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

In the Matter of the Accusation Against: Yasser El-Wahidy Farrag, M.D. Physician's and Surgeon's Certificate No. A 81307 Respondent.	Case No. 800-2022-085069

DECISION

The attached Stipulated Surrender of License 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 December 23, 2025.

IT IS SO ORDERED December 16, 2025.

MEDICAL BOARD OF CALIFORNIA

Reji Varghese
Executive Director

ROB BONTA
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Attorneys for the People

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

In the Matter of the Accusation Against: **YASSER EL-WAHIDY FARRAG, M.D.** **2300 Pacific Avenue, Unit 304** **San Francisco, CA 94115** **Physician's and Surgeon's Certificate No. A 81307,** Respondent.	Case No. 800-2022-085069 OAH No. 2025020770 **STIPULATED SURRENDER OF LICENSE 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. Reji Varghese (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 Keith C. Shaw, Deputy Attorney General.

2. Yasser El-Wahidy Farrag, M.D. (Respondent) is represented in this proceeding by attorney Jeffrey A. Walker, Esq., whose address is: 10832 Laurel Street, Suite 204, Rancho Cucamonga, CA 91730-7690.

3. On or about December 4, 2002, the Board issued Physician's and Surgeon's Certificate No. A 81307 to Respondent. That license was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2022-085069 and expired on December 31, 2024, and is presently in delinquent status.

JURISDICTION

4. Accusation No. 800-2022-085069 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 January 10, 2025. Respondent filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2022-085069 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2022-085069. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Disciplinary 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 understands that the charges and allegations in Accusation No. 800-2022-085069, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

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9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent gives up his right to contest that, at a hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations contained in the Accusation.

10. Respondent agrees that if an accusation is ever filed against him before the Medical Board of California, all of the charges and allegations contained in Accusation No. 800-2022-085069 shall be deemed true, correct, and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

11. 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 without further process.

CONTINGENCY

12. 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."

13. 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 81307 without further notice to, or opportunity to be heard by, Respondent.

14. 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.

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

ADDITIONAL PROVISIONS

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

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

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

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 81307, issued to Respondent Yasser El-Wahidy Farrag, 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. 800-2022-085069 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $55,839.00 prior to issuance of a new or reinstated license.

6. 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. 800-2022-085069 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.

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ACCEPTANCE

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

DATED: 11/26/2025

YASSER EL-WAHIDY FARRAG, M.D.
Respondent

I have read and fully discussed with Respondent Yasser El-Wahidy Farrag, M.D., the terms and conditions and other matters contained in this Stipulated Surrender of License and Disciplinary Order. I approve its form and content.

DATED: 11/26/25

JEFFREY A. WALKER, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: 11/26/2025

Respectfully submitted,

ROB BONTA
Attorney General of California
ALEXANDRA M. ALVAREZ
Supervising Deputy Attorney General

Keith Shaw

KEITH C. SHAW
Deputy Attorney General
Attorneys for Complainant

SF2024304708

Exhibit A

Accusation No. 800-2022-085069

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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: **YASSER EL-WAHIDY FARRAG, M.D.** **2300 Pacific Avenue, Unit 304** **San Francisco, CA 94115** **Physician's and Surgeon's Certificate No. A 81307,** Respondent.	Case No. 800-2022-085069 **ACCUSATION**

PARTIES

1. Reji Varghese (Complainant) 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 December 4, 2002, the Medical Board issued Physician's and Surgeon's Certificate No. A 81307 to Yasser El-Wahidy Farrag, 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 expired on December 31, 2024, and has not been 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 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.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

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STATUTORY PROVISIONS

5. Section 2234 of the Code states, in part:

"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:

"..."

"(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.

"(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.

"..."

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."

7. Section 2229 of the Code states that the protection of the public shall be the highest priority for the Board in exercising their disciplinary authority. While attempts to rehabilitate a licensee should be made when possible, Section 2229, subdivision (c), states that when rehabilitation and protection are inconsistent, protection shall be paramount.

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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.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct: Gross Negligence)

9. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of Patients C, H, J, K, and W,[1] as more particularly alleged hereinafter:

PATIENT C

10. On or about May 29, 2021, Patient C, a then 69-year-old female, presented to the emergency department at Sutter Coast Hospital for urinary retention, as well as confusion. Patient C had a history of diabetes mellitus type 2 (DM2), congestive heart failure, hypertension, chronic kidney disease, obstructive sleep apnea, and esophageal reflux disease. Patient C was admitted to the hospital due to encephalopathy, urinary tract infection, acute kidney injury (AKI), and respiratory failure. Her blood pressure was low requiring fluid resuscitation but recovered with treatment. Patient C initially required intubation but was extubated on or about June 3, 2021.

11. On or about June 8, 2021, Respondent, a hospitalist at Sutter Coast Hospital specializing in internal medicine, began treating Patient C during her hospital admission. Patient C was noted to be confused and hallucinating, which was not fully addressed by Respondent. Patient C's systolic blood pressure measured as high as approximately 170. Medications included

[1] The patients listed in this document are unnamed to protect their privacy. Respondent knows the names of the patients and can confirm their identity through discovery. All patient care occurred at Sutter Coast Hospital.

peripheral parental nutrition, scopolamine transdermal patch, insulin, famotidine, DuoNeb, Synthroid, polyethylene powder, aspirin, fluoxetine, heparin, and senna.

12. Respondent's assessment notes included acute respiratory failure due to obesity hyperventilation syndrome, DM2, AKI, and post-intubation/extubation dysphagia. Respondent also diagnosed Patient C as having an altered mental status likely due to polypharmacy, but it is not clarified how he arrived at this conclusion as the patient was given the same medications as the previous day, and more medications were added the following day. Neurological exam notes indicated Patient C was awake, alert, and grossly non-focal. Respondent's plan included initiating Zyprexa and Ativan for altered mental status, peripheral parenteral nutrition for dysphagia, oxygen supplementation, and DuoNeb for respiratory issues and monitoring.

13. On or about June 9, 2021, Respondent noted that Patient C refused all treatment and blood draws. Medications were largely unchanged from the previous day except for the addition of Zyprexa. Vitals were noted from June 7-8, 2021. The exam notes were identical as the previous day, as were the assessment notes apart from resolving the altered mental status.

14. On or about June 10, 2021, Respondent noted that Patient C was alert and oriented but had pulled out her intravenous fluids (IVF). Medications listed were largely unchanged from the previous day with the exception of adding hydralazine to manage hypertension.[2] Vitals were again recorded from June 7-8, 2021. The exam was also noted as identical from the previous day. Respondent noted resolved conditions included acute respiratory failure and altered mental status.

15. On or about June 11, 2021, Respondent noted that Patient C developed an altered mental state. Her listed medications were largely unchanged from the previous day with the exception of adding lisinopril to treat hypertension. The vitals were taken from June 7-8, 2021. The exam was also noted as the previous day, and the neurological exam was noted as normal despite Patient C being in an altered mental state. Patient C was placed back on BiPap (a

[2] Respondent started the patient on hydralazine 100 mg (twice daily); however, hydralazine is not recommended for the initial management of hypertension. Further, hydralazine is indicated to be administered four times daily to treat high blood pressure when acting as a single agent, as twice daily is ineffective.

noninvasive mechanical ventilation device) and transferred to the Intensive Care Unit (ICU) for acute respiratory failure due to obesity hypoventilation syndrome.

16. Following transfer to the ICU, Patient C was determined to have transitioned to a terminal stage. Respondent issued orders for DNR/DNI (Do Not Revive/Do Not Intubate) and comfort care pursuant to his discussion with Patient C's daughter. However, there was no record that Respondent placed any medication orders to manage Patient C's air hunger, dyspnea, or anxiety, which would have caused the patient to suffer prior to passing and not be consistent with the goals of comfort care. Another physician placed orders for morphine and lorazepam for comfort care, and Patient C was administered multiple doses of both medications prior to passing on or about June 12, 2021.

17. During the time Respondent treated Patient C, essential details were missing from his documentation, including updated vitals and the daily oxygen requirement for a patient with acute hypoxic respiratory failure. Additionally, many of Respondent's notes were cut and pasted from the previous day, which would have made it difficult for another covering hospitalist to properly understand the patient's current condition and provide appropriate treatment.[3] Further, Respondent's notes included conflicting information and abnormal findings which were not fully addressed. Finally, change of plans were not fully explained, such as the addition of hydrazine.

18. Respondent committed unprofessional conduct and is subject to disciplinary action under section 2234, subdivision (b), of the Code in that Respondent was grossly negligent in his care and treatment of Patient C, including but not limited to the following:

a) Respondent failed to keep adequate and accurate documentation; and

b) Respondent failed to appropriately initiate comfort care in a hospital setting.

PATIENT H

19. On or about August 4, 2021, Patient H, a then 41-year-old female, was admitted to the hospital due to morbid obesity, acute hypoxic respiratory failure, Covid-19 pneumonia and

[3] Hospitalists, such as Respondent, work in shifts, which make it essential that timely, adequate, and accurate documentation is maintained for the nighttime hospitalist to appropriately treat the patient.

sepsis. She was started on remdesivir to treat Covid-19 and dexamethasone to treat inflammation. It was noted her oxygen saturation was declining.

20. On or about August 6, 2021, Respondent began treating Patient H during her hospitalization. Respondent noted Patient H to be "SOB on O2" (short of breath and on oxygen). Medications included were benzonatate, codeine/guaifenesin, remdesivir, dexamethasone, Lovenox, and Zofran. The vitals for Patient H in the past 24 hours were notable for oxygen saturation in the 70s and 80s. The physical exam was within normal limits. Respondent's assessment included acute respiratory failure due to bilateral Covid-19 pneumonitis and his plan was to use high oxygen levels, remdesivir, decadron and Lovenox. On the same day, an overnight hospitalist noted that oxygen supplementation was required and intubation was considered.

21. Respondent saw Patient H each day from approximately August 6, 2021, through August 14, 2021. His notes were largely cut and pasted from the previous day, making it difficult for a covering hospitalist to discern the current condition of the patient. For instance, there was inconsistent information about which medications the patient was currently taking, as dexamethasone was off the medication list the last day Respondent saw Patient H, but his plan still included the use of dexamethasone. Further, Respondent did not fully explain management of medication doses, including increasing the dosage of Lovenox. Additionally, Patient H showed concerning signs for potential respiratory failure, as she was consistently on high flow oxygen or a non-breather oxygen mask, yet Respondent failed to consult a pulmonary specialist for consideration of additional treatment options, including possible intubation or mechanical ventilation.[4]

22. On each visit, Respondent noted that Patient H's physical exam was within normal limits, yet conflictingly noted that her condition began worsening with shortness of breath and she would be monitored for a potential transfer to the ICU on or about August 7, 2021, leading Respondent to call the patient's husband the following day to discuss her "poor prognosis."

[4] On or about August 7, 2021, an overnight hospitalist obtained pulmonary consultation, yet Respondent failed to do so.

Respondent then cut and pasted this note about the patient's worsening condition, ICU monitoring, and discussing her poor prognosis for each visit thereafter, even though the patient was showing signs of improvement on or about August 12, 2021.[5] Another hospitalist took over care of Patient H the following day and she was noted to improve clinically. On or about August 17, 2021, Patient H was discharged with home oxygen.

23. Respondent committed unprofessional conduct and is subject to disciplinary action under section 2234, subdivision (b), of the Code in that Respondent was grossly negligent in his care and treatment of Patient H, including but not limited to the following:

a) Respondent failed to keep adequate and accurate documentation; and

b) Respondent failed to seek pulmonary consultation for impending respiratory failure.

PATIENT J

24. On or about January 14, 2021, Patient J, a then 19-year-old male with a history of diabetes mellitus, type 1, presented to the emergency department with a fever, malaise, and shortness of breath. He was found to be in diabetic ketoacidosis (DKA).[6]

25. Respondent saw Patient J the same day and admitted him to the hospital. Patient J reported he had not been taking insulin for two weeks, but Respondent noted it had only been two days. Respondent's assessment included DKA and hypokalemia[7] (with multiple serum potassium levels at or below 3.3) with a plan for admission to the ICU with IVF, insulin drip, and potassium to be replaced and rechecked. Respondent did not address abnormal findings found in a chest X-ray, leukocytosis, and urinalysis, which could have been potential causes for DKA if an infection was present. Additionally, even though Respondent indicated potassium would be replaced, there

[5] Patient H was transferred to the ICU between approximately August 10-11, 2021, then returned to less intensive care thereafter.

[6] Diabetic ketoacidosis is a serious and potentially life-threatening complication of diabetes that occurs when the body doesn't have enough insulin.

[7] Hypokalemia, or low potassium levels in the blood, significantly increases the risk of cardiac arrhythmia.

were no such orders placed by Respondent. Instead, another hospitalist placed the potassium replacement orders. Patient J was discharged the following day with insulin prescriptions.

26. Respondent committed unprofessional conduct and is subject to disciplinary action under section 2234, subdivision (b), of the Code in that Respondent was grossly negligent in his care and treatment of Patient J, including but not limited to the following:

a) Respondent failed to appropriately place potassium replacement orders for the management of hypokalemia in DKA.

PATIENT K

27. On or about December 24, 2020, Patient K, a then 70-year-old male visiting from out-of-state, presented to the emergency department with a fever and shortness of breath. He was found to be hypoxic due to Covid-19 and required a high level of oxygen supplementation.

28. Respondent saw Patient K the same day and admitted him to the hospital. His vitals were listed within normal range, but he was noted to be in moderate respiratory distress.[8] Respondent's assessment included bilateral pneumonitis likely due to Covid-19 and shortness of breath with hypoxemia, and the plan included IV Decadron, Lovenox, remdesivir, vitamins C and B, zinc, oxygen supplementation, and negative room isolation.

29. On or about December 25, 2020, Patient K was transferred to the ICU due to profound hypoxia. Respondent saw Patient K shortly after and noted shortness of breath. Patient K's medications included dexamethasone, Lovenox, azithromycin, ceftriaxone, normal saline, acetaminophen, ascorbic acid, atorvastatin, aspirin, Dulcolax, cholecalciferol, lorazepam, milk of magnesia, melatonin, morphine, Zofran, polyethylene glycol, senna, thiamine, and zinc sulfate. Vitals were unremarkable but no oxygen level was documented, even though the patient was noted to be in moderate respiratory distress. The assessment included acute hypoxic respiratory failure due to bilateral Covid-19 pneumonia and a history of salivary gland cancer, as well as rheumatoid arthritis. Respondent's plan included IV Decadron, Lovenox at therapeutic dose, remdesivir, vitamins C and B, zinc, ICU monitoring, high flow oxygen, and negative room

[8] Despite Patient K being at an elevated risk for respiratory failure due to being in moderate respiratory distress, Respondent failed to consult a pulmonary specialist for consideration of additional treatment and diagnostic options, as well as transfer to the ICU.

isolation. While Patient K's medications included antibiotics, as well as remdesivir for Covid-19 pneumonia, no explanation was provided.

30. Respondent saw the patient each day from approximately December 26, 2020, through December 30, 2020. Respondent's notes were largely cut and pasted from the previous day, making it difficult for a covering hospitalist to discern the current condition of the patient. On each visit, Respondent noted outdated vitals from December 24-25, 2020, and the assessment and plan largely mirrored the previous day. On each occasion, Patient K was noted to be in moderate respiratory distress and on high flow oxygen. On or about December 29, 2020, critical condition was discussed with the patient's wife.

31. Respondent next documented seeing Patient K each day from approximately January 10, 2021, through January 14, 2021. However, the progress notes for each of these days were not created until on or about January 14, 2021, calling into question whether covering hospitalists had any notes to rely on during this period. Again, Respondent's notes were largely cut and pasted from each previous day. On or about January 13, 2021, Respondent noted that Patient K was intubated, but lacked any details about this critical event. Respondent also noted a discussion with the patient's family about poor prognosis.

32. On or about January 14, 2021, another hospitalist was contacted to assist in Patient K's care and issued a discharge summary due to not being able to reach Respondent. Patient K was noted to have multiple hematomas and nosebleeds, therefore, a disseminated intravascular coagulation (DIC)[9] panel was ordered. Cefepime (an antibiotic) was added for dual antipseudomonal coverage in the respiratory culture from approximately January 7, 2021. A repeat CT scan revealed worsening infiltrates (substance that accumulates in the lungs) and increased density in the lungs with desaturation without any movement and 85% FiO2 (fraction of inspired oxygen). Patient K's wife requested he be transferred to a higher level of care and conveyed that she had been making the same request previously during his admission. Given the severity of Patient K's condition, it was determined he would benefit from pulmonary/critical

[9] DIC is a rare but serious condition that causes abnormal blood clotting throughout the body.

care and a higher level ICU.[10] A request for transfer was made and a bed at Providence Medford was secured in two hours. Respondent also noted a discharge summary for Patient K's transfer, which was not signed until the following day.

33. Respondent committed unprofessional conduct and is subject to disciplinary action under section 2234, subdivision (b), of the Code in that Respondent was grossly negligent in his care and treatment of Patient K, including but not limited to the following:

a) Respondent failed to keep timely, adequate and accurate documentation;

b) Respondent failed to seek pulmonary consultation for impending respiratory failure; and

c) Respondent failed to appropriately consider and discuss with the patient or his family transfer to a different hospital that could provide a higher level of care given the lack of on-site pulmonary/critical care.

PATIENT W

34. On or about August 6, 2021, Patient W, a then 67-year-old male with a history of hypertension, diabetes, and left ventricle issues, presented to the emergency department in an altered mental state from Pelican Bay Prison. He was determined to have a Glasgow Coma Scale (GCS)[11] score of 3 and required emergency intubation. A CT chest scan revealed pulmonary edema.[12] Patient W then became hypotensive without improvement upon saline. Patient W was admitted for pneumonia, possible congestive heart failure, as well as possible non-ST elevation myocardial infarction (NSTEMI).

35. Following admission, Sutter Coast Hospital received a Physician Orders for Life-Sustaining Treatment (POLST) from the prison indicating Patient W was on DNR/comfort care

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[10] Given that Sutter Coast Hospital did not have an on-site pulmonary/critical care unit, in conjunction with the request of Patient K's wife for transfer to a higher level of care, the option for transfer should have at least been discussed and explored with the patient or his wife.

[11] A GCS score of 3 indicates the lowest possible level of consciousness, meaning a patient is completely unresponsive and in a deep coma, and often associated with a very poor prognosis and high mortality rate.

[12] Pulmonary edema is a condition where fluid builds up in the lungs, making it difficult to breathe normally.

measures only. Respondent confirmed goals of care with the prison physician and ordered extubation. Despite nursing staff attempting to contact Respondent for orders regarding pain and air hunger, there was no record that Respondent placed any medication orders to manage Patient W's air hunger or pain. Respondent noted Patient W would be transferred back to prison for comfort care; however, comfort care orders should have initiated as soon as the patient was placed on comfort care.

36. On the same day, Respondent noted Patient W was intubated and sedated. Respondent's discharge summary was copied and pasted from another hospitalist's history and physical. While Respondent noted the patient had a poor prognosis and would be transferred back to the prison for comfort care, there lacked any documentation of a terminal diagnosis within the discharge summary and no explanations were provided.

37. Respondent committed unprofessional conduct and is subject to disciplinary action under section 2234, subdivision (b), of the Code in that Respondent was grossly negligent in his care and treatment of Patient W, including but not limited to the following:

a) Respondent failed to appropriately initiate comfort care in a hospital setting.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

38. 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 acts in his care and treatment of Patients C, H, J, K, and W, as more particularly alleged herein.

PATIENT C

39. Respondent committed repeated negligent acts in his care and treatment of Patient C, which included, but was not limited to, the following:

(a) Paragraphs 10 through 18, above, are hereby incorporated by reference and realleged as if fully set forth herein; and

(b) Respondent improperly managed the patient's hypertension in a hospital setting.

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PATIENT H

40. Respondent committed repeated negligent acts in his care and treatment of Patient H, which included, but was not limited to, the following:

(a) Paragraphs 19 through 23, above, are hereby incorporated by reference and realleged as if fully set forth herein.

PATIENT J

41. Respondent committed repeated negligent acts in his care and treatment of Patient J, which included, but was not limited to, the following:

(a) Paragraphs 24 through 26, above, are hereby incorporated by reference and realleged as if fully set forth herein; and

(b) Respondent failed to keep adequate and accurate documentation.

PATIENT K

42. Respondent committed repeated negligent acts in his care and treatment of Patient K, which included, but was not limited to, the following:

(a) Paragraphs 27 through 33, above, are hereby incorporated by reference and realleged as if fully set forth herein.

PATIENT W

43. Respondent committed repeated negligent acts in his care and treatment of Patient W, which included, but was not limited to, the following:

(a) Paragraphs 34 through 37, above, are hereby incorporated by reference and realleged as if fully set forth herein; and

(b) Respondent failed to keep adequate and accurate documentation.

THIRD CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

44. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that Respondent failed to maintain adequate and accurate records regarding his care and treatment of Patients C, H, J, K, and W, as more particularly

alleged in paragraphs 10 through 43, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence)

45. 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, as more particularly alleged hereinafter:

46. Respondent was hired as a hospitalist for Sutter Coast Hospital in approximately 2020. During the credentialing process, Respondent submitted four peer references. On or about December 29, 2021, it was discovered that Respondent submitted incorrect phone numbers (each off by a single digit) and incorrect email addresses for each of his four peer references. It was determined that Respondent submitted false peer refences and his hospital privileges were suspended.

47. Respondent committed gross negligence which included, but was not limited to, the following:

(a) Respondent provided false peer references during the credentialing process at Sutter Coast Hospital.

FIFTH CAUSE FOR DISCIPLINE

(Dishonesty)

48. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (e), of the Code, in that he committed an act involving dishonesty, as more particularly alleged in paragraphs 45 through 47, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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 81307, issued to Respondent Yasser El-Wahidy Farrag, M.D.;

2. Revoking, suspending or denying approval of Respondent Yasser El-Wahidy Farrag, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Yasser El-Wahidy Farrag, 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: JAN 10 2025

REJI VARGHESE
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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