STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF
DISCIPLINARY PROCEEDINGS AGAINST

NICHOLAS L. OWEN, M.D., LS 9107302 MED

Respondent

FINAL DECISION AND ORDER

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

Nicholas L. Owen, M.D.
2015 East Newport Avenue, Ste. 208
Milwaukee WI 53211

FILE COPY

Wisconsin Medical Examining Board
Department of Regulation and Licensing
P.O. Box 8935
Madison WI 53708

Division of Enforcement
Department of Regulation and Licensing
P.O. Box 8935
Madison WI 53708

A hearing was held in this matter on December 1, 2, and 21, 1992. Respondent Nicholas Owen, M.D., appeared in person and with counsel, Michael P. Malone of the firm Hinshaw & Culbertson, 100 East Wisconsin Avenue, Suite 2600, Milwaukee, WI 53202-4115. Complainant was represented by Arthur Thexton of the Division of Enforcement.

The administrative law judge filed his Proposed Decision on September 28, 1993. Attorney for complainant filed his objections to the Proposed Decision on October 20, 1993. Respondent's attorney filed his reply to complainant's objections on or about October 22, 1993. Oral arguments on the objections were heard by the board on December 20, 1993, and the board considered the matter on that date.

Based upon the entire record of the proceeding, the Medical Examining Board makes the following Findings of Fact, Conclusions of Law and Order.

FINDINGS OF FACT

1. Nicholas L. Owen, M.D., is licensed to practice medicine and surgery in the state of Wisconsin, and his latest address on file with the Department of Regulation and Licensing is 2015 East Newport Avenue, Suite 208, Milwaukee, Wisconsin 53211.

2. Dr. Owen treated Thomas Ahern from April 17, 1986, until Ahern's death on October 7, 1986. Mr. Ahern was 38 years old at the time of his death. The cause of death was myocardial ischemia and cardiac arrythmia. The autopsy showed significant arteriosclerosis in the anterior descending coronary artery.

3. Mr. Ahern first presented to Dr. Owen on April 17, 1986. Dr. Owen performed an examination, which is generally poorly documented in his records, and ordered a complete blood count, a blood chemistry panel, and a urinalysis. All laboratory reports were essentially normal, with a slightly elevated cholesterol count. Mr. Ahern reported no commonly recognized risk factors for cardiac disease.

4. Dr. Owen's record of the visit indicates that there was some discussion of Mr. Ahern's symptoms, which were ascribed to heartburn. Whether Mr. Ahern described the symptoms as heartburn, or Dr. Owen decided the symptoms described heartburn, is impossible to determine.

5. Mr. Ahern's symptoms were pain in the middle of his chest, in "attacks" lasting for several hours. The occurrences of the pain were unrelated to exertion. Mr. Ahern was an avid runner, and ran on a daily frequency, covering distances of 3 to 8 miles during each exercise session. The symptoms about which he complained to Dr. Owen never appeared during or shortly after his running sessions.

6. Dr. Owen recommended some dietary changes for the prevention of the attacks, and prescribed antacids for the relief of attacks which were not prevented.

7. On May 14, 1986, Mr. Ahern telephoned Dr. Owen's office, and complained of continued bad attacks of heartburn. The note of the telephone call states that he wanted to know why he was having the attacks. Dr. Owen scheduled Mr. Ahern for an upper gastrointestinal study and gallbladder ultrasound on May 19, 1986.

8. On May 19, 1986, Mr. Ahern had a barium UGI study, which resulted in a report of possible duodenitis, with a suggestion that the condition by followed by clinical study, and a gallbladder ultrasound, which resulted in a finding that there were no gallstones and that the gallbladder and ducts were in normal condition.

9. Mr. Ahern returned for his second and final office visit with Dr. Owen on August 7, 1986. At that visit, Dr. Owen noted that Mr. Ahern weighed 141 pounds and had lost two pounds from the April, 1986 visit, and noted that there was some discussion of heartburn. Mr. Ahern provided Dr. Owen with two pages of notes about his attacks, by date, with notes on food intake, stressors of the day, and the duration of the attacks.

10. The notes Mr. Ahern provided to Dr. Owen about the attacks of pain were brief, and did not provide any description of the symptoms. The notes indicated that Mr. Ahern had had attacks on May 27, June 20, June 30, and July 21, 1986, and two "minor" attacks, with no details at all mentioned, on July 20 and August 6, 1986. The attacks which had led Mr. Ahern to provide some detail in the notes lasted 2 to 3 hours each, except for the one on July 21, which lasted 6 hours. There is no duration noted for the attack on May 27.

11. On August 19, 1986, Dr. Owen referred Mr. Ahern to Dr. Patrick Regan, a gastroenterologist, for a consultation.

12. On August 21, 1986, Mr. Ahern had a consultation with Dr. Regan. Dr. Regan's notes indicate that Mr. Ahern had been complaining of "substernal burning (plus or minus) cramping in discrete severe attacks since 2/86. ? like heartburn. Nonexertional. Not clearly related to meals. Recent course of Mylanta II helped (,) the <u>very</u> brief trial of Zantac (was without) help. Family History negative. No meds. No dysphasia or aspiration. UGI series showed ? duodenitis. No DH (diaphragmatic hernia)."

13. Dr. Regan examined Mr. Ahern with the specific intent of determining the cause of Mr. Ahern's continued symptoms. Dr. Regan performed an examination of Mr. Ahern's heart, lungs, vital signs and abdomen, and concluded that Mr. Ahern had atypical chest pain of possibly esophageal origin. Dr. Regan noted a long discussion with Mr. Ahern about the symptoms, and recommended an endoscopy, to be followed with appropriate therapy. Because there was no indication that Mr. Ahern was in any immediate danger, Dr. Regan scheduled the endoscopy for September 12, 1986, three weeks later.

14. Nothing about Mr. Ahern's symptoms, Dr. Regan's examination of Mr. Ahern, or the discussion Dr. Regan had with Mr. Ahern suggested to Dr. Regan that Mr. Ahern's complaint was cardiac in origin.

15. On September 12, 1986, Dr. Regan performed an endoscopy on Mr. Ahern. Dr. Regan reported the results of the endoscopic examination to Dr. Owen on September 17, 1986, in summary fashion, saying the examination was essentially normal. Dr. Regan informed Dr. Owen that he thought Mr. Ahern's symptoms were most likely functional in nature, but that there was a possibility of an unspecified esophogeal motility disorder. Dr. Regan also noted that Mr. Ahern seemed to be relatively asymptomatic on the dietary and antacid regimen, and that he had advised Mr. Ahern to continue with the same course.

16. Mr. Ahern died suddenly on October 7, 1986.

17. Dr. Owen's care and treatment of Mr. Ahern was at or above the level of minimally competent practice of medicine and surgery for 1986.

18. Dr. Owen's records of his examinations of Mr. Ahern, and of his consultations with Mr. Ahern, provide little information to a reader unfamiliar with Mr. Ahern, or Dr. Owen's personal system of collecting and evaluating information from his patients.

19. Although there was a substantial range of acceptable quality of physician's notes in the medical community in 1986, Dr. Owen's records of his care and treatment of Thomas Ahern were below the standard of minimally competent practice of medicine and surgery for 1986.

CONCLUSIONS OF LAW

1. The Medical Examining Board has jurisdiction in this matter pursuant to §448.02(3), Stats.

2. Dr. Owen's care and treatment of Thomas Ahern did not constitute practice or conduct which tends to constitute a danger to the health, welfare, or safety of a patient or the public, and did not violate § Med 10.02(2)(h), Wis. Admin. Code.

3. Dr. Owen's records of his care and treatment of Thomas Ahern constituted a practice or conduct which tends to constitute a danger to the health, welfare, or safety of a patient or the public, in violation of § Med 10.02(2)(h), Wis. Admin. Code.

ORDER

NOW THEREFORE IT IS ORDERED that Nicholas L. Owen, M.D., be, and hereby is, reprimanded.

IT IS FURTHER ORDERED that within 60 days of the date hereof, Dr. Owen shall participate in an assessment of his knowledge and skills in the preparation of patient treatment records, to be conducted by the University of Wisconsin School of Medicine, Continuing Education Program. The assessment shall be coordinated by Dr. Thomas Meyer, Director of the Continuing Education Program. Dr. Owen shall, within 12 months of the date hereof, participate in and successfully complete any education program recommended pursuant to the assessment. At the conclusion of the program, if any, Dr. Meyer shall submit a report to the Medical Examining Board evaluating respondent's participation and performance in the program and indicating successful completion of the program if accomplished.

IT IS FURTHER ORDERED that pursuant to sec. 440.22, Stats., one-third of the costs of this proceeding shall be assessed against Dr. Owen.

EXPLANATION OF VARIANCE

The administrative law judge recommended that the board find that "There was [in 1986] no uniform standard of minimally acceptable notekeeping to which physicians subscribed, despite a slow trend in the direction of 'SOAP' (Subjective, Objective, Assessment, Plan) notes by physicians." The board instead finds that "Although there was a substantial range of acceptable quality of physician's notes in the medical community in 1986, Dr. Owen's records of his care and treatment of Thomas Ahern were below the standard of minimally competent practice of medicine and surgery for 1986."

One of complainant's expert witnesses, Edwin L. Overholt, M.D., testified at length on the quality of Dr. Owen's record keeping in this instance. Included in that testimony is the following:

> Q. (by Mr. Thexton) Doctor, do you have an opinion which you are reasonably sure is correct as a physician as to whether or not the initial examination materials by Dr. Owen that were created on or about April 17, 1986, meet the standard of practice for an internist at that time?
>
> A. They do not. . . . The history is very skimpy. The term heartburn begs qualification of where the pain is, does it have any radiation, is it high in the chest,

low in the chest, high in the abdomen, does it -- is there any associated symptoms? Has it -- is there any aggravation by chest wall movement.

Heartburn is a very general term, and for an intern, it begs a careful history of qualifying terms to sort out the various possibilities because there are several possibilities, not only just the gastrointestinal tract. It can involve the chest wall. It can involve the middle part of the chest, mediastinal disease. It can even be in the back with radiation anteriorly. Moreover, even in a differential diagnosis is a possibility of heart disease. And these -- there's no evidence in this record that there's any qualifying terms whatsoever except the term heartburn.

Moreover, in terms of the physical exam, there isn't any indication as to whether there is careful assessment of the abdomen, whether there's any high abdominal pain -- or correction, tenderness or mass, any aggravation -- fist pounding on the back of the spine, aggravation on breathing, movement.

There's no qualification in the history or physical examination about this gentleman's terminology -- the patient's problem, which was described as heartburn. That's a very nonspecific term. It begs, for may internists, a differential diagnosis and a careful assessment of at least that area of the body.

* * * *

Q. In his deposition, Dr. Owen said that it was his practice to only record positive findings and that he did not record negative findings. Does this chart -- is this chart consistent with that stated practice?

A. Yes, he put a zero for -- under specific areas of the body, he puts zero.

Q. Okay, is that an acceptable way of conducting an initial physical examination on a patient?

A. No.

Q. Okay, why not?

A. Well, you should at least focus, if you have limited opportunity to meet with a patient, on their specific area of the body and make some qualifying terms, such as the lungs were clear; there wasn't any pain on pressure on the chest wall; checking the spine, pounding it to see if it could be any relationship to his chest distress. We don't even know whether he has -- the term heartburn is so

nonspecific that there's no qualifying aspect of his -- whatever this man is feeling. We don't know whether it's in his -- I don't know whether it's in his upper abdomen, whether it's up in the substernal area of the lower part of his chest, or I don't know if it's in the mid-part, or I don't know if it's in the upper part. . . . But ordinarily when you do a physical exam, at least a limited one even, you -- you at least point out specifically the negative aspects of your physical exam, not just zero. That tells you that you've carefully assessed that.

Q. Why is it important to document these things in a chart as opposed to merely doing them and knowing that you did them, and carrying that information in your head?

A. It just is an appropriate way for a history and physical exam for an internist. It's a more careful assessment. The internist's forte is a careful history and physical exam.

Q. Why is it not enough to do it and not document it, but just do it and remember it?

A. That's -- you can't remember. You're seeing 30 patients or 20 patients a day. You've got to go back and reevaluate your chart, reassess your problems. It's -- it's just an inadequate record.

Q. Is failing to keep an adequate record -- or does failing to keep an adequate record pose a risk to the future health of the patient?

A. Certainly increases the risk.

The board accepts Dr. Overholt's testimony that Dr. Owen's records in this instance were inadequate in failing to provide sufficient information to permit Dr. Owen to determine what his previous assessments and determinations were and to thereby permit him to reevaluate those previous assessments and findings as the course of treatment proceeded. Accordingly, the board finds that Dr. Owen's patient record for Mr. Ahern demonstrates a practice or conduct which constitutes a danger to the health, welfare, or safety of patient or public.

Notwithstanding Dr. Owen's inadequate record-keeping in this case, the board does not find that the actual care provided to Mr. Ahern demonstrated either incompetence or negligence. There is therefore no basis for ordering any interruption in his practice or any remedial training pertaining to his medical skills. The board deems it

appropriate, however, that Dr. Owen be reprimanded, and that he be ordered to receive an evaluation of his record-keeping skills. Should that evaluation demonstrate shortcomings in that regard, he will of course be required to undertake an educational program designed to remedy any such shortcomings.

Finally, complainant has petitioned that the board assess the costs of this proceeding against Dr. Owen. In light of the fact that the board did not find Dr. Owen's medical treatment of Mr. Ahern to have been either negligent or to have fallen below minimum standards of the profession -- and inasmuch as those were the principal allegations of the Complaint -- the board finds it appropriate to assess no more than one-third of the costs.

Dated this 27 day of December, 1993.

STATE OF WISCONSIN
MEDICAL EXAMINING BOARD

by _____
Clark O. Olsen, M.D.
Secretary

WRA:BDLS2:4033

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STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST NICHOLAS L. OWEN, M.D., RESPONDENT.	: : : : :	NOTICE OF FILING PROPOSED DECISION LS9107302MED

TO: Michael P. Malone, Attorney
Hinshaw & Culbertson
100 East Wisconsin Avenue
Suite 2600
Milwaukee, WI 53202-4115
Certified P 992 818 969

Arthur Thexton, Attorney
Department of Regulation and Licensing
Division of Enforcement
P.O. Box 8935
Madison, WI 53708

PLEASE TAKE NOTICE that a Proposed Decision in the above-captioned matter has been filed with the Medical Examining Board by the Administrative Law Judge, James E. Polewski. A copy of the Proposed Decision is attached hereto.

If you have objections to the Proposed Decision, you may file your objections in writing, briefly stating the reasons, authorities, and supporting arguments for each objection. Your objections and argument must be received at the office of the Medical Examining Board, Department of Regulation and Licensing, Room 178, 1400 East Washington Avenue, P.O. Box 8935, Madison, Wisconsin 53708, on or before October 20, 1993. You must also provide a copy of your objections and argument to all other parties by the same date.

You may also file a written response to any objections to the Proposed Decision. Your response must be received at the office of the Medical Examining Board no later than seven (7) days after receipt of the objections. You must also provide a copy of your response to all other parties by the same date.

The attached Proposed Decision is the Administrative Law Judge's recommendation in this case and the Order included in the Proposed Decision is not binding upon you. After reviewing the Proposed Decision, together with any objections and arguments filed, the Medical Examining Board will issue a binding Final Decision and Order.

Dated at Madison, Wisconsin this 28th day of September, 1993.

James E. Polewski
James E. Polewski
Administrative Law Judge

STATE OF WISCONSIN
BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST

NICHOLAS L. OWEN, M.D.,
RESPONDENT.

LS 9107302 MED

PROPOSED DECISION

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

Nicholas L. Owen, M.D.
2015 East Newport Avenue, Ste. 208
Milwaukee WI 53211

Wisconsin Medical Examining Board
Department of Regulation and Licensing
P.O. Box 8935
Madison WI 53708

Division of Enforcement
Department of Regulation and Licensing
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Based upon the entire record of the proceeding, the Administrative Law Judge recommends that the Medical Examining Board adopt the following Findings of Fact, Conclusions of Law and Order as its Final Decision in this matter.

FINDINGS OF FACT

1. Nicholas L. Owen, M.D., is licensed to practice medicine and surgery in the state of Wisconsin, and his latest address on file with the Department of Regulation and Licensing is 2015 East Newport Avenue, Suite 208, Milwaukee, Wisconsin 53211.

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10. The notes Mr. Ahern provided to Dr. Owen about the attacks of pain were brief, and did not provide any description of the symptoms. The notes indicated that Mr. Ahern had had attacks on May 27, June 20, June 30, and July 21, 1986, and two "minor" attacks, with no details at all mentioned, on July 20 and August 6, 1986. The attacks which had led Mr. Ahern to provide some detail in the notes lasted 2 to 3 hours each, except for the one on July 21, which lasted 6 hours. There is no duration noted for the attack on May 27.

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13. Dr. Regan examined Mr. Ahern with the specific intent of determining the cause of Mr. Ahern's continued symptoms. Dr. Regan performed an examination of Mr. Ahern's heart, lungs, vital signs and abdomen, and concluded that Mr. Ahern had atypical chest pain of possibly esophageal origin. Dr. Regan noted a long discussion with Mr. Ahern about the symptoms, and recommended an endoscopy, to be followed with appropriate therapy. Because there was no indication that Mr. Ahern was in any immediate danger, Dr. Regan scheduled the endoscopy for September 12, 1986, three weeks later.

14. Nothing about Mr. Ahern's symptoms, Dr. Regan's examination of Mr. Ahern, or the discussion Dr. Regan had with Mr. Ahern suggested to Dr. Regan that Mr. Ahern's complaint was cardiac in origin.

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there was a possibility of an unspecified esophogeal motility disorder. Dr. Regan also noted that Mr. Ahern seemed to be relatively asymptomatic on the dietary and antacid regimen, and that he had advised Mr. Ahern to continue with the same course.

16. Mr. Ahern died suddenly on October 7, 1986.

17. Dr. Owen's care and treatment of Mr. Ahern was at or above the level of minimally competent practice of medicine and surgery for 1986.

18. Dr. Owen's records of his examinations of Mr. Ahern, and of his consultations with Mr. Ahern, provide little information to a reader unfamiliar with Mr. Ahern, or Dr. Owen's personal system of collecting and evaluating information from his patients.

19. There was a substantial range of acceptable quality of physician's notes in the medical community in 1986. There was no uniform standard of minimally acceptable notekeeping to which physicians subscribed, despite a slow trend in the direction of "SOAP" (Subjective, Objective, Assessment, Plan) notes by physicians.

20. Dr. Owen's records of his care and treatment of Thomas Ahern were at or above the standard of minimally competent practice of medicine and surgery for 1986.

CONCLUSIONS OF LAW

1. The Medical Examining Board has jurisdiction in this matter pursuant to §448.02(3), Stats.

2. Dr. Owen's care and treatment of Thomas Ahern did not constitute practice or conduct which tends to constitute a danger to the health, welfare, or safety of a patient or the public, and did not violate § Med 10.02(2)(h), Wis. Admin. Code.

3. Dr. Owen's records of his care and treatment of Thomas Ahern did not constitute a practice or conduct which tends to constitute a danger to the health, welfare, or safety of a patient or the public, and did not violate § Med 10.02(2)(h), Wis. Admin. Code.

ORDER

NOW THEREFORE IT IS ORDERED that the disciplinary proceedings against Nicholas L. Owen, M.D., be and hereby are DISMISSED.

OPINION

Young, active men are not supposed to die of heart attacks, especially not when they are educated, professionally observant and personally health conscious individuals. Nonetheless, Thomas Ahern died suddenly because his heart stopped working.

His widow blames the physician for not recognizing that her husband, the father of her young son, was in danger of sudden death because of heart disease. The question in this proceeding is, was the physician practicing below the standard of minimal competency when he failed to recognize the danger to his patient? The complaint alleges that he was, in that his care tended to constitute a danger to the health, safety and welfare of the patient; the physician says he was acting in a competent fashion, despite the fact the patient died.

The uncontroverted evidence in this proceeding is that Mr. Ahern died as a result of a sudden disruption of his cardiac function. The presumed cause of that disruption is a form of variant or atypical angina which caused a section of a major vessel to go into spasm, constricting the vessel, depriving the heart of blood, resulting in fibrillation and death. The expert testimony consists of three major points: First, that the condition which caused Mr. Ahern's death is unusual, but not so rare that a competent internist could reasonably be ignorant of the fact that the condition does occur. Second, that the diagnosis of the condition in a particular patient is not a matter of routine interpretation of common tests, but is rather one which requires a rather sensitive feel for subtle indications on otherwise normal charts from stress EKG tests. Third, that there is medically reasonable grounds for an internist deciding not to order a stress EKG of a person who has no particular statistical risk factors for heart disease, and whose chest pains are not related to exertion.

The expert testimony adduced by the Complainant here was, in my opinion, fairly clearly addressing a standard of practice of medicine best described as superior to optimal. While it is obvious that Doctors Overholt and Chahine, the Complainant's experts, are experts in internal medicine and cardiology respectively, it is also clear that both of them were testifying as to what could have been done better in the treatment of Mr. Ahern. That is not the issue in this proceeding. In a review of a case with a bad result in order to avoid the same result in the future,

the critiques offered by Dr. Overholt and Dr. Chahine are undoubtedly most helpful. However, in light of the focus of this proceeding, the critiques lead not to the conclusion that Dr. Owen was a less than competent internist, but that Mr. Ahern presented a particularly difficult case which even a competent cardiologist might well have difficulty diagnosing.

Dr. Overholt, the Complainant's expert internist, was unwilling to testify to the effect that Dr. Owen's treatment of Mr. Ahern was less than competent, even though Dr. Overholt clearly believes Dr. Owen could have done better. Indeed, Dr. Overholt clearly communicated the idea that Dr. Owen should have done better, but he did it in the context of meeting Dr. Overholt's standards of the constant pursuit of excellence.

From the evidence in the case, it is clear to me that Dr. Owen was within the acceptable standard of practice of medicine and surgery when he failed to recognize the danger to Thomas Ahern. I base this conclusion on the testimony of both the Respondent's experts, and of Dr. Patrick Regan, who also examined Thomas Ahern looking for the cause of his symptoms, and the testimony of Dr. Overholt, complainant's expert. The testimony of each of the experts, and of Dr. Regan, is that the condition from which Thomas Ahern died was very unusual. The greater weight of the evidence is that diagnostic tests targeted on the function of the heart would have had little probability of ferreting out the condition which eventually killed Mr. Ahern simply because the unusual condition from which he suffered is not reliably detected by the diagnostic methods available.

There is some opinion testimony in the record that a stress EKG was a minimum requirement of competent practice when Mr. Ahern failed to respond positively to changes in diet and the use of antacids. There are several difficulties with accepting the use of a stress EKG as a necessary criterion of minimally competent practice in this circumstance. First, it is beyond dispute that Mr. Ahern's chest pain never occurred in conjunction with vigorous exercise. Second, there is good reason to question whether Mr. Ahern was compliant with the dietary changes recommended, for the treatment of what seemed to be heartburn, and third, there is reasonable indication that Mr. Ahern himself reported that sometimes the antacids seemed to help. Not reliably every time, to be sure, but often enough, apparently, that he was able to tell Dr. Regan that it seemed to be helping.

There is no basis on which to conclude that Dr. Owen was minimally required to order a stress EKG immediately after his first consultation with Mr. Ahern in April, 1986. The State does not appear to claim that Dr. Owen's plan between April and June, 1986, was less than minimally competent, or that either a resting or stress EKG was a required response for a minimally competent physician presented with Mr. Ahern's circumstances at the initial visit or as follow-up shortly thereafter. Nor is there any basis to conclude that the order of a UGI series and gallbladder ultrasound in May, 1986, was a less than competent response to Mr. Ahern's telephone call saying he was still having attacks.

The State's case against Dr. Owen is that at some time between the receipt of an essentially normal upper gastrointestinal barium study and gallbladder ultrasound, and the date of Mr. Ahern's death, Dr. Owen fell below the standard of practice of a minimally competent physician in not doing a cardiac study of Mr. Ahern. The State's experts all agree that a cardiac evaluation would have been a good idea at sometime between June and October, 1986; however, none of them are really able to say that the failure to do one under the circumstances with which Dr. Owen was presented constitutes the less than minimally competent practice of medicine. It should come as no surprise that cardiologists would respond to a patient's complaints of pain in the chest with a cardiac evaluation, and that cardiologists would be inclined to run the cardiac possibilities through every reasonably defensible diagnostic procedure until they had completely ruled out a cardiac cause for the pains in the chest. When the State's expert cardiologist provides a deposition supporting that line of inquiry as the first choice of a competent physician, it is impossible to argue that the expert is unreasonable. He is, after all, a cardiologist, trained and specializing in diseases of the heart, and the patient did die of heart disease.

The State's case, though vague as to the point in time at which Dr. Owen allegedly slipped below the standard of minimally competent practice, is not unreasonable. It is, however, without that degree of factual and analytical support which would permit a finding that it is more likely than not that a minimally competent physician would have done something different than Dr. Owen did.

Dr. Overholt, the State's lead expert, is either unable or unwilling to state that Dr. Owen was less than minimally competent, even though he is quite willing to critique the performance as something less than optimum. Dr. Overholt is accepted by all concerned as an interest of excellent reputation. Dr. Overholt is known as a teacher of aspiring internists; it is clear that his personal standards are of the highest caliber, and that he demands his students' best efforts. Dr. Overholt is able to clearly communicate the idea that Dr. Owen's treatment of Mr. Ahern is of a lower standard of intensity and curiosity than the medical community aspires to provide, but he is not willing to commit to the position that Dr. Owen's performance was less than minimally competent. The issue in this licensure discipline case is not whether the physician could have done better, but whether his performance was less than minimally competent and so constituted a danger to Mr. Ahern.

One should also clearly recognize that there is a substantial difference between Dr. Owen's treatment being so poor as to constitute a danger and Mr. Ahern's underlying condition being so dangerous that nothing but extraordinarily good care could have protected him. Dr. Owen is an internist, and Dr. Overholt testified that if Mr. Ahern had communicated to Dr. Owen that he, Ahern, was having crushing, squeezing pains in his chest under his breastbone that Dr. Owen

would have immediately suspected cardiac problems, simply because Dr. Overholt concluded that Dr. Owen "knows the business" too well to miss the diagnosis. Mr. Ahern's wife testified that Mr. Ahern did describe the pain as intense, crushing and squeezing, and a friend seconds the description. I conclude that while Mr. Ahern may well have used such a description with his wife and his friend, he did not use that description with any physician. Even if one were to accept the argument that Dr. Owen's notes are so poor as to be useless to Dr. Owen or anyone else, and I do not, one would have to also accept the argument that not only did Dr. Owen ascribe the symptoms to heartburn, and convince an educated, professionally observant patient that the symptoms described were only heartburn, but that the patient was then persuaded to describe the symptoms to a consulting physician in such a way that the consulting physician also thought a gastric or esophogeal condition was a reasonable hypothesis to pursue in explaining the pain. The string of unlikely and improbable events may possibly be the fact; however, there is nothing in the record which would support a conclusion that this string of improbable happenstance is more likely than the improbability that Mr. Ahern told either or both Dr. Owen or Dr. Regan symptoms which would lead a minimally competent physician to suspect heart disease.

Dr. Rex MacAlpin is a cardiologist, with professional credentials which are apparently equal to those possessed by Dr. Chahine, the State's expert cardiologist. Dr. MacAlpin's deposition and report support the conclusion that Mr. Ahern's death was tragic, but not the result of less than competent treatment by Dr. Owen. Dr. MacAlpin recites the facts which were unquestionably known to Dr. Owen, and concludes that it was not unreasonable or unacceptable for Dr. Owen to proceed as he did. Mr. Ahern never had any pain during or in temporal proximity to his fairly frequent exercise runs; he was only 38 years old, he had no notable risk factors for heart disease, he had no particularly notable cholesterol level, he was not overweight, he was intelligent, well educated, observant and presumably able to communicate clearly what he observed, in as much as he was employed as a reporter and editor at a major newspaper. Dr. MacAlpin is not at all confident that a stress EKG would have provided the necessary clues to diagnose Mr. Ahern's atypical angina. Dr. Chahine believes it would have, and the record includes an article he wrote which supports that belief.

Dr. Owen saw Mr. Ahern for the second and last time in August, 1986. At that visit, Mr. Ahern presented Dr. Owen with two pages of notes briefly stating a history of when he had had attacks of chest pain, noting a stressor of the day ranging from a job interview to worry about a sick child. The notes usually included mention of the day's diet, and the duration of the attack. There is no evidence which shows that it is more likely than not that Mr. Ahern told Dr. Owen the details of the pain, the nausea, the cold sweat, and the incapacitating condition which would transform "heartburn" into something entirely different. Much of this case comes down to speculating on what Mr. Ahern told Dr. Owen. The State alleges that Mr. Ahern must have told Dr. Owen everything because Mr. Ahern told most of the details to his wife and friend, but even

Dr. Overholt is unwilling to accept that. In Dr. Overholt's words, Dr. Owen "knows the business" too well for that. There is, additionally, the fact that Mr. Ahern apparently did not tell those details to Dr. Regan.

It appears that the only expert in the case who would be willing to say that Dr. Owen fell below the standard of practice of a minimally competent physician in his treatment of Mr. Ahern is Dr. Chahine, and that opinion is based on the information in Dr. Chahine's article. With all due respect to Dr. Chahine, and recognizing that he may well be correct that it is possible to detect Prinzmettal's angina by subtle changes in a stress EKG recording in some significant number of instances where there is no apparent angina, one article in a cardiology medical journal does not establish a standard of practice for internal medicine. The question here is, did Dr. Owen fall below an established standard of minimally competent practice? I am convinced that the answer is no. The standard is not optimal practice, or best practicable practice, but minimal competence. Dr. Owen is well beyond minimal competence; wrong, in this case, but not a danger to public health, safety or welfare because of his imperfection. No physician can be expected to be right all the time, nor can every physician be required to practice consistently at optimal standards.

The standard required of a physician's notes on a patient's care is obviously related to the severity of the condition being treated, the duration of the condition, the changes in the condition, and the risk posed by the condition. Dr. Owen saw Mr. Ahern twice; the first time, the reasonable assessment was "heartburn" and the notes are sufficient for that. The second time, Mr. Ahern provided the notes of the major portion of the discussion, and it is not unreasonable for the physician to use them. This is not a case where the physician is confronted time and time again that the patient's condition is unchanged, or worse, and does nothing but note that the patient says "no change" or "worse." This is a case where apparently reasonable inquiry with reasonable follow through turns out to be insufficient to prevent the patient's untimely death from an unusual condition which is difficult to detect, and one where the physician had less than complete information from the patient to start with. There is insufficient basis to conclude that Dr. Owen's notes in this case were so poor as to constitute a danger to Mr. Ahern's health, safety and welfare, or that his notes were below the standard of minimal competence for the practice of medicine.

Dated this 28th day of September, 1993.

James E. Polewski

James E. Polewski
Administrative Law Judge

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