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

In the Matter of the Accusation Against: Ferdinand Reyes Rico, M.D. Physician's and Surgeon's Certificate No. A 114111 Respondent.	Case No. 800-2020-073967

DECISION

The attached Stipulated Surrender of License and 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 February 9, 2024.

IT IS SO ORDERED January 12, 2024.

MEDICAL BOARD OF CALIFORNIA

JENNA JONES FOR
Reji Varghese
Executive Director

1 ROB BONTA
Attorney General of California
2 MATTHEW M. DAVIS
Supervising Deputy Attorney General
3 TESSA L. HEUNIS
Deputy Attorney General
4 State Bar No. 241559
600 West Broadway, Suite 1800
5 San Diego, CA 92101
P.O. Box 85266
6 San Diego, CA 92186-5266
Telephone: (619) 738-9403
7 Facsimile: (619) 645-2061
8 *Attorneys for Complainant*
9
10 **BEFORE THE**
MEDICAL BOARD OF CALIFORNIA
11 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA
12

13 In the Matter of the Accusation Against: 14 **FERDINAND REYES RICO, M.D.** **PO Box 8508** 15 **Utica, NY 13505-8508** 16 **Physician's and Surgeon's Certificate No. A 114111** 17 Respondent.	Case No. 800-2020-073967 **STIPULATED SURRENDER OF LICENSE AND ORDER**

18
19 **IT IS HEREBY STIPULATED AND AGREED by and between the parties to the**
20 **above-entitled proceedings that the following matters are true:**

21 **PARTIES**

22 1. Reji Varghese (Complainant) is the Executive Director of the Medical Board of
23 California (Board). He brought this action solely in his official capacity and is represented in this
24 matter by Rob Bonta, Attorney General of the State of California, by Tessa L. Heunis, Deputy
25 Attorney General.

26 2. Ferdinand Reyes Rico, M.D. (Respondent) is represented in this proceeding by
27 attorney Raymond J. McMahon, Esq., whose address is: 5440 Trabuco Road, Irvine, CA 92620.
28 ////

3. On or about September 22, 2010, the Board issued Physician's and Surgeon's Certificate No. A 114111 to Respondent. That license was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2020-073967 and will expire on February 29, 2024, unless renewed.

JURISDICTION

4. On May 5, 2023, Accusation No. 800-2020-073967 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 May 5, 2023. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2020-073967 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and fully understands the charges and allegations in Accusation No. 800-2020-073967. Respondent also has carefully read, fully discussed with counsel, and fully understands the effects of this Stipulated Surrender of License and Order.

6. 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.

7. Having the benefit of counsel, Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. 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. 800-2020-073967 and that his Physician's and Surgeon's Certificate No. A 114111 is

////

therefore subject to discipline. Respondent hereby surrenders his Physician's and Surgeon's Certificate No. A 114111 for the Board's formal acceptance.

9. Respondent agrees that if he ever petitions for reinstatement of his Physician's and Surgeon's Certificate No. A 114111, all of the charges and allegations contained in Accusation No. 800-2020-073967 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 or elsewhere.

10. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate No. A 114111 without further process.

CONTINGENCY

11. Business and Professions Code section 2224, subdivision (b), provides, in pertinent part, that the Medical Board "shall delegate to its executive director the authority to adopt a ... stipulation for surrender of a license."

12. Respondent understands that, by signing this stipulation, he enables the Executive Director of the Board to issue an order, on behalf of the Board, accepting the surrender of his Physician's and Surgeon's Certificate No. A 114111 without further notice to, or opportunity to be heard by, Respondent.

13. This Stipulated Surrender of License and Disciplinary Order shall be subject to the approval of the Executive Director on behalf of the Board. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be submitted to the Executive Director for his consideration in the above-entitled matter and, further, that the Executive Director shall have a reasonable period of time in which to consider and act on this Stipulated Surrender of License and Disciplinary Order after receiving it. By signing this stipulation, Respondent fully understands and agrees that he may not withdraw his agreement or seek to rescind this stipulation prior to the time the Executive Director, on behalf of the Medical Board, considers and acts upon it.

14. The parties agree that this Stipulated Surrender of License and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the

1 Executive Director on behalf of the Board, except for this paragraph, which shall remain in full
2 force and effect. Respondent fully understands and agrees that in deciding whether or not to
3 approve and adopt this Stipulated Surrender of License and Disciplinary Order, the Executive
4 Director and/or the Board may receive oral and written communications from its staff and/or the
5 Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the
6 Executive Director, the Board, any member thereof, and/or any other person from future
7 participation in this or any other matter affecting or involving respondent. In the event that the
8 Executive Director on behalf of the Board does not, in his discretion, approve and adopt this
9 Stipulated Surrender of License and Disciplinary Order, with the exception of this paragraph, it
10 shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied
11 upon or introduced in any disciplinary action by either party hereto. Respondent further agrees
12 that should this Stipulated Surrender of License and Disciplinary Order be rejected for any reason
13 by the Executive Director on behalf of the Board, Respondent will assert no claim that the
14 Executive Director, the Board, or any member thereof, was prejudiced by its/his/her review,
15 discussion and/or consideration of this Stipulated Surrender of License and Disciplinary Order or
16 of any matter or matters related hereto.

17 **ADDITIONAL PROVISIONS**

18 15. This Stipulated Surrender of License and Disciplinary Order is intended by the parties
19 herein to be an integrated writing representing the complete, final and exclusive embodiment of
20 the agreements of the parties in the above-entitled matter.

21 16. The parties agree that copies of this Stipulated Surrender of License and Disciplinary
22 Order, including copies of the signatures of the parties, may be used in lieu of original documents
23 and signatures and, further, that such copies shall have the same force and effect as originals.

24 17. In consideration of the foregoing admissions and stipulations, the parties agree the
25 Executive Director of the Board may, without further notice to or opportunity to be heard by
26 Respondent, issue and enter the following Disciplinary Order on behalf of the Board:

27 ////

28 ////

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 114111, issued to Respondent Ferdinand Reyes Rico, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a Physician and Surgeon in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2020-073967 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. 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 agency in the State of California, all of the charges and allegations contained in Accusation No. 800-2020-073967 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 licensure.

6. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $29,576.75 (twenty-nine thousand five hundred and seventy-six dollars and 75/100) prior to issuance of a new or reinstated license.

////

////

////

1 **ACCEPTANCE**

2 I have carefully read the above Stipulated Surrender of License and Order and have fully
3 discussed it with my attorney, Raymond J. McMahon, Esq. I fully understand the stipulation and
4 the effect it will have on my Physician's and Surgeon's Certificate No. A 114111. Having the
5 benefit of counsel, I enter into this Stipulated Surrender of License and Order voluntarily,
6 knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical
7 Board of California.

8 11/14/2023 DocuSigned by: Ferdinand Rico
9 DATED: ______________ 0C9979084BCD4A0...
10 FERDINAND REYES RICO, M.D.
Respondent

11 I have read and fully discussed with Respondent Ferdinand Reyes Rico, M.D. the terms and
12 conditions and other matters contained in this Stipulated Surrender of License and Order. I
13 approve its form and content.

14 DATED: November 14, 2023 ______________
15 RAYMOND J. MCMAHON, ESQ.
Attorney for Respondent

16

17 **ENDORSEMENT**

18 The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted
19 for consideration by the Medical Board of California of the Department of Consumer Affairs.

20 DATED: November 16, 2023 Respectfully submitted,

21 ROB BONTA
Attorney General of California
22 MATTHEW M. DAVIS
Supervising Deputy Attorney General
23

24

25 TESSA L. HEUNIS
Deputy Attorney General
26 *Attorneys for Complainant*

27

28

Exhibit A

Accusation No. 800-2020-073967

ROB BONTA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General
TESSA L. HEUNIS
Deputy Attorney General
State Bar No. 241559
600 West Broadway, Suite 1800
San Diego, CA 92101
P.O. Box 85266
San Diego, CA 92186-5266
Telephone: (619) 738-9403
Facsimile: (619) 645-2061

Attorneys for Complainant

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

In the Matter of the Accusation Against:	Case No. 800-2020-073967
FERDINAND REYES RICO, M.D. **PO Box 8508** **Utica, NY 13505-8508**	**ACCUSATION**
Physician's and Surgeon's Certificate No. A 114111,	
Respondent.	

PARTIES

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

2. On or about September 22, 2010, the Medical Board issued Physician's and Surgeon's Certificate No. A 114111 to Ferdinand Reyes Rico, 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 February 29, 2024, unless renewed.

////

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 2004 of the Code states:

> The board shall have the responsibility for the following:
>
> (a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.
>
> (b) The administration and hearing of disciplinary actions.
>
> (c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.
>
> (d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.
>
> (e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.
>
> ...

5. Section 2220 of the Code states:

> Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter. The board shall enforce and administer this article as to physician and surgeon certificate holders, including those who hold certificates that do not permit them to practice medicine, such as, but not limited to, retired, inactive, or disabled status certificate holders, and the board shall have all the powers granted in this chapter for these purposes ...

6. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

////

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

...

STATUTORY PROVISIONS

7. 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.

...

COST RECOVERY

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licensee to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

////

////

FACTUAL ALLEGATIONS

9. At all relevant times, Respondent was a board-certified general surgeon with a sub-specialty in surgical critical care.

Patient 1:[1]

10. At the time of care, Patient 1 was a 32-year old morbidly obese female with a body mass index (BMI) of 54.[2] She presented to the emergency department on or about June 5, 2020, with a known history of an anterior abdominal wall hernia[3] and complaint of abdominal pain that had become significantly more painful. Patient 1 had an elevated white blood cell (WBC) count[4], and a computed tomography (CT)[5] report was concerning for incarceration and/or obstruction.

11. In his initial consultation note, Respondent documented a "recurrent incarcerated incisional hernia."[6] Respondent ordered a small bowel follow-through study, then a repeat CT scan after Patient 1's WBC count rose further, and recommended a combined bariatric operation and hernia repair.

12. The pre-operative CT scan on or about June 7, 2020, showed a six to eight centimeter abscess, indicating the altered bowel function could be due to an intra-abdominal infection.

---

[1] The identities of the patients are known to all parties but not disclosed herein for patient privacy.

[2] An incisional hernia, also called a ventral hernia, is a bulge or protrusion that occurs near or directly along a prior abdominal surgical incision. An incarcerated hernia is a hernia which is no longer reducible.

[3] Patient 1 had an umbilical hernia repair about ten years prior, followed by recurrence of the hernia. Recurrent hernia repair, approximately two years prior, had failed, leaving Patient 1 with multiple incisional hernias.

[4] The normal number of white blood cells ("WBC") in the blood is 4,500 to 11,000 WBCs per microliter (4,500 to 11.0×10^9/L). An elevated WBC count (more than 11,000 [leuko-cytosis]) can indicate the presence of (and the body's attempts to counteract) infection or inflammation, among other causes. A low WBC count (less than 4,500 [leukopenia]) can interfere with the ability to fight infection.

[5] A computed tomography (CT) scan is a procedure that uses a computer linked to an x-ray machine to make a series of detailed pictures of areas inside the body. The pictures are taken from different angles and are used to create 3-dimensional (3-D) views of tissues and organs.

[6] An incisional hernia, also called a ventral hernia, is a bulge or protrusion that occurs near or directly along a prior abdominal surgical incision. An incarcerated hernia is a hernia which is no longer reducible.

13. Patient 1 signed a consent form for "emergency exploratory laparotomy with possible bowel resection" at or around 21:39 on June 7, 2020.

14. An acute abdomen[7] with abscess requires both drainage and clarification of what caused the abscess. The source of infection must be controlled either at the first procedure or at a planned second procedure.

15. Just after midnight on or about June 8, 2020 (the first procedure), Respondent performed an open abdominal exploration, took down adhesions, reduced the small and large bowel from the hernia, removed two areas of small bowel, and washed out the abscess. In his operative note, dictated immediately post-operatively, Respondent does not describe a search for the origin of the abscess, noting only that he drained it: "In the middle of the dissection there was a pocket of abscess noted in the right side lower part of the hernia. This was suctioned around 250 ml and swabbed for culture sensitivity." This operation took three hours and two minutes, and finished with a temporary abdominal closure.

16. In reality, the source of the abscess was Patient 1's perforated appendix. Respondent neither identified the source of the abscess nor removed it. Instead, Respondent removed at least 175 cm of small bowel, to no clear purpose.

17. Respondent's plan, after the first procedure, was to "return to the OR Tuesday morning [June 9, 2020] for definitive hernia repair with component separation."

18. At or around 20:00 on June 8, 2020, Respondent obtained telephone consent from Patient 1's mother for a second operation, namely, "abdominal reexploration, possible bowel resection, possible hernia repair and related procedures."

19. Respondent performed the second operation on or about June 9, 2020 (the second procedure). His findings included a perforated appendix with adjacent cecal inflammation, and he removed Patient 1's appendix. Respondent also removed another segment of small bowel for

////

[7] An acute abdomen is a condition that demands urgent attention and treatment. The acute abdomen may be caused by an infection, inflammation, vascular occlusion, or obstruction. The patient will usually present with sudden onset of abdominal pain with associated nausea or vomiting.

"some ischemia[8] of the proximal small bowel stump" and did a right hemicolectomy, a primary anastomosis.[9] Respondent also noted, "On inspection of the lesser sac there was an abscess collection as well involving the posterior part of the stomach with inflammation and questionable ischemia," and he responded to this by doing a partial gastrectomy and omentectomy.[10] Respondent also believed the gallbladder to be inflamed, so he removed it. This operation took four hours and three minutes, and finished with a temporary abdominal closure.

20. With an initially neglected perforation of the appendix and diffuse peritonitis, the gallbladder could be expected to look (and be) secondarily inflamed. It is unlikely that it was sufficiently inflamed to warrant removal. In addition, Respondent had already planned abdominal reexploration "for definitive hernia repair with component separation" and abdominal closure. Any serious question about Patient 1's gallbladder should have waited and been reconsidered at the next operation.

21. The partial gastrectomy, too, was unnecessary and an ultra-high-risk procedure in the critically ill Patient 1. The neglected perforation of the appendix and diffuse peritonitis would also have caused secondary inflammation of the stomach. The stomach has a dual and robust blood supply, and ischemia of the stomach is vanishingly rare in all circumstances. If Respondent believed there was "questionable ischemia," he should have waited and looked at it again at the upcoming re-exploration.

22. Respondent performed a third operation on Patient 1 on or about June 10, 2020, and a fourth operation on or about June 22, 2020.

////

////

[8] Ischemia is a deficient supply of blood.

[9] A right hemicolectomy involves removing the right side of the colon and attaching the small intestine to the remaining portion of the colon. Connecting these structures is referred to as an anastomosis.

[10] A partial gastrectomy is the removal of the lower part of the stomach. An omentectomy is removal of all or part of the omentum. (The omentum is a fold of fatty tissue inside the abdomen that surrounds the stomach, large intestine and other abdominal organs.)

Patient 2:

23. At the time of care, Patient 2 was a 75-year old obese man with a BMI of 32.2. Patient 2 had a background of severe chronic obstructive pulmonary disease, congestive heart failure, and alcoholic cirrhosis of the liver (while continuing to smoke tobacco and drink alcohol). Patient 2 was on an anticoagulant for bilateral lower extremity deep venous thrombosis.

24. On or about September 9, 2020, Patient 2 presented to the ER with "multiple falls in the past week," and reported falling "at least four times" that day. He was found to have abdominal pain and a CT scan showed a sigmoid colon mass without signs of obstruction.

25. Patient 2 was admitted in the early morning of September 10, 2020. A colonoscopy on or about September 13, 2020, revealed a rectosigmoid colon mass. A biopsy confirmed "moderately differentiated invasive adenocarcinoma."

26. Most rectosigmoid colorectal cancers require surgery. When a rectosigmoid cancer is inoperable, a palliative loop colostomy is often done for impending obstruction. Urgent major cancer resections should be avoided in the sickest patients.

27. Patient 2 was able to tolerate the purgative 'bowel prep' for his colonoscopy, indicating his colon was not obstructed to liquids. During the colonoscopy, the gastroenterologist was able to pass the scope through the tumor and all the way up to the cecum; consequently, solid feces of the same diameter as the scope could also pass the tumor. The gastroenterologist described Patient 2's tumor as "partially obstructing."

28. A second CT scan, performed on or about September 14, 2020, also showed a large but non-obstructing sigmoid colon mass.

29. Respondent was consulted on or about September 14, 2020. In his "general surgery consultation" dated September 14, 2020, Respondent documented his plan as follows:

> "Patient with significant co-morbidities; will discuss with family if the[y] would like to proceed with surgery – if so, would do laparoscopic low anterior sigmoid resection, possible open during this admission."

30. On or about September 15, 2020, before committing to surgery, Patient 2 had a palliative care consultation with discussion of goals of care, attended by Patient 2's daughter and the medical team, including Respondent. The relevant note in Patient 2's chart states:

"[Respondent] explained that [Patient 2's] biopsy has come back positive for cancer and that the mass that was biopsied is obstructive, resulting in difficulty with the patient's ability to have bowel movements. [Respondent] recommended a palliative open colectomy[11] with colostomy[12] placement and a feeding tube." (Emphasis added.)

31. Respondent's documented "Comprehensive Assessment/Plan" for the surgery, dated September 17, 2020, included "palliative surgery pending: open colostomy" (emphasis added), an alternative and less ambitious operation than previously noted.

32. Patient 2 was sick when he presented to the ER on or about September 9, 2020, and he became sicker in the ensuing nine (9) days. His nutritional state also worsened during that time.

33. Notwithstanding the prior plan for a palliative open colostomy on Patient 2, on or about September 18, 2020, consent was obtained for a more complex "open proctocolectomy,[13] colostomy, Stamm gastrostomy and related procedures." On the same date, Respondent did an open exploration of Patient 2's abdomen, assisted by another surgeon.

34. In his operative report, Respondent describes his initial exploration and three separate discoveries that made removing the tumor from Patient 2 more difficult and the operation more dangerous.

First, he "encountered multiple matted tissues":

'Large mass was noted to be adherent to the urinary bladder and circumferentially to the right and pelvic without any enough space for dissection due to huge size ... Encountered multiple matted tissues."

Second, Respondent noted that the mass was in the rectum rather than the sigmoid colon, as previously believed.

////

////

////

[11] A colectomy is a procedure to remove all or part of the colon.

[12] A colostomy is a surgical operation in which a piece of the colon is diverted to an artificial opening in the abdominal wall so as to bypass a damaged part of the colon.

[13] A proctocolectomy is a surgical procedure to remove the colon and the rectum.

Third, Respondent noted his belief that the tumor involved bladder and ureter,[14] and that to remove the tumor he would have to resect parts of these structures and do a complex reconstruction.

35. When intraoperative findings make an operation too high-risk, a surgeon must change plans intraoperatively. A temporizing proximal loop colostomy is an effective 'bailout option' for a rectosigmoid tumor resection that proves too difficult or dangerous.

36. Respondent proceeded with his plan to remove the tumor. He performed an open low anterior rectosigmoid resection, with removal of part of the bladder and the distal right ureter. He made an end descending colostomy, repaired the bladder, and hooked up the remnant right ureter to the undamaged left ureter. He also made a gastrostomy for post-operative feeding.

Patient 3:

37. At the time of care, Patient 3 was a 58-year old woman with a history of renal failure (on dialysis) and peptic ulcer disease. She was admitted to hospital on or about June 9, 2020, with a gastric ulcer and bleeding from an epiphrenic diverticulum. Endoscopic attempts to fix Patient 3's bleeding were unsuccessful.

38. Consent for surgical procedures should use detailed, descriptive and understandable language. The words "exploratory" and "exploration" are used in situations of diagnostic uncertainty and allow the surgeon to exercise intraoperative judgment. Whenever possible, this should be qualified by wording that narrows the scope and states what is likely to be done.

39. On or about June 17, 2020, due to Patient 3's bleeding and inability to eat, Respondent obtained Patient 3's consent for "exploratory laparotomy; hiatal hernia repair with fundoplication, possible mesh; truncal vagotomy, antrectomy; Billroth II Roux-en-Y jejunostomy, incisional hernia repair with mesh." On the same date, he operated on Patient 3 (the first procedure).

40. Four days later, on or about June 21, 2020, Respondent performed a second procedure on Patient 3. Respondent documented the indications for the second procedure as follows:

---

[14] Pathology would subsequently show that Patient 2's bladder and ureter were tumor-free.

> Postoperatively [after the first procedure] the patient is very stable but on testing for Gastrografin esophagram patient has delayed transit time of the esophagus. Differential diagnosis may be a tight fundoplication, tight crura plasty, or with her pre-existing epiphrenic diverticulum, she may have a form of mild achalasia in the distal LES or high-pressure LES. She consented after discussion of options risks and benefits of the contemplated procedure.

The consent obtained from Patient 3 for the second procedure was for "abdominal re-exploration."

41. During the second procedure, on or about June 21, 2020, Respondent released the Toupet fundoplication sutures (placed during the first procedure), did a Heller myotomy (release of lower esophageal sphincter muscle), performed a Dor fundoplication (another antireflux procedure), then had his colleague put a scope into the stomach directly to examine it from the inside, then scoped via the mouth to look at the esophageal repair, then used the scope hole to create a gastrostomy, and finished the operation by placing a wound VAC.

42. Five days later, on or about June 26, 2020, Respondent performed a third procedure on Patient 3. Respondent documented the indications for the third procedure as follows:

> 58 female postop for surgical repair of epiphrenic diverticulum, gastric ulcer surgery, and incisional hernia repair. Postoperatively complicated with wound VAC sponge bowel perforation.
>
> Emergent exploration ensued. Patient consented after discussion of options risks and benefits of the contemplated procedure.

The consent obtained from Patient 3 for the third procedure was for "exploration of abdominal wound with possible exploratory laparotomy."

43. During the third procedure, on or about June 26, 2020, Respondent irrigated and debrided, did a small bowel resection for perforation, and performed a damage-control closure, leaving the wound open with an ABTHERA™ suction[15] setup (the third procedure).

44. Patient 3 then leaked and bled from the transgastric scope exam/gastrostomy site, and a fourth procedure was performed on or about June 27, 2020 (the fourth procedure). The consent obtained for this fourth procedure on Patient 3 provides for "emergency abdominal exploration."

////

---

[15] ABTHERA™ Open Abdomen Negative Pressure Therapy is a temporary abdominal closure system where primary closure is not possible and/or repeated abdominal entries are necessary. It allows for rapid access for re-entry and does not require sutures for placement.

45. During the fourth procedure, Respondent took down the gastrostomy, with the site being stapled closed. Necrotic material (including omentum) was debrided, and the abdomen was left open again using ABTHERA™ suction.

46. On or about June 28, 2020, Respondent performed a fifth procedure. Respondent documented the indications for this as follows:

> 58-year-old female patient with multiple surgeries and had a bowel perforation while on the floor. Underwent emergent surgery for bowel perforation and leak of stool on the subcutaneous fascial level. In the ICU postop patient was found to have exudative pericardial effusion per Dr Ashtiani. Plan to connect all the intestine and stomach with fascial closure. Has been consented after discussion of options risks and benefits of the contemplated procedure.

The consent obtained for this fifth procedure on Patient 3 was for "abdominal exploration, possible closure."

47. During the fifth procedure, Respondent did a loop gastrojejunostomy[16] to enhance gastric drainage, then debrided wound edges and closed the abdomen.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

48. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patient 1, as more fully set out in paragraphs 9 through 47, above, which are hereby realleged and incorporated by this reference as if fully set forth herein, and that include, but are not limited to:

49. On or about June 9, 2020, Respondent removed one or more organs unnecessarily in his operation on the critically ill Patient 1.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

50. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent

[16] Gastrojejunostomy is a surgical procedure in which an anastomosis or connection is created between the stomach and the proximal loop of the jejunum.

acts in his care and treatment of Patient 1, Patient 2, and/or Patient 3, as more fully set out in paragraphs 9 through 47 above, which are hereby realleged and incorporated by this reference as if fully set forth herein, and that include, but are not limited to:

51. Paragraph 49, above, is realleged and incorporated by this reference as if fully set forth herein.

52. On or about June 8, 2020, Respondent failed to identify and control the source of Patient 1's infection and/or her acute abdomen.

53. On or about September 18, 2020, in his care and treatment of the very ill Patient 2, whose colon was not obstructed, Respondent attempted curative resection of Patient 2's rectosigmoid tumor on an urgent basis.

54. On or about September 18, 2020, when intraoperative findings revealed an elevated risk in removing the tumor from Patient 2, Respondent failed to bail out and terminate the exploration with a palliative diverting loop colostomy.

55. On or about June 21, 2020, Respondent failed to obtain Patient 3's informed consent for her second procedure.

56. On or about June 26, 2020, Respondent failed to obtain Patient 3's informed consent for her third procedure.

57. On or about June 27, 2020, Respondent failed to obtain Patient 3's informed consent for her fourth procedure.

58. On or about June 28, 2020, Respondent failed to obtain Patient 3's informed consent for her fifth procedure.

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 No, A 114111, issued to Respondent Ferdinand Reyes Rico, M.D.;

2. Revoking, suspending or denying approval of Respondent Ferdinand Reyes Rico, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Ferdinand Reyes Rico, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

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

DATED: MAY 0 5 2023

Jenna Jones for
REJI VARGHESE
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant