

1 **BEFORE THE BOARD OF MEDICAL EXAMINERS**

2 **IN THE STATE OF ARIZONA**

3
4 In the Matter of

5 **STEVEN LEIBSOHN, M.D.**

6 Holder of License No. **17701**
7 For the Practice of Medicine
8 In the State of Arizona.

CASE NO. MD-00-0289

Investigation No. 13725

**FINDINGS OF FACT,
CONCLUSIONS OF LAW
AND ORDER**

(Decree of Censure)

9 **INTRODUCTION**

10 This matter was considered by the Arizona Board of Medical Examiners
11 ("Board") at its public meeting on February 15, 2001. Steven Leibsohn, M.D.,
12 appeared before the Board with counsel, Harding Cure, Esq., for the purpose of the
13 Board conducting a formal interview, pursuant to the authority vested in the Board by
14 A.R.S. § 32-1451(G). After due consideration of the facts and law applicable to this
15 matter, the Board voted to issue the following findings of fact, conclusions of law and
16 order.

17 **FINDINGS OF FACT**

- 18
- 19 1. The Board is the duly constituted authority for the regulation and control
20 of the practice of allopathic medicine in the State of Arizona.
 - 21 2. Dr. Leibsohn is the holder of License No. 17701 for the practice of
22 medicine in the State of Arizona.
 - 23 3. Board Investigation No. 13725 arose from a medical malpractice lawsuit
24 in which it was alleged that the medical care rendered to a patient was
25 negligent.

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4. On December 26, 1996, the patient, a 27-year-old female, presented to Dr. Leibsohn with complaints of lower abdominal pain of approximately two weeks duration. The patient also desired a tubal ligation. Dr. Leibsohn had been providing care for this patient since October of 1992, and the patient had a relatively complex medical and surgical history. Dr. Leibsohn assessed unknown etiology for the pelvic pain and recommended that she undergo a diagnostic laparoscopy along with a tubal ligation.
5. On December 30, 1996, the patient signed the standard consent form for surgery in the presence of Dr. Leibsohn's scheduler.
6. On January 2, 1997, Dr. Leibsohn performed a closed laparoscopic tubal ligation on the patient at Arrowhead Community Hospital. The surgery was relatively uneventful. During the procedure, Dr. Leibsohn encountered some minimal adhesions of the bladder and the uterus as well as a ruptured corpus luteum cyst on the right side that was aspirated.
7. The patient was discharged to recovery in stable condition with no complications. Postoperatively the patient complained of significant pain and nausea and was given I.V. fluids for erratic blood pressure. She was eventually discharged home accompanied by her husband and given a prescription for Percocet for pain control.
8. On January 3, 1997, the patient called Dr. Leibsohn with complaints of gas pain. Dr. Leibsohn instructed her to continue to take gas medication and also instructed the patient to go to a hospital if she had any fever or chills. Dr. Leibsohn instructed his staff to call in a change of pain

1 medication to Lortab. It should be noted that the patient had indicated
2 she was allergic to codeine. Later that same day the patient was
3 transported by ambulance to Columbia Paradise Valley Hospital with
4 continued complaints of abdominal pain, nausea and hypotension. She
5 was admitted with an acute abdomen.

6 9. Subsequent surgery revealed perforation of the intestines found following
7 her admission, felt to be from the laparoscopic-placed ports at the
8 surgery performed by Dr. Leibsohn.

9 10. There was an extensive history of previous abdominal surgery; a
10 gunshot wound to the abdomen as a youth which had resulted in the
11 amputation of her leg; previous cesarean section and laparoscopic
12 cholecystectomy.

13 11. Documentation for the surgery performed by Dr. Leibsohn is sketchy.
14 There is no detailed discussion of the risks especially in the face of
15 previous known abdominal surgery. The postoperative records only
16 record one call from the office to the family which was not addressed
17 personally by Dr. Leibsohn but by his nurse.

18 12. The patient went on to have multiple surgeries by another surgeon and
19 multiple perforations. She had multiple complications from intravenous
20 feedings, clotting, anticoagulant therapy, and eventual fatal intracerebral
21 bleed.

22 13. Dr. Leibsohn fell below the standard of care in failing to adequately
23 inform the patient of the complications associated with the surgery he
24 performed, and for deciding to proceed with surgery on this patient.
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CONCLUSIONS OF LAW

1. The Board of Medical Examiners of the State of Arizona possesses jurisdiction over the subject matter hereof and over Steven Leibsohn, M.D.
2. The Board has received substantial evidence supporting the Findings of Facts described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.
3. The conduct and circumstances described above in paragraphs 3 through 12 constitute unprofessional conduct pursuant to A.R.S. §§ 32-1401(25)(q) (any conduct or practice which is or might be harmful or dangerous to the health of the patient or the public); -1401(25)(II) (conduct that the Board determines is gross negligence, repeated negligence or negligence resulting in harm to or death of a patient).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED AS FOLLOWS:

1. A decree of censure for (a) failure to adequately inform the patient of potential complications, and (b) poor selection of surgical procedure, be issued to Dr. Leibsohn;
2. Dr. Leibsohn is hereby placed on probation for a period of six (6) months;
3. Dr. Leibsohn shall obtain twenty (20) hours of Board staff pre-approved Category I CME in laparoscopic procedures to be completed within six (6) months from the date of this Order, in addition to the required twenty hours of CME required for license renewal. If Dr. Leibsohn has obtained any hours of CME in laparoscopic surgery within

1 the last six months, these may be accepted toward meeting this requirement if reviewed
2 and approved by Board staff.

3 **RIGHT TO PETITION FOR REVIEW**

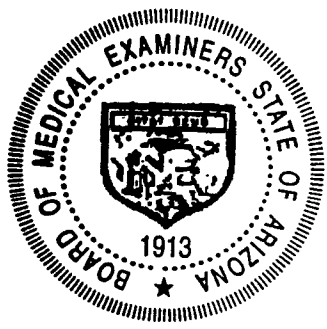
4 Dr. Leibsohn is hereby notified that he has the right to petition for a rehearing.
5 Pursuant to A.R.S. § 41-1092.09, as amended, the petition for rehearing must be filed with
6 the Board's Executive Director within thirty (30) days after service of this Order and
7 pursuant to A.A.C. R4-16-102, it must set forth legally sufficient reasons for granting a
8 rehearing. Service of this Order is effective five (5) days after the date of mailing. If a
9 motion for rehearing is not filed, the Board's Order becomes effective thirty-five (35) days
10 after it is mailed to Dr. Leibsohn.

11 Dr. Leibsohn is further notified that the filing of a petition for rehearing is required to
12 preserve any rights of appeal to the Superior Court that he may wish to pursue.

13
14 DATED this 22nd day of March, 2001.

15 BOARD OF MEDICAL EXAMINERS
16 OF THE STATE OF ARIZONA

17 (SEAL)



18 By Claudia Foutz
19 CLAUDIA FOUTZ
20 Executive Director
TOM ADAMS
Deputy Director

21 ORIGINAL of the foregoing filed
22 this 22nd day of March, 2001, with:

23 The Arizona Board of Medical Examiners
24 9545 East Doubletree Ranch Road
25 Scottsdale, Arizona 85258

1 EXECUTED COPY of the foregoing mailed by
2 Certified Mail this 22nd day of March, 2001, to:


3 Seven Leibsohn, M.D.
4 6525 West Sack Drive - Ste. 201
5 Glendale, AZ 85308

6 EXECUTED COPY of the foregoing mailed
7 this 22nd day of March, 2001, to:

8 Harding Cure, Esq.
9 The Cavanaugh Law Firm
10 One East Camelback - Ste. 900
11 Phoenix, AZ 85012-1656
12 Counsel for Dr. Leibsohn

13 COPY of the foregoing hand-delivered this
14 22nd day of March, 2001, to:

15 Richard F. Albrecht, Esq., Assistant Attorney General
16 c/o Arizona Board of Medical Examiners
17 9545 E. Doubletree Ranch Road
18 Scottsdale, AZ 85258
19 Counsel for the Board

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26 Tamara Turner
27 Board Operations Coordinator