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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Ragaa Rezk Ibrahim, M.D.** **5601 DeSoto Avenue** **Woodland Hills, CA 91365** **Physician's and Surgeon's Certificate No. C 52906,** Respondent.	Case No. 800-2018-044499 **A C C U S A T I O N**

PARTIES

1. William Prasifka brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about July 1, 2007, the Medical Board issued Physician's and Surgeon's Certificate Number C 52906 to Ragaa Rezk Ibrahim, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2021, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
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> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
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> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.
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> (2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.
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> (d) Incompetence.
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> (e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.
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> (f) Any action or conduct that would have warranted the denial of a certificate.
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> (g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

6. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

FACTUAL ALLEGATIONS

7. Patient 1[1] was a 66-year-old female when she was hospitalized at Community Memorial Hospital in Ventura, California (CMH), after coming to the Emergency Department on March 29, 2014, complaining of severe abdominal pain, diarrhea and weakness.

8. Patient 1 had a complex medical history, which included bladder cancer with resection and neobladder, a mastectomy, Type 2 diabetes, hypertension, chronic kidney disease and depression. She was admitted to the CMH Intensive Care Unit (ICU). Patient 1 was diagnosed as suffering from sepsis, pancreatitis, kidney failure, and a urinary tract infection. Shortness of breath was noted. While she was in the ICU, she was aggressively hydrated and given antibiotics, but she became fluid overloaded due to her kidney failure. So she was given a temporary catheter for urgent hemodialysis.

9. After Patient 1 was stabilized in the ICU, she was transferred to the hospital's telemetry floor, on April 3, 2014, where she became Respondent's patient. On April 3, 2014 Respondent documented in a progress note that the patient's pancreatitis was improving, but that the renal failure was slightly worse. Respondent noted that the patient's leukocytosis persists and that she is on "high dose steroids." Respondent's plan was to advance the diet, prescribe physical therapy, a multivitamin, and hemodialysis as per nephrology.

10. At the time when Respondent received the patient in transfer from the ICU, and throughout her hospital stay, the patient's test results showed an elevated white blood cell count and bandemia, despite her being on antibiotics. There was little or no mention of this in Respondent's progress notes, except to attribute this to corticosteroid therapy, even though corticosteroids would not account for the patient's bandemia. When corticosteroids were discontinued, the elevated white blood count and bandemia persisted. Likewise, during this stay

[1] The patient is identified by a number to preserve privacy. Respondent is aware of the patient's identity, and/or the patient's identifying information will be provided to Respondent in response to a Request for Discovery.

at CMH, Patient 1 had a persistently elevated C-Reactive Protein, which is also indicative of an ongoing bacterial infection. The patient's fluid retention was evident to Respondent, and pitting edema was documented by the nursing staff. During her stay at CMH, the patient's chest imaging showed that she suffered from a pleural effusion, and pneumonia was suspected. She also needed oxygen supplementation.

11. Respondent's progress note on April 4, 2014 again noted renal failure, the pancreatitis, and leukocytosis. Respondent noted that the patient was tolerating food, but continued to have diarrhea, and remained weak. His plan was to advance the diet, follow the renal function and consider discontinuing the dialysis catheter if not needed. Respondent discontinued the hydrocortisone and prescribed DVT prophylaxis and physical therapy. A C-Reactive Protein on April 4, 2014 was 21, significantly above normal, and indicative of an ongoing infection. On that date, the nursing staff documented pitting edema, indicative of the patient's fluid overload.

12. Respondent's progress note on April 5, 2014 noted that the patient was again improving from her acute pancreatitis, while the leukocytosis persisted. Respondent noted the patient's history of diabetes, bladder and breast cancers, and weakness. Even though the patient's anemia is not discussed or noted in the record, Respondent planned to transfuse one unit of packed red blood cells, as well as to remove the right groin dialysis catheter and to send the tip for culture. Respondent did not consider or document consideration of the impact of the transfusion on the patient's hemodynamic status. At that time, the patient's C-Reactive Protein value was 19.5, which is less than previously reported value, yet still very significantly elevated. Even though the patient was significantly ill, Respondent noted an improving trend in her condition and began discharge planning. Respondent planned to continue antibiotics, and physical therapy, and wrote in the Patient's record: "If stable -> home am as per patient, family request with P.T. but ideally should go back to SNF." Thus, Respondent was planning to release the patient from hospital care to a skilled nursing facility, but the patient and her family wanted her to be released to go home. On April 5, 2014, Respondent ordered intravenous metoprolol, an anti-hypertensive, at 12.5 mg over 12 hours. Throughout her hospital stay, the patient was also

on intravenous antibiotics. She remained on intravenous antibiotics until her discharge, at which time she was switched to oral antibiotics to facilitate her discharge.

13. On April 5, 2014, shortly after 3:00 p.m. a rapid response was called because Patient 1 became unresponsive and with a blank stare, according to her husband who was at her bedside at the time. The patient had been drinking water and choked, and had a six second pause on her telemetry monitor. Respondent evaluated the patient in person, but did not document this event, or his evaluation, in the patient's medical record. Respondent prescribed metoprolol without an appropriate titration period to identify the effect on the patient's heart and patient's stability, before discharging her. Respondent's plan to discharge the patient did not change.

14. Patient 1's nursing notes on April 6, 2014 at 03:49 a.m. document that the patient completed receiving one unit of packed red cells. Respondent did not assess and did not document an assessment of the patient's hemoglobin response or the effect of giving her a fluid bolus, in the form of the blood transfusion, when the patient was suffering from very limited renal function and consequent fluid overload. At 5:00 a.m. the patient was noted by the nursing staff to be short of breath and her oxygen saturation on 2 liters of oxygen was 89-90%. The oxygen was increased to 4 liters per minute from 2 liters a minute with improvement in her oxygen saturation to 97%. Respondent ordered a bedside swallow evaluation by Speech Therapy at 08:39 a.m. Respondent's plan to discharge the patient did not change.

15. Respondent then issued a discharge order to "SNF" at 12:47 p.m on April 6, 2020. Respondent changed the manner of discharge at approximately 1:51 p.m., noting that instead of a skilled nursing facility the patient was discharged home. In making the change in the manner of discharge, Respondent did not consider and did not document a consideration of the fact that the patient would receive a different level of follow-up care at home than she would at a skilled nursing facility. Respondent did not have and did not document a discussion with the patient or the patient's family concerning the seriousness of her condition and Respondent's recommendation that she be discharged to a skilled nursing facility.

16. Even though the manner of her discharge was changed from "SNF" to "Home" based on Respondent's order, the patient and her husband were given standard discharge instructions,

that if patient experienced any fever over 101 F to call her doctor and to return to the emergency department for any concerning symptoms. There were no discharge instructions that took into account the patient's specific concerns, or that the patient was being released to a lower level of care than Respondent ordered initially. The patient was to follow up with a nephrologist with regard to her suprapubic catheter, and to see her primary care doctor in 1 week.

17. On the day of discharge, April 6, 2014, at approximately 2:00 p.m., the patient's oxygen saturation decreased to 82% with ambulation. Respondent explained to the Board investigators that he was not told about this event by the CMH nursing staff. Patient 1 left CMH to go home at approximately 5:30 p.m. Respondent did not write a progress note for April 6, 2014. He did, however, dictate a discharge summary at approximately 6:18 p.m. on April 6, 2014. In the discharge summary, Respondent made no mention of the patient's decreased oxygen saturation. Respondent documented that the patient's diagnosis at discharge was: "1) Acute on cronic renal failure requiring hemodialysis for few times; 2) Acute Pancreatitis, improved; 3) Hypertension; 4) Type 2 Diabetes; 5) Hyperlipidemia; 6) Diarrhea; 7) Generalized Weakness; 8) Episodes of vertigo; 9) Anxiety; 10) Hiatal hernia; 11) Depression; 12) Carpal tunnel syndrome; 13) History of urinary bladder cancer with status post iron surgical repair with neobladder."

18. Respondent's daily progress notes and discharge summary failed to document and fully address Patient 1's hospital problems, including urinary tract infection, leukocytosis with persistently elevated C-Reactive Protein and bandemia, telemetry pause, persistent weakness and shortness of breath coupled with imaging consistent with possible pneumonia, and the patient's fluid status. The patient had inadequate stabilization of fluid status and renal function prior to her discharge on April 6, 2014.

19. Less than 24-hours after discharge, on April 7, 2014, Patient 1 was readmitted to CMH, after her home health care nurse found her oxygen saturation was very low. The patient was transferred to CMH ICU on April 8, 2014, with respiratory failure. Patient 1 passed away at CMH ICU on April 9, 2014. The discharge diagnosis after her death was: 1) Septic shock; 2) Chronic renal insufficiency; 3) Acute renal injury with complete renal failure; 4) Pulmonary edema secondary to renal failure and fluid overload; 5) Ongoing leukocytosis; 6) History of

bladder cancer with Indiana pouch; 7) History of breast cancer; 8) Anemia secondary to renal failure, requiring transfusion; 9) Abnormal process in the mesentery thought to be possibly malignant by Radiology; 10) Pneumonia present on admission; 11) Respiratory failure secondary to pneumonia and fluid overload.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

20. Respondent Ragaa Rezk Ibrahim, M.D. is subject to disciplinary action under Business and Professions Code section 2234, subdivision (b) in that he was grossly negligent in his care and treatment of Patient 1. The circumstances are as follows:

21. The allegations of paragraphs 7-19 are incorporated herein.

22. Respondent's discharge of Patient 1 to home under the circumstances alleged herein was an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

23. Respondent Ragaa Rezk Ibrahim, M.D. is subject to disciplinary action under Business and Professions Code section 2234, subdivision (c) in that Respondent committed repeated negligent acts. The circumstances are as follows:

24. The allegations of paragraphs 7-19 are incorporated herein.

25. Respondent's discharge of Patient 1 to home under circumstances alleged herein was a departure from the standard of care.

26. Respondent's diagnosis and management of sepsis that afflicted Patient 1 was a departure from the standard of care.

27. Respondent's scant chart documentation, including omission of information from Patient 1's medical records was a departure from the standard of care.

28. Respondent's discharge instructions for Patient 1 under the circumstances constituted a departure from the standard of care.

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29. Respondent's failure to communicate the severity of Patient 1's illness and Respondent's recommendation that she be discharged to a skilled nursing facility to the Patient and/or her family, before discharging her home, was a departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Record Keeping)

30. Respondent Ragaa Rezk Ibrahim, M.D. is subject to disciplinary action under section 2266 in that Respondent failed to keep adequate and accurate records relating to the provision of services to Patient 1. The circumstances are as follows:

31. Allegations of Paragraphs 7-19 are incorporated herein by reference.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number C 52906, issued to Ragaa Rezk Ibrahim, M.D.;

2. Revoking, suspending or denying approval of Ragaa Rezk Ibrahim, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Ragaa Rezk Ibrahim, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: JUL 09 2020

WILLIAM PRASIFKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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