

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

In the Matter of the First Amended
Accusation Against:

Pramod Multani, M.D.

Physician's and Surgeon's
Certificate No. A 38056

Respondent.

Case No.: 800-2017-030467

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 16, 2023.

IT IS SO ORDERED: February 14, 2023.

MEDICAL BOARD OF CALIFORNIA



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

1 ROB BONTA
Attorney General of California
2 EDWARD KIM
Supervising Deputy Attorney General
3 State Bar No. 195729
Department of Justice
4 300 So. Spring Street, Suite 1702
Los Angeles, CA 90013
5 Telephone: (213) 269-6000
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6 *Attorneys for Complainant*

7
8 **BEFORE THE**
9 **MEDICAL BOARD OF CALIFORNIA**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

11 In the Matter of the First Amended Accusation Against:	Case No. 800-2017-030467
12 PRAMOD MULTANI, M.D. 13 12214 Lakewood Blvd., Suite 110 14 Downey, CA 90242-2662	OAH No. 2020060911.1
15 Physician's and Surgeon's Certificate No. A 38056,	STIPULATED SETTLEMENT AND DISCIPLINARY ORDER
16 Respondent.	

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

19 **PARTIES**

20 1. William Prasifka (Complainant) is the Executive Director of the Medical Board of
21 California (Board). He brought this action solely in his official capacity and is represented in this
22 matter by Rob Bonta, Attorney General of the State of California, by Edward Kim, Supervising
23 Deputy Attorney General.

24 2. Respondent Pramod Multani, M.D. (Respondent) is represented in this proceeding by
25 attorney Gregory D. Werre, whose address is: Reback, McAndrews & Blessey, LLP,
26 1230 Rosecrans Avenue, Suite 450, Manhattan Beach, CA 90266.

27 3. On or about February 22, 1982, the Board issued Physician's and Surgeon's
28 Certificate No. A 38056 to Pramod Multani, M.D. (Respondent). The Physician's and Surgeon's

1 Certificate was in full force and effect at all times relevant to the charges brought in First
2 Amended Accusation No. 800-2017-030467, and will expire on June 30, 2023, unless renewed.

3 **JURISDICTION**

4 4. First Amended Accusation No. 800-2017-030467 was filed before the Board, and is
5 currently pending against Respondent. The First Amended Accusation and all other statutorily
6 required documents were properly served on Respondent. Respondent timely filed his Notice of
7 Defense contesting the Accusation.

8 5. A copy of First Amended Accusation No. 800-2017-030467 is attached as Exhibit A
9 and incorporated herein by reference.

10 **ADVISEMENT AND WAIVERS**

11 6. Respondent has carefully read, fully discussed with counsel, and understands the
12 charges and allegations in First Amended Accusation No. 800-2017-030467. Respondent has
13 also carefully read, fully discussed with his counsel, and understands the effects of this Stipulated
14 Settlement and Disciplinary Order.

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

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

24 **CULPABILITY**

25 9. Respondent understands and agrees that the charges and allegations in First Amended
26 Accusation No. 800-2017-030467, if proven at a hearing, constitute cause for imposing discipline
27 upon his Physician's and Surgeon's Certificate. Respondent agrees that, at a hearing, Complainant
28 could establish a prima facie case or factual basis for the charges in First Amended Accusation

1 No. 800-2017-030467, and that Respondent hereby gives up his right to contest those charges.

2 10. Notwithstanding anything to the contrary contained herein, Respondent admits that he
3 failed to adequately document his decision making and conversations with Patient A relating to
4 her refusal to receive treatment for her deteriorating kidney functioning and the decision that she
5 be placed in hospice, in violation of Business and Professions Code section 2266.

6 11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to
7 discipline and he agrees to be bound by the Board's probationary terms as set forth in the
8 Disciplinary Order below.

9 **CONTINGENCY**

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

20 13. Respondent agrees that if he ever petitions for early termination or modification of
21 probation, or if an accusation and/or petition to revoke probation is filed against him before the
22 Board, all of the charges and allegations contained in First Amended Accusation No. 800-2017-
23 030467 shall be deemed true, correct and fully admitted by respondent for purposes of any such
24 proceeding or any other licensing proceeding involving Respondent in the State of California.

25 14. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to
26 be an integrated writing representing the complete, final, and exclusive embodiment of the
27 agreements of the parties in the above-entitled matter.

28 15. The parties understand and agree that Portable Document Format (PDF) and facsimile

1 copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile
2 signatures thereto, shall have the same force and effect as the originals.

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

6 **DISCIPLINARY ORDER**

7 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 38056 issued
8 to Respondent PRAMOD MULTANI, M.D. is revoked. However, the revocation is stayed and
9 Respondent is placed on probation for five (5) years on the following terms and conditions:

10 1. **EDUCATION COURSE.** Within 60 calendar days of the effective date of this
11 Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee
12 for its prior approval educational program(s) or course(s) which shall not be less than 60 hours
13 per year, for each year of probation. The educational program(s) or course(s) shall be aimed at
14 correcting any areas of deficient practice or knowledge and shall be Category I certified. The
15 educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to
16 the Continuing Medical Education (CME) requirements for renewal of licensure. Following the
17 completion of each course, the Board or its designee may administer an examination to test
18 Respondent's knowledge of the course. Respondent shall provide proof of attendance for 85
19 hours of CME of which 60 hours were in satisfaction of this condition.

20 2. **MEDICAL RECORD KEEPING COURSE.** Within 60 calendar days of the effective
21 date of this Decision, Respondent shall enroll in a course in medical record keeping approved in
22 advance by the Board or its designee. Respondent shall provide the approved course provider
23 with any information and documents that the approved course provider may deem pertinent.
24 Respondent shall participate in and successfully complete the classroom component of the course
25 not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully
26 complete any other component of the course within one (1) year of enrollment. The medical
27 record keeping course shall be at Respondent's expense and shall be in addition to the Continuing
28 Medical Education (CME) requirements for renewal of licensure.

1 A medical record keeping course taken after the acts that gave rise to the charges in the
2 First Amended Accusation, but prior to the effective date of the Decision may, in the sole
3 discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the
4 course would have been approved by the Board or its designee had the course been taken after the
5 effective date of this Decision.

6 Respondent shall submit a certification of successful completion to the Board or its
7 designee not later than 15 calendar days after successfully completing the course, or not later than
8 15 calendar days after the effective date of the Decision, whichever is later.

9 3. PROFESSIONALISM PROGRAM (ETHICS COURSE). Within 60 calendar days of
10 the effective date of this Decision, Respondent shall enroll in a professionalism program, that
11 meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1.
12 Respondent shall participate in and successfully complete that program. Respondent shall
13 provide any information and documents that the program may deem pertinent. Respondent shall
14 successfully complete the classroom component of the program not later than six (6) months after
15 Respondent's initial enrollment, and the longitudinal component of the program not later than the
16 time specified by the program, but no later than one (1) year after attending the classroom
17 component. The professionalism program shall be at Respondent's expense and shall be in
18 addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

19 A professionalism program taken after the acts that gave rise to the charges in the First
20 Amended Accusation, but prior to the effective date of the Decision may, in the sole discretion of
21 the Board or its designee, be accepted towards the fulfillment of this condition if the program
22 would have been approved by the Board or its designee had the program been taken after the
23 effective date of this Decision.

24 Respondent shall submit a certification of successful completion to the Board or its
25 designee not later than 15 calendar days after successfully completing the program or not later
26 than 15 calendar days after the effective date of the Decision, whichever is later.

27 4. CLINICAL COMPETENCE ASSESSMENT PROGRAM. Within 60 calendar days
28 of the effective date of this Decision, Respondent shall enroll in a clinical competence assessment

1 program approved in advance by the Board or its designee. Respondent shall successfully
2 complete the program not later than six (6) months after Respondent's initial enrollment unless
3 the Board or its designee agrees in writing to an extension of that time.

4 The program shall consist of a comprehensive assessment of Respondent's physical and
5 mental health and the six general domains of clinical competence as defined by the Accreditation
6 Council on Graduate Medical Education and American Board of Medical Specialties pertaining to
7 Respondent's current or intended area of practice. The program shall take into account data
8 obtained from the pre-assessment, self-report forms and interview, and the Decision(s),
9 Accusation(s), and any other information that the Board or its designee deems relevant. The
10 program shall require Respondent's on-site participation for a minimum of three (3) and no more
11 than five (5) days as determined by the program for the assessment and clinical education
12 evaluation. Respondent shall pay all expenses associated with the clinical competence
13 assessment program.

14 At the end of the evaluation, the program will submit a report to the Board or its designee
15 which unequivocally states whether the Respondent has demonstrated the ability to practice
16 safely and independently. Based on Respondent's performance on the clinical competence
17 assessment, the program will advise the Board or its designee of its recommendation(s) for the
18 scope and length of any additional educational or clinical training, evaluation or treatment for any
19 medical condition or psychological condition, or anything else affecting Respondent's practice of
20 medicine. Respondent shall comply with the program's recommendations.

21 Determination as to whether Respondent successfully completed the clinical competence
22 assessment program is solely within the program's jurisdiction.

23 If Respondent fails to enroll, participate in, or successfully complete the clinical
24 competence assessment program within the designated time period, Respondent shall receive a
25 notification from the Board or its designee to cease the practice of medicine within three (3)
26 calendar days after being so notified. The Respondent shall not resume the practice of medicine
27 until enrollment or participation in the outstanding portions of the clinical competence assessment
28 program have been completed. If the Respondent did not successfully complete the clinical

1 competence assessment program, the Respondent shall not resume the practice of medicine until a
2 final decision has been rendered on the accusation and/or a petition to revoke probation. The
3 cessation of practice shall not apply to the reduction of the probationary time period.

4 5. SOLO PRACTICE PROHIBITION. Respondent is prohibited from engaging in the
5 solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice
6 where: 1) Respondent merely shares office space with another physician but is not affiliated for
7 purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that
8 location.

9 If Respondent fails to establish a practice with another physician or secure employment in
10 an appropriate practice setting within 60 calendar days of the effective date of this Decision,
11 Respondent shall receive a notification from the Board or its designee to cease the practice of
12 medicine within three (3) calendar days after being so notified. The Respondent shall not resume
13 practice until an appropriate practice setting is established.

14 If, during the course of the probation, the Respondent's practice setting changes and the
15 Respondent is no longer practicing in a setting in compliance with this Decision, the Respondent
16 shall notify the Board or its designee within five (5) calendar days of the practice setting change.
17 If Respondent fails to establish a practice with another physician or secure employment in an
18 appropriate practice setting within 60 calendar days of the practice setting change, Respondent
19 shall receive a notification from the Board or its designee to cease the practice of medicine within
20 three (3) calendar days after being so notified. The Respondent shall not resume practice until an
21 appropriate practice setting is established.

22 6. PROHIBITIONS ON PRACTICE. Respondent shall have the following restrictions
23 on his medical practice:

24 (A) Respondent is prohibited from practicing medicine within the same premises,
25 including, without limitation, any building, where Anju Multani (his spouse) practices law.

26 (B) Respondent is prohibited from recommending, prescribing, and/or ordering any patient
27 into hospice care ("Hospice Order") unless the following conditions are met:

28 (i) Respondent must physically evaluate the patient through a face-to-face visit and

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prepare a written certification on the date of such evaluation which includes:

- (a) a statement that the patient has a medical prognosis of 6 months or less if the terminal illness runs its normal course; and
- (b) a brief narrative statement that includes patient-specific clinical findings and other documentation supporting a life expectancy of 6 months or less (e.g., signs, symptoms, laboratory testing, weights, anthropomorphic measurements, oral intake) and Respondent’s rationale for his Hospice Order;

(ii) Respondent must obtain a documented informed consent from the patient, and the patient must acknowledge in writing that the patient accepts hospice and comfort care (palliative care) instead of treatment for any terminal illness and related conditions; and

(iii) Respondent must document that a second physician and surgeon (the patient’s primary care physician, if the patient has a primary care physician) has physically evaluated the patient through a face-to-face visit, and that second physician and surgeon must certify in writing that the patient is terminally ill (with a life expectancy of 6 months or less).

After the effective date of this Decision, all patients being treated by the Respondent and who are (a) to his knowledge, current or former clients of his spouse, and/or (b) patients who are likely to become hospice patients within six months, shall be notified that the Respondent is subject to these conditions of prohibited practice. Any new patients, who are (a) to his knowledge, current or former clients of his spouse, and/or (b) patients who are likely to become hospice patients in within six months, must be provided this notification at the time of their initial appointment. Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient’s name, address and phone number; 2) patient’s medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

7. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the

1 Respondent shall provide a true copy of this Decision and First Amended Accusation to the Chief
2 of Staff or the Chief Executive Officer at every hospital where privileges or membership are
3 extended to Respondent, at any other facility where Respondent engages in the practice of
4 medicine, including all physician and locum tenens registries or other similar agencies, and to the
5 Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage
6 to Respondent. Respondent shall submit proof of compliance to the Board or its designee within
7 15 calendar days.

8 This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

9 8. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules
10 governing the practice of medicine in California and remain in full compliance with any court
11 ordered criminal probation, payments, and other orders.

12 9. INVESTIGATION/ENFORCEMENT COST RECOVERY. Respondent is hereby
13 ordered to reimburse the Board its costs of investigation and enforcement, in the amount of
14 \$64,000 (sixty-four thousand dollars). Costs shall be payable to the Medical Board of California.
15 Failure to pay such costs shall be considered a violation of probation.

16 Payment must be made in full within 30 calendar days of the effective date of the Order, or
17 by a payment plan approved by the Medical Board of California. Any and all requests for a
18 payment plan shall be submitted in writing by Respondent to the Board. Failure to comply with
19 the payment plan shall be considered a violation of probation.

20 The filing of bankruptcy by Respondent shall not relieve respondent of the responsibility to
21 repay investigation and enforcement costs.

22 10. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations
23 under penalty of perjury on forms provided by the Board, stating whether there has been
24 compliance with all the conditions of probation.

25 Respondent shall submit quarterly declarations not later than 10 calendar days after the end
26 of the preceding quarter.

27 11. GENERAL PROBATION REQUIREMENTS.

28 Compliance with Probation Unit

1 Respondent shall comply with the Board's probation unit.

2 Address Changes

3 Respondent shall, at all times, keep the Board informed of Respondent's business and
4 residence addresses, email address (if available), and telephone number. Changes of such
5 addresses shall be immediately communicated in writing to the Board or its designee. Under no
6 circumstances shall a post office box serve as an address of record, except as allowed by Business
7 and Professions Code section 2021, subdivision (b).

8 Place of Practice

9 Respondent shall not engage in the practice of medicine in Respondent's or patient's place
10 of residence, unless the patient resides in a skilled nursing facility or other similar licensed
11 facility.

12 License Renewal

13 Respondent shall maintain a current and renewed California physician's and surgeon's
14 license.

15 Travel or Residence Outside California

16 Respondent shall immediately inform the Board or its designee, in writing, of travel to any
17 areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty
18 (30) calendar days.

19 In the event Respondent should leave the State of California to reside or to practice
20 Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of
21 departure and return.

22 12. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be
23 available in person upon request for interviews either at Respondent's place of business or at the
24 probation unit office, with or without prior notice throughout the term of probation.

25 13. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or
26 its designee in writing within 15 calendar days of any periods of non-practice lasting more than
27 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is
28 defined as any period of time Respondent is not practicing medicine as defined in Business and

1 Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct
2 patient care, clinical activity or teaching, or other activity as approved by the Board. If
3 Respondent resides in California and is considered to be in non-practice, Respondent shall
4 comply with all terms and conditions of probation. All time spent in an intensive training
5 program which has been approved by the Board or its designee shall not be considered non-
6 practice and does not relieve Respondent from complying with all the terms and conditions of
7 probation. Practicing medicine in another state of the United States or Federal jurisdiction while
8 on probation with the medical licensing authority of that state or jurisdiction shall not be
9 considered non-practice. A Board-ordered suspension of practice shall not be considered as a
10 period of non-practice.

11 In the event Respondent's period of non-practice while on probation exceeds 18 calendar
12 months, Respondent shall successfully complete the Federation of State Medical Boards's Special
13 Purpose Examination, or, at the Board's discretion, a clinical competence assessment program
14 that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model
15 Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

16 Respondent's period of non-practice while on probation shall not exceed two (2) years.

17 Periods of non-practice will not apply to the reduction of the probationary term.

18 Periods of non-practice for a Respondent residing outside of California will relieve
19 Respondent of the responsibility to comply with the probationary terms and conditions with the
20 exception of this condition and the following terms and conditions of probation: Obey All Laws;
21 General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or
22 Controlled Substances; and Biological Fluid Testing.

23 14. COMPLETION OF PROBATION. Respondent shall comply with all financial
24 obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the
25 completion of probation. This term does not include cost recovery, which is due within 30
26 calendar days of the effective date of the Order, or by a payment plan approved by the Medical
27 Board and timely satisfied. Upon successful completion of probation, Respondent's certificate
28 shall be fully restored.

1 15. VIOLATION OF PROBATION. Failure to fully comply with any term or condition
2 of probation is a violation of probation. If Respondent violates probation in any respect, the
3 Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and
4 carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke
5 Probation, or an Interim Suspension Order is filed against Respondent during probation, the
6 Board shall have continuing jurisdiction until the matter is final, and the period of probation shall
7 be extended until the matter is final.

8 16. LICENSE SURRENDER. Following the effective date of this Decision, if
9 Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy
10 the terms and conditions of probation, Respondent may request to surrender his or her license.
11 The Board reserves the right to evaluate Respondent's request and to exercise its discretion in
12 determining whether or not to grant the request, or to take any other action deemed appropriate
13 and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent
14 shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its
15 designee and Respondent shall no longer practice medicine. Respondent will no longer be subject
16 to the terms and conditions of probation. If Respondent re-applies for a medical license, the
17 application shall be treated as a petition for reinstatement of a revoked certificate.

18 17. PROBATION MONITORING COSTS. Respondent shall pay the costs associated
19 with probation monitoring each and every year of probation, as designated by the Board, which
20 may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of
21 California and delivered to the Board or its designee no later than January 31 of each calendar
22 year.

23 18. FUTURE ADMISSIONS CLAUSE. If Respondent should ever apply or reapply for a
24 new license or certification, or petition for reinstatement of a license, by any other health care
25 licensing action agency in the State of California, all of the charges and allegations contained in
26 First Amended Accusation No. 800-2017-030467 shall be deemed to be true, correct, and
27 admitted by Respondent for the purpose of any Statement of Issues or any other proceeding
28 seeking to deny or restrict license.


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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Gregory D. Werre. 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: 9/22/2022 
PRAMOD MULTANI, M.D.
Respondent

I have read and fully discussed with Respondent Pramod Multani, 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: 9/22/22 
GREGORY D. WERRE
Attorney for Respondent

ENDORSEMENT

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

DATED: _____

Respectfully submitted,

ROB BONTA
Attorney General of California

Edward Kim
Digitally signed by Edward Kim
Date: 2022.09.26
20:48:09 -07'00'

EDWARD KIM
Supervising Deputy Attorney General
Attorneys for Complainant

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7 *Attorneys for Complainant*

8 **BEFORE THE**
9 **MEDICAL BOARD OF CALIFORNIA**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
STATE OF CALIFORNIA

11 In the Matter of the First Amended Accusation	Case No. 800-2017-030467
12 Against:	
13 PRAMOD MULTANI, M.D.	FIRST AMENDED
14 11480 Brookshire Avenue, Suite 204	ACCUSATION
15 Downey, CA 90241-5018	
16 Physician's and Surgeon's	
17 Certificate No. A 38056,	
18 Respondent.	

17 **PARTIES**

18 1. William Prasifka (Complainant) brings this First Amended Accusation (hereinafter,
19 "Accusation") solely in his official capacity as the Executive Director of the Medical Board of
20 California, Department of Consumer Affairs ("Board").

21 2. On or about February 22, 1982, the Medical Board issued Physician's and Surgeon's
22 Certificate Number A 38056 to Pramod Multani, M.D. ("Respondent"). The Physician's and
23 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought
24 herein and will expire on June 30, 2021, unless renewed.

25 **JURISDICTION**

26 3. This Accusation is brought before the Board, under the authority of the following
27 laws. All section references are to the Business and Professions Code ("Code") unless otherwise
28 indicated.

1 4. Section 2227 of the Code provides that a licensee who is found guilty under the
2 Medical Practice Act may have his or her license revoked, suspended for a period not to exceed
3 one year, placed on probation and required to pay the costs of probation monitoring, or such other
4 action taken in relation to discipline as the Board deems proper.

5 5. Section 2234 of the Code, states:

6 The board shall take action against any licensee who is charged with
7 unprofessional conduct. In addition to other provisions of this article, unprofessional
8 conduct includes, but is not limited to, the following:

9 (a) Violating or attempting to violate, directly or indirectly, assisting in or
10 abetting the violation of, or conspiring to violate any provision of this chapter.

11 (b) Gross negligence.

12 (c) Repeated negligent acts. To be repeated, there must be two or more
13 negligent acts or omissions. An initial negligent act or omission followed by a
14 separate and distinct departure from the applicable standard of care shall constitute
15 repeated negligent acts.

16 (1) An initial negligent diagnosis followed by an act or omission medically
17 appropriate for that negligent diagnosis of the patient shall constitute a single
18 negligent act.

19 (2) When the standard of care requires a change in the diagnosis, act, or
20 omission that constitutes the negligent act described in paragraph (1), including, but
21 not limited to, a reevaluation of the diagnosis or a change in treatment, and the
22 licensee's conduct departs from the applicable standard of care, each departure
23 constitutes a separate and distinct breach of the standard of care.

24 (d) Incompetence.

25 (e) The commission of any act involving dishonesty or corruption that is
26 substantially related to the qualifications, functions, or duties of a physician and
27 surgeon.

28 (f) Any action or conduct that 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.

///

1 **FACTUAL ALLEGATIONS**

2 7. The Board received a complaint from the grandchild of Patient A,¹ an 88-year-old
3 elderly woman who died on January 20, 2016 after Respondent took over her medical care, which
4 had formerly been provided by another medical group for many years. The complaint alleged
5 that Respondent's wife is a lawyer whose office is a converted patient room at Respondent's
6 medical practice, that they share a receptionist, and that she had to expend significant resources to
7 regain control of Patient A's estate from Respondent's spouse, A.M., who is an attorney. The
8 complaint further alleged that during the month prior to her death, Patient A was in relatively
9 good health, but somehow she had been placed under hospice care in or around December 2015
10 where she received a fentanyl patch, oral morphine and Ativan, even though she had been an
11 opiate naive person.

12 8. Respondent first saw Patient A on or about July 17, 2015. She had been receiving
13 medical services from Memorial Cardiology Medical Group for many years with a different
14 cardiologist. Patient A's multiple medical conditions included:² severe mitral regurgitation;
15 severe tricuspid regurgitation; hypertension; implanting of a Medtronic pacemaker on or about
16 May 8, 2012; chronic atrial fibrillation; a history of Coumadin³ use (for anticoagulation for stroke
17 prevention in light of atrial fibrillation which carries a significant risk of stroke and embolism);
18 chronic anemia; thrombocytopenia (low platelets) treated with IV romiplostim (Nplate) weekly
19 infusions; chronic recurring leg edema treated with diuretics; hypertension treated with Benicar,
20 amlodipine and Lasix; coronary artery disease; and a diagnosis of peripheral artery disease.

21 9. At that first visit with Respondent, Patient A's complaints included hypertension and
22 dizziness. However, Respondent's chart entry for history of present illness was blank. Further,
23 there was no description of dizziness in the chart for that day. There was no narrative regarding
24 her past medical history. An EKG revealed a paced rhythm. There was no narrative assessment

25 ¹ The patients are designated by letters to address privacy concerns. The identity of the
26 patients is known to the Respondent.

27 ² As used herein, including or included means, including, without limitation.

28 ³ Coumadin is a trade name for warfarin which is a medication that is used as an
anticoagulant (blood thinner). It is commonly used to treat blood clots such as deep vein
thrombosis and pulmonary embolism and to prevent stroke in people who have atrial fibrillation,
valvular heart disease or artificial heart valves.

1 either. Respondent's plan included ordering a CT of the brain, carotid Doppler study and
2 echocardiogram.

3 10. A CT scan of Patient A's brain was performed on or about July 28, 2015. It revealed
4 moderate cerebral atrophy, small remote left basal ganglia lacunar infarct (prior stroke) and mild
5 to moderate left parieto-occipital encephalomalacia compatible with residual/remote cerebral
6 infarction (prior stroke). The report of the CT of the patient's head, dated July 30, 2015, included
7 handwritten notes as "discussed" on September 10, 2015.

8 11. Lab results for a sample dated August 28, 2015, included: HCT of 28.6 with platelets
9 134,000, BUN of 62 and creatinine: 1.4 with potassium 4.7, an HBA1c of 5.3 and LDL
10 cholesterol of 57, and TSH of 0.31. A note written on the lab results page stated that the patient
11 must see an endocrinologist.

12 12. A letter dated September 10, 2015, addressed to Patient A informed her to reduce the
13 furosemide (Lasix) from 40 mg to 20 mg a day. A note also told Patient A about an upcoming
14 appointment with Respondent on September 15th along with scheduling a carotid Doppler study
15 and echocardiogram on September 23, 2015.

16 13. On or about September 14, 2015, Respondent saw Patient A again. There was a
17 handwritten note and typed note. The chief complaint and history section only listed
18 hypertension. The documentation failed to contain any information regarding symptoms or test
19 results. Medications listed were metoprolol tartrate 50 mg a day, metolazone 5 mg at bedtime,
20 Benicar 40 mg once a day prn, clonidine 0.1 mg once daily for BP greater than 160/95, Lyrica 75
21 mg three times a day, warfarin 2.5 mg a day, amlodipine 5 mg a day, furosemide 40 mg a day,
22 glipizide 2.5 mg a day and Lopressor 50 mg a day. The assessment portion of the chart listed
23 anemia, non-insulin-dependent diabetes mellitus (NIDDM), hyperlipidemia, hypertension,
24 warfarin therapy, and pacemaker. There was no narrative describing the assessment. The plan
25 was for further labwork, including⁴ CBC, CMP and uric acid. Edema and murmur were noted on
26 the handwritten note but not typed note.

27 14. Lab results for a sample dated September 14, 2015, included: HCT of 29.2 and

28 ⁴ As used herein, including means, including without limitation.

1 platelets 105,000, Bun of 27 and creatinine of 1.1 with potassium 4.3.

2 15. On or about September 23, 2015, the patient underwent a carotid Doppler study
3 which revealed carotid stenosis. On or about September 23, 2015, the patient underwent an
4 echocardiogram which revealed normal left ventricular systolic function with moderate mitral
5 regurgitation and mild pulmonary hypertension.

6 16. Patient A's September 25, 2015, medication list, included amlodipine, digoxin,
7 metoprolol, Benicar, Ambien, Lasix, KCL. A urinalysis, dated the same date revealed two plus
8 leukocytes.

9 17. On or about November 5, 2015 Patient A was seen in urgent care for urinary tract
10 infection, wheezing and edema. Macrobid was prescribed as well as ProAir inhaler. Nebulizer
11 was given during visit.

12 18. On or about November 6, 2015, Respondent saw Patient A, who had a history listing
13 only dyspnea and edema. Medication listed was metoprolol tartrate 50 mg a day, metolazone
14 5 mg at bedtime, Benicar 40 mg once a day pm, clonidine 0.1mg once daily for BP greater than
15 160/95, Lyrica 75 mg three times a day, warfarin 2.5 mg a day, amlodipine 5 mg a day,
16 furosemide 40 mg a day, glipizide 2.5 mg a day and Lopressor 50 mg a day. The assessment
17 included shortness of breath, chronic anemia, chronic NIDDM, hyperlipidemia, chronic
18 hypertension, warfarin therapy, chronic pacemaker. The plan included CBC, CMP and PT/INR
19 next visit, double Lasix and potassium, check daily weights and pm to PIH Downey ER.

20 19. On or about November 11, 2015, Patient A's medication list included amlodipine,
21 digoxin, metoprolol, Benicar, Ambien, Lasix, and KCL. On or about November 12, 2015, a
22 swallowing evaluation from November 10, 2015 was faxed for dysphagia.

23 20. On or about November 18, 2015, the patient had prescriptions for Levaquin 500 mg a
24 day for 7 days, KCL, and her medication list included metoprolol succinate, Benicar,
25 levothyroxine, digoxin and HCTZ.

26 21. On or about November 18, 2015, lab results were as follows: HCT of 29.9 and
27 platelets 60,000, BUN of 61, creatinine of 2.6, potassium of 6.1, and INR of 1.16.

28 22. On or about November 20, 2015, the patient received a swallowing evaluation due to

1 coughing with liquids and difficulty in swallowing.

2 23. On or about November 21, 2015, Respondent ordered a physical therapy evaluation
3 and follow-ups due to decreased endurance, decreased balance and coordination.

4 24. On or about November 21, 2015, Respondent received a request to sign
5 videoflouroscopic study and sign for recommendations and summary from PIH-Downey
6 Outpatient Rehabilitation Department.

7 25. On or about December 1, 2015, Respondent faxed a request for records from Dr. W.,
8 the patient's former cardiologist.

9 26. On or about December 1, 2015, Respondent's nurse practitioner L, saw the patient,
10 and noted worsening leg edema for 2-3 months. No shortness of breath was noted. BMP was
11 ordered, the plan was to follow up in one month.

12 27. On or about December 2, 2015, labs results showed BUN of 61, creatinine of 1.75
13 and potassium of 5.4, HbA1c of 5.6, Uric Acid of 11.3, and vitamin D of 28ng/ml.

14 28. On or about December 7, 2015, an order was made for hematology/oncology
15 consultation to evaluate thrombocytopenia, anemia and myelodysplastic syndrome.

16 29. On or about December 8, 2015, Respondent's nurse practitioner L. saw the patient
17 again. Patient A was noted to have pacer checked with normal function. She had underlying
18 atrial fibrillation in VVIR mode. Patient A was also having difficulty with urination for 2-3
19 weeks. Three plus edema was noted on examination. The patient's written list of medications
20 included: amlodipine, digoxin, metoprolol succinate, Benicar, Lasix, KCL, allopurinol, and
21 Bactrim DS.

22 30. The patient's Medtronic pacemaker was interrogated on or about December 8, 2015
23 in VVIR Mode and the lower rate was 75 bpm.

24 31. On or about December 8, 2015, urinalysis results showed greater than 100 WBCS and
25 culture showed E-coli growth. The culture was resistant to Bactrim. Bactrim was stopped and
26 Levaquin 500 mg was referenced but the documentation is unclear.

27 32. On or about December 21, 2015, labs results showed HCT 31.1 and platelets count
28 was 44,000.

1 33. On or about December 15, 2015, 28 pages of Patient A's medical records were
2 received from Dr. W. (patient's prior Cardiologist), via fax.

3 34. On or about December 16, 2015, labs results showed HCT of 29.1 with of platelets
4 93,000 and the note was "stable" as of December 17, 2015.

5 35. On or about December 18, 2015, Respondent saw Patient A with complaints of
6 dyspnea and edema. The medications listed in his note included, metoprolol tartrate, metolazone,
7 Benicar, clonidine, Lyrica, warfarin, amlodipine, furoscamide, glipizide and Lopressor. The
8 assessment showed a shortness of breath and the plan included a CBC, CMP and home nurse
9 follow-up. The other assessment was chronic anemia, NIDDM, chronic hyperlipidemia, chronic
10 hypertension, warfarin therapy patient, chronic pacemaker and CHF. He also noted that
11 amlodipine was discontinued and HCTZ started. Levothyroxine, digoxin, metoprolol and KCL
12 were refilled. Oxygen saturation was noted at 86% and Oxygen 2 liters was ordered.

13 36. On or about December 23, 2015, lab results showed that HCT of 31.3, platelets of
14 172, potassium of 6.0, BUN of 94 and creatinine of 3.6, and BNP of 828. Labs were noted as
15 "stable" as of December 29, 2015.

16 37. On or about December 23, 2015, Lincare indicated that home oxygen was prescribed
17 due to congestive heart failure ("CHF") and low oxygen saturation of 86%. An order of medical
18 necessity was signed by Respondent on or about January 6, 2015.

19 38. On or about December 31, 2015, Respondent allegedly had a telephone conversation
20 with Patient A, during which an alleged decision was made for Patient A to undergo a hospice
21 evaluation. An order to Sunset Hospice care, dated December 31, 2015 was made, and home
22 health with Rae Star Health systems was terminated. An order with a written certification was
23 prepared, indicating that Patient A had a terminal illness and a life expectancy of six months or
24 less.

25 39. On or about December 31, 2015, Sunset Hospice evaluated Patient A. At that time
26 her medication included: Tylenol, Colace, Lasix, KCL, digoxin, levothyroxine, metoprolol
27 succinate, Benicar, HCTZ, Duoneb, Lumigan and Alphagan eye drops for glaucoma.

28 40. On or about January 20, 2016, Patient A expired. A private autopsy performed by

1 another doctor noted that Patient A had severe arteriosclerosis, emphysema and cirrhosis.

2 41. On or about March 26, 2019, a Department of Consumer Affairs investigator and
3 medical consultant conducted a subject interview ("SI") of Respondent on behalf of the Board,
4 during which he made many conflicting statements and provided information that was not
5 documented in the patient's medical record. He described how Patient A began treatment with
6 him. He stated that her prior cardiologist, Dr. W. had some health issues and retired. And, that
7 she was looking for another cardiologist and that another patient recommended that she come to
8 see him. He described that Patient A "was a lovely lady, very elegant . . . very smart, very
9 knowledgeable." In addition, he described Patient A as mentally sharp, "very, very sharp,
10 extremely sharp." He also stated that his office switched to electronic record keeping in or
11 around the third quarter of 2015.

12 42. In fact, Dr. W. did not retire. Moreover, Respondent's wife who shares an office
13 space with the Respondent saw Patient A, on or about April 21, 2015, in connection with revising
14 Patient A's estate plan. Further, Respondent's medical records contain Patient A's new patient
15 information sheet signed by the patient on July 15, 2015, which lists Respondent's wife at 8333
16 Iowa Street, Suite 201, Downey, CA 90241, under the patient's "Spouse/Emergency Contact
17 Info." Curiously, despite Dr. W.'s alleged retirement, Respondent requested medical records
18 from his office on or about December 1, 2015, nearly nine months after his alleged retirement.

19 43. During his SI, Respondent incredulously stated that he did not know that his wife's
20 employee, R.A.⁵ ("Paralegal") was a caregiver for Patient A at her home until after Patient A had
21 passed away and litigation ensued from Patient A's family who sought to gain back control of
22 Patient A's estate. Respondent's wife had made an unsuccessful attempt to obtain control of
23 Patient A's estate through conservatorship.

24 44. On or about June 18, 2018, Respondent stated at a deposition (the "June 18 Depo"),
25 that Paralegal had stopped working for him in or around 2003.

26 ⁵ Paralegal had been Respondent's former employee (assistant billing manager) which he
27 estimated was about 15 years prior to the then current date. In addition, Paralegal was previously
28 convicted in 2003 of grand theft and forgery and also she suffered a civil judgment in 2002 in
connection with a complaint alleging embezzlement of funds through check forgery and credit
card use in an amount over \$107,000.

1 45. Paralegal's name appears throughout Respondent's medical chart for Patient A,
2 including on a faxed order for a swallow evaluation, dated November 10, 2005 from Paralegal; on
3 physician orders, dated November 25, 2015 and December 31, 2015; on correspondence relating
4 to a prescription, dated November 16, 2016; and on a faxed request for records to another
5 provider, dated July 27, 2013.⁶ This was despite the fact that he stated that Paralegal did not do
6 any medical services, was not a certified medical assistant, and was unlicensed. Respondent
7 stated that Paralegal's only role was in providing billing services.

8 46. Unbelievably, Respondent also stated that he did not know about his wife's legal
9 maneuverings over Patient A's estate until after the aforesaid litigation. When asked, "how does
10 [Paralegal] have time to function as a caregiver for somebody like Patient A when she's working
11 full time for [Respondent's] wife," Respondent replied, "You know, from what I understand, she
12 used to do it in the evening, after work." In addition to being involved with Patient A's medical
13 care, Paralegal allegedly used Patient A's credit card and received checks from Patient A's bank
14 accounts.

15 47. At the June 18 Depo, Respondent also stated that Patient A's "condition really started
16 deteriorating" probably towards September. However, at his SI, Respondent indicated that
17 Patient A's condition took a turn for the worse in November and that in "November/December,
18 she really started, you know, going downhill." At the June 18 Depo, Respondent also claimed
19 that he was not aware that Paralegal was a caregiver for Patient A on November 24, 2015.
20 Respondent further stated that he never had a conversation with Paralegal about how she became
21 a caregiver for Patient A. However, the records of Rae Star Health Systems contain a physician's
22 order, dated December 3, 2015, stating, "Received a call from [Paralegal] (PCG) informing the
23 agency about an order/instructions below." The order included medication for potassium chloride
24 and noted that the patient had a small cut on her big toe and ordered to cleanse the affected area
25 and apply a topical antibiotic.

26 ⁶ At the June 18 Depo, Respondent admitted that these references were to his wife's
27 Paralegal in his medical records. He also stated that his wife's office and his own were "in the
28 same office, same floor, and people might mingle with each other, and that "she would be in the
hallway." In fact, Respondent and his wife shared a receptionist in addition to the physical space
where their offices were located.

1 **FIRST CAUSE FOR DISCIPLINE**

2 **(Repeated Negligent Acts)**

3 48. Respondent is subject to disciplinary action under Code section 2234, subdivision (c),
4 in that Respondent committed repeated negligent acts in connection with his provision of medical
5 services to Patient A. The circumstances are as follows: Paragraphs 7 through 47, inclusive, are
6 incorporated herein by reference as if fully set forth.

7 **Initial Evaluation, Documentation and Evaluation of Dizziness.**

8 49. On or about July 17, 2015 and thereafter, Respondent committed negligence when he
9 failed to adequately perform and/or document, an evaluation and assessment of Patient A at his
10 initial visit with her, including his failure to document a full history, complete past medical
11 history and clinical assessment. He also negligently failed to adequately follow up with the
12 Patient's complaints of dizziness and her history of prior strokes.

13 (a) Regarding Patient A's presentation at her first patient visit with Respondent, he
14 failed to adequately document a proper narrative of the patient's initial history. Instead,
15 only two words were listed, "Hypertension" and "dizziness." He also failed to adequately
16 describe the patient's symptoms, e.g., the location, quality, severity, duration, timing,
17 context, modifying factors and associated signs and symptoms. None of these details were
18 documented. Furthermore, characteristics and precipitating factors were not documented.
19 He also failed to perform, obtain, and/or document an adequate past medical history.

20 (b) In addition, his diagnoses failed to include mitral regurgitation and atrial
21 fibrillation. Respondent further failed to render any opinion or differential diagnosis
22 regarding the etiology of the dizziness. At his subject interview, Respondent stated that the
23 patient "was very frail," and "had clinical signs of -- congestive heart failure" and that he
24 was concerned about protecting the patient from a stroke or a hemorrhage in the brain
25 (results of a CT scan of the patient's head were abnormal and showed two prior strokes).
26 Despite his alleged concerns, Respondent never adequately performed and/or documented
27 any re-assessment, treatment and follow-up on the patient's dizziness and prior strokes at
28 follow-up visits.

1 Patient A's Prior Stroke and Atrial Fibrillation.

2 50. On or about July 17, 2015, and thereafter, Respondent committed negligence in
3 connection with his care of Patient A regarding the diagnosis, treatment and/or medical
4 addressing of her atrial fibrillation and/or risk of stroke. The patient presented to him with atrial
5 fibrillation and a history of stroke. However, his records did not include documentation
6 adequately addressing the patient's atrial fibrillation and history of stroke; he only documented
7 warfarin therapy. Further, his records include incorrect documentation regarding antithrombotic
8 treatment of atrial fibrillation. In addition, his records also failed to include an adequate
9 discussion with the patient regarding the risks and benefits of anticoagulation for atrial fibrillation
10 given her clinical presentation.

11 (a) Respondent's records fail to include a narrative regarding the history of present
12 illness. Further, there is no documentation of a discussion regarding the risks and benefits
13 of anticoagulation for a patient with atrial fibrillation and a history of stroke in any of
14 Respondent's notes throughout the time he cared for Patient A. CT images of Patient A's
15 head revealed two areas of stroke. Additionally, the patient had chronic atrial fibrillation,
16 which made her a high risk for recurrent thromboembolic stroke. Yet, atrial fibrillation was
17 never documented, only warfarin therapy. The Patient had chronic atrial fibrillation and a
18 pacemaker in VVIR⁷ mode (the setting for atrial fibrillation). Her CHADsVASC⁸ score of
19 7 (prior CVA 2 points, age 2 points, female, hypertension and diabetes) was very high.
20 Patient A also had a high risk of bleeding due to prior CVA, age, a prior GI bleed, anemia
21 and thrombocytopenia.

22 (b) Although chronic warfarin therapy is listed on Respondent's initial note and is

23 ⁷ VVI(R) is ventricular demand pacing. The ventricle is paced, sensed, and the pulse
24 generator inhibits pacing output in response to a sensed ventricular event. This mode of pacing
25 prevents ventricular bradycardia and is primarily indicated in patients with atrial fibrillation with
a slow ventricular response

26 ⁸ The CHADsVASC score is a clinical prediction tool for estimating the risk of stroke in
27 patients with atrial fibrillation (AF), a common and serious heart arrhythmia associated with
28 thromboembolic stroke. Such a score is used to determine whether or not treatment is required
with anticoagulation therapy or antiplatelet therapy, since AF can cause stasis of blood in the
upper heart chambers, leading to the formation of a mural thrombus that can dislodge into the
blood flow, reach the brain, cut off supply to the brain, and cause a stroke.

1 listed on her medication list dated July 17, 2015, it is unlikely that Patient A was taking
2 warfarin. On or about November 18, 2015, an INR⁹ test result was 1.16 which is consistent
3 with Patient A not taking warfarin or the appropriate dose thereof. Nonetheless, the INR
4 results and the need for regular checks were not documented in Respondent's medical
5 record. Further, her prior doctor, Dr. W's, did not include warfarin in his last note.
6 Warfarin had been stopped by Dr. L. in or around October 2012 due to a recurrent
7 gastrointestinal bleed. However, Respondent's note incorrectly listed warfarin as an
8 ongoing medication. At his SI, Respondent alleged that he still believed that Patient A was
9 on anticoagulant therapy with warfarin. Doctors treating patients with atrial fibrillation and
10 antithrombotic therapy should adequately discuss with them the benefits and risks of
11 treatment, including stroke and bleeding. Options should be discussed such as aspirin,
12 restarting Coumadin or trying newer anti coagulation medications, including Eliquis.
13 However, no such discussion was documented. Thus, Respondent, negligently failed to
14 discuss and/or document the risks and benefits of anticoagulation treatment for Patient A
15 who had atrial fibrillation and a very high risk of recurrent stroke.

16 Dyspnea, Hypoxia, Renal Insufficiency; and Refusal of Treatment,

17 51. On or about July 17, 2015 and thereafter, Respondent committed negligence in
18 connection with his care of Patient A regarding his failure on or about December 18, 2015, to
19 adequately perform and/or document, an adequate evaluation, assessment and treatment plan for
20 Patient A regarding her health conditions, including, dyspnea, hypoxia, renal insufficiency, and
21 cardiac health issues, including congestive heart failure.

22 52. On or about July 17, 2015, and thereafter, Respondent committed negligence in
23 connection with his care of Patient A regarding his failure on December 18, 2015, to adequately
24 perform and/or document, the patient's refusal of treatment, including, an informed refusal by the
25 patient to undergo a hospital evaluation, and/or to see a nephrologist, among others.

26 _____
27 ⁹ International Normalised Ratio (INR) testing is well established as an integral part of
28 warfarin treatment. INR has a critical role in maintaining the warfarin response within a
therapeutic range, to provide the benefits of anticoagulation, while avoiding the risks of
hemorrhage.

1 53. On or about December 18, 2015, Respondent saw Patient A with a chief complaint of
2 dyspnea and lower extremity edema. However, he failed to document any narrative regarding the
3 history of present illness. He also failed to describe any symptoms, i.e., the location, quality,
4 severity, duration, timing, context, modifying factors and associated signs and symptoms. His
5 records were inadequate and inaccurate.

6 (a) Respondent's physical exam notations document a normal lung exam (not
7 consistent with congestive heart failure) and 3-4 plus pedal edema. He also listed shortness
8 of breath. Respondent further documented congestive heart failure in his assessment, but
9 failed to document any narrative assessment or differential of a possible etiology.

10 Respondent also failed to explain why Patient A would develop significant congestive heart
11 failure (as well as worsening renal failure) or why she deteriorated. Respondent failed to
12 explain if the patient's etiology was a systolic dysfunction, diastolic dysfunction or due to
13 valvular disease. Respondent stated in his SI that Patient A had severe valvular disease that
14 would require surgery, but Patient A had a more recent echocardiogram performed by
15 Respondent that revealed only moderate mitral regurgitation, which was not significant and
16 did not require surgery. Mitral regurgitation or valvular heart disease was never mentioned
17 in Respondent's progress notes. The past medical records from Patient A's prior
18 cardiologist, Dr. W., had only been received by Respondent on or about December 15,
19 2015, but there is no note that these records were reviewed in his December 15, 2015 chart
20 note. No update of any diagnoses (e.g. severe mitral regurgitation) or medication list (e.g.
21 patient not on warfarin) was documented by Respondent. These prior records should have
22 been obtained and reviewed soon after Respondent initiated care for Patient A on or about
23 July 17, 2015. Knowledge of past and current conditions is necessary to treat a new patient
24 to ensure proper treatment, e.g., correct medications and testing.

25 (b) Hypoxia with oxygen saturation of 86% is noted and oxygen (2 liters) was
26 recommended. However, there were no rales noted in his lung exam. He also failed to
27
28

1 order a chest X-ray, despite his diagnosis of CHF. Amlodipine¹⁰ was stopped and HCTZ,¹¹
2 12.5 mg a day was ordered, without any explanation. Patient A's creatinine had been
3 elevated up to 1.7 and 2.6 with elevated potassium. However, these findings were never
4 mentioned in his progress notes (e.g. diagnosis renal insufficiency and hyperkalemia). His
5 record failed to address the elevated creatinine and potassium levels.¹² He also stated that
6 despite his desire that she see a nephrologist, she refused to go; but this interaction was not
7 documented. He also failed to adequately address the patient's digoxin level.¹³ Due to
8 significant hypoxia, Patient A should have been referred to the emergency room for
9 evaluation, admission and treatment. However, Respondent's records do not address this.
10 Given all her life-threatening conditions, Respondent should have discussed the risks and
11 benefits of her options and clearly documented the process, including her refusal of
12 treatment. However, he negligently failed to do so.

13 Placing Patient A in Hospice on or about December 31, 2015.

14 54. On or about July 17, 2015 and thereafter, Respondent committed negligence in
15 connection with his care of Patient A regarding performing and/or documenting, the patient's
16 decision making process regarding the patient's decision to choose hospice care at her home as
17 opposed to hospitalization for end-of-life concerns, and/or a discussion of Patient A's options and
18 alternatives for treatment. On or about December 23, 2015, Patient A's labs revealed
19 significantly abnormality. Her kidney function had significantly deteriorated.

20 55. On or about December 31, 2015, Respondent alleged, incredulously, that an
21 undocumented call occurred between Respondent and Patient A. According to Respondent, he
22 had a five to ten minute telephone conversation with Patient A and he informed her that she was

23 ¹⁰ A high blood pressure medication.

24 ¹¹ Hydrochlorothiazide is a thiazide diuretic (water pill) that helps prevent your body from
25 absorbing too much salt, which can cause fluid retention. HCTZ treats fluid retention (edema) in
26 people with congestive heart failure, cirrhosis of the liver, or kidney disorders, or edema caused
27 by taking steroids or estrogen. This medication is also used to treat high blood pressure
(hypertension).

26 ¹² Elevated creatinine and potassium levels can indicate impaired kidney function or
27 kidney disease. Was elevated creatinine from worsening diabetic neuropathy, prerenal from
28 dehydration from diuretics or from poor cardiac output?

28 ¹³ Digoxin medication is excreted by the kidneys and can cause side effects of nausea and
anorexia (that were not noted).

1 getting worse and that she wanted to know her options. According to Respondent, Patient A was
2 not interested in aggressive measures including hospitalization or dialysis. He alleged that he
3 discussed options with Patient A, and that she opted for hospice. However, Respondent is not
4 sure about these facts. Respondent may have had this discussion on Patient A's visit on or about
5 December 18, 2015. In any event, Respondent failed to document any discussions with the
6 patient regarding hospice care as an option. Respondent did sign an order, but it did not contain
7 an adequate detailing of the process and options. He also ordered that the patient be discharged
8 from her prior facility.

9 **SECOND CAUSE FOR DISCIPLINE**

10 **(Gross Negligence and/or Repeated Negligent Acts)**

11 56. Respondent is subject to disciplinary action under Code section 2234, subdivisions
12 (b) and (c), in that he committed acts of gross negligence and/or negligence in connection with his
13 care and treatment of Patient A. The circumstances are as follows:

14 57. The allegations of the First Cause for Discipline are incorporated herein by reference
15 as if fully set forth.

16 58. In addition, Respondent failed to adequately safeguard Patient A's interests. The
17 patient-physician relationship entails special obligations for the physician to serve the patient's
18 interest because of the specialized knowledge that physicians possess, the confidential nature of
19 the relationship, the vulnerability brought on by illness, and the imbalance of expertise and power
20 between patient and physician. Physicians must avoid an appearance of impropriety and should
21 recognize and address ethical issues.

22 59. On or about July 17, 2015, and thereafter, Respondent committed gross negligence in
23 connection with the ethical issues created by the circumstances of Respondent and his spouse
24 providing services to Patient A and the involvement of Paralegal. Respondent created potential
25 ethical issues. Beginning in or around April 2015, and thereafter, Respondent's spouse provided
26 legal services to Patient A addressing issues of her trust, conservatorship, and who could make
27 medical decisions for her if she became incapacitated. In the other part of their shared office
28 suite, Respondent took over medical care for Patient A and approximately five months later

1 ordered hospice as an end of life option for her.¹⁴ Compounding this situation, Paralegal became
2 more involved in Patient A's care over time, including in connection with her changes in home
3 care, accompanying Patient A to medical appointments, the source of contact for hospice, the title
4 of home caregiver, the title of "DPOA" when Patient A entered hospice care, and financial
5 transactions on behalf of Patient A, including gifts. The situation created risks of a conflict of
6 interests that were potentially detrimental to Patient A. Further, Respondent's documentation
7 failed to provide sufficient support regarding his rationale for taking over Patient A's care. It is
8 not clear why Patient A should travel over sixteen miles from her home to seek medical care with
9 Respondent when she lived in Long Beach and had been receiving adequate treatment at a local
10 hospital and from other physicians affiliated with that hospital where she had been receiving
11 long-term care and had longstanding ties. Respondent alleged that Patient A's longtime
12 cardiologist had retired, but this is not adequately documented in his chart. Furthermore,
13 Respondent's records for Patient A listed the nearest relative as D.T, and Patient A's mailing
14 address as Respondent's and his spouse's shared office location at 8333 Iowa Street #201,
15 Downey, CA 90241 and her phone number was listed as Respondent's spouse's law office
16 number as shown on the legal pleading for the conservatorship application). Moreover,
17 Respondent's chart includes a letter dated November 16, 2015 from his wife addressed to the
18 Administrator at Grace Home HealthCare (which provided care for Patient A for several years) in
19 Long Beach, CA informing her to discharge Patient A immediately and that "your services on the
20 above-named patient will no longer be needed effective today." The letter indicated that a copy
21 of the Power of Attorney was attached, but this was not included in Respondent's chart. Thus,
22 Respondent knew that his wife was involved in Patient A's care and was aware that Patient A had
23 a designated power of attorney. Yet, he failed to document why Patient A was discharged from
24 this service and failed to obtain copies of documents regarding who would make decisions for the

25
26 ¹⁴ The records indicate that Respondent's medical care for Patient A was not limited to
27 cardiac issues. He managed her other issues including ordering and signing off on laboratory
28 studies and urinalysis results, e.g., the urinalysis collected on or about December 8, 2015 was
abnormal and the culture revealed Escherichia coli which was resistant to Bactrim and sensitive
to levofloxacin, which Respondent addressed.

1 patient. The legal documents which Respondent's spouse prepared were relevant and significant
2 to Respondent's care for Patient A and his failure to include copies of them in Patient A's chart
3 represents ethical issues including whether or not his decision to place Patient A on hospice was
4 appropriate in light of the possible conflicting incentives.¹⁵ Paralegal's involvement in Patient
5 A's care also created an additional conflict of interest. Paralegal was listed as the first DPOA
6 with Sunset Hospice Care and she represented herself as the caregiver and spoke with the hospice
7 call nurse on or about January 6, 2016. Her name appears in Respondent's chart as well as a
8 caregiver for Patient A. Respondent created potential risks for foreseeable problems that could
9 negatively affect Patient A by assuming the care of Patient A while she was also a client of his
10 spouse and could be potentially affected by her and/or Paralegal. Respondent failed to adequately
11 document an order for hospice in light of the foregoing circumstances and risks. The
12 conservatorship records and records of other providers further document potential issues
13 surrounding whether Patient A possessed the mental capacity to make important decisions about
14 her care at times, including whether to be placed in hospice care. Respondent's compromised
15 judgement in connection with his spouse's business is further evinced by the code violation when
16 he allowed her to illicitly conduct her legal practice in a patient room in his medical practice.

17 60. On or about July 17, 2015, and thereafter, Respondent committed gross negligence in
18 connection with his failure to adequately safeguard Patient A's interest in connection with his
19 decision to admit Patient A to hospice in light of the risks to her welfare, including her advanced
20 age, chronic conditions, and vulnerabilities (which had required assistance). This decision was
21 against the backdrop of amendments to Patient A's trust in April 2015 that were facilitated by
22 Respondent's wife. Patient A's advanced health care directive, dated April 21, 2015, named
23 Patient A's grandson and his spouse as agents to make all health care decisions for Patient A.
24 However, they were not contacted until after Patient A passed away. Instead, a court-appointed
25 attorney who investigated the conservatorship application found that Respondent's wife stated
26 that all of Patient A's estate planning documents were in place and that another individual, D.T.,
27 was the "Agent under her Advance Health Care Directive . . . acting as her Agent." Further,

28 ¹⁵ Patient A's net worth was estimated to be over one million dollars.

1 Respondent failed to adequately document any of Patient A's designated decision makers. This
2 occurred in the context of Respondent's wife preparing a purported amendment to Patient A's
3 trust and legal documentation regarding health care decision making authority.

4 61. On or about July 17, 2015, and thereafter, Respondent committed gross negligence in
5 connection with his care for Patient A by failing to safeguard her interests in connection with his
6 overall care for her in light of the risks to her health. The circumstances surrounding the
7 involvement of his spouse and Paralegal while Respondent managed Patient A's health created
8 risks, including that Paralegal would become more involved in Patient A's care, without
9 appropriate authorization. Patient A developed bed sores while Paralegal (who was not a licensed
10 healthcare provider) served as Patient A's home caregiver, which were not treated
11 appropriately,¹⁶ and eventually developed into painful stage III (which is defined as full thickness
12 skin loss involving damage or necrosis of subcutaneous tissue that may extend down to but not
13 through underlying fascia and presents as a deep crater). This was present on Patient A's
14 admission to Diamond Health Care Services on or about January 17, 2016 and orders were made
15 to clean the ulcer with saline, pat dry, apply hydrogel and cover with dry dressing daily and
16 elevate the bilateral lower extremities on pillows while in bed / chair. Although Respondent
17 alleges that he did not know that Paralegal was Patient A's home care provider, documents which
18 Respondent had signed include Paralegal's name. In addition, Diamond Health Care Services'
19 facesheet (upon transfer from Sunset Hospice) showed Paralegal's name and phone number as a
20 caregiver. Respondent did not request that another physician take over her care when he placed
21 Patient A on hospice with Sunset Health Care on December 31 2015, and Respondent did not
22 transfer total responsibility to the hospice physician. The nurse accepted a verbal order from
23 Respondent on or about December 31, 2015, where he certified that she was terminally ill with a
24 life expectancy of six months or less. Respondent also signed the statement that updates on the
25 Plan of Care will be forwarded to him on a regular basis and that he would be contacted directly
26 should the need arise for a change in or addition to current care. Respondent also agreed to sign

27 _____
28 ¹⁶ Patient A's nieces testified that Paralegal ordered the staff working with Patient A at her
home to apply corn starch.

1 the death certificate and did not agree to have the hospice physician assume total responsibility
2 for the care of the patient. Thus, Respondent was responsible for Patient A while she was treated
3 under the care of Sunset Health Care.

4 62. The acts and/or omissions by Respondent set forth in this second cause for discipline
5 with respect to Patient A, either collectively or in any combination thereof, constitute repeated
6 negligent acts.

7 **THIRD CAUSE FOR DISCIPLINE**
8 **(Failure to Maintain Adequate Medical Records)**

9 63. Respondent is subject to disciplinary action under Code section 2266 in that
10 Respondent failed to maintain adequate and accurate records related to the provision of medical
11 services to a patient. The circumstances are as follows:

12 64. The allegations of the First and Second Causes for Discipline, inclusive, are
13 incorporated herein by reference as if fully set forth.

14 65. In addition, during his subject interview with the Board investigator, Respondent
15 admitted that he failed to document important information, including when he discussed
16 Patient A's office visit on or about December 1, 2015, and that he recommended that she see a
17 nephrologist "because of the kidney deteriorating," but she refused. And, he failed to document
18 that refusal. He also was inconsistent in his responses to discussing Patient A's refusal of
19 hospitalization and the end-of-life options for Patient A.

20 66. In addition, Respondent's documentation of Patient A's clinical status is inconsistent
21 with someone who is terminally ill.¹⁷ Thus, his record keeping failed to adequately support his

22 ¹⁷ Patient A had known heart disease and MDS (a blood disorder), which were chronically
23 stable. She had atrial fibrillation and had been taking Coumadin (a blood thinner). Her
24 laboratory studies dated December 23, 2015, showed that her CBC was quite stable and her
25 laboratory studies dated December 29, 2015, were marked as stable as well. Yet for some
26 inexplicable reason, Respondent decided to place Patient A on hospice two days later. Similarly,
27 while Patient A's renal function fluctuated, Respondent did not clearly address whether or not the
28 patient's renal status was stable; and if he felt they were not, he failed to consult a nephrologist
before committing her to hospice. Further, Patient A's cardiac status had not significantly
changed while Respondent saw her from when she was seen by her prior cardiologist Dr. W.
Patient A also complained of dizziness in or around July of 2015 which Respondent failed to
work up. In or around November of 2015, the patient was in no acute distress. On or about
December 1, 2015, Patient A denied chest pain or shortness of breath and Respondent

1 decisions.

2 **FOURTH CAUSE FOR DISCIPLINE**

3 **(Dishonesty, Corrupt Acts and General Unprofessional Conduct)**

4 67. Respondent is subject to disciplinary action under Code section 2234, and subdivision
5 (e), in that his actions and/or omissions represent dishonest, corrupt acts and/or unprofessional
6 conduct, generally. The circumstances are as follows:

7 68. The allegations of the First, Second and Third Causes for Discipline are incorporated
8 herein by reference as if fully set forth.

9 **PRAYER**

10 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
11 and that following the hearing, the Medical Board of California issue a decision:

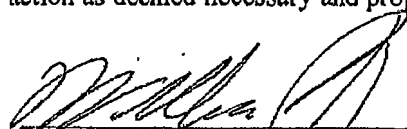
12 1. Revoking or suspending Physician's and Surgeon's Certificate Number A 38056,
13 issued to Pramod Multani, M.D.;

14 2. Revoking, suspending or denying approval of Pramod Multani, M.D.'s authority to
15 supervise physician assistants and advanced practice nurses;

16 3. Ordering Pramod Multani, M.D., if placed on probation, to pay the Board the costs of
17 probation monitoring; and

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

19
20 DATED: OCT 29 2020



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

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26 documented that her pacemaker was functioning normally, and her chest, respiratory examination
27 and heart were found to be normal. Finally, on or about December 18, 2015, the patient's vital
28 signs were stable; her lungs showed good air entry bilaterally; her heart was normal; and she was
in no distress. Lastly, Respondent failed to assess any shortness of breath and the examination
was not consistent with a patient who had shortness of breath.