WISCONSIN DEPARTMENT OF REGULATION & LICENSING

Wisconsin Department of Regulation & Licensing
Access to the Public Records of the Reports of Decisions

This Reports of Decisions document was retrieved from the Wisconsin Department of Regulation & Licensing website. These records are open to public view under Wisconsin's Open Records law, sections 19.31-19.39 Wisconsin Statutes.

Please read this agreement prior to viewing the Decision:

- The Reports of Decisions is designed to contain copies of all orders issued by credentialing authorities within the Department of Regulation and Licensing from November, 1998 to the present. In addition, many but not all orders for the time period between 1977 and November, 1998 are posted. Not all orders issued by a credentialing authority constitute a formal disciplinary action.
- Reports of Decisions contains information as it exists at a specific point in time in the Department of Regulation and Licensing data base. Because this data base changes constantly, the Department is not responsible for subsequent entries that update, correct or delete data. The Department is not responsible for notifying prior requesters of updates, modifications, corrections or deletions. All users have the responsibility to determine whether information obtained from this site is still accurate, current and complete.
- There may be discrepancies between the online copies and the original document. Original documents should be consulted as the definitive representation of the order's content. Copies of original orders may be obtained by mailing requests to the Department of Regulation and Licensing, PO Box 8935, Madison, WI 53708-8935. The Department charges copying fees. *All requests must cite the case number, the date of the order, and respondent's name* as it appears on the order.
- Reported decisions may have an appeal pending, and discipline may be stayed during the appeal. Information about the current status of a credential issued by the Department of Regulation and Licensing is shown on the Department's Web Site under "License Lookup." The status of an appeal may be found on court access websites at: http://ccap.courts.state.wi.us/InternetCourtAccess and http://www.courts.state.wi.us/wscca .
- Records not open to public inspection by statute are not contained on this website.

By viewing this document, you have read the above and agree to the use of the Reports of Decisions subject to the above terms, and that you understand the limitations of this on-line database.

Correcting information on the DRL website: An individual who believes that information on the website is inaccurate may contact the webmaster at web@drl.state.wi.gov

FILE COPY

STATE OF WISCONSIN
MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
ROBERT JOHNSTON, M.D., RESPONDENT.	:	FINAL DECISION AND ORDER LS9003061MED

The State of Wisconsin, Medical Examining Board, having considered the above-captioned matter and having reviewed the record and the Proposed Decision of the Administrative Law Judge, makes the following:

ORDER

NOW, THEREFORE, it is hereby ordered that the Proposed Decision annexed hereto, filed by the Administrative Law Judge, shall be and hereby is made and ordered the Final Decision of the State of Wisconsin, Medical Examining Board.

The rights of a party aggrieved by this Decision to petition the Board for rehearing and the petition for judicial review are set forth on the attached "Notice of Appeal Information."

Dated this 22nd day of May, 1991.

Michael P. Melby, MD

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	PROPOSED DECISION
ROBERT JOHNSTON, M.D., RESPONDENT.	:	

The parties to this proceeding for the purposes of Wis. Stats., sec. 227.53 are:

Robert Johnston, M.D.
1551 Dousman Street
Green Bay, Wisconsin 54303

Medical Examining Board
1400 East Washington Avenue
P.O. Box 8935
Madison, Wisconsin 53708

A hearing was held in the above-captioned matter on June 27-28, 1990. Jonathan Becker, Attorney at Law, appeared on behalf of the Department of Regulation and Licensing, Division of Enforcement. The respondent, Robert Johnston, M.D., appeared in person and by his attorney, Peter J. Hickey, Everson, Whitney, Everson & Brehm, S.C.

Based upon the record herein, the Administrative Law Judge recommends that the Medical Examining Board adopt as its final decision in this matter the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. Robert Johnston, M.D., 1551 Dousman Street, Green Bay, Wisconsin, is a physician duly licensed and currently registered to practice medicine and surgery in the State of Wisconsin, license #12984, said license having been granted on July 12, 1958. Respondent specializes in internal medicine.

2. Respondent provided medical care and treatment to Clyde Crozier, at least from December 7, 1983 to December 21, 1983. Respondent first saw the patient on December 7, 1983, at St. Mary's Hospital Medical Center, Green Bay, Wisconsin. The patient was referred for evaluation by Dr. Glen Heinzl.

3. The patient, Clyde Crozier, on admission to St. Mary's Hospital Medical Center on December 7, 1983 gave a history of shortness of breath and pain between his shoulder blades. The patient suffered from diabetes mellitus, and was at high risk for cardiac disease. During the December 7th, hospital admission, the patient had a cough productive of sputum, of a nature indicative of infection.

4. Respondent's initial provisional diagnosis was that the patient was suffering from hypersensitivity lung disease. Additional differential diagnoses included pulmonary sarcoid, inhalation of chemicals, lymphangitic spread of carcinoma and infectious disorder. Respondent considered the diagnosis of congestive heart failure.

5. On December 6, 1983, prior to the patient's admission to St. Mary's Hospital Medical Center, an electrocardiogram and a chest x-ray were taken for the patient at Oconto Hospital, Oconto, Wisconsin, as ordered by Dr. Heinzl. The EKG is suggestive of a possible old inferior myocardial infarction.

6. On December 8, 1983, during the patient's admission to St. Mary's Hospital, an electrocardiogram was taken for the patient as ordered by Dr. G. Murthy, an anesthesiologist. The EKG is suggestive of a possible old inferior myocardial infarction. The EKG does not show the existence of an acute anterior myocardial infarction.

7. On December 8, 1983, during the patient's admission to St. Mary's Hospital Medical Center, a chest x-ray was taken for the patient as ordered by the respondent. The chest x-ray showed mild enlargement of the heart, some hilar fullness, interstitial infiltrates and a right pleural effusion.

8. On December 9, 1983, Dr. Harris, a chest surgeon in Green Bay, Wisconsin, performed a bronchoscopy and a mediastinoscopy on the patient. The test results of the mediastinoscopy showed no evidence of sarcoid or malignancy.

9. Respondent performed an examination of the patient on December 7, 8, and 9, 1983. The respondent did not see the patient on December 10, 1983.

10. On December 10, 1983, the patient was discharged from St. Mary's Hospital by Dr. Hoegemier. The discharge diagnoses included possible hypersensitivity lung disease, diabetes mellitus and arteriosclerotic heart disease.

11. On December 14, 1983, the patient was admitted to Oconto Hospital, Oconto, Wisconsin, complaining of breathing difficulties. The patient's diagnosis upon admission was acute respiratory distress.

12. On December 15, 1983, the patient was transferred from Oconto Hospital to St. Mary's Hospital in Green Bay, Wisconsin, where he died on December 21, 1983, of acute massive posterior wall myocardial infarction.

CONCLUSIONS OF LAW

1. The Medical Examining Board has jurisdiction in this matter pursuant to s. 448.02 Wis. Stats., and s. MED 10.02 (2) Wis. Adm. Code.

2. The respondent's conduct in providing medical care and treatment to Clyde Crozier, at least from December 7, 1983 to December 21, 1983, did not fall below the minimum standards of practice established by the medical profession.

3. The respondent's conduct in providing medical care and treatment to Clyde Crozier, at least from December 7, 1983 to December 21, 1983, did not constitute a danger to the health, welfare and safety of the patient and did not constitute unprofessional conduct within the meaning of s. 448.02 (3) Stats., or s. Med 10.02 (2)(h) Wis. Adm. Code.

ORDER

NOW, THEREFORE, IT IS ORDERED that the respondent's motion to dismiss the Complaint filed in this matter, be and hereby is GRANTED.

OPINION GUIDE

OPINION

I. GENERAL OVERVIEW

The evidence presented at the hearing consisted of the testimony of four witnesses, the deposition testimony of Dr. Lewis Anthony (offered by the complainant) and the evidence contained in 17 Exhibits (Exhibits #9 and 10 were withdrawn from evidence). Robert Johnston, M.D., testified adversely at the request of the complainant and on his own behalf during the presentation of evidence supporting his position. Dr. Maury Berger testified at the request of the complainant, and Drs. Lewis Anthony and Joseph B. Grace testified at the request of the respondent.

II. LEGAL ANALYSIS

The Complaint filed in this matter alleges that Dr. Johnston's conduct in providing medical care and treatment to Clyde Crozier at St. Mary's Hospital Medical Center between December 7, 1983 and December 10, 1983, constituted unprofessional conduct within the meaning of s. 448.02 (3) Wis. Stats., and Wis. Adm. Code s. MED 10.02 (1)(h). The Answer filed by the respondent denies that he engaged in unprofessional conduct.

Dr. Maury Berger testified at the request of the complainant. Dr. Berger testified that in his opinion, Dr. Johnston's conduct in providing medical care and treatment to Clyde Crozier between December 7, 1983, and December 10, 1983, was below the minimum level of care in that the respondent:

1) failed to list cardiac disease as one of the differentials in the diagnosis;

2) failed to note or take action based upon the electrocardiograms taken for the patient on December 6, and December 8, 1983, and

3) failed to note and take action based upon the chest x-ray report dated December 8, 1983.

Dr. Berger testified that he did not have any criticism of the treatment which the respondent provided to the patient during the patient's second hospital admission to St. Mary's Hospital Medical Center starting on December 15, 1983. (Tran. p.72,105).

Drs. Anthony and Grace testified that the respondent's conduct in providing medical care and treatment to Clyde Crozier did not fall below the minimum standards of care and did not constitute a danger to the health, welfare or safety of the patient. (Tran. p.239-240; 309-310).

1. Determination

The evidence presented does not establish that the respondent's conduct in providing medical care and treatment to Clyde Crozier, between December 7, and December 21, 1983, was below the minimum standards of care established by the medical profession or that the respondent's conduct constituted a danger to the health, welfare and safety of the patient.

2. Opinion of Expert Witnesses

Dr. Berger's first criticism regarding the medical care and treatment which Dr. Johnston provided to Clyde Crozier during the patient's first hospital admission to St. Mary's Hospital between December 7, 1983 and December 10, 1983, is that the respondent failed to list cardiac disease as one of the differentials in the diagnosis. (Tran. p.72; 84, lines 19-23).

A) Differential Diagnoses

(1) In General

Dr. Berger testified that a differential diagnosis is a list of things that you have to work through depending on the patient's symptomatology. Dr. Berger stated that "to the best of your experience and history and physical examination and tests, you try and work through those differential diagnoses until you come up with what you think is the right thing". (Tran. p.84-85).

Dr. Berger stated that a standard way for a physician to list a differential diagnosis is to include it in the progress notes; that medical students are told to use a SOAP method, but in general a minimally competent physician would ask the patients how they are feeling, do a physical exam, write down the summary of the lab and reports that are in the chart, and indicate in the notes his assessment of the patient. (Tran. p.85).

Dr. Lewis Anthony testified at the request of the respondent. Dr. Anthony testified that a differential diagnosis would consist of a list of conditions, or a list of diagnoses, that might explain the presenting signs and symptoms of a patient. Dr. Anthony stated that the decision regarding what conditions to include in and/or exclude from the differential diagnoses would be based on "the symptoms which the patient describes, and the results of his preliminary physical examination, and the probability of the different conditions that might cause that type of presentation. And would exclude ... conditions that did not seem to apply to the patient's symptoms or physical findings". Dr. Anthony stated that appropriate medical practice does not require a physician to list each and every condition that is being considered as far differential diagnoses. (Tran. p.240-241).

Dr. Joseph Grace testified at the request of the respondent. Dr. Grace testified that "At the initial history and physical recording, the doctor signs off by stating that he has an 'impression'. Under that lists his most likely diagnosis, listing as an aside sometimes one, sometimes ten, sometimes no other diagnoses which would constitute the so called possible diseases or differential diagnosis, which is really a medical school educational type of requirement. Nowhere in the Joint Commission ... are required a differential diagnosis on a hospital record. It's nice to see perhaps in educating students to go through a complete differential diagnosis that would include every possible most remote situation that would in any way at all be connected with that patient's problem". (Tran. p.312).

(2) Cardiac Disease

Dr. Berger testified that in his opinion, Dr. Johnston's failure to formulate congestive heart failure as a differential diagnosis was below minimal standards of care. Dr. Berger stated that the respondent's conduct in failing to formulate myocardial infarction as a differential diagnosis was not below minimum standards. (Tran. p.83-85).

Dr. Berger testified, in reference to the patient's medical condition and electrocardiogram readings, that "the fact that the patient was at high risk for cardiac disease, with the fact that he was ... an insulin dependent diabetic. That he was overweight. That Dr. Heinzl had stated that he had noted an abnormality in the electrocardiogram on the date 12/6 in the clinic. That Dr. Heinzl did not act on that abnormal electrocardiogram also". Dr. Berger further stated that "on review of any of the depositions or the records I find no evidence that it's ever been documented that Mr. Cozier had any heart disease. And that this abnormal electrocardiogram noted by Dr. Heinzl and by the reading of 12/8 should have ... received higher impact by the physicians involved with his care". (Tran. p.73,89,120).

Dr. Berger also stated that Dr. Johnston was confronted with the possibility that the patient may have had heart disease by virtue of the patient's wife having told him that both of the patient's parents had died of heart disease (Tran. p.74,89).

Dr. Berger stated, in reference to the patient's symptoms, that "by his symptomatology of the shortness of breath coming on with coldness, with exertion, with several nocturnal episodes, are quite consistent with myocardial ischemia and angina. Dr. Berger stated, referring to Dr. Johnston, that "yes, he was thrown off by the fact that he did not have chest pain, which certainly would have brought up a red flag, but knowing that because of their nerve damage from their diabetes, their neuropathy, to realize that ... about a third of normal patients have silent heart attacks, and in diabetes the incidence of chest pain can even be higher, and to be cognizant of this fact". Dr. Berger also stated that the December 6th x-ray report relating to the x-rays taken for the patient at Oconto Hospital may have been one of the things that threw Dr. Johnston and Dr. Heinzl off, because the radiologist did not include the differential diagnosis of possible heart failure in the report as the radiologist at St. Mary's Hospital did in the December 8th x-ray report. (Tran. p.72,75)

In reference to acute myocardial infarctions, Dr. Berger stated that a patient may complain of shortness of breath and sweating, the patient's color may be pale, and the patient may or may not have heart failure associated with it. Dr. Berger stated that, although he believed some acute infarctive process was occurring on December 8th, he did not see any evidence in the records that the patient had shortness of breath, paleness of color or sweating on that date. (Tran. p.151).

Dr Johnston testified that he first saw the patient, Clyde Crozier, on December 7, 1983, at St. Mary's Hospital Medical Center, in Green Bay, Wisconsin. Dr. Johnston stated that the patient had been referred by Dr. Glen Heinzl in Oconto, and that the day before the patient was admitted to St. Mary's Hospital, Dr. Heinzl called him and explained the set of symptoms that the patient had on his presentation. (Tran. p.27, 184).

Dr. Johnston further stated that Dr. Heinzl told him that he had seen the patient with an acute onset of shortness of breath; that he had done some laboratory work, including basic spirometry which revealed a breathing capacity reduced to 32 percent of predicted normal; a white count which was elevated at 10,000 plus with a shift to the left, including one metamyelocyte and several stabs, as well as segmented neutrophils; that he had done a sedimentation rate which was elevated 41 fall millimeters per hour; a chest x-ray, which showed widening of the mediastinum with probable "hilar adenopathy -- lymph nodes"; an electrocardiogram, and that Dr. Heinzl told him that he suspected the patient might have pulmonary sarcoid. (Tr.27-29;181-184).

Dr. Johnston testified that his initial provisional diagnosis was that the patient was suffering from hypersensitivity lung disease, and that other differential diagnoses included pulmonary sarcoid, inhalation of chemicals, lymphangitic spread of carcinoma and an infectious disorder. (Tran. p.30-31; 36-37; 39-40; p. 57, lines 22-25; p.58 line 1; p.59 lines 3-7; p.64, lines 6-15; 195, 211).

In reference to congestive heart failure, Dr. Johnston stated that it was a consideration which he felt had been excluded on the basis of examination of the patient on the day of admission and subsequent follow up visits. Dr. Johnston testified that "knowing that he had an abnormal electrocardiogram with evidence of an old inferior wall infarction, heart attack, that certainly was a consideration". Dr. Johnston testified that he did not list congestive heart failure as a provisional or differential diagnosis in the patient's medical records. (Tran. p.39-40; 57, line 25; p.58, line 1; 191, lines 2-9; p.197,200).

Dr. Johnston further stated that the clinical signs and indications of congestive heart failure in the average person are "shortness of breath, inability to lie flat, distension of the neck veins, many times apprehension, enlargement of the liver, enlargement of the spleen occasionally. In advanced cases, ascites or fluid in the abdomen, swelling of the lower extremities, and moist rales within the lungs. And the heart, depending on the nature or the cause of the heart disease, whether it was a murmur or not, in the absence of a murmur in the heart in a patient with usually congestive failure you hear a gallop rhythm, which is a sign of a failing heart". Dr. Johnston stated that the respiration rate of a person in congestive heart failure is most frequently very rapid because there is inadequate oxygenation of the blood and the body or respiratory control center attempts to improve the oxygenation by increasing respiratory rate. (Tran. p.188-191, 197).

In reference to acute myocardial infarction, Dr. Johnston stated that at the time of the patient's admission, he did not formulate it as a differential diagnosis. Dr. Johnston stated that "His electrocardiogram was read. The basic studies that were done, the basic chemistries that were done, were felt to exclude an acute infarction at the present time, plus the fact that sedimentation rate had dropped down to near normal. Had we expected ... an ongoing acute infarction, then we would expect the sedimentation rate to be further elevated and not decreased". Dr. Johnston further stated that he did not list acute myocardial infarction as a provisional or differential diagnosis in the patient's medical records, and that after the EKG of 12/8 he did not order any diagnostic tests during the first hospital admission specifically to rule out or confirm an acute myocardial infarction. (Tran. p.40-41; p.60-61; 193-194; 197).

Dr. Anthony testified that in his opinion, based upon the type of information that existed during the patient's first hospitalization in St. Mary's, on December. 7, 1983, a minimally competent physician would not have been required to diagnose or treat the patient for congestive heart failure. (Tran. p.242; 284, 298).

Dr. Anthony stated in reference to the clinical signs or indications of congestive heart that "the patient would most often complain of shortness of breath, which would tend to be made worse by physical exertion. He might have a cough which might be productive of sputum. If it were productive sputum, in congestive heart failure it would frequently be bloody type sputum. The patient might complain of fatigue and weakness. On examination the patient would be noted to have shortness of breath, if he were in heart failure at that time of the examination. There might be distension of the neck veins indicating elevated filling pressures in the failing heart". Dr. Anthony further stated that more commonly in the advanced stages than in the early stages, diaphoresis, perspiration is associated with congestive heart failure, and that x-ray would be the first diagnostic test that a physician would perform if the physician though that the patient had congestive heart failure. (Tran. p.287-288; 294).

In reference to acute myocardial infarctions, Dr. Anthony stated that patients may present with little or no pain, which is seen more commonly in diabetics; that patients may present with acute onsets of shortness of breath; that an electrocardiogram is helpful in diagnosing an acute myocardial infarction early on, and is usually, but not always, diagnostic of an acute myocardial infarction. In reference to acute ischemic event, Dr. Anthony testified that the symptoms include pain or discomfort, heavy perspiration, decreased blood pressure and shortness of breath, but that one does not always find each of the symptoms with an acute ischemic event. (Tran. p.286-287; 290).

Dr. Anthony testified, in reference to the type of clinical signs and symptoms he would expect to be present if a patient were experiencing an acute ischemic event, that "most of the time patients with acute cardiac ischemic events would be experiencing some type of pain or discomfort, most typically in the chest, but which could also occur in other areas such as the upper extremities or the throat, neck or jaw, occasionally could radiate to the back. These patients also might become diaphoretic or be perspiring profusely. The patient also might have a fall in his blood pressure which could be manifested by weakness and cool, clammy skin. The patient also might experience some shortness of breath at that particular time" (Tran. p.253).

Dr. Anthony further stated that a review of the patient's hospital records for December 7, 8, 9, and 10, did not indicate that there were any clinical signs or indications of acute ischemic event. Dr. Anthony stated that "There was no indication in the doctor's progress notes at any time which would lead me to suspect that Mr. Crozier was experiencing any acute ischemic events during his hospitalization. I also reviewed the nurses' notes, since the nurses tend to see the patient much more frequently throughout the day; and there was nothing in the nurses' notes that would lead me to suspect that Mr. Crozier was having an acute ischemic event specifically at the time the electrocardiogram was done on the evening of December 8". (Tran. p.253-255).

Dr. Grace testified that in his opinion, Dr. Johnston complied with the minimum standards of care in rendering treatment to Mr. Crozier. (Tran. p.310).

Dr. Grace testified that in his opinion, based upon the information existing during the patient's first hospitalization at St. Mary's, a minimally competent physician could have diagnosed and treated congestive heart failure, if it were apparent. Dr. Grace stated that in this case the diagnosis of congestive heart failure was not apparent during the first hospitalization. (Tran. p.316).

Dr. Grace stated that in his opinion, he did not think that the patient had any congestive heart failure signs or specific symptoms. Dr. Grace stated that the "nature of his sputum was green, an infected type, and not clear or bloody. He had abnormal pulmonary function studies, or spirometry, more suggestive of bronchitis pattern or lung pattern than heart pattern. His electrocardiogram did not show extensive definite heart damage. His chest x-ray did not show significant enlargement of his heart, but did indicate some increased densities compatible with hypersensitive lung disease. His absence of chest pain could go with either, except I would think it was more likely that he would have had severe chest pain if he had severe coronary heart disease or heart failure with a severe apprehension, cyanosis, frequent drop in blood pressure, fast rate pulse to which go along with congestive heart failure". (Tran. p.315-316).

In reference to whether the patient experienced a myocardial infarction or an acute ischemic event, Dr. Grace testified that in his opinion the patient did not experience a myocardial infarction or an acute ischemic event during his hospitalization at St. Mary's between December 7 and December 10, 1983. (Tran. p.321).

(3) <u>Hypersensitivity Lung Disease</u>

Dr. Berger stated, in reference to acute hypersensitivity findings, that the patient had been working on a farm for most of his life, exposed to the allergens and that "it would be unusual at this age all of a sudden to pop up with acute hypersensitivity findings. Dr. Berger further stated that patients that come in with hypersensitivity lung disease were acutely ill, often cyanotic with a high white count and were "what we call toxic, were quite ill, that Mr. Crozier did not seen to fit that; although patients when they are withdrawn from the allergen may settle down fairly quickly". Dr. Berger stated that additional typical symptoms included: shortness of breath, dry cough, high fever, cyanosis, muscle aches, chills, malaise and elevated sed. rate. Dr. Berger stated that the patient's white count was normal and he was afebrile, but that he did have shortness of breath after exposure, and he did have an elevated sed. rate. Dr. Berger stated that although the patient did not present with the typical or classical symptoms of hypersensitivity lung disease, it would have to be considered in the differential diagnosis. (Tran. p.73; p.86-87).

Dr. Berger testified, in reference to whether the patient presented with any symptoms or clinical indications of a lung problem, that "now that I look back, sure it looks like it was heart stuff. But at the time I would have had to include some pulmonary disease as part of the differential diagnosis ...". (Tran. p.85, lines 21-25: p.86, lines 1-12).

Dr. Johnston testified, in reference to hypersensitive lung disease, that a pulmonary function study was done for the patient on December 7th; that he did not consider the function study to be a classic profile of hypersensitive lung disease; that the total classic profile of the average hypersensitivity lung disease is primarily "a product-type ventilation unless there is an element of bronchospasm", and that the most common cause is "restrictive type of ventilation but it may involve an obstruction type of ventilation also but to a smaller percentage". (Tran. p.30-34).

Dr. Johnston further stated that fever and chills are very frequently present with hypersensitivity lung disease due to antigens or fungi, particularly bacterial antigens, but that it may occur without fever. Dr. Johnston stated that the patient in this case did not present with fever or chills. In reference to diagnostic tests, Dr. Johnston stated that during the patient's first hospital admission, he ordered tests which were "sent out ... for complement fixation studies for certain of the most common fungal-type of organisms that are involved, particularly with farmers and exposure to various fungi". Dr. Johnston stated that he did not receive the results of the diagnostic tests until after the patient's second hospitalization, and that the tests "that were run were negative for those particular fungi. There was no evidence of antibodies against those particular fungi". (Tran. p.34-35; 41, 194).

Dr. Anthony testified that symptoms and/or physical findings of hypersensitivity lung disease include fever, dry rales (might be present), and cyanosis (also might be present). Dr. Anthony stated that the patient did not have fever; that he did not recall any references to dry rales, other than Dr. Heinzl's reference to dry rales, and that he didn't remember if the record indicated that the patient had cyanosis (Tran. p.290-292).

Dr. Grace testified that in his opinion, based upon a review of the initial hospitalization record at St. Mary's the most likely diagnosis for Mr. Crozier at that time was hypersensitive lung disease. Dr. Grace stated that "because of the constellation of symptoms, signs, social history, which obviously consisted of his exposure to potent causes of lung sensitivity reactions associated with the manure spreader, the work in the barn, the noxious fumes, the chemicals inhaled, and with his intermittent history of problems. Then the history he came into the hospital with. The physical findings of the bronchospasm, the lungs, the preceding rales heard elsewhere, but not so much in the hospital at St. Mary's. His absence of cardiac finding such as S-3 gallop, distended neck veins, cyanosis. He had no fever but did have an elevated white count suggesting infections, as well as an elevated sedimentation rate". Dr. Grace stated that an elevated sed. rate is compatible or suggestive of inflammatory changes in contradistinction to neoplastic or cancerous conditions or heart failure conditions. (Tran. p.314-315; 332, lines 18-25).

(4) <u>Additional Diagnoses</u>

Dr. Berger testified in reference to the patient developing sarcoidosis, that the patient at 62 and being a Caucasian male it would be very unusual for him to develop sarcoidosis at that time, and that he did not feel that an acute type of symptomatology would be really consistent with sarcoidosis. (Tran. p.73; 76, lines 14-23; p.86, lines 7-11).

Dr. Johnston testified that sarcoid is an inflammation that occurs primarily in the lungs but it can occur in the liver and spleen, the heart, and even occasionally muscles, and rarely in the brain. Dr. Johnston stated that "It's an unknown reaction that's ... felt to be some type of antigen to which the body abnormally reacts and forms what's called granulomas which are white cells and scar tissue and things called giant cells". (Tran. p.183)

In reference to pulmonary sarcoid, Dr. Johnston stated that on December 7, 1983, the patient "presented with infiltrates in the lungs that were fully defined, I considered those things that we had discussed previously. On that basis, I felt that a chest surgeon's consultation, evaluation, consideration for bronchoscopy and mediastinoscopy were warranted". Dr. Johnston stated that he asked Dr. Harris to review the chest x-ray and consider doing a mediastinoscopy and/or bronchoscopy. Dr. Johnston stated that Dr Harris did a mediastinoscopy and that the results of the test showed no evidence of sarcoid or malignancy. Dr. Johnston stated that he did not order any other tests to confirm whether the patient was suffering from pulmonary sarcoid, but that Dr. Harris performed a bronchoscopy, and ordered cytology of the aspirate, cultures for fungus, TB and routine. (Tran. p.30,37-38; 183, 191-192).

In reference to inhalation of chemicals, lymphatic carcinoma and infectious disorder, Dr. Johnston stated that there is no specific test that can be ordered for inhalation of chemicals; that they felt if the patient had a lymphangitic spread of carcinoma to explain the chest x-ray that he certainly should have had some evidence in the mediastinoscopy of spread to the mediastinum which drains the lungs, and that cultures were taken to confirm an infectious disorder. (Tran. p.38-39; 211).

B) <u>Electrocardiogram Readings</u>

Dr. Berger's <u>second</u> opinion regarding the care and treatment which Dr. Johnston provided to the patient, Clyde Crozier, is that Dr. Johnston failed to note and take action based upon the patient's electrocardiogram readings.

Dr. Berger testified, in reference to the electrocardiograms taken on December 6 (Ex. #19) and December 8 (Ex. #5), that Dr. Heinzl had stated that he noted an abnormality in the electrocardiogram of 12/6; that the abnormal electrocardiogram noted by Dr. Heinzl and the electrocardiogram of 12/8 should have received higher impact, and that he thought the electrocardiograms showed old inferior wall injury and that it showed some acute reactions in the precordial leads, which are V1, 2 and 3. Dr. Berger further stated that no matter how Dr. Johnston may have interpreted the 12/8 EKG, in regard to the "rotation ... of the heart", the computer printout says 'acute anterior wall changes and old infarct", and that the EKG should have been noted and acted upon. (Tran. p.73, 74, lines 16-21; 77; 116-120).

Dr. Berger stated, in reference to the electrocardiogram taken on December 8, 1983, (Ex. #5), that "there should be a little septal R wave at the beginning of this QRS complex for the EKG. Mr. Crozier has no R wave, indicating there may have been damage in this inferior/posterior area ... ". Dr. Berger stated that in his opinion, the EKG of December 8th indicates an old infarction located in the "inferior area, 2, 3 and AVF are the limb leads that we would include for inferior". (Tran. p.79-80).

Dr. Berger further stated that the electrocardiogram taken for the patient on December 8, 1983, indicates an acute process which occurred in the anterior of the heart and extended into the anteroseptal area which, according to Dr. Berger "would be more in the V4 area", and that the electrocardiogram showed "some reciprocal changes in leads AV1 ... and ... some T wave changes in AV1 where it's down a little". Dr. Berger stated that in his opinion, the electrocardiogram indicated an acute episode of myocardial infarction or ischemia, but that he could not tell whether it was an ischemic episode or angina or whether the patient was having a regular myocardial infarction. (Tran. p.79, 80, lines 1-9; p.81-82; p. 83, lines 8-18; p. 84, lines 19-25; p.85, lines 1-5; 92).

Dr. Berger stated that if the electrocardiogram and the chest x-ray would have been noted, "then it would have warranted in general, for a primary care doctor like myself I would have asked for a cardiology consultation to evaluate the cardiac status. That would have been standard for the community". (Tran. p.89-90).

Dr. Johnston testified that the electrocardiogram taken for the patient on December 6, 1983, was ordered by Dr. Heinzl, and that the electrocardiogram taken on December 8, 1983, was ordered by the anesthesiologist. Dr. Johnston testified that he did see the results of both electrocardiograms and that the EKG of December 8th was very similar to the EKG of December 6th. Dr. Johnston stated that "there is slight elevated ST segments in V2 and V3, which are a little more prominent than they were in V2 and V3 on December 6th", and that "there was very minimal changes". (Tran. p.42-44; 225-226).

Dr. Johnston stated that the EKG of December 8th contains a computer interpretation of the data and a reviewer's interpretation or additions; that the computer interpretation would "suggest" that there were two infarctions, and that the EKG is "highly suggestive" of an old inferior wall infarction. (Tran. p.45-46).

Dr. Johnston further stated that the EKG is not specific for an acute anterior wall infarction, and that the patient "was obese. He had a horizontal heart. They have never got over to the left side of the heart on the electrocardiogram. ... The P waves in V2 are diphasic, which indicates it's still over the right side of the heart. We don't have -- there is an R wave, initial upright R wave in V3". Dr. Johnston stated that "there is an initial tiny upright R wave in V2. The P waves are biphasic indicating it is still over the right side of the heart. There is a loss of progression of R waves across the cordial leads as the leads are placed on the chest to try and get certain sections of the heart " (Tran. p.46; p. 74, lines 16-21).

Dr. Anthony testified that the EKG of December 6, 1983, does not suggest an acute myocardial infarction; that the EKG shows what's described as a slight sinus tachycardia, which according to Dr. Anthony means that the patient's heart rate was slightly above what's considered to be normal for a person at rest; that the finding is nonspecific and could be present for any number of reasons, including anxiety, excitement, fever, anemia, or shortness of breath, "from any cause". (Tran. p.246-247).

Dr. Anthony further stated that the EKG of December 6th does show changes which would suggest the possibility that the patient has had a previous anterior myocardial infarction based on the changes in the precordial leads, which are the V leads on the electrocardiogram, and specifically leads V1 through V4. Dr. Anthony stated that his interpretation of the EKG, in addition to the sinus tachycardia and left axis deviation, would be that the patient may have had a previous anterior apical myocardial infarction, or possibly a previous anterior infarction, and a small previous inferior infarction, but that the EKG tracing alone is not entirely diagnostic of that. Dr. Anthony testified that almost always with an acute myocardial infarction the EKG will show an S-T elevation or elevation of the S-T segment, which is one of the component of the electrocardiogram. (Tran. p.247-250).

In reference to the EKG of December 8th, Dr. Anthony testified that in his opinion, the EKG does not demonstrate the existence of an acute myocardial infarction. Dr. Anthony stated that "I would say that this tracing does not indicate any acute myocardial infarction, and particularly now having the previous tracing from December 6th for comparison, the tracings are similar. So if the patient were having an acute infarction on December 6th, then I would have expected that there would be evolutionary changes that would have occurred over the course of the two or two and a half days between the tracing. But these tracings look very similar". (Tran. p.250, lines 8-17; 251-255).

Dr. Anthony further stated that the EKG of December 8th does not suggest that the patient was having an acute ischemic event; that clinical signs and symptoms of a patient experiencing acute cardiac ischemic events would be "some type of pain or discomfort, most typically in the chest, but which could also occur in other areas such as the upper extremities or the throat, neck or jaw, occasionally could radiate into the back. These patients might also become diaphoretic or be perspiring profusely. The patient also might have a fall in his blood pressure which could be manifested by weakness and cool, clammy skin. The patient also might experience some shortness of breath at that particular time". (Tran. p.250, lines 18-24; 253,255).

Finally, Dr. Anthony testified, in reference to other possible explanations for the electrocardiographic changes, that "one possibility would be that we might see something like this in a person who was very obese; and we also might see changes like this in a person who was suffering either from acute or chronic lung disease that was of such significant magnitude as to be causing symptoms, a shortness of breath, hyperinflation of the lungs. Hyperinflation of the lungs can cause the electrocardiogram to look like the patient might have had a previous anterior infarct, when indeed he has not". (Tran. p.251-253).

Dr. Grace testified, in reference to the December 6th, EKG that the strip is possibly suggestive of an old posterior myocardial infarction. Dr. Grace further stated, in reference to the EKG of December 8th that there is no acute cardiac problem evident; that there is no evidence of an acute myocardial infarction, and that there is no evidence of an acute ischemic episode. Dr. Grace stated that the EKG does suggest an old posterior wall infarction and an old anterior wall infarction. In comparing the two EKG strips, Dr. Grace stated that he did not see significant changes between the two strips and that he did not think that coronary treatment was required. (Tran. p.317-319; 320-321; 333-337).

C) Chest X Ray Report

Dr. Berger's third criticism of the medical care and treatment which Dr. Johnston provided to Clyde Crozier, is that the respondent failed to note the chest x-ray report and to take action based upon the report. Dr. Berger qualified his opinion by stating that the chest x-ray at the clinic may have been one of the things that threw Dr. Heinzl and Dr. Johnston off because the radiologist at the clinic did not include in the report the differential diagnosis of possible heart failure as the radiologist did at St. Mary's Hospital. (Tran. p.72, 147).

Dr. Berger testified that the x-rays taken at St. Mary's Hospital "showed some hilar fullness and what would be consistent with some interstitial changes and congestion. However it was not ... so overt ... okay? And this would be the kind of thing that after seeing the x-ray report, and if I wasn't hearing the things I'd like to hear on examination, I would go down to the radiologist and go over it with him and see what he had to say." (Tran. p.83-84).

Dr. Berger stated that if the x-ray report came back promptly and was on the chart during the patient's hospitalization and the x-ray report stated that congestive heart failure is a possible reading, it is his opinion that Dr. Johnson should have reacted differently to the x-rays and x-ray reports in terms of his differential diagnoses (Tran. p.76).

Dr. Berger further stated that in his opinion, the x-ray report together with the EKG are indicative of some ongoing process in the heart, and that if the chest x-ray and electrocardiogram would have been noted, "then it would have warranted in general, for a primary care doctor like myself I would have asked for a cardiology consultation to evaluate the cardiac status. That ... would have been standard for the community". (Tran. p.84, 89-90).

Finally, Dr. Berger testified that the x-ray film was not an easy film to read; that in heart failure the blood vessels in the lungs become fuller and that interstitial markings are shown in between the lungs, and that "in a patient with hypersensitivity, pneumonitis or occupational lung disease, they get little micronodular densities also and sometimes there can be a mix-up". (Tran. p.76-77; 83-84).

Dr. Johnston testified that the patient had one chest x-ray taken at Oconto Hospital on December 6, 1983, one chest x-ray taken at St. Mary's Hospital on December 8, 1983, and several chest x-rays during his second hospitalization. Dr. Johnston stated that the chest x-ray done at Oconto was a single view, a PA view; that the chest x-rays done at St. Mary's Hospital included a posterior anterior view of the heart plus of the chest, and a lateral film of the chest, and that the lateral film showed a "small right pleural effusion. The infiltrates, the fiber nodular infiltrates that were described initially seemed to be resolving, less marked". Dr. Johnston stated that according to the x-ray report from St. Mary's, the patient's heart had enlarged approximately one and a half centimeters. Dr. Johnston testified that "after the x-rays and x-ray report in St. Mary's", he did not order any diagnostic testing to rule out or confirm congestive heart failure.(Tran. p.50, 61).

Dr. Johnston further stated that he reviewed the chest x-rays with the radiologist; that he correlated the x-ray findings, their interpretation with the patient's clinical findings, and that he could not find evidence of congestive heart failure by examination of the patient (Tran. p.199-200).

Dr. Anthony testified that the chest x-rays taken for the patient were consistent with the diagnoses of congestive heart failure and hypersensitivity lung disease, and that if there was more than one possible explanation for an x-ray, the clinical findings would tend to direct the physician in his further assessment or evaluation of the patient. Dr. Anthony further stated that x-ray is the first diagnostic test that would be performed by a physician if the physician thought that the patient had congestive heart failure; that common chest x-ray findings in congestive heart failure are interstitial congestion, pleural effusion and hilar fullness, and that in most cases of congestive heart failure there is an enlargement of the cardiac silhouette. (Tran. p.288-289; 290, 292-297).

Dr. Grace testified that it is important to apply clinical information to diagnostic information from an x-ray report as far as treatment of a patient; that the patient's chest x-rays did not show a significant enlargement of his heart, but did indicate some increased densities compatible with hypersensitivity lung disease; that the x-rays were not strongly indicative but compatible with hypersensitivity lung disease; that the x-rays show a "widened mediastinal pattern" which is indicative of heart disease and is probably seen ten times more often in congestive heart patients than in hypersensitivity lung disease patients; that the x-rays show a borderline enlargement of the heart and a pattern of interstitial infiltrations, which could indicate heart disease, and that the x-rays show a "right pleural effusion", which could also indicate heart disease. (Tran. p.313-314; 316, lines 2-5; 330-332).

Dr. Grace further stated that the chest x-ray could be indicative of hypersensitivity lung disease, heart disease, possible idiopathic fibrosis or scar tissue, possible pneumonia, cancer, sarcoidosis, pulmonary tuberculosis, and that x-ray technique "being faulty could make it appear that way". Dr. Grace testified that of the possible condition which he identified, borderline heart enlargement and pleural effusion would be most commonly seen in congestive heart failure (Tran. p.331-332).

D) <u>Treatment</u>

As stated previously, Dr. Berger stated that the x-ray report together with the EKGs are indicative of some ongoing process in the heart, and that if the chest x-ray and EKG would have been noted by Dr. Johnston, then it would have warranted in general, a cardiology consultation to evaluate the cardiac status. (Tran. p.84, 89-90).

Dr. Berger testified that there are several procedures which a cardiologist would do in general if there is a suspicion of coronary artery disease, and that after a patient is stablized according to the consultant the patient would have a heart catheterization. In reference to risks of harm to the patient, Dr. Berger stated that the patient may have been discharged with an acute ongoing cardiac process, rather than being in the coronary care unit (Tran. p.90-91; 134-136).

Dr. Johnston testified that the patient was discharged on December 10, 1983; that he did not see the patient on December 10; the patient was discharged by Dr. Hoegemier, and that his instructions to Dr. Hoegemier were "if the patient was stable, and the studies were negative, then he could be discharged to the care that I instructed the patient". (Tran. p.58, 201).

Dr. Johnston further stated that he instructed the patient that he was "to be at rest at home and not go into the barn. He was not to work, until the tests were returned", and that the patient was to return to his office in one week or sooner depending on when he received the results of the lab tests. (Tran. p.62, 200-201).

Dr. Anthony testified that in his opinion, he did not think that a cardiac consultation was necessary at that time because Dr. Johnston is a specialist in internal medicine and in the course of his daily practice takes care of patients with cardiac disease and pulmonary disease on a regular basis. Dr. Anthony stated that Dr. Johnston was quite capable of assessing the status at that time, given the presenting symptoms that the patient had, given the physical findings, and the x-ray, electrocardiogram and other laboratory studies.

Dr. Anthony stated that in his opinion, given the patient's condition at that time, it was not inappropriate for Dr. Johnston to discharge the patient at that time. Dr. Anthony stated that "the patient had been admitted for diagnostic evaluation. The ... suspected diagnosis was being evaluated and had been evaluated, and some of the diagnostic studies which would help to support that diagnosis were pending. The patient's condition had improved during the hospitalizations such that he was not having any symptoms, and I don't think it was inappropriate to have -- and the patient was dismissed on the weekend. So no routine diagnostic studies would have been performed over the weekend. So I don't think it was inappropriate to discharge such a patient pending further assessment of the patient as an outpatient. (Tran. p.256-257).

Dr. Grace testified that he did not believe that a cardiac consultation was in order at that time, because "the constellation of symptom and signs the patient had. He was improving on the treatment given to him there at St. Mary's Hospital. He had no definite sign of myocardial damage, only suggestive signs are mentioned. He had no significant definite cardiac signs, as I mentioned earlier: enlarged heart, distended neck veins, S-3 gallop, bloody sputum. He had the laboratory findings more fitting lung disease by far than he did cardiac disease". (Tran. p.321-322).

Dr. Grace stated that in his opinion, it was appropriate to discharge the patient on December 10th considering that the patient was feeling well, the lack of significant untoward findings, the admonition to follow-up with treatment at home with steroids for his lung problems, to refrain from work, and to contact physicians pending the investigation or the return of the referred laboratory work (Tran. p.323).

3 Analysis

Dr. Berger's first criticism regarding Dr. Johnston's treatment of Clyde Crozier is that Dr. Johnston failed to list cardiac disease in the differential diagnoses. Dr. Berger's opinion specifically relates to the respondent's failure to formulate congestive heart failure as a differential diagnosis. Dr. Berger's opinion focuses upon 1) the patient's risks of cardiac disease, 2) the symptoms the patient had upon presentation, and 3) the findings noted in the electrocardiograms and chest x-rays taken for the patient prior to and during the patient's first admission at St. Mary's Hospital. (Tran. p.72-74, 84-85, 89).

First, in reference to the patient's risk of cardiac disease, Dr. Berger testified that in his opinion, the patient was at high risk for cardiac because the patient was a diabetic, obese and had a family history of cardiac disease. (Tran. p.73, 89).

The evidence presented establishes that at the time of the patient's first admission to St. Mary's Hospital, between December 7, and December 10, 1983, the patient was at high risk for cardiac disease. The history and physical taken by the respondent during the patient's first hospital admission, indicates that the patient was a 62 year old, Caucasian male, who was obese and suffered from diabetes mellitus. Although the report of the history and physical, dated December 10, 1983, states that the patient's "family history is noncontributory", the evidence indicates that both of the patient's parents died of heart disease. Dr. Johnston admitted that although the report of the patient's history and physical stated that "family history is noncontributory", the statement was not true in this case. Dr. Johnston further stated that the patient was moderately obese; that there is an increased incidence of heart disease in obese people; that there is an increased incidence of heart disease in males 60 or older, and that diabetics are prone to developing arteriosclerosis over the average non diabetic patient in the same age group. (Tran. p.54-55; Ex. #1).

Second, Dr. Berger testified that the patient's "symptomatology of the shortness of breath coming on with coldness, with exertion, with several nocturnal episodes, are quite consistent with myocardial ischemia and angina". Dr. Berger stated that although Dr. Johnston was "thrown off" by the fact that the patient did not have chest pains, he was required to be cognizant of the fact that a third of normal patients have silent heart attacks and in diabetics the incidence is higher. (Tran. p.75; 121-124).

The evidence presented establishes that the patient's symptoms/clinical indications upon presentation on December 7, 1983, were shortness of breath, pain between the shoulder blades and cough. There is no evidence that the patient had chest pains upon presentation or at anytime during his first admission to St. Mary's Hospital. (Tran. p.52-53; 187; Ex. #1).

The nurses' notes for December 7, 1983, read, in part, as follows:

> Becomes short of breath with exertion. Denies chest pain. States had pain between shoulder blades while short of breath last week while working. Coughs up green phlegm in morning. History of diabetes for 20 years.

Dr. Johnston testified that he did not see the nurses' notes for December 7th, until after the patient had died. Dr. Johnston stated that the patient's symptoms were shortness of breath, primarily while working in the barn, and cough. Dr. Johnston stated that the patient had experienced intermittent episodes of shortness of breath, after working in the barn, over a period of about two weeks prior to the first hospital admission. According to Dr. Anthony, the reference to the patient having shortness of breath was made on the admission history and physical and the admission nurses' notes, and that throughout the hospitalization the nurses' notes stated specifically that the patient did not complain of shortness of breath at any time. The only reference in the nurses' notes to the patient having shortness of breath is contained in the notes for December 8, at 4:30 a.m., which stated that "some dyspnea noted at 2:00 a.m. during sleep - the rest of the night none was noted". (Tran. p.34,36,53,57; 186-187; 254; Ex. #1, p.34).

Dr. Berger's testified in reference to the patient's complaint of "pain between the shoulder blades", that a differential diagnosis of back pain could be due to anything. Dr. Berger stated that "the guy is a farmer. He does a lot of heavy lifting. Could be a muscle strain, anything like that. When you have back pain associated with shortness of breath, this narrows down the diagnosis a little more. It could be associated with angina. It could be associated with hypersensitivity lung disease along with the muscle strain, but the fact that he had an acute episode that happened at the same time and then went away in a few minutes, in retrospect ... those symptoms could be consistent with angina, especially since he had changes in the inferior wall area there on the electrocardiogram". Dr. Berger admitted that one explanation for the patient's report of pain between the shoulder blades may have been muscle strain, but that he could not make a definite conclusion without further investigation of the pain. (Tran. p.93; 121-124; 148).

The patient's history and physical examination report from Oconto Memorial Hospital, dated December 14, 1983, reads, in part, as follows: Review of Systems: ... Musculoskeletal: Patient says he strained his back muscles while hauling hay bales about 2 weeks ago. (Ex. #8; Tran. p. 121-124; 148).

Dr. Johnston admitted that diabetics can present with silent myocardial infarctions, and that pain from myocardial infarction can be located in the back. (Tran. p.53)

The report of the patient's history and physical states that the patient "has had a slight nonproductive cough". Dr. Johnston testified that the patient had a productive cough "usually of ... small amount of greenish, thick material". The nurses' notes stated that the patient "coughs up green phlegm in morning". Drs. Anthony and Grace testified that in congestive heart failure cases, if a patient has a cough productive of sputum, the sputum frequently is clear or bloody and not green. (Tran. p.34, 36, 53, 187, 315; Ex. #1, p.3, 32).

According to Dr. Johnston, the clinical signs/physical findings and indications of congestive heart failure in the average person are as follows:

- shortness of breath
- inability to lie flat
- distension of the neck veins
- apprehension (many times)
- enlargement of the liver
- enlargement of the spleen (occasionally)
- ascites or fluid in the abdomen (advanced cases)
- swelling of the lower extremities (advanced cases?)
- moist rales
- rapid respiration rate
- gallop rhythm (in the absence of murmur)

Additional symptoms/clinical signs/physical findings and indications identified by Drs. Anthony and Grace include:

- chest pains
- fast pulse rate
- cyanosis
- frequent drop in blood pressure
- cough (bloody type sputum - frequently)
- complaints of fatigue and weakness

Based upon the evidence presented, the only symptoms/clinical indications (of the ones identified by Drs. Berger, Johnston, Anthony and Grace) which the patient had upon presentation that are indicative of congestive heart failure were shortness of breath, cough and pain between the shoulder blades. In reference to shortness of breath, the evidence indicates that the symptom can also be consistent with hypersensitivity lung disease, and that except for the nurses' notes for 12/8, which referred to dyspnea, there is no evidence that the patient had shortness of breath during the first hospital admission.

In reference to cough, Dr. Grace testified that the "nature of his sputum was green, an infected type, and not clear or bloody", Dr. Johnston testified that the patient had a "productive cough usually of ... small amount of greenish thick, material', and the nurses' notes for 12/7 states that the patient "coughs up green phlegm in morning". In reference to pain between the shoulder blades, the evidence indicates that the pain could have been caused by muscle strain. Dr. Berger testified that he could not make a definite conclusion as to the cause of the patient's complaint of pain between the shoulder blades without further investigation of the pain, and admitted that the pain could have been caused by muscle strain. (Tran. p.57,114; 121-124; 148; 287, lines 21-23; 315; Ex. #1, p.32,34; Ex. #8).

According to Dr. Johnston, based upon his examination of the patient during the first admission, the patient did not have a gallop rhythm, moist rales, swelling or fluid retention in his legs, an enlarged spleen, distension of neck veins nor an elevated respiration rate. (Tran. p.188-191; 200).

Dr. Anthony testified that, based upon his review of the patient's records, he did not find any evidence that from December 8 to December 10, 1983, that the patient had shortness of breath, cough, blood sputum, enlarged neck veins, moist rales, increased heart rate, an S-3 gallop or swelling in the lower extremities. As noted previously, Dr. Anthony testified that the reference to shortness of breath was made in the admission history and physical and the admission nurses' notes, and that otherwise the nurses' notes specifically stated that the patient did not complain of shortness of breath at any time. (Tran. p.254, lines 9-15; p.296-297).

Dr. Berger testified that, in general, he would expect to hear moist rales if a patient was having congestive heart failure, and that in this case, the patient records from St. Mary's relating to the patient's first admission, did not contain a reference by any physician or nurse to moist rales. (Tran. p.116).

Dr. Grace testified that the patient did not have severe chest pains, severe apprehension, cyanosis, frequent drop in blood pressure, or fast pulse rate. Dr. Grace also testified that the patient had no significant definite cardiac signs, such as enlarged heart, distended neck veins or S-3 gallop. (Tran. p.316; 321-322).

Third, Dr. Berger further stated that if the EKG and the chest x-ray would have been noted, then it would have warranted a cardiology consultation to evaluate the patient's cardiac status. (Tran. p.72, 75-77; 82-85; 89-90).

The evidence indicates that an electrocardiogram and chest x-rays were taken for the patient on December 6, 1983, at Oconto Hospital, and that an electrocardiogram and chest x-rays were taken on December 8, 1983, at St. Mary's Hospital Medical Center.

In reference to the chest x-rays, Dr. Berger stated that the report relating to the chest x-rays taken for the patient on December 8, states that congestive heart failure is a possible reading, and that Dr. Johnston should have reacted differently to the report in terms of differential diagnoses.

The chest x-ray report for December 8, (Ex. #1, p.5) reads, in part, as follows:

> The heart is mildly enlarged. There is prominence of both hilar regions. There is a right pleural effusion. There is mild prominence to the pulmonary vascularity in both lungs. There are scattered reticulonodular changes in both lungs. When compared with outside film of 12-6-83 the degree of cardiac enlargement has increased. The right pleural effusion is new.
>
> CONCLUSION: Chest x-ray today appears to be most consistent with congestive heart failure with a new right pleural effusion. Underlying interstitial lung disease can not be excluded.

According to Dr. Anthony common chest x-rays findings in congestive heart failure cases, include interstitial congestion, pleural effusion and hilar fullness, and that in most cases there is an enlargement of the heart.

The evidence presented in this case establishes that the chest x-ray taken for the patient on December 8, showed mild enlargement of the heart, some hilar fullness, interstitial infiltrates and a right pleural effusion.

Dr. Berger admitted that the x-ray films were not easy to read, and that Dr. Johnston may have been "thrown off" by the fact that the radiologist at the clinic did not include the differential diagnosis of possible heart failure as the radiologist did at St. Mary's Hospital. Dr. Berger stated that in heart failure the blood vessels in the lungs become fuller, interstitial markings are shown in between the lungs, and that in a patient with hypersensitivity, pneumonitis or occupational lung disease, "they get little micronodular densities also and sometimes there can be a mix-up". Dr. Berger testified that although the x-ray showed "some hilar fullness and what would be consistent with some interstitial changes and congestion", it was "not so overt". Dr. Berger stated that after seeing the x-ray report, if he "wasn't hearing the things" he would like to hear on examination, he would have gone down to the radiologist to see what he had to say. (Tran. p.72; 77, lines 1-6; 83-84; 147).

Dr. Johnston testified that he reviewed the chest x-rays with the radiologist; that he correlated the x-ray findings, their interpretations with the patient's clinical finding, and that he could not find evidence of congestive heart failure by examination of the patient (Tran. p.199-200).

Drs. Anthony and Grace testified that it is important to apply clinical information to diagnostic information from an x-ray report as far as evaluation and treatment of a patient. (Tran. p.293-294; 313-314).

In reference to the electrocardiograms taken for the patient, Dr. Berger testified that they were abnormal; that the EKG taken on December 6, showed evidence of "old inferior wall injury", and that the EKG taken on December 8, indicated an "acute episode of myocardial infarction or ischemia."

The evidence establishes that the electrocardiograms taken on 12/6 and 12/8 are suggestive of an old inferior myocardial infarction. The evidence does not establish that the 12/8 EKG shows evidence of an acute anterior myocardial infarction or an ischemia.

III. RECOMMENDATIONS

Based upon the evidence presented and the discussion herein, the Administrative Law Judge recommends that the Medical Examining Board adopt as its final decision in this matter, the proposed Findings of Fact, Conclusions of Law and Order as set forth herein.

Dated at Madison, Wisconsin, this 9th day of April, 1991.

Respectfully submitted,

Ruby Jefferson-Moore

Ruby Jefferson-Moore
Administrative Law Judge

NOTICE OF APPEAL INFORMATION

(Notice of Rights for Rehearing or Judicial Review, the times allowed for each and the identification of the party to be named as respondent)

The following notice is served on you as part of the final decision:

1. Rehearing.

Any person aggrieved by this order may petition for a rehearing within 20 days of the service of this decision, as provided in section 227.49 of the Wisconsin Statutes, a copy of which is attached. The 20 day period commences the day after personal service or mailing of this decision. (The date of mailing of this decision is shown below.) The petition for rehearing should be filed with the State of Wisconsin Medical Examining Board.

A petition for rehearing is not a prerequisite for appeal directly to circuit court through a petition for judicial review.

2. Judicial Review.

Any person aggrieved by this decision has a right to petition for judicial review of this decision as provided in section 227.53 of the Wisconsin Statutes, a copy of which is attached. The petition should be filed in circuit court and served upon the State of Wisconsin Medical Examining Board.

within 30 days of service of this decision if there has been no petition for rehearing, or within 30 days of service of the order finally disposing of the petition for rehearing, or within 30 days after the final disposition by operation of law of any petition for rehearing.

The 30 day period commences the day after personal service or mailing of the decision or order, or the day after the final disposition by operation of the law of any petition for rehearing. (The date of mailing of this decision is shown below.) A petition for judicial review should be served upon, and name as the respondent, the following: the State of Wisconsin Medical Examining Board.

The date of mailing of this decision is May 28, 1991.

WLD:dms
886-490

227.49 Petitions for rehearing in contested cases. (1) A petition for rehearing shall not be a prerequisite for appeal or review. Any person aggrieved by a final order may, within 20 days after service of the order, file a written petition for rehearing which shall specify in detail the grounds for the relief sought and supporting authorities. An agency may order a rehearing on its own motion within 20 days after service of a final order. This subsection does not apply to s. 17.025 (3) (e). No agency is required to conduct more than one rehearing based on a petition for rehearing filed under this subsection in any contested case.

(2) The filing of a petition for rehearing shall not suspend or delay the effective date of the order, and the order shall take effect on the date fixed by the agency and shall continue in effect unless the petition is granted or until the order is superseded, modified, or set aside as provided by law.

(3) Rehearing will be granted only on the basis of:

(a) Some material error of law.

(b) Some material error of fact.

(c) The discovery of new evidence sufficiently strong to reverse or modify the order, and which could not have been previously discovered by due diligence.

(4) Copies of petitions for rehearing shall be served on all parties of record. Parties may file replies to the petition.

(5) The agency may order a rehearing or enter an order with reference to the petition without a hearing, and shall dispose of the petition within 30 days after it is filed. If the agency does not enter an order disposing of the petition within the 30-day period, the petition shall be deemed to have been denied as of the expiration of the 30-day period.

(6) Upon granting a rehearing, the agency shall set the matter for further proceedings as soon as practicable. Proceedings upon rehearing shall conform as nearly may be to the proceedings in an original hearing except as the agency may otherwise direct. If in the agency's judgment, after such rehearing it appears that the original decision, order or determination is in any respect unlawful or unreasonable, the agency may reverse, change, modify or suspend the same accordingly. Any decision, order or determination made after such rehearing reversing, changing, modifying or suspending the original determination shall have the same force and effect as an original decision, order or determination.

227.52 Judicial review; decisions reviewable. Administrative decisions which adversely affect the substantial interests of any person, whether by action or inaction, whether affirmative or negative in form, are subject to review as provided in this chapter, except for the decisions of the department of revenue other than decisions relating to alcohol beverage permits issued under ch. 125, decisions of the department of employe trust funds, the commissioner of banking, the commissioner of credit unions, the commissioner of savings and loan, the board of state canvassers and those decisions of the department of industry, labor and human relations which are subject to review, prior to any judicial review, by the labor and industry review commission, and except as otherwise provided by law.

227.53 Parties and proceedings for review. (1) Except as otherwise specifically provided by law, any person aggrieved by a decision specified in s. 227.52 shall be entitled to judicial review thereof as provided in this chapter.

(a) Proceedings for review shall be instituted by serving a petition therefor personally or by certified mail upon the agency or one of its officials, and filing the petition in the office of the clerk of the circuit court for the county where the judicial review proceedings are to be held. Unless a rehearing is requested under s. 227.49, petitions for review under this paragraph shall be served and filed within 30 days after the service of the decision of the agency upon all parties under s. 227.48. If a rehearing is requested under s. 227.49, any party desiring judicial review shall serve and file a petition for review within 30 days after service of the order finally disposing of the application for rehearing, or within 30 days after the final disposition by operation of law of any such application for rehearing. The 30-day period for serving and filing a petition under this paragraph commences on the day after personal service or mailing of the decision by the agency. If the petitioner is a resident, the proceedings shall be held in the circuit court for the county where the petitioner resides, except that if the petitioner is an agency, the proceedings shall be in the circuit court for the county where the respondent resides and except as provided in ss. 77.59 (6) (b), 182.70 (6) and 182.71 (5) (g). The proceedings shall be in the circuit court for Dane county if the petitioner is a nonresident. If all parties stipulate and the court to which the parties desire to transfer the proceedings agrees, the proceedings may be held in the county designated by the parties. If 2 or more petitions for review of the same decision are filed in different counties, the circuit judge for the county in which a petition for review of the decision was first filed shall determine the venue for judicial review of the decision, and shall order transfer or consolidation where appropriate.

(b) The petition shall state the nature of the petitioner's interest, the facts showing that petitioner is a person aggrieved by the decision, and the grounds specified in s. 227.57 upon which petitioner contends that the decision should be reversed or modified. The petition may be amended, by leave of court, though the time for serving the same has expired. The petition shall be entitled in the name of the person serving it as petitioner and the name of the agency whose decision is sought to be reviewed as respondent, except that in petitions for review of decisions of the following agencies, the latter agency specified shall be the named respondent:

1. The tax appeals commission, the department of revenue.

2. The banking review board or the consumer credit review board, the commissioner of banking.

3. The credit union review board, the commissioner of credit unions.

4. The savings and loan review board, the commissioner of savings and loan, except if the petitioner is the commissioner of savings and loan, the prevailing parties before the savings and loan review board shall be the named respondents.

(c) Copies of the petition shall be served, personally or by certified mail, or, when service is timely admitted in writing, by first class mail, not later than 30 days after the institution of the proceeding, upon all parties who appeared before the agency in the proceeding in which the order sought to be reviewed was made.

(d) The agency (except in the case of the tax appeals commission and the banking review board, the consumer credit review board, the credit union review board, and the savings and loan review board) and all parties to the proceeding before it, shall have the right to participate in the proceedings for review. The court may permit other interested persons to intervene. Any person petitioning the court to intervene shall serve a copy of the petition on each party who appeared before the agency and any additional parties to the judicial review at least 5 days prior to the date set for hearing on the petition.

(2) Every person served with the petition for review as provided in this section and who desires to participate in the proceedings for review thereby instituted shall serve upon the petitioner, within 20 days after service of the petition upon such person, a notice of appearance clearly stating the person's position with reference to each material allegation in the petition and to the affirmance, vacation or modification of the order or decision under review. Such notice, other than by the named respondent, shall also be served on the named respondent and the attorney general, and shall be filed, together with proof of required service thereof, with the clerk of the reviewing court within 10 days after such service. Service of all subsequent papers or notices in such proceeding need be made only upon the petitioner and such other persons as have served and filed the notice as provided in this subsection or have been permitted to intervene in said proceeding, as parties thereto, by order of the reviewing court.