

**Chapter 34: The New York Methodist Hospital, Brooklyn (1995-1998)**

January 1996. A gray winter morning. We crossed the Goethals Bridge, finding Staten Island digging itself out of the “snow storm of the decade.” We drove directly towards our rented house on Sinclair Ave, at the southern tip of the island. A tall mountain of garbage bags —many of them split, discharging decaying contents into the white snow—blocked the entry to the driveway. As pre-arranged, we found the house’s keys in the mailbox; the house was relatively clean but smelt like a cheap curry joint in Bombay. We had rented it from an Indian who had introduced himself as Captain Choprakumar —I had assumed that “Captain” was his first name but it turned out that he had been a ship Captain in the Indian merchant navy. It was a typical cheaply built pseudo Tudor, two storey wooden Staten Island house—the front shrouded with a thin layer of red bricks. It consisted of a small landscaped gravel garden, four bed rooms, a spacious basement, a study on the landings, wooden stairway in the front, an alternative winding metal staircase at the back, roomy living room, polished wooden floors—not bad for \$ 1600 per month in New York.

Thus started our ten-year sojourn in New York City—long ten years: we lived, raised our sons, we had good days and bad days. But looking back at those years, I mainly see a single hazy picture: an endless commute to work and back, and non ending wars with the “enemies.” Trying to sum up our New York saga—to recapture the atmosphere— I will borrow, in chronological order, brief segments from the *roman à clef* I penned (under a pseudonym) in 2001. To a few of the protagonists mentioned I have restored their real names, others will remain with their fictive names.

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September 1998. My black 1991 Caddy-Deville reaches the top of the Verrazano Bridge and rolls on towards Brooklyn. It is misty as the sun rises from Coney Island’s side. I relish the sight, for the upper deck of the Verrazano offers a magnificent vista. In front there is Brooklyn, looking so

peaceful with the placid blanket of red and yellow leaves welcoming this late day of September. On the right Coney Island; below, the calm blue water dotted with ships steaming in and out of New York Harbor. On the left I can make out the southern tip of Manhattan and the Statue of Liberty, lit by the first rays of sunlight. And behind me Staten Island and the house we bought last year: a well built "colonial" on a quarter of an acre. It had cost us 400,000, 95 percent of which we had to borrow. But it is a pleasant house, only ten minutes by bicycle from the South Beach. The drive today is agreeable, unlike the routine rush-hour bumper-to-bumper morning crawl to Brooklyn. I tune in to the public radio station, it is too early for NPR news, but the classical music suites me just fine. Driving is the only time I can think properly. Sometimes my thoughts embrace me so tightly I end up in front of the hospital without a clue as to how I got there. I plan my day: first I have to do an appendectomy for the acute appendicitis which had been admitted during the night; if not carried out before six am it will have to wait to the end of the elective cases—which usually means in the evening. Then, at 8 am, we'll have the weekly Mortality and Morbidity Meeting. I wonder how stormy it'll be as the war with the Iranian Mafia carries on. They control everything: the Medical Board, the Board of Trustees, admissions, referrals, committees —CEO Howard is under their boots. Only Winestone and I stand up against them but are we going to win? Winestone is extremely rich and powerful and will survive but what about me—how long will I last in this hospital? In 1996, after I had joined the department, the Iranians, who were dominating the hospital's credentialing procedures, found a loophole in the bylaws to prevent me from treating patients and entering the operating rooms—"he cannot be an attending surgeon on a temporary license," they claimed. When eventually I received the Green Card, and thus a permanent New York license, they blocked my clinical privileges by repeatedly canceling the "credentialing committee". For one entire year I was limited to teaching residents and writing papers.

*Brooklyn.* I snap back to the present. I take the Thirty Eighth Street turnoff and immediately start bouncing over the potholes anchored

like landmines in the roadway. I turn right off Fourth Avenue onto Ninth Street and then into the hospital doctors' parking lot. I insert the electronic card, and the railing opens up. The lot for the attending physicians is empty now, but not for long. It would soon be filled with cars branded Mercedes Benz, BMW, Lexus, and of course the customary large jeeps and SUVs whose farthest off road trek would be crossing a grassy median.

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*Main auditorium, 8 am.*

"I present the case of MJ, a ninety-year-old female patient. Diagnosis: right carotid stenosis. Complications: stroke and mortality. Procedure: right carotid endarterectomy. Surgeon: Dr. Maghazeh. Resident: Dr. Ed Johansson."

The weekly Mortality and Morbidity conference, known to everybody as the M&M, is starting. It is probably the hottest ritual in the life of any teaching surgical department in the country. The purpose of the M&M is to discuss all so-called 'adverse outcomes' generated by any member of the Department. At the Methodist Hospital, we always had a long list of cases to discuss, and a waiting period of a couple of weeks between the actual event and its eventual analysis was not unusual. But then, of course, the patients concerned no longer stood to benefit from those discussions; it was the future patients who might benefit. The aim of the M&Ms is to educate the responsible surgeon and help him learn from his own mistakes. The best we can hope for is that repeatedly exposing members of staff to the mistakes of others will prevent them from making similar errors later on. The least we can hope for is the prevention of complications by intimidation. "If I know that all my mishaps will be routinely exposed to my colleagues," this line of reasoning goes, "I will be more cautious." In order to achieve such ambitious goals, the M&M has to be objective. The rules are simple: all complications and fatalities that occur in any patient treated by any member of the department should be presented. A complication is a complication, regardless of whether the eventual outcome is a triumph or a tragedy.

Whether or not the M&M is objective and accomplishes its objectives depends mainly on the local chairman and the political environment. Today,

Dr. Larry Winestone is conducting the meeting. The resident who shared the stage with the chairman and is presenting the case is Dr. Johansson. His tall frame dwarfs Winestone's comparatively diminutive though not small frame.

Winestone peeks above his glasses at the printed summary of the case: "Please tell us what happened, Dr. Johansson."

"This elderly woman was presented to the vascular service with transient ischemic attacks involving the right cerebral hemisphere. Arterial Duplex scan demonstrated a seventy percent stenosis of the right carotid artery. After medical clearance was obtained, the patient underwent a carotid endarterectomy under general anesthesia using a shunt. The operation was uneventful—"

There is a hush in the auditorium. The tense silence is not unusual when the weekly habitual complication of Dr. Maghazeh, the New York Methodist Hospital's Godfather, was being presented. Dr. Paul Maghazeh, in his late sixties and fragile looking, is a typical "do-it-all" Brooklyn surgeon. Name it, and he'd do it: general surgery, vascular bypasses and chest operations. Born in Iran he immigrated to France with his aristocratic family before the downfall of the Shah. He completed medical school in the Sorbonne, Paris, and a surgical residency at the Methodist Hospital long before "New York" had been added to its name. For thirty years he was considered the leading local private surgeon, gathering immense influence and wealth. The showpiece of his wealth was an oceanfront mansion and a large boat on the tip of the Island. This was where Dr. Maghazeh used to escape each Friday night after a strenuous operating week, far from his dying patients and their anxious families. Recently, in an attempt to appease the Iranian mafia, Maghazeh was nominated by Winestone as the Vice Chairman of surgery.

Maghazeh has a hearing aid, but is not using it. Instead, he cups a hand behind his right ear and appears to listen attentively. He sits in the center of the second row.

"What happened then?" Winestone adopts his characteristic calm and objective tone.

Johansson talks into the microphone: "In the recovery room the patient failed to wake up from anesthesia and was noted to suffer from a dense left hemiparesis, weakness of the left side of her body. We rushed her back into the OR and on re-exploration of the wound found the artery pulsatile and without a thrombus. A postoperative CT revealed a massive stroke of the brain on the side of the operation. The patient expired the following day."

I can't bear to listen. In my mind I had long since nicknamed Maghazeh "Terminator One". We are presented with a similar case of his every week, and yet even he is outperformed by long and far by "Terminator Two", Dr. Mohammad Oloumi. Oloumi; the almighty President of the Medical Board, is the second surgeon in the ruling triumvirate at the New York Methodist Hospital. A son of a Persian Ayatollah, he studied medicine in Iran and trained in surgery at the Methodist Hospital under Maghazeh's wings. He had married a local Irish nurse and established himself in private practice. He is a real "cowboy surgeon" and for many years considered the "top knife" by the hospital medical community. Unlike his mentor Maghazeh —always calm, controlled and poker faced, the gray eminence of the Methodist Hospital— Oloumi is loud mouthed and macho like.

My lists are full of their cases; I know their patterns. Full names are never mentioned during the M&M, but I can present Mrs. MJ's story in full detail without looking at her chart. By now I know how they manage to terminate their patients.

Dr. Johansson finishes his brief presentation. He dries the sweat from his face. Dr. Winestone looks up at him: "What can you tell us about this complication? Was it preventable, avoidable?"

The resident shrugs. "Dr. Winestone, the operation was uneventful. We had no problems."

Winestone leans over and pinches the resident on his left elbow: "Whaddya mean no problems? The patient died. This is no problem?"

Loud laughter erupts from the audience, stirring the slumber of many

junior residents. They look around briefly, quickly lose interest and start napping on their other hand. Just about everyone else appreciates the chairman's sense of humor. They know that Johansson is not terribly smart and is digging his own grave. "In fact, we were very fast. We cleaned the artery in forty-five minutes. We used a shunt to perfuse the brain," Johansson says, moistening his lips. A few of the junior residents start sitting up and shifting in their seats to get more comfortable.

"Were you happy at the end of the operation?" asks Winestone.

"Yes, we were happy!" Johansson almost screams.

The audience knows what to expect; this is a part of the weekly ritual. Slightly funny but predictable, that is unless some one dares to open his mouth. I look around. Maghazeh hides behind his poker face, and in the back David Glass is sulking. Dave is a private vascular surgeon who abhors Maghazeh. I doubt that he'll speak up.

Winestone addresses Rahman Ilkhani, the chief of vascular surgery, a Kurdistan born private surgeon. "If this were your patient, would the results have been different?" This is Winestone's famous gimmick. It makes the M&Ms more objective.

Ilkhani, a short thin man in his early fifties and completely bald, is known as a technically solid surgeon of very good judgment. His comments at the M&M meeting are usually informative and balanced—unless the discussion involves his friends, mentors or partners. Ilkhani pronounces his words with precision. "Dr. Winestone," he says, "I had the opportunity to read the Duplex scan. It showed a seventy percent occlusion in the right internal carotid artery. This is a significant lesion, which, in a symptomatic patient—as this lady was, indicates the need for an operation. Indeed, we are told here that she suffered from transient ischemic attacks. As you know, recent prospective randomized trials from this country as well as from Europe have demonstrated that the operation would have been appropriate even in the absence of any symptoms. Therefore, I find the indication for surgery appropriate. As to this unfortunate complication, we know that the combined mortality and stroke rate after such operations is five percent in the best

hands and in the top centers. I believe that Dr. Maghazeh took all the usual precautions, including administration of heparin and insertion of an intraluminal shunt. Yes, the outcome is sad, but I do not see how it could have been prevented or better managed. Operating on these old patients is risky. We have to take risks like these. We are surgeons."

"Anybody want to comment? Does anyone think that the complication could have been avoided or better handled?" asks the chairman.

Silence. The few vascular surgeons present stare at their hands. Dave Glass winks at me but doesn't open his mouth. Screw Ilkhani. What a bullshitter. To operate on a ninety-year-old bedridden woman is crazy. Ilkhani himself would not have touched her, but he is prepared to lie in public to defend his old mentor. Another kill for Terminator One.

I raise my hand and begin talking before being acknowledged by the Chairman. "Dr. Johansson," I say clearly, "could you please tell us a little about the exact nature of the patient's symptoms? Could you be more specific?"

Winestone shoots a look of mild irritation at me as if to say: "shut up and let me close this case." But Johansson responds anyway: "Mmm, I guess she had TIA's. I can't tell you more. I never talked to the lady before the operation. She arrived at the OR directly from Medicine and then she died—"

Faint laughter is heard from fellow residents. One should not say such things. Residents are supposed to know the patients they operate on. It is a key requirement stipulated by the American Board of Surgery that the operating resident evaluates his patient before the operation and takes active part in the postoperative care. Everyone knows that this is sometimes impossible and that the resident may first meet the patients when they are already deep under anesthesia, but to admit to it openly is daft!

"Dr. Maghazeh, do you have anything to add?" Winestone addresses Maghazeh himself, the attending surgeon responsible for the operation.

I stand up this time. I am not going to let this one slip so easily. *Fuck'em.* "Dr. Winestone, I asked Dr. Johansson for information on the symptoms displayed by this patient. Could I have an answer, please?"

Winestone ignores me and looks at Maghazeh, who responds in a low voice, talking quietly and swallowing words. "Dr. Winestone, this is an unfortunate case. A pleasant old lady, with a significant carotid lesion. The operation was routine. The shunt went in and out, no problems. I could not do it any better. Very unfortunate."

"Dr. Maghazeh," I blurt out before Winestone can take over. "The symptoms? What were the symptoms? Was she symptomatic at all? What was her functional status? Could she walk?"

The *Padrino*—so we call him behind his back—turns around and looks in my direction. There is a hush in the auditorium. No one had ever directly questioned the great Maghazeh about indications. For Maghazeh, the indication for surgery is the desire to operate. He speaks with belabored patience. "Dr. Schein," he says slowly and methodically, "the patient suffered from headaches and dizziness. She had a significant stenosis. Why didn't you listen to Dr. Ilkhani?"

"Because these are non-specific symptoms, not TIAs. This ninety-year-old lady was bedridden, is that not so? I do not think that there was any reason to operate on her."

Winestone holds his hand up. "Let us move to the next case," he says, pointing to Dr. Jim Rusk, who takes minutes of the meeting: "Dr. Rusk, what is our conclusion for the minutes?"

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*Ten a.m.* The grand round lecture, which follows the M & M, is over. No one bothers to ask questions. I stuff the printed M&M case summaries into the pocket of my white coat. This is confidential department material to be collected and destroyed after the meeting, with only one copy kept by the department. I'm nevertheless collecting the papers for my own files. I see others doing the same. An "insurance policy" we call it, against potential enemies—only as a prophylactic measure, of course. In the corridor I bump into Dave Glass. He put his arm around my shoulder: "Moshe, very brave, very brave. Did you notice the silence? They were astounded. To ask the old fart about indications. Unheard of at the old Methodist Hospital!" Dave has a

pleasant smiling face, a well-trimmed brown mustache, and a perfectly matching curly brown hairdo. Our residents claim it is a wig that had recently been spotted sliding down his wet scalp after a difficult repair of an abdominal aortic aneurysm. We walk towards the elevators. "Hey, Moshe," he continued. "I watched Oloumi's face during the discussion of Padrino's case. Boy, he suffered. Watch your back, though. You know Oloumi and Sosler are buddies. And I can tell you, Fat Bruce has some rough connections in this part of town." Dave is referring to the third in the aforementioned triumvirate —Dr. Bruce Sosler: a half Jew, half Italian, born and bred in Brooklyn. As a graduate of a Caribbean medical school, he completed an Internal Medicine residency in the Methodist where he met and bonded with Oloumi. Energetic despite his immense size, Sosler became a Clinical Professor of Medicine with two publications on his curriculum vitae. He and Oloumi, both in their late fifties are as close as brothers and socialize together at top Manhattan restaurants and Bahamas casinos, with women in Atlantic City. Sosler is known to have connection with the "family".

"Dave, don't get carried away. This is just a hospital in Brooklyn, not a mobster joint. But thanks anyway." We carry on down the hall. A few nurses step aside as we saunter past. We nod our thanks. "I know the risks, but I won't shut up. This simply has to be stopped. I've been here for almost three years now. Mistakes and errors happen, everywhere and to everybody. But what these guys are doing is appalling."

Glass laughs. "I am with you buddy, I am with you, but I've known them much longer than you. Prior to your arrival, the Padrino attempted to take away my vascular privileges for nothing. I mean, really. For nothing. Winestone managed to save my ass. I need to make money; you know how much my ex wife gets? You have to pay mortgage as well. You have kids in college? Expensive hey?" He ponders his own situation briefly enough for me to give my own some consideration but not long enough to come to any conclusions. "So let's be careful."

I nod. "I wonder how Winestone will react."

"He will give you shit for opening your big mouth. Just shut up, listen

to him and swallow it. Whether you like it or not, he's the boss. Larry is a good guy but he has to co-exist with these guys. He's going to give you a hard time but just shut up."

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Back on the medical floor I see a few consults. The first one is a semi-comatose, post stroke octogenarian on whom I am requested to operatively insert a stomach tube—a gastrostomy. I place the old man in a sitting position and bring a spoonful of water to his mouth. He swallows nicely. He doesn't need an operation or even an endoscopic gastrostomy; all he needs is to be patiently spoon-fed. And what is wrong with a small diameter, soft feeding tube from his nose to the stomach? "No indication for gastrostomy," I write in the consult note, knowing that a few days later somebody—like Oloumi or one of his buddies— will do the gastrostomy anyway. *Another unnecessary operation and misspent money.* Similar patients are presented frequently at the weekly M&M conferences, nationwide. "How could we let him starve?" is the usual justification, or sometimes it is: "The nursing home won't admit him, or her, without a gastrostomy."

The next patient I see is even more depressing. Three months ago I bypassed her stomach and bile duct for a widely spread pancreatic cancer. I injected her celiac plexus with alcohol, eliminating the intractable back pain. Now she is lying moribund in bed with an infected venous catheter. It was implanted elsewhere for the administration of chemotherapy. I talk to her daughter. "Didn't I tell you that chemotherapy is useless in her case?"

"Yes, but they told me that it may prolong her life."

I call the OR to book this patient for the removal of infected Portocath. Another futile procedure. *Do all terminally ill patients need to be decorated with feeding tubes and poisoned with costly and mostly ineffective chemotherapy?* One of Dr. Winestone's habitual jabs to the residents is: 'What is impossible to find in any hospital?' Answer: 'An oncologist who refuses to administer chemotherapy.'

Another consult: A ninety-five-year-old totally demented lady lying contracted in a pool of fresh feces; the obligatory stomach tube in place. Her

"acute surgical problem" are two large trochanteric bedsores for which she is receiving intravenous antibiotics. I prescribe 'local treatment' and recommend the cessation of the antibiotics, hoping for the disease to take its natural human course. I have seen similar patients subjected to major plastic reconstructive surgery, probably motivated by Medicare coverage.

Today I decide not to stop on the fourth floor. Moving around on this floor would definitely not enhance my mood. The fourth floor is dedicated to "chronic ventilator" cases; patients who have partially recovered from a severe acute illness but still need artificial breathing through a tracheal tube. After a prolonged and costly stay in the intensive care unit they are transferred to this section for long-term ventilation at a lower daily cost.

Our residents call the floor "Cape Canaveral" because it is from here that cases are launched into eternal space at night. It is predictable. The tracheal tubes require dedicated suctioning and cleaning in order to remain patent. However, this service is seldom provided, and definitely not at night. You see your patient during evening rounds smiling and well. The next morning you are even informed that he or she had expired.

"What happened?" you ask. It is a rhetorical question because you know that they suffocated, drowning in their own tracheal and bronchial secretions.

"Poor old Mrs. Santiago," the resident says. "She was launched." No further explanation is needed. We often exchange the tracheal tube in such patients, knowing how dirty and clogged they can get. No use to complain; management is not interested.

Next I have to go to a hospital committee. I dread exposure to a team of administrators in gray suits and manager-nurses in high heels, talking a neologistic jargon spiced with words such as "proactive" and "prioritized". According to them "we" are doing well, meaning the budget is positive. Every launch at Cape Canaveral, each of the unnecessary operations by Oloumi, Maghazeh and the others eventually translates into numbers in black ink, often in the shape of zeroes.

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Previously, In South Africa and Israel, I had encountered corrupted and greedy doctors; I had seen serious errors committed and hushed up. I knew that some surgeons are like vultures— they love to operate and they need to operate in order to make money, but what I had found now in New York was beyond description. The over crowding of surgeons and other specialists, the extreme “fee for service system” —you are penalized for not operating —the “balkanization” of doctors based on their ethnic origin, all led to a constant cut throat struggle for even the smallest hernia case. The corruption, malpractice, and political intrigues I encountered at the New York Methodist Hospital were astounding when observed through my relatively naïve eyes of those days. This situation seemed to prevail at least in the medical jungle of the boroughs, away from the few ivory towers of Manhattan.

But meanwhile the months and years passed by. The “cold war”, was occasionally interrupted by hot skirmishes, between *us* —Winestone and his boys—and *them* —the “private mafia”, which continued incessantly at the M & M meetings, hospital committees and in the background. As Winestone’s right hand man I was drawn into the struggle with which I have gradually become obsessed with— my personality seemed to enjoy combating forces which it perceived evil and dangerous. As in the interim, supported by Chairman Winestone, I was climbing the academic ladder at Cornell’s Medical College, the department with which I was affiliated. I was teaching residents, helping them to publish, and writing and editing a few books. My clinical practice, however, never grew to be busy enough, as all referrals from the hospital and community were channeled by our enemies to themselves, and away from us. Otherwise, in retrospect at least, our life was satisfying: our previously dire financial situation improved, the family was reasonably happy, we traveled extensively —nationally and abroad—Staten Island restaurants offered the best Italian food. Only the daily commute was horrendous and nerve wrecking. But, hey, what do you want? This was New York!

[See pictures below](#)



Our rented house on Sinclair Avenue, Staten Island



The leaders of the New York Methodist Hospital: CEO Howard (behind) and Vice Chairman for Medical Affairs, Dr. Farbstein (the couple nicknamed: Don Quixote and Sancho Pancha)

More pictures below...



The Verrazano Bridge, leaving Staten Island



Our house on Dahlia Street, Staten Island



Dr. Paul Maghazeh (the "Padrino")