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.** **Physician's and Surgeon's Certificate No. C 52906** **Respondent.**	**Case No.: 800-2018-044499**

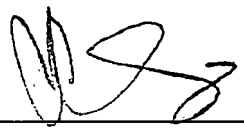
DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on January 6, 2022.

IT IS SO ORDERED: December 7, 2021.

MEDICAL BOARD OF CALIFORNIA



Laurie Rose Lubiano, J.D., Chair
Panel A

ROB BONTA
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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 OAH No. 2021020537 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Christina Sein Goot, Deputy Attorney General.

2. Respondent Ragaa Rezk Ibrahim, M.D. (Respondent) is represented in this proceeding by attorney Fredrick M. Ray, whose address is: 5000 Birch Street, Suite 7000 Newport Beach, CA 92660-2127.

3. On or about July 1, 2007, the Board issued Physician's and Surgeon's Certificate No. C 52906 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2018-044499, and will expire on July 31, 2023, unless renewed.

JURISDICTION

4. Accusation No. 800-2018-044499 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on July 9, 2020. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2018-044499 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2018-044499. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2018-044499, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent does not contest that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in Accusation No. 800-2018-044499, that he has thereby subjected his license to disciplinary action and hereby gives up his right to contest those charges.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

12. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. Respondent agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition to revoke probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2018-044499 shall be deemed true, correct and fully admitted by Respondent for purposes of any such proceeding or any other licensing proceeding involving Respondent in the State of California.

14. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or opportunity to be heard by the Respondent, issue and

enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. C 52906 issued to Respondent RAGAA REZK IBRAHIM, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years on the following terms and conditions:

1. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of

this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to

Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

5. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

6. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

7. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

8. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

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License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice ,Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

9. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

10. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar

months, Respondent shall successfully complete the Federation of State Medical Boards's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing..

11. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

12. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

13. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent

shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

14. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

15. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing action agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2018-044499 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict license.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Fredrick M. Ray. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 9/16/2021

RAGAA REZK IBRAHIM, M.D.
Respondent

[Signatures on following page]

I have read and fully discussed with Respondent Ragaa Rezk Ibrahim, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 9/16/2021

FREDRICK M. RAY, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: 09/16/2021

Respectfully submitted,

ROB BONTA
Attorney General of California
ROBERT MCKIM BELL
Supervising Deputy Attorney General

CHRISTINA SEIN GOOT
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

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Attorneys for Complainant

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 **ACCUSATION**

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:
>
> (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.
>
> (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.
>
> (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.
>
> (d) Incompetence.
>
> (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.
>
> (f) Any action or conduct that would have warranted the denial of a certificate.
>
> (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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