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STATE OF WISCONSIN

BEFORE THE MEDICAL EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY

PROCEEDINGS AGAINST FINAL DECISION AND ORDER

LS0109171MED

LESTER YAN, M.D.,

RESPONDENT.

The parties in this matter under § 227.44, Stats., and for purposes of review under § 227.53, Stats., are:

Lester Yan, M.D.

2906 South 20th Street

Milwaukee, WI 53215

Medical Examining Board

P.O. Box 8935

Madison, WI 53708-8935

Department of Regulation and Licensing

Division of Enforcement

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This proceeding was commenced by the filing of a Notice of Hearing and Complaint on September 17, 2001. The Answer was filed on October 10, 2001. The hearing was held on April 17, 2002, and the hearing transcript was filed on May 9, 2002. Attorney James E. Polewski appeared on behalf of the Department of Regulation and Licensing, Division of Enforcement. Attorney Lance S. Grady, The Schroeder Group, S.C., appeared on behalf of Dr. Yan.

The Administrative Law Judge fled her Proposed Decision on June 28, 2002. Attorney Polewski filed his objections on July 23, 2002; and Attorney Grady filed respondent's objections on July 23, 2002. The parties appeared before the Medical Examining Board on August 21, 2002, for oral arguments on their objections, and the board considered the matter on that date.

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

FINDINGS OF FACT

1. Lester Yan (d.o.b. 07/18/59), 2906 South 20th Street, Milwaukee, WI 53215, was, at all time material to the Complaint filed in this matter, a physician and surgeon licensed by the state of Wisconsin, license #33218, which was first granted on May 21, 1992.

2. Dr. Yan is a family practice physician at the Edgerton Health Center in Milwaukee. He provides primary care to patients at the Health Center. At least in April 1998, Dr. Yan also worked in the urgent care center at the Health Center.

3. On April 6, 1998, Patient RM, a 41-year-old male, presented at the Edgerton Avenue urgent care clinic at 7:24 p.m., complaining of substantial left lower ribcage pain, nausea, chills, and diaphoresis. He had congestion and for two weeks prior to that he experienced shortness of breath and intermittent chest pain. His chest pain had started at 11:00 a.m., that morning.

4. On April 6, 1998, while working in the urgent care unit at the Edgerton Health Center, Dr. Yan provided treatment to Patient RM. He evaluated the Patient RM immediately. The patient appeared malaise. He ambulated into the urgent care center and into the treatment room. His lungs were clear. He was tachycardic (his heart rate was above 100). His blood pressure was borderline low (98/80), but he was not dizzy. His CPK level was 1,118.

5. On the basis of the patient's subjective report and an EKG performed at the urgent care clinic immediately following the patient's arrival, Dr. Yan diagnosed an acute anterior myocardial infarct.

6. Dr. Yan gave Patient RM "the usual ACLS algorithm MONA" (morphine, oxygen, nitroglycerine and aspirin). In addition, the patient was placed on a cardiac monitor and he was constantly monitored by Dr. Yan and the nursing staff. An EKG was ordered. The patient was given IV fluids and Valium.

7. Based upon Patient RM's history, physical and EKG, Dr. Yan made a decision, at or around 7:45 p.m., to transfer Patient RM to a hospital. Dr. Yan concluded that the patient had to be transported because the patient was having a myocardial infarction and he needed further care which he could not render. Dr. Yan instructed Kristen Sobocinski, a LPN nurse on duty at the urgent care center, to call an ambulance with an ACLS certified RN on board.

8. At or around 7:45 p.m., Nurse Sobocinski called Medicare, a private ambulance company, to transport Patient RM to the hospital. Nurse Sobocinski asked Dr. Yan if she could call 911 and he said no because Patient RM was stable. Historically, at the urgent care center, the response time for Medicare was from 20 to 40 minutes. The response time for 911 was 5 to 10 minutes. Nurse Sobocinski said that she believes that she asked Dr. Yan three times if she should call 911. At approximately 8:10 p.m., after waiting for approximately 25 minutes, Dr. Yan instructed Nurse Sobocinski to call 911.

9. On April 6, 1998, at or around 8:20 p.m., the 911 ambulance arrive at the Edgerton urgent care center and then transported Patient RM to St. Francis Hospital.

CONCLUSIONS OF LAW

1. The Medical Examining Board has jurisdiction in this matter pursuant to s. 448.02 (3) Wis. Stats., and s. MED 10.02 (2) Wis. Adm. Code.

2. There is insufficient evidence to establish that Respondent's conduct in this matter was below the minimum standards of the medical profession, exposed the patient to risks to which a minimally competent physician would not expose a patient, or constituted a danger to the health, welfare and safety of the patient, in violation of s. 448.02 (3), Stats., and s. MED 10.02 (2) (h), Wis. Adm. Code.

ORDER

NOW, THEREFORE, IT IS ORDERED that this matter be, and hereby is, dismissed.

EXPLANATION OF VARIANCE

The board has accepted the Findings of Fact recommended by the administrative law judge, with the exception of Finding of Fact # 10, which is a mixed finding and conclusion stating in part that by failing to arrange for the quickest and most rapid mode of transportation to transfer the patient to the hospital, Dr. Yan exposed the patient to unreasonable risks of harm.

The administrative law judge recommended as a Conclusion of Law that Respondent's conduct in this matter was below the minimum standards of the medical profession, exposed the patient to risks to which a minimally competent physician would not expose a patient, and constituted a danger to the health, welfare and safety of the patient, in violation of s. 448.02 (3), Stats., and s. MED 10.02 (2) (h), Wis. Adm. Code. The board instead decides that there is insufficient evidence to conclude that any such violations occurred. Accordingly, the board has dismissed the matter.

The record establishes that greater Milwaukee area cardiologists at the receiving hospitals have specifically requested that transferring physicians utilize Medicare or other private ambulance services when transferring patients between facilities to permit the physicians at both facilities to maintain control over the patient’s care while en route to the second facility. Dr. Humberto Rodriguez, who is employed full time in the emergency department of West Allis Hospital, testified in part as follows:

Q. (by Mr. Grady) Now, doctor, what is your understanding in terms of what Dr. Yan's decision was with respect to the transport of [patient RM]?

A. Well, I -- what he -- his initial decision to call Medicare with an ambulance is pretty much what everybody does, at least what I do, what the other doctors that I worked with do and what -- so I was surprised that this was an issue because this is basically what everybody does in Milwaukee.

Q. Doctor, why is it not the practice of your department to call 911?

A. Well, that's a good question. We have talked about this over the years and basically what we've done -- and I don't know what Family Health Plan did and how they came to this decision but what we did was that we had -- and we continue to have meetings with cardiologists or the people that receive these patients at the other end and we ask them, "What would you like us to do? What's the best way to provide a service for these patients? How do we get them to you as quickly possible and what are your priorities?" Essentially what do you want us to do? And with the system that we've come up with is to call this particular ambulance service or any of the other ones that have nurses for a number of reasons. We call them because they provide a level of skill that allows the physicians at both ends the flexibility to do whatever they think needs to be done. Since each patient is a little bit different we want to be able to have the ability and the cardiologists want to be able to have the ability to direct their care if there's any changes that need to be made. . . . When you call 911 in Milwaukee you are essentially handing over care of the patient to the 911 system. They are a rescue system that will come and they will do the best thing that they can do. And they do what they do very well. I would not in any way imply any criticism of them. But what they do is they transfer the patient first of all to the nearest hospital. We don't have any control over that. They -- their mandate is to transfer -- to rescue a patient in any circumstances and they will rescue a patient from anywhere, from a house, from a parking mall, from a clinic, from a hospital. But they will transfer the patient to the nearest hospital so of course it wouldn't make any sense for us to call 911 because the patient is already in the hospital. But even beyond that if as a courtesy they -- we call them and they elected to help us they are bound by their protocols. They have -- they're not licensed to do certain things. They have protocols that are specific to their training and directed from a base in Milwaukee County Hospital or what used to be Milwaukee County Hospital. So essentially once you call 911 you're transferring the care of the patient to a -- to a service and they take them as fast as they can to another facility. And if anything happens in route, if anything changes they do whatever they think is the right thing to do based on whatever protocols they have. They're not under our direction anymore.

Q. And doctor, the base for the paramedic units in Milwaukee is Frater, is that correct?

A. Right, that's correct.

Q. All right. So if a decision has to be made with respect to the care of the patient based upon an issue that has arisen during the course of the transport is it the practice of the paramedics then to get in touch with their base at Frater?

A. That's correct.

Q. Okay. They do not deal with orders issued by the physician at the receiving facility?

A. That's correct.

Q. Doctor, based on your experience is the calling of 911 the standard of care for interfacility transports in the Milwaukee area?

A. Absolutely not. (Tr., pp. 92-95)

The board credits that testimony.

The evidence indicates that the information given to Dr. Yan was that the average response time for 911 was 10 minutes, and that the response time for the Medicare ambulance would be 20 minutes. Dr. Robert W. Stuart, a board certified emergency medicine physician, concurred with Dr. Rodriguez' testimony set forth above, then testified as to the significance of the 10 minute disparity in response times as follows:

Q. (by Mr. Grady) Okay. Now, doctor, in this case you briefly mentioned time differences. What is your understanding as to the time difference between calling for a paramedic unit versus calling for an RN ACLS unit let's say through Medicare?

A. My experience is there is no given time that you can count on. There are ball park numbers. The paramedics as quoted by the state shoot for nine minutes in 90% of the time. That's a goal, that's not necessarily reflecting data as far as I know. When I did my work with Bell Ambulance there were a number of times when it was clearly longer than nine minutes. In this case it was ten minutes. But you -- what happens is -- you have to understand is that when your -- when you call for an advanced -- you know, a paramedic, not a primary responder, not an engine company. If there's one local you'll get them. If they're in the middle of a car accident then they have to find a different paramedic service that might be nearby or if the nearby – you know, the next city over's tied up then somebody from the north side has to come down. And it is not infrequent that you get somebody from a ways away and it's much longer than you hope for. That's the best they can do. When it comes to the private ambulance companies my experience has been 15 to 20 minutes is very common.

Q. For an RN ACLS staffed unit?

A. Right. And we're only interested in the advanced life support teams. We don't call basic ambulances for this type of -- of clinical syndrome. 15 or 20 minutes is very common but just like the paramedics they might be tied up. So we call them. We call them and ask them how long. And once again depending on how long they're going to be then we make a decision to use them or not. I had a patient with chest pain in urgent care two days ago. They were there in ten minutes. Their experience is when you call and they say they're tied up, we can't be there for an hour, then you go

on to somebody else. You have to make the decision about what time frame is appropriate in your eyes for whatever this patient has.

Q. Doctor, in this case when 911 was called how long did it take them for -- for them to arrive at the clinic?

A. My understanding is ten minutes.

Q. Okay. Now, what is your understanding as to the information received by Dr. Yan as to how long it would take for Medicare to arrive when the first call was made?

A. 20 minutes.

Q. Now -- so in effect we have a ten minute difference?

A. Correct.

Q. Okay. Based upon your experience does that ten minute difference -- is that in anyway significant or does that make any difference when you look at the condition that [patient RM] was in?

A. I think that's the crucial thing you have to look at each -- each patient's scenario. The patient was having eight hours of chest pain. There's a ten minute difference in the clinic. I don't think it had any bearing on his clinical outcome.

Q. Is there any evidence in the record that the patient's condition destabilized based on Dr. Yan's initial decision to call Medicare?

A. No, and in fact there's clinical evidence that there was no deterioration. (Tr., pp. 116-119)

To be sure, not all the testimony was in accord with the respondent's expert witnesses. Dr. Alan Scwartzstein's testimony for the prosecution included the following:

Q. (by Mr. Polewski) What is the minimally competent medical response to an anterior wall myocardial infarction in an urgent care setting? What do you do with that person?

A. To provide the stabilization that one can in that setting and as expeditiously as possible

transfer that person to a hospital where they can be adequately treated.

Q. Does it matter to the minimally competent physician whether the transport service is generally considered to be an inter-facility transport or a rescue service?

A. Yes.

Q. Why?

A. Again, time in this situation is the essence. If the patient is unstable it's a patient for whom minutes could make a difference in terms of their morbidity and mortality. And therefore time is an over -- is an overriding consideration in this situation.

Q. Is use of a rescue service in Mr. Major's situation inappropriate in any way?

A. No.

Q. Is it less than minimally competent medical practice to intentionally choose a slower means of transportation in this instance?

A. It's not the standard of care that I'm familiar with and it's not the standard of care that I have worked with in any locality that I've been in before. And I believe it is below the minimal standard of care, yes.

Q. Why?

A. Minutes can matter in someone that's having acute myocardial infarction. And arranging for a transport that one can be more dependent is going to arrive quickly and transport the patient quickly is more important than some of the possibilities. The public ambulance might be able to provide for more stable, long term settings for more stable patients. (Tr. pp. 45-46)

Based upon that testimony, and that of the prosecution's other witness, Nurse Kristen Sobocinski, it is concluded that the prosecution was substantially justified in bringing this case. Nonetheless, the board finds the expert testimony of Drs. Rodriguez and Stuart to be the more compelling, and therefore also concludes that Dr. Yan's actions, in first calling for the Medicare ambulance, and then instructing the nurse to call for 911 transport when the Medicare ambulance failed to appear after 25 minutes, were reasonable, and did not constitute conduct below the minimum standards of the profession or expose the patient to risks which a minimally competent physician would not have exposed him. Accordingly, the matter must be dismissed.

Dated this 28th day of August, 2002.

STATE OF WISCONSIN

MEDICAL EXAMINING BOARD

Virginia S. Heinemann

Board Secretary