BEFORE THE REVIEW COMMITTEE OF THE ARIZONA MEDICAL BOARD

In the Matter of **LEE S. YOSOWITZ, M.D.** Holder of License No. 12610 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-20-0660A, MD-20-1055A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR LETTER OF REPRIMAND AND PROBATION**

The Review Committee of the Arizona Medical Board ("Board") considered this matter at its public meeting on October 25, 2021. Lee S. Yosowitz, M.D. ("Respondent"), appeared with legal counsel, Steve Myers, Esq., before the Review Committee for a Formal Interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(P). The Review Committee voted to issue Findings of Fact, Conclusions of Law and Order for Letter of Reprimand and Probation after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

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

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

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3. The Board initiated case number after receiving notification that a Hospital where Respondent held privileges revoked Respondent's privileges to perform forceps-assisted deliveries. Respondent subsequently voluntarily resigned his clinical privileges at the Hospital. Based on the complaint, Board staff requested Medical Consultant ("MC") review of three patient charts.

4. MR was a 34 year-old gravita 6 para 4 patient who was admitted to the Hospital on November 6, 2019 at term with ruptured membranes. MR progressed after an

epidural. During the second stage of labor, fetal heart rate ("FHR") decelerations were noted. When decelerations became severe and the patient was noted to be crowning, Respondent elected to use forceps to expedite the delivery. Leukhart-Simpson forceps were used with the infant in the left occiput anterior ("LOA") position, the forceps slipped off and required replacement to complete the delivery. A tight nuchal cord was reduced on the perineum.

5. The infant ("JS") had Apgar scores of 7 and 9 and weighed 8 pounds 8 ounces with arterial blood gasses ("ABG") of 7.303. In the nursery, JS was noted to have facial bruising and had swelling in his right upper eyelid, which would not open spontaneously. JS's pupils were noted to be unequal, with the right pupil measuring 8mm while the left was 3mm. No visible hemorrhage of the right eye was present and neither pupil had any obvious reaction to light. An intracranial ultrasound was normal and a pediatric ophthalmologist assessed the infant. 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.

6. AC was a 26 year-old gravita 4 para 2 patient who was seen at the Hospital on November 10, 2018, to check her HCG level after being treated with Methotrexate ("MTX") for an ectopic pregnancy three days prior. Respondent was called and indicated to the nursing staff that he would be coming in 20 minutes. Over an hour later, he was called again and stated that he'd seen the patient, but the patient stated he had not been in to see her. Respondent arrived three hours after the initial call and reportedly saw the patient but did not evaluate her and did not document the interaction. The MC commented that there was no patient harm, but noted that his behavior was unprofessional, which was acknowledged by Respondent during the course of the Board's investigation. Respondent reported that he had changed his care to avoid a similar event in the future.

7. SC was a 29 year-old gravita 4 para 2 patient with a history of a previous C-section, who presented in labor at term on June 7, 2019. A repeat C-section was performed with delivery at 0850 of an 8'1" infant and a 1200cc blood loss noted.

8. SC developed uterine atony in the PACU and Respondent was called and responded telephonically, initially ordering Pitocin to be increased and then adding Cytotec at 1054, which reportedly helped. At 1145, Respondent ordered Methergine in addition to other medications for ongoing bleeding.

9. By 1154, a decision was made to take SC to surgery due to an inadequate response to the medications and two units of PRBCs were administered. Respondent arrived at 1146. The procedure was carried out under IV sedation and included a curettage and placement of a Bakri balloon, which was partially inflated in the OR. A total of 2650 cc of blood loss (including the 1200 from the C-section) was calculated after the second procedure. The Bakri balloon was further filled when bleeding continued post-operatively and a total loss of 3235 cc was calculated overall. Hemabate was given in the PACU. Two days after the procedures, the patient was stable with an H&H of 7.7/22.8. The MC noted that Respondent failed to document details regarding blood transfusions or medications administered during the procedure.

10. The standard of care requires a physician to properly place the forceps when performing a forceps-assisted delivery. Respondent deviated from this standard of care by improperly placing forceps when performing a forceps-assisted delivery for MR and JS.

11. The standard of care requires a physician to evaluate a patient with post-partum hemorrhage to determine the cause of the problem. Respondent deviated from the standard of care by failing to timely evaluate Patient SC's post-partum hemorrhage requiring medical and surgical intervention.

12. Actual patient harm was identified in that Patient JS experienced aniscoria and SC's treatment of her post-partum hemorrhage was delayed.

13. There was the potential for patient harm in that JS was at risk of additional injury due to the improperly placed foreceps. SC was at risk of additional surgical intervention and maternal death.

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14. The Board initiated case number MD-20-1055A after receiving a complaint regarding Respondent's care and treatment of a 36 year-old female patient ("AB") alleging inappropriate care and treatment, inappropriate performance of a C-section, and failure to transfer care to a urologist.

15. AB, a gravita 5 para 3 pregnant female at 38 weeks presented to a different Hospital where Respondent held privileges on November 4, 2020 complaining of leaking fluid for 30 minutes. AB's problem list included polyhydramnios possible macrosomia. AB's cervical exam showed she was dilated at 4cm. The fetal heart rate (FHR) was a category 2.

16. At 1850, AB's cervical exam showed she was dilated at 7cm with FHA at category 2 with indeterminate tracing. Respondent recommended a C-section at 2144, and noted that AB requested more time to decide.

17. At 2331, Respondent performed the C-section. During the procedure, Respondent noted that the foley catheter and bulb had penetrated a portion of AB's bladder dome that had been adherent to the lower uterine segment, and were located in the peritoneal cavity. Respondent documented repair via Alice clamps and three layer closure.

18. On November 5, 2020, a urology consult was obtained due to the bladder laceration associated with the C-section. A CT urogram showed persistent focal 7.8 mm

perforation site associated with right anterior bladder. Associated mild extravasation of contrast from the bladder adjacent to the drainage catheter was also identified.

19. On November 17, 2020, AB was seen by urology for irritable bladder symptoms. AB was evaluated with cystoscopy and required lysis of two adhesions within the bladder anterior and posterior walls.

20. The Board's MC reviewed the case and found that Respondent met the standard of care. However, the MC opined that Respondent's documentation lacked a detailed description of the bladder injury or an intraoperative urology consultation. The MC also noted that there was little or no documentation of addressing FHR concerns. The MC opined that better documentation could have improved communication with urologist and reassured the patient.

Formal Interview

21. During a Formal Interview on this matter, Respondent testified regarding his care and treatment of the patients at issue. With regard to the descriptions in the operative report for Patient AB, Respondent testified that he believed his documentation was adequate. With regard to Patient AC, Respondent testified that he was not required to talk to the Patient; but rather, only to be present face to face, to make certain that she had been provided with the appropriate information that there were no problems. Respondent testified that he did speak with the nurse. Respondent testified regarding his belief that he practiced within the standard of care for each case reviewed.

22. During that same Formal Interview, Review Committee members discussed the case findings and whether the matter rose to the level of discipline. Committee members commented that Respondent did not appear to have been sufficiently available to his patients, and expressed concern regarding Respondent's continued assertions that

he met the standard of care. The Committee agreed that the case rose to the level of discipline and agreed that continuing medical education was warranted.

CONCLUSIONS OF LAW

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

2. The conduct and circumstances described above constitute unprofessional conduct pursuant to A.R.S. § 32-1401(27)(e) ("Failing or refusing to maintain adequate records on a patient.").

3. The conduct and circumstances described in MD-20-0660A constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(r) ("Committing any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Letter of Reprimand.
2. Respondent is placed on Probation for a period of six months with the following terms and conditions:

   a. **Continuing Medical Education**

Respondent shall within 6 months of the date of this Order, complete the Improving Inter-Professional Communication Course offered by the Center for Personalized Education for Professionals ("CPEP"). Respondent shall within **thirty days** of the effective date of this Order submit satisfactory proof of enrollment with Board staff. Upon completion of the CME, Respondent shall provide Board staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for the biennial renewal of medical

licensure. The Probation shall terminate upon Respondent's proof of successful completion of the CME.

b. Obey All Laws

Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court ordered criminal probation, payments and other orders.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED AND EFFECTIVE this 1st day of December, 2021.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Patricia E. McSorley
Executive Director

1 EXECUTED COPY of the foregoing mailed
this 1st day of December, 2021 to:

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3 Stephen Myers, Esq.
4 Mitchell Stein Carey Chapman, PC
2 North Central Avenue #1450
5 Phoenix, Arizona 85004
Attorney for Respondent

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7 ORIGINAL of the foregoing filed
this 1st day of December, 2021 with:

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Arizona Medical Board
9 1740 West Adams, Suite 4000
Phoenix, Arizona 85007

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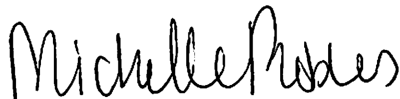

12 Board staff

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