita walks in. She tries to talk to my father but he's sleeping and she has a hard time arousing him to look at her. She examines the peg and says it looks good.

Early Sunday evening my father wakes up and looks at me, touches me when suddenly his O2 goes from the upper 90's to the upper 80's. He's going back to sleep. As I call for help nurse Ron Gibbs comes

running in. Says he just happened to see and hear the pulse O2 alarming on the monitor at the nurse's station while he was getting history and came in to see what's wrong. He suctions my father and the sat rate goes right back up. He tells me it was a plug that just got in the way of his windpipe. He asks when my father was extubated. When he hears that it was 6 days ago he says there is an error in the history. He had it down as only 3 days – which would have put my father at great risk of needing reintubation. "I was about to call for an anesthesiologist. I'll correct the history."

When Ron comes back to the room I point out that my father has not received any levaquin today. He checks and says he has a call in to the nurse prior to the last one to find out if she gave it to him. He says "this wouldn't be the first time she's forgotten such things. By 8:00 pm he verifies with the pharmacy that they have an extra dose and he has the drug delivered. He tells me he will make note in his record that this med was given 6 hours late so that it is not administered too early on Monday.

Later Sunday night my father's bed is in the raised position. He is looking at me and kissing me when Dr. Heinz walks in. I tell my father "look, it's Dr. Heinz." She says hello to him and examines him with her stethoscope. When we go outside to the hallway I ask her how my father is doing. She says he's doing great. I tell her what Dr. Weiner said the previous Monday when he was extubated and how stunned and hurt I was. "Did he have a right to talk like that to me, in front of my father, no less? And look how he is defying Dr. Weiner's expectations." She replied, "I appreciate what you are telling me, but there is not much I can do. He is my boss." I told her I merely wished for her to listen and to be aware. She thanked me.

Monday (March 24) morning - Dr. Nawaz's last day before vacation. He finds my father awake and responsive to him. He tells me that two liver numbers are very high. It may be indicative of liver failure but more likely is a reaction the the TPN or the Haldol. He is withholding haldol now and will schedule an ultrasound of the gallbladder STAT. As he is leaving the room I start to tell Dr. Nawaz about my father not getting the antibiotic yesterday. He says "yeah, I think he's only getting one now, which is more than enough." I go out to the nurse's station where he is busy writing and when he looks up at me I say "I'm worried about the white count. If it were my father I'd be breaking out the vanco right about now." He laughs and says, "Well I disagree. He's getting a broad spectrum antibiotic that covers everything that's out there."

Later Dr. Kariya visits. I tell him about the 02 going into the 80's briefly on Sunday night before Ron suctioned my father. Dr. Kariya tells me not to worry, recalling a recent mountain-climbing trip where he took a pulse oximeter along and found that in the thin air his 02 level would occasionally go into the low 80's with no ill-effect. I feel relieved. A few hours later I see Dr. Kariya in the hallway. I ask him if he can order more frequent respiratory therapy, perhaps every 4 hours. He says to me "you know, to the patient, each time you suction it feels like choking. It's torture. At some point you have to ask yourself if you are doing it for his benefit or for yours."

My friend Natalia visits. As she sits with me a man with a waxing machine enters the room. The room fills with a cloud of dust and we all start coughing. Natalia asks him in Spanish if he could please stop.

As the day goes by each nurse has something different to say about the ultrasound test, one saying she sees nothing on record, another that's its non-emergent so my father is in the queue, still another tells me it's scheduled for tomorrow morning.

Monday late afternoon my father wakes up a bit. He is awake for a few hours. I notice the infuser dispensing the rocephin was not moving. There were no alarms but it was frozen in place. The nurse came in and started to remove the IV when I pointed out that it was still ¾ full. I suggested to her that the batteries probably were dead. She tried to figure out how to open it and replace the batteries. She left it

on my father's lap while she went to look for another infuser. She came back saying that the office in charge of this was already closed. This medication can be given "bolus," pushed very slowly every few minutes. I left for about 10 minutes and when I returned the syringe was gone.

I recall feeling very uneasy. Should I believe that I was just fortunate to be around the two times there were antibiotic delivery problems, or should I extrapolate and wonder how many times these kinds of things happened when I wasn't there.

[On either Monday or Tuesday morning I asked my father's nurse if she gave him his heparin injection. She said it was not on the computerized list of medications that she was responsible for. She could not tell me anything else. I went and inquired of the charge nurse and a few minutes later my father received the injection.]

Later in the evening a respiratory tech named Henry came in to do suctioning. I sat outside the room in the hallway feeling very downcast. As Henry came out he asked me if I was alright. I nodded as he continued, "you know your father can pull through this. He has a strong cough. He's doing 70 percent of the work bringing up his secretions; I'm just suctioning from the very top." I told him I heard suctioning felt like chocking to the patient and Henry vigorously disagreed. "I've been doing this since the Vietnam War," he told me, "and I can tell how a patient feels by his reaction. Your father actually appreciates having his airways cleared and being able to immediately breathe easier. You can just feel how relieved he is." Henry continued, "If I didn't think your father could pull through I would have just told you that I'm finished and you can go back in. Believe me, he can pull through."

Henry tells me he was on the team that took my father down to X-ray 8 days ago when they tried to insert the NG tube and failed. "You moved things up 48-hours by calling Dr. White in and insisting that the PICC line and NG attempts be made on Sunday," he said. "You can't be serious," I replied, and he said he was. "If not for your actions your father wouldn't have had his PICC line until Wednesday."

Tuesday (March 25) early in the morning I see Jorde at the nurse's station. I tell him that I am worried about the continued high white count and the antibiotics. "Why don't they just give him some vanco already and get it over with. What are they waiting for?" Horde replies that you can't use vancomycin indiscriminately; doing so can do more harm than good. "Harm to society or to my father?" I ask. He acknowledges my point but says that vancomycin can actually harm my father if it is not appropriate to the bacteria he has. He thinks that my father is on the other teaching team and if so I can be assured that each day the nature of the bacteria is assessed and the antibiotics adjusted accordingly.

I leave to pick up Nomeda and bring her to the hospital. I just have a good feeling about today. It is a warm day and I play music in the car. I tell Nomeda "today will be a good day. You'll see."

Back at the hospital I speak with charge nurse Darlene about the ultrasound test that was to be done yesterday. She checks and says there is no record of any order for a test. She has a call in to Dr. Riar & Shamim's office. Dr. Riar will look into the matter and get back with her.

Quite suddenly around 10:00 am my father's eyes open and he starts talking and moving his arms. He has not been this awake since he sat up in the ICU last week. He is asking questions (where am I, why am I here) and gently humming. He is smiling and affectionate. Nomeda and I take turns leaning over to him and engaging him. Now he is not falling back asleep or getting groggy. He is wide awake. His speech is very soft. He asks when he will be discharged to go home. Can we make it to the Mincha prayer? I am translating the Yiddish for Nomeda. My father says "I am so thirsty. Give me something to drink. Give me something to eat. If you don't give me something to eat you're killing me."

The stomach feeding had been stopped from noon in preparation for the ultrasound test now scheduled for 4:00.

I got an apple juice with ice and dipped a foam lollipop into it for my father to suck. (We'd been doing this with apple juice or water for the past few days, always wringing out the foam before putting it to his lips or his tongue.) Now my father was sucking for dear life. He was pulling so hard on the lollipop we had difficulty getting it out. I would say "open up so I can get you more." Nomeda and I took turns giving my father these lollipops.

During the afternoon I call Dr. Shamim's office to inquire (and request if needed) that my father is assigned to a teaching team. Mrs. Altschuler answers. She wants me to know that she & Dr. Altschuler visited my father the previous week. I tell her that my father is awake and talking and she says that is a very good sign.

Caroline Williams came in to see me about my complaint regarding Dr. Weiner. We met in a room across from Susan King's office. She takes detailed notes as I describe the way Dr. Weiner screamed at me and waved his finger. She tells me such behavior is unacceptable and will be investigated. I will hear back from her within 30 days. I tell her how relieved I am that my father is finally on the road to recovery.

Dr. Shamim walks into the room to examine my father and is very surprised to see him this awake. I introduce him to my father, and demonstrate to him how my father is sucking. "Oh good," he says, "He's swallowing." My father is put on a gurney to go down for the ultrasound. Dr. Shamim rides in the same elevator and says goodbye to him. My father smiles at me and talks throughout the test.

Nomeda waits outside while the ultrasound is done. Afterward we go back to the room, put my father back in his bed and Nomeda is ready to leave for the day. I apologize for not being able to take her to the metro, but won't leave my father even for a few minutes now that he is awake.

Very suddenly my father's breathing becomes rapid and he is fighting for air. I call for help. First the nurses increase the airflow to his canula and soon they give him a mask. Dr. Kariya comes in for his rounds. I tell him what happened and he listens to my father's lungs and quickly goes out to the nurse's station. After a few minutes I go out to look for him and a nurse tells me he is gone. "Wasn't he in to see your father?" she asks? An x-ray is taken. The nurse tells me it shows "aspiration pneumonia."

My father is still awake and pulling the mask off every few seconds. I gently hold his hands and kiss them and tell him that he has to keep the mask on. I move back to watch him. He pulls the mask off. As I come toward him he looks straight at me and screams in pure anger, "Gey Avek. Avek!!" Sleep takes hold and my father is never to wake up again.

I see his sat levels going into the upper and even middle 80s. I see nobody in the hallway or the nurse's station to ask for help. I go into the waiting room to call Anita and ask for her advice when I see a young resident getting into the elevator. I stop him and tell him I need his help. I ask him to come into my father's room. Dr. Al-Quatami follows me in, looks at my father and quickly says "he needs to be intubated." I ask if they can try suctioning him first, explaining how good things had been all day. He replies that he will call respiratory but that suctioning is not going to help. He runs out to the nurse's station while I stay with my father.

Dr. Al-Quatami comes back in and tells me that in looking through the record he sees reluctance on the part of the doctors to intubate my father because of his age. "We know from experience that older people don't do very well on the respirator. It is also a very uncomfortable procedure. Do you know that even when you stick someone over and over with a needle to draw blood you are hurting them. If I were to tell

you that intubating him would only prolong the inevitable would you still want it done?" I recall thinking about the utter ridiculousness of his remark about needles as I explained to him that there is no certainty at all that this is a hopeless situation. "My father was walking around our apartment buildings 2 weeks ago," I told him. "He comes here with no co-morbidities, a healthy heart and lungs. He deserves the benefit of any doubt." I contrasted it with my mother who passed away of lung cancer where I did not request a respirator or CPR. "Even more importantly," I tell him, "I am my father's advocate and he would want to follow Jewish Halacha. He has complete faith in the guidance he receives from his Rabbi, who made himself very clear on the matter." Dr. Al-Quatami asks "If I show you the records and the doctors' opinions about this would it change your mind?" I say no!

He asks if he might talk with the Rabbi about this, and I give him Rabbi Anemer's number, relieved to be over this hurdle. I thank him for all he has done for us, noting that I pulled him out of an elevator and he came to our rescue. "This white coat obligates me to help anyone anytime," he replies, "even someone in the street." He leaves the room and a female respiratory tech begins suctioning my father. His rough breathing doesn't change but the tech says she suctioned out quite a bit. Dr. Al-Quatami returns and says "Your Rabbi doesn't want to budge. We're gonna need to intubate." I reply "ok, do it."

My father's mask is replaced with a 100 % oxygen mask (this mask has a plastic air-filled bag under the part that fits over the nose and mouth) and his breathing immediately becomes easier. He is in a peaceful sleep and I am staying by his side and holding his hand waiting for the doctor to return. A nurse soon comes in and replaces the mask with his previous mask. His respiration and heart rate immediately go up. His breathing is labored. I go out into the hallway asking for Dr. Al-Qatami. I'm told he is on another floor. I reach him on the phone and ask what became of the intubation. "It won't happen tonight," he replied. "The situation is under control and we're keeping a close watch. We have your father on oxygen and his breathing is better." I pointed out that since they switched masks this wasn't the case any longer; now his breathing is labored once again. "We can't keep him on 100% O2 for very long," he tells me, "his respiratory muscles will become accustomed to it. They have to be kept working." I go home exhausted, gratified that we apparently dodged the intubation bullet and that the hospital is on top of the situation. I was very worried though; I knew we're in trouble.

Early **Wednesday (March 26)** morning I come in to find my father in the same condition - rapid breathing and heart rate, but now with the 100% mask. A respiratory tech comes to give inhalation treatment. I ask for suctioning but am told that it is only done when the tech hears impaired breathing that can benefit from suctioning. Nomeda comes in and is shocked at what she finds. Soon Ruthie is there too. I spot Dr. Kariya at the nurse's station and I tell him "my father is in big trouble and no one wants to help him." "I agree with the first part of your statement," he replies, "but not with the second." He gets up and goes straight into my father's room. As Ruthie watches he asks me to help him turn my father to his side. He explains that he wants the fluid in the lungs to drain in that direction. He listens to my father's chest very carefully. I tell him how well my father was doing before it all suddenly collapsed. "You are wondering why he is suddenly doing so poorly," he observes. "I was wondering all this time why he was doing so well."

Dr. Kariya begins to suction my father. I am across the bed watching. As the secretions come up he mutters to himself "I can't believe he's still infected after all that antibiotic." I tell him that as my father was pulling off his mask last night he pushed me away screaming "go away." Those were his last words to me. Dr. Kariya asks "Do you think that he may have been angry at you for trying to keep him alive?" I shake my head in disbelief at the disconnect between the reality of what happened (the new mask was simply annoying my father) and what this man was thinking. He makes a point to explain the rationale for having my father turned on his side to Ruthie and then walks out of the room with me. At the nurse's station he asks if I have funeral arrangements in place. He says he didn't want to ask me this in front of

my father. I tell him I do but that I'm not hoping for a funeral. I ask about the liver enzyme numbers and he tells me they are coming back down to normal.

[Rabbi Koss came in and spoke with me briefly while Dr. Kariya was suctioning my father.]

My father's heart and respiratory rates continue to clime throughout the day (HR 110-120, RR 38-44) but his pulse 02 levels are in the mid 90s. Finally after a few hours I figure it out; indeed his O2 sat rate is high but he's paying a terrible price for it. He needs to be intubated and they're not doing it!

Just then Dr. Shamim walks in and appears as surprised as Nomeda was to see the condition my father is in. He asks me what happened and I fill him in. I point to the monitor and ask him "how much longer can a heart beat like that? I think my father needs to be intubated." Dr. Shamim replies, "I think you're right. If his heart keeps beating this fast it's going to 'get tired.' He should be intubated. I'm going to call a pulmonologist." (A sick feeling comes over me as I realize this probably should have been done a long time ago – but help is finally at hand.)

He comes back a moment later with Dr. Weiner. "Why do you want to intubate him?" Dr. Weiner asks. "I thought you said you were just gonna do this once." I tell him he has to help my father. "He was getting better and I did this to him," I said. He asks what I'm talking about and I explain that I very likely caused my father to aspirate by giving him lollipops to suck on. "It would have happened anyway," he replied, "if not today then next week." He orders a blood gas test. The lady who draws the blood is wearing a scarf or headcovering. As she leaves Dr. Weiner waves his hand toward my father and remarks "I would never do this to my parent."

I told him how important Jewish Halacha is to my father; the esteem in which he holds Rabbi Anemer and Rabbi Anemer holds him. I told him that the Rabbi is reluctant to even enter an ICU because he is a Kohen, yet he came to see my father. "I thought a Mikva takes care of that sort of thing," Dr. Weiner replied.

He asks me, "Hasn't everything I said come true? Remember when I told you on again- off again, on again-off again? Remember when I asked you how many 105-year-olds you know, how many 100-year-olds you know?" I interrupt him to point out that he predicted my father would be on and off a respirator every 3 days; he was extubated 9 days ago, and... "Makes no difference," Dr. Weiner replies. "I'm sure you realize now it's not possible that Dr. Nawaz could have told you he'll let him go home the next day."

He is standing on the side of the bed near the window. I am across from him and Dr. Shamim is at my father's feet. I say to Dr. Weiner "my father looked so good yesterday. He was awake and talking - tell him, Dr. Shamim." Dr. Shamim is silent as Dr. Weiner rips into me: "Let's make sure we understand this. Your father looked good? *You* look 'okay.' I'm 53 years old. *I* look 'okay.' Your father doesn't look 'okay' and he certainly never looked good." I reply that 2 weeks ago he was walking outside in circles around our apartment complex. "I did this to him by giving him too much liquid yesterday." Dr. Weiner walks around the bed to my side and says: "If you take one thing away from this it should be that you did nothing to hurt your father. He was dead the day he got here."

The lady comes back in with the blood gas results. The numbers are handwritten on an envelope or piece of paper that she holds up to him. Dr. Weiner tells her "We're not going to intubate." I say to him "Doctor, if there is even the slightest chance of survival we have to give my father that chance." He replies, "Don't you hear what I'm telling you? Zero. His chances are zero. His life as you knew it is over. His condition makes him incapable of life off of a machine. Zero."

He walks back toward the window. I tell him “I want him intubated.” He responds, “Mr. Neustadter, intubation is a very dangerous procedure. We don’t just intubate anytime someone asks; something can go wrong.” (Even as I sense condescension in the tone of his voice and his choice of words I still accept what he says medically, having never met a doctor who would purposely mislead a patient.) He turns to Dr. Shamim and says something I couldn't quite make out, and ends with "in any case he’ll be dead within the next 3 days.” As the two doctors walk out of the room together Dr. Weiner stops for a moment near the door, turns back to me and asks “How can you say he was walking around the building? He could barely move.”

I stay with my father and pray. I don't really understand. Did my father get too sick too quickly to even risk an intubation? What happened? Do the blood gas numbers have to fall below a certain level before an intubation is mandated? Two weeks ago they only intubated when his pulse O2 fell into the mid 80s; now it’s still in the 90s. Was the prognosis as poor from the start as Dr. Weiner just depicted? From my perspective he was certainly getting better over the past few days. I remember Dr. Chanales telling me that Weiner is a very good doctor but with a reputation for being “a little rough around the edges.” All this time were the doctors seeing something that I was unable to see? I don't know how we got "from there to here" so fast, when things looked so good to me just yesterday - but if they can't intubate it's all over, isn't it?

I went into the hallway and called (or took a call from) Rabbi Anemer. I told him how bad the situation was. I remember relating to him how Dr. Weiner said “I would never do this to my parents” and Rabbi Anemer replied, “Well, we know that. Of course he wouldn’t.” I told Rabbi Anemer that I heard Dr. Weiner say my father would be dead within 3 days no matter what. He said “nu, baruch hashem" (thank God he won't have to suffer too much longer.)

Ruthie came to the hospital toward the evening and stayed for a few hours. At one point my father’s pulse O2 went down to the upper 80’s and I called the nurse into the room. She left and soon came back with 3 or 4 people including lady with the headcovering who had taken the blood gas test earlier. She asked us if we could wait outside while they attended to my father. “We want to try to see what we can do to avoid having to intubate,” she said. I waited in the hallway with Ruthie. While waiting I called Anita and updated her on what was happening and how they were repositioning my father. (She recalls my telling her that I couldn't find anyone who was willing to intubate but that I was still hopeful I'd get someone to do it.) She gave me encouragement but asked no specific questions. “Hang in there," she advised, "Just go with the flow. They know what they're doing, let them do their job.”

The people leave my father’s room and the lady comes over to me and Ruthie and informs us that his oxygen level is now back to around 96. “We have him positioned just the way we want him,” she says. “Be careful not to move him or change the position of the bed.” This reinforces my view that they are trying everything to avoid a much-too-risky intubation. In other words, they are treating my father as best they can. I also began to understand that it looks terminal. They’re just waiting for something to happen because there is nothing else they can do.

Ruthie leaves and I stay with my father. Sometime after 10:00 pm two technicians come in to do an EKG. I lower the bed to the flat position and my father’s heart rate on the monitor goes down to the upper 40’s and 50’s. He starts shaking. I run to the bed and raise it again. He stabilizes. The techs are angry. They tell me they can’t take an EKG this way. I tell them yes, but look what happened to his heart rate; look how he was shaking. One tech says to the other. “I will tell the nurse that the family is interfering with the test.” Turns to me and says, “Sir, we just want to do the test real quickly. It is normal for a 91 year old to shake.” They straightened the bed out again with the same result but they did the test quickly and put the bed up again.

I never felt more alone in my life. It was around 11:00 pm and I asked to speak with a resident. An Asian lady came to see me. I asked her if it was "safe" for me to go home or might something happen. She looked at my father, asked how long he had been this way and told me that nothing was likely to happen but if anything did she would call me at once.

Thursday morning (March 27) I was back around 4:30 am. As I get out of the elevator on the 6th floor I see one of the respiratory techs from late last night. He tells me my father was fine all night. I go into the room to find him completely naked, shivering. His heart rate is 140 and his RR is in the 40's. His nurse comes in and tells me she has him uncovered to try to break the fever. "I know it looks cruel but it is for his benefit. We'll cover him soon." [I went down to the ER to speak with Dr. White. He advised me to go hold my father hand...] I hold my father's hand and don't let go. At 7:30 am Nomeda walks in. She stays at my father's feet. My father's face looks hollow, sunken in. His pillowcase is wet from sweat. I call for a respiratory tech to see if they can suction my father. The tech tells me that there is nothing to suction, the secretions are too deep down in the lungs.

I recall telling myself that precisely because I caused my father to be in the situation he is in now I will be tempted to order CPR when his heart stops. I know CPR entails ventilation. It would be ill advised to condemn him to spend the rest of his life on a vent with no chance of recovery to lessen my guilt. That would be the worst thing I could do and I should fight the temptation no matter how strong.

I spread a Talis (prayer shawl) over my father's lap and make a blessing on his Tflillin (Phylacteries.) I bring them to his lips and say "you're going to have one more Mitzvah" (fulfill one more commandment.)

Suddenly at exactly 8:50 am my father's breathing seems to collapse. The respiration rate drops from the 40s to single digits. The heart rate goes down to 89. My father is gasping for air. I will never forget the sound. His pulse O2 is now in the lower 70s. I am frozen in place, thinking his heart is going to stop. If this is Hashem's will I accept it. Nomeda asks me if she should go out and call for a nurse. I tell her not to leave me. I press the call button and tell them my father is having trouble breathing. Please come! A voice responds "we'll be in right away."

My father's left eye is tearing and the right eye lower lid is curling up and pink. I am holding his hand and pressing the call button again asking for someone to come in at once. Again they reply that someone will be in. I am now in total disbelief at what is happening. His heart has clearly not stopped and I fear we've passed the threshold for certain brain damage. I'm expecting someone to come through the door any moment. Will they offer to intubate him now or is it too late? Why didn't I run into the hallway the minute this happened?

At 9:50 am, exactly one hour later, x-ray comes in for a picture. I say to the two technicians "look at him!" They go back out and a moment later I hear Denise's voice in the hallway: "He's refusing an x-ray? Ok, just remove the entry from the computer; we're not playing games today." I am astonished at those words and I fear my father is now in a situation with no way out. "Unbelievable," I'm thinking to myself as I'm holding his hand, keeping my eyes closed and praying . I look up and Dr. Weiner is at the bedside, our positions exactly reversed from the night before. It is precisely 10:00 am. He asks simply, "What do you want me to do?" (What kind of a question is that? I told him what to do last night!) At once I understand that games are indeed being played and that the medical personnel around me simply didn't want to treat my father. Dr. Weiner refused my pleas last night when I was alone, but he is now asking for my guidance in the light-of-day to cover himself as people surround him and after my father has been deprived of oxygen for over an hour! "I want you to please leave the room," I tell him. My thoughts at that moment are that he is not worthy of being in the same room as my father.

Dr. Weiner quickly escorts everyone out. "The son wishes to be alone with his father." Within a minute Denise and my father's nurse Elaine come in asking if I want further treatment. I say no. A moment later Elaine again returns and starts explaining DNR to me. I tell her that I need to speak to Dr. Weiner at once. We did not have a conversation about what happened to my father and what options are still available now. I need to talk to him. She runs out and quickly comes back to tell me that he is just outside the room on the hallway phone. I go out and approach him, sticking my arm out to get his attention. He glances up at me and quickly averts his gaze, looking down at his shoes as he is talking. I am a foot away, saying "excuse me!" and he ignores me. I go back into the room and tell the nurse and Nomeda that the doctor won't get off the phone to talk to me. I ask Nomeda to let me know as soon as he is off the phone. Five minutes later she comes back and says he's still out there. I have Nomeda hold my father's hand as I go back out. Dr. Weiner is still on the phone and I approach him once again and stick my hand in front of his face. He still doesn't acknowledge, looking purposefully downward. Again I am only about a foot away. I can hear the conversation he is having: "He says he's not HIV positive but I don't believe him. If I don't hear anything by tomorrow I'll just admit him."

I go back into the room and again tell Nomeda and Elaine that the doctor won't talk to me. Nomeda goes back outside. Moments later she returns and says that Dr. Weiner is now in the next room seeing a patient. I tell Elaine to please get him in. She comes back in a few minutes and says Dr. Weiner has now left the floor. I ask to see any other pulmonologist quickly. I ask that Dr. Weiner be paged. Caroline Williams comes into the room along with a lady who identified herself as being with management. She later tells me that she's a doctor. I told them what happened and that I needed to speak to a pulmonologist – any pulmonologist. Chaplin Susan Mitchell comes in and I relate everything to her. They appear to be trying to honor my request to speak to a pulmonologist but it never happens.

Elaine asks me if I would like my father to receive morphine for his pain. This is the first moment I become fully aware that my father may have been choking all this time and could be in indescribable agony. It takes over 30 minutes for them to get it. "Where is the morphine?" I keep asking. My father's new nurse, Jim, introduces himself. Another lady comes in to explain the hospice program. They will move my father to a facility where he will be given medication for pain but no life-prolonging treatment. I ask the lady how long my father will be in this condition. She says it can last for many days. I marvel at the ignorance, each staffer practicing her specialty and all of them clueless. Can't they tell by looking at him that he is near death? Yet the system grinds on.

Dr. Shamim visits sometime after noon and examines my father. He says the breathing is very shallow and it won't be much longer. He expresses his condolences. I recall repeating to the people in the room more than once that I needed to speak to Dr. Weiner when he was on the phone and he wouldn't talk to me. The lady who identified herself as being from management explained to me that doctors have a habit of focusing intensely on whatever medical conversation they are having. He probably didn't even notice me. Susan Mitchell remarks on how I was very attached to my father and this was just a "tough case" from the start. It is as though she is summing things up to herself.

At 1:40 pm my father's breathing stopped and the heart monitor alarmed and went to zero. Only Nomeda was in the room with me at that time. She came over and hugged me as I held onto my father's hand. Soon Jim came in, listened with his stethoscope and said "I believe he has passed."

He left the room and some 15 minutes later charge nurse Denise walks in and asks if I would like them to inject chemicals to try to revive my father. I just look straight into her eyes in silence – still holding my father's hand. She repeats the question and I just stare at her. She turns to Nomeda and asks "does he understand me?" Nomeda says yes and walks Denise to the door. I recall thinking to myself: "I don't believe any of this. Nobody else will either."

When I requested the medical records from Holy Cross in April, Lorna from the records office informed me that they were not complete because the discharge summary had not been received. Doctors have 30 days in which to complete this report. When it was still not submitted on May 6, 2003 the records were released to me and marked “incomplete.”

Doctor Nawaz finally dictated the report on June 19, 2003. The records office declined to provide it to me at the time because their policy is not to release reports prior to review and signature.

The report was redictated on June 25, 2003, and on July 2, 2003 Ileana of the records office informed me that the signed report was now waiting for me to pick up. She told me that Dr. Nawaz had been placed on suspension that week for failing to file the report.

I walked in around 5:30 pm and the receptionist went to get the report. Moments later I saw Dr. Nawaz eyeing me from the back of the office. He came over and expressed his condolences saying he didn’t have a chance to call me. He asked me if there was anything he could do. I told him that I was deeply concerned about a number of things. Before I could finish my sentence he simply turned away and walked back into the records area. He went to a cubicle where he was working on my father’s chart. I told records officer Nancy Gross that I was here to pick up the report that Ileana said was waiting for me. Dr. Nawaz replied from behind his cubicle “I have it right here. I’m not touching that one, I’m correcting an earlier report.” He then got up and walked by me without saying a word.

Nancy Gross provided me with the discharge summary as well as the earlier version that was stricken.

Was Medical Standard of Care Breached?

1. After being placed on dyazide for 3 weeks by admitting physician patient felt ill. A stat BMP & CBC on Feb 27 showed hyponatremia (sodium=125) and leukocytosis (WBC=14.3 w/left shift.) Dyazide was held but white count results were overlooked. Dyazide, a diuretic, is associated with leukopenia. A leukocytosis of 14.3 with left-shift in the presence of hyponatremia mandates antibiotic treatment or at least follow-up. The patient's life depends on it.

2. 1 week later a repeat BMP was done but no follow-up CBC. Physician is informed that patient still symptomatic but takes no action. Patient presents in ER 5 days later with a WBC of 38,000, sinusitis, sepsis, atypical pneumonia.

3. Admitting physician's orders cut Levaquin to 250 mg after one dose but nurse's notes show 500 mg for 3 doses. Patient response from day 2 > seems consistent with lowered dose. Any dosage reduction is unwarranted.

4. Hospital appears to ignore warning signs of continuing infection. WBC allowed to hover at 20,000 indefinitely. Copious secretions arouse no concern. Antibiotic treatment never reassessed. 3-day gap in antibiotic orders.

5. Hospital fails to address nutritional issue in a timely manner. 1 full week elapses w/o nutrition. 58 hours elapse from nutrutional consult to PPN delivery due to error. Prealbumin sinks to 3.8 (reference = 20-40) indicative of starvation.

6. No attempt to address Zenkers Diverticulum - the underlying, longstanding deformity preventing insertion of NG tube and suspected of causing aspiration. It can be repaired endoscopically or with low-risk surgery. No attempt to perform temporary tracheotomy to protect airway. Patient in otherwise excellent health, excellent quality of life.

7. When patient suddenly develops respiratory distress after breathing independently for eight days (receiving peg tube and becoming alert during this time) doctors fail to provide life-sustaining treatment and fail to inform family that patient requires such treatment. The following day they deny family's direct request for intubation saying unequivocally that it cannot be done. Patient succumbs to respiratory distress a day later after pulmonologist refuses to talk with family and hospital fails to secure another doctor. Patient was full-code.

8. Progress notes omit lengthy visit of primary care pulmonologist Dr. Weiner, who examined patient, ordered and received blood gas test results and unequivocally refused family's plea for intubation. Notes state that another doctor was contacted and that blood gas results should be called in.[1]

9. Discharge summary falsely states doctors informed family intubation was needed and family declined such treatment![2]

10. Progress notes indicate patient and family were Orthodox Jewish, unwavering in demand for life-sustaining treatment; show no indication that family refused such treatment at any time; indicate pulmonologist was hoping aggressive treatment would be avoided yet knew that family desired such treatment; show no indication of discussion about intubation by any of the primary-care doctors with family; zero compliance with Maryland's HCDA.

Was Ethical Standard of Care Upheld?

"The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the preferences of the patient should prevail."

"Physicians should provide all relevant medical information and explain to surrogate decision makers that decisions regarding withholding or withdrawing life-sustaining treatment should be based on substituted judgment (what the patient would have decided) when there is evidence of the patient's preferences and values. In making a substituted judgment, decision makers may consider the patient's advance directive (if any); the patient's values about life and the way it should be lived; and the patient's attitudes towards sickness, suffering, medical procedures, and death."

"There is no ethical distinction between withdrawing and withholding life-sustaining treatment."

American Medical Association, Code of Medical Ethics, E-2.20

1. Handover to Dr. Weiner confirmed by deposition and trial testimony.
2. Dr. Nawaz now admits he had no basis for this statement (he made it up).
   According to Holy Cross Hospital intubation was never "recommended" for this patient.

14

HC
HOLY CROSS HOSPITAL

DO NOT RESUSCITATE PHYSICIAN ORDER FORM

H141

BEUSTADTER, ISRAEL 91Y
03/10/03 0306900162
3127 [illegible]
I/P 8155
1111 UNIV BLVD W.
SILVER SPRIN
301 649-1310 Addressograph

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 [illegible] (PATIENT NAME)
with [illegible] (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: [signature] 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: [signature] 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 docoment.

PtID	TxDate	TxTime	Station	GenMedName	Dosage	Strength	UnitsMeasure	Volume	Route	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		0		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		0		WITHDRAWN 2
0306900162	03/13/2003	18:34:56	ICU	VASELINE (PETROLATUM)	Tube	0		30	GM	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

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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.

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.

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.