

Israel Neustadter

Analysis & Opinion by Dr. Paul Genecin Director, Yale University Health Services

Office Notes: Dr. Ahmed Nawaz:

2/27/03 -continuation sheet – leg weakness, family noted more lethargic since dayside. Check labs ordered

2/27/03 Na 125; K 3.8, CL 88, Co2 25. BUN/Cr 18/.8 WBC 14.3, H/H 11.5/32, plts 227K, neutrophils 79.2 % on automated differential.

3/5/03 Na 132, Na 4.3 off diuretic.

3/10/03 -fell at home, tired, not responding the way he usually does. Hit his head. Has bibasilar rhonchi. Assessment is sepsis vs subdural hematoma. 911 called and taken to Holy Cross Hospital; spoke with ER physician.

I don't find summary of these events for transfer to ED. Specifically, he had changes in his BP meds with diuretics inducing electrolyte abnormalities/deH2O. This led to dizziness and falls. Na of 125 found and diuretic dc'ed. The fact that he also had WBC 14.3 was surely relevant but was not acted on and fact was not transmitted to ED. Anemia also ignored. Doesn't seem that Nawaz sent records to the ED or that they made into his own Hospital notes.

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Holy Cross Hospital:

3/10/03 ED:

BP 90/50 sitting, 130/53 suping, P 62, T 98.3, SaO2 98% Fell at home 2 nights ago. Lives with son. Gradually disoriented since fall. Normally carries on conversation and responds to questions but has gotten progressively worse. He saw Dr. Nawaz today and sent to ED. Fall is listed. Decreased level of consciousness over days. Baseline with mild dementia. Now significant decrease in consciousness. ? of head trauma raised. There are no data from Nawaz, including h/o CBC, electrolyte disarray, etc. History includes elevated lipids, htn, thyroid, CAD, mild Alzheimer's. On pe, frail and elderly: confused and poor historian. Well-hydrated. Ecchymotic contusion of lip. Contusion of posterior occipital scalp. Lung normal. Cardiac negative. Neuro – nonverbal and groans.

CT: no skull fx, atrophy +; no blood. No mass or shift

ECG lad, lv strain, 1 degree HB.

Na 132. Hct 30.6, Hb 10.7, WBC 38,500.

CK normal. Troponin neg. CXR with cardiomegaly, diffuse increased interstitial markings c/w CHR and pulm edema. Clinical h/o SOB not supported in notes thus far.

Admitting dxs altered level of consciousness and dehydration/sepsis.

Problem list: altered level of consciousness; major concussion with LOC, CHF, DeH2O, Sepsis, head injury, confusion, dense aphasia, diffuse CNS small vessel disease, mod hypoNa, Marked leukocytosis, h/o hyperLipid, h/o Htn, ASCVD, dementia, chronic Alzheimer type, acute maxillary sinusitis, LAD, etc.

Amazing list of problems (30+) listed but no basic statement of the history facts pre-hospital (from Nawaz, whom they surely could have called and asked for records.).

The fact that the patient is hypothyroid is not considered, tested or treated. We lack a list of allergies. The pacemaker doesn't make it into the hx.

At admission, the h/o falls due to hyponatremia and dehydration is lost. This was iatrogenic.

The issue of sinusitis/pneumonia/sepsis.

His volume status is uncertain. His pacer is pacing at a low rate (56) but no plan to adjust, despite h/o falls, now septic.

His mental status is acutely altered. The mild underlying dementia was not keeping him from having an enjoyable and meaningful life.

His anemia leads to no w/u or rx.

Admitted with orders stating "pneumonia, sepsis, hypotension, dementia"

Put on D5NS at 100/hr, Levaquin, Rocephin, and MADE DNR. Given 2L02.

Ativan prn agitation.

Initial dosing of Rocephin is 1 g/day; this is ½ of dose for sepsis.

Initial dosing of Levaquin, 500 mg/day is correct but the order is then changed to halve the dose of Levaquin. This is altogether ½ the appropriate dosing of abx.

Initially admitted to regular floor, which was inappropriate, but then transferred to IMCU(?), still with rocephin 1 g/day, levaquin to 250/ day, iv to 75 cc. posy prn.

3/10 progress note by RN (15:30) – a&o x 0. Moves all 4. h/o diarrhea mentioned. Got agitated and asked for his son. Has foley, iv, 02 sat 98 RA. He was alert. No mention of pacer. SaO2 not strongly suggestive of severe pneumonia or CHF. No evidence for appropriate level of RN admission assessment.

Handwritten note (also dictated somewhere) with impressions community acquired pneumonia; sepsis; prerenal azotemia; dementia; reducible umbilical hernia.

Admitted to regular floor, abx, foley, iv ativan prn, FULL CODE specified in note. (CF admission orders which state DNR.) The DNR order is never rescinded or clarified.

3/11/03 progress: WBC down to 20K, dc foley; pt consult. More alert. Pulm consult.

There are 2 pulmonary consultants.

3/11 – pulmonary consult feels pneumonia related to Zenkers. Also dementia, htn, recent hypoNa. Wants to “address code status” had long talk with son and son will consult his rabbi. Barium swallow recommended when possible. DNR order should have been rescinded and plan made for full level of intervention pending any change in decision by the son. Aspiration is not the same as CAP.

Neither pulmonologist corrects abx dosing.

3/11 Pulm also: babbling, with anxious son. “tried to explain to son limited prospects for total recovery. Impressions: falling because of low BP, partly due to dehydration from diuretics and likely sepsis as well (pneumonia/sinusitis), pneumonia aspiration ?due to Zenkers, underlying dementia “but good quality of life”. Plan to give IVF, abx, O2, “intubate if necessary – after long talk c son. He will think about DNR but tends against it for religious reasons.”

3/11 3PM critical care/pulmonary note. Apparently became desaturated (hard to read on page 18;) to have CXR stat; continue abx; change to FoO2 100% on nonrebreather, titrate SaO2 to ?, “I d/w son code status. Patient is full code, will intubate and transfer to icu if needed.” Also d/w house staff. But DNR order not rescinded.

3/11/03 2100 medicine accept:

Notes that at admission, CXR had LLL pneumonia with small pleural eff. Got agitated HD2 with pulse ox to low 80's, abg with severe hypox. Agitated and given haldol, cxr with bilat pleural effusions, increased from admission. Given lasix. Note specifies “**Pt is currently DNR**”. T was 100.3, p 67-102, rr 21-32, BP 103/136/33-64) SaO2 93% on 100% nrb.

Crackles ½ up. Edema 1+. WBC 20.7 with Neut 96.3%. felt he was fluid overloaded. Agitation calmed with haldol.

Addendum from resident is that son very anxious.

Misconception that patient is DNR is not clarified and they think he is DNR. This must affect aggressiveness of care.

Never any clarification of thyroid situation.

3/12/03 – cardiology writes “lengthy d/w son regarding all issues. I advised against mechanical ventilation should this become an issue given advanced age, dementia and expected debilitation.” Written by Schneider. Another person advocating against full court press.

3/12 WBC 17.2. continue meds. Good urine output.

3/12/03 pulm: looks better. "Pt/son had "stormy: night" but now at baseline sitting in chair. **Coughing/choking when swallowing clears**, but son says this is baseline. Son wants full code but no PEG. Dr. feels these decisions may not logically flow. "Son (unmarried, only family member) remains hopeful, perhaps unrealistically so.:"
Clearly is aspirating at this point, witnessed by Pulm. Yet no PEG or TPN.

3/12/03 Nawaz note – status quo.p 24

3/13 med student note. Agitated last PM, pulling off O2 with desats. Soft restraints used. Aspiration pneumonia not yet resolved and worsening on CXR. To get 2-D echo today. Patient still full code. Yet order never clarified.
In addendum at 1015 – to get central line for aggressive electrolyte repletion because k

2.8. WBC 21.8, N 89.8%,.

Medical student says son's wishes seem to change daily. Not clear on what this is based.

3/13/03 pulm. States patient lethargic and looks septic. Crackles on lung exam. CXR with infiltrates diffuse/throughout. Impression is bilat pneumonia with resp failure worsening, hypokalemia, discussed with son "Patient will need mech vent c any further deterioration if aggressive rx desired. Given his age I doubt it will (change) outcome. The son will decide after consultation with his rabbi if he wants mech vent"

3/13/03 12PM – attempted TLC and got it with "no complications" after many tries.

3/13/03 medicine (Nawaz)- resp distress and only responds to painful stimuli. "pt needs to be intubated"

3/13/03 – intubated by anesthesia. When sent to ICU. There is no real ICU admit note. The thyroid situation unclarified. No change in substandard abx doses. He has new RUL infiltrate, which is clearly aspiration, yet no plan is made to address Zenkers. He doesn't get feeding tube or TPN.

Could have had ENT help with NGT. Noted on suction of ETT to have aspirated food.

3/14/03 – intubated and marginal uop. Disimpacted. WBC 23.3. lytes better. Put on propofol for sedation. Continue iv abx.

3/14/03 – ABG with pO2 only 97 on FI02 100%. Decreased FI02 to 75% but increased PEEP to 8. versed and MSO4 for pain.

3/14 GI consult – no attempt at NG tube, no TPN. (Son objects to this – and it is very unclear why nutrition would have been withheld.) – p 32.

See consult on page 100 where the consultant did recommend Procalamine and intralipid if they were putting in a central line.

3/14 some improved O2. "NGT difficult to place because of Zenkers' diverticulum."

3/14 cross coverage note in which son did not accept explanation offered about dad's sedation (p34)

3/15 stable and comfortable "might need to start him on procalamine & lipids"

3/15: apparently mistaken order for central rather than peripheral nutrition which delays nutrition another day. PPN arrives Sunday night (3/16) at 8 PM, 58 hours after first recommended. Son notes prealb 3.8 (20-40) indicative of starvation. P 36.

3/15 pulm: unable to pass NGT ... will start procalamine"

3/15 CXR much improved from 3/12, continued RUL infiltrate.

3/16/03 -NGT attempted multiple times without success. Son worried about his nutrition. Vent down to fiO2 45%, PEEP 8. WBC down to 19,

3/16 Nawaz: WBC 17.3, radiology will try NGT under fluoro.

3/16/03 – radiology also unable to pass NGT.

3/16/03-consult Dr. Ball says "Son wishes no CPR." (son on page 43 explains that Jewish law takes this case by case.) Unclear what was done about this re: completion of usual form and consent of son.

3/17 IPN thinks dohoff placed but it really wasn't. "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."

He gets Haldol 5 q8 which seems very high. This continues until 3/22 at least.

3/17 Pulm. Getting TPN. Trials CPAP. Starting to manage elevated BP's. albumin low. Prealbumin drawn comes back low (3.8=critical) on 3/19. TPN didn't start until day 5, I think.

3/17/03 – GI – to continue TPN for now. Hopefully extubate and feed at some point. No plan formulated for tx of Zenkers and future likelihood that he will aspirate if this is not addressed or PEG placed.

3/17 Dr. Nawaz: doing better. More alert. Will try to wean him. Long conversation with son – to hold off on NGT. PICC line under fluoro.

3/17 PICC placed.

For some reason he is noted lethargic and has thick phlegm, but they extubate him in evening (6:11 pm)

3/18/03 – lethargic.

Nawaz note says he was extubated. Rhonchi noted. WBC 17.1. ABG 7.51/33.8/74.4 Groggy but opening eyes with commands. “spoke with son and discussed about reintubation issue, he’s going to talk with his friends and rabbi and let me know.” Are they pushing him on issue of not re-intubating?

3/19/03 – more responsive. 7.52/34.6/66.1 might need PEG. Aggressive Pulm toilet. CXR in AM

3/19 – Pulm – no gag reflex. Scattered rhonchi. Low pO₂ noted. Will probably need PEG. Finally!

3/20/03 – pulm notes failure to thrive, long term very grim, while son notes (p 49) that nurse says more alert and active, reaching and trying to talk, breathing more relaxed, and PT notes that he is “sitting at edge of bed, able to dangle 10-15 minutes. Rehab potential fair.” Son feels that his copious resp secretions are being ignored. (see page 50-51 for nurse notes on this as well as respiratory.)

3/20 OT eval notes “DNR”-Son things this is not true.

3/20 Nawaz says more responsive. Bibasilar rhonchi.

3/20 GI stops haldol because of rigidity – but this isn’t ordered!

Swallow eval goes very badly and increased risk for aspiration and need to consider how to protect airway and provide nutrition through alternative route seem obvious but are ignored by everyone.

3/21 Pulm notes prognosis very grim. Transfer to step down. Continue supportive rx.

3/21/03 – EGD PEG placed. Large Zenkers noted. Note this is 8 days into hospitalization. Not exactly increasing likelihood that he will succeed off vent. Starving.

3/22/03 – having eye contact. Following commands. Certainly not neurologically in end-stage. Rhonchi still. PEG in place. Transferred to IMCU.

3/22/03 – stop TPN. Taking PEG feeding. Needs suctioning. Lots of problems with pulmonary toilet.

I think levaquin and rocephin are dc’ed after 3/22- at least according to med sheets.

3/22/03 Pulm finds him lethargic but arousable and agrees with PT consult.

3/23/03 – medicine finds him alert and following commands. WBC 16, pulm stable with suctioning. WBC going down. SS consult for placement. Continue TF.

3/23 GI re PEG, Zenkers, etc.

3/23/03 – Pulmonary: more awake. Says he will need to complete two weeks abx and recheck CXR four weeks. Decrease FiO₂.

There is episode of drop in SaO₂ which reversed with suction.

3/24 – same. Mile increased LFT's. ?haldol versus TPN. Gb u/s planned. Dc haldol – at last.

3/24 – Pulm -“not conscious to me, obvious gurgling. “He may be slowly improving re asp pn & recent extubation, long d/w son re limited goals”
son points out that RN that day found him “calm, alert, oriented x 1, son at the bedside.”

This fluctuation is compatible with delirium.

Daily vitals show orientation for Monday night and Tuesday as x 2. (p 60)
nursing notes still showing secretions and need for suctioning.

Nawaz away after this.

On 3/25 at 1705 suddenly in resp distress. Son took responsibility – gave father apple juice and ice. Suctioned and did somewhat better. See p 61. “what son could deny such a father ventilation? What Dr would deny such a patient ventilation? What hospital would allow it?”

3/25 6 PM pulm notes severe deterioration but not intubated. Son objects that doctor wrote “patient remains tenuous and son remains unrealistic. No new suggestions”

Apparently at 8:30 PM rabbi said that Jewish law mandated intubation. Why no intubation? (see p 63).

3/25 830PM note by resident shows severe decompensation but “contacted Dr. Shamim and discuss poss of intubation. ICU dr covering and Dr. Kariya wa also consulted and agrees (At this point will readdress code status due to poor prognosis). Will also keep pt on 100% NRB on suction prn. Then contradictory statements about intubation with intern saying that son says he doesn't want Dad reintubated but son really did and rabbi was explicit that Jewish law required intubation.

Duty to clarify level of care/code status not fulfilled.

3/26 Pulm - feels he will continue to aspirate and cannot control secretions. Possibility of trach not mentioned. MD's urge more guarded approach and son wants everything done. P 64.

3/26 medicine - Son feels they intentionally conceal family wish to reintubate for severe resp distress. WBC up to 37.6 and they feel he is in bad shape on 100% NRB, restarting Zosyn/Levaquin, suctioning and getting ICU consult – but not intubating. They ordered

ABG and consult of ICU attending, CXR, then MSO4 but no intubation.

3/27 nurse note says pat refused cxr and all preventative care. “son acting very bizarre (sic) and confused stating don’t do anything else for my father, then later stating no call a new dr. I want everything done. Pastoral c called for support, psych nurse, h.o. spoke with son and made comfort as poss. ...”

at 1400 pt dying and son in room at bedside... “son refused any treatment for pt. expired. Pronounced at 2:15 pm.

3/27 note from pulm says he looks terminal. Says son doesn’t want tx. WBC are up to 43K.

Actual events surrounding decision to allow him to die rather than intubating and appropriately treating with abx are fuzzy in the record.

3/27/03 – nurse note about how son was on board with DNR at 1200. Unclear if this was so and on what basis.

He was never made DNR and decision to allow him to die is not supported by medical decision making that was transparent, aligned with wishes of family and documented.

6/25/05 death summary -(NOTE LONG DELAY) – says at the end that the family decided not to intubate the patient and continue the aggressive medical treatment with suctioning. (p 106)

Yet this was situation in which history was not faithfully recounted; issues of withholding nutrition, adequate abx, airway protection, thyroid etc not included in this statement or in DC summary. Although aspiration pneumonia stated with sepsis, he was not treated for these dx’s according to the standard.

DC summary delay caused Nawaz to have privileges suspended for a week.

See page 108 for ethics letters, first from Dr. Eig on March 30, 2004 (108) and son’s response (109) In brief, “Dr. Eig, the unthinkable did happen in your hospital: Doctors surreptitiously wrestled control of a patient’s care from the patient and his family. An “unrealistic son” was let 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 these options. As a result the patient’s life ended prematurely, possibly very prematurely. By our Judeo-Christian standards this was essentially a murder.”

See page 113, in which son demands details of Levaquin dosing, PPN delivery (ordered March 14 and not started for 59 hours, and on 3/27, the delay in response to his crash.

On page 114 he states:

Records show pt with sudden resp distress who needed ventilation (last day)
Show senior pulm doctor bemoaning his differences with the family regarding prognosis and their desired life-sustaining treatments rather than providing the options.

Family repeatedly asked doctors to come to room to help with distress.

No indication that docs offered or that the family refused vent at the end- and there was no DNR order.

On page 121, son contests reduction of Levaquin dose from 500 to 250. He is angry about a full week before his father received any nutritional support (and delay after the order for PPN)

He contests (p 122) legal issues re: withholding of ventilation on 3/25. He says that he did not agree to have father not intubated. There are a number of points along these lines in son's summary here.

There is a lengthy diary written by the son. – up to page 138.

For son's questions entitled "Was Medical Standard of Care Breached?" (page 139)

1 When there was an alteration of mental status associated with leukocytosis, work up and treatment for infection were warranted. They were not done.

2 A week later, a follow up CBC was indicated but was not done.

3 The adult dose of Levoquin for pneumonia is 500 or 750 mg/day and is not adjusted for elderly patients; 250 mg was low.

4 There was an initial response to rocephin and levoquin but no work up for cause of persistent leukocytosis in the 20K range.

5 There was a delay in initiating nutritional support. This is clearly a departure from the standard.

6 The problem with swallowing, irrespective of Zenkers, could have been addressed with trach. He was not a candidate for surgery during this admission but could have been trach'ed, given nutrition and stabilized for future surgery on Zenkers.

7/8. Standard would require that patient be intubated if patient's family wanted it or that they obtain family's agreement not to re-intubate. If there is a situation in which clinicians are concerned about futility of intervention, they can refer it to ethics committee. This should have happened rather than refusing to intubate.

9/10. If family did not agree to withhold endotracheal tube, it should not have been withheld; the notes are equivocal about son's behavior during terminal day(s). There seems to be shift of blame for decision onto son rather than taking responsibility for creating setting in which appropriate questions about care strategy could be addressed.

PG Opinions:

1. **Lack of appropriate pre-hospitalization treatment of s/s infection; this was Nawaz.**
 - a. **Lack of pre-hospitalization attention to high WBC contributed to bad outcome by ignoring early sign of infection, likely originating in sinus and/or pneumonia due to aspiration.**
 - b. **Likelihood that he would decompensate and aspirate due to lethargy and worsened mental status and become septic was increased by failure to treat early infection & by potentially over-treating with antihypertensive medication.**
2. **Lack of relevant information sent to ED; this was Nawaz.**
 - a. **Even as attending of record, he failed to give accurate history and background.**
3. **Lack of effort in ED to elicit info from Nawaz –since they could have called Nawaz and gotten the info. However, Nawaz was the attending of record and should have brought in the pertinent history.**
 - a. **Pt. Med list was good example.**
 - b. **Allergies.**
 - c. **Problem list**
 - d. **Info about his premorbid condition.**
4. **Actual history of events was missing, including his baseline mental status, which had acutely worsened.**
 - i. **In other words, he may have looked a lot worse in the hospital than his pre-morbid baseline (he was mildly demented but living good quality of life.) Assumption that he was worse off than he really was might have led providers to confuse delirium (acute and transient if properly treated) for worse dementia than he actually had. This could have led to less aggressive care. So adequate information from Nawaz was lacking and neither he nor hospital remedied this information gap.**
5. **Thyroid condition drops off list of problems and is not treated or even tested.**
 - a. **Hypothyroid state would have worsened status and prognosis.**
6. **His nutrition is treated as an elective, *even unimportant* issue despite failure to give nutrition. He had critical prealbumins (3.8 on 3/17- reported 3/19; 7.5 on 3/20 and 11.5 on 3/24) and observations about nutritional status made repeatedly by son.**
 - a. **Assessment of his nutritional status waited until prealbumin finally sent 3/17. This was a significant delay.**
 - b. **PEG took over a week. TPN started at least 5 days after admission despite son's realistic concern about starvation.**

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

7. Antibiotics: Mr. N. needed an ID consult, as his internist and pulmonologists did not seem to give his pneumonia therapy proper thought. This was not community acquired pneumonia; it was aspiration pneumonia.

a. His ceftriaxone was at $\frac{1}{2}$ the dose recommended for sepsis and his Levaquin was at $\frac{1}{2}$ dose. This critical factor in lessening likelihood of recovery from pneumonia/sepsis.

b. The choice of antibiotics was questionable, which also lessened the likelihood of cure.

i. There is redundancy between Levaquin and Rocephin.

ii. There is a gap in coverage for aspiration pneumonia, which mandates antibiotic regimen with good anaerobic spectrum.

1 eg Clindamycin (or high dose PCN G) plus Levaquin OR

2 eg monotherapy with Timentin or Zosyn (extended spectrum beta-lactams plus betalactamase inhibitor.)

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

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

a. Evening at ~6PM unusual hour to choose, but this isn't really relevant in the big scheme.

b. Nutrition not optimized and there was little evidence that he was 'ready to fly' off the vent at this point. (This is salient).

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

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

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

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

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

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

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

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

17. The benefits of effective medical treatment for Mr. N. outweighed the risks. He had a meaningful life to go home to. He had treatable problems. i.e., this was not futile care. These treatments were all low-risk and included:
 - a. adequate nutrition,
 - b. appropriate antibiotic therapy,
 - c. standard care of his airway,
 - d. thyroid hormone replacement therapy.
 - e. There were no radical treatment interventions on the table.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

