2011 NATIONAL STUDENT TRIAL ADVOCACY COMPETITION

OFFICIAL RULES

and

FACT PATTERN

Endowed by Baldwin & Baldwin, LLP
Important Dates:

Requests for fact pattern clarification due: December 17, 2010
Team registration forms due (students must be AAJ members): Jan. 28, 2011
Regional Competitions: March 3-6, 2011
National Final Competition: March 31-April 3, 2011

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AAJ’s 2011 Fact Pattern is authored by Donald H. Beskind of Raleigh, NC. AAJ extends its thanks and appreciation to Mr. Beskind for developing the 2011 Fact Pattern.

Please note:

All information regarding the 2011 Student Trial Advocacy Competition is also available at www.justice.org/STAC and will be updated frequently.

All questions and correspondence should be addressed to:

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American Association for Justice
Formerly the Association of Trial Lawyers of America
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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 17, 2010. 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.

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 Schools 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 2010, 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 2011.

*Each student participant must be an AAJ student member by January 28, 2011 in order to participate.*

**REGISTRATION PROCEDURES**

**Refund Policy**

Requests for a refund of a school’s registration fee were due in writing before November 12, 2010. 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 28, 2011 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 28, 2011. *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 28, 2011 is not permitted except in the case of personal emergencies. Requests for substitution after the January 28 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 Final Competition

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

Situation 2:
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 Dorothy Hiller and Michael Benson, P.E.
- Defendant must call Charles Cutler and Charlotte Darling, P.E.

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 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 of the segment during which they are being used.

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 score 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.
DOROTHY HILLER V. CHARLES CUTLER AND FLEET TRUCKING CO.

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Case Summary

Dorothy Hiller\(^1\) v. Charles Cutler and Fleet Trucking Company

This case involves a head-on collision between a car driven by Dorothy Hiller and a tractor trailer driven by Charles Cutler and owned by Fleet Trucking Company. The vehicles were approaching each other on a two-lane rural highway in South Carolina.

Mrs. Hiller contends that she came down the street from her house to the highway intending to turn right. She stopped, looked to her left, saw a truck a long way back and turned right, pulled out onto the highway headed the same way as the distant approaching truck. She gradually increased her speed to the limit, 55 M.P.H. After she had been going that speed for a short while, the truck came up from behind her and went to pass her on the left. As the rear of the trailer was about even with her door, the truck suddenly pulled into her lane. The rear tire struck her door and knocked her car into the guardrail to her right. After hitting that guardrail, Mrs. Hiller’s car caromed across the road hitting the guardrail on the opposite side of the highway. After hitting this second guardrail, her car bounced off it into the path of an oncoming large dump truck which hit her nearly head on.

Charles Cutler and Fleet Trucking, his employer, contend that Mrs. Hiller came down the street to the highway, never looked in his direction, and pulled out in front of Mr. Cutler leaving him with too little room between him and her. Mr. Cutler says he had only three options: run off into a ditch on his right, slam into Mrs. Hiller from behind, or pull out to pass into the lane for oncoming traffic. He chose the latter option once he realized there was nothing coming for nearly a mile ahead in that line. Once he started to pass, he says that Mrs. Hiller must have panicked because she increased her speed to 70 M.P.H., making it take longer for him to get around her. Despite the increased speed, Mr. Cutler was successful in getting past her, and after checking his rear view mirror and seeing that he had room, pulled back into his lane in front of Mrs. Hiller. Mr. Cutler then noticed trucks approaching in the opposite lane. Mr. Cutler never felt any contact between his vehicle and Mrs. Hiller’s car. He was surprised when he heard on the CB that Mrs. Hiller was in a wreck.

Mrs. Hiller had multiple fractures and several surgeries. The extent of her need for future treatment is disputed.

Plaintiff has ordinary negligence and punitive damages claims, the latter under a reckless disregard of the rights and safety of others theory. She seeks compensatory and punitive damages. The parties have stipulated that her medical and hospital bills as of the time of trial are $242,311.42, that all those charges were incurred as a result of injuries sustained in the accident, and that all charges were reasonable and customary for the services

\(^1\)The author wishes to thank the real plaintiff for her gracious permission to use her actual medical records and documents from her case to help train law students. The facts as portrayed are largely taken from public records in the actual case. In only a few places have they been modified for use as a training file.
provided. Cutler and Fleet Trucking deny any negligence. Fleet Trucking, however, has admitted that Cutler was in the course and scope of his employment when this accident occurred. Plaintiff’s only cause of action against Fleet is respondeat superior. Bolt has $51,000,000 in insurance coverage for this incident.

Witnesses available for trial:

- Dorothy Hiller, Plaintiff
- Michael Benson, Engineer
- Charles Cutler, Defendant
- Charlotte Darling, Engineer

Notes:

1. Assume that James McGinn, the driver of the dump truck that struck Ms. Hiller after she had careened off the guardrails, was not deposed and is not available as a witness. Though he is very much alive in real life, please assume for this program that he passed away before he could be deposed.

2. Plaintiff has a full life care plan prepared by Cynthia Orson, a life care planner. That report is omitted because of its length. It was, however, provided to Dr. Finley Suh, Plaintiff’s economist, who used it as the basis of his report which is an attachment to this file.
DEPOSITION OF DEFENDANT CHARLES CUTLER

My name is Charles Cutler and I was born in Raleigh, NC on January 25, 1964. My father died when I was 17. I left school halfway through my senior year and have never gotten a GED. I am divorced and have no kids. Ever since I left high school I have been driving trucks, all kinds, big and small. I have a lousy memory for dates and places, but I have probably worked for more than 25 companies since I started driving. Being a truck driver means you are at the mercy of the work available and the companies who have it. It’s hard to stay with one company very long. I don’t take a lot of stuff off people and, you know, rather than argue with them, I go down the road and find me another job. All the companies I have worked for are in the Southeast and most of my driving has been in this region. At the time this happened I was working for Fleet Trucking which is an eight truck operation. We mainly hauled ash from a power plant in South Carolina to other companies in other states that used it for things.

I am looking at the driving record you have marked as Exhibit 1 to my deposition. Despite how it looks, my record really isn’t very bad. Lots of the tickets were just situations where I didn’t do it but couldn’t afford a lawyer so I had to pay the ticket or situations where I couldn’t pay so my license was temporarily suspended. Some of these other things, I just don’t remember. I certainly don’t remember any reckless driving convictions. I’m the type of person, you know, something from a week ago -- I just block it out of my head. Yes, I do remember getting caught twice when I was driving with my license suspended but I think those suspensions were mistakes.

When I applied for my job with Fleet in ‘99, I pulled my record with the DMV like you have to do and showed it to Mr. Ewing at Fleet. It was relatively clean. I think I may have had one or two speeding convictions on it but they were real minor.

My criminal record is a joke, all misdemeanors. Money is always tight for me so I have a bunch of bad checks. You have just had me count them and I think there are 26 on the page you showed me. I also have a misdemeanor larceny for stealing some bread when I was just 18. I was just with some kids who were fooling around and took the bread left by a delivery person outside a store. They were under 18 and got off easy. I had to do months of community service.

The conviction from unauthorized use of a motor vehicle is also bogus. I was working for Beasley Concrete. I was having problems with the brakes on the mixer they gave me to drive. I went to their shop to get it fixed but they didn’t have time and sent me out anyway. I picked up a full load and went to deliver it. When I got to the site, they only wanted a half a load delivered even though they were paying for a full load and had no place for me to dump it on site. The guy there told me I could do what I wanted with it. On the way back, I had to brake for a school bus and the brakes got even worse. I wasn’t far from my house so I took the truck there to get a wrench and try and fix the brakes. When I was backing down my driveway the wheel got off to the side into the ditch. I called a local contractor to tow me out. At this point the concrete had been on the truck for six hours and is pretty much no good. The contractor pulled me out and told me he
was pouring a slab in front of his shop. He said that rather than charging Beasley for the
towing, I could just dump the concrete where he was pouring his slab which I did.
Someone from the company saw me and when I got back to the office they fired me.
Before I even got home, I had been arrested and charged with stealing the truck. When
the case came up, I was in jail for a DWI or worthless checks. I know I was not
convicted for the DWI. My lawyer worked it out and I got a slap on the wrist with a fine
and community service.

I do have a couple of game warden convictions - one for undersized bass and one for
undersized flounder. They weren’t mine, they belonged to the people I was fishing with.
I got charged because the cooler they were in was mine.

Q: Tell me what happened the day of this accident.

A: Do you want the details or you just want the short version?

Q: I want the detailed version.

A: I come out of Georgetown, South Carolina. I don’t remember exactly
what highway it was -- 52 or 59, something like that. I was headed up to a factory in
North Carolina. I come up to a four way intersection. There was a store on my left. I
looked left, looked straight ahead, looked to my right. There was nothing on either road.
There was nobody in the parking lot at the store.

I made my right hand turn, got my speed up. I was carrying about 18 ½
tons of ash from the power plant. And shortly, as I changed my last gear, got into my
highest gear, I notice a white vehicle pulling out what seemed to be a dirt road, which
turned out to be later a driveway, but it was a long driveway. She – and I noticed her
pulling out because the background behind the car was completely green from pine trees
and other trees.

Q: What color was her car?

A: White.

Q: What happened next?

A: Okay. And I happened to look at the lady driving – a little bitty old lady,
very short, you could barely see her. And I noticed that she did not look towards me as
she was approaching the highway. She just pulled straight out in front of me.

And as I started, as I got into my highest gear, as she approached the highway and
proceeded into the highway, I was a tenth of a mile behind her, approaching her vehicle.
As she approached into the road, I immediately had three choices. I could either get hit
by her from behind or run the truck off the road into the ditch on the right, and I didn’t
want to do either of those things. So, I took the third choice. There was nothing coming
for as far as you could see, and at that point you could see for almost a mile ahead of you because it was flat land, straight.

I dropped over into the left lane, went – started to go around her. As the tractor of my truck came up beside her, she panicked. She nailed the gas. She made it a drag race. So when I finally overtook her, I looked in my right mirror and saw that I had just cleared her.

And about that time, I heard on the CB, “We got one passing up ahead of us.” And I looked up and there was three tractor trailers coming from the opposite direction.

At that point, we were just before getting to the Mingo Creek Bridge, which from the intersection is less than a half of a mile from where I made my right turn on to Highway 41. When I got to Mingo Creek Bridge, I – as she entered the bridge, I had already cleared the beginning of the bridge and proceeded back into my lane. Just as I done that, one of the other truck drivers said, “Boy, was that close.”

Just as soon as he got that out of his mouth, she come over the yellow line into the oncoming lane, hit what would be the guardrail on the bridge. At that point, I was already back in my lane proceeding straight. The oncoming first truck dropped over into my lane behind me after I passed him to try to avoid hitting her head on.

Then as she careened off the bridge back into her lane they hit – driver’s side fender to driver’s side fender. And I went down approximately two tenths of a mile. There was a road turns off to the right. There was a little place to turn around, so I turned around and came back.

When I got back, other people were already helping the two drivers. I just stayed with my rig. And when the police officer got there, he asked me what happened, and I told him the same thing, went down and showed him where the driveway was. The officer told me that if she pulled out in front of me he wouldn’t charge me since it would have been her fault. I was really pissed off later when he gave me a ticket for improper passing.

Q: Are you aware that a witness who was driving behind you saw the whole thing and says that Mrs. Hiller did not cut out in front of you and that you were just trying to pass her when all this happened?

A: There’s no way anyone could have seen that. There was no one behind me and no one coming from the opposite direction except the three trucks and they were too far away to see her pull out on me. The only witness who told the officer the truth was the neighbor who came over while I was talking to the cops.

Q: What neighbor?
A: There was some man there that I heard telling the officer that the lady pulled out on me. He apparently lives nearby or something and saw it from his porch. He told the officer that the lady pulled down her driveway and out in front of me and that I had nowhere to go.

Q: So it is your testimony that you were making a right turn onto Highway 41?

A: Uh-huh.

Q: How far was it from where you made the right to where to the driveway where you say the lady pulled out?

A: It was a tenth of a mile.

Q: Are you saying you got all the way to tenth gear in a tenth of a mile?

A: That’s what happened.

Q: So, when she pulled out, you were going approximately 55 miles per hour?

A: Uh-huh.

Q: And how close to the lady were you when she pulled out?

A: About the length of this conference room – maybe ten more feet. I’d say 30 feet, 35 feet tops.

Q: When you pulled out to go around the lady, how far could you see down the road?

A: Roughly a mile, maybe a little less. You could see good. It was flat and straight.

Q: Could you see over the Mingo Creek Bridge?

A: Yes.

Q. OK, so she pulls out 35 feet in front of you when you are going 55 miles per hour, and you pull over to the other lane. What happens then?

A: When I got my truck up beside her car, she nailed the gas and made it a drag race.

Q: So she was racing you?
A: More or less.

Q: And then...

A: Well by speeding up, she increased the distance I needed to get by her since she kept running along side of me instead of letting me pass. Had she just pulled out in front of me and let me by her, I could have been around her in the length of a football field.

Q: How far was it from the point where she pulled out of the driveway to the Mingo Creek Bridge?

A: Just over two tenths of a mile, not quite three tenths.

Q: What happened after that?

A: Just as we were entering our side of the Mingo Creek Bridge, I had cleared the front of her and after checking my mirrors I went back over into our lane. Next thing I know she is careening all over the bridge and then she goes into the lane of the oncoming truck and hits him head on.

Q: Did your truck ever hit her car?

A: I never touched her car.

Q: How would you know?

A: I could see in my mirrors as I cut back in.

Q: What happened after that?

A: I was already slowing when I heard a driver on the CB say, “Driver, driver, there has been an accident behind your truck.” I said, “Yeah, I know. I am on the phone now calling 911.”

Q: If you were going 55 miles per hour when the lady pulled out 30 or 35 feet in front of you, why couldn’t you have cleared her in just a few seconds and not much distance?

A: Because she came roaring out and gunned her engine once she got out in front of me.

Q: Are you saying that she gunned it and fully accelerated?

A: Un-huh. Like I said she made it a drag race.

Q: And about how fast were both of you going at the highest speed?
A: I would say somewhere in the neighborhood of 70.

Q: Is it your contention that this wreck was Dorothy Hiller’s fault?

A: No doubt. No doubt in my mind whatsoever.

Q: And you had no responsibility for the wreck?

A: None whatsoever.

Q: And what did she do wrong?

A: One, she pulled out in front of me; two, she sped up to stop me from going by her. I was trying to avoid an accident; she was trying to cause one by speeding up and pulling out in front of somebody.

Q: At what point in the passing of Mrs. Hiller did you first see the other tractor-trailer coming in your direction?

A: Just as I had cleared her at the beginning of Mingo Creek Bridge.

Q: What lane were you in at the time?

A: The left lane. I had already passed Mrs. Hiller and was fixing to get into my right lane when I heard them on the radio.

Q: By them, do you mean the oncoming truckers?

A: Yes, one of them was saying “Back it down, we have a truck in our lane ahead passing.”

Q: What could Mrs. Hiller have done to prevent this accident?

A: All she had to do was talk her foot off the gas and that would have been it.

Q: What did you do about the ticket you got for this wreck?

A: I probably threw it away, I was so pissed off. I’ve never done anything about it.

Q: Did the oncoming truck do anything wrong?

A: No, he was trying to avoid an accident just like I was.
I am Daniel Wilson. I stay off Van Blake Road. I am 35 years old and I am not currently working. I am divorced and live with my girlfriend at her home right now. My educational background is that I went partway through high school and dropped out. I have no schooling since. I have two kids who live with their mothers. I was married to one, but not to the other.

Q: Did you see the wreck in which Mrs. Hiller was injured?
A: Sure did.

Q: What did you see?
A: I saw this old lady that lives down the street from my girlfriend going down Van Blake to the highway. She sort of stopped at the highway stop sign and then pulled out right in front of the truck. She couldn’t have looked. Anyway, the trucker had no choice but to pull into the other lane. Problem was, he couldn’t get around her before the oncoming truck so he had to pull in right in front of her. She apparently slammed on her brakes, lost control, bounced all over the road, and got hit by the oncoming truck. That was about it.

Q: Is there anything else you saw?
A: I think that was it except that I did see the lady’s brake lights come on just before the truck pulled back in front of her.

Q: Where were you?
A: I was on the porch of my girlfriend’s house, hanging out.

Q: What were you doing?
A: Nothing, just watching cars go by.

Q: Anyone there with you?
A: Nope.

Q: Any radio or music?
A: Nope.

Q: TV?
A: Nope.
Q: Were you eating anything?
A: I had some Doritos and some bean dip.
Q: What kind of beer were you drinking?
A: Bud.
Q: How many had you had?
A: Just a couple.
Q: That’d be five or six, right?
A: I had a six that day. I can’t say how many I had by then, but I was fine.
Q: Could you have had all six by then?
A: I doubt it. I didn’t start drinking until a couple of hours before the wreck.
Q: What were you doing before then?
A: Sleeping.
Q: You said that you weren’t working. Why is that?
A: Laid off from the factory.
Q: What was the first thing you saw?
A: The woman going down Van Blake.
Q: How fast was she going?
A: Just normal.
Q: What did she do at the end of Van Blake?
A: She sorta stopped?
Q: What does sorta mean?
A: Well, if she stopped she didn’t stop for long.
Q: Then what did she do?
A: She turned right.
Q: Where was the truck?
A: Man, he couldn’t have been more than 100 feet behind her when she turned.
Q: How fast was he going?
A: Just regular truck speed.
Q: What do you mean by regular truck speed?
A: Most trucks out there run about 65.
Q: What’s the limit?
A: 55.
Q: Was there anyone behind the truck?
A: Not that I saw for some distance.
Q: Did the truck pull over into the lane for oncoming traffic?
A: Right away.
Q: Did he sound his horn?
A: Nope.
Q: What did he do?
A: He tried to pass her.
Q: What did she do?
A: She sped up. It was like she didn’t see him.
Q: Then what happened?
A: It was over in a flash. I saw her brakes go on as the truck pulled over and then she was all over the road and then boom.
Q: Did the truck hit her car when he cut back in?
A: Not that I saw.
Q: Did you talk to the officer?
A: I told him I saw it.

Q: What did he say?
A: He asked me to point out where I was.

Q: Did you?
A: I did.

Q: How far is where you were from where the lady pulled out?
A: I clocked it later. It’s about two or three tenths of a mile.

Q: Did the officer ask you anything else?
A: He asked me if I had been drinking.

Q: What did you tell him?
A: Same thing I told you, that I had a couple.

Q: What did he ask you after that?
A: He kind of blew me off and didn’t ask anything more except for my name and address. He seemed more interested in talking to some woman witness.
DEPOSITION OF EMT EDSEL ALLEN

I am Edsel Allen. I work as a firefighter EMT. I took six months of classes to be an EMT and got my license to do that not long before this wreck. I had been a firefighter already for 8 years then. I remember this accident well. I also wrote a report that I have with me today.

We got a 911 1050 dispatcher call for a motor vehicle accident on Highway 41/51. A 1050 is the call for a motor vehicle accident. We got the call at 1630 and arrived about five minutes later.

Q: Tell us what you found when you arrived on the scene.

A: I pulled up and noticed there was an 18 wheeler and a car that was heavily damaged. I jumped out of the truck and ran over to the car and saw a woman was trapped inside. I ran back to my truck and told them we needed the jaws of life because we had entrapment. The lady’s legs were pinned under the dash and steering wheel.

Q: What happened then?

A: While we waited about five minutes for them to bring the Jaws of Life to the scene, we checked on the woman and the other patient, the driver of the 18 wheeler. The woman was conscious, alert and appeared to be hurting pretty good. I don’t remember her yelling, but I know she was in pain by the way she was entrapped in it. If she wasn’t, she would have come out by the time we opened the door.

Q: Describe getting her out of the car.

A: First thing we did was cut away the windshield post, the A post, to give her some freeway. Then we tried to break the door pins with spreaders. Then we put a chain and a come along on the steering well to get it back away from her. All the time we were doing this, the lady was having to go through more pain because we’re moving her and the car around.

Q: Was the air bag out?

A: Yes, but it was collapsed back down by the time we got there.

Q: How long did it take to cut Mrs. Hiller out?

A: Actual time using the Jaws of Life was 15 minutes probably. We try to do it as quick and as safely as possible because we know moving the people around hurts them.

Q: What happened after you finished with the Jaws of Life?
A: We extricated her onto a back board with C-spine precautions, then some other people took over splinting and bracing her everywhere and then she went to the helicopter which had landed about 500 feet away in the highway. They flew her on to the hospital.

Q: What are C-spine precautions?

A: We put a C-collar around the neck and strap them to the back board to keep the spine stable.
DEPOSITION OF TROOPER C.W. JOHNSON

I am Trooper C.W. Johnson. I have two years of college and I’ve been with the SC Highway Patrol for eight years. I enforce the SC traffic laws, investigate accidents, detect intoxicated drivers and assist in the prosecution of cases. I investigated an accident on April 7, 1999 near the Mingo Creek Bridge.

According to my report, I was called to the scene at 16:32 and I arrived at 17:00.

Q: Can you describe the accident scene when you arrived?

A: This particular accident scene from what I remember was a very nasty accident scene. There were lots of EMS personnel, lots of backed up traffic, a lot of debris in the road, a lot of oil in the road, two very mangled vehicles, one being a Chevy Capri and the other being an 18 wheeler.

Q: When you got to the scene, what did you do?

A: I talked with the EMS to find out who my drivers were, whether they had been transported, what their condition was, and then started to take photographs and to take my measurements.

My job is to find out who the drivers are, talk with each driver and find out exactly what happened and through my training that I’ve received, I apply that to the scene. What I mean is that I look to see if everything adds up, the paint transfer, areas of damage on the vehicle, and just apply it to what I’ve learned.

Q: Who were the drivers in this case?

A: Dorothy Hiller who was airlifted from the scene was driving the Chevy Capri and Charles Cutler was driving the first truck that hit Ms. Hiller and James McGinn was driving the truck that ended up on top of her vehicle.

Q: Was Mrs. Hiller gone when you arrived?

A: No, initially I was told that she was deceased, but shortly after they said that they had resuscitated her and were going to airlift her out. I never really saw her before they flew her off because there were medical personnel all around her. I was told that she wasn’t doing well when I checked on her at one point.

Q: Did you ever talk with Mrs. Hiller?

A: I spoke to her on the telephone a couple of days later. She said she had made a right turn from Van Blake Drive onto the highway and the next thing she knows an 18 wheeler is trying to pass her and he came over on her and hit her. That’s all she told me.
Q: Were you able to talk with Mr. Cutler, who was driving the Fleet Company truck?

A: His story was that Mrs. Hiller made a right turn out of Van Blake Drive directly in front of him and that he attempted to pass her. He saw an oncoming 18 wheeler and attempted a lane change and didn’t think he hit her and didn’t know anything about the accident until someone called him on his CB to say there had been an accident.

Q: Did his story make sense to you?

A: It made sense as far as looking at the damages to the vehicle. I find it hard to believe that he didn’t know he made contact because you can see the damage from his truck to her car in the photo. To me it looks like the damage from his trailer on her car started at the rear of the driver’s door on the car. You could see the damage on his trailer tires on the right rear of the trailer and there was white paint on his tires that looked like it came from her car.

Q: Who else did you interview at the scene?

A: I interviewed Thewanda Finch who said she was directly behind Mrs. Hiller when all this happened. What she said is in her statement which is attached to my police report. She told me, in effect, that all this happened because Cutler tried to pass Mrs. Hiller and cut her off when he went back into his lane because of oncoming traffic. She said Mrs. Hiller did not cut the truck off when she pulled out.

Q: Did you talk to the driver of the oncoming truck, Mr. McGinn?

A: I did. He said he saw a truck coming toward him in his lane which was Cutler driving the Fleet Company truck. Just before they would have hit, Cutler pulled back into his lane hitting Mrs. Hiller and sending her bouncing around and into the front of Mr. McGinn. McGinn said that as soon as Cutler pulled out he got on his brakes because he knew that Cutler would not have room to pass. McGinn also said he radioed the people in the trucks behind them to warn that he was slowing down to avoid an accident.

Q: Did Mr. Cutler deny that he had caused this accident when you talked to him?

A: He seemed a little belligerent when I was talking to him. He was upset when I told him that I was going to report that he was at fault and wanted to know how I could do that when Mrs. Hiller pulled out right in front of him.

Q: And what did you tell him?

A: He was attempting to pass. That was his choice to make the pass and when he attempted to make that lane change is when he went wrong and came over Mrs. Hiller and why I showed him at fault in the accident.
BY DEFENSE COUNSEL:

Q: Now, from talking to Mrs. Hiller and Ms. Finch, you did determine that Ms. Hiller had pulled out onto the highway pretty close to where the accident occurred, is that right?

A: About a tenth of a mile, give or take a few inches.

Q: Mr. Cutler was clear with you that he did not realize he had hit anyone, isn’t that right?

A: He said the first he knew of the accident was when he got a call on the CB.

Q: When you looked and photographed the side of the car, that was after the Jaws of Life had been used to get Mrs. Hiller out, correct?

A: Yes.

Q: You said you saw marks on the right rear tires of the trailer and photographed them?

A: Yes.

Q: Did you photograph any other tires?

A: No.

Q: Mr. Cutler was in a legal passing zone, right?

A: Right.

Q: And the road was level, clear, and straight for some distance.

A: Correct.

Q: How far was it from the site of the collision to where Mrs. Hiller pulled onto the road?

A: One tenth mile. I didn’t measure it exactly but that’s a very close estimate.
DEPOSITION OF DEFENDANT’S ORTHOPAEDIC SURGEON DR. SHISLER

Q. Identify yourself please.

A. I’m Herbert Shisler. I am a practicing orthopaedic surgeon in Asheville, North Carolina.

Q. Could you please tell me a bit about your educational background?

A. Yes. After attending public schools in Maryland I attended Harvard College. I received my BS degree in physics in 1982. I then moved on to Yale where I studied Medicine – receiving my MD degree in 1986. I completed a one year surgical internship at the Hospital for Special Surgery in New York City. I remained at HSS to complete an orthopaedic surgery residency in 1991. After my residency I spent one year in a total joint arthroplasty fellowship at UCLA.

Q. Are you board certified in orthopaedics?

A. Yes. I am board certified in orthopaedics and am a member of the Knee Society and a Fellow of the American Academy of Orthopaedic Surgeons. My practice focuses on hip and knee replacement – mostly knee replacement.

Q. Dr. Shisler, have you ever been asked to testify in medicolegal cases before?

A. Yes I have.

Q. And when you testified in the past – how many times would you say you have testified?

A. Perhaps a dozen or so.

Q. And on those previous occasions were you called to testify for the defendant or for the plaintiff?

A. Well, I’ve testified for both.

Q. Of the 12 times you mentioned you have testified how many were for the defense and how many were for the plaintiff?

A. Perhaps 10 for the defense and 1 or 2 for the plaintiff.

Q. Dr. Shisler, are you being paid by the defense to give your testimony today?

A. No. I’m being paid by the defense to be here and give truthful and honest answers to all questions. My testimony has not been purchased. My time is being reimbursed – just like yours.
Q. How much are you being paid today?
A. I am being reimbursed at a rate of $450/hour.

Q. Doctor, what have you done related to this case?
A. I was asked to review the medical records by defense counsel and give my opinions as to the extent of Mrs. Hiller’s injuries, the appropriateness of her treatment, her likely needs for future treatment and her disability, if any.

Q. Did you review anything else?
A. Some copies of her X-rays, and her deposition and that of Dr. Martin.

Q. Is there anything you requested that you did not receive?
A. No.

Q. Anything you received that you did not review?
A. No.

Q. I would first like to ask you some questions about Mrs. Hiller’s right knee. You did have a chance to review the x-rays of Mrs. Hiller’s patella fractures and of her right tibial plateau fracture as they appeared prior to her knee replacement did you not?
A. Yes.

Q. Let me share with you first the film of the right knee. Now in looking at the x-rays of Mrs. Hiller’s right knee how would you describe her right patella fracture?
A. The patella fracture involves the upper half with a fragment from the upper pole swung outward. There is a soft tissue injury above the patella but I don’t see any air in the knee to suggest an open fracture. The tibial plateau fracture involves both the lateral and the medial plateau. Both of these areas are depressed – actually crushed. The lateral view confirms this significant compression. The bone appears to be very osteoporotic. I agree with their decision not to try to operate on this fracture.

Q. Now I would like to show you the x-rays of Mrs. Hiller’s left knee. Looking at the x-rays of Mrs. Hiller’s right knee how would you describe her left patella fracture?
A. Well the left patella fracture is even more comminuted – by that I mean it is in many more pieces. The articular surface of the patella is disrupted. I know from the record that they placed a circular band around the left patella to try to reduce this fracture.
Q. Now I’d like you to take a look at these x-rays of Mrs. Hiller’s left knee replacement as it appeared just after surgery. Could you tell me what you see in this post surgical film?

A. The knee replacement appears to have been well done. The femoral, tibial and patella components are all well aligned.

Q. Would you say that the x-ray looks stable?

A. The x-ray suggest that the sizing and positioning of all of the components is correct. Given that it is likely that the knee is stable.

Q. Can you know for sure without examining a knee whether it is stable?

A. No.

Q. And what would be the significance of an unstable knee replacement?

A. Assuming, hypothetically, that the knee replacement was unstable, then the components would have excessive motion and excessive wear.

Q. Would an unstable knee replacement be more likely to fail?

A. An unstable knee replacement would be more likely to need revision and revision surgery is by definition indicative of failure.

Q. Are there any other problems that can go along with an unstable knee?

A. I want to be certain that you understand that I have not said that this knee is unstable.

Q. Certainly. Are there any other problems that can go along with an unstable knee?

A. Well yes. An unstable knee replacement is likely to buckle or even dislocate. If a balancing of the ligaments and the replacement components has not been done correctly the knee can give way side to side or front to back. The patella can dislocate. Bad things can happen. But again, I am not saying that Mrs. Hiller’s x-rays show any evidence of instability.

Q. If the components in an unstable knee replacement were to suffer increased wear what would happen?

A. In the case of excessive or unusual strain the polyethylene liner will wear and polyethylene debris will collect in the joint. That debris can lead directly to loosening of the components.
Q. How does it lead to loosening?

A. The molecules of polyethylene induce an inflammatory response. The inflammatory response release chemicals that can directly breakdown the bone/cement bonding.

Q. How long will it take for this to occur in an unstable knee?

A. It is hard to say. Perhaps 5 years or less.

Q. Could you refer back to this x-ray of the right knee plaintiff and comment specifically on the patella?

A. Yes. The patella has been resurfaced. The bone appears to have healed following that previous fracture. The patella replacement button is placed slightly medially as is often done.

Q. How thick is the patella?

A. Yes this patella measures about 15mm thick with the implant. The minimal thickness of the bone is 6 or 7 mm. The fracture has healed with the patella spread a bit laterally and medially. I think it may also be spread a bit superiorly and inferiorly.

Q. What risks are associated with a thinner patella following a knee replacement surgery?

A. We like to keep the minimal thickness of the patella to 10mm since the literature shows an increased incidence of patella fracture if it is thinned below that thickness.

Q. And if a patella fracture occurs following a knee replacement a surgical, what has to be done?

A: A repair is sometimes required to correct that problem. Not always.

Q. How successful are those repairs.

A: Some patients do well, others do not.

Q: What is the significance of osteoporosis for future fractures in an older woman?

A: It increases their risk depending on the severity of the osteoporosis.

Q: From the X-rays what can you say about Mrs. Hiller’s case?

A: She clearly has it but it is not the worst case I ever seen.
Q: What is the effect of balance and gait problems on the risk for fracture?

A: I haven’t seen studies on that but I would think it would increase a person’s risk.

Q: Getting back to the area of the knee. If an elderly lady with a knee replacement and significant osteoporosis were to fall would she be at increased risk for fracture about the knee?

A: Yes she would.

Q: Tell us about that.

A: Such a fall might cause a fracture about the knee. Usually the fracture occurs at the distal femur. These fractures are notoriously difficult to treat. Surgery with bone grafting is usually required. Loss of range of motion usually follows and the rehabilitation can be extensive. Following such a fracture elderly patients often are relegated to the nursing home for skilled care.

Q: Would such a fracture potentially cause a more early failure of the knee replacement necessitating revision surgery?

A: Yes that is possible but I really can’t speak to the statistics or likelihood of that effect.

Q: A revision surgery of the knee is a more difficult surgery?

A: Yes it certainly is.

Q: Is it also a more expensive surgery?

A: Yes, about 30% more expensive.

Q: Are there greater complications in revision knee surgery?

A: Yes, we see more complications in repeat total knees.

Q: How does the risk of infection change for revision surgery?

A: In primary knee replacement the risk of infection is about 1%. In revision knee replacement that risk increases to 2% to 4%.

Q: How is the range of motion after a revision?

A: Not quite as good – often 10 degrees less.
Q: Overall, can you assign percentages of success to total knees and revisions of total knees?

A: Revisions in general do not do as well. In primary knee replacements 90% have a good or excellent result. In revision knee replacements the number of fair and poor results increases.

Q: How about the life of a revision surgery?

A: Much shorter. The articles speak to an 80% survival of the implant at 5 years.

Q: Do you feel that the orthopaedic treatment that Mrs. Hiller received was adequate?

A: In general I would say it was quite good.

Q: Do you have any criticism of any part of her orthopaedic care?

A: No, not really.

Q: Is there anything you would have done differently in managing Mrs. Hiller’s case?

A: No I don’t think so.

Q: Is there anything she failed to do or did not do well that made a difference in her result?

A: Not that I could see.
DEPOSITION OF RECONSTRUCTION ENGINEER CHARLOTTE DARLING

My name is Charlotte Darling. I am a licensed professional engineer in South Carolina and have been for the past ten years. I went to the University of South Carolina for my bachelors and masters degrees, both of which were in engineering. Ever since leaving school, I have worked for SCRE, South Carolina Reconstruction Engineers in Columbia. All we do is analyze failure to determine the cause. We work on accidents – auto, aviation, construction, nautical and others. We also do materials failure analysis. Some of our engineers worked for NASA on the Challenger shuttle crash from the standpoint of analysis of the O-ring failure.

Q: What were you asked to do in this case?
A: I was asked to review the report and deposition of Michael Benson, the accident reconstruction engineer employed by the plaintiff in this case.

Q: What did you review?
A: Just those two things and the trooper’s accident report.

Q: Any depositions?
A: No, I was not asked to do that.

Q: Any witness statements?
A: No, really, all I read was just the accident report and the Benson report. Nothing else.

Q: Aside from reading, did you look at anything else?
A: No.

Q: Go anywhere?
A: No.

Q: Have any other information at all when you were doing your work on this case?
A: No.

Q: Let me turn your attention to the opinions given by Mr. Benson in his report, you have a copy in front of you right?
A: I do.
Q: With which ones do you disagree?

A: Well, some of them are not even appropriate subjects for opinions of an engineer. For example, he says “Mr. McGinn stated that he was reducing speed in response to the Cutler truck.” That’s simply a quote from a witness which may or may not be true. So, it’s not so much that I disagree with that but that it’s just not an appropriate opinion.

Q: Any others like that?

A: In the same one, number 8, Mr. Benson says, “Mr. Cutler moved his truck into the side of the Hiller’s car to avoid a head on collision with Mr. McGinn.” He’s entitled to his opinion about whether the Cutler trailer hit the Hiller’s car, but he has absolutely no way to know why it happened, even if he thinks it did happen.

Q: Do you dispute his finding that the trailer hit the car?

A: No, I don’t dispute it in the sense of having an alternate theory. One can make the case that the rear wheel of the trailer on the non-driver side did make contact with the front driver’s side of Hiller’s vehicle. On the other hand, after a full investigation other explanations might emerge. So, the answer to your question is that I don’t dispute it, but I don’t agree with it either.

Q: Are there other things that Mr. Benson says in his list of opinions that you think are not opinions or not appropriate opinions?

A: No, I think those are the two that fit in that category.

Q: How about opinions that you agree with?

A: Well, I agree with his first opinion that Mrs. Hiller turned right from Van Vlake (or Van Blake) Drive onto northbound SC 41. And I agree that it is approximately 1,575 from Van Vlake to the south end of the bridge at Mingo Creek on SC 41.

Q: How do you know whether you agree or not?

A: I called the SC DOT and asked them to measure it off their highway map and they did that for me.

Q: What else did you have them do?

A: That’s it, other than confirming that the limit there is 55 miles per hour.

Q: Did you talk to anyone else, anywhere, other than counsel for the defendants, in doing your work in this case?

A: No.
Q: Any other opinions you agree with?

A: I agree with the second opinion that the initial impact was south of the south end of the Mingo Creek bridge because Mr. Benson does not purport to know exactly where it was since apparently there were no marks on the road. I think “just south” may imply more than he knows but I suppose it is acceptably vague.

I also agree that Mr. Cutler moved from the southbound lane to the northbound lane after passing Ms. Hiller. There’s no other explanation that’s consistent with the physical evidence other than Mr. Cutler was passing Ms. Hiller in the southbound lane and then returned to the northbound lane.

And, also in number two, I agree that if there was contact between the Cutler and Hiller vehicles, the initial contact was between the right side tires of the trailer and the left fender and driver’s door of the car. I should point out that Mr. Benson’s opinion is either intentionally or accidentally vague where it could be more specific in two places. He could have said the right side rear tires of the trailer and he could have said the front fender of the car. I would be interested to hear his explanation of why he left those two pieces of information out. With those pieces in place, I agree with his second opinion based on the evidence I have seen and without conducting my own investigation.

Q: Any others you agree with?

A: Yes, I agree with number 5 about the sightlines. I drive that road occasionally and I have been by there since and he is correct about that.

Q: Did you do any investigation at the scene?

A: No, just that one drive by.

Q: Did you stop?

A: No, just slowed so I could eyeball the dents in the guardrails and the gouges in the road.

Q: Anything you saw that was inconsistent with Mr. Benson’s field investigation and report?

A: No.

Q: Did you make any other observations that you have relied on in giving your opinions in this case?

A: No.

Q: Do I take it then that you disagree with opinions three, four, six and seven?
A: Yes.

Q: Any others?

A: No other than what I said about number eight already.

Q: What do you disagree with in opinion three?

A: It’s simply impossible for him to say what he is saying there with any degree of accuracy?

Q: Why?

A: There are so many variables that he needs to estimate to say that and not enough information on which to base his estimates or assumptions. For example, to do this calculation he needs to know how fast she accelerated. He says it took her 25 seconds to travel from Van Vlake Drive to the initial point of contact. Do we assume he is including the time it took her to start up and turn? Do we start counting from after the turn when she is already on 41? We don’t even know when he starts counting from his report or from his deposition. Even if you assume that he starts from when she was on Van Vlake, how do you know how long it took her to go approximately that distance? If she gunned it from the start knowing that she was cutting in front of the truck, it would take one amount of time. If she took her time accelerating, oblivious to the truck, it would take much longer. There’s no way to know for sure so what he did was assume that Mrs. Hiller was telling the truth which he should not be doing. If he’s doing his job correctly he has to base his opinion on objective data.

Q: Do you have any other disagreements with Mr. Benson’s third opinion?

A: Yes. If he can’t know her rate of travel, then he must have some way of measuring how long she was traveling before the impact. This requires knowing where the impact was and as to that he can only speculate because there were no marks on the roadway associated with any impact between the Cutler and Hiller vehicles, only for the impact between the McGinn and Hiller vehicles. No matter how you cut it, there is no reliable scientific basis for saying where this wreck took place or how long she was traveling until she reached that point.

Q: Any other criticisms of the third opinion?

A: No.

Q: What disagreements do you have with opinion number four?

A: This is entirely based on speculation. He backs it out from his time and distance opinion. He bases it on the witness’s statements about speed saying they are consistent, but they aren’t. Among other things, you would have to base it on assumptions about the
speed of the Cutler truck approaching Van Vlake and then factor that in with the opinion in number three that we already discussed. That’s all entirely speculative. While we can get a range of speed for the truck and for the car, when you put both ranges into an estimate, you would get an enormous range. How anyone can say with a straight face that it was at least 800 feet is beyond me. There is no objective evidence on which to base that opinion. Remember, all we have in this case is lots of different witnesses saying different things, banged up guardrails on both sides of the road, and a gouge where the McGinn and Hiller vehicles collided. He can make a rational case for Cutler passing Hiller, then sideswiping Hiller as he pulls back in, for Hiller first hitting the railing on the right and then on the left, and for Hiller hitting McGinn in his lane, but that’s all the physical evidence will support. His estimate of 800 feet is absolute junk, there’s no science to it.

Q: Did you calculate the ranges and if you did what was the closest you had the truck to the car when the car pulled out?
A: No.

Q: Why didn’t you do the calculation?
A: I didn’t think it would be helpful – reliable. I do not believe it can be done accurately without taking one person’s version over another. I can assure you that if I wanted to pick some versions and ignore others as he did, the truck would have been much closer to the car when it pulled out. That’s obvious.

Q: Do you plan to do it between now and the trial?
A: Depends on whether defense counsel asks me to do it. I will not be doing it unless asked.

Q: What are your opinions about Mr. Benson’s sixth opinion?
A: It depends on the two we just discussed, so it includes and compounds the errors in the earlier opinions. If he is unreliable as to the time it took Ms. Hiller to go the distance from Van Vlake to the sideswipe and therefore about her rate of acceleration, and if he is unreliable as to the distance the truck had before reaching where Ms. Hiller entered the highway, because he cannot know the speed of the truck as it approached, then he cannot reliably say that the truck had no need to brake or take other evasive action when the car pulled out.

Q: Are those all your comments about the sixth opinion?
A: All I can think of.

Q: Are there any opinions in the written report with which you disagree other than number seven that we have not talked about?
A: No.

Q: OK, let’s finish the report with number seven. With what do you disagree in that opinion?

A: This is the culmination of speculation piled on speculation and adds a new assumption. Here, based on all the assumptions that have gone before, Mr. Benson opines that Mr. Cutler could have braked and pulled in behind Mrs. Hiller once he was out in the southbound lane. Of course, to make this opinion correct, Mr. Benson has to assume that Ms. Hiller doesn’t brake at the same time thinking that’s what she should do to help Mr. Cutler get around. Of course, he admits in his deposition that some witnesses say that she did brake before the sideswipe. If they both brake, then Mr. Cutler is stuck in the southbound lane and what we have is two massive trucks running head on into each other.

Q: Anything else you have to say about what’s wrong with opinion seven?

A: No. That’s it.

Q: Now let’s talk about Mr. Benson’s deposition. With what that he said there do you disagree?

A: A lot but I think I’ve pretty much covered it in going through his opinions.

Q: Is there any other disagreement with his opinions or what’s in his deposition that you can think of as you sit here today?

A: You’ve heard all the ones that matter. I am just astounded that someone would be willing to give opinions based on what some witnesses say and ignoring others. I understand that after doing reconstructions you sometimes have to say about witnesses that they cannot be right or that they have to be right, but this guy completely turns it around and decides who is telling the truth first and then reaches his opinions based on that. When he’s doing that, all he is is a calculator for one side of a case not an independent engineer. That’s it. That’s my speech for the day. I’m done.

Q: Thank you for your time today.
DEPOSITION OF DOROTHY HILLER

My name is Dorothy Hiller and I was born on 4/30/31. I went as far as the 7th grade in school in Williamsburg County in South Carolina. I lived most of my life except for a couple of years in South Carolina. Those couple of years were in Virginia just after I got married.

My husband was James Hiller. We married in 1946. I worked as a waitress at the bus station in Florence, SC and at South of the Border in Dillon, SC. Then I worked at the Duplex Envelope Company factory for six years and as a dispatcher for the Yellow Cab Company. Later I worked at Reynolds’s Drug Store in Andrews, SC and at Oneida Knitting Mills in Andrews, SC. I think Oneida was the last job I had before I quit working.

I have two kids. One of them is Randy, sitting over there. His real name is Johnny but we call him Randy and he was born in 1955. My older son is Jerry and he was born in 1952. Jerry sells vending machines and lives near Richmond, VA. Randy does construction work and also lives in Richmond. I’ve got several grandchildren ranging in age from the oldest at 22 to the youngest who is 2.

My husband died in 1989 of cancer. He was a supervisor at the Oneida Knitting Mill. He also worked as a machinist at Duplex and did something for Phillip Morris. I remarried about a year after my husband passed away and we were together for eight months but it didn’t work out and we were divorced.

I get social security for a spine disability from a car accident in 1958. It was a one-car accident where I lost control on a bad curve because I was going too fast and I hit a light pole. There was no lawsuit or anything. In fact, I have never sued anyone before this and nobody has ever sued me. I have had a couple of speeding tickets in my life but nothing more than 10 or 15 miles over the limit and those were years and years ago. I did have to see a psychiatrist after the wreck where I hit the pole. I was pretty depressed after that and they give me some pills for a while but I did better after a while and they had me stop taking them.

After my husband died and the remarriage didn’t work out, I lived alone and took care of my dogs and chickens. I took care of myself just fine, thank you. I had a man who helped me cut the grass using my riding lawn mower. I wanted him to teach me how to drive it but I don’t think he believed me but eventually he did and I was cutting my own grass after that. I had a riding lawn mower and a weed eater to cut the grass by my fence. My place was an acre and a half with the river out in front. I got a little two-man boat down there with an electric motor for fishing.

Since the accident I don’t drive. I’ve tried but my legs don’t work well enough. I can’t do volunteer work like I used to. I used to visit the sick, fix meals for them and help them.
Before this, I never really had a family doctor because I was never really sick. I had a chiropractor friend who would check my back from time to time and adjust it but that was about it. I did have a doctor I saw for an irregular heartbeat, a think they called it a flutter, but I took some pills for that, half of a 25 mg. Tendonol each day. I was on that medication for about a year before the accident.

I think I had some arthritis in my spine before this but I never got any treatment other than the occasional adjustment from a chiropractor. If I got a cold or flu I just doctored myself. I never got regular physicals. I think I once got one for a job but that was about it.

I’ve never been charged with any kind of crime and just had those two speeding tickets I told you about.

Q: Tell us what you did on April 7, 1999?

A: Well, I got up like usual and it was on a Wednesday. And I went to visit with my friend in Andrews, Faye Lyons. And I would go down and we would have – I’d go by Hardee’s and pick up some coffee and maybe a sweet roll or something for us. Or she would bring things and we would have coffee and sit around and talk some that morning. And I do little things for her and then I would go back home. I did that and I went back home. Then I was going up to Hemmingway to get my lunch. Sometimes I would go around to the Senior Citizen Center, and then I would just buy it maybe at the Hardee’s or Burger King or Seafood Shack. If it was late enough in the day I would eat at the Seafood Shack a good bit.

Q: So what happened then?

A: I left my house going to Hemmingway and I was about a mile from my house when all this happened. I’m not real good at distances. I had been on the road for four or five minutes, I guess. I left the house and went out to the highway, 41, and I stopped. I looked. And I saw the truck, it was way down the road and I knew I had plenty of time to get out. I pulled out and turned right. When I got up to 55, I hit my cruise control. And shortly after I hit my cruise control I was at the bridge where all this happened. Right then the truck pulled up along side of me and just as he got his cab by me he jerked to the right real good and ran me into the guardrail on the right and then I bounced off and went back across the road. By now my hands had been knocked off the wheel. Then I hit the guardrail on the other side and then I got hit by the big dump truck.

Q: You said when the cab got by you he started cutting in on you?

A: Looked like it jerked it over on me.

Q: Now did his truck or trailer hit your car?

A: I don’t know what hit it, but as his cab got by me there, I went over on the ---
Q: So something either pushed or knocked your car on the guardrail?
A: Knocked me over on the guardrail.

Q: Then you bounced off that guardrail across the road and hit the other one?
A: The other guardrail and then that, back in front of the truck.

Q: Were you ever knocked out?
A: I don’t hardly know. I remember somebody saying the cops will be here in a moment and then they covered my face while they were cutting me out. I don’t remember them taking me out of the car, but I do remember being in the helicopter and then the next thing I remember is being in the emergency room, they was doing something to my legs and I was hollering, telling them it hurt, don’t move it, it hurts, and things like that.

Q: About how long had you been on 41 before this happened?
A: Not but a few minutes.

Q: Was it more or less than a mile?
A: No, sir. It was – it wasn’t very far. Because after you turn on the road, on 41, you don’t go very far until you hit the bridge. But I had – when I pulled out on the road I hit – I got my speed limit up to 55 and mashed my cruise control. And shortly after – but that was before I hit the bridge. And right after that I hit the bridge and then the accident happened.

Q: You broke your finger and have a knot in it now, right?
A: Yes.

Q: You broke a bone in your right hand?
A: Yes, the one that runs into my little finger.

Q: Did you have any other broken bones in your right or left hand or arm?
A: No, but for a long time afterwards pieces of glass were working their way out of my hand in different places.

Q: Did you cut your face or break any bones there?
A: I don’t think so.
Q: So, you had to do pretty much everything with your left arm and hand for a while, right?

A: Yes, sir.

Q: Now, I understand you broke both of your knee caps, right?

A: My right kneecap was cut in two, and my left one was broke up. My left ankle and heel was all squashed up, broke up. And my left foot had two broke toes. I also broke a bone that runs down the left side of my leg on the outside.

Q: Did you break any of your thighbones or your hip?

A: No.

Q: You had your right knee replaced?

A: Right. They did total replacement in both legs. They tried doing it with a scope on the left one but that didn’t work so they had to replace it.

Q: Had you had arthritis problems with your knees before this?

A: Not before this, no, sir.

Q: Did the knee replacements get rid of your pain in your knees?

A: No, sir, I’m still in pain all the time. It’s not as bad but it’s still there.

Q: Does your left ankle hurt you?

A: Yes, sir. It’s in pain right now.

Q: Even sitting?

A: Even sitting.

Q: How about your right ankle?

A: It’s fine.

Q: And your hips and pelvis?

A: No problems.

Q: How about your right hand?
A: Both elbows give me trouble.
Q: Anyone tell you where that came from?
A: I say it’s arthritis.
Q: Do you still have to use a wheelchair?
A: No.
Q: How about the walker?
A: Only when both my legs are hurting me bad.
Q: And your cane?
A: I can get around without it at Randy’s because it’s small enough that I can always touch something, but if I go out, I never go out without my cane.
Q: Are you still getting physical therapy?
A: No, but I still do my exercises and have my bike to keep my legs moveable.
Q: You use an exercise bike?
A: Every day for at least ten minutes.
Q: Who do you live with now?
A: I’ve been living with Randy pretty much since I was well enough to be transported to Virginia. There was no way I could take care of myself. Randy’s now built a room and a bathroom onto his house for me. It’s got an intercom and everything. It’s nice but I still want to go back to my house in South Carolina and my friends but they tell me they have to either tear down the house or make lots of changes so I can get around with the walker when I need it.
Q: Have you been treated for any depression since this wreck?
A: No, sir. I have had something to help my sleep, but as far as depression, I haven’t had any. When I get depressed, I usually find Randy and cry on his shoulder and he’ll calm me down.
Q: What do you take for pain now?
A: Tylenol 3. I’ve also used Darvocet and two or three others I can’t remember.
Q: What have you been told about driving?

A: That I should be able to do it eventually.

Q: Have any of your doctors told you that you are going to need more surgery?

A: Dr. Martin told me I might have to have my knees replaced since these will only last for 10 or 12 years.

Q: Is there anything else you would like to tell us about this wreck or explain about your health?

A: It’s just changed my life all together because I can’t be in my home. I can’t do things like I want to. I can’t even visit with my other son because I can’t get up his steps. And I can’t be with my granddaughter, my great-grandchild because they live some distance away and I can’t drive to see them.

I can’t clean and do things like I want to. And I have to depend on somebody to take me everywhere I go. And you – you finally reach the point that you feel like people gets tired of doing that, and it is just putting an awful strain on me. If I could just get it straightened out and go back home where I could do for myself and be able to go and come like I want to and do for other people like I want to, but right now I can’t do that.
DEPOSITION OF ROBERT MARTIN, M.D.

I am Bob Martin and I work at the Medical College of Virginia in Richmond where I am a professor of surgery and chairman of the Department of Orthopaedics. I have been there since 1976 and have been Chairman since February of 2002.

I got my bachelors at Lehigh University in industrial engineering and applied science in 1966 and 1967, respectively. I went to the University of Pennsylvania Medical School and graduated in 1971. Then I went to Duke University where I did an internship in medicine and then six months of a surgical residency. In 1972, I joined the orthopedics department at Duke and did an orthopaedic residency for four years which I finished in 1976. I’ve been here ever since.

I am board certified in orthopaedics and hand surgery, 1977 for orthopaedics and 1990 for hand surgery. I specialize on hand and upper extremity, feet, ankles and trauma. I give depositions about three times a month.

I have treated patients of plaintiff’s counsel before since they are one of the bigger firms in town. I probably testify for their clients three times a year on average.

I do total knee replacements fairly often, probably 50 a year. That number has increasingly slowed over the years. I have edited one book relevant to this case called Complex Foot and Ankle Trauma. It’s published by Lippincott. In addition, I’ve written many publications on ankle fractures and trauma around the foot. My CV has all of them listed. Yes, it is 37 pages long.

I am a member of the American Orthopaedic Academy and the American Orthopaedic Foot and Ankle Society. I am a member of the American Society for Hand Surgeons, and I’m a member of the Orthopaedic Trauma Association, past member of that – founding member.

Q: When did you first see Mrs. Hiller?

A: About two months after her injuries which were in April of 1999. My first office note is dated May 10, 1999.

Q: Do you know how she was referred to you?

A: I really don’t.

Q: Had you ever seen or heard of her or any members of her family before that date?

A: No.

Q: When she presented herself to you, what were her chief complaints?
A: She had multiple injuries and she was in a wheelchair. She had fractures of both kneecaps, a tibial plateau fracture which is a fracture through the articular surface of her tibia. She had a fracture of her heel called a calcaneus fracture on the left side, which had flattened and crushed her heel. She had a metacarpal fracture on one of her hands. Those were the major issues.

Q: Other than talking to her, what records did you have?

A: They brought X-rays with her and we took more of our own. I also think I had her records from South Carolina, or at least relevant portions.

Q: Have you ever spoken to any of the South Carolina doctors?

A: No.

Q: Have you ever seen her pre-accident medical records?

A: No.

Q: What was or is your understanding of the treatment she had before she saw you?

A: She was placed in various casts for her heel fracture. She also had splints on both her knees for her patellar fractures and her plateau fractures. The fracture was open on the side she had the plateau fracture on, and so that was cleaned out on her initial admission in SC.

Q: What was her condition when you saw her in May of 1999?

A: Well, the condition of her injuries were that they – one injury alone would have been enough for a person, but she had – because of the osteoporosis that she has, or her limitation in her density of bone, that when – she had significant joint fractures in both kneecaps and to the tibial plateau and to the heel, each one as a separate entity would have been a problem fracture because they entered the joints. As I put in my note, I was worried that if she put any weight on the tibial fracture she could split apart that fracture.

Q: What did you recommend for treatment?

A: We started her in a range of motion program, but not weight bearing.

Q: Moving forward to your June 11, 1999 note, you say “The patient demonstrated that she is slow to heal these various fractures.” What did you mean by that?

A: She had multiple injuries and she had osteoporosis. When you have multiple injuries, your nutritional status for healing one injury is enough, but with multiple injuries, there may not be adequate nutrition or adequate cellular activity to heal all these fractures at once. So I thought she was a little delayed in her healing properties.
Q: How long did you keep her non-weight bearing?

A: I believe for about two and a half months after her injury. We like to get people up as soon as possible because the bone heals quicker but in her particular case we did not feel it was appropriate.

Q: On July 12, 1999 you sent her into rehab, is that correct?

A: Correct.

Q: How did she do in rehab?

A: She did well. She, you know, tried to get up, had a hard time, had pain in both her knees, pain in her heel. The metacarpal of her hand was healed by that time so she could put weight on that. She participated actively and I think did pretty well considering her injuries.

Q: As of August 9, 1999 you were uncertain whether she would need knee replacements?

A: Yes. She had major pain in both knees. I hoped she wouldn’t need replacements, but as time went on it was clear that she would. My hunch was all along she would need replacement first, if at all, on the side that had the tibial plateau fracture. But, what you do is you let them heal and go through rehab fully. If they continue to have pain and discomfort to the point where they can’t walk, then you consider a total knee. All these people need a total knee, we just try to see if they can live without it.

Q: Your next note from September 8, 1999 indicates you were considering arthroscopic surgery. Why was that?

A: This is less intrusive than a total knee so we were thinking about trying that first to see if we could avoid doing a total knee on that side. Sometimes you can smooth out the kneecap or do a chondroplasty, shaving away some of the cartilage or rough areas down.

Q: On December 8, 1999 you note the development of arthritic disease in her right knee. In your opinion is this related to her traumatic injuries?

A: Yes, she had no preexisting problems that we know of.

Q: How do you know that?

A: You can tell by looking at her original X-rays. She had no spurring or degenerative changes in her knee. All she had was fracture findings.

Q: What did you use for the injection you gave her in December?
A: Cortisone and a long and short acting anesthetic. We do that to decrease inflammation, decrease pain and improve the ability of the patient to use the joint.

Q: How did she respond?

A: Initially, pretty well, but always when you have fixed articular problems, she subsequently didn’t respond as well to future injections.

Q: In February you recommend the arthroscopy, correct?

A: Yes, just on the left knee because it had the least injury and the best chance of success. I was trying to get her a useable knee as quickly as possible.

Q: Your note mentions a lot of arthrosis under her knee cap. Was that related to the traumatic injury?

A: Yes, she had patellar fracture with articular changes.

Q: When did you do the arthroscopy in the left knee and how did it go?

A: March of 2000. Essentially we put a telescope in the patient’s knee with the patient asleep, and we looked at her joint. She did have minor changes in the joint itself, but the menisci, the shock absorbers, were intact.

Her abnormal findings were underneath her kneecap where we shaved her kneecap down and then did what we call a lateral retinacular release, which is releasing the tissue on the outside to allow decrease pressure on the kneecap.

Q: Were the changes you found under the kneecap directly related to the trauma?

A: Yes. I say that because she had no prior history and because her initial X-rays did not show degenerative changes.

Q: How did she do after this procedure?

A: She did pretty well for a while, but her right knee was a real problem. I’m not sure why they were worse then, maybe because she was more active after we worked on her left knee, but her problems were not surprising given the extent of her injury.

Q: What did you do then?

A: We injected the right knee with the same medications we had used earlier.

Q: How did she do?
A: She continued to have problems and we started talking about a total knee on the right side.

Q: Why?

A: With a total knee we hope to get a knee which is stable, which they can walk on with or without a cane. Usually, the results are good.

Q: Should a total knee replacement result in pain relief?

A: It may, but total knees are notorious to have some aching associated with them. They are not like total hips. Total hips are a lot better than total knees for pain relief because the knee is so superficial. It has a difficult time with the long therapy required and the total knee incision is pretty traumatic to the tissues. So, I guess the answer to your question is that I never seen anyone with total pain relief after a total knee because the scar tissue that forms after the procedure and the nerves that have been cut during the procedure. I think the problems that remain are mainly soft tissue and nerves initially and wear patterns and breakdown of the prostheses latter.

Q: Does the total knee eliminate concerns about post traumatic arthritis in the knee?

A: It helps a great deal.

Q: How long should a total knee last?

A: Depends on weight, osteoporosis, and their co-morbid state. I like to see them last about ten years. If she doesn’t walk much and is particularly sedentary she might go longer but I wouldn’t say that was probable. If she is very active, it could well last less. Again, though, I think it will probably last ten years in her case.

Q: You ended up doing the other knee, too. Why didn’t you do them both at once?

A: You don’t really want to do both knees at the same time unless you’re forced to because it may be that if you do one knee that’s good enough and you don’t need to do the second one.

Q: Is there any possibility that Mrs. Hiller would have needed one or both knees replaced if she hadn’t had this traumatic injury?

A: I don’t feel this patient had any history that would be indicative that she would be needing total knee services or knee arthritis services before the accident.

Q: What do you make of the fact that before this traumatic injury, Mrs. Hiller had arthritic changes in other parts of her body, in particular in her lumbar spine?
A: Everyone gets spinal stenosis and degeneration of the facet joins and slippage of the joints because the joints are moving as they get older. I didn’t see anything in looking at her initial X-rays that indicated that she had underlying arthritis in her hips, knees or ankles.

Q: She had osteoporosis and osteopenic bone, doesn’t that make her more likely to have arthritis?

A: No, osteopenic bone and arthritis are two different processes. Actually, if people are osteoarthritic they are not osteoporotic.

Q: How did she do after her total left knee?

A: Well. There were no adverse events that I know of.

Q: Why did you recommend that she have a total right knee?

A: Ongoing continued symptoms.

Q: Is it your opinion that both total knees were necessitated solely because of the auto accident?

A: Yes.

Q: How was her course after the right total knee?

A: Pretty normal.

Q: What was her condition when you last saw her?

A: She still had some soreness in the lateral tibia of her left knee.

Q: What is her prognosis with regard to her knees?

A: Both knees have to be watched and they have to be protected with antibiotics if she goes to the dentist or has any other type of surgery. I think she still has a gait problem where she’s walking with very short steps and a broad-based gait, which means she’s unsteady. I suspect the pain she has now will continue. She’s almost a year out of surgery. I also anticipate that after ten years she will need two new knees.

Q: Please review the treatment and prognosis for her calcaneus fracture.

A: Initially she was given a soft dressing and then a cast. We’ve done no surgery or anything like that. I have not given her any orthotic devices. We talked about a brace but she didn’t want to wear it. At some point in the future she will need a fusion of her subtalar joint, a part of the hind foot. That’s a surgical procedure done with bone graft
taken from her pelvis and a couple of screws. She'll be in the hospital a total of three
days. She'll also need about ten weeks of PT after that. That should improve her left
heel pain. That should take care of her heel as best we can. She can do that whenever
she is ready.

Q: What would you expect the effects to be on her daily activities from her injuries?
A: She’s still pretty weak from her injuries. She walks with a very short gait and a
limp. She often needs a cane. She has to live with a full time attendant because of her
unsteadiness and weakness. I just don’t think she will ever get to the point where she will
be independent again because of her unsteadiness, her problems with stairs, and her need
for help getting up when she has been down for a while. I also think she will always need
her cane.

Q: What would you expect her situation to be with regard to pain?
A: She’ll always have some pain in her knees.

Q: Have you ever given her a permanency rating?
A: I don’t believe I was ever asked to do that, but she certainly has a permanent
injury.

Q: Is there anything else you think she will probably need in the future?
A: A once a year check in with the orthopaedist and annual X-rays of the various
fracture sites. I would expect the X-rays to cost about $200 a year plus doctor charges of
$80 to $100. I also think she should go on Fossamax for her osteoporosis.

Q: How has she been as a patient?
A: Fully compliant and very cooperative.

Q: Has she reached maximum medical improvement?
A: I think so except perhaps for the heel surgery which may reduce her pain.
I am Michael Benson, a licensed professional engineer in the State of North Carolina. I work for Accident Research Specialists, PLLC in Cary, North Carolina. We investigate motor vehicle and other accidents in order to determine from a scientific standpoint how the accident happens. We also look at slip and fall cases and construction accidents. We work for both sides in these cases. From 1987 until 2001, when I started ARS, I worked with Accident Reconstruction Analysis in Raleigh. When I was there I worked as a consulting engineer.

I have a B.S. in Engineering from North Carolina State University; I also have a M.S. from State in Mechanical Engineering. I also did all the course work for a Ph.D. but never finished what I had to do to get the degree. Right, I didn’t write the dissertation. I am a licensed professional engineer in North Carolina and I take all the necessary courses annually to keep my license up. I’ve written one article on use of reconstruction testimony in lawsuits which was published in the Campbell University School of Law’s Law Review in 1994.

In any given case, who we are working for largely depends on who calls us first. In this case, Plaintiff’s counsel did. I have worked more than twenty times for the firm of plaintiff’s counsel and probably two or three for defense counsel’s firm. Overall, I would say that half my work is for the defense and half for plaintiffs. All of my income comes from this work. I charge $175 for my time, less for other people. I think I did almost all the work in this case.

In this case, after being contacted by plaintiff’s counsel in March of 2002, we were provided the materials listed in our report and visited the accident scene on June 6, 2002, making measurements and taking photographs.

Q: How long were you at the accident scene?
A: About two hours.

Q: Have you or anyone working for you been there any other time?
A: No.

Q: What did you do there?
A: I measured the main features of the roadway as shown on my exhibit 5 which you had me identify earlier. I drove up Van Vlake Drive to confirm that was the road that she lived on and would have been coming out. I measured Van Vlake to the bridge. I matched up photos with the damage to the guardrails in various places. I also examined gouge marks in the roadway on the bridge which would be where Hiller and McGinn hit each other. I measured the line of sight distance to the fork north of the bridge to Van Vlake and from Van Vlake south down 41.
Q: How did you measure these distances?
A: Using my roller tape.

Q: Have you done anything else by way of investigation like interview anyone?
A: No.

Q: Let’s look at Exhibit 1 which are your field notes you identified earlier. Explain them, please?
A: I started from Reference Point No. 1 which was a power pole south of Van Vlake Drive. Then I headed north and there was a passing zone that begins three feet one inch north of the reference point. The center line of Van Vlake Drive is forty five feet inches north. A no pass zone for southbound traffic begins at 844 feet. There’s a bridges ice before roadways sign at 861 feet. The guardrail begins on the right shoulder at 1,021 feet and it goes all the way across the bridge. From the beginning of the guardrail to the south end of the bridge is 601 feet, so it’s 1,622 feet from the reference point to the south end of the bridge. I measured the width of the lanes which were 12 feet. The paved shoulders varied from nine to eleven inches. On the north side of the bridge I picked another reference point, No. 3, another power pole. Going north to the curve where the fork is was three tenths of a mile, 1,575 feet. South of reference point No. 3 it was 95 feet to a bridges ice sign like the one on the other side. At 719 feet the guardrail starts and the north end of the bridge is at 853 feet. The bridge itself is 238 feet. I found gouging in the southbound lane beginning at 117 feet from the north end.

Q: Did you determine the total sight distance from Van Vlake looking south?
A: I did not make those measurements but I would estimate it to be about 1,000 feet.

Q: Did you measure the sight distance southbound when you come around the curve?
A: Again, an estimate, but is about a mile looking south and correspondingly it’s a mile looking north to the curve.

Q: Did you ever speaking with the investigating officer?
A: No.

Q: Tell me your process for reaching your conclusions.
A: I sat down with the measurements I took and then I reviewed the statements and depositions I had and the accident report. I then put together a time and distance relationship about the events that happened in the accident.
Q; Did you use any computer simulations or programs in doing your analysis?
A: No.

Q; Did you prepare an animation?
A: No.

Q: Have you completed your work?
A: Yes, unless counsel asks me to do something more.

Q; Were you asked to do a speed analysis in this case?
A: I wasn’t asked to. I just more or less took the speeds from the depositions of the witnesses since they are more or less consistent at least the speeds I needed for my analysis.

Q: Was it possible to do a speed analysis with the evidence you had in this case?
A: Not with the evidence I have. You could probably do one on McGinn’s truck but not on Cutler’s. There’s not enough information. The same for Mrs. Hiller.

Q: Did you do any vehicle damage analysis?
A: Not in the sense I think you are thinking which is to determine the force of impacts. I did look at the photos of the vehicles to determine what hit Mrs. Hiller if anything other than the McGinn truck.

Q: What did you determine?
A: The rear tandem tires on Cutler’s trailer hit the driver’s side door and forward on the Hiller car. You can see it on the pictures.

Q: Show me.
A: You can see here on the leading edge of the driver’s door on the Hiller car some black tire swirl marks. Also, here, see, on the trailer’s tires there appear to be some white transfer marks. Both those things are consistent with what I have seen in the past when a trailer sideswipes a car.

Q: Is it possible those marks could have been made by something else, for example the McGinn truck or the vehicles used to extricate Mrs. Hiller?
A: They would have to be made by a moving vehicle, and one moving in the same direction which McGinn was not. I don’t see it as being related to the McGinn
impact because it’s on the opposite side of the car. So, I think that the tire transfer was from Cutler’s tires and that is consistent with what the witnesses were saying. So, in answer to your question, I don’t think it’s possible that it was made by something else.

Q: Now, other than the marks you have just pointed out to me, do you have any other basis for saying there was contact between the Cutler and Hiller vehicles?

A: No, not other than what the witnesses said and what I saw in the photos which was all consistent. Nothing else would have been in a position to make those marks.

Q: Let me show you your exhibit No. 5 which you indicated earlier was your analysis and calculations. Is the first numbered page just a summary of the calculations you made at the scene?

A: Yes. No opinions or analysis, just my measurements all put together in one place.

Q: Explain the calculations on page 2 of Exhibit 5.

A: I looked at the distance from Van Vlake for a car pulling out to the south end of the bridge which was 1,577 feet and gave a few feet to turn out making it 1,600 feet. That was the distance Mrs. Hiller traveled to the point of impact with Cutler just before the south end of the bridge. Then I had the marks from where she first hit the guardrail after the contact on the right and those marks end about 80 feet south of the bridge and there are about 50 feet of them before they end. I added in one second to make it from the impact to the guardrail and you add all these together and you get the initial point of contact between the Cutler and Hiller vehicles about 210 feet south of the bridge. Then you take the one second for getting to the guardrail and .75 sec for sliding along the guardrail and another 120 feet to the point of impact with Mr. McGinn. At a fairly rapid acceleration over that speed range you get a total of 23 or 24 seconds. So then I looked how long it takes from her to get from Van Vlake to the point of impact. Essentially the quicker she gets to 55, the more distance she has to cover at 55, so it kind of works out. Roughly it takes her 25 seconds to get to the point of initial contact.

Q: So you are assuming she is doing 55 at the initial point of contact?

A: Correct. Of course she could have been going faster or she could have been slowing down at that point.

Q: Let me understand your calculations, in determining the initial point of contact with Mr. Cutler you take the initial point of damage on the guardrail and back it up one second.

A: That’s it.
Q: And you are assuming 55 miles per hour then, correct?
A: Yes.

Q: You have a calculation with a time from zero to 55 and you show that it’s 23 ¾ seconds to 25 seconds from when she pulls out to impact.
A: Yes.

Q: What’s at the bottom?
A: That shows the trucks situation using his testimony that he was doing 55 and then sped up to 70 when he passed. Using those numbers, it shows that he was averaging 62.5 miles per hour during the time in question and therefore over the same period of time would have traveled 2176-2290 feet to the initial point of contact.

Q: Where does that put the truck in relation to Van Vlake drive when Mrs. Hiller pulls out?
A: That’s on page three and it shows that the truck was 750 to 860 feet back from Van Vlake when she pulled out. We know that has to be right because if he’s correct about doing 55 and speeding up, if she had pulled out right in front of him at a slow speed and he pulled out to the left at 55, he would have been around her before she knew what hit her, especially if he was speeding up to 70.

Q: If he was going faster than 55 coming up 41, then the distance back from Van Vlake is even further, correct?
A: Absolutely.

Q: Also, if it took her longer than 25 seconds to get the point of impact, he would also have been further back when she pulled out?
A: Correct.

Q: Can you say what she did after she reached 55?
A: No there’s not enough physical evidence to tell how fast she was going at impact. I know at least one witness said she was slowing down before the impact. I just assumed she stayed at 55.

Q: What is this notation, brake, 55 to 0, 226 feet?
A: I wouldn’t expect Mr. Cutler to brake to a stop in this instance from where the car pulls out, but it was just a reference that at 55, fully loaded, he could stop in that distance. What’s more important is the next number because you have 800 feet from him to her when she pulls out, so she had an 800 foot head start and she is starting to accelerate constantly moving away from him accelerating up to 55. If you work the numbers, if he’s traveling say 64 miles per hour, then he can never catch up to her, he just stays in his lane behind her.

Q: That assumes the 800 feet is correct?
A: Yes. But even if you chose other numbers for that if he’s going anywhere from 55 to 65, he doesn’t have to do anything, not even brake and he can fall in behind her just by letting off the gas. Think of it this way, at 55 it takes him 17 seconds to catch up with her, but it only takes her 13 to 16 seconds to get to 55. Now if he speeds up to 70 he will overtake her.

Q: How many feet per second at 55 miles per hour?
A: 81.

Q: How many at 65?
A: I believe it’s 93, something like that.

Q: Did you know the exact weight of Mr. Cutler’s truck with its load when you came up with the distance he needed to brake to a stop?
A: No, I just assumed that he was carrying his full legal load.

Q: Is it possible Cutler was closer to Van Vlake when Mrs. Hiller pulled out?
A: Not unless he was going slower than he says he was. But, if that’s true there’s no way he catches up to her.

Q: What if it takes longer than a second to get from the initial impact to the guardrail?
A: That would make a difference and would put the point of contact closer to Van Vlake and would put him closer to Van Vlake when she pulls out.

Q: What are the calculations on page 4?
A: There I am looking at the timing between the completed pass and where McGinn is, the time that it would take Cutler to complete his lane change. I’m predicting that it took Ms. Hiller about 4 ½ seconds after the initial impact to strike McGinn and about 2 ½ seconds for Mr. Cutler to complete his lane change. So, the result
is that Mr. Cutler and Mr. McGinn were about 215 feet apart when Mr. Cutler completed his lane change. At their respective speeds that means they missed each other by only a second and a quarter, a fairly close call.

Q: Did you calculate where Mr. Cutler was when he pulled out to pass Ms. Hiller?

A: No, you can only go by what Mr. McGinn said that he was just past the curve when he saw Mr. Cutler pull out.

Q: Mr. Benson, your first opinion is that “Ms. Hiller made a right hand turn onto Northbound SC 41 from Van Vlake Drive. Van Vlake Drive is approximately 1,575 from the south end of the Mingo Creek Bridge, is that correct?

A: Yes, since we did the report, I have learned that some people call it Van Vlake and others call it Van Blake.

Q: That’s based on your measurements at the scene and what else?

A: Just the measurements.

Q: Your second opinion begins with “the initial impact was located just south of the Mingo Creek Bridge.” Have we gone over everything that went into reaching that opinion and how you made that calculation?

A: Yes.

Q: That opinion goes on to say, “the initial impact occurred when Mr. Cutler moved from the southbound lane into the northbound lane after partially passing Ms. Hiller’s car.” And I understand the basis for that opinion to be your examination of the photographs. Was there anything else?

A: No, just the photos and the witnesses as I testified earlier.

Q: “The contact occurred between the right side trailer tires and the left fender and drivers door of the car.” The same thing?

A: My answer is the same, yes.

Q: Your third opinion says that “Ms. Hiller traveled northbound for approximately 25 seconds from Van Vlake Drive to the point of initial contact.” I take it that is based on the calculations that you explained to me on page 2 of Exhibit 5?

A: Yes.

Q: Is there any additional basis for that opinion?
A: No.

Q: Your fourth opinion reads, “Mr. Cutler would have been at least 800 feet south of Van Vlake Drive when Mrs. Hiller pulled into the road.” Any additional calculation or basis for that opinion other than what we have already discussed?

A: No.

Q: Opinion five in your report says, in essence that when Mr. Cutler pulled out he could have seen Mr. McGinn’s oncoming truck from then until he pulled back in.” Is that based on anything other than your measurements at the scene?

A: No.

Q: The sixth opinion in your report reads, “The movement by the Hiller vehicle into the road would not have required any evasive action by Mr. Cutler.” And I believe you explained the basis for that opinion to me when you were explaining the bottom of page 3 on exhibit 5 where you have the notation “can’t do nothing” at the bottom?

A: Yes, that’s correct.

Q: Any other basis other than the calculations you’ve already explained to me?

A: No.

Q: Your next opinion, number 7 states, “Mr. Cutler would have had sufficient time and distance to move back into the northbound lane behind the Hiller vehicle during his passing movement. Are you saying that Mr. Cutler could have pulled in behind Ms. Hiller without being hit by Mr. McGinn’s oncoming truck?

A: You said it better than I did.

Q: What is the basis for that opinion?

A: Just reviewing the numbers and looking at the total time that the accident happened over. He needs about two and a half seconds to change lanes and the event happened over 20 plus seconds. So he would have had time, if he wanted to, to decide not to pass and pull back in or once he started the pass to brake and pull back in. That’s pretty obvious from the numbers.

Q: And, your final opinion is “based on the timing and positioning of the three vehicles before the accident, Mr. Cutler moved his truck into the side of the Hiller car to avoid a head on collision with Mr. McGinn. Mr. McGinn stated he was reducing speed in response to the Cutler truck.” Have I got that right?

A: You do.
Q: The last sentence is simply a quote from an interview with Mr. McGinn, correct?
A: Yes.

Q: What is the basis for the remainder of the opinion?
A: They are all on page four of my calculations. I was just calculating to see whether Mr. Cutler had to get over or not, and he clearly did.

Q: Did you ever calculate whether this accident could have been avoided if Mrs. Hiller slowed down?
A: I think she or someone says that she did. I didn’t do the calculation because I don’t know at what point it was reasonable to expect her to start braking.

Q: What’s the stopping distance for her car at 55 miles per hour.
A: Should be about 140 feet.

Q: How fast can she slow down?
A: About 15 miles per hour per second.

Q: Could this accident have happened because Mrs. Hiller pulled out in front of Mr. Cutler?
A: No. There is no way he did not have an opportunity to adjust his speed to a car pulling out. It’s just normal driving, what vehicles do all the time.

Q: You’ve got her getting to 55 in 1.35 to 16.2 seconds, could she have done it faster than that?
A: I suspect the 0 to 60 time is more like 14 seconds, so yes she could have done it faster, maybe if she really gunned it in 12 seconds but I don’t think that changes anything in this case.

Q: Have we covered all your opinions and the basis for each of them?
A: We have.

Q: Thank you for your time.
Please refer to the image for the text content.
1,577' + turn out  = 1,590' to S. end of bridge

= ORIGINAL ROI, from photos
- 80' to south end
- 50' on G-Rail  = 3/4 sec
- 1 sec; ROI to G-Rail  = 80' = 4 1/4 sec
210' total, or less.

or 1,570' - 210' = 1,380 feet = 2 1/4 of a mile

Distance Hiller travels to initial contact w/truck

0 - 55 mph
C = \frac{fps^2}{t}
\begin{align*}
d &= 550' \\
t &= 13.5 \text{ sec}
\end{align*}

\frac{1,380' - 650'}{8 fps} = t
10 1/4 sec

\begin{align*}
t &= 23 3/4 \text{ sec} \\
t &= 25 \text{ sec}
\end{align*}

\text{Truck:}
\begin{align*}
V &= \frac{55 + 70}{2} = 62.5 \text{ mph / 91.6 fps}
\end{align*}

Truck is C 2176' to 2290' back
1427 - 2476' = 749' to Von Viele to front of

\[ d = \frac{749' + 863'}{2} = 806\text{ feet} \]

Brake 55 - 20 in 226 feet

\[ 749' + 863' = 800' \]

Distance to
Cover til
Hiller gets
in 15 sec

93 fps / 64 mph

or 17.3 sec @ 88 mph

Can do nothing.
- Hiller must go behind cutter
- Cutter lane change
  2.5 sec @ 70 mph / 102.6 fps
  \( d = 254' \)
  \( \approx 65 \text{ mph} / 95.7 \text{ fps} \)
  \( d = 238' \)
  \( 1/27 + 238' = 1.665' \)
  \( \approx 16.75' \)

- Contact to POI is \( \approx 1 \text{ sec} + 3/4 \text{ sec} + 2.75 \text{ sec} \)
  \( \approx 4.75 \text{ sec} \)

- \( 41/2 - 21/2 = 2 \text{ sec} \)
- \( 2 \text{ sec} \times 98.9 \text{ fps} \) (65-70 mph)
  \( = 198' \)
  \( 16.75 + 198 = 1873' \) @ impact

- \( 1743 - 1675 = 68' \) Cutter to POI @ end of lane change
- \( 2 \text{ sec} \times 73.3 = 146' \) McGinn to POI

- Apart

- Close @ 50' 65/70

- 74 -

or 172 fps \( 1/4 \text{ sec} \)
**GEORGETOWN COUNTY FIRE DEPARTMENT**

P.O. Drawer 1270  
GEORGETOWN, SC 29443  
TELEPHONE (803) 546-6344

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<th>1996 CHEVY</th>
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<tr>
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<tbody>
<tr>
<td>Owner</td>
<td>Fleet Trucking Company</td>
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<tr>
<th>Year and Make</th>
<th>Peterbilt</th>
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<th>18 Wheeler VN11911D383L3D3536</th>
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<tbody>
<tr>
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<td>Insurance Co.</td>
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**Brief Incident Description:** E-5/14 B-43 responded to a 10-50. Your arrival here was a 18-wheeler / a car head-on collision. We used the jaws to free person in car once helicopter came to get for. We assisted extricating both of car. D.A.R.E. Nighting. Depth was for spillage sent by until cars were removed.

**Equipment Used:** Shovel, laces, chains, cam-axes, + Jaws of Life

**Operations Officer:** Edel Allen  
**Report By:** Edel Allen
<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Event Location</th>
<th>Event Type</th>
<th>Vehicle Type</th>
<th>Driver Name</th>
<th>Driver Address</th>
<th>Speed</th>
<th>Distance</th>
<th>Other Details</th>
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</thead>
<tbody>
<tr>
<td>4.7.99</td>
<td>1625</td>
<td>FLEETWOOD RD</td>
<td>Collided</td>
<td>Commercial</td>
<td>John Smith</td>
<td>1234 Main St</td>
<td>45</td>
<td>500</td>
<td>Left</td>
</tr>
<tr>
<td>4.7.99</td>
<td>1625</td>
<td>FLEETWOOD RD</td>
<td>Collided</td>
<td>Commercial</td>
<td>John Smith</td>
<td>1234 Main St</td>
<td>45</td>
<td>500</td>
<td>Left</td>
</tr>
</tbody>
</table>

Directions:
- Left turn
- Collided with another vehicle

Other Notes:
- Vehicle 1: Commercial, 18-wheeler
- Vehicle 2: Personal car
**South Carolina Traffic Collision Report**

**Date:** 4-7-99  
**Time:** 16:35  
**County:** 22-A  
**Route Category:** 1-A  
**Route Number:** 1-Loop  
**Distance:** 0-0  
**Location:** 413  
**Main Line:** 1-A  
**Secondary:**  
**Other:**  

**Screening Information:**

**Number of Qualifying Vehicles Involved:**
- A truck with 8 or more tires: 2
- A vehicle with a hazardous material placed: 0
- A bus designed to carry 16 or more passengers, including the driver: 0

**Number of Persons Involved:**
- Sustained fatal injuries: 0
- Transferred for immediate medical services: 2

**Vehicle Information:**
- Gross Vehicle Weight Rating: 31,800 lbs
- Trailers or Trailers Total: 49,400 lbs

**Vehicle Configuration:**
- Any 4-ton Vehicle: 0
- Double Trailer Only: 0
- Single Unit Truck (2 axle/8 or more lbs): 1
- Single Unit Truck (3 or more axles): 0
- Truck with Tractor: 0
- Other: 0

**Hazardous Material Involvement:**
- Was this vehicle carrying hazardous materials?: 1
- Yes: 2
- No: 0
- Unknown: 0

**Carrier Information:**
- Name: Fleetwood Co., Inc.
- Source: 1 - Shipping Papers
- Vehicle: 4 - Log Book
- Driver: 5 - Unknown

**Address:** Broad Ave

**Identification Numbers:**
- US DOT: 0488452
- ICC No: 254304

**Driver Information:**
- Name: Johnson, C.A.
- Age: 1
- Sex: R
- VitalStats: 1
- Driver's License: 0-0-0-0
- Driver's Class: 0-0-0-0
- Medical Condition: 0-0-0-0
- Rate Of Speed: 5-0-0-0
- Alcohol: 0-0-0-0
- Other Offense: 0-0-0-0
**SUPPLEMENTAL BUS & TRUCK ACCIDENT REPORT**

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<tr>
<th>SCREENING INFORMATION</th>
<th>ACCIDENT LOCATION/ENVIRONMENT INFORMATION</th>
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<tr>
<td>NUMBER OF QUALIFYING VEHICLES INVOLVED</td>
<td>ACCESSES CONTROL</td>
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<tr>
<td>A truck with 8 or more tons</td>
<td>1 - No Control of Access (Unmarked Area)</td>
</tr>
<tr>
<td>OR</td>
<td>2 - Full Control of Access (Only Access Entry or Exit)</td>
</tr>
<tr>
<td>A vehicle with a hazardous material placard</td>
<td>3 - Other</td>
</tr>
<tr>
<td>OR</td>
<td></td>
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<tr>
<td>A bus designed to carry 19 or more persons, including the driver</td>
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</table>

<table>
<thead>
<tr>
<th>NUMBER OF VEHICLES INVOLVED</th>
<th>VEHICLE INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sustaining total injuries</td>
<td>Gross Vehicle Weight Rating</td>
</tr>
<tr>
<td>Transferred for immediate medical services</td>
<td>Truck or Tractor</td>
</tr>
<tr>
<td>NUMBER OF VEHICLES TOWED/PROVIDED ASSISTANCE</td>
<td>Trailers or Trailers Total</td>
</tr>
<tr>
<td>Towed from scene due to damage or provided assistance</td>
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**TOTAL NUMBER OF SUPPLEMENTAL FORMS REQUIRED**: 2

<table>
<thead>
<tr>
<th>UNIT NUMBER</th>
<th>CARRIER INFORMATION</th>
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<td>3 PR-10 NUMBER</td>
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<table>
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<tr>
<th>NAME</th>
<th>FLEET TRANSPORT INC</th>
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<th>SOURCE</th>
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<td>577 CARRICER RD</td>
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<table>
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<tr>
<th>STATE</th>
<th>DRIVER INFORMATION (Apparent Driver Condition)</th>
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**NOTIFICATION**

**SEQUENCE OF EVENTS (for THIS VEHICLE)**

<table>
<thead>
<tr>
<th>Event 1</th>
<th>Event 2</th>
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<tbody>
<tr>
<td>11 - Run Off Road</td>
<td>12 - Jackknifed</td>
</tr>
<tr>
<td>13 - Overturned or Overturned</td>
<td>14 - Off Road Runaway</td>
</tr>
<tr>
<td>15 - Cargo lost or Shift</td>
<td>16 - Explosion or Fire</td>
</tr>
<tr>
<td>17 - Separation of Units</td>
<td>18 - Other Events</td>
</tr>
</tbody>
</table>
I, Thewonda Finch, personally appeared before the above-named officer, who states:

I reside at 800 North Buech Ave. Apt A in Andrew, SC 29045.

Date of Birth: 8/15/78. Social Security Number: 123-45-6789.

I have 12 1/2 years of education, and I cannot read and write. This statement is given on 4-7-99, at 17:15, and in the presence of [Signature], who has officially identified himself/herself as a member of the SOUTH CAROLINA HIGHWAY PATROL.

I, Thewonda Finch, was behind the truck in the right lane going 45-50 miles per hour. I noticed the truck trying to pass the white car. It was in the right lane when the truck was cut off. The truck veered back onto the right lane, then cut off a car in the right lane, and the white car was还要 nearest to the left lane. I saw the back of the white car. I was driving about 60 to 70 miles per hour. The white car was going about 45-45 miles per hour. The truck was going about 60 to 70 miles, but it was the one that was going slower. The truck that hit the car was doing well its hard to say because he broke his speed when the truck was in his lane. The white car did not pull out in front of the big truck. He took a chance trying to pass her on the bridge and it caused this accident.

[Signature]
# Index of Dorothy Hiller's Medical Records

<table>
<thead>
<tr>
<th>Date</th>
<th>Record</th>
<th>Pages</th>
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<tr>
<td>04/07/99</td>
<td>DHEC Patient Care Form</td>
<td>A</td>
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<tr>
<td>04/07/99 -</td>
<td>Discharge Summary – Medical University of SC – Dr. Merrill</td>
<td>1-3</td>
</tr>
<tr>
<td>04/14/99</td>
<td>Air Transfer Patient Data Log</td>
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<td>05/14/99</td>
<td>Office Note – Dr. Foster</td>
<td>5-6</td>
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<tr>
<td>04/16/99</td>
<td>History &amp; Physical – Chippenham and Johnson-Willis Hospitals (CJWH) – Dr. Rivers</td>
<td>7-9</td>
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<tr>
<td>04/16/99 -</td>
<td>CJWH Discharge Summary – Dr. Rivers</td>
<td>10-11</td>
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<tr>
<td>04/27/99</td>
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<td>04/29/99</td>
<td>Office Note – Dr. Foster</td>
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<td>05/01/99</td>
<td>History &amp; Physical CJWH – Dr. Rivers</td>
<td>13-15</td>
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<tr>
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<td>CJWH Discharge Summary – Dr. Rivers</td>
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<td>Office Note – Dr. Martin</td>
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<td>06/04/99</td>
<td>Office Note – Dr. Martin</td>
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<td>Office Note – Dr. Martin</td>
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<td>07/12/99</td>
<td>Office Note – Dr. Martin</td>
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<td>08/09/99</td>
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<tr>
<td>08/17/99</td>
<td>Office Note – Dr. Rivers</td>
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<td>10/13/99</td>
<td>Prescription – Dr. Martin</td>
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<td>01/05/00</td>
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<td>01/17/00</td>
<td>Telephone Note – Dr. Rivers</td>
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<td>Office Note – Dr. Martin</td>
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<td>Letter from Mrs. Hiller to Dr. Martin (found in Dr. Martin’s medical records)</td>
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<td>03/06/00</td>
<td>History &amp; Physical CJWH – Dr. Rivers</td>
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<td>03/06/00</td>
<td>Consultation Report – Dr. Hughes</td>
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<td>03/06/00</td>
<td>Office Note – Dr. Rivers</td>
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<td>03/23/00</td>
<td>Operative Report – Medical College of Virginia (MCV) - Dr. Martin</td>
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<td>Discharge Summary – MCV – Dr. Martin</td>
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<td>08/30/00</td>
<td>Letter – Dr. Martin to Plaintiff’s Counsel</td>
<td>44-45</td>
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<td>10/10/00</td>
<td>Office Note – Dr. Martin</td>
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<td>04/22/01</td>
<td>History &amp; Physical CJWH – Dr. Caruso</td>
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<td>Cardiac Catheterization – Dr. Hughes</td>
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<tr>
<td>01/30/02</td>
<td>Office Note – Dr. Martin</td>
<td>57</td>
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</tbody>
</table>
HOSPITAL DISCHARGE SUMMARY

Patient Name: HILLER, DOROTHY

Admitted: 04/07/89
Discharged: 04/14/89
Service: Orthopedic Surgery
Attending: Keith D. Merrill, M.D.

Referring:

ADMITTING DIAGNOSIS: Status post motor vehicle accident with multiple orthopedic injuries including:
1. Comminuted left os calcis fracture and nondisplaced talar neck fracture.
2. Comminuted left patella fracture.
3. Comminuted right patella fracture with overlying lacerations that did not involve the fracture itself.
4. Highly comminuted bicondylar right tibial plateau fracture.
5. Fracture of the base of the 5th metacarpal of the right hand.

SPECIAL PROCEDURES:
1. Irrigation and debridement of right knee wound, performed in the emergency room on admission and again in the operating room the following day.
2. Examination under anesthesia of both patella fractures and open reduction and internal fixation of the right patella fracture using a cerclage suture technique.

HISTORY OF PRESENT ILLNESS: The patient is a 67-year-old white female with a history of angina, who was involved in a motor vehicle accident in which she was a restrained driver. She was hit from the front by a tractor trailer truck. She does recall events of the accident, but there was an uncertain transient loss of consciousness. She remained hemodynamically stable in the field and during her evaluation in the emergency room. She was transported to the Medical University Hospital 1 West Trauma Center via EMS, complaining of midsternal chest pain, bilateral ankle pain and right knee pain.

Her examination in the emergency room revealed the above outlined injuries. She was initially admitted to the trauma service and transferred to the orthopedic service.

HOSPITAL COURSE: Patient was evaluated in 1 West Trauma Center and found to have the injuries as outline above. Her knee wound was
thoroughly irrigated and loosely closed. It was not felt to communicate with the underlying patella fracture and did not communicate with the knee joint, after injection of the knee joint. She was taken the following day to the operating room for examination under anesthesia both for patella fractures and further management. It was felt that her calcaneal fracture and her tibial plateau fractures were much too comminuted, and osteopenic to be able to withstand open reduction and internal fixation. Her left patella fracture, although comminuted, remained in a relatively good position and stayed well aligned through a range of motion, indicating the entire retinaculum and sleeve remained intact. Thus, open reduction and internal fixation was not performed on the side.

There was a large rotated fragment on the right patella fracture and as an attempt was being made to excise this fragment and actually reduce it to an anatomic position, thus it was left in its position and a cerclage suture was used around the entire patella to hold this intact. This patella also tract very well through a range of motion and remained in continuity, indicating that the retinaculum was intact. Formal open reduction and internal fixation was not performed.

The laceration which had been previously irrigated and closed, was irrigated once again and debrided and was closed once again. She was placed in bilateral knee immobilizer, as well as a left ankle splint. It was felt that she would be nonweight-bearing for an extended period of time, and that she would not be a candidate for rehab.

The remainder of the patient's hospital course was largely unremarkable. She recovered quite well from her injuries and there were no unforeseen events during her stay on the floor. Her dressings were changed prior to her discharge, and all of her wounds appeared to be healing nicely. She is at the current time, stable for discharge back to Virginia, where she lives.

DISPOSITION: Patient is being discharged to the home of her son, which is handicapped equipped. Arrangements have been made for home equipment, as well as home nursing and therapy. Her family is arranging her orthopedic follow up in Richmond, Virginia. We gave her the name of Dr. John Carr at MCV and they will contact him if they wish to. She will be transported via fix wing aircraft because of the inability of her to bend either or her knees and her overall condition.

She was given prescriptions for Lovenox and also Darvocet for pain. She had been instructed that she is to remain nonweight-bearing on both lower extremities and is a total lift for transfer to a wheelchair. Arrangements have been made for home physical therapy and home nursing. She should follow up within a week with an
orthopedic surgeon in Richmond, and can contact us at any time for any questions she may have. She was given copies of her x-rays, discharge summary and her operative notes, prior to her departure. She will take these to her new physician.

We did discuss with her at length during her hospital stay, that her osteopenic bone prohibited definitive fixation of either her calcaneal fracture or her tibial plateau fracture and that these may be problems for her in the future. She does understand that she has a significant chance of developing posttraumatic arthritis, especially in the right knee, which is the site of the tibial plateau fracture, but we did explain to her that there were surgical options including total knee joint arthroplasty, which could be done if she does have problems.

Keith D. Merrill, M.D.
Attending

HD: 658/3122
ED: 04/14/99
ET: 04/14/99
Additional CC: __________________________
PATIENT DATA LOG
FROM: Charleston, SC TO: Richmond, VA
COMPANY: Adv Air Ambulance
PLANE TAIL NO.: N1882C
MAX CABIN ALTITUDE PRESSURE: 1200

DATE: 4/1/09
PATIENT NAME: DOROTHY HILLER
AGE: 68 YO
WT: 125 lb
DIAGNOSIS: MVA (Brain - Legal (R))
ADDRESS: Home - 42904 River Rd
Chesterfield, VA

ALLERGIES: N/A
DR.'S ORDERS: Air Transport from
Charleston, SC to Richmond, VA

Table:

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<th>AMT.</th>
<th>Time</th>
<th>Type</th>
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Total:

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</table>

Notes:

PH transported patient at 0549. Patient is alert oriented OS/NS.
From VA PH in VA. PH is oriented OS/NS.
Patient is brady at 120BPM. PH is stable at this time.
PH transferred to hospital. PH is incident of takeoff at 11:35PM. Flight to Richmond, VA.
PH was in MVA.
PH sustained DBT for injuries. Being transported by air ambulance in VA.
PH is on oral and nasal O2. PH is N/V.
PH is at 97.8°F. PH is responsive and can follow commands.
PH is complaining of headache. PH is complaining of neck pain.
PH is having difficulty sleeping.
PH is a 75 y/o, still in pain.

Signature and Title: [Signature]
PRINT NAME: [Name]
MCV AMBULATORY CARE CENTER
OFFICE NOTE

DATE: 4/15/99

NAME: DOROTHY HILLER
MR # 662133

IMPRESSION:
1. FRACTURE RT 5TH METACARPAL BASE
2. FRACTURE RT PATELLA, S/P ORIF
3. FRACTURE LT PATELLA
4. FRACTURE RT TIBIAL PLATEAU
5. FRACTURE LT CALCANEUS

DISPOSITION:
1. PLACED IN A NEW LEFT SHORT LEG CAST
2. LEFT IN HER KNEE IMMOBILIZER
3. TO REMAIN NON WEIGHT BEARING
4. LEFT IN HER SHORT ARM CAST
5. RETURN IN 2 WEEKS WITH AN X-RAY OF HER RIGHT 5TH METACARPAL AREA
6. X-RAY OF HER RIGHT KNEE
7. X-RAY OF HER LEFT CALCANEUS

COMMENTS: MS HILLER IS A 67 YEAR OLD LADY WHO WAS INJURED IN AN AUTOMOBILE ACCIDENT 8 DAYS AGO. HER CAR WAS HIT BY 2 DIFFERENT TRUCKS WHILE CROSSING A BRIDGE. SHE HAS THE ABOVE INUMERATED INJURIES. HER METACARPAL WAS TREATED WITH CLOSED REDUCTION AND CASTING. SHE PRESENTED WITH PRE AND POST REDUCTION X-RAYS. THE POST REDUCTION X-RAYS LOOK EXCELLENT. HER RIGHT PATELLA FRACTURE WAS TREATED WITH AN OPEN REDUCTION INTERNAL FIXATION AND CERCLAGE WIRING. IT APPEARS TO HAVE A NICELY HEALING WOUND. HER CALCANEUS AND TIBIAL PLATEAU FRACTURE WERE TREATED CLOSED BECAUSE THEY WERE FELT TO BE SO COMMINUTED AND OSTEOPOOROTIC THAT SURGERY WAS UNLIKELY TO BE OF PARTICULAR BENEFIT. THAT DECISION SEEMS REASONABLE IN VIEW OF MY REVIEW OF HER X-RAYS. IT HAS ALREADY BEEN DISCUSSED WITH HER THAT SHE WILL ALMOST CERTAINLY REQUIRE A TOTAL KNEE REPLACEMENT AT SOME POINT IN THE FUTURE. HER PAST MEDICAL HISTORY REVEALS THAT SHE HAS ANGINA WHICH REALLY HASN'T BOtherED HER SINCE THE INJURY.

I DID NOT GET NEW X-RAYS TODAY BECAUSE THE ONES SHE BROUGHT WITH HER ARE SO RECENT. IT APPEARS THAT HER TREATMENT HAS BEEN QUITE SATISFACTORY AND REASONABLE. I DON'T THINK I WOULD CHANGE
THE PLANS MADE BY THE DOCTORS IN SOUTH CAROLINA AT THIS POINT IN TIME. I HAVE ASKED HER TO RETURN TO SEE ME IN 2 WEEKS WITH X-RAYS OF BASICALLY ALL OF HER INJURIES.

WILLIAM FOSTER, M.D.
Ms. HILLER is a very pleasant 67 year old lady seen at the request of Dr. Ramsey in the Emergency Room. She presents because of complaints of chest pain, shortness of breath, and hemoptysis.

Her recent history is significant for a motor vehicle accident on 4/7/99. She was a restrained driver who was hit from the front by a tractor trailer log truck. She apparently recalled events of the accident but there was some concern about a transient loss of consciousness. She was stable at the scene and transferred to the Medical University Hospital in Charleston, South Carolina, evaluated in the Trauma Center, and admitted later to the Orthopedic Service. She sustained multiple fractures including a comminuted left os calcis fracture and non-displaced talar neck fracture. She had a comminuted left patellar fracture, comminuted right patellar fracture with overlying lacerations that did not involve the fracture itself. There was a highly comminuted bicondylar right tibial plateau fracture, fracture of the base of the 5th metacarpal of the right hand, and blunt abdominal trauma. She was evaluated in the Operating Room. She had open reduction of the left patella fracture and stabilization of other fractures. Notes from the Medical University of South Carolina indicate that her hospital stay was uncomplicated. She was discharged on 4/14/99 and transferred by air to her son's home here in Richmond. Medications at the time of discharge included Lovenox 40mg subcu every 12 hours, Darvocet N-100 3 to 4 times a day for pain, Atenolol 25mg daily, and aspirin daily.

Further review of systems reveals that she has noticed some mild breathlessness since transfer to Richmond. This became more apparent today and was more bothersome. She has not been bothered by cough or sputum production until today. She coughed once and felt something in her throat and mobilized a small clot of dried blood. This was noticed by the Home Health nurse who was concerned about this as well as the other complaints and urged the son to have her come to the hospital. She also felt a chest pain which she describes as a substernal pain initially, not like indigestion. The pain did not have a definite pleuritic component. It did feel tight, it was not a sharp knife-like pain. She also notes that it was not like previous angina pains that she has experienced in the past. The pain did not
HISTORY & PHYSICAL

PATIENT: HILLER, DOROTHY

There was no associated nausea or vomiting. No diaphoresis. She has, however, felt hot today. She has had a problem with nausea but that was less bothersome today. Her appetite was good, in fact, this morning. In the past, she has been fairly active. She was diagnosed as having angina about 6 months ago. Her description of the angina pain sounds atypical because they seem to be relatively short fleeting pains, not necessarily associated with exertion. She also gives a history of having an irregular heart beat since childhood. She comments that she was told that every third beat was irregular. There was never any particular treatment for this. Otherwise she seems to have been in pretty good health.

PAST SURGICAL HISTORY: She has had prior surgery including an appendectomy, subsequent bowel obstruction, and hysterectomy. She was in an auto accident in 1958 and required a tracheostomy.

SOCIAL HISTORY: She apparently lives alone in South Carolina. She is now here to stay with her son and receive care. She is totally dependent on others for care at the present time. She quit smoking in 1973.

FAMILY HISTORY: Her grandfather was an active game warden until the age of 101. Her father died in his 60's. Mother died in her 80's.

EXAMINATION: She is not in distress.

HEART: Unremarkable.

Neck: In a brace which she wears when being transported only.

Chest Exam: Does reveal diminished breath sounds at the left base. There are inspiratory rales at the left base but no rub. The right base is clear. No wheezes were audible over the chest.

Heart Exam: Revealed a systolic murmur grade II. Rate was regular, a bit increased. There was no rub.

Abdomen: Soft and non-tender. There is mild deepened thigh edema. She can wiggle her toes but it hurts to have any pressure on the left toes. She does have some edema in the right foot about 1+.

Neurological: Seems to be intact.

Chest x-ray does show a left pleural effusion with some discoid atelectasis above the effusion. The right lung appears clear. Her sodium is 136, potassium 3.7, BUN 16, and creatinine .8. White count is increased to 15,100, hemoglobin 9.2, and platelets 540,000. Her
HISTORY & PHYSICAL

PATIENT: HILLER DOROTHY

CK marker is 50. Troponin levels are pending. EKG does not appear abnormal.

ASSESSMENT:

1. Dyspnea, chest pain, and hemoptysis. In this clinical setting, very suspicious for pulmonary thromboembolus. Chest pain is not characteristic embolic pain and given her history of angina, need to rule out an MI.

2. Left pleural effusion and discoid atelectasis. Very likely related to a pulmonary embolus and possible infarct. Pneumonitis seems less likely.

3. Fever, probably secondary to pulmonary embolus and atelectasis, rule out urinary tract infection. Rule out pneumonia.


5. Status post motor vehicle accident with multiple trauma as noted above.

PLANS: Proceed with a spiral CT scan of the chest. If this is positive, of course, will begin IV heparin. If negative, will begin IV heparin and proceed with a pulmonary angiogram in the morning because of the high degree of suspicion. Will request help from physical therapy, occupational therapy, and orthopedics. Will add incentive spirometry, continue oxygen, and use nitroglycerin if needed. Continue the Darvocet N-100. Will need to follow her hemoglobin and hematocrit very closely.

Cullen B. Rivers, M.D.*

TR: sbw 0
DD: 4/16/99
DT: 04/16/99
CHIPPENHAM AND JOHNSTON-WILLIS HOSPITALS, INC.

7101 Jahnke Road
Richmond, VA 23225

1401 Johnston-Willis Dr.
Richmond, VA 23235

PATIENT: HILLER, DOROTHY
DOB: 04/30/31
ADM DATE: 04/16/99
ROOM #: D.C206
SSN #: DIS DATE: 04/27/99

ATTENDING PHYSICIAN: Rivers Cullen B

FINAL DIAGNOSES:
1. Pulmonary thromboembolus
2. Left pleural effusion and atelectasis
   left lower lobe secondary to pleural effusion
3. Motor vehicle accident with multiple
   fractures including both knees and right arm. Unable to stand or sit. Both legs bent
4. Atherosclerotic heart disease.
5. History of angina pectoris

DISCHARGE MEDICATIONS: He will continue on:
1. Levaquin, 500 mg. daily for five days.
2. Iron Sulfate, 325 mg. twice a day.
3. Citrucel one pack daily.
4. Colace 100 mg. daily at bedtime.
5. Doxepin 10 mg. at bedtime.
6. Atenolol, 25 mg. daily.
7. Celebrex 100 mg. twice a day for two weeks
8. Pepcid 20 mg. daily
9. Coumadin 2 mg. tablets on Tuesday, Thursday, Saturday and Sunday, 4 mg. on Monday, Wednesday and Friday
10. Darvocet N. 100 as needed for pain

FOLLOW UP: She will be followed by home health which will provide physical therapy, personal care, aid and nurse visits. She is to have a prothrombin time and INR on 4-29 and 5-3-99 and then weekly thereafter. Plans are to request a home chest Xray in two weeks to evaluate the effusion and atelectasis in the left leg. She is to follow up with Dr. John Carr at the Medical College of Virginia on 4-29-99 for decisions about further treatment of the leg fractures.

HISTORY OF PRESENT ILLNESS: The patient is a 67 year old lady whom I saw in the Emergency Room on the evening of admission at the request of the Emergency Room physician. She presented with complaints of increasing shortness of breath, substernal discomfort, chest discomfort and tightness in her chest. This had been present most of the day and had been intermittently present for two to three days. Also, on the day of admission, she had hemoptysis and low grade fever.
PATIENT: MILLER, DOROTHY
Chippenham Medical Center

PAST MEDICAL HISTORY: Recent past history was significant for a motor vehicle accident on 4-7-99. She was hit head on by a log truck in South Carolina. She was initially treated at the Medical University of South Carolina where her fractures were explored and stabilized. She was discharged from there on 4-14-99 by air transport to her home here in Richmond. The day before admission here she was seen at the Medical College of Virginia by Dr. John Carr. At home, she had been on Lovenox 40 mg. daily, Atenolol 25 mg. daily, Aspirin daily and Darvocet.

PAST MEDICAL HISTORY: Also significant for angina about six months ago with infrequent discomfort relieved by Nitroglycerin.

PHYSICAL EXAMINATION: She was not in distress. The oxygen saturation on two liters was 97%. The chest examination revealed decreased sounds and rales at the left base. The heart examination revealed a systolic murmur, regular rate and rhythm. The abdomen was negative. The extremities were either in a splint or cast. The chest Xray did show a left lower lobe effusion and atelectasis.

LABORATORY DATA: Spiral CT scan of the chest was performed and did show evidence of pulmonary thromboemboli as well as bilateral deep vein thrombosis involving both legs below the knee. There was question of a small clot in the pelvis as well.

HOSPITAL COURSE: She was started on Coumadin and Heparin. The hospital stay for the most part, was uncomplicated. She did have fever which was thought to be related to the atelectasis and inflammation in the left lung from probable pulmonary infarct. She never coughed up any purulent sputa, only once or twice did she cough some blood.

On the day of discharge she feels good. Xray is stable with the effusion. There was a dullness at the extreme base. There are fewer crackles in the left lung. Her prothrombin time on the day of discharge is 19.5 with an INR of 2.56 which is in the therapeutic range.

She was discharged to continue meds and follow up as noted.

Cullen B. Rivers, M.D.
MCV AMBULATORY CARE CENTER
OFFICE NOTE

DATE: 4/29/1999

NAME: DOROTHY HILLER

IMPRESSION:
1. FRACTURE RT 6TH METACARPAL
2. FRACTURE LT PATELLA
3. FRACTURE LT CALCANEUS
4. FRACTURE RT PATELLA
5. FRACTURE RT TIBIAL PLATEAU

DISPOSITION:
1. LEFT OUT OF HER RT ARM CAST
2. LEFT OUT OF HER LT KNEE BRACE
3. NEW SHORT LEG CAST
4. PHYSICAL THERAPY PROGRAM
5. RETURN 3 WEEKS WITH AN X-RAY OF THE RT KNEE AND LT HEEL

COMMENTS: MS HILLER IS DOING SATISFACTORYLY. SINCE I LAST SAW HE SHE HAS BEEN IN THE HOSPITAL WITH PULMONARY EMBOLI. SHE IS NOT HAVING A GREAT DEAL OF DISCOMFORT. I REMOVED HER RIGHT ARM CAST AND TOOK AN X-RAY. HER FRACTURE IS STILL NOT REALLY DISPLACED. I THINK IT IS 3 WEEKS OUT FROM HER INJURY WE CAN LEAVE HER OUT OF A CAST FOR HER NON DISPLACED HAND FRACTURE. HER LEFT PATELLA IS ALSO REMAINING LINED UP NICELY. HER KNEE IS NOT SWOLLEN NOR IS IT PARTICULARLY TENDER. I AM GOING TO LEAVE HER OUT OF THAT SPLINT AND BEGIN DOING SOME STRENGTHENING AND MOTION EXERCISES FOR THAT. HER LEFT HEEL LOOKS THE SAME. IT IS SIGNIFICANTLY FRACTURED AND DISPLACED BUT I THINK LOOKS THE SAME WHICH IS SATISFACTORY. I AM GOING TO LEAVE HER IN A CAST FOR THAT. WE PLACED HER IN A NEW SHORT ARM CAST. HER RIGHT KNEE HAD BOTH PATELLA AND TIBIAL PLATEAU FRACTURES. I DON'T BELIEVE THAT AT THIS POINT WE ARE SAFE LEAVING HER OUT OF HER SPLINT. I AM ASKING PHYSICAL THERAPY TO BEGIN MOTION ON HER LEFT KNEE AS WELL AS SOME QUAD STRENGTHENING AND I HAVE ASKED THEM TO BEGIN JUST SOME QUAD STRENGTHENING IN THE BRACE ON HER RIGHT KNEE. SHE WILL RETURN IN 3 WEEKS WITH X-RAYS AS NOTED ABOVE.

WILLIAM C FOSTER, M.D.
HISTORY & PHYSICAL

cc: Dr. John Carr, Medical College of Virginia

HISTORY OF PRESENT ILLNESS: Ms. Hiller is a 68 year old lady, who is back in the Emergency Room this evening because of problems or complaints of dyspnea and extreme tiredness, as well as chest discomfort and transient nausea. This developed after she had been up in a chair for 2-3 hours, and was the second day after discharge from the hospital on 4/27/99. The family noted that she was breathing hard with her mouth open. Also noted perioral cyanosis. The patient felt better after laying down, but the family, as well as the certified nursing assistant attending her, were concerned about these changes.

Her recent history is significant for pulmonary embolus. She was involved in a motor vehicle accident on 4/7/99 in Charleston, South Carolina. She was hospitalized at the Medical University of South Carolina until 4/14/99. She sustained multiple fractures, including fracture of the right and left patella, right tibial plateau, left os calcis, and talar neck, right hand, and chest wall trauma, with small area of flail. I first met her when she presented in the Chippenham Medical Center Emergency Room on 4/16/99. She had been transported by air from Charleston to Richmond on 4/14/99. She was staying with her son. She came to the Emergency Room here two days later because of complaints of shortness of breath, left pleuritic chest pain, and hemoptysis. The day prior to admission here she had been at the Medical College of Virginia Orthopedic Clinic to see Dr. John Carr.

Further review of systems: She is not short of breath now. She had had no nausea or shortness of breath prior to the period of time in the chair earlier in the evening. She has been using her incentive spirometry regularly and is now up to about 1500 cc. She did have a prothrombin time drawn yesterday, the results apparently were not called to the office.

PAST MEDICAL HISTORY:

1. History of angina pectoris. She has used Nitroglycerin rarely. She is on Atenolol 25 mg q d.
HISTORY & PHYSICAL

PATIENT:  Hiller  DOROTHY

PAST SURGICAL HISTORY:

1. Appendectomy.
2. Bowel obstruction.
3. Hysterectomy.
4. She was hospitalized in 1958 following a motor vehicle accident requiring a tracheostomy at that time.

SOCIAL HISTORY: She quit smoking in 1973. She is currently cared for by her son and daughter-in-law.

FAMILY HISTORY: As noted before, her father died in his 60's. Mother died in her 80's. She had an active game warden until age 101.

PHYSICAL EXAMINATION:

General: In the Emergency Room this evening, she appears in no acute distress now. She in fact is lying flat. Oxygen saturation on room air at rest is 95-96%.

Vital signs: Initial blood pressure in the Emergency Room was 95 systolic, but now is 120 systolic sitting upright.

HEENT: Unremarkable. No evidence of any cyanosis now.

Neck: Supple.

Lungs: Chest examination actually reveals improved air movement into the lower lobes, especially on the left side. There is some dullness at the extreme left base. Breath sounds have less tubular quality and there are fewer crackles at the lung bases now than last week. No wheezes were audible.

Heart: Revealed a regular rate and rhythm.

Abdomen: Generally soft and nontender. Bowel sounds were present.

Extremities: Reveal cast below the left knee now. The right arm cast has been removed. She does not have edema in her feet. Trace edema in the dependent thigh.

LABORATORY DATA: Basic metabolic profile, CBC, protime, PTT are pending. X-ray also pending.

ASSESSMENT:

1. Recurrent breathlessness, possibly related to fatigue, but need to exclude and rule out recurrent pulmonary embolus on Coumadin. Also need to rule out a decrease in hemoglobin.
HISTORY & PHYSICAL

PATIENT: Hiller, DOROTHY

2. Status post fracture of the right and left patella, right tibial plateau, left os calcis and talar neck, right hand, and chest wall blunt trauma.
3. Atherosclerotic heart disease with history of angina.
4. Anemia.

PLAN:

1. Admit to the hospital.
2. Continue anticoagulation. If her prothrombin time is in the therapeutic range, will simply continue Coumadin. If prothrombin time is subtherapeutic, will begin Heparin.
3. Tomorrow morning, plan to proceed with a spiral CT Scan of the chest, and if there is evidence of new emboli, will proceed with placement of an inferior vena caval filter. Obviously, if more anemic, indicative of blood loss on Coumadin, also an indication for placement of an inferior vena caval filter.

Cullen B. Rivers, M.D.

TR: pg 0
DD: 05/01/99
DT: 05/02/99
CHIPENHAM AND JOHNSTON-WILLIS HOSPITALS, INC.
7101 Jahnke Road  1401 Johnston-Willis Dr.
Richmond, VA 23225 Richmond, VA 23235

PATIENT:  Hiller, DOROTHY
DOB:  04/30/31
ADM DATE:  05/01/99 ROOM #:  D.C206
DIS DATE:  05/07/99

ATTENDING PHYSICIAN: Rivers Cullen B

DISCHARGE SUMMARY

Chippenham Medical Center

cc:  John Carr, M. D., Medical College of Virginia

FINAL DIAGNOSIS:
1. Pulmonary thromboembolus, possible recurrent pulmonary embolus.
2. Status post motor vehicle accident with fractures of both legs and arm.
3. Anemia.
4. Atherosclerotic heart disease with history of angina, stable.

DISCHARGE MEDICATIONS: She will continue on Coumadin 2 mg. tabs take 6 mgs. on Saturday and Sunday, Monday dose will be based on repeat prothrombin time. She will stop Celebrex, stop Levaquin, continue Atenolol 25 mgs. daily, continue Colace in the evening and Iron supplement twice daily. She will be followed by home health who will check the pro time on Monday. She will have physical therapy and personal aide. She is to follow up with Dr. John Carr next week at Medical College of Virginia for orthopedic care. I have asked her to return to my office in 4-6 weeks or when she is more ambulatory. I will be communicating regarding her condition with the home health and following the prothrombin time once or twice a week.

PRESENT ILLNESS & HOSPITAL COURSE: Mrs. Hiller is a 68 year old lady who returned to the Emergency Room because of dyspnea and extreme tiredness and chest discomfort. She had been out of the hospital a couple of days and was doing well until the evening of admission. Family noted that she was breathing hard and had some peripheral or perioral cyanosis.

In the Emergency Room she was quite stable and her oxygen saturation was normal. Chest examination did reveal some persistent dullness at the left base with a few rales. Chest x-ray showed persistent left lower lobe atelectasis and effusion. Her hemoglobin was stable. Her prothrombin time was not in a therapeutic range. Repeat spiral CT scan of the chest showed no new emboli. There was still concern, however, that she had had recurrent pulmonary embolus.

She was admitted to the hospital and begun on Heparin. An inferior
vena caval filter was placed the following day. She has continued on Heparin. Prothrombin time is now approaching therapeutic range. She is discharged to continue Coumadin at home. Anticipate having her on this at least 6 months and until fully ambulatory.

Cullen B. Rivers, M.D.*
MCV Hospital - Orthopedics
Office Visit

Date: 05-10-99
Name: Hiller, Dorothy

SUBJECTIVE:
This patient, at the request of the family, was transferred to my care from South Carolina where she was involved in a motor vehicle accident. She is 68 years old. She had multiple injuries, including a left calcaneus fracture which was through the joint. This also caused flattening of the joint. There was also a severe tibial plateau fracture, bicondylar, with a split down the tibia and a patella fracture, which was open. At that time, the decision was that she would probably do better letting the bone heal and then considering a total knee in the future. She had many complications, including phlebitis and a pulmonary embolus. She was on, initially, Lovenox and then needed to have a Greenfield filter. Now she is on Coumadin. She had on the left hand, at the base of the fifth metacarpal, a fracture.

We are about 4 weeks out today.

LABORATORY / X-RAY DATA:
We x-rayed her knee and her patella. We moved them. They did not show any significant subluxation. I was worried that the femoral condyle may compress down into the lateral plateau.

PLAN:
1. We have placed a moving brace on her today.
2. We will start motion in 2 weeks, but not weight-bearing.
3. She will come back and see me in 1 month. We will repeat her x-rays by Xi-scan at that time, including the heel, the knee and the fifth metacarpal, which seems not to be healed yet, but she was taken out of her brace. I do not think it will be any problem leaving her out of the brace, but she may develop a nonunion.

Robert Martin  M.D.
RA/mmii:pcb
MCV Hospital - Orthopedics
Office Visit

Date: 06-04-99
Name: Hiller Dorothy

SUBJECTIVE:
This patient is being followed for a fractured tibial plateau from which she is approximately 2 months out now.

LABORATORY / X-RAY DATA:
The x-rays today demonstrated that the fracture looked to be consolidating well, both on AP and lateral, by Xi-scan.

On the other side, her calcaneus fracture was healing well. The x-rays were taken.

She required ambulance transportation today due to the fact that she was not ambulatory at all with both of her legs being fractured.

PLAN:
1. We are going to start a little bit of pressure on the foot with her brace on.
2. She will be using a walker.
3. She was placed back in a short-leg walking cast today.
4. A cast shoe was provided.
5. She was also given a prescription for a walker.

Robert Martin, M.D.

RA/mm11: pcb
This patient returns with continued pain in the left knee where she has had a knee cap fracture in the past and was not immobilized because she was in a wheelchair. She has also had problems with her cast which has been removed from the left ankle and also problems in the right fifth metacarpal shaft where she continues to have pain in the area where she had a fracture.

Examination today and x-rays by Xi-scan over the patella shows that the patella is still not healed on the left side but is in fairly good anatomic position. We placed her in a knee immobilizer today which she can use when she gets up on the left side. In addition, she uses a brace on the right side. Her fibula seems to be healed and we have taken her out of a cast and put her in an air splint. The right fifth metacarpal is still not healed and I feel that immobilizing that would be quite difficult because of the fact that she has to use that hand to get around. We are still trying to get her immobilized with minimal weight on the right and left sides now. This patient has demonstrated that she is slow to heal these various fractures, however. We will get Xi scans of all her fractured areas when she returns, including the right and left patella, the fifth metacarpal on the right hand, left ankle and tibial plateau on the right side.

db/
This patient who was injured on 4/2/99 has been relatively in a wheelchair for about the last two months. She has been doing some partial weight bearing for the last month.

X-rays today of her patella on the right demonstrate that she has a unifying patella fracture and her tibial plateau also appears healed. The calcaneal fracture on the left side also demonstrates healing after the cast is removed.

In summary, this patient had bilateral patella fractures with a right tibial plateau fracture and a left calcaneus fracture and a right ankle fracture. In addition, she had a 5th metatarsal fracture of her hand. I believe she is ready for a rehabilitation consult to assist her in getting up because of her age and the fact that she has been relatively immobile for a period of time. We contacted Dr. Khokhar and he feels that this patient appropriately would be a good candidate for admission to work on some intense therapy. It is my opinion that the patient could start to bear weight using a walker with equal weight on both feet.

:cc
This patient has been at the Johnston-Willis rehabilitation center for about 10 days. She is actually doing pretty well and walking. She feels giving way in both her legs and is having problems in her right ankle and both knees.

On examination, she has fairly restrictive motion around both patella joints, particularly on the right side where she has a great deal of crepitation. She has discomfort in her ankle on the right side in the fibular area. We did do x-rays showing that both patella have healed but they are significantly comminuted. The tibial plateau has healed. The calcaneus is healed and she has a squashed heel on the axial view but no significant deformity. On her right side where she was having pain, it looks like she had a fibular fracture also.

All in all she is doing quite well. I do not know if we will need a total knee in the future or not with her right knee, but at this time she will continue with her therapy program and strengthening program to build up her quads and continue to walk.
8/17/1993  CULLEN B. RIVERS, M.D.  
OPD-FOLLOW UP VISIT  
Chippewah Office  

BP: 132/70  
TDP: 98.8-95-16  
WT: 98  
HT: 5'9 1/2"  

ALLERGIES:  Morphine  

Ms. Hiller, is a 68 year old lady who was involved in a truck-car accident back in late April. I saw her when she presented in the Chippewah Emergency Room with severe pleuritic chest pain. She was found to have multiple pulmonary emboli. She subsequently required placement of an inferior vena caval filter but has also been able to continue on Coumadin.  

About 2 weeks ago she was at Johnston Willis inpatient rehab. Is now undergoing outpatient rehab and making remarkable progress in terms of her lower extremities. She is beginning to ambulate with just a brace on her left knee and around her left ankle.  

Review of systems reveals no significant problems with breathlessness. She has only an occasional cough with no significant amounts of sputa. She has had no chest pain. She has had no dizziness or lightheadedness. Stools have been dark related to the iron. She has a mild amount of edema in the left ankle.  

On exam today her vital signs are stable. Pulse is low at around 53-55 beats per minutes. Blood pressure stable and oxygen saturation is 95% on room air. HEENT unremarkable. Neck supple. Chest examination reveals excellent air movement. No rales or wheezes. Heart exam did reveal slow but regular pulse. Abdomen unremarkable. Extremities reveal trace edema around the lower part of the left leg.  

Assessment:  
1. Pulmonary thromboembolic disease secondary to multiple trauma. Because she was so bed fast, an inferior vena caval filter was placed.  
2. S/P multiple trauma with fractures to the leg and pelvis from which she is recovering very nicely.  

Plans: To continue Coumadin. She is scheduled for repeat protine INR this Wednesday. I have written a prescription for the home health to draw a CBC to check her hemoglobin to make sure that iron has been effective and that her hemoglobin is stable. She will continue Atenolol 1/2 tab daily.  

Plans are to see her back in December or January. I think that we can consider stopping the anticoagulants when she is fully ambulatory.
8/17/1999
CULLEN B. RIVERS, M.D.

GFC-FOLLOW UP VISIT
She may indeed need a left total knee replacement. She would need to be back
on anticoagulants at that time.

Cullen B. Rivers, M.D.

arl
This patient is still in outpatient therapy at this time. She is having difficulty with the pain in both knees, the left knee being worse. There is swelling in the left ankle. She wears the knee immobilizer to control some of the pain and discomfort in the left knee. The ankle itself does not seem to bother her very much other than where the swelling is concerned. She has a lot of grating in both knee caps.

Examination shows that she can actually come to full extension in both knees, but the amount of arthrosis is fairly significant in both knee caps. The ankle does not have any swelling today and she had some limitation in ankle motion but no instability noted. We will get x-rays of both knees and the ankle. In the ankle, we did not see any significant pathology for her age group, but both her knees show severe comminution of her patella but no joint arthrosis. In the future, she may require some arthroscopic surgery for her patellae and may require debridement of the distal pole leaving the proximal pole intact. She is going to return to see us in a few months and continue her therapy. She will stop wearing a knee immobilizer on the left side because of the weakness it is causing.

11/18/99 - Long chat & Debbie about Dorothy of her (left) knee & ankle pain. She sees Dr. Martin 12/8 so we will re-xray & see if she's reached max improvement or is surgery indicated? [Signature]
1801 5607942
Pot Throat
Scrotal Firms

[Handwritten notes and signatures]
HILLER DOROTHY

OV 12/8/99

This patient continues to be on Coumadin due to a suspected pulmonary embolism. Therefore, she hasn’t been able to be placed on anti-inflammatory agents at this time. She continues to have discomfort in her left ankle and heel. Also in both knees, the left greater than the right particularly localized to the patellar border. She had a patella fracture which was severe on the left side. A patella fracture on the right but the lateral tibial plateau also.

Examination today reveals that she lacks about 10 degrees of full extension in each knee. She flexes to about 130 degrees and has no swelling, effusions or instability of her knees at this time.

X-rays reveal that she has fairly severe arthritic disease in the right knee joint secondary to the tibial plateau fracture and in the left knee secondary to the patella fracture. She also has arthrosis of the subtalar joint secondary to the calcaneus fracture which has totally healed. At this time, we injected both of her knees today and we will have to wait until she comes off the Coumadin to start her on an anti-inflammatory regimen. She will see us back in 6 months.

/scrib

2/17/00 - Left message returning their call about pain. I asked where Dr can they double up on Darvocet for short period? [Signature]

2/22/00 Left another long message asking her to leave phone # if she’s elsewhere because she is saying I am not calling. This a.m. our phones were out at office & power. Also I renewed her Darvocet for pain in legs. [Signature]
1/05/2000
CULLEN B. RIVERS, M.D.
OPU-FOLLOW UP VISIT
Chippinman Office

BP: 130/80
TFR: 97-60-16
WT: 104
HT: 59 1/2"

ALLERGIRES: Morphine

Ms. Hiller is a 68 year old lady here today for follow up. She sustained multiple trauma early in 1999. I saw her when she moved from South Carolina to Richmond. She was hospitalized with pulmonary emboli.

Her progress through physical therapy over the past 6 months has been successful and she is now walking with just a cane.

She is followed by MCV orthopedics. They have recently placed her on Vioxx because of problems with arthritis and discomfort. Decisions to be made in the next 6 months as to whether or not she might need more surgery.

Review of systems reveals some morning cough related to sinus drainage. Last week she did have edema for 2-3 days treated with bedrest and it did resolve. She is mildly breathless. This is not a new finding. Her appetite is good. Weight is stable.

On examination today her vital signs are normal. Her oxygen saturation on room air at rest is 97%. Chest examination reveals excellent air movement. Heart exam revealed a regular rate and rhythm. Abdomen unremarkable. Extremities do reveal trace edema.

Assessment:
2. S/P multiple trauma to her lower extremity.
3. History of atherosclerotic heart disease.

Plan: To continue Coumadin. She would like to have no more than 2 protimes a month and will try to adjust Coumadin so that will be possible. I gave her Maxride 75/50 to take 1/2 to 1 tab once or twice a month as needed for edema.

Plans are to see her back in 6 months or before if needed.

Cullen B. Rivers, M.D.
Cullen B. Rivers, M.D.

1/17/2000

TEL-DOCTOR
Chippenham Office

She apparently had some GI distress related to Vioxx. Stopped that. Has continued however to have some diarrhea. According to what the daughter states it sounds like she might have some viral illness. She will take some Imodium, resume the Pepcid. If she has continuing problems, she may need to see a gastroenterologist. I did phone a prescription for Compazine.

A11
This patient continues to have persistent problems in her left knee, worse than the right, but both knees are giving her trouble. Her range of motion is fairly good and runs from 0 to about 100 degrees. Her x-rays today show that she looks like she has healed her fracture but she has a lot of arthritis underneath the knee cap. I recommended that she consider an arthroscopic debridement and possibly a retinacular release of her patella to take some of the pressure off it. It may be that she will need a total knee in the future.

We will do the left knee. She has had some angina in the past and had a head injury in the past when she was out for about 21 days in 1958. We will get her seen by anesthesia. She will probably need a stress test. She has also had a Greenfield filter after the bilateral lower leg injuries. She is on Coumadin and she needs to stop that two weeks before surgery and then start it again about 1 week after surgery.

3/21/00 - Spoke to Debbie (her daughter) about what to expect post-op. She will be on walker probably should stay on them a few days and bring her meds to her but remain NPO until.

3/24/00 - Dorothy is in pain right post-op. I suggested using Tylenol for 3 days since she's off her Coumadin. I said to continue RICE and her other pain med Endocet, too. She will (Debbie) call back if still the same Monday.

February 28, 2000

Dr. Martin

My condition as of today is as follows:

1. both legs hurt
2. left knee and ankle hurts worse
3. after being on my legs, pain goes down side of left leg
4. during the night left upper thigh area hurts
5. headaches and not sleeping well at night
6. right knee gets stiff
7. Must do exercise in the morning prior to walking because of stiffness in both knees.
8. Left knee seams to lock up sometimes.

Vioxx may have caused nausea and stomach cramps. Dot had symptoms 3 or 4 days then stopped Vioxx for 7 days, returned to Vioxx for one week. Mild nausea returned continued Vioxx, nausea began to worsen, end of second week nausea was severe, stopped Vioxx, nausea and cramps stopped within 1-2 days.

List of current medications:

<table>
<thead>
<tr>
<th>Medications</th>
<th>X</th>
<th>Dose</th>
<th>X</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atenolol 25mg</td>
<td>1/2</td>
<td>Tablet</td>
<td>1</td>
<td>Day</td>
</tr>
<tr>
<td>Citrucel</td>
<td>1</td>
<td>Pack</td>
<td>1</td>
<td>Day</td>
</tr>
<tr>
<td>Coumadin 4mg</td>
<td>1 Tablet (4mg)</td>
<td>1</td>
<td>5:00 PM on Tues, Thurs, Sat, Sun</td>
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</tr>
<tr>
<td>Coumadin 4mg</td>
<td>2</td>
<td>Tablet (8mg)</td>
<td>1</td>
<td>5:00 PM on Mon, Wed, Fri</td>
</tr>
</tbody>
</table>

Do not take Vitamin K. Do not take aspiring-containing products

| Ferrous Sulfate (Iron) | 1 Tablet | 2 | Day |
| Pepcid 10mg            | 2 Tablet  | 1 | Day |

AS NEEDED:

| Darvocet-N 100         | As needed |
| TYLENOL PM             | As Needed |
HISTORY AND PHYSICAL

HISTORY OF PRESENT ILLNESS: Ms. Hiller is a 68 year old lady, who came to the office today for a preoperative evaluation. She is scheduled to undergo knee surgery by Dr. Robert Martin at Medical College of Virginia. She is having problems with severe pain as a result of multiple fractures sustained in a motor vehicle accident in April of 1999. She moved here to be close to her son and his family. I saw her when she presented in the Chippenham Medical Center Emergency Room with breathlessness. She was found to have a pulmonary embolus. Subsequently, she had an inferior vena caval filter placed. She is here today for a preop evaluation as noted; however, she presents with two relatively new problems. Yesterday, she noted sudden onset of nausea, ran to the bathroom, felt that she was going to vomit, and at the same time noted onset of a piercing headache. The headache has been persistent since yesterday. She had no loss of consciousness, no visual disturbance, no localized weakness, but generally feels weak. 3-4 days before that she noted in the evening a pressing chest discomfort that lasted for several minutes to an hour, finally resolving. This has not been recurrent. She also notes that she has felt weak, that she has noted palpitations since that time.

Further review of systems reveals no fever, chills, or sweats, no significant cough or sputum production, no significant heartburn or indigestion. She has not had any recurrent edema of the lower extremities.

PAST MEDICAL HISTORY:

1. As noted, significant for angina pectoris, diagnosed about two years ago. She has been on Atenolol 25 mg, half tab daily. As best she can recall, she did not have cardiac catheterization at that time.
2. She was involved in a motor vehicle accident in April of 1999, sustained multiple fractures, including fractures of the right and left patella, right tibial plateau, left os calcis, and talar neck of the right hand, and chest wall trauma with a small area of flail chest.

PAST SURGICAL HISTORY:

1. Appendectomy.
2. Bowel obstruction.
3. Hysterectomy.
4. In 1958 she had a tracheostomy following an accident.
5. She also had surgery for the multiple fractures sustained in April of 1999.
PATIENT: HILLER DOROTHY

SOCIAL HISTORY: She quit smoking in 1973. She lives in Richmond under the care of her son.

FAMILY HISTORY: Father died in his 60's. Mother died in her 80's.

PHYSICAL EXAMINATION:

General: On examination in the office today, she appears in no distress.

Vital signs: Oxygen saturation was 97% on room air. Blood pressure was 100/60, temperature 98.6, pulse 82, respirations 18, weight 102.

HEENT: Unremarkable.

Neck: Supple.

Lungs: Chest examination revealed diminished breath sounds, but good air movement with no rales or wheezes.

Cardiac: Exam revealed a regular rate and rhythm with an occasional ectopic beat. There was prominent S2. Faint systolic murmur.

Abdomen: Soft, nontender.

Extremities: Reveal no pitting edema.

ASSESSMENT:

1. Sudden onset nausea and headache. She is also on Coumadin, which raises concern of possible intracranial bleed. This needs to be excluded.
2. Chest pain 3-4 days ago; history of angina. Need to rule out a myocardial event prior to planned surgery on March 23rd.

PLAN:

1. Proceed with hospitalization.
2. Placement on a Telemetry monitor.
3. She will have an echocardiogram, electrocardiogram, cardiac isoenzymes, and troponin.
4. Will request Cardiology consultation.
5. Will go ahead with a CT scan of the head as well.

TR: pck
DD: 03/06/2000
DT: 03/06/2000
DRFT: 03/06/2000
F/E: F

CULLEN B. RIVERA, M.D. [F]

CC: ROBERT S. M.D.
HISTORY OF PRESENT ILLNESS: The patient is a 68 year old female, who, for several days has been having problems with intermittent nausea, and a couple of episodes of vomiting after which she had a severe splitting headache a couple of nights ago. She also had some vague discomfort in her chest during the evening about 3-4 days ago which occurred briefly yesterday and has not recurred. She described this very vaguely. She has generally felt weak and run down for the last 4-5 days. She notices some intermittent skips in her pulse, but states that she has had these for many, many years. She was placed on what she described as Atenolol several years ago for this. She has had no syncope, but had some light headedness with vomiting a couple of nights ago. She had no hematemesis. There is no history of exertional chest pain. She has chronic dyspnea on exertion, no paroxysmal nocturnal dyspnea or orthopnea. She has not noted any ankle edema.

PAST MEDICAL HISTORY: Negative for hypertension and diabetes. She has had multiple fractures in the past, from an automobile accident and subsequent pulmonary emboli. She has been on Coumadin and she had an inferior vena cava filter. She was told that she had elevated cholesterol years ago but she has not had it rechecked since. She has been told on occasion that she has had a murmur in the past. There is no history of myocardial infarction or rheumatid fever.

MEDICATIONS:
1. Atenolol 25 mg. daily

SOCIAL HISTORY: She stopped smoking many years ago. She uses no alcohol.

FAMILY HISTORY: Father died in his late 50's or early 60's of a suspected heart attack. She has a brother who had some heart problems. Her mother had diabetes and heart problems.

REVIEW OF SYSTEMS: Poor appetite for a few days, otherwise her appetite has been good. No weight change recently. She had some sweats the other night when she was nauseated. No fever or chills. Neurologic: Severe headaches as
Patient: HILLER, DOROTHY

noted. No other neurologic symptomatology. ENT: No tenderness or vertigo.
Eyes revealed no diplopia. Respiratory: No cough, sputum production or
hemoptysis. GI: Nausea and vomiting as above. No hematemesis. No melena,
abdominal pain or hematocritias. GU: No dysuria. All other systems revealed
no reported symptoms.

PHYSICAL EXAMINATION: The blood pressure was 135/75, pulse 70 and regular,
respirations 13. NECK: Clear conjunctivae. The fundi are not well seen.
The neck was supple without neck vein distention. The thyroid was not
palpable. The chest was symmetric. There was good expansion bilaterally.
There were no wheezes or rales. The cardiac examination revealed the PMI in
the fifth intercostal space at the midclavicular line, normal intensity. The
S-1 and S-2 are normal. There was a I/VI ejection quality murmur at the left
sternal border. No diastolic murmur was heard. There was no gallop heard.
The abdomen was non-tender. The liver, spleen and aorta were not palpable.
The extremities revealed no edema. There were 1-2+ pulses.

LABORATORY DATA: Electrocardiogram is unremarkable other than incomplete
right bundle branch block.

IMPRESSIONS:
1. Chest pain which is atypical. I think this is probably non-ischemic given
her descriptions.
2. Severe headache, etiology not clear. Given her other complexity of
symptoms one questions whether she might have had some sort of viral syndrome
or sinus problem.
3. History of pulmonary embolus
4. History of hypercholesterolemia

DISPOSITION: We will check her lipids. I will recheck her CK in the
morning. If this is negative I think we can go ahead and screen her for
ischemia, probably doing a Dobutamine echocardiogram as the simplest means of
screening her at this point.

Thank you for the privilege of helping taking part in her care.

TR:        bjw
DD:        03/06/2000
DT:        03/06/2000
DRPT:      03/06/2000
F/E:        PE

DAVID G. HUGHES, M.D. [F E]
cc:         CULLEN B. RIVERS, M.D. [F]
Electronically Signed by David G Hughes on 03/07/00 at 0712
3/06/2000  CULLEN B. RIVERS, M.D.
OPC-FOLLOW UP VISIT
Chippenham Office

BP: 100/60  02 SAT % : 97 RA
TPR: 98.6-82-18
WT: 102  HT: 59 1/2"

ALLERGIES: morphine

Ms. Hiller is a 68 year old lady who presents in the office today for a preop evaluation. She tells me however that she had onset of sudden nausea yesterday followed by a severe headache which has persisted. Three or four days ago she also had chest pain that bothered her when she went to bed. It finally resolved but since then she has been very weak. She notes prominent palpitations as well.

I decided to go ahead and admit her to the hospital on telemetry to R/O arrhythmia. Will get an EKG, cardiac enzymes, echocardiogram and cardiology consultation. Also need to do a CT scan of the head to R/O an intracranial bleed.

Cullen B. Rivers, M.D.
OPERATIVE REPORT

Patient Name: MILLER DOROTHY
Procedure Date: 03/23/2000
Clinical Service: ORTHOPEDIC SURGERY
Attending: ROBERT S. ADELAAR, M.D.

SURGEON: ROBERT S. MARTIN, M.D.
ASSISTANT: CHARLES R. SHUFF, M.D.

PREOPERATIVE DIAGNOSIS: Status post patellar fracture of the left knee with patellofemoral pain.

POSTOPERATIVE DIAGNOSIS: Status post patellar fracture of the left knee with patellofemoral pain.

PROCEDURE PERFORMED: Left arthroscopic debridement of patella and lateral retinacular release, left knee, arthroscopically.

ANESTHESIA: General.

PROCEDURE IN DETAIL: The patient was placed in the supine position with the well leg on the well leg holder. She was prepped and draped. An arthroscopic instrument was placed in the lateral infrapatellar puncture and an instrument portal through the medial infrapatellar puncture. Complete visualization of the knee was done, including looking at the patella, identifying the fracture. She had a fairly large medial plica, that eventually was resected, in addition to some synovitis around her patella. The medial and lateral joint line had no evidence of meniscal tears. The lateral joint line was almost normal. The medial joint line did have some chondromalacia, and the meniscus was intact. Both menisci were probed. We then put the full-radius debrider in and debrided some of the medial plica and fibrosis in the patellofemoral joint. We did not shave down the patella, since it was pretty solid cartilage. We felt that we would change contact area by putting a cautery in and then releasing the lateral retinaculum. This was done. The lateral retinaculum was released from the lateral infrapatellar portal, with an arthroscope through the medial infrapatellar portal. After this was accomplished, we then put Marcaine into the knee joint. Closure of the puncture sites were done with 4-0 nylon. A compressive dressing was applied.

The patient tolerated the procedure well.

Dr. Martin was present for the entire endoscopic procedure.

Robert Martin

HILLER, DOROTHY

OV  4/4/00

This patient had an arthroscopy recently on the left knee with the finding that she did have articular damage on the patella secondary to her fracture in addition to mild arthritis in the rest of her knee joint.

Her range of motion is well. Her sutures are out today. She is going to start back at the Sheltering Arms facility for some swimming, range of motion and strengthening. We will see her back in 6 weeks.

/sem
HILLER DOROTHY

5-17-00

This patient's left knee is doing quite well at this time where she had a previous arthroscopy on 3-23. She is having a lot of symptoms in her right knee. She has limited ability to extend the right knee. She is still working with some type of senior citizen exercise program with Sheltering Arms. I believe she is also taking Celebrex.

We did examine her right knee which is the new problem and found that she has lack of extension to 15 degrees. She could only flex to 90 degrees. She has a lot of discomfort. We injected the right knee. We may have to do an arthroscopic procedure on the right knee in the future. She had a fractured patella in that knee.

7/24/00 - Moved 8/10 to 8/2/00 @ 8:45 because her legs are worse & pain... Her son-in-law comes in here, too, so this will be more convenient & sooner for her.

(neut - 30%) 74% Ennis
1% inside FAP

Knee Total 11/45
Patella / Tibia Plate

Posterior 4000 prn
Medial 4000 prn

Lah000
Righ 000
This patient continues to have significant pain in both of her knees. Actually, her left knee is giving her a little bit more trouble than the right. She has had injections and the injections are wearing off in about two months. She takes anti-inflammatory agents. Her x-rays today demonstrate the right knee has significant arthrosis of her tibial plateau fracture and her patellar fracture. She is losing her ability to extend her right knee. She has better extension of her left. She has good ligamentous control of both knees. In the future, she will need bilateral total knees. I recommend she start with the right knee since it is a lot worse on x-ray. That may take some of the stress off of her left knee for the future. We will plan to inject her left knee today and set her up for a total knee in the future and giving one unit of blood under epidural or general and she will need to have anesthesia see her.

/sem

9/12/00 - Seen today in pop clinic, staples removed & steri-strips applied, wrapped with ace bandage. P.T. ordered for 9/18/00 x 3 wks. Current meds: Dilaudid 3mg, ½-1 po prn q 4-6h. Coumadin 2.5mg QD. Atenolol (by another physician). MCV Care @ Home contacted.

Bennis FNP
MEDICAL COLLEGE OF VIRGINIA HOSPITALS AND PHYSICIANS  
Virginia Commonwealth University  
Richmond, Virginia 23298

DISCHARGE SUMMARY

Patient Name: HILLER  DOROTHY
Admitted: 08/29/00
Attending: Robert Martin, M.D.
Clinical Service: ORTHOPEDIC SURGERY
Discharged: 09/01/00

ADMISSION DIAGNOSIS: Osteoarthritis of the right knee.

HISTORY OF PRESENT ILLNESS: The patient is a 69-year-old white female who presented to the Medical College of Virginia Hospital orthopedic service for right total knee arthroplasty. The patient was involved in a motor vehicle accident in April 1999, during which she received injuries to both of her knees and since that time has had near continuous pain of both knees. Both knees are giving problems when walking, left greater than right. X-rays of the knees revealed that the right tibial fracture and patellar fracture developed significant arthritis of her right knee and she has been unable to extend her right knee.


MEDICATIONS ON ADMISSION: 1. Atenolol 25 mg half tablet q.d. 2. Celebrex. 3. Lipitor. 4. Doxepin.

ALLERGIES: Morphine. The patient is also allergic to all tapes except for paper tape.

PHYSICAL EXAMINATION: Afebrile, vital signs stable. HEENT: Pupils equally round and reactive to light and accommodation. The extraocular movements are intact. Neck: The trachea was midline with no lymphadenopathy. Lungs: Clear to auscultation bilaterally. Heart: Regular rate and rhythm with no murmurs, rubs or gallops. Abdomen: Positive bowel sounds, soft, nontender, nondistended. Extremities: An extension lag of 10 degrees on the right knee; the left knee reveals full extension. Strength examination on the right iliopsoas 5/5, quadriceps 4/5, hamstrings 4/5, extensor hallucis longus 5/5 and PHL 5/5. Left leg reveals iliopsoas 5/5 strength, quadriceps 4/4, hamstrings 4/4 secondary to knee pain, EHL 5/5, PHL 5/5. Sensation is intact to pinprick and light touch distally in bilateral lower extremities. Dorsalis pedis pulses are 1+ bilaterally with good capillary refill.

HOSPITAL COURSE: The patient was taken to the operating room on hospital day #1 for a right total knee arthroplasty submitted. The patient tolerated the procedure well and was returned to the floor in stable condition. The patient was started on a seven-day course of antibiotics. Also she was started continued passive motion of her right knee. She was placed on Coumadin for deep venous thrombosis prophylaxis. The right knee was placed in a knee immobilizer and she was allowed to fully weightbear as tolerated.
On postoperative day #1 the patient remained afebrile with good pain control. The patient's Foley catheter was discontinued. The patient continued on deep venous thrombosis prophylaxis. On postoperative day #1 the patient had a temperature of 102.6 and was instructed on pulmonary toilet. The patient was also transfused with 2 units of red blood cells for a hemoglobin of 7.6.

On postoperative day #2 the patient was afebrile, hemoglobin was 10.5 after 2 units of red blood cells and the patient was doing well. The patient progressed well with physical therapy using a walker, weightbearing using a knee immobilizer on the right knee. On postoperative day #2 the patient’s Hemovac was discontinued. On postoperative day #3 the patient cleared physical therapy and was discharged.

DISPOSITION: Discharged to home.

DISCHARGE INSTRUCTIONS: Diet no restrictions. The patient was to use a walker for walking and may weightbear on the right lower extremity as tolerated. The patient was instructed to wear the elastic stockings during the day and they may be removed at night, but should be placed on again before getting out of bed. The patient was to avoid driving until discussed with Dr. Adelaar at the followup visit. No heavy lifting. Showering, the patient may shower and pat the staples dry and was to avoid sitting in a tub. She may leave the staples to the open air. The patient was instructed to call the doctor if there was increased pain, heat, redness, discharge or swelling in the knee incision.

DISCHARGE MEDICATIONS: 1. Cephradine 500 mg 1 tablet p.o. q.i.d., quantity dispensed 40. 2. Warfarin 5 mg 1 tablet p.o. q.d., quantity dispensed 30 tablets. 3. Docusate capsule 100 mg 1 tablet b.i.d., quantity dispensed 24 tablets. 4. Hydromorphone 2 mg tablets 1 to 2 tablets p.o. q.4-6h. p.r.n. pain, quantity dispensed 60.
FOLLOWUP: The patient was to have an appointment in one week with the attending physician. The clerk was to make an appointment.
August 30, 2000

Letter to Ms. Hiller's Counsel

Re: Dorothy Hiller

Dear Mr. [Name]

I am writing in reference to Dorothy Hiller who we have accepted in transfer for treatment of injuries resulting from an automobile accident that occurred on April 7, 1999. She suffered fractures at that time of the left calcaneus that had crushed her heel and the fracture went through the joint. She also had a fracture of her left kneecap which had significant comminution. She had fractures of the right patella or kneecap that underwent an open reduction internal fixation and a closed reduction of the upper right tibia joint fracture and fracture of her right metacarpal bone in her hand. When she came to us, she was in a wheelchair and we treated her with continued bracing of both kneecap fractures and her tibial plateau and casting of her heel fracture with splinting of her metacarpal fracture. Over a 3-month period we were able to get her out of the braces and start her on a physical therapy program. She spent 3 1/2 months in a wheelchair unable to walk due to the number of injuries she had which subsequently takes its toll with muscle wasting and bone osteopenia. This required that she go to a rehabilitation center to recoup some of her strength so she could walk with the assistance of a walker. Since that time, she has been a very diligent patient attempting to regain her strength, ambulatory ability and balance. Unfortunately, she has several different injuries, any one of which would severely disable her, but both knees have continued to have arthritic complaints secondary to the trauma which prevent her from climbing, walking and standing effectively without pain. She has been on anti-inflammatory agents and has had multiple injections. She also had an arthroscopic procedure to her left knee on March 23, 2000, whereby we debrided some of the articular surface which was arthritic under her patella and released some lateral structures of her knee to put less pressure on her kneecap.

On August 29, 2000, she had a right total knee done because of the severity of the arthritis, injuries and lack of motion she has. She will continue to have pain and discomfort in her left knee and eventually will require a total knee of that knee as well. Additionally, she has pain in the area of her left hindfoot and ankle.
secondary to the fractures she had. The metacarpal fracture has not caused her any residual disability.

With regard to disability in the future, it is our opinion that her right lower extremity will have a 30% disability after the total knee arthroplasty. Her left lower extremity will have a 30% disability after the total knee arthroplasty in addition to 12% disability because of her calcaneal fracture, giving her a total disability of 42% in the left leg and we believe that within five years she will have both total knees.

The future cost of each total knee would be approximately $4,200 in professional fees and $25,000 for hospitalization fees and $4,000 for the post-operative rehabilitation fees, including medication. The subtalar joint will have to be fused on the left side due to the arthritis secondary to the calcaneal fracture with a hospitalization fee of $10,000, a professional fee of $2,000 and a post-operative rehabilitation fee of $2,000.

In summary, I tried to relate some of the probable future costs and disabilities that will affect Ms. Dorothy Powers in the future.

Sincerely,

[Signature]

Robert Martin M.D.

RSA:db
HILLER DOROTHY

OV 10/10/00

This patient presents after her total knee done on 8/29/00. She developed a little bit of drainage superficially near the center of her wound and she had a little inflammation which responded very well to antibiotics by mouth. She was placed on Keflex 500. We have redone the Keflex for 100 so she will be on it for about 4 weeks total and she will continue with her physical therapy. She is doing excellent as far as her range of motion is concerned and goes from 0 to 115 already.

/sem

10/20/00 - Doing is in PT therapy and doing well. She will stop Coumadin 10/29/00. So no more bloodwork.

Bennie FRP
This patient is doing well with her total knee which was done on the right side on August 29, 2000. She has full extension and can go to about 115 degrees of flexion. We are seeing her also for her opposite knee; the left knee where she is having pain and discomfort in the knee. She feels that the patella is tracking in a lateral direction and causing pain. She had fractures of the patella and in addition she has had some pain and discomfort in there. An arthroscopy was done and she would be considered for a total knee in the future.

/addendum: We will see her back in 6 months and at that time I would like an AP standing of both of her knees and a lateral of each knee.
**HISTORY AND PHYSICAL**

**REASON FOR ENCOUNTER:** Chest pain.

**HISTORY OF PRESENT ILLNESS:** Sixty-nine year old woman, with history of pulmonary embolus leading to inferior vena caval filter, now with chest pain. This was vaguely described. The patient is unclear as to whether or not she has coronary disease. There is a question of past diagnosis of angina. Review of medical records reveals no objective evidence of coronary disease or history of myocardial infarction, despite coronary risk factors of elevated cholesterol, former tobacco use and family history of coronary disease. The patient has no history of diabetes mellitus or hypertension. The patient has been treated in the past with Atenolol for PAC's. Patient with unremarkable Dobutamine stress echo performed at this institution, 3/7/2000 and has reportedly undergone a nuclear medicine guided stress test at MCV within the past year, also unremarkable. The patient unfortunately does has a history of pulmonary embolus leading to inferior vena caval filter placement following motor vehicle accident.

**ALLERGIES:** Unclear. Patient with sensitivity to Morphine at one time in the past.

**MEDICATIONS:**
1. Atenolol 50 mg. PO QD
2. Lipitor 20 mg. Q HS
3. Celebrex prn
4. Darvocet prn

**SOCIAL HISTORY:** Remarkable for former tobacco use, none for over twenty years. The patient does not consume alcohol.

**PAST MEDICAL HISTORY:**
1. Degenerative joint disease
2. Multiple trauma following motor vehicle accident, with right total knee replacement within the past year.
3. History of recurrent urinary tract infections due to ureteral problems secondary to motor vehicle accident in the past.
4. Anxiety and depression

**PHYSICAL EXAMINATION:** Blood pressure 114/61, pulse 55, O2 saturation 97%, patient is pain free at this time. Examination of the neck reveals no
evidence of JVD, no thyroid enlargement or nodularity, no carotid bruits. Lungs are clear to auscultation and percussion. Cardiovascular examination reveals PMI without evidence of murmurs or gallops. Abdominal examination is benign. Examination of extremities reveals no evidence of peripheral edema. Distal pulses are intact. Electrocardiogram demonstrates sinus rhythm with first degree AV block, T wave abnormality, potassium 4.1, BUN 19, creatinine 0.8, pro-time 11.0

IMPRESSION: Chest pain. I believe Heparin, spiral CT to evaluate PE are reasonable, will begin aspirin and Heparin and continue the patient's outpatient medications. In this woman who has had two negative assessments for coronary disease in the past fourteen months, I would be extremely surprised if coronary disease is playing a role today. Unfortunately, the patient's insistence on past diagnosis of angina and tendency to come to the Emergency Room, was most likely musculoskeletal pain. It may be reasonable to proceed with coronary angiography, if only to eliminate this possibility, as the patient may be undergo left total knee replacement in the near future. I believe this would also be important in convincing the patient that coronary disease is not an active problem at this time. If on the other hand, coronary disease is found, I believe it would be important to treat this aggressively in this woman with upcoming surgery.
CARDIAC CATHETERIZATION

PROCEDURE: Left heart catheterization, left ventriculogram, coronary angiograms.

INDICATIONS: Recurrent chest pain, history of prior angina pectoris.

TECHNIQUE: Judkins with single wall puncture of right femoral artery.

CATHETERS & MEDICATIONS: Per pressure sheet.

COMMENTS: The procedure was well tolerated with evidence of complications. Estimated blood loss 10 ccs. The arterial puncture was closed with Angio-Seal.

FINDINGS: Left heart pressures were normal with LVEDP of 7.

The left ventricle was opacified in the RAO and LAO projections. All segments of the left ventricle contract well. Estimated EF 60%. No obvious mitral regurgitation is seen.

The left main coronary is widely patent.

The left circumflex gives rise to one large marginal vessel which tapers smoothly and is free of disease. There is no continued AV groove branch. There are a couple of small intermediate marginal branches proximally which have no significant disease.

There is a large LAD which is somewhat tortuous, but tapers smoothly down the anterior wall, around the apex, and slightly on to the inferior wall with no evidence of plaquing. There is a moderate size mid diagonal branch which also tapers smoothly.

The right coronary is a moderate size vessel with a small posterior descending branch and a large continued AV groove and distal posterolateral system. All of these vessels taper smoothly and appear free of disease.
Patient: Hiller DOROTHY

CONCLUSIONS: 1. Normal left heart pressures.
2. Normal left ventriculogram.

TR:    dkh
DD:    05/03/2001
DT:    05/07/2001
DRPT:  05/07/2001
F/R:   

DAVID G. HUGHES, M.D. [F B]
cc:    CHIPPENHAM CATH LAB
Electronically Signed by David G Hughes on 05/07/01 at 1200
HILLER, DOROTHY

OV 06/04/01

This patient had a total knee done and is about six months out at this time. She also has arthritis of the left knee. Her total knee was done on the right side. She is doing quite well. She still uses the cane on the right side because of her left knee problems. She has had patellar problems in that left knee from trauma.

Examination today shows that she goes to full extension and gets a 120 degrees of flexion out of her knee. Her left knee is primarily grating and patellar problems that we can palpate. We are seeing her back in one year and when she comes back she will need an AP standing of both her knees and a lateral of each knee before I see her.

/agg
HILLER DOROTHY

OV 09/17/01

This patient is still having problems with her left knee. She has discomfort localized in and around the left knee in the patella femur and occasionally going down to the ankle on the left side. Her medical problems are stable, her right knee is doing well, she still uses a cane because of the left knee. X-ray examination of both knees reveal she has significant patella femoral arthritis of the left knee and arthritis in the medial lateral compartment which is not as bad, as well as osteoporosis.

Our plan will be to inject her today, we've examined both her knees today and her right knee has full range of motion. If after the injection she doesn't get lasting relief she should be scheduled for a total knee arthroplasty on the left side.

/PM

12/4/01 - Touched base with her about home health & her knee brace.

1/14/02 - Today & Friday talked to her about stopping Coumadin and taking baby ASA QD.

[Signature]

EMMA PNP
MEDICAL COLLEGE OF VIRGINIA HOSPITALS AND PHYSICIANS
Virginia Commonwealth University
Richmond, Virginia 23298

DISCHARGE SUMMARY

Patient Name: HILLER DOROTHY
Admitted: 11/27/2001
Attending: Robert Martin M.D.
Clinical Service: ORTHOPEDIC SURGERY

Discharged: 11/30/2001

ADMISSION DIAGNOSIS: Degenerative joint disease of the left knee.

DISCHARGE DIAGNOSIS: Degenerative joint disease of the left knee.

SURGICAL PROCEDURES: Left total knee arthroplasty on 11/27/01.

HISTORY OF PRESENT ILLNESS: The patient is a 70-year-old female who has had progressive pain in her left knee for several years. She is status post right total knee arthroplasty and has done very well with that; however, she ambulates with a cane and is debilitated by the pain in her left knee. She has failed conservative management, including non-steroidal anti-inflammatories and injections.

PAST MEDICAL HISTORY: 1. Significant for chest pain approximately nine months ago. Underwent a cardiac catheterization, which revealed normal coronaries, and an ejection fraction of 60%. 2. Greenfield filter placement for DVT.

PAST SURGICAL HISTORY: 1. Right total knee arthroplasty approximately 1 1/2 years ago. 2. Appendectomy. 3. Hysterectomy. 4. Partial bowel resection. 5. IVC filter. 6. Tracheostomy after motor vehicle accident approximately 40 years ago.

MEDICATIONS: 1. Atenolol 12.5 mg q.d. 2. Darvocet p.r.n. 3. Tylenol No. 3 p.r.n.

PHYSICAL EXAMINATION: Her general examination, including heart, lungs, and abdomen were within normal limits. Left lower extremity: Demonstrated swollen knee with full range of motion and diffuse tenderness. The knee was stable with a stress, as well as a Lachman. Motor: 5/5 throughout, light touch was in touch, and there is a + dorsalis pedis pulse.

HOSPITAL COURSE: The patient was admitted to the Orthopedic Surgery Service for the above-named procedure. She tolerated the procedure well and remained stable and afebrile throughout her postoperative course. Postoperatively, she was started on Coumadin for DVT prophylaxis. She did receive one unit of packed red blood cells for hemoglobin of 8.7 on postoperative day #1. She progressed very rapidly with physical and occupational therapy, and was ready for discharge by postoperative day 3.

DISCHARGE MEDICATIONS: 1. Atenolol 12.5 mg q.d. 2. Percocet p.r.n. pain. 3. Coumadin 2.5 mg q.d. 4. Keflex 500 mg q.i.d. x 7 days. 5. Colace 100 mg p.r.n.

DISCHARGE INSTRUCTIONS: The patient will receive home health PT and lab draws for INR checks to be faxed to Dr. Robert S. Adlzear's
office. She will follow-up with Dr. Robert in approximately two weeks.

Robert Martin, M.D., Dictated by: Jason Hull, M.D.
HILLER, DOROTHY

OV 12/18/01

This patient is about 3 weeks out from her total knee. She is doing fine with the exception she has not regained her full extension yet. Her wound looks good. It has been a little warm during physical therapy but I told her that would be expected. Our plan will be to keep her on her Coumadin for 6 weeks. She is on Lortab 7.5 over 5, she is also on physical therapy 3 times a week for a period of 6 weeks. She will return to see us at that time. She should be sent for an AP standing and a lateral of her knee before I see her.

/sem
HILLER  DOROTHY

OV 1/30/02

This patient has completed her physical therapy. She still has some soreness, primarily in
the lateral tibia of her left knee which was done on 11/27/01. She still continues to have
discomfort with that knee when standing. There still is not full extension on examination,
she lacks about 10°, she comes to about 100° of flexion. X-rays today show that she has
a little bit of laxity under the medial plateau of the left knee, otherwise the prosthesis looks
good. She’ll see us back in one year, I’ve given her a prescription for Tylenol #3 and
some Ambien to which she will go to her family doctor for follow up.

/pm
PRELIMINARY

AGGREGATE TABLE

PRESENT VALUE OF THE ECONOMIC LOSS OF

Dorothy Hiller

TOTAL ECONOMIC LOSS
(COSTS OF PRODUCTS AND SERVICES)
FOR REASON OF PERMANENT DISABILITY

= See Attachment

ASSUMPTIONS

A. Services and products assumed to continue to statutory life expectancy, to statutory life expectancy plus 5 years, and to statutory life expectancy plus 10 years
B. Current costs of services and products = variable - see Life Care Plan
C. Future costs adjusted and present value at net discount rate = (1.2%) to 2%
D. Net self-maintenance expenses deducted at zero
E. Discounted for mortality
F. See Life Care Plan prepared by C. Orson, received July, 2002, and September 5, 2002 (revision)
ATTACHMENT TO PRELIMINARY AGGREGATE TABLE A

SPECIFICATIONS
OF THE COSTS OF PRODUCTS AND SERVICES
For Dorothy HILLER

LIFE CARE PLAN -- OPTION #1

<table>
<thead>
<tr>
<th>Products and Services</th>
<th>To S.L.E.*</th>
<th>To S.L.E.* + 5 Years</th>
<th>To S.L.E.* + 10 Years</th>
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LIFE CARE PLAN -- OPTION #2

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<th>Products and Services</th>
<th>To S.L.E.*</th>
<th>To S.L.E.* + 5 Years</th>
<th>To S.L.E.* + 10 Years</th>
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*S.L.E. = Statutory Life Expectancy
Introduction

Accident Research Specialists, PLLC (ARS) was asked to investigate a motor vehicle accident that occurred on SC 41 near Andrews, South Carolina on April 7, 1999. The three vehicle accident involved Dorothy Hiller, Charles Cutler, and James McGinn. The accident occurred during daylight in dry and clear weather.

Investigation

The following materials were reviewed:

1. The accident reports prepared by Trooper Johnson, the investigating officer, with supplements.

2. An interview with Trooper Johnson

3. An interview with James McGinn

4. Photographs of the accident scene on the day of the accident.

5. Photographs of the accident site taken by the trooper after the vehicles had been removed.


7. Photographs of the Cutler tractor trailer.

8. Photographs of the McGinn tractor trailer.
9. Complaint with Attached Request for Admissions, Interrogatories and Request for Production.

10. Defendant Fleet-Trucking Company's Answer.


12. The deposition transcript of Dorothy Hiller

13. The deposition transcript of Charles Cutler

In addition, ARS examined, measured and photographed the accident site.

**Analysis**

The analysis of the accident was based on the physical evidence shown in the officer’s investigation, the photographs of the vehicles and roadway, the measurements of the roadway, and the properties of the vehicles. The timing of the pre-impact positions and movements of the vehicles were then determined. The testimony of the drivers and the witness were compared with the analysis of the accident.

**Opinions**

The following opinions are based on the investigation and analysis of the accident and the education and experience of the undersigned.

1. Ms. Hiller made a right hand turn onto northbound SC 41 from Van Vlake Drive. Van Vlake Drive is approximately 1,575 feet from the south end of Mingo Creek Bridge.
2. The initial impact was located just south of the south end of the Mingo Creek Bridge. The initial impact occurred when Mr. Cutler moved from the southbound lane into the northbound lane after partially passing Ms. Hiller's car. The contact occurred between the right side trailer tires and the left fender and driver's door of the car.

3. Ms. Hiller traveled northbound for approximately 25 seconds from Van Vlak Drive to the point of initial contact.

4. Mr. Cutler would have been at least 800 feet south of Van Vlak Drive when Ms. Hiller pulled into the road.

5. The total overall sight distance on both sides of the bridge is approximately one mile. The approaching southbound tractor trailer driven by Mr. McGinn would have been visible to Mr. Cutler at the time that Ms. Hiller pulled into the road, during his passing movement in the southbound lane, and until the time of the accident.

6. The movement of the Hiller vehicle into the road would not have required any evasive action by Mr. Cutler.

7. Mr. Cutler would have had sufficient time and distance to move back into the northbound lane behind the Hiller vehicle during his passing movement.

8. Based on the timing and positioning of the three vehicles before the accident, Mr. Cutler moved his truck into the side of the Hiller car to avoid a head-on collision with Mr. McGinn. Mr. McGinn stated that he was reducing speed in response to the Cutler truck.

Respectfully submitted,

Accident Research Specialists, PLLC

[Signature]

Michael Benson, P.E.
Photograph List

1. Van Vlake Drive and reference pole. (omitted)
2. Views south and north at Van Vlake Drive.
3. Views south and north 250 feet from Van Vlake Drive. (omitted)
4. Views south and north 500 feet from Van Vlake Drive.
5. Views south and north 750 feet from Van Vlake Drive. (omitted)
6. Views south and north 1,000 feet from Van Vlake Drive.
7.-8. Northbound shoulder.
9. Southbound shoulder. (omitted)
10. Fieldcrest Road located off Van Vlake Drive. (omitted)
11. Views south on SC 41 from Van Vlake Drive. (omitted)
12. Views north on SC 41 from Van Vlake Drive. (omitted)
13. View south on SC 41 toward accident site. (omitted)
15.-18. Views of the bridge. (15-17 omitted)
19. Guardrail damage south of bridge.
## DEFENDANT CUTLER’S CRIMINAL AND DRIVING RECORD

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<tr>
<th>Date</th>
<th>Charge</th>
<th>Disposition</th>
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<tbody>
<tr>
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<td>Guilty Plea</td>
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<td>No Seat Belt</td>
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<td>1/10/00</td>
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<td></td>
<td>Worthless Check</td>
<td>Guilty plea</td>
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<td>12/18/99</td>
<td>Speeding</td>
<td>Guilty plea</td>
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<td>1/14/00</td>
<td>Worthless check</td>
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<td>Possession of undersized bass</td>
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<td>Possession of undersized flounder</td>
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<td>1/10/95</td>
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<td>1/10/94</td>
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<td>4/6/92</td>
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<td>Reckless driving to endanger</td>
<td>Guilty plea on both</td>
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<td>Unsafe movement</td>
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<td>5/20/92</td>
<td>Noise ordinance violation</td>
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<td>Covering/disguising license plate</td>
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<td>1/31/90</td>
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<td>Civil license revocation – 30 days</td>
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<td>4/24/89</td>
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<td>Illegal Use of Red Light</td>
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<tr>
<td>12/2/83</td>
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</tr>
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</table>

For purposes of your examinations, you may assume this is a certified record.
Fracture of the base of the 5th metacarpal
Comminuted fracture of calcaneus
Status post total knee replacement, comminuted fracture of patella
Bicondylar tibial plateau fracture, fracture of fibular head, comminuted fracture of patella
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.