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Note to Chart

The following is a summary of a meeting held in my office at 12:15PM on November 26, 2018. In attendance were William Husel, D.O., and David Ralston, M.D., along with myself. This was the one and only conversation I had with Dr. Husel related to his dosing practices. I had previously met with him to let him know about the suspension, but we didn't talk about the details then.

I initially explained to Dr. Husel that the purpose of the meeting was to discuss a report we had received about 3 recent patients that had been palliatively extubated by him and had been given very high doses of Fentanyl and Versed as part of that procedure. There are serious concerns about these doses in particular.

Dr. Husel responded that he was aware that some might consider these to be high doses, but he is trained as an Anesthesiologist, and therefore has a lot of experience with these drugs and is very comfortable using them, even at higher than normal doses. He admitted that the use of these drugs at these doses is his "routine" practice in these situations. He indicated that he tries to improve areas of his practice on a regular basis, and has recently been focusing on palliative care of patients in the ICU. He also stated that in the past he has had experience with this type of patient whereby the procedure of extubation has been accompanied by extreme agitation, anxiety, and even panic by these patients. This is often very troubling and emotionally traumatic to patients' family and loved ones. He wants to avoid these reactions by the patient and wants to ensure comfort and a peaceful expiration.

Dr. Husel stated that he never changes patient's code status and discontinues care without a patient, their POA or family first approaching him and requesting this be done. Often, these loved ones will specifically state that they want to make sure the patient is comfortable, not resistant, and calm. He is trying to ensure that.

I told Dr. Husel that questions have been raised regarding the care of these patients, specifically whether or not these drugs are hastening the death of the patients. Dr. Husel seemed shocked by the comment, and stated he never would want to harm a patient, but his care is strictly to try and provide comfort. He also stated he does not believe these medications have caused the death of the patients, in that death often does not occur until an hour or more after the drugs are given, and is usually not due to respiratory arrest.

I asked Dr. Ralston to comment on the use of these drugs at these doses in these situations, and to describe his practice. He agreed that these are high doses and not typically used. He indicated that he uses other narcotics, usually Morphine, at lower comparative doses and re-doses frequently if needed. He does use Versed sometimes, but usually at a dose of 1-2mg. He also spoke about his conversations with families prior to the procedure, to help them understand what to expect, and address that, even though the patient may sometimes seem agitated, this is a physiologic reaction and the patient will not be conscious, or actually experiencing anxiety, etc.

Dr. Ralston and I also spoke about the possibility of working with Dr. Santa-Emma to develop an order set that could be adopted as a policy and be used as a standard in these situations by all physicians in the ICU. Dr. Husel was supportive of the concept and agreed to be a part of a group that would draft such an order set.

Dr. Husel stated he never intended this practice to be disruptive, or cause any concerns, and he would be happy to change his practice to use other drugs at lower doses frequently as needed in order to practice in a fashion that would be more in line with other physicians' practice.

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