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

In the Matter of the Accusation Against: Pritpal Singh Randhawa, M.D. Physician's & Surgeon's Certificate No A 83324 Respondent	Case No. 800-2017-035552

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 June 16, 2021.

IT IS SO ORDERED May 17, 2021.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D., Chair
Panel B

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General
JOHN S. GATSCHET
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California Department of Justice
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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: **PRITPAL SINGH RANDHAWA, M.D.** 1100 Marshall Way Placerville, CA 95667-6533 Physician' and Surgeon's Certificate No. A 83324 Respondent.	Case No. 800-2017-035552 OAH No. 2020090070 **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 John S. Gatschet, Deputy Attorney General.

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2. Respondent Pritpal Singh Randhawa, M.D. ("Respondent") is represented in this proceeding by attorney Dominique A. Pollara, whose address is:

Pollara Law Group
100 Howe Avenue, Suite 165-N
Sacramento, CA 95825

3. On or about May 30, 2003, the Board issued Physician's and Surgeon's Certificate No. A 83324 to Pritpal Singh Randhawa, M.D. ("Respondent"). That Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2017-035552, and will expire on April 30, 2021, unless renewed.

JURISDICTION

4. Accusation No. 800-2017-035552 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 August 11, 2020. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2017-035552 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2017-035552. Respondent has also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2017-035552, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. Respondent agrees that, at a hearing, Complainant could establish a *prima facia* basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent agrees that his Physician's and Surgeon's Certificate No. A 83324 is subject to discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

CONTINGENCY

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

13. 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.

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

DISCIPLINARY ORDER

A. PUBLIC REPRIMAND

IT IS HEREBY ORDERED THAT upon completion of the following course-work set forth in Conditions B and C of the Disciplinary Order, the Physician's and Surgeon's Certificate No. A 83324 issued to Respondent Pritpal Singh Randhawa, M.D. shall be and is hereby publically reprimanded pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This Public Reprimand, which is issued in connection with Accusation No. 800-2017-035552, is as follows:

"On or about July 17, 2017, through July 18, 2017, while treating Patient A, you failed to perform a focused neurological physical examination, failed to urgently order an MRI, and failed to urgently order a specialist consultation, and failed to keep adequate medical records, as more fully described in Accusation No. 800-2017-035552."

B. EDUCATION COURSE

Within 60 calendar days of the effective date of this Decision, the 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 20 hours. The education program(s) and/or course(s) shall be in addition to the 25 hours required for license renewal. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice and/or knowledge and shall be Category I certified. The Medical Board specifically requests that coursework concentrate on the care and treatment of pneumonia, spinal/epidural abscesses, and/or any other infectious disease process that can lead to paralysis in an in-patient setting and/or any other critical care patient management. 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 successfully complete all coursework

and provide proof of completion of 20 hours of additional CME to the Board within one year of the effective date of the Decision and Order.

C. MEDICAL RECORD KEEPING COURSE.

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

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.

The Respondent was scheduled to complete the Western Institute of Legal Medicine, Inc.'s Medical Record-Keeping Course on February 20-21, 2021, and that course is acceptable to satisfy this condition. Respondent shall submit a certification of successful completion from that program to the Board or its designee within thirty (30) calendar days of the effective date of this Decision and Order for inclusion in his file showing course completion in satisfaction of this term and condition.

D. FAILURE TO COMPLY

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 as required by the express language of the Decision and Order. In addition, failure to successfully complete the educational program(s) or course(s) outlined above shall also constitute unprofessional conduct and is grounds for further disciplinary action.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Dominique A. Pollara. 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: 3/1/2021

PRITPAL SINGH RANDHAWA, M.D.
Respondent

I have read and fully discussed with Respondent Pritpal Singh Randhawa, 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: 3/5/21

DOMINIQUE A. POLLARA
Attorney for Respondent

ENDORSEMENT

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

DATED: March 8, 2021

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVEN D. MUNI
Supervising Deputy Attorney General

JOHN S. GATSCHET
Deputy Attorney General
Attorneys for Complainant

SA2020301671/Approved PR Stipulation.docx

Exhibit A

XAVIER BECERRA
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STEVEN D. MUNI
Supervising Deputy Attorney General
JOHN S. GATSCHET
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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: **Pritpal Singh Randhawa, M.D.** 1100 Marshall Way Placerville, CA 95667-6533 Physician's and Surgeon's Certificate No. A 83324, Respondent.	Case No. 800-2017-035552 **ACCUSATION**

PARTIES

1. William Prasfika ("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 May 30, 2003, the Medical Board issued Physician's and Surgeon's Certificate Number A 83324 to Pritpal Singh Randhawa, M.D. ("Respondent"). That certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2021, 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 2227 of the Code, states in pertinent part, that a licensee who is found guilty under the Medical Quality Hearing Panel 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, in pertinent 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:
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> (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.
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> ...

6. Section 2266 of the Code states, in pertinent part:

> 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. On or about July 16, 2017, at approximately 10:42 p.m., Patient A[1] presented in the emergency department of Mercy Hospital of Folsom. Patient A presented with left-sided chest pain with shortness of breath and a one-week onset of back pain. Patient A reported seeing his primary care physician at the onset of back pain and that he had been given a lidocaine shot. According to the patient, a chest x-ray had previously shown no acute findings but possible lung collapse. Patient A also reported that he had difficulty walking and generalized weakness for the past three hours. Patient A reported he had a history of neuropathy. Patient A reported that he

[1] The Board will fully identified all witnesses in discovery. Alpha Numeric characters have been used in order to protect confidentiality.

had no radiating pain but that the symptoms were constant, moderate and exacerbated by movement.

8. The emergency department staff documented a differential diagnosis of myocardial infarction, atypical chest pain, pneumonia, pleurisy, chest wall pain, dyspnea, chronic obstructive pulmonary disease, and bronchitis. The emergency department staff had Patient A provide a series of labs, and performed an electrocardiogram, a CT[2] angiogram of Patient A's chest with contrast, and a chest x-ray. The medical imaging indicated the presence of multifocal bronchopneumonia. Following a review of the test results, the emergency department diagnosed that the patient was suffering from bilateral pneumonia, hypertension, and anxiety disorder. The emergency department staff had the patient admitted to the hospital at approximately 3:00 a.m. on or about July 17, 2017. The emergency department did not do a formal neurological evaluation.

9. On or about July 17, 2017, at approximately 3:45 a.m.[3], Hospitalist B on the overnight shift at Mercy Hospital of Folsom documented an admitting history and physical for Patient A. Hospitalist B documented that Patient A had no significant past medical history apart from anxiety disorder, who presented with chest pressure and difficulty breathing. According to Hospitalist B, Patient A had symptoms starting on July 12, 2017, or July 13, 2017, and had gone to his primary care physician who had previously ordered a chest x-ray. Hospitalist B documented that Patient A reported that the x-ray was not clear and that Patient A's wife stated that Patient A had been told he had a "collapsed lung" but no one referred him to the emergency department. According to Hospitalist B's documentation, Patient A had improved over the next few days but on July 16, 2017, he became acutely short of breath and had difficulty breathing. According to the documentation, Patient A reported that he had a "pressure like sensation" on his chest. Patient denied chest pain, fever, chills, presyncope, nausea, vomiting, or diaphoresis. According to Hospitalist B, Patient A's bloodwork was remarkable for a marked leukocytosis of 35.7 with an 85% left shift and an 8% bandemia. In addition, Patient A's D-dimer level was

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[2] A CT scan, or computed tomography scan, is a medical imaging procedure that uses computer processed combinations of many x-ray measurements taken from different angles to product cross-sectional images.

[3] The history and physical was signed later on July 26, 2017, at 4:53 p.m.

significantly elevated at 2773. Hospitalist B documented that Patient A's CT angiogram was negative for a pleural effusion but that it did show patchy bilateral consolidation of the lung bases as well as ground glass opacity in the right upper lobe suggestive of multifocal pneumonia. According to Hospitalist B, he reviewed all ten systems and noted the systems were negative aside from what was set forth in his history and physical. Hospitalist B documented that Patient A's extremities were warm with no edema. Hospitalist B did not perform a neurological focused examination and did not mention whether or not Patient A was suffering from back pain or had lower extremity weakness. Hospitalist B diagnosed Patient A as having bilateral pneumonia, hypertension, and anxiety disorder. Hospitalist B documented that Patient A was on antibiotics, bronchodilators, and supplemental oxygen to treat the pneumonia. Finally, Hospitalist B documented that he spent 35 minutes going over Patient A's admission.

10. On July 17, 2017, at 5:00 a.m., according to the nursing notes, Patient A's neuro motor strength for his left and right lower extremities was documented as 4/5. On July 17, 2017, at 8:00 a.m., Patient A's neuro motor strength for his left and right lower extremities was documented as 3/5, which indicated possible worsening. On July 17, 2017, at 5:00 p.m., Patient A's neuro motor strength for his left and right lower extremities was scored as 4/5. Six hours later, at 11:00 p.m. on July 17, 2017, Patient A's neuro motor strength for his left and right lower extremities was documented as 4/5. On July 18, 2017, at 8:00 a.m., Patient A's neuro motor strength for his left and right lower extremities was documented as 4/5. On July 18, 2017, at 7:37 p.m., the nursing note first documented that Patient A's left and right lower extremities was now scoring 0/5, indicating a rapid decompensation of the patient. In addition, a nursing note documented on July 17, 2017, at 9:56 a.m., and prior to Respondent seeing Patient A, noted that a nurse contacted the Respondent and informed him that Patient A was suffering from generalized weakness and that Patient A had experienced a weakness episode where he had been found on his knees by the sink. According to the nursing note, the patient and his family denied any history of fall and they stated the patient had slowly got on his knees due to feeling weak. Respondent did not document the conversation with the nurse in his July 17, 2017, progress note, nor did he

document that Patient A's neuro motor strength for his left and right lower extremities was documented as 3/5 at approximately 8:00 a.m. on July 17, 2017.

11. On or about July 17, 2017, at approximately 2:44 p.m., the Respondent documented in a brief progress note that he had reviewed Patient A's history and physical. The Respondent was the hospitalist on duty and in charge of the patient on July 17, 2017, from 6:00 a.m. to 6:00 p.m. The Respondent documented that Patient A was complaining of significant low back pain for the last four days, which was limiting his mobility and was new for the patient. The Respondent also documented that Patient A had significant urinary retention and that a Foley urine catheter had been ordered which did not help with pain. The Respondent documented that Patient A continued to have low back pain and Respondent documented that he would order an MRI[4] of Patient A's lumbar sacral spine. The Respondent did not document performing a formal neurological examination including specifically indicating whether Patient A was suffering from lower extremity weaknesses, Patient A's reflexes, Patient A's motor strength, and Patient A's sensations in his extremities.

12. The Respondent documented that he changed Patient A's antibiotics and that he would keep the treatment plan in place as outlined in the history and physical that had been outlined by Hospitalist B. According to the records, Respondent ordered a routine lumbar spine MRI of Patient A's lower spine on July 17, 2017, at 2:45 p.m. Respondent did not order the lumbar spine MRI to be completed "stat[5]". Respondent was interviewed by the Medical Board on March 2, 2020, regarding his care and treatment of Patient A. According to Respondent, he saw Patient A at approximately 11:00 a.m. on July 17, 2017. Respondent stated that Patient A had been admitted for pneumonia and had a high white count and that he had previously met Patient A in the hospital on previous visits. As Respondent performed a focused exam for pneumonia, he asked Patient A to sit up and he noticed it took Patient A some effort to sit up. The Respondent stated that he asked Patient A what was going on and Patient A stated his back had been hurting.

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[4] An MRI, or Magnetic Resonance Imaging, is a medical imaging technique used in radiology to form pictures of the anatomy and the physiological processes of the body through the use of magnetic fields, magnetic field gradients, and radio waves.

[5] "Stat" is an abbreviation of the Latin word statim, meaning immediately, without delay.

The Respondent asked him to sit up on the side of the bed and Patient A swung his legs to the side but had to use extra effort with his arm. Respondent noted that it was concerning Patient A had to use extra effort with his arm. Respondent stated that he listened to Patient A's lungs and then remembers Patient A stood up. Respondent noticed that Patient A took extra effort to sit down and that Respondent was concerned regarding Patient A's lumbar spine. The Respondent did not document any of his stated observations related to Patient A having difficulty sitting up, swinging his legs to the side of the bed, or sitting down in his July 17, 2017, progress note.

13. The Respondent's shift ended at 6:00 p.m. on July 17, 2017. Hospital staff completed the Respondent's routine lumbar MRI on July 17, 2017, at approximately 8:10 p.m. and subsequently notified Respondent. According to the July 17, 2017, MRI report there was "soft tissue swelling at the L2/L3 level as well as extensive T2 and STIR hyperintensity involving the bilateral psoas musculature extending from L3 through the visualized S1 levels. These findings are concerning for infection. No definite abscess or drainable fluid collection is identified." In addition the report also stated that, "(s)ignificant T2 and STIR hyperintensity involving the L3/L4 disc space. Given the significant adjacent inflammatory changes this is concerning for discitis." According to Respondent, he received the results of the July 17, 2017, lumbar spine MRI showing discitis in the afternoon and text messaged one of the hospital's on-call infectious disease specialists for a consultation. According to the Respondent, the infectious disease specialist stated they would see Patient A the next day. Despite receiving an initial MRI that indicated Patient A's lumbar spine revealed discitis, Respondent failed to have a "stat" neurological examination performed and failed to seek a "stat" neurological consultation with a neurology specialist. In addition, Respondent only requested a regular infectious disease consultation rather than indicating that a "stat" infectious disease consultation was required. Respondent also asked the infectious disease specialist if Patient A's antibiotics should be changed and the infectious disease specialist requested that the antibiotics remain the same until they say Patient A for the consultation. On the next day, July 18, 2017, Respondent documented that he made the infectious disease consultation in his July 18, 2017, progress note.

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14. According to Respondent, he next saw Patient A on July 18, 2017, between 10:00 a.m. and 11:00 a.m. Respondent drafted and signed a progress note July 18, 2017, at 2:44 p.m. Respondent's progress note documented that Patient A's lumbar spine MRI from July 17, 2017, showed evidence of discitis and that Respondent had obtained an infectious disease consultation and that the specialist was scheduled to see the patient. At the time of Respondent's visit with Patient A on July 18, 2017, between 10:00 and 11:00 a.m., the infectious disease specialist had not yet seen Patient A. At this point more than twelve hours had elapsed since Respondent had received the results of Patient A's lumbar spine MRI. Respondent noted that Patient A's chest CT scan indicated multifocal pneumonia and that blood cultures were presumptive for MSSA[6]. The Respondent documented that Patient A reported that his back pain was better as compared to yesterday. Respondent documented under the neurological examination that there were no complaints of headache or weakness and under the back examination, that Patient A was positive for low back pain. There is no evidence that Respondent performed a comprehensive neurological examination including, whether Patient A was suffering from lower extremity weaknesses, Patient A's reflexes, Patient A's motor strength, and Patient A's sensations in his extremities.

15. During Respondent's interview with the Medical Board on March 2, 2020, he stated that he saw Patient A on July 18, 2017, and that the patient reported to him that his pain was better. The Respondent said he performed his examination and then the infectious disease specialist saw Patient A. According to Respondent, he was writing his July 18, 2017, progress note when the infectious disease specialist came up to him around 2:00 p.m. and the infectious disease specialist was concerned with the patient because the patient had weakness in his legs. According to the Respondent, the infectious disease specialist stated he would order an MRI for the rest of Patient A's spine. The Respondent stated that he went off shift at 6:00 p.m. and the comprehensive MRI results were not back yet when he went off shift. Respondent told the nurses to call him after hours when the MRI results came back. The Respondent stated that when he received the comprehensive MRI results, he called the on-call hospitalist who began looking for a

[6] Methicillin-sensitive Staphylococcus aureus.

consultation for spine surgery. Eventually, the hospital physicians learned that there were no surgical spine services in the area that could treat Patient A's abscess and Patient A was transferred out of the area to a more specialized hospital.

16. The infectious disease specialist documented a progress note on July 18, 2017, and signed it on July 24, 2017. In the infectious disease specialist's progress note of his visit with Patient A at approximately 3:00 p.m., he documented that Patient A had staph sepsis, severe back pain with abnormal lumbar imaging, and bilateral lower extremity neuropathy. The infectious disease specialist also documented that he consulted with a spine specialist at the time he performed his examination of Patient A and the spine specialist recommended a comprehensive MRI. As noted above the infectious disease specialist ordered the comprehensive MRI. The infectious disease specialist noted that Patient A was having a hard time moving his lower extremities on neurological examination. On July 15, 2020, during an interview with the Medical Board, the infectious disease specialist stated that the Respondent failed to indicate to him during the initial consultation on July 17, 2017, whether the infectious disease consultation with Patient A was urgent. The infectious disease specialist stated that he did not know Patient A's status or any of the developments of the case prior to his examination on July 18, 2017. According to the infectious disease consultant, he did not see the patient earlier than 3:00 p.m. on July 18, 2017, because the Respondent did not classify the consultation as being urgent.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

17. Respondent's license is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he committed gross negligence during the care and treatment of Patient A. The circumstances are as follows:

18. Complainant realleges paragraphs 7 through 16, and those paragraphs are incorporated by reference as if fully set forth herein.

19. Respondent's care and treatment of Patient A shows gross negligence because he failed to perform a formal neurological examination and assessment and/or order expedited medical imaging and/or make an expedited referral for specialist consultation despite the fact that

Patient A exhibited a clear infectious process, had back pain, needed a Foley catheter, and experienced deteriorating neurologic symptoms.

SECOND CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Medical Record Keeping)

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

21. Complainant realleges paragraphs 7 through 19, and those paragraphs are incorporated by reference as if fully set forth herein.

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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 83324, issued to Pritpal Singh Randhawa, M.D.;

2. Revoking, suspending or denying approval of Pritpal Singh Randhawa, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Pritpal Singh Randhawa, 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: AUG 11 2020

WILLIAM PRASFIKA
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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