



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

In the Matter of:

WASSIM G. EL-HABRE, M.D.

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 the results of an investigation conducted by the Panel focused upon care provided to patient L.K. following her admission to a New Jersey hospital on February 1, 2008. The Panel commenced its investigation of this matter upon receiving a medical malpractice payment report detailing that a payment was made on behalf of another physician (who also provided care to L.K.) to settle a civil malpractice action brought by L.K.'s estate, wherein it was alleged that a delay in recognizing and repairing an anastomotic leak following cecal volvulus surgery caused L.K. to suffer anoxic brain injury and death.

In the course of investigating this matter, the Panel reviewed not only care provided by the surgeon on whose behalf payment in this matter was reported to have been made, but also

care provided by other physicians to L.K. prior to February 16, 2008 (the date on which L.K. coded in the operating room and sustained an anoxic brain injury), to include care provided by Respondent Wassim G. El-Habre, M.D. The Panel considered available information, to include L.K.'s hospital records for the period February 1, 2008 through February 18, 2008 and testimony offered by Respondent when he appeared for an investigative hearing on April 25, 2014 represented by Carolyn R. Sleeper, Esq. As authorized by N.J.S.A. 45:9-19.9(c), the Panel was assisted by a consultant, Angela Lanfranchi, M.D., in its investigation of this matter.

The Panel found that L.K. was initially hospitalized on February 1, 2008, after being involved in a serious motor vehicle accident. L.K.'s main injuries at that time were bilateral ankle fractures. A closed reduction of the right ankle fracture was performed on February 2, 2008. L.K. thereafter underwent internal fixation of a right pilon fracture and a left bilateral malleolar fracture on February 7, 2008.

L.K. developed a new onset of abdominal pain and distention on February 9, 2008. A cecal volvulus was identified on a CT scan performed at approximately 8:00 p.m. on February 9, 2008. Surgery to repair the volvulus, however, did not commence for a period of approximately 48 hours following the initial diagnosis.

On February 11, 2008, a right hemicolectomy was performed, at which time perforated and gangrenous bowel was found.

An anastomic leak developed following that surgery, however the leak was not suspected until approximately four days later. L.K. was ultimately transferred to the ICU at approximately 4:30 p.m. on February 15, 2008, in profound respiratory distress and septic shock. She was taken to the operating room at 3:42 a.m. on February 16, 2008, for a planned exploratory laparotomy to control and remove the source of her sepsis.¹ The patient arrested when being transferred to the operating table and, although CPR was successful, she sustained anoxic brain injury. L.K. remained hospitalized thereafter through August 10, 2009, when she was transferred to a nursing home, where she remained until her death on December 29, 2009.

Respondent El-Habre was the trauma attending physician with primary responsibility for L.K.'s care from February 4, 2008

¹ The medical malpractice report received by the Panel detailed that the settlement in this case was paid solely on behalf of the surgeon who took L.K. to the operating room (in lieu of identifying said surgeon, we herein refer to the physician as Dr. Z, not a real initial). Records available to the Panel, however, suggest that Dr. Z had limited involvement in L.K.'s care, first commencing when L.K. was transferred to the Trauma ICU on February 15, 2008. The Panel could find no basis to support any finding that Dr. Z thereafter inappropriately delayed recognizing a leak and/or performing surgery. Rather, the Panel found that Dr. Z received a patient who was in profound septic shock, respiratory failure and near death when she arrived in the ICU, and that Dr. Z. initiated appropriate care to prevent L.K.'s immediate death from septic shock. The Panel further found that Dr. Z acted as quickly as possible to first stabilize L.K. to a point that would allow her to be taken to the operating room. The Panel thus concluded that the unfortunate outcome which occurred in this case was not attributable to any negligence by Dr. Z, but rather the product of gross negligence of other physicians involved in L.K.'s care prior to her transfer for surgery on February 15, 2008, including Respondent El-Habre.

through 8:00 a.m. on February 11, 2008. On February 9, 2008, L.K. developed abdominal distention, complained of nausea and abdominal pain, and was found to have blood tinged urine. Respondent ordered an abdominal CT scan, which was performed at approximately 8:00 p.m. on February 9. A suspected cecal volvulus was found. The radiologist communicated that finding to a trauma resident at approximately 10:20 p.m. A gastroenterologist consultant was called, and that consultant recommended that surgical intervention be considered to prevent bowel ischemia and necrosis. The G.I. consultant discussed his recommendation with both the trauma resident and the on-call trauma attending physician (not Dr. El-Habre, as he was not on-call that evening).

Respondent learned of the results of the CT scan upon starting his next shift at approximately 8:00 a.m. on February 10, 2008. Upon his arrival at the hospital, Respondent was aware, or should have been aware, of the CT findings, the consultant's recommendation, and that L.K.'s clinical condition was consistent with Systemic Inflammatory Response Syndrome ("SIRS") and/or intra-abdominal sepsis. Without limitation, L.K. then had fever, elevated respiratory rates, an elevated white blood count and evidence of endothelial dysfunction. The Panel found that Respondent engaged in gross negligence by failing to then ensure that an immediate surgical intervention occurred, noting that the

standard of care for a cecal volvulus above the sigmoid level is immediate surgery.

Thereafter, through the end of respondent's on-call responsibilities at 8:00 a.m. on February 11, 2008, Respondent continued to delay initiation of surgery to address the cecal volvulus, notwithstanding clinical and radiologic evidence which showed that L.K.'s sepsis and her overall medical condition continued to markedly deteriorate.² When appearing before the Panel, respondent testified that he evaluated L.K. several times throughout the day and night on February 10, 2008, and that his decision to delay surgery was based on his clinical impression that L.K. was not acidotic and clinically improved. The Panel rejected respondent's contentions, instead finding that Respondent's failure

² Without limitation, the Panel found that the medical record included evidence of consistent elevation of respiratory rates, consistent fever, elevated white blood cell counts, a urine screen positive for pseudomonas and increasing requirements for fluids to maintain blood pressure and urinary output (over a 24 hour period, L.K. received a total of 4800 cc of IV fluids). Additionally, an abdominal x-ray performed at 12:00 noon on February 10, 2008 showed "a dilated cecum that extended across the abdomen."

Dr. El-Habre performed a sigmoidoscopy at 2:00 p.m. on February 10, 2008, however the Panel found that to be an irrelevant procedure for a patient with cecal volvulus, as any bowel which might have been ischemic could not be visualized by sigmoidoscopy.

Following the conclusion of Respondent's shift on February 11, 2008, a subsequent trauma attending physician reviewed the very same body of medical information that had been available to Dr. El-Habre, and based thereon decided to pursue immediate surgical intervention. Thereafter, a right hemicolectomy with primary anastomosis was performed starting at 7:51 p.m. on February 11, and a cecal volvulus, with ischemia and perforation, was found.

to have recognized the need for emergent surgical intervention when caring for L.K. on February 10 and 11, 2008, and his overall treatment of L.K. during that time period, also independently constituted gross negligence.

The Board has adopted all findings made by the Panel, and concludes that basis for disciplinary action against respondent exists pursuant to N.J.S.A. 45:1-21(c) (engaging in acts of gross negligence, gross malpractice or gross incompetence). Dr. El-Habre neither admits nor denies the findings made by the Panel. The parties desiring to resolve this matter without the need for further administrative proceedings, and the Board finding that good cause exists for entry of this Order:

IT IS on this ^{4th} day of April, 2016

ORDERED and AGREED:

1. Respondent Wassim G. El-Habre, M.D. is formally reprimanded for having engaged in gross negligence in caring for patient L.K., for the reasons set forth above.

2. Respondent is hereby assessed a civil penalty in the amount of \$10,000, which penalty shall be payable in full at the time of filing of this Order.

NEW JERSEY STATE BOARD
OF MEDICAL EXAMINERS

By:



Stewart A. Berkowitz, M.D.
Board President

I represent that I have
carefully reviewed this Order,
and consent to the entry of the
Order by the Board.

El-Habre

Wassim G. El-Habre, M.D.

Dated:

3-30-16

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

Carolyn R. Sleeper

Carolyn R. Sleeper, Esq.
Counsel for Dr. El-Habre

Dated:

4-4-16

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.