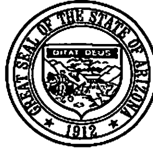

Arizona Medical Board

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FINAL MINUTES FOR BOARD REVIEW COMMITTEE A TELECONFERENCE MEETING
Held on Monday, October 25, 2021
1740 W. Adams St., Board Room A • Phoenix, Arizona

Committee Members
R. Screven Farmer, M.D., Chair
Jodi A. Bain, M.A., J.D., LL.M.
James M. Gillard, M.D., M.S., F.A.C.E.P., F.A.A.E.M.
Pamela E. Jones
Lois E. Krahn, M.D.

GENERAL BUSINESS

A. CALL TO ORDER

Chairman Farmer called the Committee's meeting to order at 8:04 a.m.

B. ROLL CALL

The following Committee members participated in the virtual meeting: Dr. Farmer, Ms. Bain, Dr. Gillard and Dr. Krahn. The following Committee meeting was absent: Ms. Jones.

ALSO PRESENT

The following Board staff participated in the virtual meeting: Patricia McSorley, Executive Director; William Wolf, M.D., Chief Medical Consultant and Michelle Robles, Board Operations Manager. Carrie Smith, Assistant Attorney General ("AAG") was also present.

C. OPENING STATEMENTS

D. PUBLIC STATEMENTS REGARDING MATTERS LISTED ON THE AGENDA

No individuals addressed the Committee during the Public Statements portion of the meeting.

E. APPROVAL OF MINUTES

- February 11, 2021 Board Review Committee A Teleconference

MOTION: Dr. Gillard moved for the Committee to approve the February 11, 2021 Board Review Committee A Teleconference.
SECOND: Dr. Krahn.
Ms. Bain noted that she was not present on the Committee for this meeting.
VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Dr. Gillard and Dr. Krahn. The following Committee abstained: Ms. Bain. The following Committee member was absent: Ms. Jones.
VOTE: 3-yay, 0-nay, 1-abstain, 0-recuse, 1-absent.
MOTION PASSED.

LEGAL MATTERS

F. FORMAL INTERVIEWS

1. MD-20-0450A, ALBERTO G. CORICA, M.D., LIC. #55657
   Dr. Corica was present virtually with counsel Kendall Steele.

Board staff summarized that the Board that the case arose from a malpractice settlement from a case alleging that Dr. Corica failed to provide proper care to a patient with priapism. AH presented to a Hospital in New Mexico for priapism lasting 48 hours. AH had a history of multiple prior episodes of priapism with spontaneous resolution. The ED physician contacted the on-call urologist, Dr. Corica, for consultation. Dr. Corica recommended discharge with outpatient follow-up as an outpatient. AH presented the following day to with associated pain. A different urologist took AH to the operating room for irrigation and eventually "extensive" distal shunting which left the patient with permanent impotence. The Board's Medical Consultant ("MC") stated that Dr. Corica deviated from the standard of care by failing to evaluate a patient presenting to the emergency department. The MC stated that Dr. Corica should have personally evaluated the patient to stratify the risk as this is one of the few urological emergencies rather than relying on information give over the phone. The MC stated that Dr. Corica deviated from the standard of care by failing to evaluate a patient presenting to the emergency department with persistent priapism.

Mr. Steele provided an opening statement on behalf of Dr. Corica, stating that he met the standard of care and that the care was appropriate.
During questioning, Dr. Corica explained that there are two types of priapism. One of them is not a medical emergency. Dr. Corica informed the Board of the on call situation in New Mexico and was not a situation that he could make a choice on when and where he would be on call. Dr. Corica noted that there is always room for improvement and that now that he's not in New Mexico but practicing in Tucson he now has the ability to be on call for only one hospital at a time. In the event of an emergency, have more interaction with the physician on the phone and have a low threshold now to get further workup if needed. Dr. Corica stated that given what was presented at the time by the ER physician had at the time it was clear enough to make a diagnosis of non-emergent priapism. In hindsight he could have been more emphatic with the ER physician that if the patient's symptoms change to return to the ER.

In closing, Mr. Steele stated that given Dr. Corica's history he has enough experience to determine a non-emergent versus an emergent priapism and that the patient waited to return to the ER until the next day. Dr. Corica recognized that better interaction with the ER physician and better communication about what this patient should do if pain presented and priapism continued after he left the ER. Mr. Steele requested that the Board consider an Advisory Letter with CME as apposed to the recommended discipline.

Board staff reiterated the MC's statement that priapism is one of the true urological emergencies and it went unattended.

MOTION: Dr. Gillard moved for findings of unprofessional conduct in violation of A.R.S. § 32-1401(27)(r) for reasons stated by SIRC.
SECOND: Ms. Bain.
VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Dr. Gillard, Ms. Bain and Dr. Krahn. The following Committee member was absent: Ms. Jones.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

Dr. Gillard commented that this was a very unfortunate outcome however, found it mitigating that the die was cast before the patient presented to Dr. Corica. Dr. Gillard opined that a Letter of Reprimand and CME would not be appropriate in this situation as there has been discipline already with the malpractice. Dr. Gillard noted that the physician commented that he has learned from this situation and that he would not be in the position to be on call for multiple hospitals again. This physician has no previous Board history.

MOTION: Dr. Gillard moved for an Advisory Letter for failing to timely evaluate a patient presenting to the emergency department with persistent priapism. While

there is insufficient evidence to support disciplinary action, the board believes that continuation of the activities that led to the investigation may result in further board action against the licensee.
SECOND: Dr. Krahn.
Dr. Gillard opined that the harm was already done and that things could have been better if the physician had appeared however this would not have changed the outcome. Dr. Gillard noted that the ER physician was comfortable enough to discharge the patient.
VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Dr. Gillard and Dr. Krahn. The following Committee member voted against the motion: Ms. Bain. The following Committee member was absent: Ms. Jones.
VOTE: 3-yay, 1-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

G. FORMAL INTERVIEWS

1. MD-20-0852A, TODD K. MALAN, M.D., LIC. #34046
   This case was pulled from the agenda.

   MOTION: Dr. Krahn moved for a break until 9:25 a.m.
   SECOND: Dr. Gillard.
   VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Dr. Gillard, Ms. Bain and Dr. Krahn. The following Committee member was absent: Ms. Jones.
   VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
   MOTION PASSED.

H. FORMAL INTERVIEWS

1. THIS CASE HAS BEEN PULLED FROM THE AGENDA.

I. FORMAL INTERVIEWS

1. MD-20-0660A, MD-20-1055A, LEE S. YOSOWITZ, M.D., LIC. #12610
   Dr. Yosowitz was present virtually with counsel Steve Myers.

   Board staff summarized that three patient charts were reviewed after receiving notification that Yuma Regional Medical Center (YRMC) revoked Dr. Yosowitz's privileges to perform forceps-assisted deliveries. MR was a 34 year-old patient admitted in labor. Decelerations were noted in the second stage and Dr. Yosowitz elected to use forceps to when the fetus was crowning in the (LOA) position, the forceps slipped off and required replacement to complete the delivery. In the nursery, JS was noted to have swelling of the right eyelid. An intracranial ultrasound was normal and a pediatric ophthalmologist assessed the infant with resolution expected in 2-3 weeks. One month later, a diagnosis of right oculomotor nerve palsy was made after an MRI showed a subdural hematoma pressing on the third cranial nerve. The next patient, AC was seen at YRMC three days after Methotrexate (MTX) had been administered for an ectopic pregnancy and blood was drawn to check her HCG level. The staff contacted Dr. Yosowitz numerous times as it was required he see the patient prior to discharge. Initially he had told staff he would be in shortly and then stated that he'd seen the patient but the patient stated he had not been in. Dr. Yosowitz arrived hours later after the initial call and reportedly walked in and out of the patient's room saying without documenting the visit. Patient SC was a 29 year-old who presented in labor at term. A repeat C-section was performed with a 1200cc blood loss noted. Uterine atony developed in the PACU and Dr. Yosowitz was called and ordered Pitocin to be increased initially and subsequently Cytotec with temporary improvement. Within the hour Methergine was ordered for ongoing bleeding. Dr. Yosowitz arrived at the hospital an hour after being initially contacted and carried out a curettage and placement of a Bakri balloon, which was partially filled when the bleeding continued. A total loss of 3235 cc was calculated overall. Hemabate and transfusions were reportedly administered though it is difficult to determine this since no documentation by Dr. Yosowitz was made aware of the details of transfusions or medications. In case MD-20-1055A, the patient AB was a 36 year old patient who presented in labor at term with spontaneous ruptured membranes and a C-

section was recommended. After the surgery there was a note of a bladdery injury but this could not determine if this occur before or during the surgery. The MC reviewed the case and determined that Dr. Yosowitz met the standard of care but record keeping was inadequate.

Dr. Yosowitz provided an opening statement on his own behalf..

Mr. Myers also provided an opening statement on behalf of Dr. Yosowitz.

During questioning, Dr. Yosowitz explained that he had control of any and all patients that presented to the hospital regardless of emergency room, OB triage, labor and delivery, the practice was turned over to him for hospital care. Dr. Yosowitz further explained that he would be first in line to take care of any and all patients. Dr. Yosowitz informed the Board that uterotonics are used a first line of defense and it is important to note that they do not require beside evaluation. This can be done over the phone. In this case Dr. Yosowitz stated that he did not leave the hospital with the patient still bleeding and that she was having good uterotonics, uterine tone and hemostatic control. After the first phone call when the patient resumed bleeding uterotonics were given and initially did work. When the bleeding continued, Dr. Yosowitz stated he promptly came in and the overall timeframe was well within the standard of care. With regards to the bladder injury, Dr. Yosowitz explained that there is documentation in the chart that the urologist was called as soon as it happened. The urologist answered the phone and Dr. Yosowitz stated that he described the circumstances to him and did the repair that was well within his scope of practice under the circumstances of the location of the repair. Dr. Yosowitz opined his medical records were impeccable and within the standard of care but noted that most medical records could have more detail. With regards to the patient that must be seen by a physician per hospital policy Dr. Yosowitz explained that he interacted mostly with the nurse and that the interaction was short and curt. Dr. Yosowitz noted that he was the third physician to see her and that she had knowledge of her situation prior to seeing him. Dr. Yosowitz informed the Board of his circumstances regarding the Yuma hearing for the forceps case and that it was political. He did not need to resign from Yuma as his job ended and the revocation of forceps was the only thing revoked. Dr. Yosowitz stated that he believes everyone of these cases were within the standard of care and that he did not deviate and did everything a reasonable and prudent doctor would have done who also possessed the same skill and expertise.

Mr. Myers provided a closing argument on behalf of his client.

In closing, Dr. Yosowitz stated his conduct met the stand of care in these cases.

Board staff noted in the timing of the third case where there was postpartum hemorrhage, the documentation does indicate that the first call was at 10:54 with the physician arriving and stated physician at bedside one hour later.

Dr. Krahn opined that there was unprofessional conduct for the reasons stated by SIRC.

MOTION: Dr. Krahn moved for findings of unprofessional conduct in violation of A.R.S. § 32-1401(27)(e) and (r) for reasons stated by SIRC.
SECOND: Ms. Bain.
Dr. Krahn clarified that the E violation is in regards to both cases and the R violation is in regards to case 0660A.
VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Dr. Gillard, Ms. Bain and Dr. Krahn. The following Committee member was absent: Ms. Jones.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

Dr. Krahn opined that the cases rise to the level of discipline.

MOTION: Dr. Krahn moved for the Committee to issue a draft Findings of Fact, Conclusions of Law and Order for Letter of Reprimand and Probation. Within six months, complete CPEP's Peer Communication Course. The CME hours shall be in addition to the hours required for license renewal. The Probation shall terminate upon proof of successful completion of the CME coursework.
SECOND: Ms. Bain.
Dr. Gillard stated he is against discipline but spoke in favor of CME for medical recordkeeping. Dr. Krahn opined that there were an array of different issues in this case that caused her concern and noted that while there was no hypoxic injury or infant death, these could have occurred. Dr. Krahn opined that a postpartum bleed can become an incredibly urgent life threatening situation, and she was not convinced that this physician was sufficiently available to the possible needs of the patient. Ms. Bain agreed that there are two main issues- the inattentiveness to the situation, and lack of understanding that in retrospect this physician could have done something differently. Ms. Bain also expressed a cotncern that there is a lack of sensitivity to the emergence of some of these issues. Board staff commented that excessive transfusion could be considered patient harm. Dr. Farmer commented that this is a complicated case since the Board is considering many different issues. Dr. Farmer agreed with the discussion and that the reaction in the case with the blood loss concerned him the most.
VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Ms. Bain and Dr. Krahn. The following Committee member voted against the motion: Dr. Gillard. The following Committee member was absent: Ms. Jones.
VOTE: 3-yay, 1-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

GENERAL BUSINESS

J. DISCUSSION REGARDING DEBRIEFING ON COMMITTEE PROCESSES

Dr. Krahn commented that today's situation was unusual with the second and third interviews were pulled resulting in an extended break however this format does work and is very efficient. Dr. Farmer commented that staff does attempt to balance the Board's time with the physician and attorney's time.

K. ADJOURNMENT

MOTION: Dr. Krahn moved for the Committee to adjourn.
SECOND: Dr. Gillard.
VOTE: The following Committee members voted in favor of the motion: Dr. Farmer, Ms. Bain, Dr. Gillard and Dr. Krahn. The following Committee member was absent: Ms. Jones.
VOTE: 4-yay, 0-nay, 0-abstain, 0-recuse, 1-absent.
MOTION PASSED.

The Committee's meeting adjourned at 10:51 a.m.

Patricia E. McSorley, Executive Director