SUMMARY REPORT OF MEDICAL CARE

04/28/2006

Prepared by forensic experts at the request of James R. Goldberg, father of the deceased. For further information please consult the book, "The American Medical Money Machine: The Destruction of Healthcare in America and the Rise of Medical Tourism" available on Amazon and in Kindle format.

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I. SUMMARY REPORT OF MEDICAL CARE

Joshua Goldberg was a 23 year old white man who was admitted to Bumrungard International Hospital, Bangkok, Thailand, on February 12, 2006 for "inability to walk" in "guarded" condition with diagnosis of myelopathy, rule out radiculopathy.

Prior to the admission on February 12, 2006, Mr. Goldberg was treated in Chaing Mai, Thailand, on February 5 , 2006 with Doxycicline and Morphine sulfate, orally for a bleb –like lesion on the left medial malleolus (left ankle) and back pain attributed to 'kidney infection". Whether spontaneously or attributed to these medications, some improvement in the lesion occurred.

By February 12, 2006 Mr. Goldberg developed progressive swelling of the left buttock and hip with diffuse rash over the coccyx, right hip and left buttock. Dr. Sira Sooparb (66902) did not record the patient's history, did not identify/record the underlying cause of the disease, did not work up the patient's past medical history, did not evaluate or consider and record the patient's medication/drug history or alcohol use, did not review/record patient's review of systems and failed to record/consider family history.

On admission, pertinent laboratory findings/evaluation showed : CPK 9153 u/l (30-160 u/l), elevated liver functions SGOT/SGPT 282/128 u/l (5-40 ul), elevated C-reactive protein 9.86 mg/l ((0-5 mg/l),

minimally elevated ESR at 21 mm/hr (up 15 mm/hr), normal blood count, and normal kidney function.

Subsequent to admission and by February 14, 2006, the patient's swelling continued to worsen and a foot drop with zero strength developed followed by decreased sensitivity and shooting pain over the left leg The CPK fell, myoglobin and urine or kidney function tests were not ordered.

During his hospitalization, from February 12th, 2006 to February 24th, 2006, Mr. Goldberg was seen by many physicians; apparently an internist, a neurologist, a pain management specialist, an infectious disease specialist, a drug abuse specialist, a psychiatrist, a physical rehabilitation clinician and a nutritionist. Two grand rounds were conducted without any recommendations and no notes are included in his chart as delivered to Mr. James Goldberg on or around 8 March 06.

Mr. Goldberg had a known opiates addiction and Bumrungrad's drug addiction specialist reported this as early as February 13, 2006. Additionally, this was recorded on a prior file for a previous admission during July of 2005. Further, Mr. Goldberg indicated that he was not actively using drugs in the last year and he no longer drank alcohol.

The evaluation of Mr. Goldberg involved multiple tests:

These include:

1. February 16th, 2006 an ultrasound of the buttocks and upper thighs showed no fluid or abscess.
2. The ultrasound was repeated on February 21, 2006 with normal results.
3. An MRI with contrast of the lumbar sacral plexus was performed on February 13, 2006 which showed normal plexus.
4. An MRI with and without contrast of the lumbar sacral spine showed a minimal L 4-5 stenosis and muscle spasm and mild left transverse root abutting on February 13, 2006. An X-ray same date, normal.
5. A CT brain of February 12, 2006 was normal.
6. Electromyogram and nerve conduction studies were performed. The nerve conduction study was interpreted as a "myelopathy" on February 16, 2006 in the chart note, but not recorded on the typed final report of the EMG-NC study.
7. A lumbar puncture with tests on spinal fluid was performed on February 14, 2006; cell count, protein, sugar normal, no microorganisms, no fungal elements.
8. A Venous Duplex scan was performed on February 21, 2006 of the left lower extremity; normal venous system of the deep venous system was seen.
9. Rickettsia IgG and Tick Typhus, was normal on February 14, 2006.

10. Hepatitis B, Hepatitis C, ANA profile, Antineutrophilic antibodies, complement , thyroid functions , c-reactive protein, erythrocyte sedimentation rate (ESR) were normal on February 14, 2006.
11. Last blood test for kidney function on February 16, 2006 was normal; CPK was abnormal at 1197 ul/g.
12. Blood for culture and sensitivity obtained on February 12, 2006 indicated no growth after seven days on February 19, 2006.
13. Two requests for gnathostomiasis antibodies were made and several additional requests to the patient's insurance company were made to approve testing for Hereditary Neuropathy with Liability to Pressure Palsies. These pre-authorization requests were denied.
14. A Toxic screen was ordered on February 23, 2006, no results included in the chart provided to Mr. James Goldberg, the patient's father, on or around the 8th of March 06.
15. On February 14, 2006, a blood test for Lyme disease antibodies was send to MAYO MEDICAL LABORATORIES, Rochester, MN; received on February 16, 2006 and reported as normal on February 17, 2006.
16. On February 14, a random urine specimen was collected for protein electrophoresis, lab number 823/14 (Sorapol Laboratories); final results were not included in or attached to the patient's chart. Total creatine and protein were elevated 255.7 mg/dl (normal 30-120) and protein 18.36 mg/dl (0-12)

Overall, the notes of physical examinations are sketchy, incomplete and inconsistent since February 14, 2006.

On admission, Mr. Goldberg received intravenous fluids at 80 cc/hr and subsequently 40 cc/hr, apparently only for a few hours.

Bed rest was prescribed on admission. On or about February 14, 2006, Mr. Goldberg was permitted to ambulate in a wheelchair till his death as per physician orders. Bed rest and inactivity are contraindicated with elevated CPK (rhabdomyolysis).

Mr. Goldberg increasingly began demanding opiate medications, despite low pain levels as indicated by pain assessment logs. Intravenous Morphine Sulfate 5mg every 4-6 hours was administered without medical justification.

Pain assessments were stopped on February 21, 2004. Mr. Goldberg, appeared by medications administered, to have developed acute psychosis on or after February 14, 2006.

After a careful examination of the patient's chart, I have been unable to find medication orders after February 22, 2006. However, Morphine sulfate administered intravenously, continued through February 22, 2006 despite lack of pain. In addition, pharmacy records indicate, despite lack of orders, that numerous other medications continued to

be administered up to the night of February 23, 2006, just a few hours prior to the reported time of his death.

Further the patient consumed less than 50% of his daily caloric requirements thus increasing his chances of fluid and electrolyte imbalance.

Mr. Goldberg was given multiple medications; a full list provided by Bumrungrad's Pharmacy is attached as EXHIBIT #1. These medications were administered concurrently or in close proximity including but not limited to intravenous Morphine 5mg, every 4 hours , Methadone in escalating doses up to 75 mg daily, intravenous Meperedine, Fentanyl patch, Tramadol, Amitriptiline, Mirzatripine, Oxcarbmazepine, Trazadone, Gabapentin, intravenous Dexamethasone, non-steroidal anti-inflammatory agents and Ziprasidone.

Most of the medications administered are not only known to have severe drug to drug interactions and were listed as contraindicated on the hospital's "Global Care" pharmacy computer, but are also widely known and by virtue of the drug inserts which accompany medications to cause confusion, psychosis, polymorphic ventricular tachycardia, cardiac arrest and rhabdomyolysis.

Further, on February 22, 2006, Mr. Goldberg received 10,000 mg of Acetaminophen/Tylenol (5,000 mg is a maximum allowable dose), Ultracet (Tramadol and Acetaminophen), enough to cause liver failure and death. Death from acetaminophen overdose and liver failure can occur up to 96 hours after ingestion.

Some of the medications prescribed are drugs known to cause rhabdomyolisis which include acetaminophen, antidepressants (tricyclics in particular), antipsychotics, benzodiazepines, dexamethasone, as well as all narcotics including but not limited to Morphine, Methadone, Tramadol administered to Mr. Goldberg often simultaneously. Dexamethasone, the most potent corticosteroid, was used from February 13, 2006 through February 19, 2006 by order sheets and is known to cause rhabdomyolysis, confusion, and manic states. Steroids are also contraindicated for abscess/cellulites but were nonetheless administered.

Many tests administered lacked medical indications or were based on the lack of the history, physical examination and misinterpretation of the available data, including but not limited to:

1. CT brain scan. No Central Nervous System symptoms or fever were present.
2. Lumbar puncture. No Central Nervous System symptoms or fever were present.
3. Repeat ultrasounds of the buttocks on February 21, 2006.
4. Testing for infectious disorders such as Lyme's disease, Rickhetsia, typhoid fever and typhus due to lack of any symptoms compatible with such infections.

5. Persistent requests for hereditary neuropathy with liability to pressure palsies. (This is an autosomal dominant disorder that is one in which the biological parents must have had it, yet no inquiries were made with the parents pertaining to this possibility.)
6. Electromyogram and nerve conduction studies in the setting of the elevated CPK and clear cut compartment syndrome or compression of the peripheral nerve by swollen tissue.
7. Gnathostomiasis, a parasite requires fish consumption, elevated esonophils, and the larvae are migrating in the skin or eyes .The testing was not indicated due to lack of historical and physical findings.
8. Blood cultures were not indicated due to lack of indications: no fevers, normal blood counts, sedimentation rate.
9. ANA profile had no medical justifications. Mr. Goldberg did not have symptoms, signs or laboratory examination indicating acute Systemic Lupus Erythymatousus or related conditions.
10. Indicated test, urine for protein electrophoresis, but not myoglobin was not completed or is not on file on February 16, 2006.

II. SUMMARY OF MEDICAL CARE: THE LAST HOURS

His vital signs changed dramatically at 6 PM on February 23, 2006, but monitoring was stopped following these significant changes. On all other dates during his hospitalization the monitoring continued through the night.

It is alleged that Mr. Goldberg was found without respiration or pulse rate at 6 AM on February 24, 2006, by a person whose name is yet to be identified. The notes also indicate asystole by EKG at 6 am.

Mr. Goldberg occupied a middle bed, thus other patient(s) were probably in the room.

Two separate EKG strips were provided to the father. One, at the time he was given his son’s chart by the hospital, on or around March 8, 2006, and the other, about a week later.

It is highly significant that the EKG/ECG recording began on February 24, 2006, 5:57:55 AM of both strips provided to the patient’s father. (Strip 1 as provided in the chart first given to Mr. James Goldberg on or around March 8, 2006, and strip 2, the new strip, provided about one week later, via DHL, in response to the father’s request for the full trace)

However, Strip 2, ends at 6 23 06 AM on February 2, 2006 or 10 days prior to the patient’s admission to the hospital and 12 days and 12 minutes before reported code 3 termination on February 24, 2006.

The rhythm is wide complex tachycardia, with occasional ventricular couplets and PSVT waves. According to Code 3 nursing notes, arrest occurred at 6 AM and Mr. Goldberg was in ASYSTOLE according to the chart notes.

Resuscitation is reported to have started at 6:03 21, fully or 3 min and 21 seconds after Josh was allegedly found unresponsive at 6.00 AM.

Asystole, (no pulse) 5 58 5 AM is present for 10 sec and is followed by a resumption of rhythm, yet the Chart notes indicate that EKG showed NO PULSE (asystole). The time of such a finding is NOT indicated on either of the EKG strip(s); Strip 1 or Strip 2.

At 6:00:18 AM of February 24, 2006, monitoring was discontinued or at the time of the supposed “arrest” The rhythm had accelerated and had several clearly ventricular complexes (a couplet), strip 1.

Strip 2 indicates that 23 minutes after the first trace had ceased, and which motivated Mr. Goldberg to question why the original tape provided was so short, the new EKG trace, Strip 2, indicates a date stamp of February 1, 2006 when the EKG was reported to have been restarted. This portion of the tape displays a wide complex tachycardia followed by a supposed Asystole at 6 23 18 AM on February 1, 2006 followed by normal QRS, several P waves and narrow complex waves which are possibly ventricular.

It is important to note that the time of 6 23 18 appears to have been altered by hand from the time automatically stamped by the EKG. It is also highly significant to note that the first part of the trace was dated on the day the patient was reported to have expired. Strip 2, said to show the expiration of Mr. Joshua Goldberg, and is dated fully 22 days earlier or February 2, 2006.

There is NO evidence of defibrillation efforts by either of the EKG tracings, Strip 1 or Strip 2, or in the chart notes for Code 3. The chart only contains information that CPR was performed from 6:03 AM to 6:35 AM on February 24, 2006 inserted manually on the Code 3 order sheet dated February 22, 2006.

There is also no evidence of defibrillation efforts by code notes. Chemical conversion (lidocaine) was not used; the patient was primarily given adrenaline from 6:06 to 6:29:21 as per nurses’ records, possibly a bolus of saline at 6:06 AM of 50 ml just for an IV access.

However, due to the inconsistency of the times on the chart, ECG Strips, 1 and 2, are completely inconsistent with the “official”, Thai Government, time of death indicated on the Death Certificate, 5.00 AM on February 24, 2006. Thus, the entire record and actual events regarding the last hours of Joshua Goldberg’s life is confused and unreliable.

Additionally, Joshua Goldberg was said to have been intubated at 6:08, or 8 minutes after alleged Asystole, a delay of 8 minutes from the alleged time the patient was said to have been discovered without pulse and unresponsive.

It appears that 5 (five) doctors were present at the code and 5 nurses. Joshua Goldberg was pronounced dead at 6:35 by a person indicated on the death certificate and whose name is yet to be identified. The Code 3 orders by an MD (name to be identified) are stamp dated February 22, 2006, yet all other pages in the file, up to that time, correspond to the dates orders/progress notes appear to be dated correctly. This means the Code 3 orders were issued 2 days prior to the patient's Code 3 and ensuing death.

The Death summary portion of the Chart was not filled out by physicians or nurses.

The Cause of death was not filled out in the chart and remains unknown.

The "person" (s) who had last seen Joshua Goldberg alive, has been omitted.

The name of the attending physician at the time of death is omitted.

The time of death is corrected by hand and remains unclear as it appears in the chart/notes.

All required information, in blank, for death certificate was in the chart/file, but is completely devoid of any entry.

It is clear, from the available records that the untimely and unexpected death of Mr. Goldberg occurred at Bumrungrad International Hospital, after 5:30 pm local time on or about February 23, 2006 but before 5AM February 24, 2006 according to the government issued death certificate.

Based on an order for a toxicology screen the results of which do not appear in the chart/notes, it is clear that severe problems occurred on or about 23 February 06. Yet the results of this screen are not in the copy of the file provided.

Nursing notes indicated rise in pulse at 6 pm of February 23, 2006. Other than the supposed Code 3 notes, there are no notes after this time except for administration of Amitriptiline, allegedly 25 mg at 8 pm.

There are no indications on file that any of the physicians communicated with Mr. Goldberg's family at any time during his hospitalization or after his unexpected death.

III. SUMMARY OF CARE CONCLUSIONS

It is clear that defibrillation was not attempted.

It is clear that Mr. Goldberg received doses of Amitriptiline at toxic levels in combination with Zisprasidone without any required evaluation and monitoring and contrary to pharmacy system warnings and manufacturer warnings.

The patient was known to have been allergic to all antipsychotics, per the summary sheet of February 14, 2006, including Zyprexa, and Seroquel, chemical names (Olanzapine and Quetaipine) which appears at the top of all pages of his chart and which is in the same family of drugs of tricyclics, atypical antipsychotic Zeldox (Zisprasidone) as those administered to the patient on the day before and the day of his death concurrently.

It is clear that Mr. Goldberg was given toxic combinations of medications without medical justification.

The hospital course, medications, tests, delays in discharge (planned twice on February 18th, nursing notes and February 20, physicians orders), exact cause of death, time of death, code procedures, and /or witnesses to his last hours remain unclear, at best.

IV. STANDARDS OF CARE

Standards of Care are action(s) a reasonable, competent physician would have taken under similar circumstances.

1. Accurate, timely, complete history, physical examination, laboratory tests and available records review are required of any competent physician.
2. Appropriate interpretation of findings and basic knowledge of the significance of test results are required of any competent physician.
3. Performance of only medically necessary test based on the history, physical examination and preliminary laboratory evaluation are required of any competent physician.
4. It is ESSENTIAL to monitor serum electrolytes, Calcium, Magnesium and Phosphorus in a patient receiving toxic potentially lethal combination of medications and are required. There are no known exceptions to this standard.
5. Appropriate triage and monitoring of the patients admitted in guarded condition, requires a monitored bed at a minimum is a fact known to any competent physician.
6. Immediate discontinuation of all medications in patients with elevated CPK and liver function tests is a known intervention to any competent physician.
7. Appropriate treatment of the acute moderate pain. This does not include intravenous Morphine Sulfate, intravenous Meperidine or any other medications used for chronic pain neuropathic pain control is a medical fact known to any competent physician.
8. Avoidance of the medications patient reports allergies to is required of any competent physician, pharmacist or nurse.

9. Avoidance of the intravenous pain medications when patient can take oral medications is the medical fact known to any competent physician.
10. Appropriate evaluation of pain level and indications for narcotics in a patient with the history of opiate dependence is a medical fact known to any competent physician.
11. Appropriate evaluation and treatment of the confusion, delirium and psychosis in the hospital setting and polypharmacy is required of any competent physician.
12. Knowledge of the drug to drug interactions, consultations by or with the pharmacist when in doubt, use of medications for known indications is required of any competent physician.
13. Airways protection, intubation and defibrillation are the first actions during a Code 3 procedure during in-hospital arrest or medical personnel attended arrest. Hospital staff is required to be certified in advanced life support and Code 3 procedures.
14. Use of Adrenaline without defibrillation is not an acceptable procedure by any authority on resuscitation.
15. Uninterrupted monitoring during the Code 3 till death is pronounced by a physician is required during in-hospital arrest.
16. Complete and accurate notes of the Code 3 procedure are required during in –hospital arrest or any arrest attended by medical professionals.
17. Administration of an antidote is required following consumption of 10 gm of the acetaminophen to prevent acute liver failure and death and is a medical fact known to any competent physician, pharmacist or nurse. An acetaminophen level, electrolytes, glucose and liver functions must be also obtained even if such overdose is suspected.

V. FAILURES TO MEET THE ACCEPTED STANDARD OF CARE

Failures to meet Standards of Care are action(s) not taken by a reasonable, competent physician under similar circumstances

1. Failure to diagnose rhabdomyolisis and to follow this common and lethal medical problem.
2. Failure to treat rhabdomyolysis.
3. Failure to prevent early and late complications of rhabdomyolisis, resulting in unnecessary pain, suffering and death.
4. Failure to exercise prudent caution with known multiple severe drug to drug interactions and direct contraindications resulting in psychosis, unnecessary pain and suffering and ultimately death.
5. Failure to provide standard evaluation and Intensive Care admission for a patient with guarded prognosis, complex medical history.

6. Failure to obtain and record medical history, physical examination and diagnosis.
7. Failure of communications between physicians, pharmacists and nursing staff with concurrent use of multiple directly contraindicated medications, resulting in unnecessary pain, suffering and death.
8. Failure to consult family and or patient's US based physician and to obtain family consent.
9. Indiscriminate medications administration, without medical indications resulting in psychosis, unnecessary pain, suffering and ultimately death.
10. Failure to treat pain and evaluate pain appropriately in a patient with known opiate addiction resulting in psychosis, rapid development of severe dependency, drug to drug interaction and exacerbation of rhabdomyolysis in addition to prolongation of the QT-intervals.
11. Failure to record tests and/or medications administration justification.
12. Failure to prevent administration of the medications patient reported allergies to such as Fentanyl, antipsychotics, Sulfa.
13. Failure to provide appropriate testing including electrolytes, myoglobin blood and urine, liver functions, CBC and CPK till resolution of the symptoms while performing multiple painful tests without medical justification.
14. Failure to discharge patient home as scheduled on February 20, 2006 for unclear reasons.
15. Failure to record medical consultations in appropriate format and failure to dictate the findings.
16. Failure to discuss the intended or actual administration of dangerous medications with the patient and/or his family, in fact administering medications patient specifically refused.
17. Failure to monitor patient with deteriorating vital signs on February 23, 2006.
18. Failure to provide complete and accurate records of the resuscitation efforts.
19. Failure to record death summary.
20. Failure to indicate cause of death, allegedly cardiac arrest due to unspecified cause.
21. Failure to fill out the entire death certificate using known and available information.
22. Hand written corrections of the time of death on the written records.
23. Failure to obtain or provide EKG during entire Code 3, electrolytes, calcium, phosphorus and magnesium levels. The written record exists of EKG showing asystole and of elevated Potassium but the actual results are not in the provided copy of the files.

24. Failure to administer standard resuscitation procedure for in-hospital arrest: immediate defibrillation and intubations.

VI. MEDICAL CONCLUSIONS

Within a reasonable degree of medical probability actions of the physicians, pharmacists and nurses involved in care of Mr. Goldberg caused him unnecessary pain, suffering and ultimately death.

In conclusion, within reasonable medical probability it is the actions of Bumrungard International Hospital and its staff, caused Mr. Goldberg unnecessary pain, suffering and ultimately death.

Failures of the standard of care during hospitalization, cardiac arrest and after death are so egregious that a full investigation of Mr. Joshua Goldberg’s care and circumstances of his tragic death by the independent third party is mandatory.

Opinions are based on my review of the available medical records and current medical information indexed by Medline/Plumbed, New England Journal of Medicine, current editions of the medical texts. Opinions may change as further or different information is presented for a further medical review.

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