Anna Pou: No homicide, no euthanasia.

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The case of Anna Pou in New Orleans has generated enormous controversy. Briefly she was arrested for homicide in the deaths of four patients at Memorial Medical Center in the aftermath of hurricane Katrina. The local medical examiner did not find that the deaths were caused by homicide. A Grand Jury declined to refer charges for criminal homicide. Even so, the families of several of the decedents are proceeding with civil suits related to the deaths. Furthermore, experts for Louisiana Attorney General Charles Foti continue to publicly proclaim that Dr. Pou committed suicide.

Mr. Foti's experts reports are on line at
http://i.a.cnn.net/cnn/2007/images/08/27/memorial.medical.center.pdf

Dr. Pou's attorney asked me to review this material and I have done so. I have not taken any money and do not intend to do so for this case.

Here is my analysis.

- I am a Minnesota licensed physician, who is board certified and recertified in both Internal Medicine and Geriatric Medicine and who practices and teaches hospitalist medicine at the University of Minnesota.
- I have a federal license to use narcotics and regularly use such drugs, including morphine and midazolam, in my clinical work.
- I have extensive experience treating extremely frail persons with chronic conditions similar to those at issue in this report and have treated such persons in nursing homes, hospitals and clinics.
- I have an extensive and distinguished background in medical ethics and palliative care and have published and taught on this subject.
- I have worked in disaster situations since 1979 in various locations with the American Refugee Committee. These experiences have given me a working knowledge of situations where an environmental emergency is accompanied by the collapse of a medical infrastructure. I have published on this topic.
http://www.ahc.umn.edu/bioethics/facstaff/miles_s.html
- I have provided medicolegal expertise for investigating lethal events in health care facilities—most often with regard to asphyxial accidents in beds. This experience has

given me practical experience with the format and content of medical examiner's products and forensic investigations.

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General Comments on Reviewed Material

It is unusual that the request for records made per Louisiana revised statues 44:32 was not answered with copies of death certificates, police reports and the medical examiners' reports (aside from the autopsy report) as such documents are usually public records.[1]

Relevance of the Katrina-affected Hospital Infrastructure

Hurricane Katrina made landfall on August 29, 2005. Seven hundred people died in New Orleans as the city flooded and city services shut down. The city medical system failed. A Select Bipartisan Congressional Committee described the medical system in New Orleans during and immediately after Katrina this way.

- Medical care suffered from a lack of advance preparations, inadequate communications and difficulties coordinating efforts.
- Deployment of medical personnel was reactive, not proactive.

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[1] TITLE 44: PUBLIC RECORDS AND RECORDERS CHAPTER 1. PUBLIC RECORDS PART I. §1. General definitions. (2)(a) All books, records, writings, accounts, letters and letter books, maps, drawings, photographs, cards, tapes, recordings, memoranda, and papers, and all copies, duplicates, photographs, including microfilm, or other reproductions thereof, or any other documentary materials, regardless of physical form or characteristics, including information contained in electronic data processing equipment, having been used, being in use, or prepared, possessed, or retained for use in the conduct, transaction, or performance of any business, transaction, work, duty, or function which was conducted, transacted, or performed by or under the authority of the constitution or laws of this state, or by or under the authority of any ordinance, regulation, mandate, or order of any public body or concerning the receipt or payment of any money received or paid by or under the authority of the constitution or the laws of this state, are "***public records***", except as otherwise provided in this Chapter or the Constitution of Louisiana.

- There was poor planning and pre-positioning of medical supplies and equipment led to delays and shortages.
- New Orleans was unprepared to provide evacuations and medical care for its special needs population and dialysis patients, and Louisiana officials lacked a common definition of "special needs."
- Most hospitals' emergency plans did not offer concrete guidance about if or when evacuations should take place.
- New Orleans hospitals were not adequately prepared for a full evacuation of medical facilities.
- The government did not effectively coordinate private air transport capabilities for the evacuation of medical patients.
- Hospitals' emergency plans did not adequately prepare for communication needs.
- Following Hurricane Katrina, New Orleans hospitals' inability to communicate impeded their ability to ask for help.
- Medical responders did not have adequate communications equipment or operability.
- Lack of electronic patient medical records contributed to difficulties and delays in medical treatment of evacuees.
- Lack of coordination led to delays in recovering dead bodies.
- Deployment confusion, uncertainty about mission assignments, and government red tape delayed medical care.[2]

Dr. Pou and her colleagues and the seventh floor of Memorial Medical Center were at the epicenter of this kind of health care system. Outside--Katrina and a dysfunctional city. Inside—a collapsed and isolated medical infrastructure.

Normally, when we say that a hospital patient is on life support, we are referring to a particular piece of machinery such as a respirator. We take for granted how that one machine is a piece of the larger life support system that we call a "hospital." That system includes a dynamic web of pulmonologists, respiratory technicians, nurses and machinists. Monitors and tests scrutinize the present physiology and give subtle clues about forthcoming medical needs. Complex and redundant communications networks move information between testing facilities, clinical staff, pharmacies and various physician and non-physician specialists. Matériel, including gasses, drugs or information, moves by messenger and mechanical conduits. The hospital requires electrical power and computers. It requires a steady stream of fresh personnel, reagents, drugs and blood products, bactericidal soap and gloves. Some of this matériel must move through a continuous chain of cold transport from outside, within and through the hospital. All of these things are part of the life-support system that is called a hospital. All of them were compromised at Memorial Medical Center.

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[2] Select Bipartisan Committee to Investigate the Preparation for and Response to Hurricane Katrina Executive Summary, 2006-2-15, http://www.gpoaccess.gov/katrinareport/execsummary.pdf

Several of the experts, all but one of whom were not treating clinicians, referred to some of the patients as "stable." [It is worth noting that the one active clinical physician did not conclusively state that any of the evaluated patients died of homicide.] The stability of any ill patient reflects a balance between the patient's condition and the hospital's capability. As a sequestered staff burn out or are diverted to evacuations or as material resources are consumed, the hospital's treatment capacity falls and the patient becomes frailer and has less margin for cure vis a vis the remaining hospital capacity. Time matters. The longer a patient in a collapsed hospital goes without customary monitoring with laboratory tests and radiographs, the more likely it becomes that a latent problem with become a crisis.

Medical records including clinicians' notes, consent forms, care plans, records of vital signs, drug administration sheets, orders and discharge summaries are also integral to the modern hospital. All are kept for posterity for further treatment, and for utilization review, quality assurance and legal oversight. The lack of consent forms and orders played a key role in each of the state's expert's opinions. None of these experts seemed familiar with how the dynamics of a collapsed hospital changes record keeping.

- Scarce time and short staff most dramatically reduce record keeping that simply records the past fact of treatment. Dire resource scarcities work against making records for posterity. Personnel, who do not expect reinforcements, need sleep to continue to work. Batteries are properly allocated for patient care, e.g. powering flashlights to observe patients or to power glucometers to treat diabetes, rather than for keeping retrospective notes for posterity.
- The collapsed hospital infrastructure also affects records, such as a physician's orders, that *effect* care plans. In ordinary circumstances, the physician writes an order that is transcribed by a station secretary who enters it into a computer that transmits it to a lab or pharmacy that sends an electronic acknowledgement back and which then sends back the appropriate drug or technician. Consider though a hospital where any link in this chain is broken: the station secretary has been diverted to carrying drugs or moving patients to boats, the computer system is down, there is no lab or pharmacy receptor for computer information, or the drugs are procured by a courier who shuttles between the doctor or nurse and the pharmacy. In such a case, the record or the physician's order does not *effect* treatment—it simply notes it for posterity. The hospital-in-crisis adjusts its job descriptions and documenting procedures.
- Records, such a care plans, communicate important facts to new shifts. But if there are no new shifts coming in, then this function might well be triaged as a low priority activity.

Given the highly degraded hospital environment, I do not feel that it is possible, as the experts presume, to assess clinical charting on agitation, vital signs, or drug administration without comparing such to a sample of other patients from the same ward at the same time.

The infrastructure collapse of Memorial Medical Center during Katrina did not change the fundamental ethical principles of medicine, including a fiduciary responsibility to the patient's well being. It did, however, diminish and change the technical resources of the hospital in a manner that called for a proper accommodation in work assignments in the service of those principles. Indeed, if the clinicians inside Memorial Medical Center had burned their personal and electrical batteries for completing billing forms, discharge summaries, or medicine and treatment administration sheets, had they gone through the traditional motions of recordkeeping even though the hospital infrastructure could not transcribe, transmit, or effectuate those records, they would have been justly condemned. In this environment their ethical duty was to work like clinicians rather than act like martinets.

I have been in such situations.

Comments on the Morphine Forensic Evaluations

Three tacit and unsupported assumptions underlie the experts' conclusions that the morphine or morphine-midazolam drugs were lethal.

- First, the four medical experts opine that research has defined a lethal toxicologic dose of morphine or midazolam. The experts' do not offer support for this opinion and there is no evidence that the experts reviewed the literature.

  ⇒ Dr. Wecht gives one citation to data on the toxic levels of morphine, R. Basalt [sic, actually Beselt]. *Disposition of Toxic Drugs and Chemicals in Man*. 7th edition, 2004 Biomedical Publications, Foster City CA. The data he refers to is on page 761; it comes from one 1974 paper discussing *seven* morphine deaths.[3] A more recent and comprehensive survey lists the "comatose to fatal" range of .1-4 mg/kg instead of Wecht's .2-2.3, about 74% higher.[4]

  ⇒ Dr. Young offers no citations for his opinion that the levels were "high enough to cause death."

  ⇒ Dr. Baden offers no citations as he concludes that one case had "significant levels of morphine and Midazolam," one showed the "presence of" morphine and midazolam, one showed "a very high level of morphine in the liver" and one showed "the presence of morphine and Versed sufficient to cause death by impairing the ability to breathe."

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[3] Felby S, Christensen H, Lund A. Morphine concentrations in blood and organs in cases of fatal poisoning. J Forensic Sci 1974;3:77–81.

[4] Schulz M, Schmoldt A. Therapeutic and toxic blood concentrations of more than 500 drugs. Pharmazie 1997;52:895-910.

⇒ Dr. Brescia offers no support for his opinion that "multiple tissue specimens demonstrating suspiciously high values of morphine and in some cases morphine and midozolam (sic)."

- Second, all of the experts presume that the morphine levels in the post mortem tissue samples reflect levels at the time of death. This may be untrue because of the phenomenon pertaining to post-mortem drug levels that is called "necrokinetics."[5] None of the experts took this into account in interpreting the morphine levels.

  ⇒ Many forces affect drug levels after death. Some drugs decompose on their own. Gravity takes some drugs to dependent parts of the body and out of the customary sampling sites. Diffusion moves others drugs into unusual areas. Putrefaction, sometimes accelerated by heat or the evolving acidity of the corpse, enables normally present bacteria to metabolize drugs after death. Some drug levels even increase after death. For example, after heroin overdoses, post mortem morphine levels may *rise* due to bacterial metabolism.[6] [7] The decedents in this matter lay in the warm hospital until September 11, 11 to 12 days after their deaths. The decomposing bodies were not autopsied for another week or more. The autopsies of Rose Savoie, Wilda McManus and Elaine Nelson were performed on 9/18; Alice Hutzler died on August 29 and was autopsied on 9/21. Ordinarily the purge fluid, liver and bile have exceptionally high levels because of premortem concentration of morphine in the liver where it is metabolized; these post mortem levels tend to be much higher than premortem serum morphine levels. The brain levels are probably closest to the perimortal morphine level but no studies discuss the necrokinetics for this extreme duration of decomposition at this warm ambient temperature.[8] [9] This was true in these cases; see Figure 1.

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[5] Leiken JB, Watson WA. Post-mortem Toxicology: What the Dead Can and Cannot Tell Us. Clin Tox 2003;41:47-56.

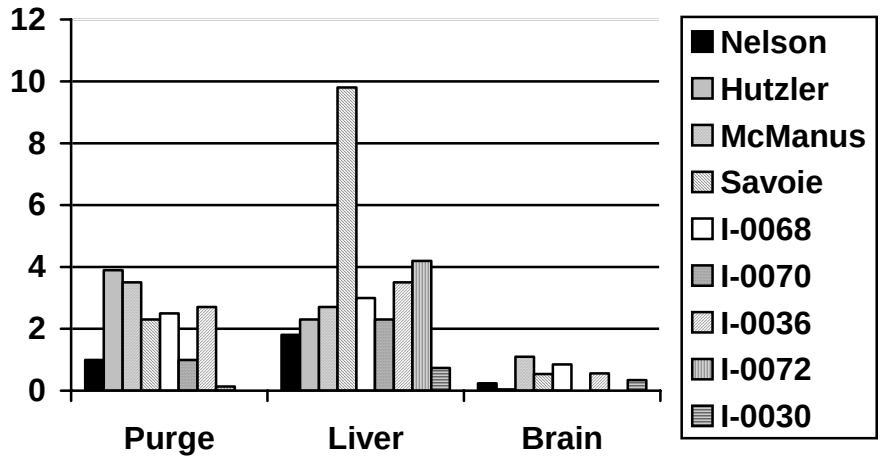
[6] Skopp G et al. Postmortem distribution pattern of morphine and morphine glucuronides in heroin overdose. Int J Legal Med 1996;109:2-7.

[7] Carroll, F, et al. Morphine-3-D Glucuronide Stability in Postmortem Specimens Exposed to Bacterial Enzymatic Hydrolysis. Am J Forensic Med & Path 2000;21:323-329.

[8] Logan BK, Smimow D. Postmortem distribution and redistribution of morphine in man. J Forensic Sci 1996;41:37–46.

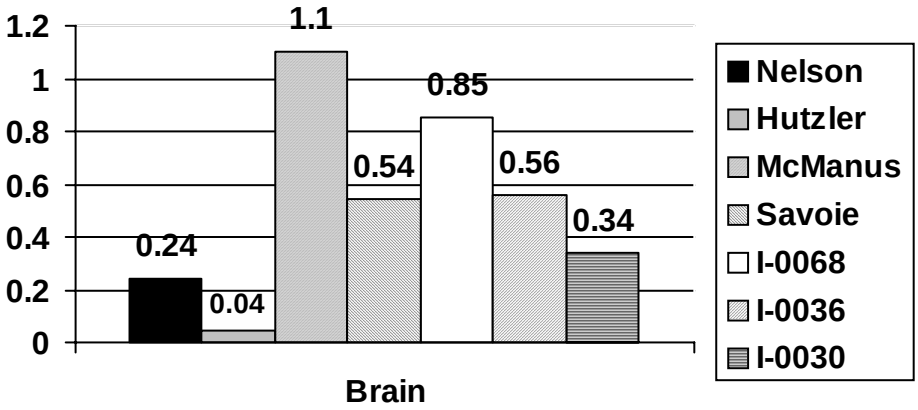
[9] Chan SC, Chan EM, Kaliciak HA. Distribution of morphine in body fluids and tissues in fatal overdose. J Forensic Sci 1986;31:1487–91.

Fig. 1. Morphine levels mgm/kg



These brain levels in the seven toxicology reports in which they were measured are not so high as to be reliably lethal. See Figure 2.

Fig 2. Brain Morphine levels mgm/kg



- Third, the experts tacitly assume that there is a standard dosing by physicians of these drugs because exceeding such doses is reliably lethal. In fact, prescribed doses among patients who are perceived to be at the end of their lives vary hugely and such variations do not appear to affect time to death.

  ⇒ A prospective study in six university-affiliated hospitals of 206 intensive care patients for whom mechanical ventilators were withdrawn found that the cumulative doses [median (range)] during the four hours before death were:

morphine 119 patients, 24 mg, (2-450 mg); midazolam [Versed] 45 patients, 24 mg, (2-380 mg); and lorazepam 35 patients, 4 mg, (1-80 mg). These doses did not differ among the three time periods before death. Drug use in the hours before death was not associated with the time to death.[10]

⇒ A prospective case series of consecutive critically ill patients in intensive care units at a county hospital (N=22) and a university hospital (N=22) found that palliative drugs were given to 75% of patients during withholding and withdrawal of life support. (Comatose patients did not receive medication because they would not benefit from it.) The median time until death following the initiation of the withholding or withdrawal of life support was 3.5 hours in the patients who received drugs and 1.3 hours in those patients who did not (P, not significant). "The amounts of benzodiazepines and opiates averaged 2.2 mg/h of diazepam and 3.3 mg/h of morphine sulfate in the 24 hours before withholding and withdrawal of life support and 9.8 mg/h and 11.2 mg/h in the 24 hours thereafter (P less than .025 and P less than .001, respectively). Large doses of sedatives and analgesics were ordered primarily to relieve pain and suffering during the withholding and withdrawal of life support, and death was not hastened by drug administration."[11]

⇒ A retrospective cohort study in two medical-surgical tertiary-care intensive care units in a Canadian regional referral teaching hospital studied 174 patients who died between July 1, 1996, and June 30, 1997 after life support was withdrawn. Once the decision to withdraw life support was made, death occurred in 4.3 h (2.1 to 6.5 h; mean [95% confidence interval]). Physician differences of more than 10 fold were seen for the prescribed doses of morphine and sedative agents regardless of whether life support was withheld or withdrawn. The median cumulative dose of morphine prescribed during the final 12 h was larger (fivefold) in patients undergoing withdrawal of life support.[12]

Comments on the Experts' Reports

General Comments on Experts' Reports

1. It is not clear that the reports supplied to me is a complete set of all the medical experts who were consulted by the Attorney General.
2. The experts' reports do not refer to a single set of patients. All of the patient's names were blacked out and the experts' letters refer to various dates, locations,

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[10] Rocker GM et al. Most critically ill patients are perceived to die in comfort during withdrawal of life support: a Canadian multicentre study. Canadian J Anaesthesia 2004;51:623-30.

[11] Wilson WC et al. Ordering and administration of sedatives and analgesics during the withholding and withdrawal of life support from critically ill patients. JAMA 1992;267:949-53.

[12] Hall RI, Rocker GM. End-of-life care in the ICU: treatments provided when life support was or was not withdrawn. Chest 2000;118:1424-30.

and numbers of patients. The experts express conclusions on from four to sixteen deaths although it is not clear which, if any, of the patients in each report were those who were the subject of the indictment. Thus it is not clear if the experts were agreeing on the four persons named in the arrest affidavit. This is a remarkable kind of "Which shell is hiding the pea?" game in which the stakes were Dr. Pou's reputation, livelihood, assets and liberty. This may be an act of culpable misconduct on the part of the Attorney General.[13] See Table 1.

TABLE 1: Experts' Universe of Patients

Expert	August 31 floor 2	September 1 floor 7
Dr. Cyril Wecht	11 homicides	5 homicides
Dr. Michael Baden October 2 letters	4 homicides (heart weight in case #1 does not match Savoie, Hutzler, McManus, or Nelson autopsies	
Dr. Michael Baden October 3 letters		9 homicides (includes the 4 from October 2)
Dr. James Young	9 homicides one floor	
Dr. Arthur Caplan	9 homicides	
Dr. Frank Brescia	9 homicides	

3. Mr. Simmons has sent me a document entitled MEMORIAL MEDICAL CENTER; CASE #59-2653 EXECUTIVE SUMMARY. The document is undated and unsigned but resembles material that was cited in the press as part of the Affidavit announcing the arrest warrants. The document reads more like a script for a television drama than a compendium of evidence. It makes no attempt to clarify the evidentiary value of the numerous factual claims, i.e. whether they are from sworn depositions, signed statements or investigators' notes; whether the content of the conversations was given by the speaker or was hearsay, or even whether the events were directly seen by the witness conveying the information, etc. I do not know if this highly prejudicial document was given to the experts who evaluated this case for the State of Louisiana. It is my opinion that any expert witness who saw and relied on such information should be impeached.
4. It is extraordinary that the experts were apparently willing to express a conclusion on the possible cause of four to sixteen deaths without seeing the death certificate

[13] 8.4:500 Conduct Prejudicial to the Administration of Justice. http://www.law.cornell.edu/ethics/la/narr/LA_NARR_8.HTM

or final medical examiner's report in each death.[14] The experts should have, in each death, explained how they arrived at two conclusions: 1) how the medical examiner most proximate to the investigation had come to make an error in not attributing the death to homicide and 2) how the expert came to the conclusion that each death was in fact a homicide. For the experts to reject four to sixteen of the Medical Examiner's conclusions without noting possible incompetence or corruption in the Medical Examiner's office strikes me as arrogant, negligent, incomplete and professionally incompetent.

5. Dr. Young is the only expert who clearly states that a pathologist's conclusion of homicide is not the same thing as a charge or finding of criminal homicide.[15] While such a clarification may not be necessary to the Attorney General, the point is not widely known understood by the public and it should have been explicitly clear in the experts' reports and in the process of releasing them. Dr. Brescia apparently did not grasp the difference between a medical finding of death due to homicide and a legal finding that a homicide was a criminal act.
6. Dr. Caplan and Dr. Young and perhaps other experts apparently did not reach their conclusions independently but relied on other experts to form their opinions on matters at the heart of this matter. The nature of this reliance should have been explicated.

Dr. Cyril Wecht's materials

- Sept 29, 2006. Dr. Wecht states that he has "completed his review and analysis" of the Lifecare and Memorial Hospital records of patients, all [unnamed ELEVEN] of whom died on August 31, 2005 when they were patients on **the second floor of**

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[14] The New Orleans' coroner's report that the manner of death was "undetermined" did not come out until January 31, long after the experts' opinions. Meitrodt J. N.O. coroner finds no evidence of homicide. Memorial doctor still faces grand jury in 4 deaths Times-Picayune Press. Feb 1, 2007.

[15] 14.29 Homicide is the killing of a human being by the act, procurement, or culpable omission of another. Criminal homicide is of five grades: (1) First degree murder, (2) Second degree murder, (3) Manslaughter, (4) Negligent homicide, (5) Vehicular homicide, Amended by Acts 1973, No. 110, §1; Acts 1978, No. 393, §1; Acts 1983, No. 635, §1.

46. 1842. In this Chapter: (1) "Crime" means an act defined as a felony, misdemeanor, or delinquency under state law. (1.1 a) Any homicide or any felony offense defined or enumerated in R.S. 14:2(B). Culpable omission is a complex term that is not defined in Louisiana statutes.

Art. 105. Coroner's report; admissibility in evidence. In a case involving the apparent commission of a crime, the coroner shall make a written report of his investigation to the district attorney within ten days after the completion thereof. In homicide cases the coroner's report shall certify the cause of death. A coroner's report and a process verbal of an autopsy shall be competent evidence of death and the cause thereof, but not of any other fact.

that facility. He also refers to his "examination of all the materials and information pertaining to these patients that have been submitted to me." This information is not specified. He then goes on to attribute the cause of death **of these 11 unnamed patients** to acute drug toxicity and homicide.

- September 29, Dr Wecht asks for approval of his format before he finalizes his report.
- Oct 3, 2006: Dr. Wecht states that he has "completed his review and analysis of the Lifecare (Memorial Hospital) records of the following [**unnamed FIVE**] patients, all of who died on September 1, 2005 when they **were patients on the seventh floor of the facility**." He also refers to undescribed "materials and information" pertaining to those patients.
- Oct 20 2006: Dr. Wecht states that the toxicological date of [**unnamed FIVE**] patients, died on September 1, 2005 died of acute drug toxicity when they **were patients on the seventh floor of the facility.** He also refers to undescribed "materials and information" pertaining to those patients.
- Dr. Wecht did no analysis of the hospital infrastructure.

Dr. James Young's materials of September 29, 2006

- Dr. Young's CV (page 2-8/8) does not list any publications although my literature review found several publications that may be by him. I do not have Appendix B which he produced for Ontario Coroners to assist them in investigating deaths during palliative care.[16]
- Dr. Young describes himself as "fairly aggressive" in investigating potential medical homicides that appear to be palliative care; his office investigates 2-4 per year, a figure that seems higher than United States coroners.[17] He instructs his coroners to consider the worst possibility or 'think dirty.'[18] Of palliative care, he asserts, "If the dose increases dramatically and quickly, then the intent would appear to be to end life and that line must never be crossed. That line of judging intent is not cut and dried, and I wouldn't want to pretend it is. However, I wouldn't think any practitioner would want to take it that close to the line."[19]
- Dr. Young claims to have reviewed the medical charts, toxicology reports, autopsy reports, and reports unnamed coroners and unnamed experts pertaining to **nine unnamed** patients however he does not describe the material sufficiently to

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[16] A paper cites this as Young, JG. Memorandum to Ontario coroners – memo a 603. Nov. 29 1991

[17] http://www.cmaj.ca/cgi/reprint/157/6/757.pdf

[18] http://www.the-shipman-inquiry.org.uk/tr_page.asp?id=240.

[19] Robb N. Death in a Halifax hospital: a murder case highlights a profession's divisions CMAJ 1997;157:757-62.

understand the completeness or time frame of this material. It appears that he did not see a death certificate or a medical examiners final report.

- Dr. Young identifies nine deaths on one floor as homicides with varying degree of certainty and notes that homicide is not culpability. He reacts to the non-documented nature of the drugs, the high toxicology levels and the "cluster" of deaths.
- Dr. Young makes repeated assumptions about documentation that are appropriate to an ordinarily functioning hospital and makes no reference to how the collapsing infrastructure might have affected clinical monitoring or documentation.

Dr. Arthur Caplan's materials of January 26, 2007

- Dr. Caplan, a philosopher, is not qualified to make any independent conclusion about the cause of death. It appears that he did not see a death certificate or a medical examiner's final report. He is not qualified to choose between contending explanations of the cause of death as determined by the local medical examiner although he accepts the contention of the pathologists who elected to attribute the nine causes of death to morphine (p 5), in effect saying that it is his opinion that the medical examiner was incorrect. He should have, and did not, recuse himself on this matter.
- Dr. Caplan incorrectly asserts that "Euthanasia is the deliberate, involuntary, killing of a person by a health professional." The concept of voluntary active euthanasia is so well established that it has its own Medline keyword that currently finds 1407 articles, including position papers by major medical associations.[20] [21]
- Dr. Caplan claims to have reviewed the hospital notes, medical records, toxicology reports, autopsy reports, and reports unnamed coroners and unnamed experts pertaining to **nine unnamed** patients however he does not describe the material sufficiently to understand the nature of this material.
- Dr. Caplan makes repeated assumptions about documentation procedures that are appropriate to an ordinarily functioning hospital and makes no reference to how the collapsing infrastructure might have affected monitoring or documentation.

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[20] This Medline search was done on July 31, 2007 on the Ovid data base, using a regular keyword, not a text word search.

#	Search History	Results
1	Euthanasia, Active, Voluntary/	1407

[21] American Geriatrics Society Ethics Committee. Physician-Assisted Suicide and Voluntary Active Euthanasia. 2007
http://www.americangeriatrics.org/products/positionpapers/vae94.shtml

Dr. Frank Brescia's materials (undated)

- Dr. Brescia's CV does not list any publications although my literature search found several publications that he may have written. I believe that Dr. Brescia's employment information may be out of date.
- Dr. Brescia claims to have reviewed the "records" pertaining to **nine unnamed** patients however he does not describe the material sufficiently to understand the nature of this material. It appears that he did not see a death certificate or a medical examiners final report.
- Dr. Brescia does not grasp the difference between homicide as a medical finding and criminal homicide.
- Dr. Brescia describes no case in which he can medically conclude that homicide was the cause of death although he says that toxicology reports should be explained and concludes, "I feel that the manner of death in these individuals, especially in four cases, obligates the legal process to consider them as homicides."
- Dr. Brescia notes how the collapsing hospital infrastructure may have adversely affected documentation.

Dr. Michael Baden materials

- **Letter of October 2.** Dr. Baden claims to have reviewed the medical records, autopsy and toxicology findings and the circumstances of death pertaining to **four unnamed** patients and concludes that the manner of death was homicide due to morphine with or without versed. It appears that he did not see a death certificate or a medical examiners final report.
- **Letter of October 3.** Dr. Baden claims to have reviewed the medical records, autopsy and toxicology findings and the circumstances of death pertaining to **five additional unnamed** patients and concludes that the manner of death was homicide due to morphine with or without versed. It appears that he did not see a death certificate or a medical examiners final report.
- Dr. Baden does not note how the collapsing hospital infrastructure may have adversely affected documentation.

Comments on the Patients' Medical Care and Records

I have not been given access to medical records or death certificates and will withhold comment until such are available.

Preliminary Conclusions.

These conclusions are preliminary and based on the very limited information that I have described. These conclusions may be amended as additional information becomes available.

1. Memorial Medical Center from August 29 through the deaths of these patients was a profoundly compromised hospital that lacked customary clinical, data, staffing and environmental services.
    a. This hospital environment properly called for altered and improvised job descriptions albeit within the normative framework of beneficence. The medical and bioethics experts do not provide sufficient support for the claim that the presence or absence of orders for morphine or midazolam is material to the conclusion that the cases that they discussed were homicides.
    b. The compromised hospital environment suffered a substantial and prolonged loss of treatment and monitoring capacities for profoundly ill persons. The medical experts' conclusions that some or all of these persons were stable or did not die of a fulminant medical condition are not supported by reference to outcomes and clinical courses in this *particular* hospital environment.
2. The medical experts do not provide sufficient support for any conclusion as to the lethality of the morphine levels seen in these cases.
3. The medical experts do not provide sufficient support to conclude that the drugs were given in doses that were higher than customary in these cases.

Sincerely,

Steven Miles, MD