EXHIBIT "A"

SUMMARY OF TERMINAL ILLNESS
OF MRS. JANE DUCHENE AND IT'S
MANAGEMENT BY VICTOR CORBETT M.D.

These notes result from my learning from Mary Jane Duchene that Barry Reed had heard from Dr. Corbett with regard to the doctor's role in the final month of Mrs. Jane Duchene's life. Corbett is reported as explaining the reduction of his patient's daily insulin on October 23, 1986 as a necessary change to avoid significant hypoglaycemic episodes. I am unclear what was different then about his patient who had been subject to such episodes for years and especially in May, June and July 1986, when much smaller adjustments of dosage of insulin were made.

No reduction of insulin previously had led to persistent high blood sugar levels. Dr. Corbett had previously set an upper limit of mg/100cc of glucose, at which he was to be informed. That was abandoned after October 23, 1986. There was no precedent for this final large reduction in essential daily insulin nor for failure to raise the dose back to viable levels. If there had been, I suggest that his patient would have died in several weeks, as she did in 1986, whether or not she had any other serious illness.

Reading the Wedgewood nursing notes up to mid October, 1986 one gets a picture of slow and undramatic decline in the patient's overall clinical and general condition. She was getting weaker very gradually. She was leading a vegetative existence, quietly sitting in her room. She did not read, or participate in activities, watch TV. She hardly conversed. She sat. She would go to the dining room where she ate sparingly and at times not at all. Loss of taste and disinterest in food had been present continuously since and before her stay in United Hospital (January - February, 1986).

She did not complain but was said to be "irritable if her privacy was invaded". In mid October weight was stable, circa 80lbs. Skin was clear of rashes, sores etc. She was continent. Blood sugars via the glaucometer showed instability but less so than over the summer. While said to care for her "grooming" it was noted that she would put on the same clothes unless a nurse saw that she changed every second day.

On October 22, 1986 a nursing care conference regarding this patient noted her condition was in decline. She was "well adjusted" to the nursing home and it's routine. Said to be "withdrawn", she was, as stated, esentially vegetative, sitting doing nothing but sit in her room. Weakness generally was noted and a pitting edema or swelling by tissue fluids was seen in both feet. Weight was stable then.

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A day later Dr. Corbett phoned in a change of insulin orders substantially reducing the daily hormone given. This is a big reduction (I won't repeat the orders here - see charts).

On October 23, 1986 glaucomter reading early of 67 later became 229. Two days later patient was confused, disorientated and [redacted] delusional. She was up and in the process of going home." Told it was 5:30am, she said she had only half an hour to get ready - or some such thought.

Each day seemed to bring a worsening of her state. After the 23rd of October, 1986 extreme deterioration replaces decline. She indeed does deteriorate rapidly and is dead by November 19, 1986, less than a month after the doctor changed insulin orders.

Blood sugars became HHH - high on the glaucometer and stayed high well over the level ([redacted]-250) Dr. Corbett set before us that requiring he be informed.

Weakness increased. Confusion mentally was noticed and noted, acetone breath was present and nurses noted patient to be dehydrated. Bed sores, not present in mid October appeared and spread (hardly a triumph of good nursing, but by then the patient was incontinent of urine) Skin was dry and hot then the membranes of her mouth dried out also. She ate even less and dehydration continued. Her blood pressure fell to very low levels, respiratory rates increased as did pulse rate, quite often. She was feverish at times.

Dehydration and starvation were major phenomena clinically after October 23, 1986. These were essentially untreated conditions. So was the apparent precipitant of the abrupt change of course from gradual decline to plummetting downhill to death within a month; i.e. withdrawl of insulin and adminstration of a low non-theraputic dosage on and after October 23, 1986.

From 80 lbs Mrs. Jane Duchene wasted away to 68 lbs. seven days before she sho was pronounced dead. She lost 12lbs. between November 3, 1986 and November 12, 1986 while under continuous medical responsibility and direct nursing supervision and care in the Wedgewood Healthcare Center. No explanation is offerred as to the extraordinary wasting in a helpless patient in a nursing facility.

No explanation is offerred as to the etiology of the terrible downhill course in October - November of 1986. No notes refer to clinical examination by doctors or laboratory studies, or other efforts to account for this ominous delapidation.

The deterioration followed immediately on Dr. Corbett's phoning in a major reduction of insulin for the patient. There was a rapid worsening from then on.

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The clinical condition was consistent with a case of untreated diabetes complicated by acidosis and ketosis. It proceeded to coma and death. Starvation and dehydration were prominent.

They were notable in being, essentially, untreated. Intravenous fluids were not used to overcome these physiological abnormalities. No feeding tubes, nasal or stomach, were employed.

There was no return of the dosage of insulin to one consistent with treated diabetes.

It is as certain as night following day that insufficient insulin will lead the body to rapidly manifest evidence of abnormal metabolism e.g. acetone breath. Blood sugar levels will be high and stay high.

Mrs. Duchene's changes started right after her doctor cut her insulin down and they were suggestive if not indicative of diabetic ketosis and acidosis, developing into a fatal coma. That is, administration of insufficient hormone predictably precipitated illness known to terminate fatally within several weeks at the most.

Assuming this conclusion is valid and absent convincing proof of an alternative, this is what occurred. Certain points of view must be asserted:

1. Assuming a good faith alteration made in insulin dosage by the doctor, it would be a matter of course for a physician to keep track of the effects, good or bad.
2. The abrupt dilapidation consequent to less insulin, a cause and effect situation, would be corrected by giving enough insulin to restore the metabolic state to a viable condition. Sufficient insulin would be given to ensure this and promptly.
3. Treatment of the dehydration, and the disturbed electrolyte balance, e.g., loss of sodium and potassium, would be corrected by skilled intravenous fluid administration.
4. Blood work to identify sugar levels, etc., would be done.
5. It would be kept in mind, perhaps, that acidosis makes the body more refractory to insulin so adequate dosage of insulin must keep up until clinical response is satisfactory and the patient out of immediate danger.
6. The physician would be present working with the gravely ill patient in a Diabetic Coma until, say, after 6-8 hours, the crisis is overcome.

In this case I read of no reference to the serious changes being related to reduction of insulin. There was no resumption of adequate dosage of insulin.

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There was no explicit recognition that there was a treatable clinical problem. It was left, undiagnosed and untreated.

The specialist in metabolic disease could hardly be unaware that he had precipitated [redacted] onset of illness. The senior nursing staff, at least, should and may have recognised untreated diabetes leading to coma and death. From the nursing notes and the glaring omission of any mention of diagnostic or therapeutic activities, from the acceptance of the patients worsening, it appeared that the patient was expected if not scheduled to die shortly. Eight days after Dr. Corbett started the new low insulin regime, Ms. Mennard, head of nursing, had a "Discussion with Jane" (not Mrs. Duchene but "Jane"; a form of address suggesting an ageless, sexless, roleless 'thing' called Jane). The subject was approaching death for which "Jane" was "ready". As a apparent last wish, she wanted some coca cola, having to ask for diet coke;- and it is not recorded whether diet coke or regular coke was given or brought by Bessie Krause (who according to the notes said she would bring some coke the next day). If a "let her have it" attitude prevailed and ordinary coke was given this would have [redacted] the glucose bath in her blood stream. She had coke p.r.n. from that time. What she should have had, and did not, was a correct diagnosis of the sequelae of Dr. Corbett's reduction of the insulin and immediate correction.

Dr. Corbett, as was his wont, has this woman brought to his offices in a social services bus without any [redacted] medical supervison during the travel times to and from his office, on October 27, 1986, a day when her glaucometer meter reading was over 450 at 6:00 am. It was a day she needed assistance to go to the bathroom and the day before she was seen to be dragging one leg, both legs being oedematous. She was unsteady walking. The nurse noticed and noted that she had acetone breath that day. She responded enigmatically when asked how she felt that day with "I'm ready". The nurses notes on October 28, 1986 state "extreme deterioration this past week". Presumably concerned about her growing areas of bed sores, the nursing staff call Dr. Corbett to ask if Mrs. Duchene can have a "egg shell" mattress, and Dr. Corbett allows this. This last instance describes the pattern of "care" given by Dr. Corbett and others.

Corbett never initiates care by visiting and examining his patient in the nursing home. He initiates very little. The nurses ask for the mattress, then the Clinitron bed, as they asked for help with the insulin reactions early in 1986. Dr. Corbett is a telephone doctor and a office doctor.

This ill woman, rapidly worsening in consequence of Dr. Corbett's underdosing her, with forseeably fatal consequences, is brought to his office

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on October 27, 1986. The visit does the patient no good nor is it necessarily intended to do so. It enables Dr. Corbett to endorse, by his unsubstantiated assertions [redacted], the alledged legal competence of his patient at that time. In this instance a CAT scan, a neurologist and a psychologist had presented incontrovertable evidence of organic brain syndrome and an advanced one. She was severely demented then yet Corbett clears her for another sordid legal manuever in the efforts by his associates or friends to disinherit Mary Jane Duchene via having this moribund woman sign her name to a document she cannot have comprehended a lease for her and Mary Jane Duchene's home to persons found or known by attorney Dennis Briguet alledgedly signed on October 21, 1986. Dr. Corbett did not see his patient alive again, I believe, after this visit. He did not diagnose or attempt to diagnose the symptoms of changes for the worse at this visit. But he knew, could hardly, if conscious, not know more clearly than anyone, what was happening to Mrs. Jane Duchene.

As I see it, (absent further information which has not been forthcoming despite a meeting with Barry Reed and Dr. Corbett at which Dr. Corbett should have been eager to give any rational and honest explanation if there was one;) it is demonstrated that elimination of adequate insulin on October 23, 1986 was followed immediately by clinical changes produced by keto-acidosis and that Mrs. Jane Duchene died of a diabetic coma.

This sequence of events could not have escaped a qualified internist. He could not have been ignorant of his causal role. He chose then to hasten death artificially by witholding essential insulin from his helpless, defenseless and brain damaged (cerebral atrophy, metastatic carcinoma) patient.

Dr. Corbett's record of medical treatment of his quiet undemanding patient in her final illness is a noteworthy one.

He did not examine her or visit her in the nursing home at all. His three contacts with her - they were contacts at his office and initiative - were on the three occassions when one or other of his associates or friends needed an opinion that Mrs. Duchene's signature on a money-related legal document was made with full testamentary capacity and that she was legally competent to make it. Dr. Corbett gave unstintingly on these occassions. He gave her next to nothing however. The cold inhuman neglect of a quietly dying patient is odious. He didn't see to her comfort, or check for complications e.g. metastases, he didn't give her an opportunity to discuss fears or other issues of dying. He precipitated her death by cunningly simulating "natural causes" in reducing the insulin to token level. Once he launched her on his plan for her death he

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let it proceed. That is, his initiative was a killing or murdering one, not a healing one.

The presence of metastatic cancer was not a cause of death as far as I know - How did cancer kill her? Cancer was destroying her brain and had disordered her mind early in that year but while it would have destroyed her life later (according to Pat Gallagher's notes Dr. Corbett had given Jane Duchene 6 months to one year on October 6, 1986 in a telephone conversation between the two), diabetes did instead. Diabetes was not reported by Dr. Corbett on Mrs. Duchene's death certificate, and the coroner who did the autopsy did not sign that death certificate a[redacted]

While ready to certify his patient's "competence" he [redacted] ready to be a doctor to her as is clear from his indifference to her over her final months.

Dr. Corbett's assumption of an expert in forensic psychiatry (role) is unfortunate and unconvincing. Despite his testifying in District Court that he was [redacted] more capable of evaluating Mrs. Duchene's legal competence and testamentary capacity than any psychiatrist, psychologist or neurologist he essentially, like Dr. McCafferty (and possibly in conversations he apparently had with Dr. McCafferty), relied on assertions of his "opinion" in trying to give a medicological ~~medical~~ legal green light for the several financial depredations which occurred concurrent to the only times he saw his patient as she was dying. He is at fault, in my opinion, for substituting his rubber stamps for established scientific and clinical methodology involving psychiatric [redacted] evaluations of data, neurological examinations and psychological test evaluations, as well as ancillary methods e.g. CAT scan; which are readily available in the geographical area [redacted] and which were explicitly requested by Mary Jane Duchene via Pat Gallagher.

Although a lot of sound data was available, Corbett ignored these objective findings and diagnoses.

His lack of direction, active or passive opposition to prompt thorough consultation by qualified specialists to establish the issue of testamentary capacity and legal competence early on was a serious disservice to his patient and a young woman unknown to him, Ms. Mary Jane Duchene. Due to his incompetence and arrogance in this matter, incalculable damage has been done to Jane and Mary Jane Duchene, their estate has been dissipated and ugly unfinished litigation continues.

If Corbett were a person who had a real relationship with his patient, if

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he knew her, had been interested in her, cared anything about her at all, I might respect his effort to report on competency and testamentary capacity whether I was in agreement or not. But nothing existed there ... he did not know her, he treated her as an object, a thing.

Finally, Dr. Corbett can hardly congratulate himself on diagnostic acumen, or diligence, after Mrs. Duchene consulted him regarding unexplained weight loss in 1985, prior to Mary Jane Duchene's visit in July and August in St. Paul with her mother that same year. She had seen Corbett, worried about loosing weight. No diagnosis was offerred to her to explain her weight loss, nor was ongoing diagnostic study done according to Dr. Corbett's records and Mary Jane Duchene's recollections, that summer, and she apparently continued to loose weight as she weighed just over 80 lbs when admitted to United Hospital in early 1986. It was in December of 1985 that she [redacted] again, [redacted] presented by that time with extensive pleural involvment by carcinoma and a hemi-thorax full of fluid. Dr. Corbett sent her to United Hospital and a diagnosis of the lung cancer was made.

While I don't know precisely how it was that Mrs. Jane Duchene passed from "nothing found" to advanced cancer without intervening diagnostic work being done, it has something to do with Dr. Corbett.

A person who objurates the issue of the patient's competency and who doesn't facilitate the efficient and responsible clarification of that issue by or at least immediately after March 20, 1986, is not treating his patient responsibly. It is akin to his subsequent disinterest in her condition, as if as her doctor he had no responsibility to her. Even when reliable findings did exist (and were in his records shortly after October 7, 1986) - Corbett wasn't interested in facts available to him to make an accurate diagnosis. Rather, he repeated his opinions, based on assertion, and avoidance of the data obtained by the neurologist, psychologist and CAT Scan.

The curious features of this grotesque, ugly and complex case are many. It is important that it be clearly recognised how irrational internal and external forces can drive seemingly intelligent people into inexplicable folly or much worse.

It is unfathomable, or at least unfathomed, what internal mental and emotional factors led Dr. Corbett to deal or misdeal with Jane Duchene, as well as Mary Jane Duchene, as he has done. His conduct in relation to his patient and her daughter and others who cared about Jane Duchene has been ignominious or worse. It has not been defined or made undeniably clear what drives him.

The fact that Dr. Corbett's conduct appears so irrational and so unrealistic tends to cast doubt on the realities of what was done. The bizarre, repellant

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and horrifying aspects of so much, centering around the illness and death of Jane Duchene sheds unwelcome light on the sordid and evil depths of and acts resorted to by unremarkable people. That light should not blind anyone to the realities which are no less real for being unexpected and grotesque.

Humanity has employed philosphy, theology, art forms and many other studies and disciplines for thousands of years to reach for [redacted] solution, to and dynamics of the dark side of the coin, that is the dark side of human nature. The conduct that occurred in relation to the terminal illness and death of Jane Duchene is another drop in the ocean of an age old quest to understand, rectify and improve. It is not an isolated case from a wider viewpoint and unfortunately could have happpened to others before and could happon again, most probably.

B. William Murphy M.D., P.A.

NB. Two pages of physicans's orders from Wedgewood Health Care Center's medical records, recording the discontinuation of insulin and other orders is attatched to this summary and are pages nine and ten.

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PHYSICIAN'S ORDERS

STANDING HOUSE ORDERS

REHAB. POTENTIAL: Fair

DISCHARGE PLAN: Permanent Placement

LEVEL OF CARE: ~~ICF~~ skilled [illegible]

Restraints per nursing care plan for safety.

DIET: ✓2000 Cal ADA

MEDICATIONS:

✓~~Lente U-100 Insulin 12U sub-q qAM & 4U Regular sub-q qAM~~ DC [illegible]
~~PM 3U Lente U-100 Insulin sub-q q4PM~~ – DC [illegible]
✓~~Use sliding scale for Regular Insulin PM schedule~~
✓200-250 BS 4U Regular Insulin sub-q qPM
✓251-300 BS 5U Regular Insulin sub-q qPM
✓301-350 BS 6U Regular Insulin sub-q qPM
✓Greater than 350 BS 8U Regular Insulin sub-q qPM
DC 11/18/86
✓Desyrel 50 mgm po qHS DC 11/18/86
✓HCTZ 25 mg po qod PRN HOLD 10/22/86
✓Ensure (8 oz) po TID-may have 4th can PRN [illegible] 10-27-86
Reglan 10 mgm po qid prn / Gastric distress DC 11/18/

TREATMENTS: ✓Glucometer BID before breakfast & supper DC 11/18/86

1986 Flu Vaccine .5 ml IM X1

[illegible]

RENEWAL FOR 90 DAYS
PLAN OF CARE REVIEW

DR.

[illegible signature]

Sandra Ford [illegible] 10-16-86

~~[illegible] DC [illegible] Regular Insulin [illegible]~~

EXHIBIT C-20

DUCHENE, JANE D 531394
845 DR CORBETT WHCC
DOB 6 21 18

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PHYSICIAN'S ORDER

10/10/86 Reglan 10mg po qid prn as needed for gastric distress.
T.O. Dr. Corbett / D. Harris RN
D. Harris RN 10/10/86

10/16/86 May have 1986 Flu Vaccine .5cc IM
T.O. Dr. Corbett / [illegible]
10/16/86 [illegible]

10/22/86 3-11 Hold HCTZ
Call office in AM to arrange up date appt
T.O. Dr. Corbett / [illegible]

10/22/86 [illegible]

10/23/86 (1) D.C. [illegible] UNITS AND 1/2 U LENTE REGULAR INSULIN IN AM
(2) GIVE 6 UNITS LENTE INSULIN SUBQ IN AM
(3) D/C 3 UNITS LENTE IN PM
(4) CONTINUE USING SLIDING SCALE FOR REGULAR INSULIN IN AM
T.O. Dr. CORBETT / J. Costa RN
10/23/86 J Costa RN [illegible]

10-27-86 3P
DNR
Ensure i can po qid
Copied from M.I.E. signed by Dr Corbett / Sandra Ford
Sandra Ford [illegible] 10-27-86 3P

10-28-86 2:30
Use egg shell mattress
T.O. Dr Corbett / Sandra Ford [illegible]
Sandra Ford [illegible] 10-28-86

11-21-86 1p
Macu [illegible] Plenitum [illegible]

EXHIBIT C-21
[illegible]