

Patient Name - Medical Opinion

DOB: MM/DD/YYYY

DOD: MM/DD/YYYY

Summary of merit:

The patient, Ms. XXXX, a 23-year-old female with a longstanding medical history of Type 2 diabetes mellitus (T2DM), hypothyroidism, and microalbuminuria, was under the care of various healthcare providers throughout her treatment course. Notably, her diabetes management included insulin therapy, but the patient encountered significant challenges due to lapses in her care, ultimately culminating in her hospitalization, critical deterioration, and subsequent death. It is important to emphasize that Ms. XXXX's clinical history necessitated continuous monitoring and medication management, including insulin therapy, to control her glucose levels. However, several critical incidents during her care appear to have contributed directly to her tragic outcome.

On the eve of Ms. XXXX's deterioration, it was reported that her primary care physician (PCP) Dr. XXX cancelled a vital appointment, which directly impacted her ability to receive the insulin refill she so urgently required. The cancellation of this appointment led to a gap in her insulin therapy, exacerbating her already precarious glycemic control. Without the timely administration of insulin, her blood glucose levels rose precipitously, resulting in severe hyperglycemia and the subsequent onset of diabetic ketoacidosis (DKA). This condition, coupled with the patient's missed insulin doses, set the stage for her critical illness. The cancellation of the PCP appointment led to the pharmacy's inability to fulfill Ms. Velazquez's insulin prescription, further compounding her condition. The failure to secure this essential medication contributed to her severe hyperglycemia, which was only partially managed during her subsequent ER visit.

Ms. XXXX presented to the emergency room on Sunday, with heart rate abnormalities, elevated blood glucose (500 mg/dL), and evidence of a severe infection, specifically pyelonephritis. Despite her critical condition, there are clear and concerning gaps in her management while under the care of the ICU team. Between October 6, YYYY, and October 8, YYYY, the patient's care in the ICU failed to meet appropriate standards of clinical management. The ICU team did not provide a comprehensive approach to address Ms. Velazquez's worsening condition, which included diabetic ketoacidosis, sepsis, and kidney infection. The ICU attending failed to act with the necessary urgency or clarity in addressing the patient's deteriorating clinical state. There was an evident lack of coordinated and aggressive treatment. Notably, there was insufficient engagement with the anesthesiology team during this critical period. Given the patient's significant risk factors—including uncontrolled diabetes, infection, and the requirement for intensive monitoring—the involvement of anesthesiology should

have been prioritized to provide a more thorough approach to managing her airway and respiratory function, especially considering the patient's cardiovascular instability and the need for meticulous glucose control. Moreover, despite Ms. XXXX's deteriorating state, which included signs of acute distress and signs of ischemia, her care seemed reactive rather than proactive. Her condition was allowed to deteriorate without the necessary interventions to prevent cardiac and multi-organ failure.

On the morning of October 8, YYYY, Ms. XXXX experienced three consecutive heart attacks within a short time frame. At 9:30 AM, she suffered her first heart attack, followed by a second at 10:00 AM, and a third at 10:30 AM, after which she fell into a coma. Despite the critical nature of her condition, the communication between healthcare providers was grossly inadequate. The family, particularly the patient's partner, was not informed in a timely manner regarding the extent of the patient's deterioration or the interventions being performed. The failure to convey critical information to the family during this time period contributed to a breakdown in trust and understanding, compounding the family's distress.

When Ms. XXXX's condition worsened, her request for transfer to Wyckoff Hospital was denied, despite the fact that she was in critical condition. This refusal to facilitate a transfer, coupled with the lack of action taken to stabilize her glucose and treat her underlying infection, led to further deterioration. On the morning of October 8, YYYY, Ms. XXXX passed away. The delay in treatment, the absence of timely interventions, the mismanagement of her glycemic control, the failure to engage anesthesiology in her care, and the lack of transparency with the family all culminated in this tragic outcome.

The failure to provide timely and appropriate insulin therapy, the lack of adequate clinical oversight in the ICU, and the lack of proper engagement with anesthesiology and other specialists significantly contributed to the patient's death. The miscommunication regarding her care, particularly the refusal to transfer her to a different facility and the lack of information provided to her family, further compounded the tragedy. It is my professional opinion that these lapses in care ultimately led to the loss of Ms. Velazquez's life. It is imperative that further investigation be conducted into the specific failures of the healthcare providers involved, and that a comprehensive review of the protocols followed in this case be undertaken to ensure that such a tragic outcome is prevented in the future.

Defendants:

- Primary Care Physician Dr. XXX (responsible for cancelling the appointment and failing to provide the necessary insulin prescription).
- ICU Team In Charge during the patient's admission from 10/06/YYYY to 10/08/YYYY for failing to provide comprehensive and timely treatment, including proper glucose management, engagement with anesthesiology, and coordinated care.

Breaches in the standard of care:

Primary Care Physician (PCP): Dr. XXX

- **Cancellation of the appointment:** The PCP cancelled a vital appointment, leading to a gap in the patient's insulin therapy. This disrupted the management of her diabetes and contributed to the development of diabetic ketoacidosis (DKA).
- **Failure to provide necessary insulin prescription:** The cancellation of the appointment resulted in the pharmacy being unable to fill the prescription for insulin, leading to an escalation in the patient's blood glucose levels and subsequent deterioration.

ICU Team (In Charge from 10/06/YYYY to 10/08/YYYY):

- **Inadequate management of Diabetic Ketoacidosis (DKA):** Despite the patient's severe hyperglycemia and DKA, the ICU team failed to implement timely and aggressive measures to control her glucose levels and stabilize her condition.
- **Failure to engage Anesthesiology:** Given the patient's cardiovascular instability, risk of respiratory failure, and need for intensive monitoring, the ICU team failed to properly engage anesthesiology to manage her airway and ensure proper ventilation, which could have helped mitigate her deteriorating state.
- **Lack of comprehensive treatment:** The ICU team did not provide a comprehensive and coordinated approach to managing the patient's sepsis, infection, and worsening multi-organ failure. Interventions appeared reactive rather than proactive.
- **Failure to provide timely communication:** The ICU team failed to communicate clearly with the patient's family, particularly regarding the patient's critical condition and the interventions being carried out. This lack of transparency contributed to the family's distress and lack of understanding about the care provided.
- **Failure to appropriately address critical needs:** The patient was not given food or adequate nutrition during her stay, despite her condition being critical, which exacerbated her overall decline.

Damages:

- Uncontrolled hyperglycemia leading to Diabetic Ketoacidosis (DKA).
- Worsening cardiovascular instability, including multiple heart attacks.
- Respiratory failure and organ failure due to inadequate treatment.
- Exacerbation of kidney infection (pyelonephritis) due to lack of proper management.
- Anxiety and distress caused by the patient's critical condition and failure to receive proper care.

- Suffering due to the lack of communication from the medical team regarding the patient's deteriorating state.
- Emotional trauma from the sudden death of a young individual with manageable conditions.
- Wrongful death of Ms. XXXX due to inadequate medical care.
- Preventable death from untreated diabetes complications, sepsis, and infection.
- Medical expenses incurred due to the hospitalization, ICU care, and prolonged treatments.
- Additional costs from failed transfer attempts to another facility.
- Extended hospitalization costs due to the delay in providing proper care and interventions.
- The patient's inability to have a normal life due to complications and prolonged medical issues.
- The loss of future life experiences and opportunities due to her untimely death.
- Emotional and financial impact on family members, particularly the partner, from the loss of their loved one.
- Distress from witnessing the decline and death of the patient due to substandard care.
- Physical pain and suffering from untreated medical conditions, including DKA, sepsis, and heart attacks.
- Psychological pain and suffering during the prolonged and deteriorating hospitalization.

Case overview:

XXXX, born on March 25, 2001. XXXX's medical history included several visits to the Emergency Department and clinics. In 2018, she visited a clinic for ear complaints, where she was treated by Dr. XXX for diffuse otitis externa on August 14 and for impacted cerumen on October 30. In 2020, she visited the dental clinic on December 31, where Dr. XXX noted a loose tooth and uncontrolled diabetes. On February 25, 2021, she had tooth #19 extracted by Dr. XXX Rodriguez. On March 9, 2020, XXXX visited the Emergency Department, where she was treated by Dr. XXX and NP Sylvan Ryder for an acute issue. Tests during this visit revealed very high glucose levels.

She was admitted to Wyckoff Heights Medical Center on February 16, YYYY, and discharged on February 18, YYYY. Her attending physician was Dr. XXX, and her care was overseen by residents including Dr. XXX Herrera, Dr. XXX, and Dr. XXX. Upon admission, triage was completed by RN Christine Scheppa. Throughout her stay, XXXX underwent extensive evaluations, treatments, and laboratory testing.

On February 16, YYYY, Dr. XXX ordered an electrocardiogram, while Dr. XXX ordered a portable chest x-ray. The x-ray, interpreted by Dr. XXX, revealed mild peribronchial thickening without evidence of heart failure or other complications. Laboratory tests ordered on this day included a comprehensive metabolic panel, CRP, lactic acid, BHCG, a complete blood count (CBC), sed rate, and blood cultures. Results revealed significant abnormalities, including low albumin, sodium, chloride, and creatinine levels, high glucose levels, and an elevated CRP of 206.50 mg/L. The BHCG

test was negative, and no bacterial growth was noted in the blood cultures after five days. Additionally, a CBC revealed a low hematocrit with high MCH and MCHC. Point-of-care glucose tests and a urine pregnancy test showed very high glucose levels and a negative pregnancy result, respectively.

On February 17, YYYY, further laboratory testing was conducted. A repeat comprehensive metabolic panel revealed low calcium, albumin, sodium, and blood urea nitrogen levels, along with persistently high glucose levels. Additional tests included serum magnesium, which was normal, and serum phosphorus, which was low. An HGB A1C level of 11.8% indicated poor long-term glycemic control. Blood cultures revealed rare gram-positive cocci and light growth of *Staphylococcus aureus* with inducible clindamycin resistance. Throughout the day, multiple point-of-care glucose tests continued to show elevated readings. XXXX also received medications and treatments, including insulin glargine, sliding scale insulin lispro, magnesium oxide, and IV antibiotics such as clindamycin. On February 18, YYYY, point-of-care glucose tests remained elevated, and XXXX received additional treatments, including oral sodium-potassium-phosphorus supplementation.

On March 8, YYYY, she had another clinic visit and was seen by Dr. XXX and Dr. XXX Herrera. She was s/p ED I&D of left upper back abscess. Patient came in for follow up after. Patient said that the wound looked better and had gotten smaller.

On October 6, YYYY, Ms. XXXX, a 23-year-old female with a history of type 2 diabetes mellitus (T2DM) with microalbuminuria since age 14 and hypothyroidism, presented to the Woodhull Internal Medicine Emergency Department with complaints of fever, bilateral sharp chest and rib pain, decreased oral intake, and abdominal pain associated with nausea since the previous Friday. She reported not taking her home diabetes medications, Basaglar 32 units and Mounjaro, for a week. The patient also mentioned feeling lightheaded when standing, a longstanding history of palpitations since childhood, and one episode of watery diarrhea and vomiting. In the Emergency Department, she was tachycardic with a heart rate of 145, tachypneic with a respiratory rate of 22, saturating at 100% on room air, and spiked a fever of 103°F. Laboratory results were significant for diabetic ketoacidosis (DKA). Urinalysis showed positive ketones, leukocyte esterase, and many bacteria. A CT scan of the abdomen and pelvis with contrast revealed right-sided pyelonephritis. The patient was admitted to the Progressive Care Unit (PCU) for DKA in the context of missed insulin and an active infection (acute pyelonephritis). She was started on intravenous ceftriaxone and placed on a DKA protocol with insulin infusion.

Dr. XXX, MD, examined the patient at the bedside on October 7, YYYY, and discussed the plan of care with the MICU team, PCU team, and SMR. The findings of the resident were reviewed and revised as follows: The patient was admitted to the PCU on October 6, YYYY, due to diabetic ketoacidosis (DKA) and sepsis secondary to pyelonephritis, as confirmed by a CT scan. The patient reported bilateral chest and rib pain, abdominal pain, nausea, vomiting, episodes of diarrhea, and poor

oral intake, with a history of not taking insulin over the past few days. She had a baseline history of diabetes mellitus since the age of 14, hypothyroidism, and palpitations. During the morning rounds, the patient was evaluated and continued to be seen throughout the day until approximately 5:30 PM, with sign-out to night coverage. Communication regarding the plan of care continued with the critical care attending physician on call until around 10:00 PM.

At the time of examination, the patient appeared comfortable but had a heart rate in the range of 120-130 while in the PCU. She reported feeling better and expressed a willingness to eat. Mildly increased respiratory rate was noted without signs of respiratory distress, and the abdomen was tender but soft to palpation. The DKA was attributed to infection/sepsis and the patient not taking insulin. The protocol was adjusted to replace D5Water with half-normal saline ($\frac{1}{2}$ NS) due to hyponatremia, with ongoing electrolyte monitoring for potential further changes. The patient expressed frustration over being unable to eat, and it was explained that she would be allowed to eat once the anion gap closed and subcutaneous insulin was administered. The sepsis was managed with antibiotic treatment for pyelonephritis based on the CT findings, alongside obtaining cultures and administering IV fluids per the DKA protocol. Lactate levels were ordered, and close input/output monitoring was maintained.

On October 8, YYYY, at 10:38 AM, Dr. XXX responded promptly to a code blue, proceeded to the ICU, and spoke with the ICU attending. The patient had been intubated, and bilateral breath sounds were confirmed. The patient's SpO2 was observed at 98% on the monitor during the code. Dr. XXX had previously intubated the patient at 9:03 AM but continued to respond to each code, though the ICU attending did not require further assistance. The patient was intubated during cardiac arrest, with an endotracheal tube (ETT) size 7.0 inserted and secured at 21 cm at the lip line. Tube placement was confirmed using auscultation and EZ-CAP. After the pulse was retrieved, the patient was placed on mechanical ventilation, with the ventilator parameters documented. The patient was stable at the time, with alarms set and audible, and monitoring was continued.

On October 8, YYYY, Dr. XXX was called to the patient's bedside to pronounce the patient deceased. No spontaneous movements were observed, and there was no response to verbal or tactile stimuli. The pupils were mid-dilated and fixed, with absent corneal reflexes. Breath sounds were not appreciated over either lung field, carotid pulses were not palpable, and no heart sounds were auscultated over the entire precordium.
