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RE: Neustadter – Phone call with Dr. Genecin. 1/08/2007, 2:45PM

TO: File Date: January 8, 2007

FROM: RHJ

RE: Neustadter – Phone call with Dr. Genecin. 1/08/2007, 2:45PM

Phone call with Dr. Genecin. Went over the additional materials in notebook, and Dr. Phillips' 80 page report. Lot of editorializing. But Dr. Phillips goes through chart with fine comb.

Dr. G has now listed additional points salient. Addressed issues Dr, nurses, hospital.

Lack appropriate prehospital treatment. Dr. N. If treatment for high white count, before septic, could have avoided hospital. Once dehydrated & electrolytes abnormal & being overtreatment with hypertensive. Takes stable patient, weakened him. Made more likely to aspirate.

Lack of relevant information given to hospital when admitted. Fail to give doctors information re patient condition. Dr. N did not bring information. E.g., No med list, no allergies list, no history, etc. No mental status given for history of patient -- important. Mental condition had worsened. Looked worse in hospital than he had been by history. History was good -- quality of life was good up until then. When patient came in, he was in trouble, moribund. Worse dementia appearance than he had been previously. If Nawaz had said that this is an abnormal baseline, the direction of patient's care might have been different.

Thyroid issue. Hypo-thyroid would worsen his condition. Make recovery less likely.

Son's point. Patient was systematically starved. Hospital / Nawaz treated this as unimportant issue. No evaluation. Critical low albumin was there. Not evaluated for 7 days. Peg got in. Huge issue per ability to get better / survive off ventilator. Dr. Phillips has good point -- athlete in training.

Antibiotic. ½ dose recommended. Proper Dose: 1 gram per day for pneumonia. But 2gm / day if septic. He was septic. Leviquan should have been 500 mg. Not reduced for any reason. He only got 250 mg / day.

Dr. Phillips good point: Aspiration pneum -- not community pneum.

DNR according to the order. Never rescinded. Son's wishes not respected No clarification sought. Not sought from surrogate, son. Goals, direction of care not matched. Treated as DNR even though patient was not.

Extubated 3/17 prematurely. Recorded. He was starving when extubated. When at nadir of ability to survive off ventilator. Should not have been extubated then.

Philosophical / Ethical issue. Mild dementia. Quality of life at home good. No real diseases that threatened his life. When admitted, they treated him as final admission. Should not have been

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treated this way.

Should have been reintubated. When airway problem evident, then became critical - in last few days. Should have been no question. Son made this clear. Nothing in the notes to say otherwise.

Drs and nurses seemed to treat him from beginning as a lost cause. When there is disagreement between family and health care providers concerning whether goals are realistic, then doctors / hospital must demonstrate that goals of family are unreal. Son lobbied for better care, and when it was given, his father improved. Father sat up, talking. If care really was unrealistic, Doctors / Hospital not required to offer care. No the case here. It **WAS** realistic that father could have had goal of coming home.

Opinion -- if treated aggressively, it is likely father would have gone home.

But he was treated passively. Sort of DNR philos of care. But he was not DNR.

Son had right of informed consent as to benefits / risks as to the types of interventions that were possible. This includes the intense care available and medications like thyroid. They withheld that information from son as same time withheld the care. Left it so the son. Then wrote treatment off as unreal. But son was well enough informed that his father needed antibiotic, airway, nutrition, etc.

Hospital / doctor try to pass off to the son responsibility by making son out to be a confused guy. They all counsel him on futility of care. Includes all doctors and nurses. Cannot ask the surrogate to make decisions and then withhold from him the information he needs to evaluation and make a decision.

Nursing staff. Duty to do complete assessment at admission and transfer. No medical reconciliation -- e.g. , no thyroid evaluation or medication. DNR orders -- duty to make sure an order and a plan in place to treat consistent with family desire and physicians. Nurses did not see that there was no match between son's requests and treatment being rendered by the doctors. Nobody ask for medicine list. In assessment, need to document problems -- do such as pulmonary secretions / toilet-- but also to address with the Dr and Son. When patient clearly aspirating- needed to have in place a clear plan to treat. Nurses assumed he would die. Did not work with the Drs to insure that orders and care plan were documented, signed off and agreed to by son. Instead treatment patient as terminal case.

Ethical duty to prevent the preventable. If in situation where clearly terminal, then do not have to treat with prevention. Just keep comfortable. Where there is preventable care to be rendered, must prevent. If father had the appropriate care re infection, appropriate nutrition re starving, care for airway re aspiration, would have survived. There was substandard compliance with these goals. If there are confusing situations e.g., son, or conflict between son & doctors, must be addressed with the ethics committee of the Hospital. Hospital has duty to make this available

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and to follow through. E.g. should have gotten meeting with son and the rabbi and / or doctors. Instead, it appears that they decided at 91 years old, he was going to die . Did not do these proper steps.

Aspiration. Had 2 problems. Reality of aspiration. Should have managed the airway before got to the point of critical situation. Clearly, he had a problem and should have addressed this early. They were withholding care when it should have been rendered – this was the same as letting him die. It was treatable. Could have had tracheotomy. Could have fixed the verticulam. Pulmonary toilet. When they knew he was aspirating should have addressed then again and intubated.

Same with nutrition. Should have addressed it early. He was being starved.

Nurses share with Dr the responsibility to address nutrition.

Venue of care. Needed ICU care from the beginning. He should have been put there right away. But they did not, probably because of age – 91. Put him in room. Then step down unit. Finally ICU. Got him out right away. Did not put him in proper venue of care.

Dr. Phillips good point. OD on Haliperidol -- tranquilizer – side effect: causes muscle rigidity. Creates problem for breathing. On the 20th, recommended discontinue -- but did not discontinue until 22nd.

Allowed him to die on 27th. Never addressed the DNR status. He needed to be resuscitated. Intubation needed. Needed to clarify that status. Just withheld care, let him die.

Ethical issues. Treatment benefit outweighed risks? Man had meaningful life and was treatable. Could have had proper antibiotics, airway managed, thyroid treatment. None of these were radical treatment. These were routine care Risk did not outweigh benefits.

No alternatives to this treatment. Did not go through the problem solving exercise.

Basic interventions would not have violated the ethical considerations to treat. Take out the age of 91 and it is clear that the care is proper and necessary. So the 91 age was critical to how he got treated. No violation of ethical code to treat with these treatments. For example, not a situation where seeking heart transplant for a 91 year old.

Resources were readily available to treat him. Withheld proper interventions. They ascribed their uncertainty to the son as the son being not clear. But they did not clarify with son. They obscured it. He could have been fed, given thyroid meds, protected airway. They pushed on the son the blame. But they could not expect that the son could make a decision. They withheld from the son the information needed to make a decision.

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They advised son to let father die. Instead of saying to son this is information needed for you to make decision.

Ethical. Son as surrogate had a right to the information. Son was clear. Dr had obligation to align their decision with the son's desires. Dr made decision that father not worth treating.

Hospital. Includes its agents such as Heads of Units (ICU, nurses, etc.). Have a duty to have in place that ethical decision are made for the patient. An alarm goes off when there is disagreement with family about end of life issues. Must make resources available to surrogate to resolve disagreements over the treatment goals. Hospital is not a platform -- is a protagonist to make sure ethical decisions are getting made. They treated father as terminal. Never had conversations with son.

Dr, nurses and hosp at fault for withholding care. Thyroid, nutrition, antibiotics, airway. Failed to treat the conditions that were treatable.

Hosp must have policy and procedures in place to make decisions and resolve disagreements. See Hospital policies and procedures.

Causation discussed. If Dr. N had treated in the beginning, no hospitalization would have been likely and patient would have continued in his good quality of life. If treated in hospital properly, would have causation -- he would not have died. Agrees more likely than not that he would have survived. Ample opportunity to treat him and save his life. The sooner he would have been treated aggressively, the more likely that he could have gone through rehabilitation and returned to quality of life. The longer withheld, the more likely that even if he survived, his quality of life would have been decreased.