January 24, 2026

[redacted]

Dear Dr. Cunningham and Dr. Ekhardt,

I received the letter from Dr. Cunningham dated **December 8, 2025**, which—rather than addressing my specific inquiries—appeared to be a standardized response from legal counsel outlining general hospital protocols. These are protocols I have already had to experience and learn about in a deeply unfortunate and personal way.

Dr. Eckhardt, I have included you directly in this response because Dr. Cunningham's letter did not provide any contact information for reply. I trust that you will ensure this response reaches him.

Concern for the State of Patient Care

I am profoundly concerned about the current state of the healthcare system. I imagine that both of you were trained during a time when care was more **patient-focused** than it has become today. It has been deeply troubling to witness firsthand how **patient-specific conditions and contraindications are now routinely overridden** in service of rigid administrative protocols—and to understand that physician livelihood, compensation, and job security may be tied to compliance with these systems.

Within the span of **one year**, my family lost **both grandfathers**—both in Methodist hospitals, both following what were initially expected to be short admissions, and both after the administration of **clearly contraindicated medications**. My children watched both of their grandfathers suffer prolonged, preventable declines before death.

My Father-in-Law's Death

My father-in-law had Parkinson's disease that had long been well controlled through medication and diet. He was brought to **Methodist West** solely for overnight observation after developing nighttime hallucinations that posed a fall risk, while adjustments were being made to his Parkinson's medications.

On one evening, my mother-in-law shared dinner with him in his room, walked the hospital floor with him, and spoke with him normally. She returned the next morning to find him **unable to speak or move voluntarily**, with tremors so severe that the bed frame was violently striking the wall and floor. He soon progressed into a rigid, frozen state, completely unable to move.

In disbelief, my mother-in-law asked what had happened overnight. She was told by the nurse that he had been up with hallucinations and was therefore administered **Haloperidol**, as that was *hospital protocol* for hallucinations. The nurse relayed this information with confidence, unaware of the catastrophic implications of that medication for a patient with Parkinson's disease.

Upon hearing this, my mother-in-law's jaw dropped—fully aware that **Haloperidol is explicitly contraindicated in Parkinson's patients** due to its profound and often irreversible effects. The nurse, however, appeared unaware of why this reaction was so devastating—an alarming consequence of training rooted exclusively in protocol adherence, without understanding or recognition of contraindications and their severity.

Somehow, hospital protocol allowed the black box warning for Haloperidol use in a Parkinson's patient to be ignored or overlooked—not only by the nurse, but also by the attending physician and the hospital pharmacy.

From that point forward, his dopaminergic medications were never again effective. My children were forced to see their grandfather in a profoundly altered and unrecognizable state during repeated hospital visits, until the heartbreaking decision was made to allow him to pass in hospice. That devastating condition—caused by medication mismanagement—was the **last version of their Papa they would ever know**.

My Father's Hospitalization and Death

Exactly one year later, we found ourselves back in the hospital following my father's heart attack. After stabilization and being told to prepare for his discharge the following day, I received a call at work informing me that he could no longer be released due to the onset of atrial fibrillation.

I am aware that initial **norepinephrine was continued well beyond his declared stabilization**. Without cardioversion—and with nutrition entirely withheld by the hosital—his

already medically compromised body miraculously returned to normal sinus rhythm after a few days, and we were again told to prepare for discharge.

The following morning, I received another call from the attending physician stating that he had returned to atrial fibrillation and that, upon my asking, the cause was “unknown.” As I was hanging up, I overheard the physician ask the nurse whether the **norepinephrine drip was still running**.

What I later learned was that my father experienced overnight hypotension and—following protocol—was **restarted on norepinephrine**, despite the strong likelihood that the hypotension was caused by the cocktail of antiarrhythmic medications he had received for the prior episode, and despite the fact that his initial atrial fibrillation had been **norepinephrine-induced**. The omission of this information during that phone call strongly suggests awareness that this was a clinical misstep.

At that point, one would reasonably expect the focus to be on **urgent cardioversion** in a severely cardiopulmonary-compromised patient who had also been **deprived of nutrition for nearly a week** due to a delayed swallow study over the holiday.

Instead, cardioversion was refused unless my father consented to **Eliquis**.

My father repeatedly informed the medical team that he could not tolerate Eliquis. He had previously experienced excessive bleeding on that medication and had been explicitly instructed by his physician to avoid it permanently due to his bleeding risk and cardiopulmonary compromise. He had undergone a **successful cardioversion in 2023 using Heparin**, and I pleaded with the team to repeat that approach.

A nurse responded, “We would never do a cardioversion with Heparin.”

I now understand that this response was not based on what was safest or most appropriate for my father, but rather on **protocol compliance**.

Faced with the continued refusal of cardioversion, my father ultimately agreed to Eliquis—despite his excessive bleeding contraindication—because the life-saving procedure he needed was being withheld unless he complied. Even though it has been nearly 25 years since I studied pharmacology, I still remember that a patient’s **reported and documented intolerance is a clear contraindication for a medication**, especially when an effective and previously tolerated alternative exists.

As he had warned, Eliquis caused a **major clinical bleed**. In a cardiopulmonary-compromised, completely malnourished patient, this was catastrophic. Interestingly, as the circumstances were more dire in the following days, the medical team quietly began administration of Heparin in preparation for cardioversion. This was never acknowledged to the family and, unfortunately, it was too little too late with his condition deteriorating severely prior to an opportunity for cardioversion.

His body never recovered. My children, my mother, my family, and I were once again forced to watch the prolonged suffering and death of a grandfather—following the protocol-driven administration of yet another clearly contraindicated medication, regardless of a safe and historically effective alternative.

Closing Perspective

I want to be very clear: **we are not a litigious family**. While there were unmistakable protocol-driven medication errors in the deaths of both my father-in-law and my father, we recognize that legal action would bring no healing. Both men had chronic health conditions, and we are grateful for the time we were given with them.

What deeply troubles me is the certainty that **these are not isolated cases**.

I cannot imagine the cumulative harm being done to patients who fall outside the “standard” population model. What is even more alarming is that during my father’s stay in the CCU, I interacted with numerous residents—this is how they are being taught to practice medicine. **Rigid protocol adherence without critical thinking, without respect for contraindications, and without individualized assessment.**

I imagine that you were trained during a time when **critical thinking and patient-centered care** were still foundational. Under strictly protocol-driven systems, critical thinking cannot be taught—and therefore cannot survive.

I am truly fearful for the future of healthcare. I fully understand that your current career positions in hospital administration are dependent on your strict compliance with protocols, but I sincerely pray that you will reflect on this reality and find it within yourselves to advocate for a return to **patient-focused medicine, clinical judgment, and ethical courage**.

Respectfully,

Mindy Richtsmeier
Daughter of Richard Henrich