

STATE OF NEW JERSEY
DEPARTMENT OF LAW & PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF MEDICAL EXAMINERS

In the matter of:

MICHAEL J. SASSO, D.O.

CONSENT ORDER

This matter was opened before the New Jersey State Board of Medical Examiners (the "Board") upon the Board's receipt of a report from the Medical Practitioner Review Panel (the "Panel") detailing findings and recommendations made by the Panel upon conclusion of an investigation of respondent Michael J. Sasso, D.O. Specifically, the Panel commenced an investigation upon receipt of a report from Dr. Sasso's malpractice insurer detailing that a payment of \$250,000 was made on Dr. Sasso's behalf to settle a civil action brought by patient D.C., wherein it was generally alleged that respondent injured D.C.'s aorta during a laparoscopic cholecystectomy and thereafter failed to timely diagnose and repair the injury.

During the course of its investigation, the Panel obtained and reviewed available information, to include hospital records for patient D.C.'s two hospital admissions to Kennedy Memorial Hospital (August 31, 2005 through September 9, 2005 and September 11, 2005 through September 20, 2005) and expert reports

prepared for use in the civil malpractice action. The Panel additionally considered testimony offered by Dr. Sasso when he appeared before the Panel for an investigative hearing on December 19, 2014, represented by Michael J. Keating, Esq. The Panel was assisted in its investigation by Peter Fan, M.D., who acted as a special consultant to the Panel as authorized by N.J.S.A. 45:9-19.9(c).

The Panel found that D.C., a 23 year old woman, was admitted to Kennedy Memorial Hospital ("Kennedy") on August 31, 2005 with abdominal pain consistent with biliary colic and gallbladder disease, and on evaluation was found to have cholecystitis. Dr. Sasso, a general surgeon, took D.C. to the operating room on September 2, 2005, planning to perform a laparoscopic cholecystectomy. After beginning the procedure by inserting a Verress needle, Dr. Sasso noticed some unusual intra-abdominal free blood in the abdominal cavity, but proceeded with the planned procedure. Shortly thereafter, D.C.'s blood pressure collapsed suddenly and she went into cardiac arrest. D.C. was successfully resuscitated, and Dr. Sasso then converted the laparoscopic procedure to an open procedure. Dr. Sasso stated that he found free blood in the peritoneal cavity, but was unable to locate an obvious source for the bleeding. He then finished the procedure, to include removing the patient's gall bladder and

performing an incidental appendectomy (see further discussion below).

Post-operatively, D.C. continued to be hemodynamically unstable, and her hemoglobin levels dropped to 6.1 gm/dL in the ICU. D.C. required multiple post-operative blood transfusions, to include the immediate post-surgical transfusion of three units of blood and the transfusion of approximately four additional units of packed cells through September 4, 2005. D.C.'s hemoglobin levels thereafter stabilized at approximately 9.6 gm/dL (a normal reading for an adult woman would generally be between 12 and 16 gm/dL). On September 4, 2005, D.C. was started on anticoagulation therapy to address a finding of superficial thrombosis. D.C. was discharged on September 9, 2005 on 2.5 mg Coumadin daily.¹

On September 11, 2005, D.C. was readmitted to Kennedy with increasing abdominal pain and distension, and hypotension. While in the emergency room, D.C. went into sudden cardiac arrest with pulseless electrical activity. After she was again successfully resuscitated, a CT scan was performed and showed evidence of a massive retro-peritoneal hematoma. Dr. Sasso took D.C. to the operating room a second time, and on exploration found bleeding from an aortic bifurcation. He then called a vascular surgeon to repair the punctured aorta. Post-operatively, D.C.

¹ In light of subsequent events, it is clear that the anti-coagulation therapy was contraindicated.

developed multiple life threatening complications, remained unresponsive in the ICU with multiple organ failure, was close to death and required the services of numerous consultants. She developed left hemi-paresis, and a CT scan showed infarction of the right middle cerebral artery. D.C. was ultimately transferred from Kennedy to Temple University Medical Center on September 20, 2005, where she remained hospitalized until discharge on October 28, 2005. She was subsequently found, on neurological examination, to have residual neurocognitive deficits in brain functioning.

The Panel concluded that Dr. Sasso engaged in gross negligence, both at the time that he performed surgery on September 2, 2005 and thereafter when providing post-operative care through the time of D.C.'s initial hospital discharge on September 9, 2005. Focusing on the initial surgery, the Panel determined that Dr. Sasso most likely caused a puncture wound in D.C.'s aorta at the time he inserted the Verress needle. The Panel found that Dr. Sasso's failure to thereafter have suspected, recognized and/or diagnosed D.C.'s aortic injury constituted gross negligence. Specifically, the Panel concluded that, at a minimum, Dr. Sasso should have suspected an aortic injury in light of the patient's dramatic loss in blood pressure and her cardiac arrest during surgery. Additionally, the Panel found that Dr. Sasso failed to conduct a sufficiently thorough exploration of the abdominal cavity

to identify the source of the free blood found at the time of surgery.

Focusing on post-surgical events, the Panel found that Dr. Sasso engaged in additional and independent acts of gross negligence when he failed to adequately investigate the cause for his patient's continued decline in hemoglobin levels. The Panel suggested that Dr. Sasso should have recognized that D.C.'s need for multiple blood transfusions post-cholecystectomy was a highly unusual event, and that he should have made greater efforts to determine the reasons for her continued bleeding. At a minimum, the Panel found that respondent should have ordered diagnostic tests, to include a CT scan of the abdomen.

Separate and apart from the above delineated findings of gross negligence in the provision of medical care to D.C., the Panel also concluded that the operative report which respondent prepared for the September 2, 2005 surgery was not credible. Notwithstanding the significant complications which occurred at the time of surgery, respondent failed to dictate an operative report for a full six weeks from the date of the initial surgery (the report was dictated on October 14, 2005). Dr. Sasso's operative report was thus not prepared until well after D.C.'s second hospital admission had concluded, and was prepared at a time that respondent knew the actual cause of the complications which occurred during his first surgery. The Panel questioned the

accuracy of events detailed in the operative report, to include respondent's description therein of the amount of bleeding that occurred at the time of surgery and his description of the extent of the efforts that he undertook to inspect for retroperitoneal bleeding. The Panel also found that respondent failed to accurately report that he performed an incidental appendectomy at the time of surgery. It is clear, from both the pathology report and contemporaneous hospital record entries made at the time of surgery, that Dr. Sasso in fact performed an incidental appendectomy on September 2, 2005, and that he then removed both D.C.'s healthy appendix and her diseased gall bladder.

Finally, focusing on D.C.'s second hospital admission, the Panel found that Dr. Sasso failed to prepare either an operative report (for the surgery which he performed on September 11, 2005) or a discharge summary (following D.C.'s transfer to another institution on September 20, 2005).

The Board herein adopts all of the findings and conclusions set forth above which were made by the Panel. The Board thus finds that cause for disciplinary sanction against respondent exists pursuant to N.J.S.A. 45:1-21(c) (engaging in gross negligence, malpractice or incompetence), 45:1-21(b) (engaging in the use of dishonesty, based on the identified concerns regarding the accuracy of the operative report Dr. Sasso dictated for the September 2, 2005 operation) and 45:1-21(h) (based

on independent findings that Dr. Sasso violated the Board's record-keeping regulation, N.J.A.C. 13:35-6.5, when failing to prepare required records, to include an operative report and a discharge summary, for D.C.'s second hospital admission). Respondent neither admits nor denies the findings of fact made herein by the Board.

The parties desiring to resolve this matter without need for additional administrative proceedings, and the Board being satisfied that good cause exists for the entry of this Order,

IT IS on this 25th day of February, 2016

ORDERED and AGREED:

1. The license of respondent Michael J. Sasso, D.O., to practice medicine and surgery in the State of New Jersey is hereby suspended for a period of one year. The suspension shall be stayed in its entirety, and shall instead be served as a period of "probation," provided that respondent fully complies with all terms and conditions of this Order.

2. Respondent is hereby assessed a civil penalty in the amount of \$15,000, which penalty shall be payable in full, by certified check or money order (or any alternative payment method deemed acceptable by the Board) at the time of entry of this Order.

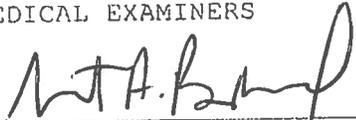
3. Respondent shall, within six months of the date of entry of this Order, complete courses acceptable to the Board in: (1) medical record keeping and (2) medical ethics. Respondent may attend any medical record keeping course and/or ethics course that

is presently approved by the Board, or, in lieu thereof, attend any course that may be approved by the Board for purposes of satisfying the requirements of this Order. In the event respondent elects to attend any course not presently approved by the Board, he shall be required to secure written pre-approval from the Medical Director of the Board for such course(s), which he may seek by providing all available information concerning any proposed course(s) to the Medical Director, who shall then review said information and determine whether the proposed course is or is not acceptable. Respondent shall be responsible to ensure that documentation of successful completion of both courses taken to satisfy the requirements of this paragraph is forwarded by the course provider(s) to the Board. In the event that respondent fails to successfully complete the course work required herein in a timely fashion (that is, in the event the Board does not receive documentation of successful completion of approved courses within six months of the date of entry of this Order), respondent shall be deemed to have failed to comply with the requirements of this Order, and his license may then be immediately suspended by the Board for failure to comply with the terms of this Order. In the event an Order of immediate suspension for failure to comply with the terms of this Order is entered, respondent's license shall thereafter continue to be actively suspended until such time as he successfully completes the required course work, documentation

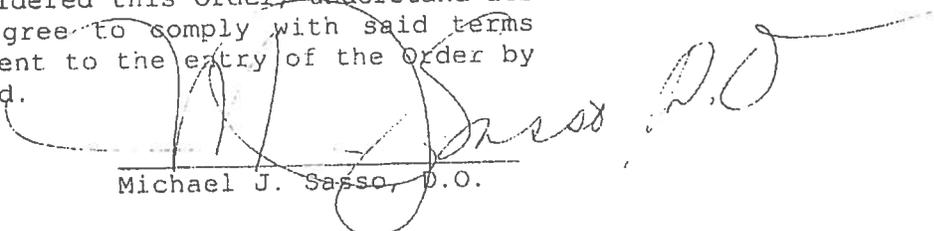
thereof is submitted to the Board, and written notice of reinstatement is provided by the Board to respondent.

NEW JERSEY STATE BOARD OF
MEDICAL EXAMINERS

By:


Stewart Berkowitz, M.D.
Board President

I represent that I have carefully read and considered this Order, understand its terms, agree to comply with said terms and consent to the entry of the Order by the Board.


Michael J. Sasso, D.O.

Dated:

2-5-16

Consent to form of Order and to the entry of this Order by the Board.


Michael J. Keating, Esq.
Counsel for Dr. Sasso

Dated:

2/5/16

**NOTICE OF REPORTING PRACTICES OF BOARD
REGARDING DISCIPLINARY ACTIONS**

Pursuant to N.J.S.A. 52:14B-3(3), all orders of the New Jersey State Board of Medical Examiners are available for public inspection. Should any inquiry be made concerning the status of a licensee, the inquirer will be informed of the existence of the order and a copy will be provided if requested. All evidentiary hearings, proceedings on motions or other applications which are conducted as public hearings and the record, including the transcript and documents marked in evidence, are available for public inspection, upon request.

Pursuant to 45 CFR Subtitle A 60.8, the Board is obligated to report to the National Practitioners Data Bank any action relating to a physician which is based on reasons relating to professional competence or professional conduct:

- (1) Which revokes or suspends (or otherwise restricts) a license,
- (2) Which censures, reprimands or places on probation,
- (3) Under which a license is surrendered.

Pursuant to 45 CFR Section 61.7, the Board is obligated to report to the Healthcare Integrity and Protection (HIP) Data Bank, any formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation or any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or any other negative action or finding by such Federal or State agency that is publicly available information.

Pursuant to N.J.S.A. 45:9-19.13, if the Board refuses to issue, suspends, revokes or otherwise places conditions on a license or permit, it is obligated to notify each licensed health care facility and health maintenance organization with which a licensee is affiliated and every other board licensee in this state with whom he or she is directly associated in private medical practice.

In accordance with an agreement with the Federation of State Medical Boards of the United States, a list of all disciplinary orders are provided to that organization on a monthly basis.

Within the month following entry of an order, a summary of the order will appear on the public agenda for the next monthly Board meeting and is forwarded to those members of the public requesting a copy. In addition, the same summary will appear in the minutes of that Board meeting, which are also made available to those requesting a copy.

Within the month following entry of an order, a summary of the order will appear in a Monthly Disciplinary Action Listing which is made available to those members of the public requesting a copy.

On a periodic basis the Board disseminates to its licensees a newsletter which includes a brief description of all of the orders entered by the Board.

From time to time, the Press Office of the Division of Consumer Affairs may issue releases including the summaries of the content of public orders.

Nothing herein is intended in any way to limit the Board, the Division or the Attorney General from disclosing any public document.