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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY	:	
PROCEEDINGS AGAINST	:	FINAL DECISION
	:	AND ORDER
DENNIS K. NESS, M.D.,	:	LS0306253MED
RESPONDENT.	:	

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 department for rehearing and the petition for judicial review are set forth on the attached "Notice of Appeal Information."

Dated this 14th day of September, 2004.

Alfred Franger
Member of the Board
Medical Examining Board

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF THE DISCIPLINARY	:	
PROCEEDINGS AGAINST	:	
	:	LS0306253MED
DENNIS KEITH NESS, M.D.	:	
RESPONDENT.	:	

PROPOSED DECISION AND ORDER

The parties to this action for purposes of §227.53, Wis. Stats., are:

Dennis Keith Ness, M.D.
1040 Division Street
Mauston, WI 53948

Medical Examining Board
P.O. Box 8935
Madison, WI 53708-8935

Department of Regulation & Licensing
Division of Enforcement
P.O. Box 8935
Madison, WI 53708-8935

PROCEDURAL HISTORY

A hearing in the above-captioned matter was held on March 29-April 1, 2004, before Administrative Law Judge Jacquelynn B. Rothstein. The Division of Enforcement appeared by attorney Gilbert C. Lubcke. Attorney Patricia J. Epstein appeared on behalf of Dennis Keith Ness, M.D.

Based on the entire record in this case, the undersigned 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. Dennis Keith Ness, M.D., (dob 10/03/48) is duly licensed to practice medicine and surgery in Wisconsin (License #19928). His license was first granted on July 1, 1976. Dr. Ness specializes in family practice. He holds a board certification in family practice with a certificate of added qualifications in geriatrics.
2. Dr. Ness's most recent address on file with the Medical Examining Board is 1040 Division Street, Mauston, Wisconsin.
3. Dr. Ness practices medicine at Hess Memorial Hospital and the Mile Bluff Clinic in Mauston, Wisconsin, and did so at the time of Arthur Slater's treatment.
4. Arthur Slater (dob 6/18/37) was Dr. Ness's patient. Mr. Slater had a medical history that included: Type II insulin dependent diabetes, hyperlipidemia, hypertension, congestive heart failure, chronic obstructive pulmonary disease (COPD), arthritis, coronary artery disease, and obesity. He had also been a smoker for approximately thirty-five years. Mr. Slater took the following medications: Hyzaar, Klor-Con, Furosemide, Lipitor, Centrum, Glucophage, over-the-counter garlic, NPH insulin, regular insulin, a triple medicated nebulizer, Albuterol, Percocet, Vicodin, ferrous gluconate, and oxygen. Mr. Slater had a significant family history of heart disease. Two of his brothers and one of his sisters died from heart disease, as did his father. None lived to age sixty-four.
5. On November 14, 2001, health care practitioners at the Mile Bluff Clinic prescribed Lipitor 20 mg p.o. q.d. for Mr. Slater.
6. On or about January 30, 2002, Mr. Slater underwent right knee arthroplasty. In the weeks after his discharge from the hospital following his knee surgery, Mr. Slater experienced shortness of breath, weight gain, and peripheral edema. He did not have any fevers or chest pain. For approximately two weeks following his knee surgery, Mr. Slater's ambulatory status continued to improve. Thereafter, he experienced a deterioration in his ability to ambulate and became more sedentary.
7. On March 6, 2002, at approximately 3:44 a.m., Mr. Slater was admitted to the emergency room at Hess Memorial Hospital complaining of difficulty breathing, shortness of breath, diaphoresis, and a recent history of chest pain. Mr. Slater reported awakening at 3:00 a.m. with chest pain, but indicated that he was no longer experiencing the chest pain at the time of his admission to the emergency room. Upon admission, Mr. Slater's blood pressure was 215/106, his pulse was 130, his respiratory rate was 32, and his oxygen saturation level was 89%.
8. The emergency room physician's evaluation disclosed 2+ edema in Mr. Slater's extremities. The chest x-ray was consistent with chronic changes but with no acute findings. The EKG showed sinus tachycardia with no acute S-T changes

but with evidence of anterior and inferior infarcts of undetermined ages. The cardiac enzymes determined from blood drawn at 4:05 a.m. on March 6, 2002, showed an elevated creatine phosphokinase (CPK) of 4,253 with a CKMB value of 24.3 and a %CKMB of 0.6. The Troponin I was 0.3. The Myoglobin was elevated at 1,357.2. The blood urea nitrogen level (BUN) was elevated at 32. The creatinine was 0.8, the sodium was 136, and the potassium was 4.8.

9. The emergency room physician initiated a cardiac protocol and admitted Mr. Slater to Hess Memorial Hospital. The admitting diagnoses were dyspnea, COPD, chest pain, and possible rhabdomyolysis. Mr. Slater weighed 292 pounds at the time of his admission to the hospital. The emergency room physician ordered a follow-up EKG, cardiac monitoring, and regularly obtained vital signs, but did not order the continuation of the Lipitor that Mr. Slater had been taking.

10. Dr. Ness assumed responsibility for the management of Mr. Slater on March 6, 2003, following his admission to Hess Memorial Hospital.

11. Dr. Ness obtained a CT scan of Mr. Slater's chest to rule out a pulmonary embolism. The CT scan was negative for a pulmonary embolism.

12. Dr. Ness also ordered and obtained serial cardiac enzymes. The CPK level remained significantly elevated but the CKMB and the %CKMB remained in the normal range.

13. On March 7, 2002, Dr. Ness concluded that Mr. Slater's serial cardiac enzymes were negative and that he had not experienced an acute myocardial infarction. Dr. Ness's examination of Mr. Slater on that same date revealed that the patient was afebrile with a pulse of 65, a respiratory rate of 32, a blood pressure of 133/72, and a weight of 294.4 pounds. Mr. Slater's heart had a regular sinus rhythm and his lungs were clear to auscultation and percussion, and his extremities showed no edema. Dr. Ness therefore concluded that Mr. Slater may have been ready for discharge on March 8, 2002.

14. On March 8, 2002, Dr. Ness's examination disclosed that Mr. Slater had become more dyspneic and his weight had increased to 298 pounds. His blood pressure ranged from 154/86 to 172/83. Mr. Slater's heart was in regular sinus tachycardia without murmurs with a pulse ranging from 99 to 120. His lungs were clear to auscultation with some tachypnea, and his extremities showed some trace of pretibial edema. Dr. Ness believed that the dyspnea was probably secondary to the COPD, and that Mr. Slater showed a borderline increase in congestive heart failure. Dr. Ness continued to manage Mr. Slater's cardiac related conditions with aspirin, a nitroglycerine patch, IV fluids, and Lasix.

15. On March 8, 2002, Dr. Ness resumed administration of Lipitor 10 mg p.o. q.d.

16. On March 8, 2002, at 10:40 p.m., a specimen was obtained from Mr. Slater, which revealed an elevated CPK level of 2,957. The CPK level from a specimen obtained at 6:35 a.m. on March 9, 2002 showed an increase to 3,375.

17. Dr. Ness examined Mr. Slater on March 9, 2002. Mr. Slater reported some right sciatica but without numbness in his legs. He further reported that his muscles felt generally weak. Mr. Slater was dyspneic with ambulation. His lungs were clear to auscultation and the chest x-ray taken on March 8, 2002, was read as stable with no pulmonary infiltrates. His weight was 296.6 pounds.

18. Following his examination of Mr. Slater on March 9, 2002, Dr. Ness concluded that Mr. Slater had COPD, controlled congestive heart failure, hyponatremia, obesity, hyperlipidemia, rhabdomyolysis, right sciatica, borderline control of diabetes mellitus, and arteriosclerotic heart disease. Based upon the increase in Mr. Slater's CPK level from 2,975 to 3,375 over the 24 hours after which he had resumed the Lipitor, Dr. Ness concluded that the rhabdomyolysis was probably secondary to administration of the Lipitor.

19. On March 9, 2002, Dr. Ness discontinued the Lipitor, decreased the Lasix to 40 mg p.o. q.a.m., and ordered a 1500 cc/24 hour fluid restriction.

20. On March 10, 2002, Mr. Slater continued to complain of sciatica and aches in his neck and perithoracic muscles. His extremities showed trace pretibial edema and his weight increased to 298 pounds; his lungs remained clear to auscultation. Dr. Ness believed that he needed to keep Mr. Slater well hydrated to treat the rhabdomyolysis while regulating fluid

management in consideration of his congestive heart failure.

21. On March 11, 2002, Dr. Ness noted that Mr. Slater's systolic blood pressure had dropped to about 70 but had returned to the 90s at the time of his (Dr. Ness's) visit. Mr. Slater's lungs remained clear, his extremities showed a trace of pretibial edema while his weight had increased to 301.1 pounds. His CPK level remained elevated at 3,922.
22. On March 11, 2002, Dr. Ness stopped the administration of the Lasix to Mr. Slater.
23. On March 12, 2002, Mr. Slater's lungs remained clear to auscultation but his weight had increased to 301.7 pounds. His CPK level was elevated at 4,449. He also had BUN of 62, a creatinine of 1.0, a sodium of 122, and a potassium of 5.7.
24. On March 12, 2002, Dr. Ness discontinued the fluid restriction that Mr. Slater had been on and ordered IV normal saline at 50 cc/hour.
25. On March 13, 2002, Mr. Slater had intermittent dyspnea and his weight was increased to 302 pounds. He had a CPK of 3,817, a BUN of 57, a creatinine of 0.9, a sodium of 125, and a potassium of 5.3. Dr. Ness continued the IV of normal saline at 50 cc/hour.
26. On March 14, 2002, Mr. Slater's lungs remained clear but his weight had increased to 304.8 pounds. His CPK level was 4,062, his BUN was 47, his creatinine was 0.8, his sodium was 124, and his potassium was 5.5. Dr. Ness ordered continuation of the IV fluids.
27. On the evening of March 15, 2002, Mr. Slater had become progressively more dyspneic and his weight had increased to 311.3 pounds. His lungs showed a few basilar rales but no wheezes or rhonchi. The chest x-ray demonstrated prominence of the pulmonary vascularity but no overt failure and no infiltrates. Mr. Slater had a CPK level of 6,086, a BUN of 39, a creatinine of 0.8, a sodium of 123, and a potassium of 5.6. Dr. Ness was of the opinion that Mr. Slater showed borderline congestive heart failure with hyponatremia and hyperkalemia. Dr. Ness initiated a 2,000 cc/24 hours fluid restriction, decreased the IV, and gave the patient Lasix 40 mg IV.
28. On March 16, 2002, Mr. Slater reported aching in his right leg after having fallen twice while ambulating on the previous evening. His lungs had a few basilar rales, but his shortness of breath had improved after he received the Lasix. He had edema in his lower abdominal wall and 1+ to 2+ pitting pretibial edema. His CPK level was 6,854, the BUN was 34, the creatinine was 0.8, the sodium was 121, and the potassium was 5.5. Dr. Ness renewed his order for the 2,000 cc/24 hours fluid restriction and ordered Lasix 40 mg to be administered on March 16, 2002, and then q.a.m.
29. On March 17, 2002, Dr. Ness left for a vacation, and James J. Logan, M.D., took over the management of Mr. Slater.
30. Thereafter, the nursing notes for March 17, 2002, indicate that Mr. Slater was alert and oriented, and that his urine output had increased to 2150 cc's. That same evening, Mr. Slater was conversant with family members and was not experiencing any shortness of breath. He was later observed to be sleeping peacefully.
31. On March 18, 2002, at approximately 5:10 a.m., Mr. Slater's daughter found him pulseless and not breathing. He was unable to be resuscitated.
32. No autopsy was conducted on Mr. Slater.

CONCLUSIONS OF LAW

1. The Medical Examining Board has jurisdiction in this matter pursuant to §448.02, Wis. Stats.
2. The evidence does not establish that Dennis Keith Ness engaged in unprofessional conduct contrary to s. 448.02 (3), Wis. Stats.

3. The evidence does not establish that Dennis Keith Ness engaged in conduct that tended to constitute a danger to the health, welfare, and safety of a patient contrary to s. MED 10.02 (2) (h), Wis. Admin. Code.

ORDER

NOW THEREFORE IT IS HEREBY ORDERED that this matter be **DISMISSED**.

OPINION

On March 18, 2002, Arthur Slater, age sixty-four, died after having been hospitalized at Hess Memorial Hospital in Mauston, Wisconsin. Mr. Slater was originally admitted to the hospital on March 6, 2002, after complaining of difficulty breathing, shortness of breath, diaphoresis, and a recent history of chest pain. At the time of his admission, however, he was no longer experiencing chest pain. Nevertheless, a chest x-ray was taken and while chronic changes were noted, there were no acute findings. An EKG showed sinus tachycardia with no acute S-T changes but with evidence of prior anterior and inferior infarcts of undetermined ages.

Mr. Slater had an extensive medical history that included: Type II insulin dependent diabetes, hyperlipidemia, hypertension, congestive heart failure, chronic obstructive pulmonary disease (COPD), coronary artery disease, arthritis, and obesity. He took the following medications for those conditions: Hyzaar, Klor-Con, Furosemide, Lipitor, Centrum, Glucophage, over-the-counter garlic, NPH insulin, regular insulin, a triple medicated nebulizer, Albuterol, Percocet, Vicodin, ferrous gluconate, and oxygen. Mr. Slater also had a significant family history of heart disease. Two of his brothers and one of his sisters died from heart disease, as did his father. None lived to age sixty-four.

During Mr. Slater's hospital stay and in addition to his existing chronic conditions, his weight increased, he suffered from rhabdomyolysis, and hyponatremia. While he was hospitalized, Dr. Ness's treatment of him is alleged to have fallen below the minimum standard of care. More specifically, Dr. Ness is alleged to have failed to adequately evaluate Mr. Slater's cardiac status, his congestive heart failure, and his coronary arteries. He is further alleged to have failed to respond appropriately and in a timely manner to Mr. Slater's deteriorating condition, thereby creating unacceptable risks to his health, welfare, and safety. According to the complaint, in order for Dr. Ness to have avoided those unacceptable risks, he should have performed additional diagnostic testing including, for instance, an echocardiogram, a gated pool study, cardiac catheterization, a cardiac stress test, or some combination thereof. The complaint also indicates that he should have consulted with specialists or had Mr. Slater transferred to another facility where the appropriate specialists would have been available to treat him. Such assertions are untenable.

John H. Morledge, M.D., a physician with over forty-five years of clinical experience in the areas of internal medicine and cardiology, and who is board certified in internal medicine and board eligible in cardiovascular disease, testified on behalf of Drs. Ness and Logan. Dr. Morledge has been published extensively in various medical journals on a wide-range of cardiac related topics and has impeccable credentials. He is a professor at the University of Wisconsin Medical School, and is also a cardiologist with staff privileges at both the University of Wisconsin Hospital and Clinics and Meriter Hospital. As such, he has an excellent understanding of the problems associated with the management and treatment of congestive heart failure. Although he once had a consulting role as a cardiologist at Hess Memorial Hospital, where he would occasionally have incidental contact with Drs. Logan and Ness, he has not done any consulting there for the past five years. Nonetheless, it was suggested that because of Dr. Morledge's prior role as a consultant at Hess Memorial Hospital, he would be biased in favor of Drs. Logan and Ness, and that his testimony would therefore reflect such bias. There was not one scintilla of evidence to indicate that Dr. Morledge was in any way biased in his assessment of the diagnosis and treatment provided by either Dr. Ness or Dr. Logan. His opinions were scientifically and factually based, and did not reflect any bias on his part. He was a competent and credible witness whose opinions were beyond reproach.

With respect to the overall treatment provided to Mr. Slater by Dr. Ness, Dr. Morledge concluded that it was very straightforward, noncontroversial, and correct. Given the host of problems with which Mr. Slater presented, and especially in light of his rhabdomyolysis, Dr. Morledge aptly summarized the physician's dilemma in treating such a patient as being "damned if you do and damned if you don't." He explained the circumstances surrounding Mr. Slater's condition in the following way:

See, ordinarily you would not want to push fluids if somebody has congestive heart failure, but if you don't and if their kidneys shut down, and you have no effective diuretics, then the patient will die. So you have to take on the lesser of the evils and say the immediate pressing problem is the rhabdomyolysis which is getting worse and the only treatment is to force the fluids and give diuretics which are -- the patient displayed one of the complications of severe rhabdomyolysis, that is, potassium levels started to go up.

[T]his man's potassium levels started to go up. It got up to 5.7 I think within the second day in the hospital. If the potassium level gets much above 7 it poisons the heart and the heart stops. So they wisely instituted a drug called kayexalate, K A Y E X A L A T E, which helps to lower the potassium level and they also administered more diuretic to try and help get rid of the potassium through the kidneys. Well, it happens by, as I recall, the third or fourth day the man's blood pressure dropped too low to about 70 over 50 which threatens kidney shutdown, kidneys don't get enough blood supply and they quit working. So they had to back off of the diuretics. And they had to back off one of the drugs they had given for previously high blood pressure, and that was perfectly good, straightforward, accurate management.

(Tr. at 545-46).

Based on Mr. Slater's electrocardiogram, it was clear that he had had two previous heart attacks. And, as Dr. Morledge noted, this is a man who, with ten years of diabetes, smoking history, a history of high cholesterol, chronic lung disease, high blood pressure, and massive overweight, had all of the risk factors classically known for many years that lead to coronary disease. Indeed, Dr. Morledge opined that it would have been miraculous for Mr. Slater not to have had coronary disease. (Tr. at 515-16). When asked whether it was necessary to determine the etiology of Mr. Slater's heart failure, Dr. Morledge responded this way, "No. I think standard, normal clinical evaluation of patients, number one, diabetes for over ten years equals coronary disease. You got it." (Tr. at 522). He was also asked whether an echocardiogram was necessary in order to make that determination. Dr. Morledge unequivocally stated that one was "clearly not necessary" and, furthermore, even if one had been ordered, that it would not have altered the manner in which Dr. Ness treated Mr. Slater. According to Dr. Morledge, the management of congestive heart failure is a "cookbook standard" consisting of bed rest, oxygen, salt restriction, a diuretic, and often an ACE inhibitor. (Tr. at 525).

While the management of congestive heart failure is straightforward and standard, there is no magic drug that acts as a cure-all for it. Furthermore, as Dr. Morledge pointed out, a physician would not wait for an echocardiogram to institute treatment of coronary disease, including congestive heart failure. And, given Mr. Slater's multi-system diseases and the development of a sudden and severe case of rhabdomyolysis, he was not a candidate for further interventions, including, for instance, a lung transplant, coronary bypass, angioplasty, or even a stress test. According to Dr. Morledge, because Mr. Slater had chronic lung disease and scar tissue from his prior heart attacks, a cardiac surgeon would be unwilling to go forward with either bypass surgery or angioplasty because the risks associated with those procedures would be too high to surmount. (Tr. at 536-41).

Indeed, the Complainant's own expert witness, Dr. Rick Reding, when asked if Mr. Slater should have been given either a treadmill stress test or a chemical stress test to determine whether he had congestive heart failure said no. (Tr. at 383-84). Dr. Reding also indicated that even if an echocardiogram had been given to Mr. Slater, the results may well have been inconclusive given Mr. Slater's obesity and his severe lung disease. (Tr. at 385).

But more to the point, as Dr. Morledge so succinctly put it, is the common sense rule in medicine that one does not order a test even if there is no risk associated with it unless you are prepared to do something with the information obtained from the test. (Tr. at 542). In other words, if you are unable or unwilling to do anything with the test results, then there is no reason to do the test in the first place. Such was the case with the echocardiogram and Mr. Slater.

When asked whether he would have done anything differently with respect to Mr. Slater, Dr. Morledge said no. He did not believe that an echocardiogram or any other test or study was needed for the diagnosis and treatment of Mr. Slater because Dr. Ness already had the necessary information about him at hand. Dr. Ness knew that Mr. Slater had a history of diabetes, hyperlipidemia, hypertension, congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease, arthritis, and obesity. He also knew that Mr. Slater's weight was increasing and that he was suffering from

rhabdomyolysis. An echocardiogram would not have elicited any additional information such that it would have changed the course of treatment for Mr. Slater. Similarly, there is no indication that a gated pool study, cardiac catheterization, or a cardiac stress test were required in order to diagnose and treat Mr. Slater any differently than he was. Nor would consulting another specialist have changed the diagnosis or treatment, as Dr. Morledge's testimony indicated.

In addition, Dr. Ness's care of Mr. Slater was also reviewed by Dr. John Beasley and Dr. Timothy Bjelland, both of whom are board certified family practice physicians. Dr. Beasley is a professor emeritus at the University of Wisconsin-Department of Family Medicine and remains on the staff of the University of Wisconsin Medical School. He reviewed Mr. Slater's medical records and concluded that Dr. Ness's treatment of him was reasonable. Dr. Bjelland, who is on the quality assurance committee at Hess Memorial Hospital, also reviewed the same records following Mr. Slater's death and concluded that the care that had been rendered by Dr. Ness was appropriate.

Dr. Ness's testimony also reveals that he was able to determine the etiology of Mr. Slater's congestive heart failure without an echocardiogram. With respect to that issue, he testified as follows:

Well, I think that we're dealing with an individual who has previous clearly documented heart attacks, so we know that we've got heart muscle that is damaged, it's not working as well. We know that we've got diffuse small vessel disease, he has peripheral neuropathy, he had a history of impotence. And impotence is a very, very sensitive marker of small vessel disease in the body. It goes concomitantly with heart disease very, very frequently with atherosclerotic disease.

We know that he had small vessel disease, diabetic disease in the eyes because he had laser treatment to each eye. So we know that he has diffuse small vessel disease. We know he's had high blood pressure, we know he has hyperlipidemia, we know he has obesity, we know he's sedentary. We know he smoked 60 pack years of cigarettes, we know that he's one of 16 siblings and the oldest of everyone in the family except his mother who died at 66 of cancer, everyone else who has died and a significant number of his siblings and his father have died, no one has gotten to 64. He's the oldest of the group.

So you add all this together, it's obvious that he's got all the risk factors, he's got atherosclerotic disease, he's got EKG evidence. We know that his heart is a little dilated, we know he's got some prominence of his pulmonary vascularity on his chest X ray. It really is a very clear diagnosis that he has a pump that's failing because of previous heart disease, because of previous MIs and because of poor circulation to the heart muscle because of small vessel disease.

(Tr. at 167-68).

His testimony further reveals the basis for his decision not to order an echocardiogram for Mr. Slater:

Q: (by Ms. Epstein) Mr. Lubcke asked you about the availability of echocardiograms at your hospital. Why did you decide not to order an echocardiogram for this patient?

A: The value of a test lies in its ability to give you information that No. 1, you don't have and No. 2, you need. Now, we had talked about what an echocardiogram can do. It looks at the heart muscle, it looks at the valves. We can see heart muscle moving. We can see if there are areas of the heart muscle that demonstrate damage, if there were previous areas of the heart muscle that have been harmed, damaged, killed by a heart attack.

We have EKGs, we know this man has previous anterior and inferior wall myocardial infarctions. That's not going to surprise me, that's not going to be something that's going to tell me something different, that I'll do something different about.

We listen to his heart, he doesn't have any murmurs or any significant heart murmurs, the echocardiogram looks at the valves of the heart and tell us whether they're working adequately or not, whether they're significantly stenosed or blocked or insufficient or floppy. But in order for it

to be clinically significant, you would have to have a murmur. You would hear a murmur. If his aortic valve were significantly stenotic or tight, we would hear an aortic stenosis murmur. If his mitral valve were leaking, we would hear a mitral insufficiency murmur.

So we know from a clinical standpoint the valves are working okay. We know from a standpoint -- from the standpoint of his -- how is his heart muscle working and whether he's had previous heart attack, we know from the EKG that he's had that. The echocardiogram can also calculate for us an ejection fraction. It can tell us how well is the heart pumping. We can look at this clinically and look at the chest X ray, auscultate the heart, talk to Mr. Slater, and we know that his heart is not working well. We know it is somewhat dilated, we know that it's not contracting well. We know he's had a couple of heart attacks. We know that he's got small vessel disease. We know his heart is not getting oxygen and getting circulation as well as it should. So we already know this.

Now, would it give me a number, yes. Well, I may even qualify that because one of the technical difficulties with an echocardiogram is that you have to shoot through the chest. And in a man who is over 300 pounds it is technically very difficult to get a good technical tracing. If you have a slim, little person where the heart is close to the chest wall, you can get a wonderful picture of the heart and the valves. But if you've got a person with a big barrel chest and those expanded lungs of emphysema and a lot of fat and you try and get a picture down in there, you get your transducer through that to get a good look at it, many times you will get very, very poor data. It will be technically very difficult to do, and technically very inadequate. So assuming that we could get good data which is very questionable in this patient, I'm going to have an ejection fraction. And I'm going to say that's nice, now I have a number. But that's all I'll have. I won't have any additional help in deciding what I'm going to do, I'm not going to do one thing differently. As it turns out, I would have spent a lot less time in a situation like this, but that's probably -- that's not the reason to order a test. The test doesn't -- I don't do a test unless it has some value and some meaning and is going to change what I do. And in this case it just wasn't going to change one bit what I did.

(Tr. at 163-66).

This testimony underscores the opinions of Drs. Morledge, Beasley, and Bjelland. While hindsight is often 20/20, there is no credible evidence that demonstrates that Dr. Ness's care and treatment of Mr. Slater fell below the minimally acceptable standards within the medical profession. The fact remains that Mr. Slater was an extremely ill man who had multi-system and multi-organ failure. His condition was undeniably complex. To his credit, however, Dr. Ness took appropriate and reasonable measures to treat him. He completed a comprehensive patient history, he conducted daily clinical assessments, he ordered serial blood work, serial x-rays, and serial EKGs, to name but a few of the measures he took. But despite Dr. Ness's many efforts, Mr. Slater unfortunately died. His demise, however, bears no relationship to the treatment he received, or, for that matter, did not receive.

The professional judgments that Dr. Ness made in his treatment and care of Mr. Slater were well-considered and appropriate. Simply put, he acted in a manner that was consistent with a patient who had multiple and complex medical problems. The fact that he did not order an echocardiogram or conduct a stress test or consult with a specialist does not mean that his conduct was sub-par or in any way fell below the minimal standard of care, especially since the results of any such tests or consultations would have had no bearing on the way in which Mr. Slater's condition was addressed. Therefore, because there is insufficient evidence to show that Dr. Ness engaged in unprofessional conduct or that his actions constituted a danger to the health, welfare, and safety of this patient it is recommended that this matter be dismissed.

Dated at Madison, Wisconsin, this 8th day of June, 2004.

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Jacquelynn B. Rothstein
Administrative Law Judge