



Formerly the Association of Trial Lawyers of America (ATLA®)

2010 NATIONAL STUDENT TRIAL ADVOCACY COMPETITION

OFFICIAL RULES

and

FACT PATTERN

Endowed by Baldwin & Baldwin, LLP

Important Dates:

Requests for fact pattern clarification due: December 18, 2009
Answers to requests for fact pattern clarification by: January 22, 2010
Team registration form(s) due: January 25, 2010
Students must be members of AAJ by: January 25, 2010
Regional competitions: February 25–28, 2010
Final competition: March 18–21, 2010 in New Orleans, LA

©The competition fact pattern is copyrighted by the American Association for Justice (AAJ), formerly The Association of Trial Lawyers of America, and may not be used for purposes other than its intended use without the express written consent of AAJ.

AAJ's 2010 Fact Pattern is authored by Paul J. Scoptur, Milwaukee, WI. AAJ extends its thanks and appreciation to Mr. Scoptur for developing the 2010 Fact Pattern.

Please note:

All information regarding the 2010 Student Trial Advocacy Competition is also available at www.justice.org/lawstudents and will be updated frequently.

All questions and correspondence should be addressed to:

Nanya Springer
American Association for Justice
Formerly the Association of Trial Lawyers of America
777 6th Street, NW
Washington, DC 20001
Phone: (800) 424-2725 or (202) 965-3500, ext. 217
Fax: (202) 625-7084
nanyamka.springer@justice.org

GENERAL INFORMATION

One of AAJ's goals is to inspire excellence in trial advocacy through training and education for both law students and practicing attorneys. One way AAJ accomplishes this goal is by sponsoring a national student mock trial competition. This is an exceptional opportunity for law students to develop and practice their trial advocacy skills before distinguished members of the bar and bench.

Because the purpose of this competition is to give law students the opportunity to develop their trial skills, the actual merits of the plaintiff's case and the defendant's case presented are irrelevant to this purpose. Competition rounds are decided not on the merits of a team's side but on the quality of a team's advocacy.

Requests for Clarification

Requests for clarifications of the rules or fact pattern must be made in writing and received by Nanya Springer via e-mail at nanyamka.springer@justice.org no later than 5:30 p.m. (EST) on December 18, 2009. *Each school is limited to five (5) questions.* No school, regardless of the number of teams it has in the competition, may submit more than five questions. Each subpart of a question is counted as a question.

Answers to questions will be posted on the Web site no later than January 22, 2010.

RULE VIOLATION AND FILING OF COMPLAINTS

A competitor or coach violating any of the rules governing the National Student Trial Advocacy Competition may be penalized or disqualified. If a team wants to file the complaint under the rules, the team's coach should immediately notify the regional coordinator at a regional competition or the final round coordinator at the final competition. The coordinator will review the complaint and make a ruling which shall be binding for that round of competition. The coordinator's rulings will be governed by the rules of the competition and the objectives of the program.

Complaints after a regional competition or after the national competition must be filed in writing with Nanya Springer at the address provided above no later than the seven (7) days following the last day of the regional or final round, as appropriate. The AAJ Law School Committee promptly will consider and rule on any such complaints.

LAW SCHOOL & STUDENT ELIGIBILITY

The competition is open to all law schools nationwide. A law school may enter up to two teams. Each team shall be comprised of four law students. A school's selection method of its trial team(s) is left for the school to determine. However, for a student to be eligible, he or she must be enrolled for a J.D. degree and be a student member of AAJ.

Students who graduate in December 2009, are eligible to participate only if the competition counts toward their credits for graduation and they will not be admitted to practice prior to March 2010.

Each student participant must be an AAJ student member by January 25, 2009 in order to participate.

REGISTRATION PROCEDURES

Refund Policy

Requests for a refund of a school's registration fee were due in writing before November 17, 2009. It is inevitable that a few teams drop out of the competition in the months leading up to the regionals. Teams placed on the waiting list because the competition is full will be contacted for participation in the order that their registrations were received. Teams on the waiting list will also be issued a refund check if it is determined that the team will not be competing. Schools that registered two teams but are only able to enter one team because the competition is full will receive a refund of the registration fee for the second team.

AAJ Student Membership

Student team members must be AAJ members by January 25, 2010 in order to participate. Please call AAJ's member hotline at (800) 424-2727 to determine whether students on the team are current members and that their memberships will be active at the time of the competition. AAJ Law Student membership dues are \$15. To become a member or to renew a membership, you may complete an application online at www.justice.org, or call AAJ's member hotline at (800) 424-2727 and join over the phone. Students should indicate that they are Student Trial Advocacy Competition participants.

Student and Coach Registration

AAJ must receive the names of the participating students and coach for each team. Each team must complete a team registration form and return it to AAJ by January 25, 2010. *Please be sure to include the complete mailing address, date of birth, and graduation date for each student on the team registration form.* This information is required to process the team registration.

Student Substitution Policy

Substitution of team members after January 25, 2010 is not permitted except in the case of personal emergencies. Requests for substitution after the January 25 deadline must be made in writing with an explanation of why the substitution is needed and sent to Nanya Springer at AAJ for consideration.

REGIONAL AND FINAL COMPETITION ASSIGNMENTS

Entering teams will be assigned to one of fourteen regional competitions based on geographical convenience *to the extent possible*. Teams from the same law school will be assigned to the same region. If a school's second team is waitlisted, there is no guarantee that second team will be sent to the same region as the first team. Teams will be notified of any date changes when regional assignments are made. Please remember that a school's second team will not be officially registered until one team from each law school has entered the mock trial competition. Then the second teams will be registered on a first-come, first-served basis until all the team slots are filled at 224 teams. If you paid for two teams and only one team is able to participate, you will receive a refund for the second team.

In order to officially compete in the competition, a team **MUST** receive their regional assignment. If a team is not informed by AAJ that it is able to compete, that team is not registered for the competition.

Coaches

A coach must accompany each team to the regional and the final competitions. The coach for a team that goes to the final competition does not have to be the person who coached the team at the regional competition.

A coach may be a law student, but may not be a student who is competing in the competition.

Only team coaches are permitted to attend the coaches' meeting. If a coach is unable to attend, he or she must notify AAJ and the regional coordinator. Only then can students be permitted to attend in the coach's absence.

Team Expenses

Travel expenses for the regional and final competitions are the responsibility of the participants. Teams competing in past competitions have obtained funds from law school deans and alumni associations, members of the local legal community, state and local trial associations, and AAJ law school chapters.

COMPETITION FORMAT

This is a trial skills competition. There is no motion or trial brief writing component. Each team will consist of four law students. Two students will be advocates and two students will play the witnesses for their side in each round. Advocates and witnesses may change their roles from round to round, but roles must remain consistent throughout each individual trial.

In the regional competitions:

- Each team will compete in three qualifying rounds
- The top four teams from the qualifying rounds will advance to a single elimination semi-final round
- The top two teams from the semi-final round will compete to determine which one team will advance to the National Finals

In the final competition:

- Each team will compete in three qualifying rounds
- The top eight teams from the qualifying rounds will advance to a single elimination quarter-final round
- The top four teams from the quarter-final round will advance to a single elimination semi-final round
- The top two teams from the semi-final round will advance to a single elimination final round

Regional Team Pairings in Qualifying Rounds

Pairing of teams in the qualifying rounds will be at random and conducted during the coaches' meeting prior to each competition. Teams may also be pre-assigned by the regional coordinator prior to the coaches' meeting. Each team will represent both plaintiff and defendant in the first two rounds. No two teams shall compete against each other more than once in the qualifying rounds. Teams from the same school will not compete against each other during any of the rounds of the regional competition or in the qualifying rounds of the national final competitions.

Team Rankings in All Other Rounds

In the semi-final round, the first-ranked team will meet the fourth-ranked team, and the second-ranked team will meet the third-ranked team.

Regional semi-final round (Normal pairings: 1 v. 4; 2 v. 3)

Situation 1: Teams ranked 1 and 4 are from the same school

New pairings: 1 v. 3; 2 v. 4

Situation 2: Teams ranked 2 and 3 are from the same school

New pairings: 1 v. 3; 2 v. 4

The ranking of teams to determine the semi-finalists and finalists will be determined by the following factors (in this order):

1. Win/Loss record
2. Number of winning votes
3. Number of total points awarded to the team

Each succeeding criterion above will be used only if the prior criterion does not fully rank the teams and will be used only to break ties created by the use of the prior criterion.

If paired regional semi-final teams have met in the qualifying rounds, they will each represent different sides than in the previous meeting. If they have not yet met, each team will take the side they represented only once in qualifying rounds. If matched teams represented the same side only once, the winner of a coin toss will choose sides.

In the regional finals, the teams will represent a different side than in the semifinal round. If two teams opposing teams each represented the same side in the semi-final round, the winner of a coin toss will choose sides. The two regional finals teams will represent a different side than in the semifinal round. If matched teams in the final round represented the same side in the semi-final round, the winner of a coin toss will choose sides.

When an odd number of teams compete at a regional competition, one randomly chosen team will receive a “bye” in each qualifying round. For ranking purposes, a bye will count as a win and the team with the bye will be deemed to have had three votes and the points equal to the average of the team’s points from the two other qualifying rounds.

NATIONAL FINALS

Quarter-final round (Normal pairings: 1 v. 8; 2 v. 7; 3 v. 6; 4 v. 5)

Situation 1: Teams ranked 1 and 8 are from the same school

New pairings: 1 v. 7; 2 v. 8; 3 v. 6; 4 v. 5

Situation 2: Teams ranked 2 and 7 are from the same school

New pairings: 1 v. 7; 2 v. 8; 3 v. 6; 4 v. 5

Situation 3: Teams ranked 3 and 6 are from the same school

New pairings: 1 v. 8; 2 v. 7; 3 v. 5; 4 v. 6

Situation 4: Teams ranked 4 and 5 are from the same school

New pairings: 1 v. 8; 2 v. 7; 3 v. 5; 4 v. 6

Semi-final round (Normal pairings: 1 v. 4; 2 v. 3)

Situation 1: Teams ranked 1 and 4 are from the same school

New pairings: 1 v. 3; 2 v. 4

Situation 2: Teams ranked 2 and 3 are from the same school

New pairings: 1 v. 3; 2 v. 4

If teams from the same school are matched to compete based on rank in the semi-final and final rounds of a regional competition, regional hosts will re-pair teams according to the following scenarios:

Determination of Team Representation

If the four national and regional semi-final teams have already met in the qualifying rounds, they will represent different sides from the previous confrontation. If they have not yet met, each team will take the side they represented only once in qualifying rounds. If matched teams represented the same side only once, the winner of a coin toss will choose sides.

The national finals semi-final teams will represent a different side than in the quarter-final round. If matched teams represented the same side in the quarter-final round, the winner of a coin toss will choose sides. The two national final teams will represent a different side than in the semi-final round. If matched teams represented the same side in the semi-final round, the winner of a coin toss will choose sides.

THE TRIAL

The competition this year involves the trial of a civil lawsuit. The same fact pattern will be used in the regional and final competitions. The trial judge previously ruled that the case would be bifurcated, and the case being tried in the competition is the first phase of the case—the liability phase. Only evidence relevant to the liability issue will be received. There are no pending third-party claims.

The Federal Rules of Evidence (FRE) and Federal Rules of Civil Procedure (FRCP) are the applicable rules of evidence and civil procedure. Only these rules, and the law provided in the fact pattern, shall be used in argument. Specifically, no statutory, regulatory, or case law shall be cited unless such law is provided in the fact pattern.

Students may argue based upon the comments or advisory notes to the Federal Rules of Evidence but may not cite the cases contained therein. No written briefs or motions, trial notebooks, or other written materials may be presented to the judge hearing a case.

No pretrial motions of any kind are allowed.

Motions for a judgment as a matter of law and evidentiary objections are permitted.

The trial will consist of the following phases by each team in this order:

- Opening statements for plaintiff followed by defendant
- Plaintiff's case-in-chief
- Plaintiff's direct of plaintiff's witness #1
- Defendant's cross of witness
- Plaintiff's redirect of witness
- Similar for plaintiff's witness #2
- Defendant's case-in-chief
- Defendant's direct of defendant's witness #1
- Plaintiff's cross of witness

- Plaintiff's redirect of witness
- Similar for defendant's witness #2
- Closing argument
- Plaintiff's first closing
- Defendant's closing
- Plaintiff's rebuttal closing

Each side is limited to two live witnesses whom they may call in any order.

- Plaintiff must call Kathie Hetzel and Keith Ness, M.D.
- Defendant must call Larry Dean, M.D. and J. Bryan Warren, M.D.

The trial has six (6) major advocacy opportunities for each team: Opening statement; Direct/Redirect examinations (2); Cross examinations (2); and Closing Argument. Each member of a team must handle three of the six opportunities. Opening statement and closing argument may not be done by the same person and neither may be split between team members.

During the competition each team will represent both parties. Pairing in the qualifying rounds will be at random, with each team representing both plaintiff and defendant at least once in the three rounds.

Except in the final round, the courtrooms will be off-limits to all team members, coaches, friends, and family members who are not associated with either team competing, unless their team has already been eliminated from the competition.

No team may receive any coaching from anyone in any form during a round, including any recesses or breaks. The regional or national coordinator, as applicable, has the authority to punish any violation of this rule by disqualifying the team from the remainder of the competition.

A team may have its trial video recorded if (1) no additional lighting is required, (2) recording of the trial does not interfere with or delay its conduct, and (3) all participants of the round, including the presiding and scoring judges and the regional or national coordinator, as applicable, agree.

Timing of the Trial

- Each team will have 80 minutes to complete its argument.
- The time limit will be strictly enforced, although it is not necessary that all time allotted be used.
- There will be no time limits for specific aspects of the trial.
- Time on cross-examination is charged against the team conducting the cross-examination.

- Time will be stopped for objections and responses to objections.
- Performance at trial will be evaluated by a panel of judges and/or attorneys, one of whom will preside over the trial as Judge, making rulings as necessary, and the remainder (up to three) of whom will act as the jury.

Facts outside the Record

Lawyers must confine the questions and witnesses must confine their answers to the facts given in the fact pattern and inferences which may reasonably be drawn therefrom (“the Record”) and any matters judicially noticeable under Rule 201 of the Federal Rules of Evidence. An “inference” is not any fact a party might wish to be true; rather, it is a fact that is likely to be true, given the other facts in the case.

Except during closing argument, no objection may be made to the effect that that the opposing team is going outside the record. Instances of a party going outside the record may be addressed, instead, by means of impeachment of the offending witness or by contradiction using another witness or document.

When true, witnesses must admit, if asked, that the “facts” they have testified to are not in their deposition or otherwise in the record. Witnesses may not qualify this response in any misleading way by saying, for example, that they were not asked about the fact at deposition, or that the facts were contained in some other portion of the deposition, which was omitted from the record. The answer from the witness who is asked to admit the material was not in the deposition must be that the questioner is correct: “Yes, I did not say that in my deposition.” All judges will be instructed as to the significance of this form of impeachment in the mock trial competitions and are likely to take into account unfair additions to the record (i.e., inferences which may not reasonably be drawn from the record) in their scoring of the witness’s team.

Witnesses

Any witness may be played by a person of either gender. Before the opening statement, each team should notify the other of the gender of each witness they intend to call and for any witness they could call but are choosing not to call.

Assume that all the witnesses have seen the exhibits and depositions. Witnesses know only the facts contained in the background information, exhibits, and depositions.

All depositions are signed and sworn. The same attorney conducting direct examination of a witness shall also conduct any redirect examination.

The only witness who may object during a witness’s testimony is the lawyer who will be examining that witness.

Witnesses may not be re-called. Witnesses will not be sequestered.

JURY INSTRUCTIONS

The instructions provided in the fact pattern are the only instructions that will be given. The instructions are the only statements of the applicable substantive law. Instructions will not be eliminated or modified. No additional instructions may be tendered or will be given.

EXHIBITS

The use of demonstrative evidence is limited to that which is provided in the fact pattern but participants are free to enlarge any diagram, statement, exhibit, or portion of the fact pattern, only if it is identical to the item enlarged or any changes provide no advantage to the party intending to use it.

Subject to rulings of the court, counsel and witnesses may draw or make simple charts or drawings in court for the purpose of illustrating testimony or argument. These materials may not be written or drawn in advance.

No demonstrative evidence, including charts or drawings may reflect facts outside the record. Participants must clear all demonstrative evidence with the regional or national coordinator, as applicable, at the coaches' meeting preceding the competition.

All exhibits are stipulated as authentic and genuine for purposes of trial.

SCORING CRITERIA

Performances at trial will be evaluated by a panel of three judges and/or attorneys, one of whom will preside as the trial judge, the others sitting as jurors. The trial judge will rule on any objections or motions for judgment as a matter of law.

Each member of the jury may award up to five points in each phase of trial for each party. A sample score sheet is attached.

If at the end of the trial, an evaluator awards the same number of points to the plaintiff and defendant, the evaluator will award one additional point to either plaintiff or defendant for effectiveness of objections and/or overall case presentation in order to break the tie.

Evaluators have been instructed not to score teams on the merits of the case.

The following criteria for scoring trial performances are set forth to assist both judges and student advocates. Evaluators are not limited to these criteria and may consider other aspects of strategy, technique, etc., which they view as important.

Evaluator Shortage

For each match, there must be three votes from evaluators. In the event due to circumstances beyond AAJ's control there are not three evaluators in a particular match, "ghost" evaluator(s) will be used to score the round.

The vote of a ghost evaluator is determined by calculating the average of all other evaluators in the session. If there is only one evaluator for a trial, the score for each of the absent evaluators will be the same as the score for the evaluator who is present.

Suggested Evaluation Criteria

OPENING STATEMENT

Did Counsel:

1. Generally confine statement to an outline of the evidence that would be presented?
2. Clearly present counsel's theory of the case?
3. Persuasively present counsel's theory of the case?
4. Personalize self and client?
5. Allow opposing attorney to make argument during opening statement?
6. Make unnecessary objections?

EXAMINATION OF WITNESSES

Did Counsel:

1. Ask questions that generated a minimum of valid objections?
2. Make/fail to make objections with tactical or substantial merit?
3. Respond appropriately to objections made?
4. Know the rules of evidence and express that knowledge clearly?
5. Develop rapport with the witness?
6. Maintain appropriate general attitude and demeanor?
7. Address court and others appropriately?
8. Demonstrate awareness of ethical considerations?

Did Direct-Examiner:

9. Unnecessarily use leading questions?
10. Develop testimony in an interesting and coherent fashion?
11. Follow up on witness' answers?
12. Present the witness in the most favorable light?

Did Cross-Examiner:

13. Appropriately use leading questions?
14. Control witness?
15. Follow up on answers and elicit helpful testimony?
16. Use impeachment opportunities?

CLOSING ARGUMENT

Did Counsel:

1. Present a cohesive theory of the case pulling all the positive arguments together?
2. Deal effectively with the weakness in his or her own case?
3. Make an argument that was persuasive?
4. Have an effective style of presentation?
5. Utilize the law effectively in the argument?
6. Inappropriately interrupt the argument of the opposing counsel?
7. Properly confine rebuttal to rebuttal matters?
8. Effectively counter the opponent's speech in rebuttal

Discrepancies in Remaining Match Time

Often bailiffs are unavailable to keep time for rounds. In such cases, one or more judges in each match should be instructed to keep time according to the timekeeping rules. Teams may keep track of time used for their own purposes. They may not, however, report their time used or that of an opposing team to the bailiff or judge for any purpose. Moreover, time use improperly reported by any team may not be considered or used by a bailiff or judge for any purpose. Notwithstanding this limitation, in the event that the match judge or judges declare the time remaining as less than the team requires for closing or other parts of the trial, during the break the coach or team member (whomever records the time discrepancy, note that coaches and team members may not communicate between rounds) should immediately consult with the Regional Coordinator, who should then evaluate the circumstances and decide the amount of time remaining. Neither the team coach nor the team member should discuss the discrepancy with the match judge. Should the team not be able to consult with the Regional Coordinator before the completion of the trial—and the team requires additional time to complete the trial, the team may elect to complete the trial beyond the time allotted. When the trial is complete, the time will be evaluated by the Regional Coordinator. The team will lose one point for every five minutes—or fraction thereof—of time that it has exceeded its allotment.

Viewing of Score Sheets by Teams

Viewing of the score sheets is done at the discretion of the regional coordinator(s). Each team will have the right to view their score sheets for each round. Teams may only view scores sheets after the completion of the second regional round. This should be done one team at a time. Teams are not allowed to take score sheets with them or make any markings to the score sheets. Teams may view score sheets only in the presence of the regional coordinator(s).

AMERICAN ASSOCIATION FOR JUSTICE

MISSION

The Mission of the American Association for Justice is to promote a fair and effective justice system—and to support the work of attorneys in their efforts to ensure that any person who is injured by the misconduct or negligence of others can obtain justice in America’s courtrooms, even when taking on the most powerful interests.

ABOUT TRIAL LAWYERS

Trial lawyers ensure access to the civil justice system for the powerless in America—working families, individual workers, and consumers who often lack the resources to take their grievances to court.

Trial lawyers play a valuable role in protecting the rights of American families. They champion the cause of those who deserve redress for injury to person or property; they promote the public good through their efforts to secure safer products, a safe workplace, a clean environment and quality health care; they uphold the rule of law and protect the rights of the accused; and they preserve the constitutional right to trial by jury and seek justice for all.

Some of the types of cases our attorneys handle include:

- A child paralyzed after being struck by a drunk driver;
- A young woman unable to have children because of a medical mistake;
- A person denied a promotion due to racial discrimination;
- An elderly man injured in a nursing home; and
- A community whose water was made toxic by a local manufacturer.

ABOUT AAJ

As one of the world’s largest trial bar, AAJ promotes justice and fairness for injured persons, safeguards victims’ rights—particularly the right to trial by jury—and strengthens the civil justice system through education and disclosure of information critical to public health and safety. With members worldwide, and a network of U.S. and Canadian affiliates involved in diverse areas of trial advocacy, AAJ provides lawyers with the information and professional assistance needed to serve clients successfully and protect the democratic values inherent in the civil justice system.

AAJ LAW STUDENT MEMBERSHIP BENEFITS

Mentor Program

You will be paired with an experienced trial lawyer who will share valuable guidance.

Student Newsletters

You will receive *From Classroom to Courtroom*, the AAJ Law Student newsletter that brings you professional advice as well as news about upcoming law student events.

Student Chapters

Chapter programs concentrate on areas of law that most interest your group. AAJ works closely with the chapters, providing lecturers and program ideas.

Law School Ambassador Program

AAJ member “ambassadors” give talks at various law schools to give students a true view of what it’s really like to be a trial lawyer.

Law Student Information Web Page

You can conduct research and participate in the AAJ Law Student list server.

AAJ’s Authoritative Legal Publications

Stay up-to-date with your free subscriptions to *TRIAL*, AAJ’s award-winning monthly magazine, and *Law Reporter*, a case-reference journal.

AAJ’s Annual Student Trial Advocacy Competition

You will be eligible for AAJ’s annual Student Trial Advocacy Competition, the nation’s premier mock trial competition.

Network with Top Trial Lawyers

AAJ’s Annual and Winter Conventions cover every aspect of trial law, all at an 85% discount for Law Student members.

Scholarships

AAJ offers several scholarships to Law Student Members.

How to Join:

Yearly dues are \$15. Call AAJ at (800) 424-2727 or visit www.justice.org/lawstudents.

MORGAN JOHNSON V. ALEX MANN, M.D.

PREPARED BY:

PAUL J. SCOPTUR

Aiken & Scoptur, S.C.
Milwaukee, WI

©The competition fact pattern is copyrighted by the American Association for Justice (AAJ), formerly The Association of Trial Lawyers of America, and may not be used for purposes other than its intended use without the express written consent of AAJ.

Table of Contents

Introduction and Summary of the Case.....	18
Complaint.....	23
Answer.....	25
Deposition of Morgan Johnson.....	27
Deposition of Dr. Taylor Bratman.....	31
Deposition of Dr. Alex Mann.....	41
Deposition of Dr. Jaime Holloway.....	47
Time Line.....	52
Office Notes.....	55
Letters to Patient.....	65
Emergency Room Notes.....	67
Autopsy Report.....	73
Jury Instructions.....	76

INTRODUCTION AND SUMMARY OF THE CASE

Morgan Johnson, on her behalf and on behalf of the Estate of Cameron Johnson, has brought a medical malpractice lawsuit against Dr. Alex Mann. She has alleged that Dr. Mann was negligent in his care and treatment of her husband in several regards. First, she alleges that a follow-up stress test with dye should have been done in November of 2002. Secondly, she alleges that her husband should have been given the option of medications for his high cholesterol levels, instead of a regimen of diet and exercise. It is her allegation that had either of these been done, her husband would not have had a fatal heart attack in December of 2004. The Complaint is attached.

Dr. Mann has denied these allegations and contends that his care and treatment of Mr. Johnson was within the medically recognized standard of care and that he exercised his medical judgment appropriately with regards to his treatment of Mr. Johnson. The Answer is attached.

Cameron Johnson was born on October 30, 1953. His date of death was December 27, 2004. Cameron was 51 years old when he died. He was married to Morgan Johnson for 25 years. They had two children. Cameron was the service director for a local car dealership prior to his death. The job

had a high level of stress, which caused him to quit his job four months before he died.

Dr. Alex Mann was Cameron's primary care physician for over 15 years. Cameron had abnormal cholesterol levels and a questionable family history of heart disease. He also had several episodes of complaints of chest pain and in fact, had gone to the emergency room for chest pain, in November of 2002. After that episode, he was told to see his doctor. He saw Dr. Mann in November 2002 and Dr. Mann ordered a stress test. The stress test was done and Cameron was unable to complete it. Dr. Singer, the doctor doing the stress test, suggested that Dr. Mann and Cameron discuss doing a second stress test, this one with dye.

Dr. Mann continued to follow Cameron for his high blood pressure and abnormal cholesterol. He put Cameron on a diet and told him to get more exercise. On November 6, 2003, Cameron complained of chest pain to Dr. Mann. Dr. Mann felt that the pain was not heart related.

On March 10, 2004, Cameron had a complete physical conducted by Dr. Mann that indicated he had high cholesterol, high triglycerides, low HDL, high LDL, and a high non-HDL. He noted that Cameron smoked half a pack of cigarettes each day, had 12 drinks each week, and did not exercise regularly. He also was told that Cameron had intermittent chest pain. He

encouraged Cameron to stop smoking and drinking, and to get regular exercise. Dr. Mann continued to treat Cameron with Atenolol and Lorazepam for his blood pressure. He was not put on any medication for his cholesterol.

On March 18, 2004, lab results came back and they were within Cameron's desired range, although not within the range of normal.

In September 2004, his cholesterol tests were better but his bad cholesterol was still not controlled.

Cameron proceeded to have chest pain and was seen in the emergency room on September 22, 2004 for a sharp, stabbing chest pain. The diagnosis was atypical chest pain and he was told to follow up with his family doctor. Cameron suffered a heart attack and died on December 27, 2004. According to the medical examiner's office autopsy, he died of sudden cardiac death due to arterial sclerotic heart disease.

He died before he was able to make any further employment decisions.

THE FOLLOWING HAS BEEN STIPULATED TO

1. The medical and autopsy records that have been provided from any health care provider are authentic and admissible.

2. The time line is attached. It is stipulated that the entries are accurate and that the time line may be used for any purpose. It is not stipulated that it is complete and contains all entries for any specific date as there may be more information in the medical records.
3. HDL is “good” cholesterol. It stands for High-density lipoprotein (HDL). It is one of the five major groups of lipoproteins (chylomicrons, VLDL, IDL, LDL, HDL) which enable lipids like cholesterol and triglycerides to be transported within the water-based blood stream. A high level of HDL seems to protect against cardiovascular diseases, and low HDL cholesterol levels increase the risk for heart disease. Cholesterol contained in HDL particles is considered beneficial for the cardiovascular health, in contrast to “bad” LDL cholesterol.
4. LDL is “bad” cholesterol. It stands for Low-density lipoprotein. It is a type of lipoprotein that transports cholesterol and triglycerides from the liver to peripheral tissues. LDL is one of the five major groups of lipoproteins; these groups include chylomicrons, very low-density lipoprotein (VLDL), intermediate-density lipoprotein (IDL), low-density lipoprotein, and high-density lipoprotein (HDL), although some alternative organizational schemes have been proposed. Like all

lipoproteins, LDL enables fats and cholesterol to move within the water-based solution of the blood stream. LDL also regulates cholesterol synthesis at these sites. It is used medically as part of a cholesterol blood test, and since high levels of LDL cholesterol can signal medical problems like cardiovascular disease, it is sometimes called “bad cholesterol,” (as opposed to HDL, which is frequently referred to as “good cholesterol” or “healthy cholesterol”).

5. Cameron Johnson discontinued Atenolol, a medicine for high blood pressure, on his own, without telling Dr. Mann.
6. The depositions of the plaintiff, defendant, and their respective experts are sworn to, authentic, and can be used for any purpose at trial.
7. The witnesses at trial are limited to the plaintiff, defendant, and their respective experts.

MORGAN JOHNSON, individually and as
Special Administrator for the Estate of
CAMERON JOHNSON

Plaintiff,

-vs-

ALEX MANN, M.D.

Defendant.

COMPLAINT

NOW COME the above plaintiff, by her attorneys, and as for her complaint against the above defendants, allege and show to the court as follows:

GENERAL ALLEGATIONS

1. That the plaintiff, Morgan Johnson, was appointed Special Administrator for the Estate of Cameron Johnson, adult, and at all times material hereto was the lawful spouse of Cameron Johnson, D.O.D. December 27, 2004.
2. That the defendant, Alex Mann, M.D., is a physician licensed to practice medicine and was so at the time of the death of Cameron Johnson.

STATEMENT OF CLAIM

NEGLIGENCE & WRONGFUL DEATH

3. Reallege and incorporate all of the allegations set forth in the previous paragraphs.
4. That the defendant, Alex Mann, M.D., rendered professional medical services to Cameron Johnson including but not limited to the time period from November 9, 1987 to March 10, 2004, inclusive; further that said defendant failed to exercise ordinary care and medical skill in keeping with his profession and the areas of his profession in which he specialized and in the manner in which he diagnosed, cared, treated, and rendered medical services to Cameron Johnson.

5. As a result of the causal negligence of the defendant, Alex Mann, M.D., Cameron Johnson endured pain and suffering and died on December 27, 2004; further, as the legal spouse of Cameron Johnson, plaintiff Morgan Johnson has been denied in the past and will continue to be denied in the future the aid, society, comfort, companionship, and consortium to which she is entitled, has and will continue to endure economic loss, including but not limited to, loss of the services of her spouse in the home, and has sustained a loss of the wages and earning capacity of her spouse both in the past and in the future.

INFORMED CONSENT

6. Reallege and incorporate all of the allegations set forth in the previous paragraphs.

7. That the defendant, Alex Mann, M.D., failed to properly inform Cameron Johnson, that there were reasonable alternative treatments and reasonable alternative diagnostic tests available to him.

8. As a result of the causal negligence of the defendant, Alex Mann, M.D., plaintiff suffered injuries more fully set forth in paragraph 5 above.

WHEREFORE, the above named plaintiffs demand judgment against the defendants, jointly and severally, as follows:

1. For the plaintiffs in an unspecified amount;
2. For interest, together with the costs, disbursements and attorney fees of this action;
3. For any other remedy the court deems just and equitable under the circumstances.

MORGAN JOHNSON, individually and as
Special Administrator for the Estate of
CAMERON JOHNSON

Plaintiff,

-vs-

ALEX MANN, M.D.

Defendant.

ANSWER

NOW COMES the above defendant, by his attorneys, and as for his answer to the complaint against the above defendants, admit and deny to the court as follows:

1. Admit paragraphs 1 through 3 as pled;
2. Answering paragraph 4 of the complaint, admits that the defendant, Alex Mann, M.D., rendered professional medical services to Cameron Johnson including but not limited to the time period from November 9, 1987 to March 10, 2004, inclusive; denies that said defendant failed to exercise ordinary care and medical skill in keeping with his profession and the areas of his profession in which he specialized and in the manner in which he diagnosed, cared, treated, and rendered medical services to Cameron Johnson and affirmatively alleges that he conformed to the standard of care at all times with regards to his medical treatment of Cameron Johnson;
3. Answering paragraph 5 of the plaintiffs' complaint, this answering defendant denies that he was causally negligent in the manner and which he provided medical services to Cameron Johnson and denies that he endured pain and suffering and died as a result of any act on the part of the defendant; further, this answering defendant denies that the plaintiff Morgan Johnson has been denied in the past and will continue to be denied in the future the aid, society, comfort, companionship and consortium to which she is entitled, has and will continue to endure economic loss, including but not limited to, loss of the services of her spouse in the home, and has sustained a loss of the wages and

earning capacity of her spouse both in the past and in the future as a result of any act on the part of the defendant;

4. Answering paragraph 6 of the plaintiffs' complaint, this answering defendant incorporates paragraph 1 through 3 above;
5. Answering paragraph 7 and 8 of the plaintiffs' complaint, this answering defendant denies each and every allegation contained therein;

AFFIRMATIVE DEFENSES

1. As and for the first affirmative defense, defendant alleges that Cameron Johnson was negligent with regards to his own health and safety and that said negligence was a cause of his death;
2. As and for the second affirmative defense, this answering defendant alleges that Morgan Johnson was negligent and that said negligence was a cause of Cameron Johnson's death;
3. As and for a third affirmative defense, this answering defendant moves to dismiss the complaint of the plaintiff as it fails to state an actionable claim upon which relief can be granted;
4. As and for a fourth affirmative defense, defendant alleges that Cameron Johnson's death was due to a superceding, intervening cause.

WHEREFORE, defendant demands judgment in favor of the defendant and against the plaintiffs, together with all taxable costs and disbursements in this action.

DEPOSITION OF MORGAN JOHNSON

My name is Morgan Johnson. I am a dental hygienist. I was married to Cameron Johnson for 25 years. Dr. Mann was my physician before Cameron became his patient. I switched doctors in 1988, as we moved to a different city.

Cameron and I were married in May of 1978. Prior to his death, Cameron had worked at Frascona Buick as a service manager. He had left that job prior to his death due to stress. It was his intention to find another job after a six-month hiatus.

Cameron quit his job in September of 2004. He was 50 years old. He wanted to take several months to regroup and enjoy life a little bit. He had been talking to someone at UPS about a job at the time of his death.

When Cameron died, I received \$100,000 of life insurance proceeds.

Cameron was a smoker. He was told to quit smoking by Dr. Mann, but he continued to keep smoking up until the time of his death. On the day my husband died, I had left the house at 7:30 in the morning. He had no complaints when I left the house. He was found in the chair by our daughter that morning. He was dead when she found him.

During that summer, I didn't see him experiencing any problems. He did the lawn, poured a driveway, and was never short of breath. He never

complained of chest pain to me while he was involved in yard work or other heavy work.

I remember going to an emergency room visit in November of 2002. It was a Monday morning. Cameron left for work, and I was getting ready for work. I came downstairs, and Cameron was laid flat out on the recliner. I asked him what was the matter, and he said “I think I’m having a heart attack.” We got in the car and drove over to the hospital. The emergency room doctor didn’t think he was having a heart attack, but they told us to follow up with Dr. Mann. They felt that a stress test was indicated, so we went home and called Dr. Mann to make an appointment.

The emergency room doctor thought that it could be GI related rather than heart, and that is why they wanted us to follow up with Dr. Mann.

After the stress test, he had a follow-up with Dr. Mann to discuss the results. Cameron came home saying he needed to also go in for an upper GI workup, which he did within a day or two after that. That was normal.

I spoke with Dr. Mann after the stress test. I asked him why he wasn’t given a cardiolute stress test, as I know what that is because I deal with a lot of medical people in my office. Dr. Mann told me there was no reason to do this, as he passed the other stress test just fine. I asked Dr. Mann if he needed a cardiac workup to make sure he’s okay, and Dr. Mann indicated

that there was nothing wrong with Cameron's heart, that in his judgment it was just anxiety and stress with regard to work. He explained to me about stress and how it can affect the heart and cause the problems Cameron was having.

My daughter-in-law is a nurse, and I talked to her about what happened in the ER with Cameron. She indicated to me that with that type of chest pain and pain in his arms, why wouldn't they do a stress test with a dye and see how the heart is pumping. I said that I didn't know. That's why I asked Dr. Mann.

I know that my husband had a visit with Dr. Mann in November of 2003, which was a year after his original emergency department visit. He told Dr. Mann that he had a bad night and woke up with pain. We went to see Dr. Mann that day, and he had an EKG. The EKG was normal.

In March of 2004, Dr. Mann recommended that Cameron take an aspirin a day. I don't think he did that. We did have aspirin in the house at that time.

I was concerned that my husband had a potential heart problem, so I suggested that Cameron get a second opinion. Cameron would always say that he had faith in Dr. Mann, that he was his doctor and that he knows what he is doing, I trust him.

On September 22, 2004, Cameron went back to the emergency room. I remember it being at the end of the day, and Cameron came home and was out in the backyard, and he didn't look well. He said that he had some chest pain, and I asked him if he wanted me to call 911 and he said no, let's just drive over to the hospital. We were there for about three to four hours, and they did an EKG and a blood draw, and they felt that it was really just indigestion. They said that if it continues to be a problem, we should contact our physician.

I know that the written instruction says that he was to see his primary physician in three to five days, but we were never told that by the emergency room. All I remember being told was that if he continued to have indigestion, he should call his doctor.

He did not have any physical complaints to me between the time of that emergency room visit and his death. Cameron died on December 27, 2004.

DEPOSITION OF TAYLOR BRATMAN, M.D.

My name is Dr. Taylor Bratman. I am a medical doctor practicing in the area of internal medicine. I am board certified in internal medicine, and I practice at the Mile Bluff Clinic. I have reviewed medical malpractice cases for both the plaintiff and defendant, but probably have reviewed more for the defendant than the plaintiff. I have reviewed cases relating to unexpected cardiac death or unexpected sudden death felt to be due to cardiac causes. One or two of them may have gone to deposition, but I do not specifically recall. I have been sued once for malpractice, but that case was dismissed.

I charge \$450 an hour for my time, which includes deposition time, review, discussion, travel, and trial testimony.

I have reviewed the following: a time line concerning the care and treatment that Mr. Johnson received, the deposition of Dr. Mann, the medical records for Mr. Johnson from Milwaukee Medical Clinic/Advanced Healthcare and Community Memorial Hospital, the deposition of Morgan Johnson, and the autopsy report.

I have worked with the plaintiffs' attorneys and their firm in the past. I have reviewed probably six cases for them over the years, and I have testified maybe twice.

In my opinion, Mr. Johnson had multiple risk factors for coronary artery disease. He was male, he was 51, he was mildly overweight, and he was a smoker. There was a family history of sudden death with regard to his mother at age 68 or 69. In addition, Mr. Johnson had hyperlipidemia, which means that his cholesterol was elevated. His lipids were never ideal or at his goal at any time prior to his death.

In addition, he had high blood pressure. He was placed on Atenolol, a drug for blood pressure, which reduced his high blood pressure, but his high blood pressure was never consistently controlled for two visits in a row. In addition to all of that, he did not do any regular exercise.

Mr. Johnson had episodes of chest pain. I cannot make a definitive determination as to every situation or every complaint of chest pain, but I believe it is clear that some of the pains were from his heart. He had episodes of worrisome chest pain, and a cardiac cause was never completely ruled out in any of those situations. Because of that, I think the diagnosis of cardiac origin for his chest pain is raised in every episode where he complained of chest pain. In each case of chest pain, there is the potential for cardiac cause and in my opinion, it was never adequately ruled out.

In my opinion, the November 11, 2002 emergency room visit is probably related to his heart. He had a relatively sudden or abrupt onset of

chest burning pain, which radiated into his neck. His symptoms were present for about 20 minutes, and he had sweating associated with it. He had some tingling in his forearms and hands and had some difficulty breathing. Those were his symptoms. He denied any prior history of cardiac pain, and he rated the pain as severe, a six out of ten. None of his symptoms suggested reflux disease. The discharge diagnosis was atypical chest pain, and it was felt that he possibly had reflux. He was given a GI cocktail, and the pain had resolved at that time. Mr. Johnson was sent to Dr. Mann for follow-up after the emergency room visit. His enzymes were normal, his EKG was normal, neither of which rules out cardiac or heart disease and because of the concern regarding heart disease or a cardiac cause of his problems, the exercise stress test was ordered.

It was appropriate for Dr. Mann to order the type of stress test that he ordered, that being without dye. Dr. Mann took an appropriate history when Mr. Johnson saw him on November 13. That included summarizing the episode of chest pain, some dizziness, and a second type of secondary dull chest pain lasting all day over the last two weeks, which is unrelated to position, activity, or meals. He told Dr. Mann that he had had several similar episodes in the morning associated with going to work and told Dr. Mann that he felt it was due to increased stress at work. The fact that it is

not related to position makes it less likely to be reflux, and the fact that it is unrelated to activity makes it less likely to be cardiac. Based on that, we are faced with the uncertainty of the diagnosis. Dr. Mann's assessment at that point was "chest pain, probably mixed causes, but suspect the primary component as stress related," and I think that is a fair initial assessment.

Because the stress test did not bring on any pain, the diagnosis is again equivocal, but it is not necessarily a reassuring finding. As a result, the standard stress test did not give any reassuring diagnosis.

He saw Dr. Mann again on November 27, 2002, and Dr. Mann's conclusion at that point was that his problems were likely due to stress. Stress does not cause pain. Stress can aggravate other underlying conditions that can be painful, as it can increase the production of acid by the stomach, which could aggravate acid reflux. It can also increase blood pressure and heart rate, which could be the cause of cardiac pain. Stress in and of itself may be a complicating and causative factor but in and of itself, it does not cause pain.

He saw Dr. Mann on several occasions in 2003, primarily for blood pressure follow-up and a check of his cholesterol. On April 30, 2003, he complained of intermittent heartburn-type symptoms. He said to Dr. Mann that he had no further chest pain. The fact that his symptoms occurred first

thing in the morning could make them more likely to be cardiac because of the physiologic effort the body goes through to awaken in the morning.

On November 6, 2003, Mr. Johnson called Dr. Mann and spoke to a medical assistant. He told her that he had recurring pain below the rib cage and had difficulty breathing without experiencing any pain. In my opinion, that was very unlikely to be a cardiac pain because it was underneath the rib cage. That sounds more like chest wall type of pain rather than heart pain. Dr. Mann saw him and felt it was chest wall pain. An EKG was done, and it was normal.

Dr. Mann did a complete physical on March 10, 2004, and Mr. Johnson's complaints were again intermittent chest pain associated with increased stress at work. They resolved in several minutes and were unrelated to exercise.

What I am concerned with at this point is that we still do not have a clear diagnosis. That is my concern. The fact that the pain is unrelated to exercise is against a cardiac cause, but we really do not have enough information or history to draw any other conclusions.

Anytime a patient complains of chest pain, cardiac cause must be in the differential diagnosis. Then a further history is taken, risk factors are evaluated and a decision is made whether the pain is likely cardiac or not.

Anytime the term chest pain comes up, a history and physical must be taken, at a minimum.

I believe that was the last visit Mr. Johnson made to Dr. Mann.

Mr. Johnson was seen in the emergency room at Community Memorial Hospital on September 22, 2004. He went to the emergency room with a complaint of chest pain that began after he had gotten home from work and had a beer. He had no shortness of breath. The chest pain was sharp and stabbing without any associated nausea, vomiting, or sweating. The records also indicate that he told the emergency room doctor that he had had similar pains in the past. The emergency room made a diagnosis of atypical chest pain, probably a gastric irritation after drinking a beer. The pain was not really in the chest. In the emergency room, they felt that the pain was not cardiac and was, instead, reflux. An EKG was done, and it was normal.

I agree that there were three EKGs done since November of 2002, and all of them were read as normal, and none of them demonstrated any kind of heart damage. However, you cannot rule out cardiac disease because the EKG is normal. Mr. Johnson was told to follow up with his physician after the emergency room visit of September 22, 2004, but he never did.

I have several criticisms of Dr. Mann. My first criticism is that he did not follow up with an electrolyte, or dye, stress test in November of 2002. A follow-up stress test was recommended by Dr. Singer but for whatever reason, one was not done. I am also critical with the way Dr. Mann managed Mr. Johnson's high cholesterol and blood pressure. It is appropriate to give him six months or 12 months of diet to see if he can successfully lower his cholesterol, but once he is not at an acceptable rate after a year the standard of care would require Dr. Mann to talk to Mr. Johnson about the issue, about the risks, and recommend taking medication. According to my review of the records, Dr. Mann never had this conversation or recommended drug management of Mr. Johnson's cholesterol. For every two points you lower the cholesterol, you decrease the risk of heart attack by one percent. Ultimately it is up to the doctor to give the patient options and then the patient can choose from those options. In my opinion, Dr. Mann should have given the option of medications to manage Mr. Johnson's lipid issues.

It is also my opinion that at the time the stress test was done in November 2002, Mr. Johnson had severe coronary artery disease. My reasoning for that is that two years later on autopsy, he had three areas of narrowing. Two were in his left anterior descending artery, and the

blockage ranged from 50 to 75 percent in one and 90 percent plus in the other. He also had some narrowing in the right coronary artery as well. Coronary artery disease does not develop overnight. It is not the kind of thing that goes from zero to 90 percent in six months, a year, two years, or three. This is a gradual process that occurs over time. To a reasonable degree of medical certainty, these areas of blockage would have shown up had a cardiolute stress test been done. In my opinion, Dr. Mann either ignored the recommendation for a cardiolute stress test, or he didn't take the time to review the report carefully. I base that on reviewing the record and reading his deposition.

In my opinion, he stated that he was aware of the recommendation of Dr. Singer, he saw Mr. Johnson for follow-up on the stress test, he had the copy of the report in front of him on the computer screen, as well as Dr. Singer's written report, he said he didn't understand what the recommendation meant, and he chose not to make a phone call to clarify it.

There would have been a number of treatments and options available to Mr. Johnson had the cardiolute stress been done and been positive. He could have been offered medical therapy. This would include anti-platelet therapy with aspirin, which leads to a 30 percent reduction in the chance of dying of a coronary event. Additionally, he could have been given other

anti-ischemic medications, such as beta-blockers and calcium antagonists. Additionally, medications could have been used to reduce cholesterol in a much more aggressive manner than Dr. Mann did. This would be starting a cholesterol-lowering drug called a statin.

Another option would have been some type of catheterization. Angioplasty could always be performed as a form of revascularization. Angioplasty would probably have been the preferred approach to provide more blood flow to Mr. Johnson.

I do acknowledge that one of Dr. Singer's reports does not say "consider stress cardiolite" and that Dr. Mann testified that he did not see that particular report. Dr. Mann did testify, however, that he had both pieces of information at the time that he saw Mr. Johnson. I do agree that at that point, it is up to Dr. Mann to make a judgment call as to whether Mr. Johnson should have had a further stress test or not. It is my opinion that regardless of what Dr. Singer said, Dr. Mann should have made the call to go on with a further stress test at that point in time. These are my criticisms of Dr. Mann in this case.

As to the cause of death, from the autopsy it is clear that Mr. Johnson had an acute heart attack due to his coronary artery disease. It was caused by a blocked artery. I do know that the emergency room record in

September of 2004 indicates that Mr. Johnson had discontinued the blood pressure medication, Atenolol, prior to going to the emergency room. I do agree that an abrupt cessation of taking a beta-blocker such as Atenolol can cause an increased risk of heart attack. In a patient such as Mr. Johnson who has abnormal coronary arteries and coronary blockage, discontinuing Atenolol would place him at a higher risk of having a heart attack.

DEPOSITION OF ALEX MANN, M.D.

My name is Dr. Alex Mann. I am an internist. I graduated from Tufts Medical School and did my residency in internal medicine at the Medical College of Wisconsin. I completed my residency, and I am board certified in internal medicine. Internal medicine includes the care of adults in a general medicine type of practice. Included in that is cardiac care. I have been employed at Advanced Healthcare for 30 years, and I have never given a deposition before.

Cameron Johnson was my patient for approximately 10 to 15 years. I was his primary care physician during that time. Cameron had some medical issues, which included high cholesterol, he had a questionable family history of heart disease, it wasn't clear, and high blood pressure.

I did a physical examination of Cameron in July of 2002. I took a history from him, and he indicated that he was a smoker, and he was overweight. I had also seen him on February 14, 2002, and I wanted to check his lipid levels. His cholesterol levels were elevated. They were 259 at that point, which is just into the high range. In addition, his triglycerides were 265, which would be in the high range; his good cholesterol, the HDL, was in the low range; and his bad cholesterol, the LDL, was in the high range.

The plan I recommended at that time was to medically manage his problems, meaning to work on his diet and work on his weight to lower the cholesterol.

We did not give him any medications at that time, as before we use medicine, we try to work on the diet and weight loss.

In July of 2002, Mr. Johnson returned for a complete physical exam. That was a routine physical exam at that time. His lipids had improved with diet and weight loss, and his cholesterol was 217, which was borderline high; his triglycerides were 149, which is within the range of desirable; his HDL was 43, which was also normal; and his LDL was 144, which was borderline high. It was clear at that point in time that he had gotten better as a result of weight loss and diet. I wrote him a letter and indicated that we were pleased with his findings. He was told to return in six months.

I next saw him on November 13, 2002. He indicated that he had been seen in the emergency room a day or two prior with complaints of chest pain. He indicated that he had been told in the emergency room that he should be seen by his internist and should have a stress test. He told me this on November 13. I ordered a stress test, and then I saw him following the stress test. The stress test was performed by another physician here at Advanced Healthcare. That physician's name is Dr. Jordan Singer. He is an

internist as well. I asked Dr. Singer to do the stress test, as I do not do stress tests as part of my practice.

The findings on the stress test were equivocal for ischemia, which is reduced blood flow to the heart, and his exercise capacity was poor. His exercise was limited by shortness of breath, and he achieved 87 percent of his maximum predicted heart rate. That is not optimal, and in fact, that is the reason that it was read out as poor exercise tolerance. Dr. Singer recommended that the patient and I discuss a cardiolute stress test, which is a stress test with dye, but Dr. Singer never communicated that to me.

I received a report from Dr. Singer that did not have that recommendation on it. I received a note from my medical assistant, Vanessa, that indicated, “was recommended to discuss cardiolute stress test.” This is different than the report that I received, which did not have that recommendation on it.

The report I had from Dr. Singer did not have any information regarding a cardiolute stress test, although the note I had from my medical assistant, did. I did not call Dr. Singer, as it was unclear where that information had come from.

In my practice, Dr. Singer usually arranges the referrals for cardiolute stress tests at the time that he sees people for stress testing if he thinks that

might be of benefit. Based on my practice, it was my impression that Dr. Singer had made arrangements for a cardiolute stress test for Cameron Johnson.

When I saw Mr. Johnson after the stress test, we discussed his chest pain. It was my judgment that it was not true anginal chest pain, and in fact, in reviewing the emergency room record, there had not been any clear evidence that this was anginal chest pain. Based on that, it was my judgment that it was not cardiac in origin. I did not discuss with Mr. Johnson a cardiolute stress test, as it was in my experience that Dr. Singer would arrange that on his own if he felt it was necessary. The information of “was recommended to discuss cardiolute stress test” was known to me by the time I saw Mr. Johnson, but because it differed from the original report that I received, I had no idea where that had come from. I did nothing to follow up as to what that meant.

I have reviewed the autopsy report. Mr. Johnson had a 50 to 75 percent obstruction within the proximal left anterior descending artery, had an obstruction in the right coronary artery, and he had a 90 percent obstruction within the more distal left anterior descending coronary artery. This is called “three vessel disease.” In my view, the stress test was a negative report because there was no indication that it was a positive report.

The stress testing individual, Dr. Singer, has the option to arrange a cardiolute stress test if he felt that was indicated.

I saw Mr. Johnson off and on over the next several years for a variety of complaints. He had a ringing in his ears, an ongoing persistent tightness in his anterior chest, although he had no sharp chest pains, and I thought he had elevated blood pressure. We gave him some medication for the blood pressure.

Mr. Johnson also had an emotional crisis, as he was quite anxious over the next several years. He indicated that this was job related, as he was under great stress at his job.

I saw him on January 8, 2003, which was a follow-up for his high blood pressure, and he denied chest pain at that time. We were concentrating on dealing with his high blood pressure and his stress factors at that time. His cholesterol levels were improved.

On April 30, 2003, he came in and had a heartburn-type pain, and we checked his blood pressure, and it was borderline high, 148 over 90. My assessment was hypertension, and I thought his symptoms were stress related. On November 6, 2003, he came into the office with chest tightness at work, and we did an electrocardiogram, and it was normal.

I saw Mr. Johnson for a physical exam on March 10, 2004, and he indicated that he had brief chest pain, not typical for anginal-type pain, and we had gone from November 2002 to March 2004 without any typical anginal-type pain. He was still smoking, and I thought that his chest pain was due to stress at work. He was on medication for his high blood pressure, so his high blood pressure was actually under control at that time. His cholesterol was high, his good cholesterol was low, and his bad cholesterol was again high. I recommended drugs for his condition at that time, but he was resistant to medication as a general rule. I felt that he needed to be on drugs, and we talked about that as an option. He declined. He was told to return in six months. That was the last time I saw him.

DEPOSITION OF JAIME HOLLOWAY, M.D.

My name is Jaime Holloway. I am a board certified doctor of internal medicine. I have a private practice, as well as being a professor of medicine at the University of Minnesota Medical School. I have reviewed the medical records from Dr. Mann, emergency room records, the autopsy report, and the depositions of Mrs. Johnson, Dr. Bratman, and Dr. Mann. In my opinion, Dr. Mann's evaluation and care of Mr. Johnson was reasonable and met the standard of care. It is further my opinion that the stress test in November of 2002 was not positive, and that based on that, Dr. Mann's management of Mr. Johnson's condition following the stress test was reasonable.

I am on the teaching faculty of the University of Minnesota. I am an assistant professor. I attend the teaching wards at Regions Hospital three to four months out of the year, seven days a week for those months. I take care of general medicine patients, including critically ill cardiac patients who come into our cardiac care unit. I also have a nursing home practice of approximately 60 patients in addition to my clinical practice, where I see adults ranging from age 18 to 101. In my practice, I treat people with hypertension, diabetes, and cardiac conditions. I do not administer stress tests.

As indicated, I believe Dr. Mann's evaluation and care of Mr. Johnson was reasonable and met the standard of care for the following reasons.

When Dr. Mann saw Mr. Johnson as a follow-up to Mr. Johnson's emergency room visit of November 11, 2002, he ordered a stress test, which is a reasonable thing to do given a one to two-week history of recurrent chest pain. He took a history of Mr. Johnson's problems, and he felt that he had chest pain was "probably mixed ideology but suspect the primary component is stress related." That was a reasonable medical judgment at that time by Dr. Mann. Based on that, he ordered the stress test. The stress test report came back indicating that there was no chest pain throughout the entire test but that he had a relatively poor exercise capacity of only 9 METS. His baseline blood pressure was slightly elevated, but a blood pressure response and heart response were normal. At the time Dr. Mann saw Mr. Johnson, he had the stress test report, and he was aware of the comment of considering doing a cardiolute stress test.

I believe Dr. Mann met the standard of care because he ordered a stress test as a way to evaluate Mr. Johnson's chest discomfort that he presented with at the emergency room. Since the stress test was read as negative, I don't believe that Dr. Mann had any obligation to do any further stress tests.

After the stress test, Dr. Mann discussed the stress test with Mr. Johnson, continued to follow the patient, and made a medical judgment that this appeared to be atypical chest pain, which was most likely associated with stress at work, with a possible GI component. He made the decision to place Mr. Johnson on drugs for his high blood pressure and addressed his high cholesterol, encouraging him to diet and lose weight. In fact, Mr. Johnson was successful at times in dropping his cholesterol and in losing weight. He was told to stop smoking, but he chose not to do that. In my view, there are only five accepted risk factors for coronary artery disease. They are family history, diabetes, high blood pressure, smoking, and high cholesterol. I disagree that he had four of the five risk factors. He had the risk factor of being a smoker. His blood pressure was controlled, his cholesterol was almost within the range of normal, and it is uncertain as to whether he had a family history of coronary artery disease.

I believe that Dr. Mann's follow-up care was appropriate. He recognized that stress was a significant component, and there is documentation that he attempted to convince Mr. Johnson to continue his medications.

To summarize, I believe that Dr. Mann met the standard of care for the following reasons: He ordered a stress test, he considered something

was causing chest discomfort and the stress test was a reasonable method to see what was going on, he made the decision to place Mr. Johnson on medication for his blood pressure, he recommended risk factor modification, he continued to follow Mr. Johnson and recognized that stress was a component and treated him for it, and he was available when the patient called and responded in a prompt fashion.

I did review the stress test strips and concur that it was normal.

I do agree that a cardiolute stress test would also be a reasonable test to do based on the recommendations of Dr. Singer. In my opinion, I disagree with Dr. Bratman, who testified that if the cardiolute stress test would have been done in November 2002, it likely would have been positive. I base my opinion on the autopsy report. Based on the autopsy report, one of the major arteries supplying the heart had only minimal plaquing. I also base this on the fact that the autopsy was performed two years after the stress test. There are cases where there is a rapid progression of coronary artery disease.

There are also cases with slow progression of coronary artery disease, so to say that it is more likely than not that there would have been significant coronary artery disease had the cardiolute stress test been done in November 2002 is simply speculation.

I also have concerns about Mr. Johnson's unilateral decision to discontinue Atenolol. In my opinion, a patient is at significant risk for a cardiac event if he or she acutely stops a beta-blocker such as Atenolol. I think it is possible that the discontinuation of the drug by Mr. Johnson played a role in his sudden cardiac death. A 90 percent blockage in and of itself is not a cause of death. The blockage and what happens because of the blockage can be a cause of death.

I do agree that if you don't know what a consultant is trying to tell you as a physician, you need to either pick up the phone and talk to him or walk over and talk to him. I also agree that Dr. Mann did testify that he didn't know what Dr. Singer meant when he said recommend cardiolute stress test. It is not appropriate to ignore what the consultant is telling you if you don't understand what it is.

"Recommend to discuss cardiolute stress test" means to me in this context that the stress test was not totally normal and that if appropriate, you might want to consider an additional imaging or diagnostic test, such as a stress test with dye. In my view, that is simply a recommendation that is to be taken into consideration when deciding how to follow-up with the patient. It is only a recommendation to be considered.

TIME LINE

Date	Provider	Notes	Charge
02/14/02	Milwaukee Medical Clinic/ Larry Dean, M.D.	Increased bluish color in L hand primarily at end of day. No pain/numbness. Smoke 1/2 pack day. Cholesterol 259 (fasting).	95.50
02/20/02	Milwaukee Medical Clinic/ Larry Dean, M.D.	Exam. Cholesterol 259. Continue w/ low cholesterol and low fat diet.	107.50
07/30/02	Milwaukee Medical Clinic/ Larry Dean, M.D.	Exam. Cholesterol levels show improvement and "basically in the borderline high range but not high enough to consider starting meds" at 217 (fasting). Exam. 5 cigs/day, 12 drinks wk, no exercise. Mother w/ acute myocardial infarction. Cholesterol 217 (fasting). Assessment-hyperlipidemia.	486.50
10/21/02	Milwaukee Medical Clinic/ Larry Dean, M.D.	Phone call, referral to gastroenterology re: colonoscopy f/u. Kathy told Timothy should have stress test. At hospital for heart problems.	0.00
10/23/02	Milwaukee Medical Clinic/ Larry Dean, M.D.	Pre-admit for colonoscopy.	0.00
11/11/02	Community Memorial Hospital E.R.	Admitted. Dizziness, ringing in ears, developed midsternal chest burning radiated to anterior neck. Sweating w/ chest discomfort, tingling in forearms & hands bilaterally. Initially had difficulty breathing. BP 158/93, ECG normal, multiple cardiac risk factors.	766.66
11/12/02	Milwaukee Medical Clinic/ Larry Dean, M.D.	Phone call. 1-2 wk history of recurrent chest pain. Cardiac stress test ordered.	0.00
11/13/02	Milwaukee Medical Clinic/ Larry Dean, M.D.	Chest pain, ringing in both ears. Stress test, no chest pain during chest. Poor exercise capacity, limited by SOB. Assessment-chest pain of mixed etiology, primary component stress.	755.50
11/15/02	Milwaukee Medical Clinic/ Larry Dean, M.D.	Phone call to verify esophagram and UGI x-rays.	0.00

11/18/02	Dr. Carol Pohl	x-rays upper GI and chest.	522.00
11/27/02	Milwaukee Medical Clinic/ Larry Dean, M.D.	Ongoing ringing in ears. UGI CT x-ray. Chest tightness. Diagnosis- chest pain from ongoing stress.	162.50
01/08/03	Milwaukee Medical Clinic/ Larry Dean, M.D.	f/up, re-elevated BP, ongoing stress. Assessment- hypertension.	111.00
04/30/03	Milwaukee Medical Clinic/ Larry Dean, M.D.	BP no significant change. Assessment- hypertension, stress related. Does not want to try SSRTs.	111.00
11/06/03	Milwaukee Medical Clinic/ Larry Dean, M.D.	Chest pain, breathing problem. Anterior chest pain increases w/ deep breathing. BP 146/90. EKG w/no acute changes. Assessment- precordial pain.	311.00
12/03/03	Milwaukee Medical Clinic/ Larry Dean, M.D.	Colonoscopy f/u.	0.00
01/16/04	Dr. Chan, Jr.	Colonoscopy	3,237.50
02/20/04	Milwaukee Medical Clinic/ Larry Dean, M.D.	Phone call, colonoscopy recall.	0.00
03/10/04	Milwaukee Medical Clinic/ Larry Dean, M.D.	Complete physical. Smokes 1/2 pack per day. 12 drinks week, no regular exercise. Cholesterol 245 (fasting). Has intermittent chest pain.	212.00
03/17/04	Milwaukee Medical Clinic/ Larry Dean, M.D.	Exam. Cholesterol moderately elevated at 245 (fasting). Work on diet. Relook at levels in 6 mos.	418.50
03/18/04	Milwaukee Medical Clinic/ Larry Dean, M.D.	Results of lab tests normal and within desired range. LDL moderately elevated. Suggest watching diet closely and exercise more.	0.00
08/03/04	Milwaukee Medical Clinic/ Larry Dean, M.D.	Would like lipid panel put into system so can have 3 mo check done.	0.00
09/18/04	Milwaukee Medical Clinic/ Larry Dean, M.D.	Exam. Total cholesterol level decreased and HDL increased. Bad cholesterol essentially the same at 224 (fasting). Relook at lipids in lyr.	138.50
09/20/04	Milwaukee Medical Clinic/ Larry Dean, M.D.	HDL increased while LDL stayed the same.	

09/22/04	Community Memorial Hospital E.R.	Chest pain, no SOB. Sharp, stabbing pain. BP 182/87. Pain 7/10. CT x-ray shows widening of mediastinum w/hilar adenopathy. Assessment-atypical chest pain.	1,257.50
09/23/04	Community Memorial Hospital E.R.	CT x-ray, no acute cardiopulmonary disease.	0.00
12/27/04	Community Memorial Hospital E.R.	Brought to hospital by Germantown Rescue Squad. Pulseless, not breathing. Found sitting in chair drooling and unresponsive. No obtainable BP. Multiple doses of epinephrine & atropine. After multiple attempts at resuscitation, coded at 12:18 p.m. Cardiac arrest.	2,389.10
12/27/04	Germantown Ambulance	Ambulance to hospital.	485.00
12/28/04	Milwaukee County Medical Examiner	Autopsy performed. Arteriosclerotic heart disease. Multifocal 50-75% obstruction. Focal up to 90% obstruction distal L anterior descending coronary artery.	0.00
12/28/04	Cesarz, Charapata Sc Zinnecker	Funeral expenses, cremation and arrangements.	8,026.38

telephone (GHIM)

Date	Time	Provider	Department	Center
11/12/2002		Mann, Alex	GHIM	GH
[REDACTED]	[REDACTED]		[REDACTED]	M

Visit Number

Reason for Visit:

Abdominal Pain [1] Cmt: ? GERD SX WANTS DISCUSSION// HAS APPT. WITH YOU TOMORROW

Allergies As of Date: 11/12/2002

(No Known Allergies)

Date Reviewed: 07/30/2002

Additional Progress Notes:

>> LARRY B DEAN Tue Nov 12, 2002 1:32 PM
1-2 wk hx of recurrent chest pain, will arrange stress test per ER and see.

>> [REDACTED] Tue Nov 12, 2002 11:31 AM

>> CALL RECEIVED. Contact: PT AT HOME 1-262-255-9066
PT WENT TO COMMUNITY MEMORIAL HOSPITAL ER MONDAY, HAD NEGATIVE CARDIAC
W/U-INCLUDING NEG EKG NEG CARDIAC ENZYMES-WHICH HE UNDERSTANDS. I CALLED THIS
PATIENT AND GAVE HIM APPT. FOR WED. AT THAT POINT HE SAID THAT WAS FINE. THIS
AM PT CALLED ME AND WANTED TO "SPEED THINGS UP A BIT" TOLD HIM HE SHOULD KEEP
HIS APPT WITH DR Mann. ON WED. HIS REQUEST IS THAT MD CALL
HIM TO DISCUSS HIS "SX OF INDIGESTION"

Order(s): CARDIAC STRESS TST, COMPLETE [93015] Order #: 6589952

Primary Visit Diagnosis: PRECORDIAL PAIN [786.51]

Encounter Status: Closed by Mann, Alex on 11/12/02

[REDACTED] Encounter Date: 11/12/02

OFFICE VISIT (GHIM)

Date	Time	Provider	Department	Center
11/13/2002	4:30 PM	3011- Mann, Alex	GHIM	GH

Visit Number 3523919

Reason for Visit:

Chest Pain [21] Cmt: WILL BE HAVING STRESS TEST -DID HAVE NEGATIVE CARDIAC W/U

Ear Problem [38] Cmt: ringing in both ears denies dizziness or fevers

Vitals: BP 154/92 | Pulse 66 | Wt 213 lbs (96.6kg)

Visit Notes:

>> [REDACTED] 11/13/2002 5:03 pm
 Denies known Latex allergy or symptoms of Latex sensitivity.
 Medications reviewed and updated.
 Saw Dr Singer for stress test today, see results-was recommended to discuss cardiolite stress test.

Allergies As of Date: 11/13/2002
 (No Known Allergies)
 Date Reviewed: 11/13/2002

Additional Progress Notes:

SUBJECTIVE:
 seen in the ER 2 days ago for 1/2 hr episode of ant chest pain radiating bilat. Began grad and increased. No nausea, but diaphoresis and some dizziness. Has 2n type of persist dull ant chest pain lasting all day over the last 2 wk. unrelated to position or activity or meals. Has had several similar episodes in the AM assoc with going to work and does feel increased stress at work.

OBJECTIVE:bp162/94
 General appearance - alert, in no distress

Neck - supple without meningismus, no adenopathy and THYROID NORMAL SIZE, NON-TENDER, WITHOUT NODULARITY
 Lungs - clear to auscultation, no tenderness
 Heart - normal, regular rate and rhythm, no murmur noted
 abd- nno tenderness or masses

ASSESSMENT:
 chest pain-probably mixed etiology but suspect the primary component is stress related.

PLAN:
 trial of ranitidine 150 bid



Encounter Date: 11/13/02

Results

Result: X-RAY CHEST 2 VW [71020] Order #: 6605622

Provider Status: Reviewed

Result: X-RAY UPPER GI W/O KUB [74240] Order #: 6605623

Provider Status: Reviewed

Office Visit (GHIM)

Date	Time	Provider	Department	Center
11/13/2002	9:00 AM	3005 Singer, Jordan	GHIM	GH

[REDACTED] M

Visit Number 3520639

Reason for Visit:

Treadmill Exam [113]

Vitals: BP 160/90

Visit Notes:

>> [REDACTED] 11/13/2002 8:48 am
Denies known Latex allergy or symptoms of Latex sensitivity.
pt, here for stress test. referred by Dr. Mann for chest pain.

Allergies As of Date: 11/13/2002

(No Known Allergies)

Date Reviewed: 11/13/2002

Additional Progress Notes:

Added by Singer, Jordan on: 11/13/2002, 9:51 AM

Modules accepted: Progress Notes

INDICATION: Chest pain- episode while driving to work two days ago. Has not reoccurred. Enzymes negative in ER.

IMPRESSION:

Pt. denied chest pain throughout the test.

Pt. developed upsloping ST depression in V4-V6 of 1.5 mm equivical for ischemia

Poor exercise capacity 9 METS. Exercise limited by SOB.

Baseline BP elevated, BP response normal. Normal HR response.

Patient achieved 87% of maximum predicted HR.

[REDACTED] Encounter Date: 11/13/02



FAMS MEDICAL
Milwaukee Medical

3/18/2004

Timothy M Hetzel
W159n10480 Old Farm Rd
Germantown, WI 53022

Dear Mr. Hetzel,

I am pleased to inform you that the results of the laboratory tests (listed below) done as part of your recent examination were all normal and within desired range.

Blood Cell Count, Blood Sugar, Electrolytes, Kidney Function, Liver Function, Prostate Specific Antigen(PSA) screening test for prostate cancer and Urinalysis

The lipid levels do show the HDL(good cholesterol) to be low and the LDL(bad cholesterol) to be moderately elevated. This has gone up from the last levels. I would suggest working on watching the diet closely and trying to increase the exercise. I would like to relook at the levels in 6 months. If the levels continue to run in this range I would consider starting meds.

If there are any questions, let me know.

Sincerely,



Larry B Dean, MD
Good Hope Road Center
3003 W Good Hope Rd
Milwaukee, WI 53209-0996
414-352-3100

Healthcare

9/20/2004

Timothy M Hetzel
W159n10480 Old Farm Rd
Germantown, WI 53022

Dear Mr. Hetzel,

your recent lipid levels do show the total cholesterol level has decreased and the HDL(good cholesterol) has increased as well as the triglyceride level has decreased. Overall the levels are an improvement from the last levels even though the LDL(bad cholesterol) was essentially the same. Keep working on the diet and the exercise and I would suggest relooking at the lipid levels in about 1 yr.

Thank you very much. If you have questions or concerns please feel free to contact my office.

Sincerely,



Larry B Dean, MD
Advanced Healthcare, SC
Milwaukee Medical Clinic
3003 W Good Hope Road
Milwaukee, WI 53209
414-352-3100

92

NAME: HETZEL , TIMOTHY M
MRN: 00000162490 ROOM NO:
ATTENDING PHYSICIAN: Nonstaff
ER PHYSICIAN: David D Gummin, MD
DATE: 11/11/2002

EMERGENCY ROOM REPORT

DATE OF BIRTH:
10/30/53

PRIVATE/PRIMARY PHYSICIAN:
Dr. Larry Dean

CHIEF COMPLAINT:
Chest discomfort.

HISTORY OF PRESENT ILLNESS:

The patient is a 49-year-old white male who states that he was leaving the house this morning en route to work at 6:30 a.m. when he suddenly developed midsternal chest "burning" which he states radiates into his anterior neck. He states the symptoms were present for about 20 minutes but resolved by the time he presented to the emergency department. He states he was sweating along with the chest discomfort and noticed a tingling in his forearms and hands bilaterally. He states that he had some initial difficulty breathing with onset of his symptoms but denies cough, sputum production, abdominal pain, or sensation of nausea or burping acidic fluid up. He denies prior history of similar discomfort. He states his pain was as severe as 6/10 in severity before it resolved. He denies recent change in dietary intake. He states he was able to eat a decent breakfast this morning.

PAST MEDICAL HISTORY:

Significant for hyperlipidemia which has not required treatment.

PAST SURGICAL HISTORY:

Negative.

FAMILY HISTORY:

Significant for his mother having died unexpectedly at age 68 of unknown etiology. She was found dead in her home.

SOCIAL HISTORY:

He is a smoker. Denies excessive alcohol or illicit drug use.

MEDICATIONS:

None.

ALLERGIES:

NONE.

REVIEW OF SYSTEMS:

All systems reviewed, all negative except as noted in the HPI and PMH.

PHYSICAL EXAMINATION:

GENERAL: Alert, in no distress.

VITAL SIGNS: Initial blood pressure is 158/93, other vital signs

EMERGENCY DEPARTMENT REPORT

1 of 2

Non ES - Status Unknown

are normal. Room air pulse oximetry 99%.
HEENT: Moist mucous membranes. Conjunctivae unremarkable.
PERRLA, EOMI. Nasal sinuses clear. Oropharynx clear. TMs clear bilaterally.
NECK: Supple with no lymphadenopathy, no mass or tenderness, no stridor.
LUNGS: Clear throughout.
CARDIAC: Regular rate and rhythm without murmur, rub, or gallop.
CHEST: Nontender to palpation.
ABDOMEN: Not distended, with normoactive bowel sounds. Soft and nontender throughout.
BACK: No CVA or flank tenderness.
EXTREMITIES: No clubbing, cyanosis or edema. Full range of motion throughout without any tenderness. No calf or medial thigh tenderness. Negative Homans sign bilateral. Pulses are 2+ and symmetric throughout.
SKIN: Normal in temperature and turgor with no external lesions or exanthem.
NEUROLOGIC: Alert, oriented x3. Cranial nerves II through XII are intact. There are no focal motor deficits. His gait is normal.

EMERGENCY DEPARTMENT COURSE:


Capped IV was placed. He was given a GI cocktail with no recurrence of his discomfort. His electrocardiogram here was completely normal. Continuous cardiac monitoring revealed persistence of a normal sinus rhythm with no significant ectopy. Cardiac enzymes were sent and returned normal. The patient had no recurrence of symptoms while in the emergency department. Dr. Dean was consulted and agreed with outpatient disposition and follow up with him this week for a noninvasive cardiac stress test. The patient is cautioned to return immediately if he develops recurrent and worsening pain, difficulty breathing, palpitations, cough, fever, vomiting, or other new symptoms arise. He is otherwise started on Pepcid 20 mg p.o. twice daily. The patient was encouraged specifically to stop smoking.

DISCHARGE DIAGNOSIS:

1. Atypical chest pain.
2. Probable gastroesophageal reflux.
3. Multiple cardiac risk factors.

CONDITION ON DISCHARGE:

His condition at the time of discharge is improved.


David D Gumm, MD

DDG: EDIX13301

D: 11/11/02 13:36 T: 11/12/02 12:54 DOCUMENT: 200211111273454600

EMERGENCY DEPARTMENT REPORT
2 of 2

Non ES - Status Unknown

NAME: HETZEL, TIMOTHY M
MRN: 162490 ROOM NO:
ATTENDING PHYSICIAN: LEE J LAWRENCE, M.D.
ER PHYSICIAN: LEE LAWRENCE, M.D.
DATE: 09/22/2004

9/22
SL

EMERGENCY ROOM REPORT

PRIVATE/PRIMARY PHYSICIAN: Falls Medical Group, Dr. Dean.

CHIEF COMPLAINT:
Chest pain.

HISTORY OF PRESENT ILLNESS:

The patient is a 50-year-old male who presents to the emergency department with the complaint of chest pain that began after he got home from work and having a beer, approximately 2 hours prior to arrival, epigastric in nature. No shortness of breath. He describes it as a sharp, stabbing type pain without any associated nausea, vomiting, or diaphoresis. The patient has had previous similar pains, in fact he was evaluated previously here in this emergency department. He was seen in her in November 2002 with atypical chest pain, probably gastroesophageal reflux. The patient does have a previous history of hypertension. No history of diabetes.

REVIEW OF SYSTEMS:

CONSTITUTIONAL: Denies fever, chills.
RESPIRATORY: Denies cough or shortness of breath.
CARDIOVASCULAR: He has epigastric type substernal chest pressure. It does not radiate.
GASTROINTESTINAL: He was previously told to take Pepcid, but has not. He did not take anything for the pain at home. Denies vomiting, diarrhea, or melena.
The rest of the review of systems are negative except for the above.

SOCIAL HISTORY:

The patient does smoke. He is married.

FAMILY HISTORY:

No history of heart disease.

MEDICATIONS:

Atenolol, lorazepam.

ALLERGIES:

NONE.

PHYSICAL EXAMINATION:

VITAL SIGNS: Blood pressure 182/87. Pulse 65. Respiratory rate 16. Temperature 99.3. The pain is a 7/10. Room air pulse oximetry 100%. Blood pressures were obtained in each arm. Right 140/86; left 159/87.
GENERAL: Well-developed, well-nourished male in no acute distress.
NECK: Supple without JVD.
LUNGS: Clear bilaterally.
HEART: Regular rate and rhythm without murmur.

CHEST: Nontender to palpation.
ABDOMEN: Mild epigastric tenderness. No guarding or rebound.
EXTREMITIES: No edema or cyanosis. Pulses strong, rather symmetric. The patient does have areas of ecchymosis to both lower extremities, he states they are chronic.
SKIN: Warm and dry.

Prior to giving anything for the pain, the patient's pain has completely resolved. An EKG had been obtained during the pain. It was a normal sinus rhythm with a ventricular rate of 62, PR interval 140 msec, QRS duration 90 msec. No acute ST elevation or significant ectopy noted.

The patient was continuously monitored while in the emergency department and remained pain free throughout the rest of this emergency room course.

Chest x-ray showed questionable widening of the mediastinum with hilar adenopathy. I will follow up with radiology if this is significant or may be just a portable nature of the chest x-ray. No old ones to compare.

Pepcid 20 mg given p.o.

Lab work was obtained. White count slightly elevated 11,500, normal H&H. Normal CPK, troponin I, D-dimer. Electrolytes: Glucose, BUN, and creatinine were all within normal limits.

FINAL DIAGNOSIS:
Atypical chest pain.

DISPOSITION:
Discharged home. Rest. Bland diet. Personal physician for re-evaluation in 3-5 days. Mylanta as needed. Return for severe or persistent pain. Pepcid 20 mg twice daily.

Multiple diagnoses were considered on this complex patient including but not limited to his likely gastroesophageal reflux, unlikely to be cardiac or vascular in nature.

CONDITION ON DISCHARGE: Good


LEE LAWRENCE, M.D.

LL/lc TSI# 292593

D: 09/22/2004 21:32 T: 09/24/2004 07:15 DOCUMENT: 24384

NAME: HETZEL, TIMOTHY M
MRN: 162490 ROOM NO:
ATTENDING PHYSICIAN: DENNIS W SHEPHERD, M.D.
ER PHYSICIAN: DENNIS SHEPHERD, M.D.
DATE: 12/27/2004

2/2/04
DWH

EMERGENCY ROOM REPORT

PRIVATE/PRIMARY PHYSICIAN: NONSTAFF

CHIEF COMPLAINT:
Pulseless, nonbreather.

HISTORY OF PRESENT ILLNESS:

The patient is a 51-year-old gentleman who was brought to the emergency room by Germantown Rescue Squad as a reported pulseless, nonbreather. The patient apparently was found sitting in a chair drooling and unresponsive at approximately 11:37 p.m. by his daughter. They called 911. When Germantown Rescue Squad arrived, they found a nonshockable rhythm with no pulse and they were unsuccessful at intubating him with a Combitube. They subsequently used bag valve ventilation and CPR was performed. He remained in a nonshockable rhythm throughout his transport. On arrival here, the patient has CPR in progress. Additional history obtained from the wife states that he had been feeling well, with no recent illness. She states that he had some dental surgery done a few weeks ago. He had some vague cardiac complaints earlier in the fall, which had been evaluated in the emergency room, as well as by his primary care doctor. He had a stress test done several years ago. There has been no documented history of coronary disease. He has been under some stress of late. He has recently quit his job. He has also had some question of hypertension in the past as well.

PAST MEDICAL HISTORY:
Hypertension.

MEDICATIONS:
Atenolol, lorazepam, and a multivitamin.

ALLERGIES:
There are no known drug allergies.

SOCIAL HISTORY:
He is married. No drug use.

FAMILY HISTORY:
Not reviewed because of critical nature in patient.

REVIEW OF SYSTEMS:
Limited to the above.

PHYSICAL EXAMINATION:
The patient is unresponsive. Pupils are fixed and dilated. He has no obtainable blood pressure or pulse. The patient is mottled and purple from the shoulders to the head. He has breath sounds with bag valve ventilation. There are no auscultated heart tones. His abdomen is soft and nondistended. Extremities are cool. Neurologically, he is unresponsive.

EMERGENCY DEPARTMENT COURSE:

The patient was immediately placed on the cardiac monitor, which showed underlying asystolic rhythm. An IV was established. Epinephrine and atropine were given per ACLS protocol. The patient had pulses with CPR. While this was being performed, I intubated this patient. Initial passage of the tube was unsuccessful. It was immediately removed and he was again hyperventilated. On the second attempt, the Combitube was placed without difficulty. A good color change was noted on the capnometer and auscultation showed bilateral breath sounds. The patient remained in asystolic rhythm. He received multiple doses of epinephrine and atropine. After multiple attempts at resuscitation, this code was called at 12:18 p.m. The patient's primary care physician, Dr. Dean, was contacted and made aware of the death. Medical examiner was also made aware.

IMPRESSION:

This is a 51-year-old gentleman who presents as a cardiac arrest with failed resuscitation. Multiple etiologies are considered, including cardiac arrest, cardiac arrhythmia, pulmonary embolism.

DIAGNOSIS:

Cardiac arrest with fatal resuscitation.

PROCEDURE PERFORMED:

Endotracheal intubation.

CONDITION ON DISCHARGE:


DENNIS SHEPHERD, M.D.

DS/cw TSI# 454425

D: 12/27/2004 16:02 T: 12/28/2004 15:39 DOCUMENT:

5231

Milwaukee County Medical Examiner
933 West Highland
Milwaukee, Wisconsin 53233

AUTOPSY PROTOCOL

NAME: HETZEL, TIMOTHY M. SEX: MALE AGE: 51 YEARS
DOB: 10/30/1953
DATE OF DEATH: DECEMBER 27, 2004 TIME: 1217 HOURS
DATE OF AUTOPSY: DECEMBER 28, 2004 TIME: 1000 HOURS
PLACE OF AUTOPSY: Milwaukee County Medical Examiner's Office

PERFORMED BY: John R. Teggatz, M.D.
Deputy Chief Medical Examiner

COPY

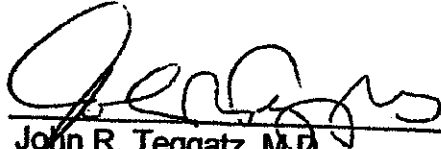
WITNESSED BY: Jeffrey M. Jentzen, M.D.
Medical Examiner

Victor Frolov, M.D.
Forensic Pathology Fellow

Tracey Shimek
Forensic Pathology Assistant

CAUSE OF DEATH: Sudden Cardiac Death
DUE TO: Arteriosclerotic Heart Disease

2005 JAN 27 AM 10:00
WASHINGTON COUNTY SHERIFF

Signed  1-19-05
John R. Teggatz, M.D. Date Signed
Deputy Chief Medical Examiner

NOTES BY: WE TYPE/CSD, MEDICAL TRANSCRIBER

Milwaukee County Medical Examiner
933 West Highland
Milwaukee, Wisconsin 53233

AUTOPSY PROTOCOL

Final Diagnoses:

- I. Arteriosclerotic heart disease.
 - A. Multifocal 50-75% obstruction, proximal left anterior descending and right coronary arteries.
 - B. Focal up to 90% obstruction, distal left anterior descending coronary artery.
 - C. Focal mottled myocardium, left ventricle, gross examination.
 - D. Microscopic findings suggestive of acute myocardial infarct.
 - E. History of hypertension, with mild left ventricular hypertrophy and dilatation.
 - F. Sudden cardiac death.
- II. Mild prostatic hypertrophy.
- III. Status post postmortem tissue procurement.

COPY

PROVISIONAL ANATOMIC FINDINGS

- I. Probable sudden cardiac death.
 - A. History of hypertension.
 - B. Mildly enlarged heart with left ventricular hypertrophy and dilatation.
 - C. Moderate to severe arteriosclerotic heart disease.
 - 1. Multifocal 50-75% obstruction, proximal left anterior descending and right coronary arteries.
 - 2. Focal up to 90% obstruction, distal left anterior descending coronary artery.
 - D. Focal mottled myocardium, left ventricle (pending microscopic examination).
 - E. Pulmonary congestion.
- II. Mild prostatic hypertrophy.
- III. Status post postmortem tissue procurement.

COPY

JURY INSTRUCTIONS

General

1. The sole issue in this case is whether the plaintiff was injured or damaged by the negligence of the defendant. On this issue, the burden of proof is on the plaintiff. This means that the plaintiff must prove, by the greater weight of the evidence, that the defendant was negligent and that such negligence was a proximate cause of the plaintiff's injury.
2. The greater weight of the evidence does not refer to the quantity of the evidence but to the convincing force of the evidence. It means that you must be persuaded, considering all the evidence, that the necessary facts are more likely to exist than not. If you are so persuaded, it would be your duty to answer the issue in favor of the party with the burden of proof. If you are not so persuaded, it would be your duty to answer the issue against the party with the burden of proof.
3. You are the sole judges of the credibility of the witnesses. You must decide for yourselves whether to believe the testimony of any witness. You may believe all, or any part, or none of that testimony. In determining whether to believe any witness you should use the same tests of truthfulness which you apply in your everyday lives including the opportunity of the witness to see, hear, know, or remember the facts or occurrences about which the witness testifies; the manner and appearance of the witness; any interest, bias, or partiality the witness may have; the apparent understanding and fairness of the witness; whether the testimony of the witness is sensible and reasonable; and whether the testimony of the witness is consistent with other believable evidence in the case.
4. Expert witnesses have testified in this case. You are the sole judges of the credibility of expert witnesses and the weight to be given the testimony of expert witnesses. Consider the testimony of any expert witnesses using the same tests you are to use with any other witness. In addition to those tests, consider any evidence about the witness' training, qualifications, and experience or the lack thereof; the reasons, if any, given for the opinion; whether or not the opinion is supported by the facts that you find from the evidence; whether or not the opinion is reasonable; and whether or not it is consistent with the other believable evidence. You should consider the opinion of an expert witness, but you are not bound by it.
5. You are also the sole judges of the weight to be given to any evidence. If you believe that certain evidence is believable, you must determine the importance of the evidence in the light of all other believable evidence in the case.

Medical Negligence

In diagnosing (plaintiff)'s condition, (doctor) was required to use the degree of care, skill, and judgment which a reasonable doctor practicing internal medicine would exercise in

the same or similar circumstances, having due regard for the state of medical science at the time. A doctor who fails to conform to this standard is negligent. The burden is on (plaintiff) to prove that (doctor) was negligent.

You have heard testimony during this trial from doctors who have testified as expert witnesses. The reason for this is because the degree of care, skill, and judgment which a reasonable doctor would exercise is not a matter within the common knowledge of laypersons. This standard is within the special knowledge of experts in the field of medicine and can only be established by the testimony of experts. You, therefore, may not speculate or guess what the standard of care, skill, and judgment is in deciding this case, but rather must attempt to determine it from the expert testimony that you heard during this trial.

A person's negligence is a cause of the plaintiff's death if the negligence was a substantial factor in producing the death. This question does not ask about "the cause" but rather "a cause." If you conclude from the evidence that the death was caused jointly by (doctor)'s negligence and also the natural progression of (plaintiff)'s condition, then you should find that the (doctor)'s negligence was a cause of the (plaintiff)'s death.

Informed Consent

A doctor has the duty to provide his or her patient with information necessary to enable the patient to make an informed decision about treatment options. If the doctor fails to perform this duty, he or she is negligent.

To meet this duty to inform his or her patient, the doctor must provide the patient with the information a reasonable person in the patient's position would regard as significant when deciding to accept or reject a medical treatment. In answering this question, you should determine what a reasonable person in the patient's position would want to know in consenting to or rejecting a medical treatment.

If (doctor) offers to you an explanation as to why he or she did not provide information to (plaintiff), and if this explanation satisfies you that a reasonable person in (plaintiff)'s position would not have wanted to know that information, then (doctor) was not negligent.