The following cases are being presented due to an increasing concern for the integrity of our hospital and the care we provide our patients. These situations were compiled from several areas in our hospital by concerned employees from multiple disciplines. These area sample of on-going behaviors that have continued to put our patients in harm's way.

This information is being presented in this manner due to a fear of retribution and retaliation.

21-year-old male admitted as status post auto-pedestrian crash. Patient admitted to ICU intubated and in a C-Collar. Patient was able to move all four extremities. At 1155, Dr. Duane notified that patient has a history of a traumatic brain injury and had short term memory loss per patient's family. Patient continued to wake up and shake head back and forth. Dr. Duane notified during rounds at 1155 and she stated, "patient needs to wake up, not receive sedation, that will fix his blood pressure, he can extubate, and get up." At 1200 during hourly neurological check, patient was then unable to move extremities and no longer had sensation from the nipple down. Dr. Duane notified of the neurological change. STAT MRI order. Patient sustained spinal cord contusion. When patient left the ICU, patient remained a tetraplegic.

21-year-old male presented with traumatic brain injury and was intubated due to his brain injury and inability to protect his airway. His injuries were deemed non-survivable by neurosurgery. Family had been informed of the prognosis but wanted to continue care. Dr. Duane walked into the room during early morning rounds, woke up the patient's father, and informed him that she was going to take out the breathing tube because he was breathing well enough on his own. Per the latest documentation by RN, the patient's GCS was 4. Dr. Duane told the family that if he needed the breathing tube put back in, we were not going to put it back in because he had a non-survivable injury. Patient has previously been made a DNR level A at this time. Dr. Duane extubated the patient at 0608 despite the fact that weaning parameters were not met per respiratory therapy. Per the primary RN, the patient immediately had oxygen desaturations into the 40s. ICU staff made an attempt to get the crash cart for resuscitation but were stopped by Dr. Duane. She stated the injury was non-survivable. Neither the rest of the family, the primary team, chaplain services, or LifeGift were notified. The patient was unable to protect his own airway and died 18 minutes later at 0626 without his mother or the rest of his family at his bedside. None of his family was involved in the decision to remove his airway. Dr. Duane called Dr. Stephenson to come pronounce the patient so that "[she could] make it to Easter mass." Chaplain Leann approached the oncoming primary RN about who we needed to talk to about what happened, because protocol was not followed. The patient was already being followed by LifeGift. Chaplain Leann was also concerned that the patient's family did not have the support they needed because chaplain was not notified. Nightshift primary RN said that patient's family was upset about the way it was done and said, "it is because we are Mexican and not English speaking." Chaplain and dayshift primary RN called Dr. Stephenson per chaplain's request to ask why the patient had been extubated and inquire about why events had transpired. Dr. Stephenson said he was called in as a favor to pronounce the patient and speak with family. He was not aware that the patient had just been extubated minutes prior to death, Dr. Duane told him that patient had passed weaning parameters the day prior. Dr. Stephenson's understanding was that the patient had been extubated yesterday; he said we needed to talk to Dr. Duane about how things had happened as he was not there.

Middle aged female admitted for strangulation. Patient extubated without notification or updating patient's family. Per the primary RN the following day, patient's family

remained unpleased with the way the extubation was handled per primary team. During rounds, Dr. Duane stated that no one was to perform CPR or reintubate despite the patient being a full code at the time of rounds per family's wishes. Dr. Duane told the SICU Resident that he needed to get family to sign Level C paperwork later that day. Dr. Duane proceeded to enter the patient's room and spoke with the patient's pastor who was visiting at the time. She told him that she needed his help explaining to the family that the patient would not be resuscitated should her heart stop and that we would not replace the breathing tube. She informed him that the patient needed to be allowed to pass peacefully. She continued to repeat that her care was futile despite being a full code. A family meeting occurred at 1700, the patient's three daughters and brother were present and were all very upset with how the situation was handled. SICU resident was able to convince two of the daughters to make the patient a level B DNR. The third daughter stormed out of the room, screaming that we killed her mother. Patient status was changed to med/surg and patient was moved out of the ICU.

23 year old female status post abortion admitted to MICU service. Patient was septic, and surgery was consulted for possible dead bowel. Dr. Duane arrived in ICU to evaluate patient and upon arrival to the unit a nurse said, "I am glad you are here, this girl is very sick" to which Dr. Duane responded, "You know why she is sick? She did this to herself." Dr. Duane saw the patient and stated she did not need to go to OR. Six hours later SICU rounded on patient again and the decision was made to go to OR. As patient was being transferred to OR, she begged the primary RN to not let her die. In the OR it was discovered that the patient had dead bowel, and the decision was made to transfer the patient back to ICU to re-evaluate bowel in a few hours. On arrival back from OR, the patient coded. Family arrived at bedside. During resuscitative measures to revive the patient, Dr. Duane walked into the room and said "What are you doing? Stop compressions." She walked over to the patient, kissed her on the forehead, gave her a hail mary, and walked out.

Middle aged male status post gunshot wound to the head being followed by LifeGift started to decompensate. SICU resident called Dr. Duane to notify her of patient condition. She replied to not code the patient. She stated that JPS was organ hungry and that we were just trying to beat out Vanderbilt.

Surgical patient was scheduled for a below the knee amputation for a vascular foot wound. Dr. Duane started the case and cut the anterior and posterior flaps too short. This showed a lack of knowledge of a procedure. She cut her anterior flap 5 cm from the tubercle; however, the standard of care is 10-12.5 cm from the tubercle. The resident then had to resect extensive muscle and manipulate in order to close the amputation and attempted to fix as much as they could. As such, the tibia had to be cut shorter than intended which resulted in a non-functioning below the knee amputation; there is no prosthesis made for this degree of amputation. After discharge, the patient got confused and fell at home which led to further injury of her BKA and then an infected wound. The patient had to undergo a revision of the below the knee amputation to an above the knee amputation.

25-year-old male had been admitted with self-inflicted gunshot wound to the head. There was an extensive legal debate between the parents and his common law wife about who would be decision maker. The common law wife did not want to withdraw care on the patient, but his parents did. After a long conversation, the common law wife agreed to withdraw care as long as she could see him prior to withdrawal of care. Dr. Duane ordered to primary RN to stop all vasopressors immediately (before the common law wife was able to see the patient as was agreed upon) resulting in a rapid decline in the patient's status. LifeGift was not informed of the changes in plan of care and did not receive an opportunity to approach the family for options.

24-year-old male status post motor vehicle collision in the trauma bay lost pulses. Patient was given blood and got pulses back. Pulses were lost again, Dr. Duane entered the bay and states to stop care and calls time of death. The residents both agree that the patient has potential for survival if they cross clamp his aorta and give him more blood. She refused to let the residents provide further care. While they waited outside the trauma bay trying to decide who would update family, the nurse yells, "Is he supposed to be breathing?" The patient was not on a ventilator at this point and was breathing completely on his own. Dr. Duane looks over and says, "Yeah, that's how they look when they are dead." She walked over to the patient who was gasping for air and placed the ultrasound on the heart to find that it was beating. He was reattached to life support and blood transfusions were restarted. Although residents advocated to take the patient to OR immediately, she ordered for STAT CTs to be completed. She then left a critical patient to evaluate a non-emergent consult. The MVC patient's CT showed a kidney avulsion, and the residents elected to take the patient to OR. The kidney had to be removed in OR. The patient passed away in the ICU due to coagulopathy. When the residents went to have the family meeting to inform them that he had passed, Dr. Duane elected to start a laparoscopic appendectomy by herself although she had admitted that she had not used the optically guided technique before with the OptiView Trocar. That patient sustained bowel injury which required substantial intervention other surgeons.

A middle-aged woman came in as a surgery patient for a normal outpatient procedure. Dr. Duane performed a thyroidectomy. Dr. Duane stated that she had not performed this procedure since she was in residency. She proceeded with the procedure as planned despite her lack of comfort with the procedure. During the procedure, Dr. Duane resected too much of the parathyroid. The patient is now having refractory hypocalcemia and is not responding to IV calcium. Synthetic parathyroid hormone is expensive and may place a financial strain on this patient.

Collectively, the staff feel like we are losing our identity at JPS and sacrificing our commitment to patient care for the hubris of one physician. We have always made it our priority to care for patients who are sick, despite their available resources. The commitment to our diverse patient population with limited access to healthcare has been our mission since JPS was founded. We take joy and satisfaction in being their voice and their advocates. Yet, we are being asked to look the other way as the Chief of Surgery commits such egregious acts as summoning the U.S. Immigration and Customs Enforcement agency to forcefully discharge patients, performing procedures well beyond her scope of practice and abilities to the point of patient endangerment, and sabotaging the goodwill between patients and physicians. We can no longer stand by and condone these acts through our silence, violating the tenet of beneficence. Further, there is a pervasive fear by the entire hospital staff of going through the usual channels (MIDAS reports and chain-of-command) to keep Dr. Duane accountable due to a very real concern of retaliation. The many MIDAS reports that have been sent have long been felt to be disregarded as there have been zero consequences and no accountability. If our concerns are not addressed, we will reach out to the Texas Medical Board.