

1 BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

3 **LEE S. YOSOWITZ, M.D.**

4 Holder of License No. 12610  
5 For the Practice of Allopathic Medicine  
6 In the State of Arizona

Case No. MD-10-1478A

**ORDER FOR LETTER OF REPRIMAND  
AND CONSENT TO THE SAME**

7 Lee S. Yosowitz, M.D. ("Respondent") elects to permanently waive any right to a  
8 hearing and appeal with respect to this Order for Letter of Reprimand; admits the  
9 jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of this Order  
10 by the Board.

11 **FINDINGS OF FACT**

12 1. The Board is the duly constituted authority for the regulation and control of  
13 the practice of allopathic medicine in the State of Arizona.

14 2. Respondent is the holder of license number 12610 for the practice of  
15 allopathic medicine in the State of Arizona.

16 3. The Board initiated case number MD-10-1478A after receiving a complaint  
17 regarding Respondent's care and treatment of a 51 year-old female patient ("DL") alleging  
18 a deficiency in laparoscopic surgical technique and inadequate operative report  
19 documentation.

20 4. On May 28, 2010, DL underwent a laparoscopic left salpingo-oophrectomy  
21 due to persistent left lower quadrant pain. During the procedure Respondent inserted a  
22 trocar without creating a pneumoperitoneum. Upon introduction of the laparoscope,  
23 bleeding was noted and when a laparotomy was carried out, numerous injuries were  
24 identified, including transection of the right external iliac artery, partial transection of the  
25 right external iliac vein and transection of the right ureter.

1           5.     In his response to the complaint, Respondent stated that he used excess  
2 force in placement of the bladed trocar, which he thought was bladeless, and he also  
3 stated the safety shield of the trocar failed for some unknown reason. Based on his  
4 dictated operative note, there is no indication that precautions were taken particularly  
5 when the bladed trocar was used.

6           6.     DL was transferred to the intensive care unit following the procedure. She  
7 was extubated and administered more units of packed red blood cells.

8           7.     Three days after the operation, DL was taken back to the operating room and  
9 the fasciotomy wounds were closed. She was transferred the next day from the intensive  
10 care unit to the telemetry floor. Bilateral pleural effusions were noted to be present and  
11 right thoracentesis was carried out. The JP drain was removed, but snapped and a portion  
12 remained in the abdomen. DL was taken to the operating room after attempts to remove  
13 the broken off part of the JP drain were unsuccessful. On June 5, 2010, a thoracentesis of  
14 the left side was carried out. The following day, the Foley catheter was removed and DL  
15 was discharged.

16          8.     The standard of care when carrying out a laparoscopic procedure requires a  
17 physician to create a pneumoperitoneum or use proper abdominal tenting with proper  
18 angling prior to inserting trocars.

19          9.     Respondent deviated from the standard of care by failing to create a  
20 pneumoperitoneum or utilize proper abdominal tenting prior to inserting trocars when  
21 carrying out a laparoscopic procedure for patient DL.

22          10.    As a result of the improper technique used for access to the peritoneal  
23 cavity, DL sustained injury to major vessels and ureter, and could have suffered massive  
24 hemorrhage and death.

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1. **CONCLUSIONS OF LAW**

2 1. The Board possesses jurisdiction over the subject matter hereof and over  
3 Respondent.

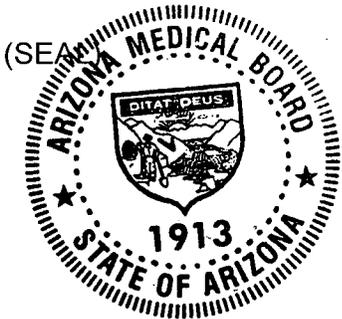
4 2. The conduct and circumstances described above constitute unprofessional  
5 conduct pursuant to A.R.S. § 32-1401(27)(q) (“[a]ny conduct or practice that is or might be  
6 harmful or dangerous to the health of the patient or the public.”).

7 3. The conduct and circumstances described above constitute unprofessional  
8 conduct pursuant to A.R.S. § 32-1401 (27)(e) (“failing or refusing to maintain adequate  
9 records on a patient.”).

10 **ORDER**

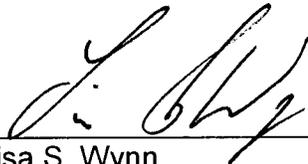
11 IT IS HEREBY ORDERED THAT Respondent is issued a Letter of Reprimand.

12  
13 DATED AND EFFECTIVE this 11<sup>th</sup> day of AUGUST, 2011.



ARIZONA MEDICAL BOARD

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By   
Lisa S. Wynn  
Executive Director

**CONSENT TO ENTRY OF ORDER**

1. Respondent has read and understands this Consent Agreement and the stipulated Findings of Fact, Conclusions of Law and Order (“Order”). Respondent acknowledges he has the right to consult with legal counsel regarding this matter.

2. Respondent acknowledges and agrees that this Order is entered into freely and voluntarily and that no promise was made or coercion used to induce such entry.

1           3.     By consenting to this Order, Respondent voluntarily relinquishes any rights to  
2 a hearing or judicial review in state or federal court on the matters alleged, or to challenge  
3 this Order in its entirety as issued by the Board, and waives any other cause of action  
4 related thereto or arising from said Order.

5           4.     The Order is not effective until approved by the Board and signed by its  
6 Executive Director.

7           5.     All admissions made by Respondent are solely for final disposition of this  
8 matter and any subsequent related administrative proceedings or civil litigation involving  
9 the Board and Respondent. Therefore, said admissions by Respondent are not intended  
10 or made for any other use, such as in the context of another state or federal government  
11 regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or  
12 any other state or federal court.

13          6.     Upon signing this agreement, and returning this document (or a copy thereof)  
14 to the Board's Executive Director, Respondent may not revoke the consent to the entry of  
15 the Order. Respondent may not make any modifications to the document. Any  
16 modifications to this original document are ineffective and void unless mutually approved  
17 by the parties.

18          7.     This Order is a public record that will be publicly disseminated as a formal  
19 disciplinary action of the Board and will be reported to the National Practitioner's Data  
20 Bank and on the Board's web site as a disciplinary action.

21          8.     If any part of the Order is later declared void or otherwise unenforceable, the  
22 remainder of the Order in its entirety shall remain in force and effect.

23          9.     If the Board does not adopt this Order, Respondent will not assert as a  
24 defense that the Board's consideration of the Order constitutes bias, prejudice,  
25 prejudgment or other similar defense.

1           10. Any violation of this Order constitutes unprofessional conduct and may result  
2 in disciplinary action. A.R.S. § § 32-1401(27)(r) (“[v]iolating a formal order, probation,  
3 consent agreement or stipulation issued or entered into by the board or its executive  
4 director under this chapter”) and 32-1451.

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DATED: 5/31/2011

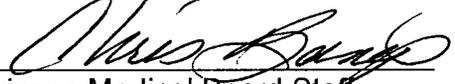
Lee S. Yosowitz, M.D.

8 EXECUTED COPY of the foregoing mailed  
9 this 11th day of August, 2011 to:

10 Lee S. Yosowitz, M.D.  
11 Address of Record

12 ORIGINAL of the foregoing filed  
13 this 11th day of August, 2011 with:

14 Arizona Medical Board  
15 9545 E. Doubletree Ranch Road  
16 Scottsdale, AZ 85258

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19 Arizona Medical Board Staff  
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