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

In the Matter of the Accusation Against: Hesham Mohamed El Mokadem, M.D. Physician's & Surgeon's Certificate No A107687 Respondent	Case No. 800-2018-041705

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 March 10, 2021.

IT IS SO ORDERED February 8, 2021.

MEDICAL BOARD OF CALIFORNIA

By: Ronald H. Lewis, MD

Ronald H. Lewis, M.D., Chair
Panel A

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
REBECCA L. SMITH
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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: **HESHAM MOHAMED EL MOKADEM, M.D.** **3975 Jackson Street, Suite 110** **Riverside, California 92503** **Physician's and Surgeon's Certificate No. A 107687,** Respondent.	Case No. 800-2018-041705 OAH No. 2020060404 **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 Xavier Becerra, Attorney General of the State of California, by Rebecca L. Smith, Deputy Attorney General.

2. Respondent Hesham Mohamed El Mokadem, M.D. ("Respondent") is represented in this proceeding by attorney Peter R. Osinoff, whose address is 355 South Grand Avenue, Suite 1750, Los Angeles, California 90071.

3. On or about May 9, 2009, the Board issued Physician's and Surgeon's Certificate No. A 107687 to Respondent. That license was in full force and effect at all times relevant to the

charges brought in Accusation No. 800-2018-041705, and will expire on June 30, 2022, unless renewed.

JURISDICTION

4. Accusation No. 800-2018-041705 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 April 15, 2020. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2018-041705 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2018-041705. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement 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. 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 in Accusation No. 800-2018-041705, and that he has thereby subjected his Physician's and Surgeon's Certificate, No. A 107687 to disciplinary action.

9. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the imposition of discipline by the Board as set forth in

the Disciplinary Order below.

10. Respondent agrees that if the Board ever takes action against Respondent pursuant to a failure to abide by a term and condition in the Disciplinary Order below, all of the charges and allegations contained in Accusation No. 800-2018-041705 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.

CONTINGENCY

11. 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 she 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.

12. 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.

13. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 107687 issued to Respondent Hesham Mohamed El Mokadem, M.D. is publicly reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4), with the following attendant terms and conditions.

A. **PUBLIC REPRIMAND.**

This Public Reprimand, which is issued in connection with Respondent's care and treatment of Patient 1 as set forth in Accusation No. 800-2018-041705, is as follows:

> In 2013, you committed acts constituting negligence in violation of Business and Professions Code section 2234, subdivision (c), in your care, management and treatment of Patient A's episiotomy repair breakdown and subsequent rectovaginal fistula. In addition, you failed to maintain adequate and accurate medical records relating to your care and treatment of the patient.

B. **EDUCATION COURSE.**

Within sixty (60) calendar days of the effective date of this Decision, 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 twenty (20) hours. 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 twenty (20) hours of CME in satisfaction of this condition.

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

If Respondent fails to enroll, participate in, or successfully complete the educational program(s) or course(s) within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the educational program(s) or course(s) has been completed. Failure to successfully complete the educational program(s) or course(s) outlined above shall constitute

unprofessional conduct and is grounds for further disciplinary action.

C. **MEDICAL RECORD KEEPING COURSE.** Within sixty (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 fifteen (15) calendar days after successfully completing the course, or not later than fifteen (15) calendar days after the effective date of the Decision, whichever is later.

If Respondent fails to enroll, participate in, or successfully complete the medical record keeping course within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the medical record keeping course has been completed. Failure to successfully complete the medical record keeping course outlined above shall constitute unprofessional conduct and is grounds for further disciplinary action.

D. **FAILURE TO COMPLY WITH ORDER.**

Failure by Respondent to comply with any provision of this order shall constitute unprofessional conduct and shall be grounds for further disciplinary action by the Board. In such

circumstances, the Complainant may reinstate Accusation No. 800-2018-041705 or file a supplemental accusation alleging any failure to comply with any provision of this order by Respondent as unprofessional conduct.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Peter R. Osinoff. 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: 11/18/20

HESHAM MOHAMED EL MOKADEM, M.D.
Respondent

I have read and fully discussed with Respondent Hesham Mohamed El Mokadem, 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: 11/18/2020

PETER R. OSINOFF
Attorney for Respondent

ENDORSEMENT

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

DATED: 11/19/2020

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

REBECCA L. SMITH
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2018-041705

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

In the Matter of the Accusation Against: **Hesham Mohamed El Mokadem, M.D.** **3100 Van Buren Blvd., Apt. 713** **Riverside, CA 92503** **Physician's and Surgeon's Certificate No. A 107687,** Respondent.	Case No. 800-2018-041705 **A C C U S A T I O N**

PARTIES

1. Christine J. Lally (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about May 9, 2009, the Medical Board issued Physician's and Surgeon's Certificate Number A 107687 to Hesham Mohamed El Mokadem, 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 June 30, 2022, 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 which is substantially related to the qualifications, functions, or duties of a physician and surgeon.
>
> (f) Any action or conduct which 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. Respondent is an OB/GYN; he maintains a private practice.

8. Patient A,[1] at that time 19-years-old, presented to Respondent on or about September 10, 2012, for prenatal care. This was her first baby; her due date was estimated to be April 23, 2013, based on the date of her last menstrual period.

9. Patient A's pregnancy progressed without complication. She was admitted to the Labor and Delivery unit of Parkview Community Hospital on April 17, 2013, at 10:45 a.m. in labor. Patient A's labor was augmented with Pitocin. Her bag-of-waters broke at 3:36 p.m. By 4:46 p.m. after repetitive variable decelerations noted on the fetal heart monitor strip, the fetal heart rate remained at 90 beats per minute. The fetal heart tracing was classified as a class III[2] by the labor and delivery nurse. Patient A was noted to be fully dilated and complete (ready to deliver) by 4:50 p.m.

10. Respondent arrived at Patient A's bedside at 4:59 p.m. He noted the fetal distress and poor maternal effort at pushing. He advised that he would be using a vacuum to assist with delivery. Prior to applying the vacuum, Respondent cut a midline episiotomy. The medical records indicate that the vacuum was applied once, with maximum pressure of 50, the fetus was in the +2 station and in the right occipital anterior position. A male infant, weighing 7lbs 7oz, was delivered. Respondent charted in the Delivery Note that he performed an episiotomy repair. He did not chart that the episiotomy had extended to a third degree tear. The nursing notes indicate that Patient A sustained a third degree perineal laceration-"extension to 3rd degree."

11. Patient A was discharged home on postpartum day 1. She was instructed to return to see Respondent in 6-weeks or call if she had an elevated temperature above 100.4 degrees; increased pain not relieved with pain relievers; vaginal bleeding; discharge with a foul odor;

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[1] The patient is identified by letter to protect her privacy.

[2] A category III fetal heart tracing is considered abnormal indicative of hypoxic risk to the fetus and possible acidemia.

perineum that is red, swollen, draining or has increased discomfort; burning or difficulty urinating; no bowel movement in 4-days; nipples that are bleeding, sore or cracked, red, hot-spot, or lump on the breast; or feelings of panic, anxiety, depression or sadness, or if feel unable to adequately care for [her] infant.

12. On May 2, 2013, Patient A returned to Respondent's office with complaints of vaginal pain and discharge. Respondent noted that Patient A had a breakdown of the episiotomy repair. He saw no signs of infection. Respondent did not perform a rectal examination on Patient A. He prescribed an antibiotic and told her to return for an episiotomy repair the next day.

13. Patient A returned to Respondent's office on May 3, 2013, for repair of the episiotomy breakdown. The procedure was performed under local anesthesia, using vicryl suture. Respondent notes that he checked the vaginal and rectal mucosa after the repair. Patient A was to follow up in one-week and continue taking the antibiotics.

14. On May 6, 2013, Patient A noted stool in her vagina. She sought treatment at Parkview Community Hospital emergency department where she was examined by Dr. E.Q. On physical examination Dr. E.Q. saw stool in the vaginal vault. Dr. E.Q. rendered a diagnosis of vaginal fistula. He prescribed Norco, an opiate narcotic, for Patient A's pain and instructed her to follow up with her OB/GYN, even if well, or return to the emergency department if worse.

15. Patient A returned to Respondent's office the next day, May 7, 2013. Respondent noted a disruption of episiotomy and instructed Patient A to return to the office in the morning and not to eat anything. Respondent was unable to perform a full examination to determine if Patient A had an infection, fistula or further breakdown to fourth degree. His plan was to admit her to Parkview Community Hospital in the morning and perform an examination and repair under general anesthesia.

16. Respondent saw Patient A in his office on May 9, 2013. He notes that the patient had lower abdominal pain and breakdown of episiotomy. Post-partum infection and breakdown of episiotomy was also noted. His plan was to send her to the emergency department for admission to receive intravenous antibiotics.

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17. Patient A was admitted to Parkview Community Hospital on May 9, 2013. She underwent a vaginal ultrasound and a vaginal cyst was noted. She was to undergo surgical repair of the episiotomy and removal of the vaginal cyst under general anesthesia the next day. On May 10, 2013, Respondent charts that Patient A "complained of perineal pain from episiotomy breakdown." She had a perineal/episiotomy breakdown with no signs of infection. Respondent was to schedule Patient A for surgical repair under general anesthesia. The surgery was performed at 7:10 p.m. on May 10th. The operative report only indicates that examination of the vagina and perineum revealed a breakdown of the episiotomy and a vaginal wall cyst. Respondent repaired the episiotomy in three layers with 0 vicryl running stitches. Rectal and vaginal exam revealed no defect. Respondent did not dictate removal of the cyst in his dictated operative note. In his handwritten post-surgical note Respondent indicates that the cyst was incised.

18. Patient A was discharged home on the evening of May 10, 2013, after her surgery.

19. Patient A saw Respondent in his office on May 14, 2013, for follow up. She complained that she continued to have feces coming through her stitches and out of her vagina. She also reported that she was in pain. Respondent noted that her perineum was open superficially, but the rectovaginal junction was intact. Respondent prescribed Keflex, an antibiotic, for one week and instructed Patient A to return in one week.

20. Patient A was seen by Respondent in his office two days later on May 16, 2013. Respondent again noted a breakdown of the perineum and episiotomy. He added possibility of rectovaginal fistula. His plan was to admit Patient A to the hospital for intravenous antibiotics and possible repair.

21. Patient A was admitted to Riverside Community Hospital on May 18, 2013. Respondent performed another perineal repair on May 19, 2013, for a midline breakdown. During the surgery, he appreciated some infection. He checked the integrity of the vagina and the rectum by injecting Asepto into the rectum and did not note any spilling into the vagina. Respondent determined there was no rectovaginal fistula, based thereon. Patient A was

discharged home on May 20, 2013, and instructed to take Keflex. This was the last time Patient A saw Respondent.

22. Thereafter, Patient A continued to have pain and continued to find fecal material in her vagina. On May 26, 2013, Patient A went to the emergency department at Arrowhead Regional Medical Center. She had complaints of pain rated 10 on a scale of 1-10; had purulent drainage and odor from her perineal area. She reported that movement and using the bathroom made her complaints worse. She also reported that she had undergone four repair surgeries. On examination it is noted that the perineal/vaginal area was difficult to assess due to pain. There was poor rectal tone noted, however. Stool was also present. Patient A was admitted for pain control, she would likely need surgical wound debridement. Her diagnosis was breakdown of episiotomy, with breakdown likely involving rectal sphincter.

23. Patient A was taken to surgery on May 27, 2013, for repair of a rectovaginal fistula from normal spontaneous vaginal birth on April 17, 2013. The operative note indicates that photo documentation was obtained preoperatively. The wound was debrided of necrotic tissue. The sutures in place were holding no tissue together. Approximately 4 cm of the connection between the rectum and the vaginal vault were present at that time.

24. Patient A continued to have fecal incontinence, vaginal infections and pain due to the rectovaginal fistula. She underwent multiple surgical corrections, including a colostomy, sphincteroplasty and colostomy take-down in an attempt to repair her perineal/vagina and rectovaginal fistula. Due to the infections and numerous surgeries, Patient A lost tissue in the perineal area as well as part of her labia and continues to have continence issues with her anal sphincter.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

25. Respondent's license is subject to disciplinary action under section 2234, subdivision (c). of the Code. The circumstances are as follows:

26. A rectovaginal fistula often causes fecal incontinence after an unrecognized injury to the middle portion of the anal canal during an operative vaginal delivery (i.e., vacuum delivery), a

breakdown of a third or fourth degree laceration, or a combination of both. On examination, the skin of the perineum will lack the typical creases created by the musculature of an intact perineal body. The standard of care requires a proper rectovaginal examination. The rectovaginal examination is essential and delineates the integrity and tone of the anal sphincter. On rectal examination, the rectovaginal septum is attenuated. When the patient is asked to contract her anal sphincter, aside from poor muscle tone, dimpling in the perianal skin from the retracted torn musculature will be pronounced. Radiologic studies are beneficial prior to any repair in order to assess the location and extent of the defect. Physical examination will miss at least 25% of these defects. Therefore, the standard of care recommends endoanal ultrasonography as well as MRI for diagnosis.

27. When Patient A's episiotomy initially broke down, Respondent opted to perform an immediate office repair. When that repair failed only days later, the standard of care called for an infectious etiology to be ruled out, including the possibility of an occult rectovaginal fistula. This is underscored by the second failed repair. Respondent also failed to document rectovaginal examinations. Respondent failed to obtain genital cultures. Cultures would have identified the presence of intestinal bacteria in the vagina or the etiology of the vaginal discharge.

28. The May 6, 2013, emergency department visit at Arrowhead Community Hospital was prompted by the patient noting stool in her vagina. This was never explained and adequate diagnostic studies were not obtained for this condition. After the third repair, the patient reported on May 14, 2013, that feces were coming through the stiches out of her vagina. These complaints and the standard of care required that a fistula be ruled out by a combination of radiologic studies and dye studies of the vagina and rectum. Respondent only documents the use of Asepto injections into the rectum looking for vaginal spillage. This is an inadequate evaluation of a possible fistula.

29. The standard of care also requires that informed consent be documented for the repeated episiotomy repairs. There must be a differential diagnosis, possible additional diagnostic studies, alternative surgical treatments, and the option of delaying closure. A thorough

discussion of the significance and treatment options for rectovaginal fistula was also warranted. There is no evidence that this was performed.

30. The standard of care requires that a physician document each patient encounter. The note should include the patient's complaints and all objective findings. The physician should note a differential diagnosis with his/her impression. A detailed plan for further treatment should be elucidated. Adequate chart notes are essential for documentation and are necessary for proper follow up care.

31. Respondent's documentation of his encounters with Patient A were inadequate. With regard to the April 14, 2013, delivery, the hospital chart does not have a history and physical, progress notes or the results of a pelvic examination detailing the adequacy of the pelvis or the vaginal anatomy germane to the complications that were encountered. The standard of care required an operative note detailing why the vacuum was used, informed consent, an empty bladder, anesthesia, the station of the fetus, the orientation of the vertex, the type of vacuum used, the duration, strength, and results of each pull, and any findings or complications. The note should include details of any lacerations or episiotomy. The third degree extension of the episiotomy requires details of both extent and the manner in which it was closed. The rectum should also be assessed and the findings documented. None of these criteria were met.

32. The encounter of May 2, 2013, was due to vaginal pain. Disruption of the episiotomy repair was noted without evidence of infection. After antibiotics were prescribed, a repair was performed in the office the next day. The note does not detail the anesthesia, the physical findings, informed consent, or home follow up care. The rectum was noted to be intact after stitching, the condition of the rectum was not assessed or documented beforehand.

33. Patient A was admitted to the hospital on May 9, 2013, following an emergency department visit for complaints of stool in her vagina. Respondent confirmed a breakdown of repair on May 7, 2013. The hospital notes offer minimal details regarding the vaginal anatomy on examination, assessment of the rectum, regional adenopathy, vaginal cultures or pathology findings on the vaginal cyst (the cyst was not sent for pathology). A work up for a possible fistula or an explanation for stool in the vagina were absent.

34. Patient A had seen Respondent on May 14, 2013, reporting that she still had feces coming through her stitches and from her vagina. Respondent recommended admission to the hospital for repair of a possible rectovaginal fistula on May 19, 2013. The notes do not detail abnormal findings on examination. The evaluation for a fistula is not documented nor is the surgical technique or the assessment of the rectum. The standard of care dictates that patients experiencing breakdown of third or fourth degree episiotomies be given prophylactic antibiotic coverage for both aerobic and anaerobic bacteria. This was not done; only Keflex was prescribed. The surgical note indicates that Patient A was evaluated with Asepto, without explanation or elaboration. No use of any type of dye was noted. Respondent stated in his interview with Board representatives that all his repairs are accompanied by digitalization of the rectum. However, this surgical technique is not described in any report of the four repairs he performed on Patient A. Also, he claimed that a second surgeon was present during the May 19, 2013 surgery; this too, was not documented.

35. The standard of care is to perform an immediate repair of an episiotomy breakdown. It must be preceded by a thorough preoperative evaluation, physical examination, and preparation for the intended procedure. Complete documentation of the procedure allows for proper evaluation of the results in the future. Proper post-operative care optimizes healing.

36. Patient A underwent a third degree episiotomy associated with her operative vacuum delivery. The laceration was repaired in routine fashion. When the repair broke down two weeks later, it was repaired similarly, under local anesthesia, in the office. Preoperative evaluation, including a rectovaginal examination was not performed. The operative note does not describe the condition encountered. The post-operative care recommendations are not documented.

37. When the repair broke down days later, again, there was no documentation of an evaluation. Differential diagnoses were not listed. The anatomy was not described in detail. The procedure was noted to be the same as the two previous attempts at repair.

38. At the time of the third repair, it was well documented that the patient was suffering from fecal incontinence with vaginal spillage. This fact was not reflected in any of Respondent's documentation. There was no endoanal ultrasound examination or MRI. Physical examinations

did not describe the cloaca or perineal anatomy in any detail. There was no evidence of the essential rectovaginal examination. There were no vaginal cultures or dye studies which would have given evidence of a possible fistula. Repair proceeded in routine fashion, ignoring possible contamination of bacteria from the rectum or the possibility of a fistula.

39. Respondent failed to refer Patient A to a colorectal surgeon who is a specialist in repair of this complication. Colorectal surgeons have far more experience with these complications and produce better outcomes. After two failed repairs, the standard of care dictated that Respondent refer Patient A to a colorectal surgeon.

40. The failure to properly evaluate and treat Patient A for a rectovaginal fistula is a departure from the standard of care.

41. The failure to properly document the evaluation, treatment and follow up of Patient A's obstetrical complication is a departure from the standard of care.

42. The repeated vaginal repairs of episiotomy breakdown are departures from the standard of care.

43. The repeated failures to obtain informed consent from Patient A for each procedure are departures from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

44. Respondent's license is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate records in his care and treatment of Patient A. The circumstances are as follows:

45. The allegations in the First Cause for Discipline are incorporated as if fully set forth.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

46. Respondent's license is subject to disciplinary action under section 2234, subdivision (a), of the Code in that he engaged in unprofessional conduct in his care and treatment of Patient A. The circumstances are as follows:

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47. The allegations in the First and Second Causes for Discipline are incorporated as if fully set forth.

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 A 107687, issued to Hesham Mohamed El Mokadem, M.D.;

2. Revoking, suspending or denying approval of Hesham Mohamed El Mokadem, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Hesham Mohamed El Mokadem, 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: APR 15 2020

CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

LA2020600090
ELMOKADEM ACCUSATION-MBC EDITS