EXHIBIT
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CONFIDENTIAL

To: Mandi Murray, Counsel for Clinical Affairs, Trinity
Rick Streck, MD, MBA, Chief Clinical Officer, Mt. Carmel HS
Tammy Lundstrom, MD, JD, Chief Medical Officer, Trinity
From: Rosalie Tocco-Bradley, MD, PhD, MHSA
Chief Clinical Officer, Trinity Michigan
Subject: General comments regarding review of 24 medical records
Date: December 16, 2018

Colleagues, I have previously reviewed the first 5 cases provided (see separate document).

In addition, I have now reviewed the medical records of 19 additional patients who expired at Mt. Carmel West or St. Ann's between 2015 and 2018. Eighteen of those patients were extubated and in most cases died within 30 minutes of the extubation. One patient (Case #23, NW) was never intubated and likely imminently terminal.

1. All the patients reviewed appeared to be critically ill with a terminal condition within less than 24 hours once patients were weaned from mechanical ventilation. Please see additional spreadsheet for specific comments by patient.
2. In every case, the decision of DNAR status appeared to be appropriate. In most cases, the documentation of family meetings and discussion around end of life and DNAR was poorly documented. This is an opportunity for improvement.
3. DNAR orders were not always entered into the record prior to the palliative extubation and patient expiring. This is another opportunity for improved documentation.
4. The functional status of the patient including mental status, pain score and other signs of discomfort (e.g. agitation) was most often absent from the records of these terminal patients who were about to be extubated. I searched physician and nursing notes as well as the MAR.
5. In most cases, based on the physician's notes of clinical condition, I inferred that the patients were minimally responsive to not responsive at all. With that in mind, the excessive doses of fentanyl +/- versed and dilaudid administered were not supported by patient distress or anticipated distress. A combination of fentanyl and versed are effective medications for pain and anxiety, but even then, often titrated in much lower doses. For example:
    a. Fentanyl is usually titrated at 50 – 100 mcg IVP up to 300 mcg over 30 minutes.
    b. Versed is typically titrated at 1 - 2 mg IVP up to 6 mg for anxiolysis over 30 minutes.
6. MAR documentation. It was notable that in several cases where the patient was noted to be obtunded or unresponsive (in physician or nursing notes), in the MAR, when the fentanyl administration was documented, the pain score was noted to be 8 – 10. This was not consistent with the medical records for that given patient.
7. In cases #1 – 16 and #18, the dose of fentanyl often combined with versed +/- dilaudid, would in most patients result in apnea and respiratory arrest in a non-ventilated patient. Outliers might include opioid dependent patients or alcoholics with very high tolerance.

8. Regarding the practice of medication safety, based on the standard titrated dose ranges of fentanyl and versed noted above, the following should happen in any culture of safety healthcare organization:
    a. When a nurse is asked to withdraw from pyxis and administer medications with doses outside of the known ranges of safety, the nurse should feel safe to question and validate this order.
    b. Verbal orders should not be accepted in any of the cases (#1 -24) for the following reasons:
        i. No requested medication was for an emergency situation. The physician should be entering the orders directly.
        ii. The doses of fentanyl, versed and dilaudid requested were outside of standard of care and range of safety.
    c. The Department of Pharmacy should/ may have a routine audit program in place to monitor outliers in the use of controlled substances within the hospital. The excessive doses of fentanyl (in particular) and versed and dilaudid used, should have been flagged with a monitoring program.
9. Palliative Care consultation and their subsequent recommendations for end of life management would likely have mitigated the decisions made to aggressively overdose most of these patients prior to and immediately following extubation.

Summary comment:

After reviewing all 24 records, I believe that each patient was terminal and appropriate for DNAR status and ventilator wean. It is appropriate to provide medications such as morphine, fentanyl and versed to terminal patients who might experience agitation, acute respiratory distress or anguish close to the time of their death. I cannot say for sure why the given clinician chose to use such large doses of palliative medications but perhaps he felt he was providing more humane pharmacologic support through the terminal stages of dying. The dosing regimen he used, to my knowledge, is outside of typical standard of care even for most terminal patients.