[Cite as *Schoewe v. Univ. of Toledo,* 2014-Ohio-5985.]

Court of Claims of Ohio
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EDWARD SCHOEWE, Admr., etc.

Plaintiff

v.

UNIVERSITY OF TOLEDO

Defendant

Case No. 2009-07369

Magistrate Holly True Shaver

DECISION OF THE MAGISTRATE

{¶1} Plaintiff, Edward Schoewe, brought this action as administrator of the estate of his wife, Sherry Schoewe, alleging claims of medical negligence and wrongful death. The issues of liability and damages were bifurcated and the case proceeded to trial on the issue of liability.[1]

{¶2} On September 3, 2008, at approximately 6:30 p.m., Sherry Schoewe presented to the emergency room at Fisher Titus Medical Center, in Norwalk, Ohio, complaining of chest pain. She described that the pain had started the previous morning when she was attempting to lift up her child,[2] that it lasted for approximately one hour, and that it started again on the morning of September 3, 2008. Schoewe reported that she had never experienced similar pain before. She described the pain as "pressure and tight," in the left chest area, and stated that she took aspirin but that it

[1]Plaintiff's June 5, 2014 motion for leave to exceed the page limitation found in L.C.C.R. 4(E) regarding his post-trial brief is GRANTED, instanter. On another matter, the court notes that on the second day of trial, plaintiff filed a motion to exclude the testimony of defendant's expert witness, Louis Cannon, M.D., on the basis that he was not qualified to render any opinion based upon his examination of the autopsy slides of Schoewe's coronary arteries. Upon review, the court finds that Dr. Cannon qualifies as an expert in the field of cardiology, and plaintiff's May 6, 2014 motion is DENIED.

[2]At the time of her admission, Schoewe's severely disabled child was nine years old.

was not effective. At the time of her admission, Schoewe was 44 years old, premenopausal, and was neither a smoker nor diabetic. However, she was obese and was taking medication for hypertension. Schoewe was admitted to the hospital and treated as a potential cardiac patient. Schoewe stayed the night in the hospital and certain standard cardiac tests were ordered, such as a chest x-ray, EKGs, enzyme tests, and a D-Dimer test.

{¶3} According to the progress notes in her medical record, at 8:16 p.m., Schoewe stated that she was "feeling much better," at 8:17 p.m., she denied chest pain, shortness of breath, nausea, or further symptoms. However, at 10:39 p.m., Schoewe reported that she was "feeling worse." At 10:40 p.m., Schoewe used her call light to report that she felt a sudden onset of sharp pain, mid-sternal, without radiation while eating a sandwich. At 10:43 p.m., she reported complete relief of the pain after one dose of nitroglycerin. After that incident, Schoewe did not report any further chest pain during her hospital stay.

{¶4} On September 4, 2008, Dr. Daniel Kosinski, M.D., a cardiologist employed by defendant, examined Schoewe pursuant to a cardiac consultation that had been requested by the attending physician, Adil Waheed, M.D. Dr. Kosinski noted in his consultation report that Schoewe had experienced two episodes of chest discomfort that she found very difficult to characterize. Prior to his consult, test results had ruled out a myocardial infarction. Dr. Kosinski noted that Schoewe had no cardiac history, no history of any coronary artery disease, and that she did not smoke. He also noted that she did not usually get chest pain.

{¶5} Dr. Kosinski noted that Schoewe's chest x-ray was normal. He evaluated both EKGs that had been performed and found that she had a normal sinus rhythm in both, but noted that the September 3 EKG showed "T wave inversion in Lead 3, which can be normal, and a nonspecific T wave change in Lead AVF, however, the remainder

was normal." (Joint Exhibit A, p. 23). Dr. Kosinski noted that Schoewe's laboratory tests, including troponins, D-Dimer, and CBCs were all within normal limits. With regard to an assessment, Dr. Kosinski found that Schoewe had nonspecific chest pain with a normal chest x-ray and normal labs. He noted that she reported no family history of any premature coronary artery disease. After the evaluation, Dr. Kosinski concluded that it appeared that Schoewe had "a low risk profile." Dr. Kosinski prescribed baby aspirin, had her continue her Lopressor medication, and instructed her to call the next day to schedule an outpatient stress test known as Cardiolite. Schoewe was released from the hospital on September 4 at approximately 6:45 p.m.

{¶6} Plaintiff returned to work on September 5. Schoewe stayed at home that day. When plaintiff arrived home from work, he took a shower and then took Schoewe out for dinner. When they returned home, Schoewe stated that she was not feeling well and went to lie down. A few minutes later, she told plaintiff that she wanted to go to the hospital. On route, Schoewe became unresponsive. When she arrived at the hospital, CPR was begun immediately, but her heart could not sustain a stable rhythm and she died. An autopsy was performed and it was discovered that Schoewe had advanced arthrosclerosis, and that her death was caused by a blockage of her left anterior descending coronary artery.

{¶7} Plaintiff's allegation of negligence centers on the care and treatment of Schoewe by Dr. Kosinski, who recommended that she be discharged and scheduled for a stress test on an outpatient basis. Plaintiff asserts that Dr. Kosinski breached the standard of care when he failed to have Schoewe undergo a stress test while she was in the hospital, and that his failure to do so was the proximate cause of her death.

{¶8} In order to prove negligence, plaintiff must prove the existence of duty and a breach of such duty, which proximately causes damages. *Armstrong v. Best Buy Co., Inc.*, 99 Ohio St.3d 79, 2003-Ohio-2573. "To maintain a wrongful death action on a

theory of negligence, a plaintiff must show (1) the existence of a duty owing to plaintiff's decedent, (2) a breach of that duty, and (3) proximate causation between the breach of duty and the death." *Littleton v. Good Samaritan Hosp. & Health Ctr.*, 39 Ohio St.3d 86, 92 (1988). Similarly, on a claim of medical malpractice or professional negligence, a plaintiff must prove, (1) the standard of care recognized by the medical community; (2) the failure of defendant to meet the requisite standard of care; and (3) a direct causal connection between the medically negligent act and the injury sustained. *Wheeler v. Wise*, 133 Ohio App.3d 564 (10th Dist.1999); *Bruni v. Tatsumi*, 46 Ohio St.2d 127 (1976).

{¶9} Dr. Kosinski, who is board-certified in cardiology and nuclear cardiology, testified that when a patient is admitted complaining of chest pain, the presence of three potential life-threatening conditions must be evaluated. One is a pulmonary embolism, which was ruled out in Schoewe's case after a D-Dimer assay was conducted. The second condition is an aortic dissection, which was ruled out based upon Schoewe's blood pressure test results. The third condition is coronary artery disease.

{¶10} Coronary artery disease is categorized into three acute coronary conditions: 1) ST elevation Myocardial Infarction (MI); 2) non-ST elevation MI, and 3) unstable angina. Dr. Kosinski described unstable angina as pain caused by coronary artery disease that is new in onset and increases in frequency, severity, or duration. According to Dr. Kosinski, if underlying coronary artery disease is severe, any of the three acute conditions can result in death.

{¶11} Dr. Kosinski explained that Schoewe had been under observation in the hospital for almost 24 hours when he first examined her. He described Schoewe's reported chest pain as intermittent, and stated that the nature of her symptoms varied significantly. For example, Schoewe reported that her pain started when she picked up

her disabled son. According to Dr. Kosinski, that was very significant because it was pain on exertion. Dr. Kosinski also stated that he did not believe that the sharp pain that Schoewe felt while eating a sandwich was cardiac in origin. Rather, he felt that pain sustained while swallowing was more likely from a gastrointestinal source.

{¶12} According to Dr. Kosinski, the September 3 EKG ruled out the possibility of ST elevation MI. In addition, her enzymes were tested, and those results ruled out non-ST elevation MI. Dr. Kosinski agreed that unstable angina remained on the differential diagnosis when he decided to release Schoewe on medications and to schedule an outpatient stress test.

{¶13} After evaluating both EKGs, Dr. Kosinski determined that her EKG readings were within normal limits. Dr. Kosinski testified that the only risk factor that Schoewe had for coronary artery disease was hypertension. Although Schoewe was obese, Dr. Kosinski stated that obesity is not a risk factor for coronary artery disease. After evaluating her, Dr. Kosinski prescribed a beta blocker to lower her heart rate and blood pressure, and baby aspirin to prevent blood clots. Dr. Kosinski also instructed Schoewe to contact the scheduling office the following day to schedule her Cardiolite test. According to Dr. Kosinski, he decided to discharge Schoewe because of her low risk profile and the results of the tests that were performed on her during her hospital stay. In Dr. Kosinski's opinion, nothing during her hospital stay indicated that Schoewe was at risk either for an occlusion of the left anterior descending artery, or that she had severe arthrosclerosis.

{¶14} Plaintiff presented the testimony of two expert witnesses: Robert Hoffman, M.D., and Alan Feit, M.D. Dr. Hoffman, who is board-certified in anatomic pathology, performed a gross examination of the retained tissues of Schoewe's heart at the coroner's office. He also prepared 9 glass microscope slides of her coronary arteries.

{¶15} With regard to the heart's anatomy, Dr. Hoffman explained that the lumen of a coronary artery is the channel through which blood flows. In the process of developing atherosclerotic plaque, fatty material (cholesterol) accumulates in the intima, the inner lining of the coronary artery. The cholesterol accumulates within the cells in the plaque, the substance in the plaque becomes semi-liquid, and that semi-liquid material remains separated from the lumen by a thin fibrous layer. If a rupture of the thin fibrous layer (intima) occurs, two things happen. Blood from the lumen is injected into the intima, which process is known as a sub-intimal hemorrhage. Simultaneously, plaque contents from the intima are extruded into the lumen. The material contained in plaque is highly thrombogenic, which means that it causes blood to clot quickly. The clotting process causes a sudden interruption of the blood flow.

{¶16} Dr. Hoffman stated that Plaintiff's Exhibit O shows that this process happened to Schoewe. In Dr. Hoffman's opinion, Schoewe had severe coronary atherosclerosis and experienced a rupture of plaque in her left anterior descending coronary artery. As a result of that plaque rupture, Schoewe sustained sudden coronary thrombosis, which caused a lethal arrhythmia. Dr. Hoffman further opined that the plaque disruption occurred sometime within 12 hours of Schoewe's death. Dr. Hoffman based that conclusion on his examination of Schoewe's heart tissues, which showed no gross or microscopic evidence of myocardial infarct. Dr. Hoffman conceded that the 12-hour window for the plaque disruption could be shorter, perhaps 4 to 6 hours, perhaps even 5 minutes after the total blockage occurred. Dr. Hoffman agreed that the more proximal to the heart the occlusion is located, the more severe the outcome. According to Dr. Hoffman, Schoewe had high grade stenosis, and he opined that her left anterior descending coronary artery was probably 90 percent stenotic prior to the rupture. Dr. Hoffman based his opinion on his examination of the tissue slide

shown in Plaintiff's Exhibit O, and the coroner's report. Dr. Hoffman agreed that high grade stenosis is an unusual condition for a 44-year-old woman.

{¶17} Plaintiff's second expert, Dr. Feit, is board-certified in cardiology, interventional cardiology, and internal medicine. Dr. Feit agreed that the appropriate considerations were on the differential diagnosis when Schoewe presented to the hospital. He also agreed that appropriate testing was done to rule out both aortic dissection and pulmonary embolism. However, with regard to coronary artery disease, Dr. Feit testified that Dr. Kosinski failed to rule out unstable angina before he discharged Schoewe from the hospital, and that failure was a breach of the standard of care.

{¶18} Dr. Feit agreed that Dr. Kosinski properly ruled out both ST segment elevation MI and non-ST elevation MI based upon Schoewe's blood tests and the EKGs. However, Dr. Feit opined that the September 3 EKG showed abnormalities that should have alerted Dr. Kosinski to the diagnosis of unstable angina. Dr. Feit described unstable angina as a changing pattern of angina, including new angina with no evidence of permanent myocardial damage, caused when the heart does not get enough blood or oxygen. Dr. Feit explained that unstable angina is a harbinger of complete vessel closure.

{¶19} Dr. Feit stated that atherosclerotic disease can go into unstable phases. He explained that once plaque is exposed to the bloodstream, clotting of the blood elements form on the plaque. He also stated that a clot can get larger and then completely close the channel, resulting in a heart attack. Dr. Feit stated that patients can experience symptoms that come and go, and that can be difficult to describe. Dr. Feit also explained that a patient with unstable angina can experience clotting then a lysing (breaking up) of the clot.

{¶20} Dr. Feit criticized Dr. Kosinski for not ruling out unstable angina before Schoewe was discharged, because unstable angina increases the risk of heart attack. Dr. Feit opined that Schoewe met the clinical presentation of a patient with unstable angina because she had new chest discomfort, and there were abnormalities present on her first EKG. Dr. Feit explained that the September 3 EKG showed non-specific abnormalities in both leads 3 and AVF. On the September 4 EKG, those abnormalities had resolved. Dr. Feit stated that the fact that her EKG changed is a sign that the pain was cardiac in nature, and an indication that she had coronary artery disease. Dr. Feit criticized Dr. Kosinski's conclusion that the pain that Schoewe sustained after eating a sandwich was gastrointestinal because it subsided after she was given nitroglycerin, a medication commonly prescribed for cardiac pain.

{¶21} Dr. Feit stated that either a stress test or a cardiac catheterization can diagnose unstable angina. Dr. Feit explained that a Cardiolite stress test utilizes radioactive dye which is injected into the heart that will show whether the heart is getting enough oxygen. Dr. Feit stated that in order for a blocked vessel to be diagnosed on a stress test, a 70 percent blockage is required. Dr. Feit noted that it is generally understood that until a channel is narrowed by about 70 percent, a patient will not show symptoms of a narrowing of the arteries. Dr. Feit agreed that usually it takes years for a patient to develop a 70 percent blockage. Dr. Feit also opined that either one of those tests would have discovered the problem, based upon the autopsy findings which state: "The left anterior descending coronary is 90-100% occluded by atherosclerotic plaque with almost complete occlusion at 2 cm." (Joint Exhibit 1, p. 195.) He also opined that the left anterior descending artery would have been approximately 90 percent occluded on September 3, based on the autopsy report.

{¶22} According to Dr. Feit, the standard of care for a cardiologist requires recognition that Schoewe should have undergone stress testing or catheterization prior

to her discharge from the hospital and that Dr. Kosinski's failure to meet the standard of care was the proximate cause of her death. Dr. Feit further opined that Schoewe's left anterior descending artery more likely than not became completely occluded shortly before she asked plaintiff to drive her to the hospital on September 5.

{¶23} On cross-examination, Dr. Feit agreed that an EKG is not a diagnostic tool, and that it cannot pinpoint a location of a blockage or narrowing of an artery. However, he insisted that Schoewe's first EKG reflected transient ischemia. Dr. Feit based his opinion that Schoewe's left anterior descending artery was 90 percent occluded when she initially arrived at the hospital on September 3 on the autopsy's description of that artery being 90 to 100 percent occluded by atherosclerotic plaque. Dr. Feit's theory is that the pain she was experiencing in the hospital was caused by instability of plaque, and that the rupture of plaque caused her death.

{¶24} Defendant presented the expert testimony of Louis Cannon, M.D., who is board-certified in internal medicine, cardiology, and interventional cardiology. Dr. Cannon stated that there are three life-threatening emergencies that must be ruled out when a patient has a suspected cardiac issue. One is an aortic dissection, which is a tear of the proximal aorta, and was ruled out after Schoewe's blood pressure and pulse readings were taken. Second is a pulmonary embolus, which is when a blood clot travels from the legs into the lungs, which condition was ruled out after testing Schoewe's oxygen saturations and D-Dimers. The third risk is whether the patient had or is having a heart attack, which can be discovered by performing an EKG and testing enzymes.

{¶25} Dr. Cannon stated that Schoewe's sole risk factor for coronary artery disease was the fact that she had hypertension. Dr. Cannon stated that hypertension is a risk factor even when it is being treated by medication. Dr. Cannon further stated that Schoewe's young age, the fact that she was premenopausal, that she was a

non-smoker and that she was not diabetic, were factors that were in her favor and are not risk factors for coronary artery disease.

{¶26} With regard to the EKGs, Dr. Cannon testified that although the computer reading says "normal" on the September 3 EKG, he opined that there are nonspecific ST and T wave changes in leads 3 and AVF, just as Dr. Kosinski found. According to Dr. Cannon, nonspecific changes could indicate a number of things such as low blood flow to the heart, someone taking in a deep breath, something gastrointestinal, or something abnormal. Dr. Cannon stated that the second EKG taken 12 hours later was normal. Dr. Cannon added that nothing on either EKG would showed a specific problem with the left anterior descending artery.

{¶27} Dr. Cannon opined to a reasonable degree of medical probability that Dr. Kosinski's consult of Schoewe met the standard of care in the cardiology profession when he assessed Schoewe's condition. Specifically, Dr. Cannon stated that Dr. Kosinski thoroughly analyzed each individual lead in the 12-lead placement EKGs. Dr. Cannon also stated that it was within the standard of care to prescribe baby aspirin, continue her on her hypertension medication, and instruct her to schedule an outpatient Cardiolite test. Dr. Cannon also opined that Schoewe should not have been kept in the hospital to do the stress test on an inpatient basis. Dr. Cannon explained that if Schoewe had an abnormal result in her enzyme tests, or if the EKGs would have shown the typical changes of a heart attack or low blood flow to the heart, she should have been kept as an inpatient and scheduled for a heart catheterization. However, based on her test results, Schoewe was considered to be in the low risk category for coronary artery disease for many reasons. First, her pain was atypical. Her EKGs did not show any findings of low blood flow to the heart. Her enzyme tests were normal and her troponin levels were normal. While under observation, Schoewe experienced an episode of pain while swallowing, but such pain was atypical in his opinion to be of

cardiac origin. Dr. Cannon further opined that even after all of the testing, there was no reasonable indication that Schoewe would have been likely to have significant heart disease or that she in fact did have significant heart disease. Dr. Cannon also stated that Schoewe's clinical presentation did not warrant a heart catheterization. In Dr. Cannon's opinion, Schoewe met the criteria for being discharged home with instructions to schedule a stress test on an outpatient basis.

{¶28} With regard to the blockage that occurred in Schoewe's left anterior descending artery, Dr. Cannon opined that the blockage was a sudden event that happened minutes to seconds before she lost consciousness in the car. Dr. Cannon described the left anterior descending artery as the most important artery of the heart, and testified that if it becomes blocked, it is very hard to survive. Dr. Cannon agreed that a blockage proximal to the left anterior descending artery is known as the "widow-maker" lesion, which results in sudden death.

{¶29} On cross-examination, Dr. Cannon agreed that the process of acute coronary syndrome is dynamic in that there is an ongoing process of clot formation and dissolution and opening and closing of an artery until it is finally closed. He also agreed that acute coronary syndrome can present as intermittent pain and then lack of pain. Dr. Cannon stated that neither an EKG nor an enzyme test can completely rule out unstable angina. Dr. Cannon stated that the only way to rule out unstable angina is to do a heart catheterization and retrospectively determine it. However, he insisted that Schoewe's clinical presentation did not warrant a heart catheterization on September 4.

{¶30} Dr. Cannon stated that chest pain that is accompanied by shortness of breath and is relieved by nitroglycerin is consistent with cardiac pain but not diagnostic of it. Dr. Cannon opined that Schoewe's initial chest pain on admission was most likely musculoskeletal pain from lifting up her disabled son. Dr. Cannon admitted that the

fact that Schoewe experienced chest pain while eating did not rule out that she was having cardiac pain, but stated that a common reason for experiencing pain while swallowing is gastrointestinal or esophageal pain. Dr. Cannon further testified that the nonspecific changes from two of the twelve leads on the September 3 EKG do not correlate to the area of the heart where the blockage was located.

{¶31} Upon review of the evidence presented, the court finds that the testimony of Dr. Cannon was more persuasive than that of Dr. Feit. It is uncontested that Schoewe had advanced arthrosclerosis, and that her death was caused by a blockage of her left anterior descending coronary artery. However, the issue to be decided is whether the standard of care required Dr. Kosinski to perform an inpatient stress test on Schoewe before he discharged her. The court finds that Dr. Cannon's testimony that it was within the standard of care for Dr. Kosinski to discharge Schoewe and instruct her to call the hospital the next day to schedule a stress test is credible and persuasive. The court finds that Dr. Kosinski met the applicable standard of care when he reviewed Schoewe's test results, found that they were within normal limits, reviewed both EKGs and found that she had nonspecific changes, and conducted his own examination of her. The court further finds that plaintiff has failed to prove by a preponderance of the evidence that the standard of care required an inpatient stress test to be conducted. The court bases this conclusion on the fact that Schoewe had essentially normal test results in the hospital, that she had a lack of cardiac history, her young age, and the other factors that placed her in a low risk category. In addition, all experts agreed that Schoewe's advanced level of atherosclerosis was unusual for a 44-year-old woman. The greater weight of the evidence shows that Dr. Kosinski met all applicable standards of care in the treatment of Schoewe.

{¶32} For the foregoing reasons, the court finds that plaintiff has failed to prove any of his claims by a preponderance of the evidence and, accordingly, judgment is recommended in favor of defendant.

{¶33} *A party may file written objections to the magistrate's decision within 14 days of the filing of the decision, whether or not the court has adopted the decision during that 14-day period as permitted by Civ.R. 53(D)(4)(e)(i). If any party timely files objections, any other party may also file objections not later than ten days after the first objections are filed. A party shall not assign as error on appeal the court's adoption of any factual finding or legal conclusion, whether or not specifically designated as a finding of fact or conclusion of law under Civ.R. 53(D)(3)(a)(ii), unless the party timely and specifically objects to that factual finding or legal conclusion within 14 days of the filing of the decision, as required by Civ.R. 53(D)(3)(b).*

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HOLLY TRUE SHAVER
Magistrate

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