

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

In the Matter of the Accusation Against:

Tejinder Singh Randhawa, M.D.

Physician's & Surgeon's  
Certificate No. A 53378

Respondent.

Case No. 800-2020-064607

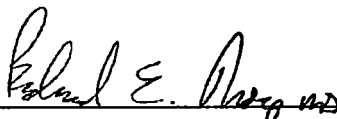
DECISION

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 21, 2024.

IT IS SO ORDERED: May 24, 2024.

MEDICAL BOARD OF CALIFORNIA



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

1 ROB BONTA  
Attorney General of California  
2 STEVE DIEHL  
Supervising Deputy Attorney General  
3 LYNETTE D. HECKER  
Deputy Attorney General  
4 State Bar No. 182198  
California Department of Justice  
5 2550 Mariposa Mall, Room 5090  
Fresno, CA 93721  
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7 *Attorneys for Complainant*

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

12 In the Matter of the Accusation Against:

13 **TEJINDER SINGH RANDHAWA, M.D.**  
14 **11189 N. Via Rimini Drive**  
**Fresno, CA 93730-7101**

15 **Physician's and Surgeon's Certificate No. A**  
16 **53378**

17 Respondent.

Case No. 800-2020-064607

OAH No. 2023030614

18  
19 **STIPULATED SETTLEMENT AND**  
20 **DISCIPLINARY ORDER**

21 In the interest of a prompt and speedy settlement of this matter, consistent with the public  
22 interest and the responsibility of the Medical Board of California of the Department of Consumer  
23 Affairs, the parties hereby agree to the following Stipulated Settlement and Disciplinary Order  
24 which will be submitted to the Board for approval and adoption as the final disposition of the  
25 Accusation.

26 **PARTIES**

27 1. Reji Varghese (Complainant) is the Executive Director of the Medical Board of  
28 California (Board). He brought this action solely in his official capacity and is represented in this  
matter by Rob Bonta, Attorney General of the State of California, by Lynette D. Hecker, Deputy  
Attorney General.

1           2. Respondent Tejinder Singh Randhawa, M.D. (Respondent) is represented in this  
 2 proceeding by attorney Michael F. Ball, whose address is: 7647 N. Fresno Street, Fresno, CA  
 3 93720-8912.

4           3. On or about August 10, 1994, the Board issued Physician's and Surgeon's Certificate  
 5 No. A 53378 to Respondent. The Physician's and Surgeon's Certificate was in full force and  
 6 effect at all times relevant to the charges brought in Accusation No. 800-2020-064607, and will  
 7 expire on April 30, 2024, unless renewed.

8                                               **JURISDICTION**

9           4. Accusation No. 800-2020-064607 was filed before the Board, and is currently  
 10 pending against Respondent. The Accusation and all other statutorily required documents were  
 11 properly served on Respondent on February 6, 2023. Respondent timely filed his Notice of  
 12 Defense contesting the Accusation.

13           5. A copy of Accusation No. 800-2020-064607 is attached as "Exhibit A" and  
 14 incorporated herein by reference.

15                                               **ADVISEMENT AND WAIVERS**

16           6. Respondent has carefully read, fully discussed with counsel, and understands the  
 17 charges and allegations in Accusation No. 800-2020-064607. Respondent has also carefully read,  
 18 fully discussed with his counsel, and understands the effects of this Stipulated Settlement and  
 19 Disciplinary Order.

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

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

28    ///

1 CULPABILITY

2 9. Respondent understands and agrees that the charges and allegations in Accusation  
3 No. 800-2020-064607, if proven at a hearing, constitute cause for imposing discipline upon his  
4 Physician's and Surgeon's Certificate.

5 10. Respondent does not contest that, at an administrative hearing, Complainant could  
6 establish a *prima facie* case or factual basis with respect to the charges and allegations in  
7 Accusation No. 800-2020-064607, that he has thereby subjected his Physician's and Surgeon's  
8 Certificate, No. A 53378 to disciplinary action, and Respondent hereby gives up his right to  
9 contest those charges.

10 11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to  
11 discipline and he agrees to be bound by the Board's imposition of discipline as set forth in the  
12 Disciplinary Order below.

13 RESERVATION

14 12. The admissions made by Respondent herein are only for the purposes of this  
15 proceeding, or any other proceedings in which the Medical Board of California or other  
16 professional licensing agency is involved, and shall not be admissible in any other criminal or  
17 civil proceeding.

18 CONTINGENCY

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

1           14. The parties understand and agree that Portable Document Format (PDF) and facsimile  
2 copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile  
3 signatures thereto, shall have the same force and effect as the originals.

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

7                           **DISCIPLINARY ORDER**

8                   **A. PUBLIC REPRIMAND**

9           IT IS HEREBY ORDERED that Respondent, TEJINDER SINGH RANDHAWA, M.D.,  
10 Physician's and Surgeon's Certificate No. A 53378, shall be and is hereby Publicly Reprimanded  
11 pursuant to California Business and Professions Code section 2227, subdivision (a)(4). This  
12 Public Reprimand is issued in connection with Respondent's care and treatment of one patient, as  
13 set forth in Accusation No. 800-2020-064607, and Respondent is reprimanded as follows: In  
14 January, 2020, you failed to adequately supervise a nurse practitioner who failed to diagnose  
15 failure to thrive in a new-born patient, and subsequently the patient died.

16                   **B. EDUCATION COURSE**

17           Within 60 calendar days of the effective date of this Decision, Respondent shall submit to  
18 the Board or its designee for its prior approval educational program(s) or course(s) which shall  
19 not be less than 40 hours and shall be aimed at supervision of staff, in particular mid-level  
20 practitioners, and shall be Category I certified. In the Board's discretion, if Respondent is unable  
21 to locate program(s) or course(s) course on this topic, he may submit to the Board or its designee  
22 for prior approval, Category I certified educational program(s) or course(s) aimed at correcting  
23 any areas of deficient practice or knowledge noted in the preceding paragraph. The educational  
24 program(s) or course(s) shall be at Respondent's expense and shall be in addition to the  
25 Continuing Medical Education (CME) requirements for renewal of licensure. Following the  
26 completion of each course, the Board or its designee may administer an examination to test  
27 Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65  
28 hours of CME, of which 40 hours were in satisfaction of this condition.

1           **C. MEDICAL RECORD KEEPING COURSE**

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

11           A medical record keeping course taken after the acts that gave rise to the charges in the  
12 Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board  
13 or its designee, be accepted towards the fulfillment of this condition if the course would have  
14 been approved by the Board or its designee had the course been taken after the effective date of  
15 this Decision.

16           Respondent shall submit a certification of successful completion to the Board or its  
17 designee not later than 15 calendar days after successfully completing the course, or not later than  
18 15 calendar days after the effective date of the Decision, whichever is later.

19           **D. INVESTIGATION/ENFORCEMENT COST RECOVERY**

20           Respondent is hereby ordered to reimburse the Board its costs of investigation and  
21 enforcement, including, but not limited to, expert review, amended accusations, legal reviews,  
22 investigation(s), and subpoena enforcement, as applicable, in the amount of \$41,250.00 (forty-one  
23 thousand two hundred fifty dollars). Costs shall be payable to the Medical Board of California.  
24 Failure to pay such costs shall be considered a violation of this stipulated order.

25           Payment must be made in full within 30 calendar days of the effective date of the Order, or  
26 by a payment plan approved by the Medical Board of California. Any and all requests for a  
27 payment plan shall be submitted in writing by Respondent to the Board. Failure to comply with  
28 the payment plan shall constitute unprofessional conduct and is grounds for further disciplinary

1 action.

2 The filing of bankruptcy by Respondent shall not relieve respondent of the responsibility to  
3 repay investigation and enforcement costs, including expert review costs (if applicable).

4 **E. FUTURE ADMISSIONS CLAUSE**

5 If Respondent should ever apply or reapply for a new license or certification, or petition for  
6 reinstatement of a license, by any other health care licensing action agency in the State of  
7 California, all of the charges and allegations contained in Accusation No. 800-2020-064607 shall  
8 be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of  
9 Issues or any other proceeding seeking to deny or restrict license.

10 **F. ENFORCEMENT**

11 Failure to timely complete the courses outlined above shall constitute unprofessional  
12 conduct and is grounds for further disciplinary action.

13 **ACCEPTANCE**

14 I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully  
15 discussed it with my attorney, Michael F. Ball. I understand the stipulation and the effect it will  
16 have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and  
17 Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the  
18 Decision and Order of the Medical Board of California.

19  
20 DATED: 1-19-2024 Tejinder Singh Randhawa  
21 TEJINDER SINGH RANDHAWA, M.D.  
*Respondent*

22 I have read and fully discussed with Respondent Tejinder Singh Randhawa, M.D. the terms  
23 and conditions and other matters contained in the above Stipulated Settlement and Disciplinary  
24 Order. I approve its form and content.

25 DATED: 01/18/2024 Michael F. Ball  
26 MICHAEL F. BALL  
*Attorney for Respondent*

27 ///

28 ///

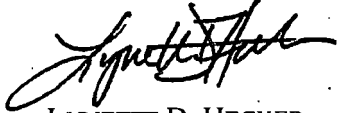
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**ENDORSEMENT**

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

DATED: 1/23/2024

Respectfully submitted,  
ROB BONTA  
Attorney General of California  
STEVE DIEHL  
Supervising Deputy Attorney General



LYNETTE D. HECKER  
Deputy Attorney General  
*Attorneys for Complainant*

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

12 In the Matter of the Accusation Against:	Case No. 800-2020-064607
13 <b>Tejinder Singh Randhawa, M.D.</b>	<b>ACCUSATION</b>
14 <b>838 E. Omaha Ave.</b>	
15 <b>Fresno, CA 93720-2193</b>	
16 <b>Physician's and Surgeon's Certificate</b>	
17 <b>No. A 53378,</b>	
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19 **PARTIES**

20 1. Reji Varghese (Complainant) brings this Accusation solely in his official capacity as  
21 the Deputy Director of the Medical Board of California, Department of Consumer Affairs  
22 (Board).  
23 2. On or about August 10, 1994, the Board issued Physician's and Surgeon's Certificate  
24 Number A 53378 to Tejinder Singh Randhawa, M.D. (Respondent). The Physician's and  
25 Surgeon's Certificate was in full force and effect at all times relevant to the charges brought  
26 herein and will expire on April 30, 2024, unless renewed.

27 ///  
28 ///

1 JURISDICTION

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

5 4. Section 2227 of the Code states:

6 (a) A licensee whose matter has been heard by an administrative law judge  
7 of the Medical Quality Hearing Panel as designated in Section 11371 of the  
8 Government Code, or whose default has been entered, and who is found guilty, or  
9 who has entered into a stipulation for disciplinary action with the board, may, in  
10 accordance with the provisions of this chapter:

11 (1) Have his or her license revoked upon order of the board.

12 (2) Have his or her right to practice suspended for a period not to exceed one  
13 year upon order of the board.

14 (3) Be placed on probation and be required to pay the costs of probation  
15 monitoring upon order of the board.

16 (4) Be publicly reprimanded by the board. The public reprimand may include  
17 a requirement that the licensee complete relevant educational courses approved by  
18 the board.

19 (5) Have any other action taken in relation to discipline as part of an order of  
20 probation, as the board or an administrative law judge may deem proper.

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

27 STATUTORY PROVISIONS

28 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:

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

(b) Gross negligence.

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

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

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

9 ...  
10 **COST RECOVERY**

11 6. Section 125.3 of the Code provides, in pertinent part, that the Board may request the  
12 administrative law judge to direct a licensee found to have committed a violation or violations of  
13 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and  
14 enforcement of the case, with failure of the licensee to comply subjecting the license to not being  
15 renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be  
16 included in a stipulated settlement.

17 **DEFINITIONS/TERMS**

18 7. A pregnancy is considered "full-term" at thirty-nine (39) weeks, and is considered  
19 "early-term" at thirty-seven (37) weeks through thirty-eight (38) weeks and six (6) days.

20 8. Most infants born between thirty-seven (37) and forty (40) weeks, weigh somewhere  
21 between five (5) pounds, eight (8) ounces (2,500 grams) and eight (8) pounds, thirteen (13)  
22 ounces (4,000 grams). A birth rate anywhere in that range is considered normal.

23 9. Bilirubin is made by the breakdown of red blood cells. It is difficult for infants to get  
24 rid of bilirubin at first. It can build up in their blood, tissues, and fluids. It makes an infant's  
25 skin, eyes, and other tissues turn yellow (jaundice). Jaundice may first appear when an infant is  
26 born. It may also show up any time after birth.

27 10. Hyperbilirubinemia happens when there is too much bilirubin in an infant's blood.

28 11. Failure to Thrive ("FTT") does not have one, set definition. Rather, diagnosis usually  
requires repeated growth measurements over time. Definitions of FTT specific to infants include  
but are not limited to:

///

- 1 a. Weight below 2nd percentile on an appropriate growth chart, with  
2 decreased velocity of weight gain that is disproportionate to growth in  
3 height;  
4 b. Weight decrease of two or more major percentile lines (90th, 75th, 50th,  
5 25th, 10th, 5th);  
6 c. In infants, a daily weight gain that is less than expected for their age;  
7 and/or  
8 d. A single measurement showing that weight percentile is markedly  
9 discrepant from other parameters (height or head circumference, e.g. when  
10 weight-for-height is < 10th percentile).

11 **FACTUAL ALLEGATIONS**

12 12. On or about December 24, 2019, an infant was born, early-term at 37 and 1/7 weeks  
13 gestation to a 23-year-old first time mother whose prenatal course had been uneventful. All  
14 prenatal tests were normal. At birth, the infant weighed only 3120 grams, which was low, at  
15 twenty-five percent (25 %) of normal. The infant's mother desired to solely breastfeed the infant.  
16 A lactation consultant visited them in the hospital and accepted the mother's report that  
17 everything was fine, but did not personally observe actual breastfeeding of the infant. Education  
18 on breastfeeding was via a handout/pamphlet. On discharge, the infant's weight had dropped to  
19 3021 grams, which was low, at twenty-two percent (22 %) of normal. Hospital staff suggested  
20 the infant be seen by a pediatrician within one to two days of being discharged.

21 13. On or about January 3, 2020, the mother presented at Respondent's office with the  
22 infant as a new patient seeking to establish care (hereinafter "the First Visit."). In the First Visit,  
23 the infant was examined solely by a nurse practitioner whom Respondent supervised. The  
24 infant's birth weight, which was 3120 grams, was incorrectly documented in the medical record  
25 for the First Visit as 6.14 grams. On or about the date of the First Visit, the infant's weight had  
26 dropped even further than the weight on discharge, and was down to 2637 grams, which was a  
27 fifteen and a half percent (15½ %) decrease from birth weight and down to at or below five  
28 percent (5 %) of normal. However, the infant's weight was charted as being at ninety to ninety-

1 five percent (90-95 %) of normal. The infant's length and head circumference were both  
2 recorded as being zero to three percent (0-3%) of normal. The plan was for a follow-up visit in  
3 two (2) weeks. A lactation consultant was neither discussed nor recommended at the First Visit,  
4 nor was any such referral made. Respondent did not see or examine the infant at the First Visit.

5 14. The medical record of the First Visit states the infant was taking "Breast milk on  
6 demand, 2-3 oz. Q2hrs.<sup>1</sup>" However, there is no documentation of either weighing the infant  
7 before and after breastfeeding, or when breast milk was pumped into a bottle, which the infant  
8 consumed. Further, the examination recorded in the medical record of the First Visit does not  
9 mention jaundice, yet "Jaundice, NB, unspecified" is listed as a diagnosis. There is no diagnosis  
10 corresponding to the infant's weight loss and there are no reasons specified for the plan of  
11 height/weight follow-up.

12 15. Respondent reviewed the nurse practitioner's chart note for the First Visit shortly  
13 after it occurred, and before the infant presented for a second visit. Respondent noted  
14 deficiencies/disparities with the documentation such as the differences in percentages of normal  
15 in comparison with the infant's actual weight. Before the infant's second visit to the office,  
16 Respondent discussed the deficiencies/disparities in the records and the need for more thorough  
17 and accurate documentation with the nurse practitioner.

18 16. On or about January 20, 2020, the mother returned with the infant to Respondent's  
19 office for the follow-up visit (the "Second Visit"). The infant was only examined by the nurse  
20 practitioner at the Second Visit. The documented examination of the infant on this visit was  
21 identical to that recorded for the First Visit. The infant's weight was up to 2778 grams, which  
22 was slightly higher than the prior visit, but still less than two percent (< 2 %) of normal.  
23 However, the infant's weight was charted as twenty-five to fifty percent (25-50 %) of normal, but  
24 the infant's length and head circumference both were noted as remaining at zero to three percent  
25 (0-3 %) of normal. The chart also noted that the infant was taking formula three (3) oz. every two  
26 (2)-hours, despite the fact that the mother was solely breastfeeding the infant. Height and weight  
27 follow-up was coded for billing, but there was no narrative assessment explaining its necessity.

28 <sup>1</sup> "Q2hrs" means every 2 hours.

1 The plan was for a one-month routine follow-up visit. A lactation consultant was neither  
2 discussed nor recommended at this visit, nor was any such referral made. Respondent did not see  
3 or examine the infant this visit. Respondent reviewed the nurse practitioner's chart note for the  
4 Second Visit shortly after it occurred, noting that it was slightly better than that recorded for the  
5 First Visit, but that deficiencies/disparities with the documentation persisted.

6 17. On or about January 27, 2020, the mother returned with the infant to Respondent's  
7 office (the "Third Visit"). The infant was only examined by the nurse practitioner at the Third  
8 Visit. The documented examination of the infant on the Third Visit was identical to that recorded  
9 for the First and Second Visits. The infant's age was listed in the medical record for the Third  
10 Visit as one-year-old, when in fact the infant was thirty-four (34) days old. At the Third Visit, the  
11 infant's weight had dropped to 2637 grams, which was still less than two percent (< 2 %) of  
12 normal. However, the infant's weight was charted as twenty-five to fifty percent (25-50 %) of  
13 normal, but the infant's length and head circumference both remained at zero to three percent (0-3  
14 %) of normal. The nurse practitioner charted a more detailed account of the infant's feeding  
15 behavior, but without explanation of the temporal relationship between breastfeeding and bottle-  
16 feeding of pumped breastmilk. There is no documentation of the feeding durations. Height and  
17 weight follow-up was again coded for billing, but there was still no narrative assessment  
18 explaining its necessity. The plan remained for a one-month routine follow-up visit with an  
19 added one-week follow-up to check the infant's weight. A lactation consultant was neither  
20 discussed nor recommended at this visit, nor was any such referral made. Respondent did not see  
21 or examine the infant at the Third Visit.

22 18. On or about February 6, 2020, the infant's parents called emergency medical services  
23 ("EMS") to their home because the infant was not breathing. The infant was transported to  
24 Valley Children's Hospital where she died approximately eleven to twelve (11 to 12) hours later.

25 19. Respondent never saw or examined the infant.

26 20. Respondent, nor his nurse practitioner ever discussed referral to a lactation  
27 consultant, nor was it ever recommended to the infant's mother, nor was any such referral ever  
28

1 made. Respondent did not review the nurse practitioner's chart note for the infant's last visit until  
2 after his office received information from Valley Children's Hospital that the infant had died.

3 **FIRST CAUSE FOR DISCIPLINE**

4 **(Gross Negligence)**

5 21. Respondent is subject to disciplinary action under section 2234, subdivision (b), of  
6 the Code, in that he engaged in act(s) or omission(s) amounting to gross negligence. The  
7 circumstances are set forth in paragraphs 12 through 20, which are incorporated here by reference  
8 as if fully set forth. Additional circumstances are as follows:

9 22. The standard of care requires a breastfeeding first-time mother of an early-term infant  
10 be referred to a Lactation consultant. Given the length of time between discharge from the  
11 hospital until the First Visit, a thorough review of the hospital chart and feeding history after  
12 discharge was of utmost importance, and perhaps might have revealed the inadequacy of lactation  
13 support that placed the infant at risk for excessive weight loss. The medical record of the First  
14 Visit notes the infant was taking "Breast milk on demand, 2-3 oz. Q2hrs" is contradictory. "On  
15 demand" means "as desired"; "Q2hrs" suggests on a schedule. In addition, the documented  
16 volume of 2-3 oz. infers that the volume of breastmilk was known. Such measurements can be  
17 obtained by either weighing an infant before and after breastfeeding, or when pumping breast  
18 milk into a bottle. However, there is no documentation of either of these procedures in the  
19 medical record. The infant's actual feeding regimen at the time of the First Visit is unclear.  
20 Further, the examination recorded in the medical record of the First Visit does not mention  
21 jaundice, yet "Jaundice, NB, unspecified" is listed as a Diagnosis. This observation should have  
22 been documented and further investigated with measurement of a serum bilirubin level.  
23 Hyperbilirubinemia, may be exacerbated by dehydration and if sufficiently elevated, may cause  
24 lethargy and poor feeding, creating a "vicious cycle." The failure to refer the infant and mother to  
25 a lactation consultant at the First Visit constitutes gross negligence.

26 23. The medical record of the Second Visit notes the infant was taking "Enfamil 3 oz.  
27 every 2 hrs." which infers that the infant's mother was no longer providing pumped milk for the  
28 bottle feedings. There is no explanation in the chart of why and when the change was made from

1 breast milk to formula. A lactation consultant referral should have been recommended to help  
2 with reestablishing breast milk production or breastfeeding. The failure to refer the infant and  
3 mother to a lactation consultant at the Second Visit constitutes gross negligence.

4 24. The medical record of the Third Visit noted the infant was breastfeeding every 2.5 to  
5 3 hrs., that at every other feeding the mother pumped milk, and that infant was ingesting about 3  
6 to 4 oz. at each feeding. It further noted that the infant was feeding every 2.5 to 3 hrs. per night  
7 time, which reflects the infant's mother's return to feeding pumped milk by bottle and the  
8 addition of breastfeeding. There is no explanation in the chart of why and when the change was  
9 made from formula back to breast milk. The amount of milk pumped suggests either a generous  
10 maternal milk supply or an inability of the infant to effectively transfer milk during breastfeeding.  
11 The failure to refer the infant and mother to a lactation consultant at the Third Visit constitutes  
12 gross negligence.

13 25. The standard of care requires that a diagnosis of Failure to Thrive ("FTT") should be  
14 considered when there is lack of expected normal physical growth. This infant was fifteen and a  
15 half percent (15½ %) below birth weight at the First Visit, at ten days of life. Pediatricians often  
16 begin medical interventions when an exclusively breastfeeding infant's weight loss exceeds ten  
17 percent (10%) below birth weight in the first week of life. These interventions can include  
18 laboratory tests to assess hydration status, referral to a lactation consultant, addition of formula  
19 feedings, and hospitalization in some cases. The infant had already met criterion for FTT at the  
20 First Visit for decreasing two major lines on the weight chart from birth to ten (10) days of age.  
21 The infant had gained some weight, one-hundred-forty-one (141) grams, by the Second Visit.  
22 However, this total weight gain reflected an average daily increase far below the expected weight  
23 gain at the infant's age on that date. The infant met criterion for FTT for a daily weight gain that  
24 was less than expected for age. Both the infant's weight and weight for height were less than the  
25 second percentile (< 2%) on the Third Visit, which met criterion for FTT. By this time, the  
26 diagnosis of FTT should have been obvious. Though the medical records contained inaccurate  
27 percentiles for the infant's weight, the simple visual of the growth chart that showed the infant's  
28 weight curve falling below the 2<sup>nd</sup> percentile (< 2%) should have sparked a concern for the



1 diagnosis of FTT. The failure to recognize and diagnose FTT in the infant by the Third Visit  
2 constitutes gross negligence.

3       26. As collaborators, physicians take responsibility for nurse practitioners' practice and  
4 are expected to determine the appropriate level of supervision. The standard of care requires a  
5 physician to determine the appropriate level of supervision, communicate regularly with the nurse  
6 practitioner, and oversee the nurse practitioner's practice and quality of care. Respondent and his  
7 partner compiled and published standardized procedures for nurse practitioners in their facilities  
8 as required by the State of California, Department of Consumer Affairs, Board of Registered  
9 Nursing. Despite the standardized procedures being in place, and the nurse practitioner having  
10 attended a lecture on FTT three years prior to the events in this case, Respondent should have  
11 provided more supervision and guidance. This is apparent since the nurse practitioner would  
12 have had to consider the diagnosis of FTT in order to develop a treatment plan and prescribe  
13 dietary counseling, including lactation consultation for a newborn infant, which was not done.  
14 Further, despite Respondent counseling the nurse practitioner about documentation deficiencies  
15 after the First Visit, the deficiencies persisted and the nurse practitioner did not document the  
16 requested information in the chart on the Second Visit. It was not until the Third Visit that the  
17 nurse practitioner's documentation included voids and stools. However, Respondent did not  
18 review the documentation from the Third Visit until after his office had been informed of the  
19 infant's death. A physician should ideally communicate with a nurse practitioner verbally and/or  
20 review visit notes on newborn infants, and give any necessary feedback by day's end. If same  
21 day communication is not feasible, communication within 24-48 hours is acceptable. Respondent  
22 did not sign chart for the Third Visit until approximately ten (10) days after he received a call  
23 from the hospital where the infant had been admitted and died. Knowing the nurse practitioner's  
24 failure to comply with the previous instructions, Respondent should have reviewed the chart from  
25 infant's Third Visit sooner rather than later. Had Respondent reviewed the infant's chart twenty-  
26 four (24) to forty-eight (48) hours after the Third Visit, he would have had the opportunity to  
27 detect the infant's excessive weight loss that was consistent with the diagnosis of FTT.  
28 Respondent could have scheduled an urgent visit to make his own assessment and plan, or

1 requested a direct hospital admission for investigation of FTT and concurrent treatment.  
2 Respondent's failure to effectively supervise the nurse practitioner's clinical performance by not  
3 reviewing the infant's chart for the Third Visit until after approximately ten (10) days had passed,  
4 constitutes gross negligence.

5 27. The standard of care dictates that complete and accurate medical records are essential  
6 for quality patient care. Respondent's counseling to improve the nurse practitioner's  
7 recordkeeping was not sufficient. Respondent counseled the nurse practitioner on the chart  
8 deficiencies, specifically "diapers," when Respondent signed the chart after the First Visit. Urine  
9 output is one of the ways pediatricians assess an infant's hydration status and is especially  
10 important in a newborn infant with weight loss. However, the nurse practitioner did not record  
11 the requested information on "diapers" until the Third Visit. Respondent's supervision of this  
12 deficiency was ineffective. Further, the birth weight was inaccurate in the records for the First  
13 Visit note and weight percentiles were inaccurate in the records for all three visits. Respondent  
14 should have counseled the nurse practitioner to manually correct the inaccurate information at  
15 each of the office visits. Accurate information on weight and weight percentiles are essential in  
16 assessing an infant's growth and, when growth is lacking, in establishing a diagnosis of FTT. The  
17 standard of care required Respondent to review the newborn infant's records after each visit,  
18 preferably by day's end, but if not feasible, within twenty-four (24) to forty-eight (48) hours.  
19 Respondent's stated policy is for infants with a "weight problem" to be seen weekly, yet in the  
20 records for the First Visit, the nurse practitioner ordered a follow-up in two weeks. The date  
21 Respondent reviewed that First Visit note is unknown and may have been too late to have the  
22 opportunity to counsel the nurse practitioner to schedule a closer follow-up date. Respondent did  
23 not review the Third Visit note until he had been notified of the infant's hospital admission, an  
24 event that took place ten (10) days after the Third Visit. Review and signature of the infant's visit  
25 note ten (10) days later rather than within twenty-four (24) to forty-eight (48) hours is  
26 insufficient. Respondent's failure to effectively supervise the nurse practitioner's medical  
27 documentation constitutes gross negligence.

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1 SECOND CAUSE FOR DISCIPLINE

2 (Repeated Negligent Acts)

3 28. Respondent is subject to disciplinary action under section 2234, subdivision (c), of  
4 the Code, in that he committed repeated acts of negligence. The circumstances are set forth in  
5 paragraphs 12 through 27, which are incorporated here by reference as if fully set forth.

6 PRAYER

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

- 9 1. Revoking or suspending Physician's and Surgeon's Certificate Number A 53378,  
10 issued to Tejinder Singh Randhawa, M.D.;
- 11 2. Revoking, suspending or denying approval of Tejinder Singh Randhawa, M.D.'s  
12 authority to supervise physician assistants and advanced practice nurses;
- 13 3. Ordering Tejinder Singh Randhawa, M.D., to pay the Board the costs of the  
14 investigation and enforcement of this case, and if placed on probation, the costs of probation  
15 monitoring; and
- 16 5. Taking such other and further action as deemed necessary and proper.

17  
18 DATED: FEB 06 2023

  
\_\_\_\_\_  
REJI VARGHESE  
Deputy Director  
Medical Board of California  
Department of Consumer Affairs  
State of California  
*Complainant*

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