BEFORE THE BOARD OF MEDICAL EXAMINERS
OF THE STATE OF NEVADA

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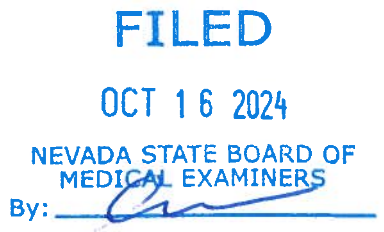
In the Matter of Charges and Complaint Against: MUSTAFA ISMAIL AHMED, M.D. Respondent.	Case No. 24-43488-1



COMPLAINT

The Investigative Committee[1] (IC) of the Nevada State Board of Medical Examiners (Board), by and through Alexander J. Hinman, Deputy General Counsel and attorney for the IC, having a reasonable basis to believe that Mustafa Ismail Ahmed, M.D. (Respondent) violated the provisions of Nevada Revised Statutes (NRS) Chapter 630 and Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the IC's charges and allegations as follows:

1. Respondent was at all times relative to this Complaint a medical doctor holding an active license to practice medicine in the State of Nevada (License No. 15815). Respondent was originally licensed by the Board on April 13, 2015.

2. Patient A[2] was a sixty-seven (67) year-old female at the time of the events at issue.

3. On December 12, 2018, Patient A first visited Respondent with an interest in pursuing surgical weight loss operations, and a full physical examination was performed.

4. Patient A returned to see Respondent on January 24, 2019, February 13, 2019, March 11, 2019, April 1, 2019, May 2, 2019, and May 24, 2019, before the surgery would ultimately be performed on June 3, 2019.

[1] The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal Complaint was authorized for filing, was composed of Board members Mr. M. Neil Duxbury, Aury Nagy, M.D., and Michael C. Edwards, M.D., FACS.

[2] Patient A's true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

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5. At each visit, the exact same physical exam was documented in the progress notes of Patient A's medical records. Each physical exam stated Respondent performed a rectal exam and a bimanual vaginal exam to palpate the cervix, uterus, and ovaries.

6. However, documented in Patient A's surgical history was a hysterectomy, which indicates that Respondent did not actually perform the documented examinations of the uterus, as Patient A's uterus was removed prior to any of these examinations.

7. On June 3, 2019, after six (6) consultations and examinations had been performed, Patient A was admitted to the hospital and underwent a laparoscopic sleeve gastrectomy with duodenojejunostomy. The operation was complicated slightly because of a miscommunication between Respondent and a CRNA. Specifically, the orogastric tube was stapled into the staple line during the sleeve gastrectomy portion of the operation. This was subsequently freed and Patient A had the stomach re-stapled successfully.

8. Patient A was admitted overnight after the procedure and was next seen by Respondent at approximately 8:00 a.m., on the morning of June 4, 2019.

9. At this time, Patient A was having abdominal pain and not feeling like she was ready for discharge; therefore, Patient A was kept in the hospital for another day for pain control.

10. On June 4, 2019, Patient A's clinical condition deteriorated throughout the morning and early afternoon, although there are no nursing or physician notes documenting the specific sequence of events. While it was not confirmed until later, Respondent had perforated Patient A's jejunum (the second part of the small intestine) during the operation on June 3, 2019.

11. At 3:25 p.m., Respondent ordered lab work for Patient A which returned a finding of acute renal failure.

12. At 5:20 p.m., a CT scan of the abdomen with oral contrast was ordered by Respondent, indicating that he was aware of Patient A's critical care; however, no resuscitation fluid was ordered. Further, more than six (6) hours had passed before the CT was resulted. The CT report listed postoperative changes and a small amount of free air and free fluid in the perihepatic, perisplenic, and dependent portions of the pelvis with a comment that a small perforation could not be excluded.

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13. Patient A continued to decline in the evening of June 4, 2019, and had multiple blood pressure readings that suggested severe sepsis. Additional lab work was performed around 9:30 p.m., which returned even more data suggesting Patient A was experiencing severe sepsis.

14. Patient A was eventually transferred to the ICU, where hospitalist and critical care consultations were obtained for resuscitation and sepsis management.

15. On June 4, 2019, at 11:27 p.m., a progress note was entered by Respondent which indicated his plans to transfer Patient A to the ICU; however, there was no physical exam included in the note and there was no indication that Respondent ever came to the hospital or saw and examined Patient A again.

16. Furthermore, there is no evidence that Respondent ever examined Patient A between the morning of June 4, 2019, and the morning of June 5, 2019, the time frame during which Patient A decompensated from the perforation of her bowel, and despite the overwhelming evidence that Patient A had a life-threatening surgical complication.

17. Once in the ICU, Patient A received crystalloid resuscitation, vasopressors, and antibiotics, but she continued to decline throughout the night and was intubated and started on mechanical ventilation. Patient A was also subsequently put on dialysis.

18. On the morning of June 5, 2019, Patient A was taken back to surgery, though there are no progress notes clarifying Respondent's medical decision making.

19. Respondent's operative note on June 5, 2019, indicated the surgery was immediately converted from laparoscopic to open when he encountered stomach bile. During the surgery, Respondent discovered an enterotomy (hole in the intestine) in the jejunum which was the source of the abdominal sepsis.

20. After the second surgery was completed, Patient A's condition continued to decline, and she experienced multiple organ failure. Patient A's condition never improved.

21. On June 6, 2019, at 11:32 p.m., Patient A was pronounced dead.

22. The causes of Patient A's death were listed as cardiopulmonary arrest, septic shock, and bowel perforation.

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COUNT I

NRS 630.301(4) - Malpractice

23. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

24. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

25. NAC 630.040 defines malpractice as "the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances."

26. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when rendering medical services to Patient A, when he failed to physically examine Patient A between the morning of June 4, 2019, and the morning of June 5, 2019, the timeframe during which Patient A decompensated, despite there being overwhelming evidence of Patient A's life-threatening complications from the surgery performed on June 3, 2019.

27. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNT II

NRS 630.301(4) - Malpractice

28. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

29. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

30. NAC 630.040 defines malpractice as "the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances."

31. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when

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rendering medical services to Patient A, when he failed to recommend emergency surgery for Patient A on the evening of June 4, 2019, when confronted with evidence that she had a bowel perforation. Further, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when he failed to recommend immediate surgery when the CT was resulted, as well as several blood pressure readings and lab work suggesting severe sepsis.

32. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

COUNT III

NRS 630.3062(1)(a) - Failure to Maintain Complete Medical Records

33. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

34. NRS 630.3062(1)(a) provides that the "failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient" constitute grounds for initiating discipline against a licensee.

35. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to correctly document his actions when he treated Patient A, whose medical records were not timely, legible, accurate, and complete, when, among other things, he documented in each of the six (6) purported physical exams, that he performed a bimanual vaginal exam to palpate Patient A's cervix, uterus, and ovaries, despite it being clear from the medical record that Patient A had a hysterectomy prior to meeting with Respondent, making a physical exam on her uterus impossible. Further, Respondent failed to make progress notes clarifying his medical decision making during his care of Patient A and when he decided to perform a second surgery on Patient A.

36. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

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WHEREFORE, the Investigative Committee prays:

1. That the Board give Respondent notice of the charges herein against him and give him notice that he may file an answer to the Complaint herein as set forth in NRS 630.339(2) within twenty (20) days of service of the Complaint;

2. That the Board set a time and place for a formal hearing after holding an Early Case Conference pursuant to NRS 630.339(3);

3. That the Board determine what sanctions to impose if it determines there has been a violation or violations of the Medical Practice Act committed by Respondent;

4. That the Board award fees and costs for the investigation and prosecution of this case as outlined in NRS 622.400;

5. That the Board make, issue and serve on Respondent its findings of fact, conclusions of law and order, in writing, that includes the sanctions imposed; and

6. That the Board take such other and further action as may be just and proper in these premises.

DATED this 16th day of October, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: Alexander J. Hinman

ALEXANDER J. HINMAN
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Attorney for the Investigative Committee

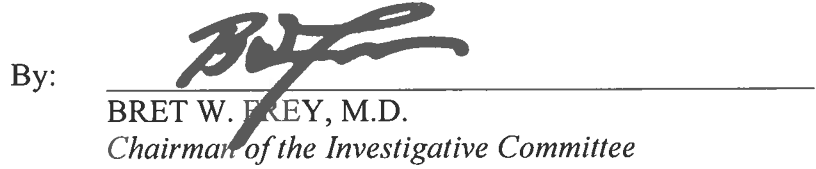
VERIFICATION

STATE OF NEVADA)
: ss.
COUNTY OF WASHOE)

Bret W. Frey, M.D., having been duly sworn, hereby deposes and states under penalty of perjury that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered in the course of the investigation into a complaint against Respondent, he believes that the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

DATED this 16th day of October, 2024.

INVESTIGATIVE COMMITTEE OF THE
NEVADA STATE BOARD OF MEDICAL EXAMINERS

By: 

BRET W. FREY, M.D.
Chairman of the Investigative Committee

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