COURT OF COMMON PLEAS OF THE STATE OF OHIO
FRANKLIN COUNTY – GENERAL DIVISION

DR. WILLIAM S. HUSEL (c/o Graff & McGovern, LPA, 604 E. Rich St., Columbus, OH 43215),	
Plaintiff,	CASE NO. ____
– against –	
MOUNT CARMEL HEALTH SYSTEM (c/o CT Corporation System, 4400 Easton Commons Way, Suite 125, Columbus, OH 43219), TRINITY HEALTH CORPORATION (c/o CT Corporation System, 4400 Easton Commons Way, Suite 125, Columbus, OH 43219), and EDWARD LAMB (c/o Mount Carmel Health System Corporate Service Center, 6150 E Broad St #1574, Columbus, OH 43213),	**COMPLAINT** **Jury Demand Endorsed Hereon**
Defendants.	

Plaintiff Dr. William S. Husel, by his undersigned counsel, allege as follows against defendants Mount Carmel Health System ("Mount Carmel"), Mount Carmel's parent organization Trinity Health Corporation ("Trinity"); and Edward Lamb:

NATURE OF THE ACTION

1. This defamation action is brought by a former employee of Mount Carmel, an intensive care doctor who worked the night shift in different Intensive Care Units ("ICU") in the Mount Carmel hospital system, most often Mount Carmel West Hospital.

2. This is no ordinary case of defamation. It would not be an exaggeration to state that Dr. Husel has suffered perhaps the most egregious case of defamation in Ohio's recent history. Dr. Husel was falsely accused by Defendants and their corporate executives of

intentionally murdering twenty-five (25) patients for whom he provided appropriate end-of-life care. The fallout from those false accusations has been profound.

3. These demonstrably false and defamatory statements were repeated on numerous occasions by way of non-stop press releases and other public statements in which the Defendants asserted time and again that Dr. Husel prescribed a fatal dose of fentanyl to patients whose families had determined to remove them from full life support. Defendants Mount Carmel and Trinity have continued to repeat the baseless and knowingly false claim that Dr. Husel prescribed the medication with the explicit intention to cause these patients' deaths and did in fact cause these patients' deaths. Even as recently as last week, the Hospital continued to defame him (and his former colleagues) by asserting in the press that it "stands by the results of [their] investigation" when they know the "investigation" was so flawed as to suggest intentional bad faith, lacked any meaningful review of medical records prior to the Defendants' incendiary announcements, and that its announced conclusion – that the doses were fatal and given to cause or hasten death – was flat wrong.

4. Indeed, Mount Carmel is currently defending against the civil suits brought by the families of the patients that Mount Carmel implicated in its charade by arguing (correctly now) that not a single death was "caused" by the fentanyl prescribed and administered after the removal of full life support.

5. Despite their repeated false statements to the public, Defendants are fully aware that the truth is now starting to come to light and that it is only a matter of time before the public learns of what they have done.

6. Defendants all presently know that their statements that Dr. Husel prescribed excessive and fatal doses of fentanyl to 29 patients were false and defamatory, and yet, on

information and belief, have not yet notified either the state medical board, nor the Prosecuting attorney's office, that their prior assertions were wrong and they do not actually believe the end-of-life pain medication prescribed by Dr. Husel and administered by nurses caused a single death, but rather all deaths were "caused" by natural causes after the removal of full life support. They have also continued to mislead the public in this regard.

7. This point will be proven when, after this complaint is filed, the Defendants will refuse to publicly state that Dr. Husel's prescription of fentanyl "caused" a single death.

8. Mount Carmel and Trinity have fought taking part in discovery in the civil cases because they have caught themselves in a bind. Defendants know that discovery in the civil cases will shed light on what actually occurred – that each patient died from their illnesses and not from medication given in their last moments to provide comfort. Defendants know that Dr. Husel provided appropriate palliative care to each and every patient. But Defendants cannot publicly admit this now without exposing the fact that their scheme to frame Dr. Husel for causing patient harm or failing to follow any hospital policy was false.

9. Defendants' strategy to avoid acknowledging they got it profoundly wrong appears to be to bury their heads in the sand, settle all the civil lawsuits to prevent the real facts from ever being exposed to daylight, let Dr. Husel be tried for the murders they accused him of (and know he did not commit), presumably with the sincere hope that the jury acquits him, and move on without ever looking back.

10. The alternative, i.e., admitting to the truth, would mean exposing that senior management at Trinity and Mount Carmel had no understanding of its ICU's policies or how care is provided in such critical end-of-life situations. It would mean admitting that its policies specifically allowed for the precise care that was given. It would mean admitting that all the

medical staff involved acted in compliance with Mount Carmel policies, but that those policies may have been insufficient to be properly approved for Medicare/Medicaid payments. And it would mean admitting it made a dreadful mistake by accusing one of its most respected and talented doctors of intentional murder and firing and reporting to the state boards 48 of its hard-working, capable employees for no legitimate reason.

11. The hospital knew full well that no policies were violated because the actual policies in effect explicitly permitted and encouraged the care Dr. Husel and the nurses provided to patients undergoing palliative withdrawal.

12. Mount Carmel had no policies with respect to very-end-of-life withdrawal of life-support, other than medication that would be administered as necessary in the judgment of the physician in order to treat pain.

13. Obviously, these false accusations destroyed Dr. Husel's life. Given the power and wealth of the hospital and its parent corporation, these corporate executives have been able to defame Dr. Husel to such an extent that the non-stop media barrage contributed to the Prosecuting attorney charging Dr. Husel with 25 counts of murder and the state Attorney General calling Dr. Husel a "serial killer." These defamatory statements – and the ongoing, unsupported, and politically-motivated criminal and regulatory proceedings notwithstanding – conflict with all eye-witness accounts, all scientific evidence, and all scientific and medical literature. The Defendants' statements are the epitome of defamation *per se*.

14. The Defendants' intentional misconduct makes them liable to Dr. Husel because they defamed him *per se* and *per quod*. Defendants should apologize to Dr. Husel, the Mount Carmel community, and to the public, and Dr. Husel should be adequately compensated for what they continue to put him through.

PARTIES

Plaintiff

15. Dr. William S. Husel is an anesthesiologist and ICU doctor that completed his residency in Anesthesiology at the Cleveland Clinic (2008-2012) and his fellowship in Critical Care at the Cleveland Clinic (2012-2013). He is married with two children and he is a resident of Columbus, Ohio.

Defendants

16. Mount Carmel Health System, according to its website, is "one of the largest integrated health systems in the community, Mount Carmel provides people-centered care at four hospitals – Mount Carmel East, Mount Carmel Grove City, Mount Carmel St. Ann's and Mount Carmel New Albany – an inpatient rehabilitation hospital, free-standing emergency centers, outpatient facilities, surgery centers, urgent care centers, primary care and specialty care physician offices, community outreach sites and homes across the region." At all relevant times, Mount Carmel also operated MC West, which has since been closed and relocated to a new facility: Mount Carmel Grove City.

17. Trinity Health Corporation, Mount Carmel's parent organization, is a national Catholic health system based in Michigan with 92 hospitals and 109 continuing care facilities, home care agencies, and outpatient centers in 22 states. Spokespeople for Trinity Health Corporation go to great lengths to highlight and rely upon its Catholic association in defense of all of its decisions and conduct. Trinity is an Indiana for-profit corporation, headquartered in Livonia, Michigan and licensed to do business in the State of Ohio.

18. At all relevant times, Edward Lamb was an employee of Mount Carmel and held the title of Chief Executive Officer of MC West.

JURISDICTION AND VENUE

19. This Court has personal jurisdiction over Mount Carmel because it is located in the county.

20. This Court has personal jurisdiction over Trinity because it owns and manages a hospital system in the county, and because it was directly involved in the acts and decisions that led to plaintiffs' injuries in this county.

21. This Court has personal jurisdiction over defendant Lamb because, at all relevant times, he was employed in the county and his actions at issue here were made in connection with his employment and taken within the county.

22. Venue is appropriate in this county because a substantial part of the events or omissions giving rise to the claim occurred herein.

STATEMENT OF FACTS – BACKGROUND AND HISTORY

The Use of Fentanyl for Prevention of Pain in Withdrawal of Life Support

23. In numerous public statements, Mount Carmel and Trinity have asserted that Dr. Husel orchestrated a campaign to intentionally murder at least 29 patients with the assistance of forty-eight nurses, pharmacists and other hospital workers. The murders, according to the hospital, were effectuated during terminal ventilator withdrawal/extubation procedures ("palliative extubation" or "palliative withdrawal") in which anywhere from 200 mcg to 2000 mcg of fentanyl was administered to patients being removed from life support. The hospital has repeated that such doses were "excessive," "potentially fatal," and in fact, "fatal." In those same public statements, Mount Carmel and Trinity have asserted that those doses were objectively excessive for palliative withdrawal/extubation procedures and caused the deaths of 29 patients.

24. That theory is unsupportable, and any physician experienced in end-of-life care in an intensive care unit would have known that for two reasons: (1) determining the appropriate

dose of pain medication for a patient in connection with the palliative withdrawal of full life support, including withdrawal of ventilatory support, is both imprecise and highly patient specific, where diagnoses, body mass, and opioid tolerance, as well as the patient's/family's beliefs and wishes are critical; and (2) medical research and best practice publications universally state that in the administration of pain medication in connection with palliative extubation, there is no upper limit to dosing because the sole criteria upon which such dosages are judged is whether they successfully alleviate pain and were intended to do so.

25. Indeed, the fact that heath care providers are legally shielded from any accusation that the administration of pain medication in connection with terminal withdrawal of life support had the "double effect" of shortening post-withdrawal life span – so long as the intent was to relieve pain – is enshrined in Ohio law and U.S. Supreme Court jurisprudence (as well as Catholic principles since the time of St. Thomas Aquinas).

26. Moreover, there is consensus in the medical community (including the official position of federal agencies) that the "fatal" fentanyl dose for opioid-naïve patients is 2000 mcg, and the only two patients at issue in the 35 cases that received 2000 mcg were both notably not opioid-naïve but *opioid tolerant*.[1] Indeed, one opioid tolerant patient continued to suffer respiratory distress after receiving an initial dose of 1000 mcg. All other relevant patients received either half or a quarter of that amount, or even less.

27. But again, the medical literature is universal in asserting that there is no "maximum dose" at all for a patient being removed from life support with the expectation that

[1] Medical literature defines opioid tolerance differently, with the United States FDA defining "opioid tolerant" as a patient who received specified doses of opioids for seven days. Opioid naïve, however, is defined as a patient who has never previously received an opioid.

they will die in minutes, and so any discussion of a "fatal dose" in this context is entirely against the medical community and scientific learning.

28. And more importantly, studies that have considered the impact of high doses of opioid medication in connection with palliative extubation have found no correlation between higher doses and a shortened post-withdrawal survival time. In fact, some studies show the opposite: that high opioid doses extend post-withdrawal survival times because, as current research suggests, the sedative effect of the medication prevents the dying patient from struggling, thus conserving the little energy they have left, so that their peaceful deaths can sometimes take slightly longer than the more pained death they might experience with less medication.

29. Therefore, in connection with palliative extubation, there is no such thing as a "fatal dose" of fentanyl. As a matter of medical ethics, it is improper to define a maximum dose, because doing so will prevent physicians from using higher doses, even if appropriate, in the case of a specific patient. The data from the 33 cases here where fentanyl was used supports the literature. (A different medication, Dilaudid, was used in the other two cases).

30. Several studies find that the median time from withdrawal of life support to death is 15-17 minutes. (Cypel *et al.*, International Society for Heart and Lung Transplantation Donation After Circulatory Death Registry Report, THE JOURNAL OF HEART AND LUNG TRANSPLANTATION, at 1278 (2015) (15-minute median in a study of 306 patients); Inci, *et al.*, Lung Transplantation with Controlled Donation after Circulatory Death Donors, ANN THORAC CARDIOVASCULAR SURGERY (2018)(17-minute median in a study of 151 patients).

31. Here, the average time to death following administration of fentanyl and withdrawal of life support in the 33 cases was 21.2 minutes with a median of 15 minutes, and a

review of the data shows that there is no correlation between dosages and survival. For example, two of the patients who received only 200 mcg of fentanyl died 5 and 9 minutes after withdrawal, while four of the patients who received 1000 mcg of fentanyl died 17, 18, 20 and 23 minutes following withdrawal. One of the patients who received 500 mcg of fentanyl died 2 minutes after withdrawal, while another who received the same dose survived for 132 minutes. Only two patients – both highly opioid tolerant – received 2000 mcg, the dosage widely discussed in the press. One expired in 5 minutes and the other in 33. The cases at issue here support the published research: there is no evidence that higher doses shorten post-withdrawal survival time.

32. Attached as Exhibit A hereto is a demonstrative table and graph, comparing the fentanyl doses at issue in the cases identified by Mount Carmel, and the times between withdrawal and death, which demonstrates the lack of any meaningful connection between dosage amount and survival times. The data from these 33 cases shows that fentanyl, even in high doses, neither hastened nor delayed death.

33. Withdrawal of life sustaining measures may include simultaneous removal of the use of a ventilator to provide for artificial breathing ("palliative extubation"), withdrawal of the use of vasopressors to maintain blood flow when the heart is not strong enough to circulate a patient's blood, withdrawal of the use of bicarbonates to combat blood acidification caused by renal and/or liver failure, and stopping dialysis. In each of the 35 cases here, once the life-sustaining interventions were removed from each patient, the underlying disease was the cause of death, not the palliative medication, which was administered to relieve symptoms of dying, including severe pain, anxiety and dyspnea (difficult or labored breathing, also called "agonal breathing").

Fentanyl Is an Appropriate Pain Medication in Palliative Extubation

34. As a threshold matter, there is no consensus regarding best practices for the use of any drugs during palliative extubation. Rather, as this is an area of medicine for which scientists and doctors are continuing to study and perfect, the best guidelines at present are that it is an extremely individualized assessment which is best left to the doctor who can consider the totality of the patient's medical history and personal (and family) beliefs and wishes, to determine the appropriate prescription and administration of pain relief.

35. As leading research in the field of very-end-of-life care emphasizes: "Although many drugs can be used to treat pain and agitation at the end of life, the importance of the practitioner's familiarity with the drug cannot be over-emphasized. In the last few hours of life, there may be only one chance to prevent pain, dyspnea, and delirium. As much expertise is necessary for the appropriate use of drug therapy at the end-of-life as for any other pharmacological intervention in critical care." Robert D. Truog, *et al.*, American College of Critical Care Medicine (2008), Recommendations for End-of-Life Care in the Intensive Care Unit: A Consensus Statement by the American College of Critical Care Medicine, CRITICAL CARE MEDICINE, 36(3):953-63. doi: 10.1097/CCM.0B013E3181659096. In the cases at issue here, the physician, Dr. Husel, was a trained anesthesiologist and intensivist who was highly familiar with fentanyl, and whose training at the Cleveland Clinic involved focusing on its different dosing ranges for different medical situations, and included the frequent use of fentanyl exceeding 4000 micrograms during surgery.

36. Since at least 2002, available research has suggested that "[i]n general, narcotics are used for pain; benzodiazepines are used for agitation and anxiety. If the patient is experiencing pain and suffering, both analgesics and sedatives are used. This combination of

drugs may provide better relief of pain and suffering at the end-of-life than either class of drug alone." Hawryluck, et al. (2002), Consensus Guidelines on Analgesia and Sedation in Dying Intensive Care Unit Patients, BMC MEDICAL ETHICS, 3, E3. doi:10.1186/1472-6939-3-3 (*available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC122088/).

37. Even today, current research concludes: "First-line therapy for management of dyspnea and pain is usually an intravenous opioid, such as fentanyl, morphine, or hydromorphone. First-line therapy for management of anxiety is usually an intravenous benzodiazepine, such as midazolam or lorazepam. Both opioids and benzodiazepines can be administered as a bolus dose or as a continuous infusion. [] The combination of an opioid plus benzodiazepine is indicated because narcotics provide relief of dyspnea and pain, while suppressing cough, whereas benzodiazepines provide sedation, and anxiolysis. Benzodiazepines also offer anticonvulsant effects that may protect from hypoxemia-related seizures." Chen, Elaine. (2015), Ventilator Withdrawal in Anticipation of Death: An Intersection of Critical Care and Palliative Care, Relias Media (at 22-24) (collecting authorities) (available at https://www.reliasmedia.com/articles/136121-ventilator-withdrawal-in-anticipation-of-death-an-intersection-of-critical-care-and-palliative-care).

38. Opioids are the mainstay for the treatment of pain and dyspnea in dying patients and demonstrate additive sedative effects as a component of drug combinations for palliative sedation. (*Id.* at 77-81). The opioid analgesics recommended in recent multisociety practice guidelines are morphine, fentanyl, and hydromorphone. (*Id.* at 82). Compared with fentanyl, morphine is associated with a greater risk of histamine release causing urticaria at the injection site, pruritus, and flushing, which may be relieved by antihistamine therapy. (*Id.* at 83). Fentanyl and hydromorphone are alternatives to morphine. (*Id.*)

39. In ICUs, fentanyl is often the preferred narcotic because of staff familiarity with this agent, while morphine is more likely to lead to toxicity (typically myoclonus) at high doses, especially in the setting of renal failure. (Massachusetts General Hospital, Ventilator Withdrawal Guidelines as of August 2019).

In Connection with Palliative Extubation, There Is No Maximum Dose of Fentanyl

40. As multiple studies have clearly indicated fentanyl as an appropriate drug for pain relief and sedation in palliative extubation procedures, research has similarly shown that there is no correct dosage of medications appropriate for every patient being terminally extubated, and studies have consistently maintained that no upper limit exists, as the patient's death is imminent, and comfort during dying is the most important consideration.

41. An article published in the peer-reviewed-journal BMC Medical Ethics in 2002 (Hawryluck, *et al.*, cited above), answers the question "Does a Maximal Dose Exist" with the following answer:

> "No maximum dose of narcotics or sedatives exist. The goal of palliative care is to provide relief of pain and suffering and whatever the amount of drugs that accomplishes this goal is the amount that is needed for that individual patient. By refusing to define a maximal dose of analgesics or sedatives, our goal is to ensure that Intensivists will use the required dose for each patient. *If a maximal dose is ever declared, some patients will be in pain and will be suffering at the end-of-life because of the Intensivist's fears of litigation if this maximal dose is exceeded.* Therefore, the intent of the physician administering the drugs becomes important in distinguishing between palliative care and assisted death (euthanasia/assisted suicide)." (Emphasis added.)

42. The same article explains that "pre-emptive dosing in anticipation of pain and suffering is not euthanasia nor assisted suicide but good palliative care." (*Id.*)

43. In November 2018, an updated peer-reviewed article published by Wolters Kluwer (a provider of medical research to hospitals and healthcare professionals) cautioned again that "[t]he required opiate doses will vary widely from patient to patient. For example,

patients who have been on high doses of opiates will likely require higher doses to control symptoms relative to patients who have not been receiving opiates. There is no upper limit on acceptable doses, as long as the dose is selected with the goal to be proportional to the patient's symptoms and is titrated to the patient's symptoms." (Douglas B. White, Withholding and Withdrawing Ventilatory Support in Adults in the Intensive Care Unit, Wolters Kluwer's UP-TO-DATE Guidelines (last updated November 1, 2018) (*abstract available at*: https://www.uptodate.com/contents/withholding-and-withdrawing-ventilatory-support-in-adults-in-the-intensive-care-unit#H462277270).

44. Professor Elaine Chen, Assistant Professor, Department of Internal Medicine, Division of Pulmonary and Critical Care, Section of Palliative Medicine, Rush University Medical Center, Chicago, in her 2015 article (cited above) instructs that to adequately manage dyspnea and anxiety during ventilator withdrawal management, "patients requir[e] higher doses of opioids or benzodiazepines than used in routine critical care," and that "the doses should be titrated to symptoms without a set ceiling."

45. As described by Richard M. Doerflinger and Carlos F. Gomez, M.D., Ph.D., in an article titled, "Killing the Pain Not the Patient: Palliative Care vs. Assisted Suicide," published by the United States Conference of Catholic Bishops (available at http://www.usccb.org/about/pro-life-activities/respect-life-program/killing-the-pain.cfm), "Many doctors hesitate to give dying patients adequate pain relief because they fear that high doses of painkillers such as morphine will suppress the breathing reflex and cause death. Yet we now know that this fear is based on false assumptions, and on inadequate training of physicians in pain management techniques." "In reality, a very large dose of [an opioid] may well cause death—if given to a healthy person who is not in pain and has not received [opioids] before. But

when administered for pain, such drugs are taken up first by the patient's pain receptors. In fact, patients regularly receiving [opioids] for pain quickly build up a resistance to side-effects such as respiratory suppression, so they can easily tolerate doses that would cause death in other people." "In short, when dosages of painkilling drugs are adjusted to relieve patients' pain, there is little if any risk that they will hasten death. This fact alone should put to rest the myth that pain control is euthanasia by another name."

46. Mr. Doerflinger, one of the authors, was the Associate Director for Policy Development, Secretariat for Pro-Life Activities, National Conference of Catholic Bishops at the time of the article's publication.

High Doses of Fentanyl Do Not Shorten Post-Withdrawal Survival Time, but Might Extend It

47. Although respiratory depression is listed on the fentanyl fact sheet available on the FDA website, as among the most common serious adverse reactions reported to occur with fentanyl (as with opioid agonists), "studies have affirmed that a very small minority of patients sedated at end of life experience life-threatening untoward adverse effects such as aspiration or respiratory depression." (Morita *et al.* Efficacy and Safety of Palliative Sedation Therapy: a Multicenter, Prospective, Observational Study Conducted on Specialized Palliative Care Units in Japan, JOURNAL OF PAIN SYMPTOM MANAGEMENT, 2005; 30:320-328) (*abstract available at* https://www.ncbi.nlm.nih.gov/pubmed/16256896).

48. One study found that among 1,524 post-operative patients treated with systemic or neuraxial morphine, a respiratory rate of less than 10 breaths/min was recorded in only 18 (1.2%) patients. (Shapiro *et al.*, (2005), The Frequency and Timing of Respiratory Depression in 1524 Postoperative Patients Treated with Systemic or Neuraxial Morphine, JOURNAL OF

CLINICAL ANESTHESIA, 17:537–542)(*abstract available at*: https://www.ncbi.nlm.nih.gov/pubmed/16297754).

49. As one Netherlands study regarding the anticipation of distress at palliative extubation concluded, "Death of an ICU patient is usually related to fatigue and dysfunction in multiple organs after withdrawal of ventilatory support and is not due to the administration of opioids." (Kompanje, *et al.*, (2008), Anticipation of Distress after Discontinuation of Mechanical Ventilation in the ICU at the End of Life, INTENSIVE CARE MEDICINE, *34*(9), 1593–1599. doi:10.1007/s00134-008-1172-y (*abstract available at*: https://www.ncbi.nlm.nih.gov/pubmed/18516588).

50. "Evidence suggests that in most cases palliative sedation does not shorten life; rather, the underlying illness itself results in death." (Olsen et al., (2010) Ethical Decision Making with End-of Life Care: Palliative Sedation and Withholding or Withdrawing Life-Sustaining Treatments, MAYO CLINIC PROCEEDINGS; 85(10): 949–954)(*available at*: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2947968/).)

51. Several studies have shown that palliative pain medication does not affect post withdrawal survival in ICU patients. (Edwards, *et al.*, (2005), Opioids and Benzodiazepines Appear Paradoxically to Delay Inevitable Death after Ventilator Withdrawal, JOURNAL OF PALLIATIVE CARE, 21:299–302 (available at: http://www.pccef.org/articles/opiods_benzodiazepines_dredwards.pdf); Wilson et al., (1992) Ordering and Administration of Sedatives and Analgesics during the Withholding and Withdrawal of Life Support from Critically Ill Patients, JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 267:949–953 (*abstract available at*: https://jamanetwork.com/journals/jama/article-abstract/395187); Daly, *et al.*, (1995) Procedures Used in Withdrawal of Mechanical

Ventilation, AMERICAN JOURNAL OF CRITICAL CARE 5:331–338 (finding that "Survival duration was unrelated to morphine dosage, but did correlate with ventilatory status at the time of withdrawal")(*abstract available at*: https://www.ncbi.nlm.nih.gov/pubmed/8870856); Chan, *et al.* (2004), Narcotic and Benzodiazepine use after Withdrawal of Life Support. Association with Time of Death?, CHEST 126:286–293)(available at: https://www.sciencedirect.com/science/article/abs/pii/S0012369215329251).

52. A number of studies have evaluated the effect of opioids and benzodiazepines on timing of death and not only have they found no definitive correlation between dose and timing of death, but in fact, that in some cases patients receiving higher doses may actually have longer survival, with the theory being that relieving dyspnea and anxiety may decrease oxygen demand. (Chen at 22-24).

Following Palliative Extubation, Patients Expire From Their Illnesses, Not Medication – the Doctrine of Double Effect

53. "Given that the patient has serious respiratory or ventilatory insufficiency, multiple organ failure, extremely diseased lungs, or severe neurological dysfunction, withdrawal of mechanical ventilation and subsequent removal of an endotracheal tube often induces or hastens death. These actions do not kill the patient, but allow the patient's disease to complete its natural course. There is an ethical mandate to both anticipate and treat (iatrogenic) induced symptoms such as pain, [dyspnea-associated respiratory distress], anxiety, delirium, post-extubation stridor, and excessive broncho-pulmonary secretions resulting from overhydration." Kompanje, *et al.*, (2008), Anticipation of Distress after Discontinuation of Mechanical Ventilation in the ICU at the End of Life, INTENSIVE CARE MEDICINE, 34(9), 1593–1599. doi:10.1007/s00134-008-1172-y (citing Edwards) (available at: ttps://www.ncbi.nlm.nih.gov/pmc/articles/PMC2517089/).

54. At the end of life, patient goals often shift to comfort, and removal of burdens and relief of suffering become paramount. Many physicians are uncomfortable removing life-sustaining therapy or providing comfort-directed medication because of confusion about the ethical soundness of such treatments. In contrast to physician-assisted suicide or euthanasia, withdrawal of or withholding life-sustaining treatment and palliative sedation are ethically sound options. (Olsen at 949–954).

55. The concept of "double effect" is relevant in relation to the cause of death in palliative sedation/analgesia – i.e., that pain relief might have an acceptable incidental effect on post-withdrawal survival. This concept is well enshrined under U.S. Supreme Court precedent and under Ohio Revised Law 2133.11 *et seq.* (Immunities) which provides that health care professionals are entirely immune from suit for care given during the withdrawal of life support and administration of pain relieving drugs so long as the intention of the administration of the drugs is to reduce pain and not to cause death.

56. The doctrine of "double effect" is not something the United States Supreme Court, the Ohio Legislature, and the Catholic Church came up with recently. The doctrine of double effect is grounded in the ethical principle of proportionality, originating in the 13th century from Thomas Aquinas, the philosopher and Catholic priest. This doctrine asserts that an action in the pursuit of a good outcome is acceptable, even if it is achieved through means with an unintended but foreseeable negative outcome, if that negative outcome is outweighed by the good outcome. When applied to the use of palliative sedation at terminal ventilator withdrawal, relief of intolerable symptoms (desired good outcome) through use of medications that will likely cause loss of social interaction and may hasten death (unintentional but foreseeable possible consequence) is ethically acceptable, given that certain conditions are met. Those

conditions include that the action (sedation) is morally good or neutral, the undesired outcome (loss of interactional function and potentially hastened death) is not directly intended, the desired effect is not necessarily a direct result of the unintended negative result (in other words that symptom relief can be achieved without the death of the patient), and that the good effect is proportional to the negative effect. (Olsen at 949–954 citing Boyle J., Medical Ethics and Double Effect: the Case of Terminal Sedation, THEOR MED BIOETH. 2004; 25:51-60).

57. Even though Catholic ethical principles and Supreme Court and Ohio law support use of palliative sedation at palliative extubation, including the use of fentanyl with no upper limit in dose, the medical literature published to date argues that the doctrine of double effect is not necessary to support the use of high doses, because studies suggest that the use of sedatives and analgesics at the end of life *does not actually hasten death*. (Sykes N, Thorns A (2003) The Use of Opioids and Sedatives at the End of Life, Lancet Oncology (*abstract available at*: https://www.ncbi.nlm.nih.gov/pubmed/12732169)("We conclude that patients are more likely to receive higher doses of both opioids and sedatives as they get closer to death. However, there is no evidence that initiation of treatment, or increases in dose of opioids or sedatives, is associated with precipitation of death. Thus, we conclude that the doctrine of double effect is not essential for justification of the use of these drugs…."); Chan, et al.; Truog, et al.; *see also*, Doerflinger & Gomez).

58. As noted above, a review of the 33 cases at issue here involving doses ranging between 200 mcg and 2000 mcg of fentanyl *confirms the absence of any connection whatsoever between dosage and survival time following palliative extubation.*

59. Still, Dr. Husel understood at the very least that the doctrine of double effect applies to palliative extubation. Dr. Husel was trained that there is a sole guideline in dosing

pain medication during the withdrawal of life support: Intent to relieve suffering. So long as the physicians' and nurses' intent was simply to relieve the patient from immense suffering and pain at the time of death, and to save the families, already traumatized from witnessing their loved ones dying, from the horrific visible and audible mechanics of the pain of death, dosage decisions cannot be reviewed for a secondary effect on post-withdrawal life span.

Actual "Fatal" Dosages of Fentanyl in Patients Who Are Not Actively Dying Is Drastically Higher Than What Mount Carmel and Trinity Have Deemed "Fatal" in Their Public Statements

60. Putting aside the scientific studies addressing the use of fentanyl and other opioids in clinical settings, there is consensus within the scientific community that the *potentially* lethal dose for an opioid naïve person is 2000 mcg. The Drug Enforcement Agency (DEA), National Institute of Health (NIH) and other official government agencies agree and consistently state that 2000 mcg is only potentially fatal in a patient who has never before been exposed to any other opioid. Tolerance changes the calculation – a well-known fact.

61. For example, the peer-reviewed medical journal, Annals of Pharmacotherapy, published an article in March 1998 describing the use of a continuous fentanyl infusion in an adult cancer patient, specifically a 66-year-old woman suffering from metastatic pancreatic carcinoma that required hospital admission for pain control after receiving five different chemotherapy regimens. The patient received a fentanyl dosage titrated to ***4250 mcg an hour, by the hospital, and continued to receive this dosage for three straight days before passing away after the third day***. The study's authors concluded that "our patient achieved good pain control with a continuous infusion of fentanyl 4250 mcg/hr" and concluded that such levels of continuous fentanyl infusions "should be considered" for treatment of pain in cancer patients when appropriate for that patient. (Lenz and Dunlap, (1998), Continuous Fentanyl Infusion: Use

in Severe Cancer Pain, ANNALS OF PHARMACOTHERAPY (abstract available at: https://www.ncbi.nlm.nih.gov/pubmed/9533063).

62. In another study, published in Anesthesiology in 1993, healthy adults without any prior history of taking opioids received 1200 mcg of fentanyl in boluses over eight minutes to study "fentanyl-induced rigidity and unconsciousness in human volunteers." (Streisand, *et al.*, (1993), Fentanyl-induced Rigidity and Unconsciousness in Human Volunteers. Incidence, Duration, and Plasma Concentrations, ANESTHESIOLOGY (abstract available at: https://www.ncbi.nlm.nih.gov/pubmed/8466061). Needless to say, the opioid-naïve volunteers in the study did not die, even though they each received more fentanyl than 31 of the 33 patients in this case, and almost triple what many of them received. Indeed, the study could not have been ethically conducted if anyone believed there was even the slightest risk of death from 1200 mcg of fentanyl.

63. The Journal of Pain and Symptom Management published an article "Intravenous Fentanyl for Cancer Pain: A 'Fast Titration' Protocol for the Emergency Room" which studied the effect of 1000 mcg of fentanyl administered as a bolus dose over 10 seconds, and concluded and "confirmed" that ***"patients with severe cancer pain who are admitted into the emergency room could have their pain controlled very fast and safely with an intravenous fentanyl titration [of] 1000 mcg over ten seconds***.'" (Soares, et al., (2003), Intravenous Fentanyl for Cancer Pain: A 'Fast Titration' Protocol for the Emergency Room, JOURNAL OF PAIN AND SYMPTOM MANAGEMENT, (abstract available at: https://www.ncbi.nlm.nih.gov/pubmed/14528871).

64. The Department of Anesthesiology at Emory University published an article studying men aged 22 to 29 with no previous history of opioid use or systemic disease. (McClain

et al., (1980) Intravenous Fentanyl Kinetics, CLINICAL PHARMACOLOGY & THERAPEUTICS). The subjects received bolus injections of up to 800 mcg of fentanyl (based on weight) to study the onset effects and gradual recovery to control state. All subjects in this study survived too. Again, the study could not have been conducted if anyone believed 800 mcg of fentanyl could possibly be fatal.

65. Indeed, the FDA approved package insert for fentanyl published by one of the pharmaceutical companies that produces and distributes it (Janssen) describes controlled studies of fentanyl in which otherwise healthy volunteers were successfully treated for pain with 600 mcg and 630 mcg of fentanyl.

66. Lexicomp, the online resource used at Mount Carmel and available to its nursing staff, identifies on page one a "high" dose of fentanyl as 2000-5000 mcg during surgery, but notes that that range "does not represent the maximum doses that may be required in some patients." Lexicomp also instructs nurses that to treat severe pain, critically ill patients can receive a continuous infusion of 700 mcg/hour of fentanyl (or more if necessary to control a patient's pain). The 41 pages of reference materials citing to hundreds of fentanyl studies ***explicitly excludes maximum dose information for palliative extubations***.

67. Notwithstanding this consensus, Mount Carmel and Trinity have publicly taken the indefensible position that any dose of fentanyl administered to patients during removal of life support at or above 500 mcg is "fatal" and its administration to a patient reflects proof of an intent to cause or hasten the patient's death.

Mount Carmel's "IV Guidelines"

68. At all relevant times prior to December 11, 2018, Mount Carmel maintained a set of "IV Guidelines" that, by their terms, set forth the "usual" dosage levels for medications to be used in most medical situations, but not all.

69. The IV guidelines enumerated several exceptional situations to which the guidelines did not apply. One of these explicit exceptions was the dosing of pain medication in connection with palliative extubation.

70. Prior to December 11, 2018, Mount Carmel *had no policies or guidelines for dosing of pain medication in connection with palliative extubation*. While the guidelines addressed the use of fentanyl, they only applied to analgesic and anesthetic use of the medication to relieve continuous pain or for procedural sedation. Under the guidelines, the "usual range" for analgesia was 25-300 mcg/hour. The "usual range" for "procedural sedation" (*i.e.*, anesthetic use) was far higher. Neither of these "usual ranges" applied to either palliative care or palliative extubation.

71. Per-hour IV dosing would be applicable for general analgesic care and anesthetic care, but would have no applicability to the terminal withdrawal of life support, as life expectancy following such an event is measured in minutes, not hours.

72. Under Mount Carmel's pre-December 2018 policies that *did apply* to palliative extubation, (which were last updated on May 26, 2017 – right in the middle of the time frame at issue here), there were no dosing guidelines for medication in palliative extubations and all decisions were left to the physician's medical discretion. The policy stated that "symptom management medications will be ordered as medically indicated," meaning based on the medical judgment of the physician and centered on the patient's presentation and condition. This "Palliative Ventilator Withdrawal" policy was not part of the IV Guidelines.

73. The lack of explicit guidelines for dosing of pain medication in connection with palliative withdrawals was consistent with the medical best practices described by the literature discussed above.

Dr. Husel's Employment and work at Mount Carmel West

74. Dr. Husel graduated from Ohio State University in 2000 and then attended the Ohio University College of Osteopathic Medicine Medical School from 2004-2008.

75. He completed four years of residency at the Cleveland Clinic in Anesthesiology during 2008-2012, which was followed by a one-year Critical Care fellowship, also at the Cleveland Clinic.

76. Dr. Husel was then hired by Mount Carmel West Hospital as a Nocturnal ICU physician in September 2013. He signed an employment agreement which provided among other things that the "Corporation shall obtain and pay for professional liability insurance coverage for all activities conducted in the course of employment pursuant to this Agreement. . ."

77. Dr. Husel's first night of work was scheduled to be September 11, 2013. He was asked to come to the hospital the night before his first shift to do a "walk through." The walk through consisted of another doctor walking him through the unit for 20 minutes to show him where certain rooms and items were located. This "orientation" included a brief overview of each ICU physician, and the numbers for the combination locks to the employee break rooms, the "call room" and "nurse lounge."

78. Dr. Husel never received any formal training from Mount Carmel as to any hospital policy or procedure. He was not provided any training for or education whatsoever on any area of care, including palliative extubation for very-end-of-life care.

79. The hospital never provided Dr. Husel with a copy of any policy or procedures manual. He was literally hired, shown around, given the security combination for the break

room and expected to work as the ICU physician at the hospital, conducting palliative extubations and whatever else was necessary.

80. Luckily, Dr. Husel's school training and fellowship prepared him for the job, and he was well equipped to handle what was asked of him. But Mount Carmel provided absolutely no guidance, instruction, or education whatsoever as to what the hospital expected of him, let alone required of him while performing his duties.

81. It was not until a full week later, that Dr. David Ralson, the ICU medical director at Mount Carmel West, emailed Dr. Husel to note that hopefully they could meet soon. In other words, within his first week of work, the ICU medical director never even personally introduced himself.

82. Notwithstanding having received no training by the hospital as to any policy or procedure, having never received any hospital policies or procedures, after his very first year working at Mount Carmel, Dr. Husel was awarded the "doctor of the year" award, formally called the Physician Recognition Award, 2014. Dr. Husel was a talented, caring doctor, a fact that everyone at Mount Carmel recognized, including the entity itself.

83. Dr. Husel's job entailed him providing medical care during palliative extubations and the removal of full life support. His first palliative extubation occurred in May of 2014, in which he prescribed a dose of 200 mcg of fentanyl. That procedure went according to plan, and the patient appeared to do well with that dose.

84. In December of 2014, he prescribed a patient 200 mcg of fentanyl during a palliative extubation, but unlike the prior patient, this one continued to suffer from respiratory distress and agonal breathing after receiving this dose. With the intention of reducing the pain and suffering the patient was experiencing, as well as the family members who were watching,

Dr. Husel ordered additional pain relief medication, including another 200 mcg of fentanyl. That dose, however, also proved insufficient to appropriately treat the patient, requiring him to prescribe more pain relief.

85. This experience had a profound effect on Dr. Husel, and his experience taught him that prescribing only 200 mcg of fentanyl during palliative withdrawal may be insufficient to properly care for certain of his patients, based upon their specific conditions. As a result, starting in 2015, Dr. Husel began to prescribe 400 mcg of fentanyl at the start of the procedure when it appeared necessary based on that specific patient's medical chart.

86. A 400 mcg dose of fentanyl appeared insufficient to adequately treat the pain anticipated for a patient in March of 2015, who had a history of chronic opioid use secondary to chronic pain from severe rheumatoid arthritis. Because of this patient's history of opioid tolerance, Dr. Husel prescribed one dose of 800 mcg of fentanyl with the intention of relieving the patient's pain and suffering during the removal of life support, which was effective. (One family member who was present during the palliative extubation and administration of fentanyl has given an interview during which he stated that he believed that his loved one passed away peacefully without any pain and had no reason to believe anything wrongful had occurred during the procedure, until the hospital called almost four years after the event, and falsely notified him that his loved one was given a fatal dose of fentanyl in connection with the procedure, intentionally causing this family member incalculable pain and suffering.)

87. During his next palliative withdrawal, which occurred two months later, in May 2015, Dr. Husel prescribed 500 mcg of fentanyl, but the patient began to exhibit signs of respiratory distress, agonal breathing, and painful suffering. As a result, Dr. Husel prescribed

another 400 mcg with the sole intention of relieving the obvious and outward signs of patient suffering.

88. As a result of these experiences, in which Dr. Husel learned that for certain patients, even doses of 500 mcg could be insufficient to adequately treat patients and permit them to die with dignity and without pain, he came to the reasoned conclusion that 1000 mcg may be necessary for the palliative withdrawal care for some patients, depending on multiple factors.

89. His experience and knowledge resulted in the next three palliative extubations being successfully completed using 1000 mcg, 400 mcg, and 400 mcg of fentanyl over the next two years. With these doses, each of these three patients appear to have not suffered or had respiratory distress after being removed from life support.

90. In April 2017, however, Dr. Husel was presented with a patient who was an opioid addict, indeed, who was found by EMS in his bathtub with a hypodermic needle lying next to him, having suffered a heart attack and hypoxemic respiratory failure caused by heroin overdose. When this patient's family had determined that further life saving measures would be futile and asked that life support be withdrawn, Dr. Husel considered the patient's medical chart, which included a high opioid tolerance, and after consulting the family, concluded that 1000 mcg was the minimal dose that would be necessary to properly care for this patient during the palliative extubation.

91. That dose of 1000 mcg, however, proved to be *insufficient* to treat this patient's pain and suffering after being removed from life support. Indeed, within several minutes of the palliative extubation, removal of the ventilator, this patient began experiencing severe pain, including respiratory distress and agonal breathing notwithstanding have been administered 1000

mcg of fentanyl. ***The family of this patient requested that the patient receive more pain medication***, and recognizing that 1000 mcg of fentanyl was insufficient, Dr. Husel prescribed another 1000 mcg, with the intention of preventing the patient from experiencing unnecessary pain and suffering in his final minutes. After receiving 2000 mcg of fentanyl (in total), the patient passed away due to complications from a heroin overdose that caused a cardiac arrest and respiratory failure, 33 minutes after the removal of full life-sustaining therapy (more than twice the average time of death following removal from life support).

92. This event had another profound effect on Dr. Husel as his experience taught him that even 1000 mcg of fentanyl might, in rare cases, be insufficient to treat pain resulting from a palliative extubation during very-end-of-life-care, and that appropriate pain relief could, in rare cases, be obtained by using 2000 mcg in certain patients. He would not prescribe this dose again, however, until 19 month later.

93. In total, Dr. Husel cared for at least 35 very-end-of-life patients whose families had requested that life saving measures be stopped and that comfort care be provided. For each of these patients, Dr. Husel prescribed what he believed to be the appropriate medications for the specific patient with the sole and exclusive intention of preventing pain and suffering in each patient's final moments, so that the patient could die with dignity and the patient's family did not have to witness a loved one dying in pain.

94. In addition to Dr. Husel's experience in Mount Carmel's ICU, Dr. Husel was well aware of significant medical literature which provided that there is no upper limit for pain medication during the removal of life support, he was aware that the United States Supreme Court recognized the concept of double-effect, and that Ohio state law provided an immunity statute that immunizes health care workers from liability for providing end-of-life care in good

faith, including by prescribing medication that might "hasten" death in addition to alleviating pain. Dr. Husel, however, also knew that the medical literature did not provide for any correlation between higher doses of fentanyl and shortening of life after removal from life support.

95. Dr. Husel also knew that, while Mount Carmel had not provided him with any policies or procedures with respect to appropriate dosages during end of life care, that the general policy was that the doses were up to the discretion of the prescribing physician.

96. Dr. Husel had no reason to suspect, that starting sometime shortly after November 21, 2019, senior corporate executives would concoct a scheme to falsely accuse him of murdering 29 Mount Carmel patients, and harming 6 others, by prescribing "excessive" and "fatal" doses of fentanyl.

97. Yet, this is exactly what they did. On November 21, 2019 Mount Carmel removed Dr. Husel from patient care, to look into the question of appropriate doses of fentanyl during palliative extubation. Then senior executives from Trinity took over and conducted a sham "investigation" into his "dosing practices," which involved the use of in-house doctors examining doses provided to patients without having possession of, reviewing, or considering, the actual patient or circumstances surrounding the prescription of any dose.

November 26, 2018 – Dr. Husel meets with Dr. Larry Swanner and Dr. David Ralston to Discuss Dr. Husel's Use of Fentanyl in Connection with Extubation – Dr. Husel Is Assured He Will Be Returned to Patient Care and Asked to Assist in Drafting Formal Hospital Polices in Connection with Fentanyl Use in Extubation

98. When Dr. Husel was first placed on leave he was not told that concerns had been raised about his dosing practices. It was not until Dr. Husel was asked to return to Mount Carmel for a meeting on November 26, 2018 (immediately following the Thanksgiving holiday) that this issue was first raised.

99. Dr. Larry Swanner and Dr. David Ralston met with Dr. Husel to discuss his dosing practices. This was the only substantive conversation Dr. Swanner had with Dr. Husel.

100. During this meeting, Dr. Swanner explained to Dr. Husel that the purpose of the meeting was to discuss a report the hospital had received about three recent patients that had each undergone a terminal extubation under his care. Dr. Swanner noted that there were "serious concerns" about "very high doses of Fentanyl and Versed" during that procedure.

101. Dr. Husel responded by explaining 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 the doses given to the patients in question.

102. Dr. Husel reported that in his practice the use of fentanyl at the 500 mcg to 1000 mcg was fairly routine during terminal extubation. Dr. Husel explained that he regularly tries to improve areas of his practice, and has recently been very focused on acute palliative care of patients in the ICU, including in the area of terminal extubation.

103. Dr. Husel then explained that in the past he had observed traumatic experiences resulting from prescribing too little doses during terminal extubation, which has resulted in severe patient suffering during the process.

104. Specifically, Dr. Husel discussed two cases from fairly early in his tenure where he prescribed 200 - 400 mcg of fentanyl during terminal extubations, where he, and the families, were able to observe pain and struggle in the expiring patients as their bodies made futile attempts to gasp for air.

105. Because their families witnessed it, these experiences were traumatic for everyone involved: the patient, the patient's family, Dr. Husel, and the nurse who administered the

medication. Based on these events, as well as his own further research and learning on the use of fentanyl during terminal extubations, Dr. Husel informed Dr. Swanner, that he began to use higher doses, specifically between 500 – 1000 mcg, but would go up to 2000 mcg on very rare occasions when warranted based on a specific patient. (In fact, Dr. Husel had only ever prescribed 2000 mcg on one occasion, with another patient receiving that dose in total when 1000 mcg was demonstrably insufficient to control that patient's suffering.)

106. Dr. Husel reiterated to Dr. Swanner that the care he provides is intended specifically and solely to avoid this suffering by patients and their loved ones, and wants to ensure comfort and peaceful expiration. Dr. Husel explained that often the patient's loved ones will specifically state that they want to make sure the patient is comfortable and calm, and his doses were titrated to ensure that based on each patient's specific medical records.

107. Dr. Swanner then told Dr. Husel that questions have been raised regarding the care of these patients, specifically whether or not these drugs are hastening the deaths of the patients. Dr. Husel was shocked by this statement and without hesitation said he would never want to harm a patient and the intent of his care is "strictly to try and provide comfort."

108. Dr. Husel explained that he does not believe these medications have caused the death of the patients. Dr. Husel then stated that he never intended his practice to be disruptive, or cause any concerns, and 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' practices.

109. Towards the end of the meeting, Dr. Swanner acknowledged that Mount Carmel did not currently have any written or unwritten policies for terminal extubation, and asked Dr. Husel if he would agree to work with Dr. Ralston (another intensivist) and Dr. Santa-Emma (a

physician in the palliative care unit) 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.

110. Dr. Husel agreed to be part of the group that would draft Mount Carmel's policies for these situations.

111. The meeting ended with Dr. Swanner patting Dr. Husel on the shoulder and telling him that "everything would be okay," and that he would "be back to work soon."

112. The very next day, on November 27, 2018, Dr. Husel's credentials were renewed by the hospital. The two references used on his application were Dr. Swanner and Dr. Ralston, both of whom had just spoken with Dr. Husel about his dosing practices.

December 3, 2018 – Trinity Assumes Control and Conducts a Sham In-House "Peer Review" of Husel's Treatment Decisions Without Reviewing Medical Records or Speaking to Anyone Involved

113. In early December, Trinity took full control of the response and called upon its Chief Clinical Officer, Dr. Rosalie Tocco-Bradley, to "review" the question of Dr. Husel's prescriptions used during five palliative extubations. Dr. Tocco-Bradley occupied a "C-Suite" clinical role at the Corporation, but she has not held a position caring for patients in several years (perhaps decades).

114. In connection with the hospital's "investigation" Dr. Tocco-Bradley was not given access to any of the patients' medical records, or any details regarding the cases, other than the patients' names, the medications they received and dosages, and then time that lapsed between the dosages and death.

115. As a result, Dr. Tocco-Bradley was not aware of any of the patients' diagnoses, comorbidities, opioid tolerances, weights, organ failures, other medications, or family wishes or requests.

116. Nevertheless, without any medical records sufficient to give any opinion whatsoever, let alone an expert opinion as to the cause of death of these patients, Dr. Tocco-Bradley opined that patients who received 2000 mcg, 1000 mcg and even 500 mcg, all received doses that were usually "fatal." In rendering this "opinion" Dr. Tocco-Bradley failed to consider any peer-reviewed medical literature regarding end-of-life care, all of which unanimously agree that there is no such thing as a "fatal dose" that can be given to patients who are being removed from full life support. Nor did Tocco-Bradley consider that not a single peer-reviewed medical study has ever suggested that any dose less than 2000 mcg could be potentially fatal, even in opioid naïve patients. Dr. Tocco-Bradley did not have the patients' medical files so she did not know that the one patient who received 2000 mcg was highly opioid tolerant, and continued to experience respiratory distress, agonal breathing, and pain and suffering after receiving 1000 mcg of fentanyl and that this patient's family requested that he be given more so that he would not die in agony.

117. Dr. Tocco-Bradley did not talk with a single physician, nurse, pharmacist, or other hospital employee who provided care to any of these five patients. She did not know the patients who received these doses were all opioid tolerant and never bothered to inquire into the question. She appears to have either not read or ignored the medical literature regarding dosing during terminal extubation.

118. Dr. Tocco-Bradley failed to include in her "expert opinion" how it is she opined that 500 mcg of fentanyl is usually a "fatal dose" when numerous studies on human subjects involve them receiving over 1000 mcg as part of the medical study. Nor did she explain why the FDA has approved package inserts describing medical studies involving 630 mcg of fentanyl, or why the hospital's own resource manual, Lexicomp, suggested that 2000 - 5000 mcg (or higher

depending on the patient) is an appropriate high-dose for anesthesia use, and 700 mcg (or higher depending on the patient) is appropriate for pain relief (*but that these doses were not applicable in palliative extubations*).

119. There was simply no legitimate medical or scientific basis for this "expert opinion" and Dr. Tocco-Bradley either knew or should have known this at the time she gave it.

120. The results of this farcical "investigation" were disclosed to the public as Dr. Husel prescribing an excessive and fatal dose of fentanyl with the assistance of dozens of hospital staff.

December 7, 2018 – At Trinity Health's Direction, Dr. Larry Swanner Contacts Homicide Cold Case Sgt. Terry McConnell to Report a Homicide

121. On December 7, 2018, at the express instruction of Mount Carmel and Trinity management, Dr. Swanner contacted the Columbus Police Department and reported that Mount Carmel had uncovered several homicides committed by Dr. Husel with the assistance of several nurses by overuse of fentanyl.

122. Dr. Swanner indicated to the police that the "fatal" dose of fentanyl was 500 mcg. There was and is no medical basis for this statement. At the time of making this false statement to the police, neither Dr. Swanner nor anyone else, was in possession of any evidence indicating that Dr. Husel and the nurses did anything with the intent to cause or hasten death.

December 27, 2018 – At Trinity Health's Direction, David Ralston and Dina Bush Call the Families of 26 Patients Who Died in the ICU and Falsely Inform Them that Their Loved Ones Were Given Lethal Doses of Fentanyl by Dr. Husel and the ICU Staff

123. On December 27, 2018, David Ralston and Dina Bush called the families of 26 patients to tell them that their loved ones had been prescribed a "fatal dose of fentanyl" by Dr. Husel, which was then administered by the nurse caring for their loved one, and specifically asserted that the "excessive dose" of fentanyl caused their death. Ralston and Bush explained

that "all individuals involved in the provision of the excessive dosage of fentanyl were suspended from patient care by Mount Carmel."

124. During the December 27 calls, Ralston and Bush warned the families that they might be contacted by law enforcement, further confirming their assertion that the death of their loved one involved foul play.

125. Ralston knew the information he was providing was false, and that each of the patients had died from their illnesses following the removal of life support.

126. Bush knew the information she was providing was false, and that each of the patients had died from their illnesses following the removal of life support.

127. Each Ralston and Bush were instructed to make the calls by Sean McKibben (at Trinity's direction) and, on information and belief, began each call by reading a script prepared and or vetted by Trinity.

January 14, 2019 – At Trinity Health's Direction, David Ralston and Dina Bush Call the Families of 27 Patients, This Time to Inform Them that the Circumstances of Their Loved-Ones Deaths Were Not Isolated

128. The severity of the defamation escalated on January 14, 2019, when Dr. David Ralston and Dina Bush made a second round of phone calls to the families of patients, some of whom had already retained counsel in response to the first call.

129. In the calls, Ralston and Bush stated that the incident of Dr. Husel prescribing and the ICU staff administering to their loved one a "fatal" dose of fentanyl that killed their loved one was not isolated, that it had occurred to dozens of patients, and that dozens of nurses, pharmacists and other staff had been involved with the administration of such lethal doses.

130. On information and belief, some of the families and/or their counsel knew to expect the calls, as the first lawsuits were filed within hours of the calls, and contained

allegations regarding the calls they had received the same day. In one instance, the certificate of merit for the claim had been executed four days earlier.

131. That same day, Mount Carmel and Trinity released statements, and the hospital published two pre-recorded videos of Edward Lamb making one statement intended to be viewed by the public at large and one statement initially intended to be viewed by hospital employees only, although the "internal" video was quickly released to the public.

132. Attached as Exhibit B, is a reproduction of all the public statements made by Edward Lamb, Mount Carmel and Trinity, highlighted to show which statements were defamatory as to Dr. Husel; which statements falsely alleged wrongful conduct; which more general statements reinforced the false allegations as to Dr. Husel and the ICU staff (such as references to "theses tragic events"); and which statements were simply false, even though not defamatory. The narrative that follows below contains excerpts of Lamb's, Trinity's, and Mount Carmel's false statements, as well references to selected press articles (of which there have been hundreds) that came out that further vilified Dr. Husel.

133. Trinity CEO, Richard J. Gilfillan, issued the following defamatory statements on January 14, 2019, against Dr. Husel:

> "Mount Carmel Health, our regional health ministry in Columbus, Ohio, recently reported to authorities the findings of an internal investigation regarding a doctor who provided intensive care. Over the last four years, *this doctor ordered significantly excessive and potentially fatal doses of pain medication for at least 27 patients who were near death and receiving intensive care.* These patients' families had requested that all life-saving measures be stopped, yet the amount of medicine this doctor ordered was more than what was needed to provide comfort to these patients.

Following the discovery, the doctor was removed from all patient care, and his employment was terminated. We're working hard to learn all we can about these cases, and *we removed 20 other hospital staff from providing further patient care while we gather more facts. This includes a number of nurses who administered the medication and a number of staff pharmacists who were also involved in the related patient care*. We also promptly reported the results of our investigation to the appropriate authorities, including law enforcement. Investigations are ongoing with our full cooperation.

.... In these cases at Mount Carmel, ...the significantly excessive doses ordered by this doctor went beyond providing comfort. In many cases, *the doses were potentially fatal, and the care ran contrary to the most basic ethical principle of medicine: Do no harm*.

We are joined by leaders of Mount Carmel in being disappointed that this aberration in care could have continued for several years, given the work we have done in many Trinity Health ministries on Just Culture. Mount Carmel, in particular, has engaged in broad-based ZeroHarm and High-Reliability training over the past 18 months to eliminate preventable harm throughout the organization by hardwiring reliable behaviors and principles into their culture.... Our integrated team is seeking to identify immediate root causes and we will continue to examine *how this happened and what we need to do to ensure it never occurs again* – we will be asking outside experts to assist us in this process.

Ultimately, our Just Culture principles and event reporting system did work – it was a colleague reporting an event that led us to identify the care pattern – this event clearly shows us that, despite the progress we have made, we have much more work to

> do. *Each person throughout our Trinity Health Ministry must not only have the right to speak up about an error or safety concern, but must know that they are expected to do so. And there should be no fear of retribution for reporting.* Trinity Health's entire leadership team is committed to building a culture that supports these critical reports across our entire national Ministry.

134. The statement above contained clear defamatory statements regarding the alleged "excessive dosages," and falsely accused Dr. Husel of engaging dozens of intentional murders. Moreover, the more generalized comments such as "how this happened and what we need to do to ensure it never occurs again" make clear that Trinity was not informing the public of a potential problem, it was reporting as fact (falsely) that the subjects of its statements had committed wrongdoing and the 27 patients had, indeed, been harmed, specifically, they had been intentionally murdered.

135. Edward Lamb, CEO of Mount Carmel issued essentially the same defamatory statement, also on January 14, while adding in a video released to the public, that "[t]he actions that created this tragedy were instigated by this physician and *carried out by a small number of people who made poor decisions. They ignored the safeguards we have in place*, and that *"[Mount Carmel's] culture of safety means that unintentional human error is not punished. Instead, we use those occasions to learn and become better. And we will. At the same time, we can't disregard colleagues ignoring policies and putting our patients' safety at risk.*"

136. Lamb's publicly-disseminated statements that the ICU nurses and pharmacists were "ignoring policies and putting our patients' safety at risk" is a highly detrimental, and false, statement. None of the plaintiffs here ignored policies, and none put patients at risk.

137. On January 15, 2019, ABC News 6 published an article titled "Mount Carmel doctor under investigation by cold-case homicide unit." The article notes that "Mount Carmel Health said in an email Tuesday 'our employees are understandably shocked and disappointed by this doctor.'" The article quoted liberally from Lamb's January 14 statement. *See* https://abc6onyourside.com/news/local/mount-carmel-doctor-under-investigation-by-cold-case-homicide-unit. None of the nurses who worked with Dr. Husel were "shocked or disappointed" by Dr. Husel's care of patients, quite the contrary, 36 of them had signed a petition requesting that he be reinstated, and told police detectives that the doses of fentanyl he prescribed were appropriate given the circumstances and they had no reason to believe he was intending to cause the death of any patient. All "shock" and "disappointment" was focused on Mount Carmel and Trinity leadership.

138. On January 22, 2019, Mount Carmel released the following statement:

> "*Based on what this doctor did to these near-death patients*, we understand that some of these families may be considering legal action. *We've apologized to these families, we've apologized publicly*, and we're continuing to cooperate with law enforcement and other authorities. We're also working to *build additional safeguards so that a tragedy like this never happens again*.

139. The January 22, 2019 statement is defamatory in the context of the previous statement that accused Dr. Husel of ordering fatal doses of medication. Statements like "*based on what this doctor did*" and "*additional safeguards so that a tragedy like this never happens again*" act as a reaffirmation by the hospital of the false allegation that Dr. Husel and his colleagues intentionally harmed, i.e., murdered patients.

140. On January 22, 2019, WBNS 10 TV published an article titled– "Second Mount Carmel video emerges with message: Caregivers and doctor made "poor decisions." The article reposted Edward Lamb's January 14 video, and quoted the statement that "we can't disregard colleagues ignoring policies and putting our patients' safety at risk" among others. *See* https://www.10tv.com/article/second-mount-carmel-video-emerges-message-caregivers-and-doctor-made-poor-decisions.

141. On January 24, NBC4i published an article titled – "Mount Carmel investigation: Number of patients affected by Dr. Husel's actions raised to 34" See https://www.nbc4i.com/news/local-news/mount-carmel-investigation-number-of-patients-affected-by-dr-Dr. Husels-actions-raised-to-34/.

142. On January 25, 2019, Mount Carmel released the following statement:

> "We received a formal report on October 25, 2018, that related to Dr. Husel's care. Based on what we learned about that report, we should have begun a more expedited process to investigate and consider immediate removal of Dr. Husel from patient care at that time. Dr. Husel was removed from patient care on November 21, 2018. *We are aware of three patients who died between October 25 and November 21 after receiving excessive and potentially fatal doses of medication ordered by Dr. Husel. We are sorry for this tragedy*, and we will continue to investigate how we responded to this report and whether there is any other information that should have led us to investigate sooner into Dr. Husel's practices.
>
> *We have identified seven additional patients who received excessive doses of pain medication that Dr. Husel ordered. One of the patients received an excessive and potentially fatal dose. The other six patients received excessive doses that went beyond*

providing comfort but were likely not the cause of their deaths. We contacted the loved ones of these patients because it was the right thing to do. *This brings the number of patients involved to at least 34, and we anticipate we might discover more as our investigation continues….*

These events are heartbreaking….

143. The January 25, 2019, statement is defamatory in the context of the previous statement that accused Dr. Husel of ordering fatal doses of medication, and implicating the nurses and pharmacists in his conduct. This statement reiterates the false allegations that patients receive "potentially fatal" and "excessive" doses. Moreover, statements like "*we are sorry for this tragedy*" and "*these events are heartbreaking*" act as a reaffirmation by the hospital of the false allegation that Dr. Husel and his colleagues wrongfully harmed patients.

144. On January 26, 2019, NBC News ran an article titled: U.S. NEWS: Ohio physician allegedly ordered 28 people potentially fatal doses of opioid painkillers. Their families wonder why he wasn't stopped." *See* https://www.nbcnews.com/news/us-news/ohio-physician-allegedly-ordered-28-people-potentially-fatal-doses-opioid-n962516. The article stated, among other things, "A pharmacist has the ability to check in with a doctor to ensure the amount is what they wanted and to stop it if they believe it to be incorrect. Nurses, too, before administering a drug can refuse or signal to their supervisor that the amount appears to be wrong." The article also quoted Lamb.

Late January-March 2019 – Mount Carmel and Trinity Continue an "Investigation" Wherein They Make More Defamatory Public Statements

145. Also, on January 29, 2019, WBNS 10 TV ran an article titled: "23 Staffers on leave at Mount Carmel in wake of fentanyl overdose," stating in part, "Thirty-four patients have been identified as having received potentially lethal doses of fentanyl. Twenty-eight of them, the

hospital says, were given fatal doses." *See* https://www.10tv.com/article/23-staffers-leave-mount-carmel-wake-fentanyl-overdose-scandal.

146. On February 14, 2019, WBNS 10 TV published an article titled "'We are all hurting: Families of Mount Carmel patients say they're reliving loved ones' deaths." *See* https://www.10tv.com/article/we-are-all-hurting-families-mount-carmel-patients-say-theyre-reliving-loved-ones-deaths.

147. On February 22, 2019, Mount Carmel made the following public statement:

> "At this point, we have identified one additional patient who received an excessive and potentially fatal dose of medication ordered by Dr. Husel. As we have done with each of the affected families, we have contacted the loved ones of this patient. This brings the number of patients involved to at least 35, including at least 29 who received a potentially fatal dose of medication ordered by Dr. Husel.
>
> As previously shared, *we also have been investigating whether any of the affected patients received excessive doses of pain medication when there was still an opportunity for treatment to improve their immediate condition. We are aware of five cases in which this possibility is a concern*, and we are reaching out to the loved ones of these patients to share this information.
>
> These events are heartbreaking, unacceptable and inconsistent with the values and care processes of Mount Carmel.

148. The February 22, 2019 statement is defamatory in the context of the previous statements that accused Dr. Husel of ordering fatal doses of medication. This statement reiterates the false allegations that patients received "potentially fatal" and "excessive" doses. Moreover, the February 22 statement made the drastic new false allegation that five of the

patients *might have survived* after withdrawal of all life support. This meant that Mount Carmel was falsely stating that Dr. Husel and the nurses/pharmacists not only hastened inevitable deaths, but had caused five avoidable deaths. At the time of these statements, Mount Carmel knew that these allegations were false, and that none of those five patients cared for by Dr. Husel and the nurses could possibly have survived without full life support.

149. These five patients were reported in the press as patients who could have survived with proper care. This was categorically wrong, but anyone with the information to set the record straight was too scared to come forward.

150. At the time, the estates of three of the five families were represented and in litigation with Mount Carmel. Prior to the public announcement, Mount Carmel contacted counsel representing those families to inform them that Mount Carmel would publicly announce that it had determined that their clients could have survived but for the actions taken in the ICU.

151. Mount Carmel's statements were false, and their falsity was known to Mount Carmel and Trinity management at the time they were made.

152. While three of the five patients did not enter the hospital with a terminal prognosis, by the time they were admitted to the ICU (for the final time), none of the five patients could have survived without full life support, as each had multiple-organ failure and had reached the point where further treatment was futile.

153. Each died from their respective illnesses following the withdrawal of life support.

154. In none of the five cases did the amount or type of pain medication the patient received contribute to their death.

155. The knowingly false statements that Dr. Husel murdered five patients who would have otherwise survived has been particularly damaging.

156. That same morning, on February 22, 2019, CBS This Morning ran a 5-minute-long story, complete with interviews of family members who had filed lawsuits. See https://www.cbsnews.com/news/mount-carmel-hospital-ohio-doctor-william-Dr. Husel-accused-lethal-doses-fentanyl/. The article notes that "Twenty-three caregivers, including 14 nurses, six pharmacists, and three managers were placed on leave."

157. On March 13, 2019, Edward Lamb released the following statement to the media: "[W]e have:

> Appointed new interim clinical leadership for Mount Carmel West as a whole, as well as new leadership in key areas of the ICU at Mount Carmel West—our previous physician, nursing and pharmacy leaders are on administrative leave; *Removed from patient care any colleague who was in any way part of medication administration for an impacted patient*; Provided information to appropriate licensing boards on all colleagues who were in any way part of medication administration for an impacted patient; and Continued our internal investigation and active cooperation with all relevant authorities and regulatory bodies....
>
> *We have identified a total of 48 nurses and pharmacists whose actions are under review and whose names have been reported to the relevant nursing and pharmacy boards*. Out of an abundance of caution, *we have removed all colleagues who were associated with medication administration for an impacted patient. In total, 30 colleagues are on administrative leave, and 18 no longer work for Mount Carmel—many of whom left years ago*."

158. The March 13, 2019, statement is defamatory in the context of the previous statements that accused Dr. Husel of ordering fatal doses of medication.

159. On March 13, 2019 NBC4i published an article titled "Mount Carmel reports 48 nurses, pharmacists under review in connection to Dr. Husel investigation." See https://www.nbc4i.com/news/local-news/mt-carmel-reports-48-nurses-pharmacists-under-review-in-connection-to-Dr. Husel-investigation/. The article stated, in part, "Mount Carmel has more than doubled the number of employees who have been removed from patient care as a result of the ongoing investigation into excessive doses of pain medication given to patients in the intensive care unit."

160. On April 10, 2019, ABC 6 published an article titled "Lawyer: Amount of fentanyl Mount Carmel West patient received could kill an elephant." *See* https://abc6onyourside.com/on-your-side/lawyer-amount-of-fentanyl-mount-carmel-west-patient-received-could-kill-an-elephant. The attorney reported in the article that "he's heard from hospital representatives that they're interested in discussing a "rapid resolution" to the civil matter." (The patient at issue had been found in his bathtub with no pulse, having suffered a cardiac arrest from a heroin (opioid) overdose, and had a reported history of illicit drug use including long-term heroin use. After his family decided to withdraw life support, he was given two separate 1000 microgram doses of fentanyl (separated by 20 minutes). The second dose of fentanyl was given because the first dose failed to alleviate the patient's pain, and it appeared to Dr. Husel, the nurse caring for the patient, and his family members, that he was suffering from physical pain as he gasped for air, and was breathing agonally.

161. Given the media frenzy and sensationalization of events, on June 5, 2019, Dr. Husel was indicted in Franklin County, charged with purposefully murdering 25 patients with the assistance of various nurses and pharmacists. Reacting to Mount Carmel's public statements about Dr. Husel and its nurses, as well as the Prosecuting Attorney's Office's actions, Ohio's

Attorney General Dave Yost stated that "[i]t looks like we've got a serial killer on the loose with a medical license and access to fentanyl." At a press conference, the Prosecuting Attorney asserted investigators could not find any motive for the crime, but noted that they weren't required to prove motive. The 25 counts of the indictment corresponded to each patient that received 500 mcg of fentanyl or more, regardless of their conditions, needs, or opioid tolerances.

162. Of the 25 patients, autopsies were performed on only 2, and both were documented opioid addicts whose cause of death was cardiac arrest and respiratory distress secondary to overdose of illicit drug use. No autopsy on any patient remotely supports an assertion that the cause of death of fentanyl administered after being removed from life support.

163. On July 10, 2019, Edward Lamb made another public video statement, which was also released in writing:

> After many months, our review of patient cases under the care of Dr. William Husel has come to a conclusion.
>
> Based on our extensive review of records of patients treated by Dr. Husel, the total number of affected patients remains 35, as previously communicated.
>
> We have examined the individual role of every colleague who was a part of the medication administration for the affected patients. After careful case-by-case analysis of colleague involvement and the members of management involved in oversight of those colleagues, we have made the following staffing decisions:
>
> - We are keeping one colleague on administrative leave.
> - We are terminating the employment of 23 colleagues—including 5 physician, nursing and pharmacy management team members—effective today.

- Eleven colleagues will have the opportunity to return to work after they complete additional training and education.

.... Mount Carmel is a strong regional system with a steadfast commitment to providing people-centered care today and for generations to come. These last months have been difficult for our healthcare system, and, in times such as these, new leadership has the ability to facilitate healing and help restore the trust of the community.

.... I am certain Mount Carmel will continue to learn from these events and grow in the future, guided by our highest priority: providing safe, high-quality, people-centered care.

.... We are deeply sorry for the additional grief and frustration this has caused and are working to provide reasonable settlements with affected families. If that cannot be accomplished, we will work through the court process.

.... Although our patient review is now complete, Mount Carmel will continue to work on strengthening our culture of safety. Mount Carmel will constantly reinforce the culture that colleagues have a right to speak up about safety concerns and are expected to do so.

.... It will take time for Mount Carmel to restore our patients' and community's trust. Mount Carmel has been making and will continue implementing meaningful changes throughout the system to ensure that our colleagues provide the best possible care, and that patients and their families can be confident in our services.

164. The above statement is defamatory in context in that it continues to assert that Dr. Husel did in fact prescribe fatal doses of fentanyl to 29 patients and caused their deaths.

165. As a direct consequence of the defamatory statements, Dr. Husel was named as a defendant in dozens of civil lawsuits and then indicted for murder. Within weeks of being indicted for acts taken in the course and scope of his employment, he asked Mount Carmel to provide for a legal defense for him, as guaranteed in his employment agreement, but Mount Carmel and Trinity refused to honor their obligation and refused to pay for his criminal defense counsel, his regulatory defense counsel in connection with his medical board hearing, or his counsel of choice in the civil cases.

166. Dr. Husel's demand for a defense in the criminal case is the subject matter of an ongoing litigation in the United States District Court for the Eastern District of Michigan. In that litigation, Mount Carmel and Trinity have falsely asserted to that court that Dr. Husel's prescriptions were in violation of hospital policies and that he was acting outside the scope of his employment when he prescribed medication for these patients.

167. It is difficult to conceive of a more outrageous and needlessly pain-causing story as the one concocted in the C-suite of Trinity against Dr. Husel. It is alarming to think that these corporate executives – who apparently never stepped foot in an ICU to care for a dying patient and lacked the basic understanding of appropriate palliative care or the policies and procedures being used in their own hospital's ICU for the prior five years– were able to falsely accuse Dr. Husel of murdering patients with the assistance of dozens of other hospital employees.

168. The law provides a remedy for such conduct.

STATEMENT OF FACTS – IMPACT OF DEFENDANTS' ACTIONS ON THE PLAINTIFF AND HIS FAMILY

169. Dr. Husel's life has been forever ruined by the Defendants' false and defamatory statements. Even after obtaining an acquittal in the criminal case, he will be unemployable in the healthcare industry (in Columbus and elsewhere) or in any industry because of the false and

defamatory allegations. It is difficult to describe what the full impact of the Defendants' conduct has been, beyond just saying it has been complete and total destruction. He and his family have been emotionally and financially decimated. Dr. Husel lost his job, his home, his income, and his freedom while he awaits an unjustified criminal trial. All of this destruction is directly tied to Defendants' indefensible conduct of falsely accusing him of causing the death of patients by ordering "excessive" doses of fentanyl.

CAUSES OF ACTION

First Cause of Action
Defamation *per se* and *per quod*

170. Plaintiff repeats and re-alleges the allegations in the preceding paragraphs as though fully set forth herein.

171. As set forth in the allegations above, Defendants each made numerous public statements (Lamb himself, and each corporate defendant through Lamb and other employees or agents acting in the scope of their employment and at the corporation's explicit direction) that were false and defamatory regarding Dr. Husel. The false statements asserted that Dr. Husel intended to murder and did in fact cause the deaths of 29 of the 35 patients and that 5 of those 29 patients might have recovered but for the actions taken by Dr. Husel and the group. In most cases the defamatory statements were according to pre-approved scripts or press releases that were jointly drafted and edited by Lamb, Mount Carmel and Trinity.

172. Moreover, Lamb, Mount Carmel and Trinity's more general statements as detailed above and in Exhibit B that, for example, referred to a "tragedy" or asserted "these actions have brought shock and hurt to our organization" and require repeated "apologizing" for the "heartbreaking events" are equally false and defamatory in context.

173. None of Lamb, Mount Carmel and/or Trinity had any legal requirement to make any public statements about Dr. Husel, nor were the statements for which damages are being sought made under any privilege.

174. Each of Lamb, Mount Carmel and Trinity were, at a minimum, negligent in making false statements regarding the appropriateness of the care given with each of the 35 patients.

175. Each of Lamb, Mount Carmel and Trinity were, at a minimum, negligent in making false statements regarding the possibility that any of the 35 patients might have recovered, but for the actions taken by Dr. Husel.

176. In fact, Lamb, Mount Carmel and Trinity knew that their statements were false, and made them for the purpose of harming Dr. Husel for the specific purpose of distracting the public and regulators/law enforcement from perceived and actual shortcomings of Mount Carmel, Trinity and their executive management.

177. The false statements reflect upon Dr. Husel's character in a manner that has and will forever cause him to be ridiculed, hated, or held in contempt.

178. The false statements reflect his character in a manner that will injure him in his trade or profession as an ICU doctor and anesthesiologist.

179. Dr. Husel did not thrust himself into or was not involved in a "public matter.

Second Cause of Action
Breach of Contract
(Against Mount Carmel)

180. Plaintiff repeats and re-alleges the allegations in the preceding paragraphs as though fully set forth herein.

181. Plaintiff signed an employment agreement with Mount Carmel in which it agreed to provide him with liability insurance and to provide for a defense for any claims asserted against him for conduct undertaken in the scope of his employment.

182. While Mount Carmel and Trinity obtained insurance for Dr. Husel, when he requested that he be provided with a defense for the criminal indictment, they refused to defend him and instead falsely told a federal judge that he was acting outside the scope of his employment when he prescribed fentanyl during the palliative withdrawals discussed herein.

183. Mount Carmel has also refused to provide for his defense in connection with his medical board hearing.

184. Mount Carmel has also refused to provide for his counsel of choice to defend him in connection with the civil lawsuits in which he has been named as a defendant.

185. The refusal to pay for his defenses for claims filed against him based on actions taken during the course and scope of his employment, specifically prescribing medicine to patients being treated in the hospital in full compliance with the policies in effect at the time, amounts to a failure to obtain insurance in compliance with the employment agreement.

186. The breach of this agreement caused damages and severe financial harm to Dr. Husel.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff demands judgment as follows:

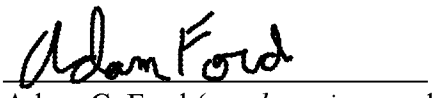
A. On the FIRST cause of action, such actual damages as Plaintiff may prove at trial but in an amount far greater than twenty-five thousand dollars in presumed and actual damages, plus punitive damages and reasonable attorney's fees;

B. On the SECOND cause of action, such actual damages as Plaintiff may prove at trial but in an amount far greater than twenty-five thousand dollars in actual damages.

C. Any further and other relief the Court deems just and proper.

Dated: December 26, 2019
New York, New York

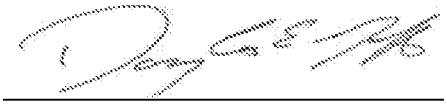
FORD O'BRIEN LLP



Adam C. Ford (*pro hac vice* pending)
575 Fifth Ave.
17th Floor
New York, New York 10017
(212) 858-0040
aford@fordobrien.com

Dated: December 26, 2019
Columbus, Ohio

GRAFF & McGOVERN, LPA



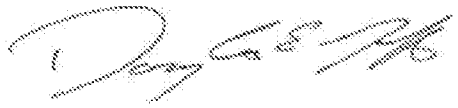
Douglas Graff, Esq. (0013222)
604 East Rich Street
Columbus, OH 43215
(614) 215-9956
Doug@grafflaw.com

Counsel for Plaintiff Dr. William S. Husel

JURY DEMAND

Pursuant to Civil Rule 38(b), Plaintiff hereby demands a jury trial on all issues so triable.

GRAFF & McGOVERN, LPA



Douglas Graff, Esq. (0013222)
604 East Rich Street
Columbus, OH 43215
(614) 215-9956
Doug@grafflaw.com