JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JANET OLSZEWSKI
DIRECTOR

MEMORANDUM

Date: May 17, 2007

To: Sherri Johnson, Manager
Allegation Section

From: Stephanie Rosenthal, Analyst
Allegation Section

Subject: James Joseph Glazier, M.D.
#43-05-99644
Investigation Authorized: November 15, 2006
File Closure

The complainant alleged that her husband was over anti-coagulated and the licensee and hospital tried to cover it up. The complainant stated that her husband was in a semi-comatose condition when he passed away.

The licensee has no other allegations listed on Licensure 2000.

[redacted] M.D., was retained as the expert witness to review this file. Dr. [redacted] noted that the licensee was dismissed from the civil suit without prejudice. Dr. [redacted] opined that this complaint should not have been filed. Dr. [redacted] opined that the licensee did not fail to meet the minimal standards of care in the treatment of this patient.

Recommendation:
Based on the expert's review that there was no violation, I recommend closing this file with no further action.

Approved:

Sherri Johnson, Manager
Allegation Section

5-17-07
Date

Ray R. Garza, Director
Health Regulatory Division

5/21/07
Date

QUESTIONS TO THE EXPERT

1. Does it appear that the licensee performed an appropriate pre-operative examination of the patient? Please explain.
2. Should the patient have been admitted under the licensee or the primary care physician? Please explain.
3. Should the patient have been heparinized when he was not experiencing atrial fibrillation or intra-ventricular thrombus? Please explain. Did the heparinization post operatively increase the cardiac risks? Please explain. Was this the decision of the licensee or the surgeon? Please explain. Should additional testing have been required prior to surgery? Please explain.
4. Was it appropriate to have the pharmacy anti-coagulation team monitor the patient's medications in this matter? Should the licensee have monitored the pharmacy anti-coagulation team to ensure the treatment provided was appropriate? Please explain.
5. Does the record reflect that the licensee reviewed the patient's lab results and was aware of the results? Did he respond appropriately to these results? Please explain.
6. Does it appear that the licensee was aware that the nursing staff failed to draw labs at the required times to check APTT levels? Did he respond, how should he have responded? Please explain.
7. Did the licensee order appropriate consults? Did the licensee work in conjunction with the surgeon to determine the etiology of the bleeding? Should more have been done given that the patient began experiencing dizziness, hypotension, nausea and diaphoresis on day three post op? Please explain.
8. Did the licensee fail to meet the minimal standards of care in the treatment of this patient? Please explain.

[redacted]

May 7, 2007

[redacted]
Allegation Section
Health Regulatory Division
Bureau of Health Professions
611 W. Ottawa
P.O. Box 30670
Lansing, MI 48909-8170

Re: James Joseph Glazier, MD
Complaint #99644

Dear [redacted]

Henry O. Clark, Jr. was a 51-year-old man with a history of dilated cardiomyopathy, paroxysmal atrial fibrillation, and left hemiparesis secondary to an embolic stroke in 1977. Other problems included history of alcoholism, remote smoking, hypertension, and gallstone pancreatitis. He was admitted to Harper Hospital on June 27, 2001 for a laparascopic cholecystectomy after holding his warfarin therapy for 3 days and started on the heparin therapy protocol by the pharmacy service team. The surgery was performed uneventfully on June 29. He had an aPTT of 106 at 5:30 am on July 1. At 1:40 pm, he had some orthostatic hypotension and was evaluated by the surgery team and by Dr. Glazier. A 5 cm hematoma was noted at the surgical site. He was re-evaluated by both parties at 6:50 pm. At 8:10 pm, he developed respiratory failure and hypovolemic shock, was intubated, and was successfully resuscitated. A pulmonary artery catheter demonstrated normal intracardiac pressures and normal cardiac output, although he remained on vasopressor therapy. He developed multisystem organ failure and septic shock (systemic vascular resistance 814 on 3 pressors and positive blood cultures for enterobacter at autopsy) over the next 2 days and died. Autopsy disclosed 3 liters of intraperitoneal blood, pancreatitis, and liver microabcesses.

The complaint was stimulated by a disgruntled employee and filed by an angry, frustrated wife. In fact, the hospital took responsibility for the failings of the phlebotomy team, the nurses, and the pharmacy service team and settled a civil suit. Dr. Glazier was dismissed from the suit without prejudice. It is not clear why this claim is being reviewed by your department.

Answers to Questions to the Expert

1-2 The patient was admitted to the cardiology service so that he could be monitored for cardiac complications. He was being cared for by the surgery service and they were responsible for all pre-operative, peri-operative, and post-operative care.

3. The patient required anticoagulation because of cardiomyopathy, paroxysmal atrial fibrillation, and history of stroke. In fact, a left ventricular mural thrombus was found at autopsy. Anticoagulation does increase the risk of bleeding, but it was felt to be worth the risk to prevent recurrent stroke. No further testing was required. It is standard operating procedure to offer "bridging anticoagulation" while warfarin is stopped for surgical procedures.

4. Harper Hospital has a process in place where the pharmacy anticoagulation team administers, monitors, and adjusts the heparin dose. This is done independent of the physician once it is ordered. This is standard of care. Failure to properly perform this function is a hospital responsibility.

5. Dr. Glazier visited the patient as required and responded to the lab results when they were abnormal.

6. See answer to question 4.

7. Dr. Glazier saw the patient twice with the surgeons on July 1. The patient was stable until he collapsed. They properly resuscitated him. Unfortunately, he had underlying disease (self-inflicted) that made him high risk for complications and could not recover from his hemodynamic instability.

8. The licensee did not fail to meet the minimal standards of care in the treatment of this patient. This complaint should not have been filed.

Sincerely,

[redacted], M.D.
Professor of Medicine

June 26, 2007

Janet Olszewski, Director
Department of Community Health
201 Townsend St., Capitol View Building – 7th floor
Lansing, MI 48913

RE: BIAS INVESTIGATION INTO THE DEATH OF HENRY O. CLARK, JR. – JAMES JOSEPH GLAZIER, MD FILE 43-05-99644

Dear Director Olszewski,

I received the conclusion to an investigation by the Bureau of Health Professions, Allegation Section in regards to James Joseph Glazier, MD. The expert addressed his conclusion to analyst Stephanie Rosenthal. And, it is signed off by the Allegation Section manager Sherry Johnson and Health Regulatory Division director Ray Garza.

There is nothing ethical about this report. This report contains bias and untrue statements about Mr. Clark, the physician assistant and me. The Department of Community Health should not have spent taxpayers' dollars on a bogus scheme to discredit my husband, the physician assistant and me. The pertinent questions provided by the Department of Community Health to be answer by the expert were not. Your department should not have hired this bias expert in the first place. And, someone at your department should have made an ethical decision to trash this report instead of accepting it as factual and final. At this time, I am requesting that this report be disregarded. In addition, I am demanding a new unbiased, ethical investigation to begin immediately.

Your department has in its possession all of the medical records including the certificate of death [signed by the attending physician James J. Glazier, MD] for Henry O. Clark, Jr. [I have enclosed eleven (11) pages of the medical records for your review.] Yet, your expert obliviously did not utilize them. It further appears that your expert was likely hand picked because of his/her bias. Your department was aware that the bias expert would produce an unethical and bias report. Garbage in, garbage out.

I need to state this LOUD AND CLEAR. Mr. Clark went into Harper Hospital to have surgery to remove his gall bladder. Mr. Clark did not die on the operating table. In fact he was up walking around and conversing. He did not kill himself. His death was not ruled as suicide. The Certificate of Death [enclosed] lists acute intraabdominal hemorrhage for about 2 days and subdiaphragnahic bleeding of undetermined endogy for unknown days. The attending physician signed the Certificate of Death, Dr. James J. Glazier.

On July 1, 2001, Mr. Clark's veins collapsed. He bled internal and external. He could not breathe. He was dizzy. He experience hypotension. All of those events occurred prior to being transferred to the ICU with Dr. Barnwell and me at Henry's side. Henry was conscious with no tubes in his nose or mouth when he arrived at the ICU. When I saw my husband the next day, he was in a semi-comatose state. Mr. Clark's eyes were half open

with a tube in his mouth. Mr. Clark's arms were inside a blanket/sheet that was pulled up close to his chin. He did not move.

This complaint was not stimulated by a disgruntled employee [as your expert stated]. I filed the complaint in October 2005 without knowledge that the PA had been fired by Harper Hospital. The physician assistant is and was a caring, dedicated person who cares very deeply for her patients. She answered Mr. Clark call for help when no one else came. And, other employees know this because one told me. She stepped up to ensure that Mr. Clark received the critical care that he needed. And, I WAS SITTING THERE when Mr. Clark said to the PA "Please don't let me die". The PA stepped up again. How is your Step Up program working?

Here are some additional facts:

1. On June 29, 2001, the day of the operation, Mr. Clark coughed and blood appeared on his gown. I notified Nurse Neino. She called the surgery team [Mr. Clark was on the cardiology floor not on the surgery floor]. WHY WAS THAT? MAYBE BECAUSE DR. GLAZIER WAS THE ATTENDING NOT DR. BARNWELL. Dr. Glazier was not there at 6:50 PM [AS STATED BY YOUR EXPERT]. The surgery unit came in to see my husband about the hematoma. The physician (surgery) applied pressure. I WAS SITTING THERE. When I left my husband for the evening he was breathing. NO ONE CALLED ME TO STATE THAT THERE WERE ANY FURTHER PROBLEMS.

2. On July 1, 2001, our daughter arrives around 5:00 PM to find her Dad dizzy. Mr. Clark complains that the nurses were not responding to him. The daughter called me at home to inform me of the problems including that Mr. Clark told nurse Neino that he takes Lasix by mouth [pill] not in the IV. I have often wondered what was really in the IV?

3. I called the nurse station spoke directly with nurse Neino and Dr. Glazier. I express my concerns about my husband being dizzy and the Lasix. [I did not know about the bleeding earlier that day] Nurse Neino stated that she did not give Mr. Clark Lasix [HOWEVER, THE MEDICAL RECORDS STATES THAT SHE WAS ORDER BY DR. GLAZIER TO HOLD THE LASIX AT 12:20 PM BUT IT WAS SIGN AT 6:05 PM.] and that the doctor is in. Nurse Neino handled the phone to Dr. Glazier. I addressed the dizziness with Dr. Glazier. I ask about a bag being place on my husband to keep him from becoming dizzy when getting up and down. Dr. Glazier stated his concern about infection with the bag. He wanted to keep Mr. Clark a few more days before releasing him on July 4, 2001; however, Mr. Clark died July 3, 2001. I told Dr. Glazier that I was on my way to the hospital. Dr. Glazier NEVER mentioned any problems that my husband may have had that day. THIS WAS THE ONLY TIME THAT I SPOKE TO DR. GLAZIER. I NEVER SAW DR. GLAZIER FROM THE TIME MY HUSBAND ENTERED THE HOSPITAL TO THE DAY MY HUSBAND DIED.

4. I WAS SITTING IN THE ROOM WHEN A TECH COULD NOT LOCATE [WORKED FOR ABOUT ½ HR -- 45 MINS.] A VEIN FOR THE IV. HE INFORMED NURSE NENIO. [I ASKED NURSE NEINO WHEN SHE RETURNED TO THE

ROOM IF THE TECH TOLD HER THAT HE COULD NOT LOCATE A VEIN. SHE SAID YES.] NURSE NEINO TELLS MY HUSBAND THAT HE IS JUST TENSE AND TO GO TO SLEEP. WHEN NEINO LEAVES THE ROOM, MY HUSBAND SAID HE COULD NOT BREATHE. I WENT TO THE NURSE STATION. T HE INSTRUCTION FROM THE DOCTOR WAS TO KEEP MR. CLARK'S BED UP. WHEN I WENT BACK TO THE ROOM TO CHECK ON THE STATUS OF THE BED; MR. CLARK YELL OUT OF THE ROOM, "I AM DYING IN HERE".

5. I WAS SITTING THERE WHEN MY HUSBAND TOLD NURSE PIPER THAT HE COULD NOT BREATHE AND ASKED FOR AN OXGEN MASK. PIPER TOLD MY HUSBAND "NO" UNTIL SHE OBTAINS A PULSE. NURSE PIPE NEVER OBTAINS A PULSE, LEAVES THE ROOM, NEVER RETURNED BUT SHE DID SEND THE PA. THE PA TOOK AN EKG AND HAND IT TO A PHYSICIAN [UNKNOWN TO ME]. HE REVIEWS IT AND WALKS OUT OF THE ROOM AND NEVER RETURN. THEN THE PA TAKES A SECOND EKG [THIS IS WHEN MY HUSBAND ASK HER NOT TO LET HIM DIE] AND LEAVES OUT THE ROOM. WITHIN SECONDS DR. BARNWELL CAME INTO THE ROOM TO FIND MY HUSBAND UNABLE TO BREATHE. DR. BARWELL ASKED ME TO STEP OUT OF THE ROOM. I HEARD DR. BARNWELL YELL OUT OF THE ROOM, "CAN I GET A NURSE IN HERE". MR. CLARK CODED WHILE DR. BARNWELL WAS WITH HIM. DR. BARNWELL AND I TOOK MY HUSBAND TO THE ICU. DR. GLAZIER WAS NOT WITH US.

6. I took my husband to Dr. James Glazier prior to being admitted to Harper Hospital. He was referred to us by Dr. Paul Soboka, my husband's former cardiologist. Dr. Glazier was the attending physician until Mr. Clark went into the ICU and starting dying; then he wanted to make other physicians the attending.

7. Dr. Glazier place Mr. Clark on heparin.

8. Your expert states in Question 3 that anticoagulation does increase the risk of bleeding but no further testing is required. THIS IS NOT TRUE. BLOOD DRAWNS ARE REQUIRED. THERE IS A TEST PTT THAT IS REQUIRED. IN FACT, MY HUSBAND WAS ON COUMIDUM. HE NEVER WAS OVER ANTICOAGULATED AT HOME. In fact, it was nurse Piper that increased the heparin to 900m/hr that caused the bleed. READ THE MEDICAL RECORDS.

9. When you read the medical records it is ONLY after Mr. Clark is in the ICU that Dr. Glazier becomes activated. Dr. Glazier brings in a physician to coordinate Mr. Clark care. He orders to stop the His actions at that time is too little and too late for my beloved husband. My husband was dying at that time. AND, DR. GLAZIER WROTE IN THE MEDICAL RECORDS THAT HE KEPT ME ABREAST OF MY HUSBAND'S CONDITION. THAT IS AN OUTRIGHT LIE. I NEVER SAW DR.GLAZIER.

10. MR. CLARK SHOULD HAVE BEEN PROPERLY CARED FOR ESPECIALLY SINCE YOUR EXPERT WANTS TO RELATE HIS HEALTH AS A FACTOR. THE

TRUTH IS THAT MR. CLARK HAD AN UNEVENTFUL SURGERY. MR. CLARK DID HIS JOB. HE REMAIN STRONG AND CAME THROUGH THE SURGERY. ALL THE PROBLEMS THAT MY HUSBAND ENCOUNTERED WERE CREATED BY HEALTH PROFESSIONALS NOT DOING THEIR JOBS. NOT CARING ABOUT THE PATIENT. THEY ALL KNEW THAT MR. CLARK WAS EXPERIENCING PROBLEMS THAT COULD LEAD TO DEATH. IN ADDITION, THE HEALTH PROFESSIONALS WERE CONTRIBUTING TO THE MULTI - SYSTEM BREAK DOWN THAT MY HUSBAND SUFFERED BY: 1. CONTINUING THE HEPARIN WITHOUT DRAWNING BLOOD TO SUBMIT FOR THE STATS.
2. DISREGARDING SYMPTOMS OF INTERNAL BLEEDING SUCH AS NO VEINS AND DIZZINESS. 3. DISREGARDING EXTERNAL BLEEDING. 4. NONE OF THEM WERE CONCERNED ABOUT THE PATIENT BECAUSE THERE IS A "DO NOT TELL" POLICY IN PLACE AND THE 'CIRCLING AROUND THE WAGON" ATTITUDE.

11. WHAT ROLE AND RESPONSIBILITY DOES THE PHYSICIAN HAVE TO HIS PATIENT AND HIS CARE? Had Dr. Glazier step up to monitor his patient care that included reading charts, lab work, investigate other possible reasons for the patient bleeding and etc. Your expert stated that Dr. Glazier saw the patient twice. And, the results of his two visits did nothing to prevent my husband from BEING OVER ANTICOAGULATED, BLEEDING OUT AND SUFFERING A MULTI-SYSTEM BREAK DOWN. READ THE MEDICAL RECORDS.

Thank you for your consideration for a new investigation.

Sincerely,

Barbara Lewis Clark

Detroit, MI 48235