

BY MAIL AND EMAIL

Dear Ms. Kronmiller,

It is just over a year that [I wrote to you](#) of my concerns about my father's case. You will recall that the essence of those concerns was patient abandonment; that my father was left to die by his doctors and by Holy Cross Hospital on March 26, 2003. Those concerns were presumably the reason you referred my case to your chief nurse, Bill Vaughan, for further review. Those concerns are presumably what needed to be looked into; no more and no less. It hasn't happened.

When Bill met with me last August to explain the results of his lengthy investigation, much to my surprise, this horrific and pivotal event in my father's care had not even been examined! At that meeting I provided Bill with even clearer and more convincing evidence of a break in the continuity of care at precisely the time that I have told you Dr. Weiner refused my plea for intubation and abandoned my father.

I gave Bill [trial transcripts](#) containing testimony from the attending physician, Dr. Shamim. He states unequivocally that he turned over care of my critically ill father to Dr. Weiner, whom he called in for an emergency consult. The issue at hand was whether my father required intubation. Dr. Shamim's recollection is very clear and corroborates what I have been saying all along. Yet, there is [no documentation whatsoever](#) in the medical record of Dr. Weiner's presence or of the life-and-death treatment decisions that needed to be made at the time. Dr. Wiener would only say that had he been called in to see the patient he would have documented it. So who was directing my father's care?

To state the obvious, a hospital must know at all times who is in control of a patient, and a hospital medical record must document all major medical visits and treatment decisions. This holds especially true for a patient whose life is hanging in the balance.

I also left with Bill a [letter from Dr. Nawaz](#) to the hospital records office, acknowledging that he had no basis to state in his [Death Summary](#) that the doctors had a long talk with me and that I decided not to intubate my father.

Bill eagerly agreed to review the material that I gave him, telling me that it provided your agency with a unique opportunity to see how a medical record compared with sworn testimony. He promised me both verbally and in writing that he would focus on the "hand-off issue," as he called it, and asked for my patience while the matter was being studied.

But on September 9, Bill informed me of a complete change in direction. Rather than investigate my father's case any further, your agency would explore the current state of care at Holy Cross Hospital. My father's case, and what happened to him, was suddenly off the table; the commitment to "focus like a laser" on the hand-off issue, rescinded.

Bill has been friendly, courteous and generous with his time. Indeed, it appears as though he is willing to investigate and discuss anything and everything but the crux of my father's case.

Ms. Kronmiller, I understand this is a sensitive matter, but perhaps for the first time in your agency's history, you have ironclad proof in the form of sworn testimony that the actual treatment of a patient differed significantly from what is indicated in the medical record - and strongly supports a complainant's charge of patient abandonment.

I trust you agree that it is not acceptable for a critically ill patient in need of mechanical ventilation to be handed off to a doctor, with no record of that doctor's presence, of the plan of care or of the treatment decisions. Once you have been presented with, and agreed to review, evidence of just such an occurrence, your agency has an obligation to investigate it and to let the chips fall where they may.

At minimum, the hospital needs to account for (or be held accountable for) the shocking gap in my full-code father's care (the hand-off issue) the night before he died.

Sincerely,

Alexander H. Neustadter