STATE OF VERMONT
BOARD OF MEDICAL PRACTICE

In re: Gamal H. Eltabbakh, M.D.	)	Docket No MPS 023-0219

SPECIFICATION OF CHARGES

NOW COMES the State of Vermont, by and through Attorney General Susanne R. Young, and alleges as follows:

1. Gamal H. Eltabbakh, M.D. ("Respondent") holds Vermont medical license number 042.0009610 first issued by the Vermont Board of Medical Practice on January 26, 1998. Respondent is a physician.

2. Jurisdiction in this matter vests with the Board pursuant to 26 V.S.A. §§ 1353-1354, 1370-1376, 3 V.S.A. §§ 809-814, and other authority.

I. Background

3. The Board opened this matter in February 2019 after it received notifications from the University of Vermont Medical Center ("UVMMC") and the National Practitioner Data Bank ("NPDB") that UVMMC denied Respondent's application for renewal of privileges and reappointment to the medical staff. The Board assigned the investigation of this matter to the South Investigative Committee of the Board ("Committee").

4. The UVMMC and NPDB notifications reported that UVMMC's denial of Respondent's application for renewal of privileges and reappointment to the medical staff was based upon findings that Respondent: (a) lacks technical proficiency; (b) routinely fails to identify important anatomic structures (such as ureters) during surgical dissection; (c) does not perform basic techniques necessary for safe surgical care; and (d) demonstrates a pattern of patient care that does not meet an acceptable standard of care.

5. The Committee obtained, via subpoenas to UVMMC, records related to the non-renewal of Respondent's privileges and his non-reappointment to the medical staff.

6. The records produced document that the UVMMC Board of Trustees voted to deny Respondent's application for renewal of privileges and reappointment to the medical staff on March 25, 2018. Respondent then requested an evidentiary hearing before the Fair Hearing Committee ("FHC") of the medical staff to challenge the proposed denial of his application.

7. After a hearing on September 12 and 13, 2018, the FHC affirmed the Board of Trustees' proposed denial of Respondent's application.

8. The Medical Staff Executive Committee ("MEC") then reviewed the FHC's decision and issued a written decision that also recommended the denial of Respondent's application for renewal of privileges and reappointment to the medical staff. Respondent then requested review of the MEC's recommendation by the Appellate Review Committee ("ARC").

9. In its February 7, 2019 report, the ARC concluded that the full record of the proceedings established that Respondent had not satisfied his obligation to demonstrate his current competence, judgment, responsiveness, and willingness to commit to the mission of UVMMC. It recommended that the Board of Trustees affirm the MEC's recommendation to deny Respondent's application for renewal of privileges and reappointment to the medical staff.

10. On February 12, 2019, the Board of Trustees voted to affirm the recommendations of the MEC and ARC and the decision to deny Respondent's application for renewal of privileges and reappointment to the medical staff became final.

11. The Committee identified two of Respondent's surgical patients – Patient A and Patient B – whose care was reviewed in connection with his application. It then obtained, via

subpoenas to Respondent and UVMMC, records of the care Respondent provided to Patient A and Patient B, including video recordings of their surgeries.

II. Respondent's Treatment of Patient A and Patient B

Patient A

12. Respondent began treating Patient A on September 29, 2017 after her gynecologist referred her for evaluation when an ultrasound revealed a thickened endometrium and a biopsy showed a grade 1 endometrial cancer. After counseling, Patient A elected to have a laparoscopically assisted vaginal hysterectomy, bilateral salpingo-oophorectomy with pelvic lymph node dissection, and cystoscopy.

13. Respondent performed the surgery on October 5, 2017. The surgery was videorecorded.

14. As the surgery began, Respondent harshly handled Patient A's tissue. While attempting to release sigmoid epiploic attachments, Respondent ripped at tissue with the harmonic scalpel and caused bleeding. Respondent also opened the broad ligament mainly by tearing the tissue with the harmonic scalpel.

15. Respondent did no further dissection in the retroperitoneum to identify the usual structures of the ureteral course, iliac vasculature, and the obturator nerve.

16. At times, the operating instrument was outside of the camera's view

17. Respondent operated from only one side of patient, which made parts of the dissection more difficult than necessary.

18. Respondent used a bipolar Kleppinger device and a harmonic scalpel to divide the ovarian vessels. However, a harmonic scalpel alone could have been used to safely perform this procedure without also using a bipolar Kleppinger device.

19. Respondent commenced the bladder flap dissection by opening the peritoneum very low in the pelvis and essentially denuded the entire anterior bladder region.

20. When Respondent dissected the bladder, he handled the tissue roughly and poked the harmonic scalpel tip into the bladder dome.

21. Respondent then proceeded to the pelvic lymph node dissection and, again, harshly handled Patient A's tissue. The nodal bundle was mainly torn from its lymphovascular attachments.

22. As Respondent performed the left dissection, he cut the genitofemoral nerve with the harmonic scalpel.

23. His operative report documented the procedure as a pelvic lymphadenectomy, but the usual nodal landmarks were not identified, and the obturator space was not dissected. It was not a full pelvic lymph node dissection, and the majority of the usual landmarks were not seen.

24. An adequate lymph node dissection for endometrial cancer requires that between eleven and twenty-two lymph nodes should be removed during a complete lymphadenectomy for it to be considered representative. Respondent removed only five lymph nodes; one lymph node from the right and four lymph nodes from the left.

25. Respondent obtained a pelvic washing even though it is no longer part of International Federation of Gynecology staging to do so for endometrial cancer.

26. Respondent documented that he performed breast exams on Patient A at her pre-operative visit and at eight post-operative visits that occurred approximately every three months. This care was unnecessary and excessive.

27. At Patient A's February 6, 2018 post-operative visit and at seven subsequent visits, Respondent obtained a pap smear of the vaginal cuff and blood for CA125 testing. It is not standard practice and is discouraged to follow endometrial cancer with pap smear of the vaginal cuff. CA125 testing is not indicated for the low grade, endometrial cancer that Patient A had.

Patient B

28. Respondent began treating Patient B on March 1, 2017 when her gynecologist referred her for evaluation after a hysteroscopy with D & C showed a grade 1 endometrioid endometrial cancer and vulvar dysplasia. After counseling, Patient B elected to have a da Vinci total laparoscopic hysterectomy, bilateral salpingo-oophorectomy, surgical staging, and simple partial vulvectomy.

29. Respondent performed the surgery on April 13, 2017. The surgery was videorecorded.

30. As the surgery began, Respondent moved the camera in and out for several minutes as the robot platform showed "adjust grip" warnings.

31. During the surgery, the camera was often within the trocar sleeve, which obscured and prevented a full field of view. The view was also further obscured because Respondent's assistant did not effectively manipulate Patient B's uterus and clear smoke plumes.

32. Respondent only utilized two of three operating arms on the robot for the entire surgery. The use of an instrument in the third arm would have improved the view.

33. Respondent opened the anterior pelvic peritoneum very low over the bladder and essentially denuded the entire anterior bladder region.

34. Respondent then divided the infundibulopelvic ligament ("IP) without first delineating the ureteral course and caused the IP to bleed. The trocar sleeve limited the view when this occurred.

35. Next, while the camera was too far out for a good view, Respondent attempted to cauterize the uterine vessels. He did not move the bladder out of the field by development of a bladder flap, the vessels were not skeletonized to move the ureter laterally, and the vessels were not adequately cauterized. As a result, there was significant bleeding when he divided the uterine vessels.

36. Respondent attempted to make a bladder flap by further dividing the peritoneum very low over the bladder. The uterine manipulator/cup was not adequately pushed in, and the planes were not clear. Respondent cut into the bladder and roughly tore at the tissue causing an injury to Patient B's bladder.

37. Respondent continued to roughly handle the bladder and the scissor tips poked into the bladder.

38. While attempting to get his assistant into position, Respondent tore the stump of the round ligament and blood puddled in the uterine area.

39. Respondent did not secure the blood supply on the left side before he exposed the vaginal cup on the right side and bipolar cauterized but did not take the IP blood supply on this side before doing so.

40. Respondent grabbed the bowel several times and opened the retroperitoneum but did not identify the ureter first. Respondent tore the uterine artery and it bled.

41. As Respondent began the right lymph node dissection, he roughly handled the tissue and cut the genitofemoral nerve and pulled on it until it bled. He cut another sensory nerve and yanked on fatty tissue to accomplish the node dissection and caused more tearing and bleeding.

42. He tore off the external iliac nerve bundle and moved to the left side but did not identify the usual nodal dissection anatomy and remove the obturator nodes. This was an incomplete lymph node dissection, though Respondent listed it as a completed procedure in the operative note.

43. When Respondent began to suture the vaginal cuff, it often took several tries for him to load the needle and he did so at odd angles and too far back on the needle. He often grabbed the needle tip which dulls the needle.

44. Respondent then pulled on the external iliac artery. As his assistant irrigated the field, the bladder injury Respondent had caused, as set forth in paragraph 36 and 37, became apparent. He began to close the defect with v-loc sutures but struggled to place the needle through the suture loop and caused excess traction on the bladder tissue that had already been torn.

45. Respondent estimated the blood lost during the surgery to be 100 mL, or about four times the amount typically lost in a surgery as straightforward as Patient B's case.

46. Respondent's total robotic surgical console time was approximately 124 minutes, or more than two times the length of time it should typically take a surgeon to accomplish a similar procedure. This unnecessarily exposed Patient B to prolonged time under anesthesia and in a steep Trendelenburg position.

III. Allegations of Unprofessional Conduct

Count 1

47. Paragraphs 1-46 above, are restated and incorporated herein by reference.

48. By one or more of the acts related to the care of Patient A, as described in Paragraphs 12-27 above, Respondent grossly failed to use and exercise on a particular occasion that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions by:

a) harshly handling and ripping and tearing at Patient A's tissue with a harmonic scalpel; and/or

b) failing to identify the usual structures of the ureteral course, iliac vasculature, and the obturator nerve; and/or

c) failing to keep the operating instrument in the camera's view; and/or

d) operating from only one side of the patient; and/or

e) dividing the ovarian vessels with a a harmonic scalpel and Kleppinger device instead of the harmonic scalpel only; and/or

f) opening the peritoneum too low in the pelvis for the bladder dissection; and/or

g) poking the harmonic scalpel tip into the bladder dome; and/or

h) tearing the pelvic lymph nodal bundle from its lymphovascular attachments; and/or

i) cutting the genitofemoral nerve with the harmonic scalpel; and/or

j) failing to identify the usual landmarks and complete a full pelvic lymphadenectomy; and/or

k) removing only five lymph nodes; and/or

l) obtaining a pelvic washing; and/or

m) performing breast exams during Patient A's pre- and post-operative care; and/or

n) obtaining pap smear of the vaginal cuff and blood for CA125 testing at eight post-operative visits.

Respondent's conduct constitutes one or more violations of 26 V.S.A. § 1354(a)(22). Such conduct is unprofessional.

49. Alternatively or cumulatively, by two or more acts related to the care of Patient A, as described in Paragraphs 12-27 above, Respondent failed to used and exercise that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions. Respondent's conduct constitutes one or more violations of 26 V.S.A. § 1354(a)(22). Such conduct is unprofessional.

50. Alternatively or cumulatively, Respondent's conduct, as described in Paragraphs 12-27 above, is unsafe or unacceptable patient care and constitutes one or more violations of 26 V.S.A. § 1354(b)(1). Such conduct is unprofessional.

51. Alternatively or cumulatively, Respondent's conduct, as described in Paragraphs 12-27 above, failed to conform to the essential standards of acceptable and prevailing practice and constitutes one or more violations of 26 V.S.A. § 1354(b)(2). Such conduct is unprofessional.

Count 2

52. Paragraphs 1-51 above, are restated and incorporated herein by reference.

53. By one or more of the acts related to the care of Patient B, as described in Paragraph 28-46 above, Respondent grossly failed to use and exercise on a particular occasion

that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions by:

a) failing to obtain and maintain an adequate camera view; and/or

b) obscuring the camera view with the trocar sleeve; and/or

c) utilizing only two of the robot operating arms; and/or

d) opening the pelvic peritoneum too low over the bladder; and/or

e) dividing the IP without delineating the ureteral course; and/or

f) failing to adequately cauterize the uterine vessels; and/or

g) poking scissor tips into and injuring Patient B's bladder while attempting to make a bladder flap; and/or

h) tearing the stump of the round ligament; and/or

i) failing to secure the blood supply before cauterizing; and/or

j) opening the retroperitoneum without identifying the ureter and tearing the uterine artery; and/or

k) cutting the genitofemoral and another sensory nerve during the right lymph node dissection; and/or.

l) failing to complete the right lymph node dissection; and/or

m) failing to properly load the needle and grabbing its tip when suturing the vaginal cuff; and/or

n) causing excess traction on bladder tissue while closing the injury he caused during the surgery; and/or

o) allowing Patient B to lose about four times the amount of blood typically lost

during a similar surgery; and/or

p) unnecessarily exposing Patient B to prolonged anesthesia while in a steep Trendelenburg position.

Respondent's conduct constitutes one or more violations of 26 V.S.A. § 1354(a)(22). Such conduct is unprofessional.

54. Alternatively or cumulatively, by two or more acts related to the care of Patient B, as described in Paragraphs 28-46 above, Respondent failed to used and exercise that degree of care, skill, and proficiency which is commonly exercised by the ordinary skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions. Respondent's conduct constitutes one or more violations of 26 V.S.A. § 1354(a)(22). Such conduct is unprofessional.

55. Alternatively or cumulatively, Respondent's conduct, as described in Paragraphs 28-46 above, is unsafe or unacceptable patient care and constitutes one or more violations of 26 V.S.A. § 1354(b)(1). Such conduct is unprofessional.

56. Alternatively or cumulatively, Respondent's conduct, as described in Paragraphs 28-46 above, failed to conform to the essential standards of acceptable and prevailing practice and constitutes one or more violations of 26 V.S.A. § 1354(b)(2). Such conduct is unprofessional.

WHEREFORE, Petitioner, State of Vermont, respectfully requests the Board to issue an Order that:

(1) Respondent shall be reprimanded;

(2) Respondent's Vermont medical license shall be conditioned to permanently prohibit

him from performing any surgical operation on any person;

(3) Respondent shall pay an administrative penalty of a minimum of $15,000.00 in accordance with 26 V.S.A. § 1374(b)(1)(A)(iii); and

(4) Take any additional disciplinary action against the medical license of Respondent permitted by 26 V.S.A. §§ 1374(b) and/or 1398 as it deems proper.

Dated at Montpelier, Vermont this 18th day of August, 2022.

STATE OF VERMONT

SUSANNE R. YOUNG
ATTORNEY GENERAL

By: Kurt A. Kuehl Digitally signed by Kurt A. Kuehl Date: 2022.08.18 09:54:06 -04'00'

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The foregoing Specification of Charges, filed by the State of Vermont, as to Gamal H. Eltabbakh, MD, Vermont Board of Medical Practice Docket Number MPS 023-0219, is hereby issued.

Dated at Fayston, Vermont this 19th day of August 2022.

VERMONT BOARD OF MEDICAL PRACTICE

David K. Herlihy Digitally signed by David K. Herlihy Date: 2022.08.19 08:47:47 -04'00'

By: _____

David K. Herlihy
Executive Director
Vermont Board of Medical Practice