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

ROB BONTA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General
LYNETTE D. HECKER
Deputy Attorney General
State Bar No. 182198
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2550 Mariposa Mall, Room 5090
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Attorneys for Complainant

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

In the Matter of the Accusation Against: **TEJINDER SINGH RANDHAWA, M.D.** **11189 N. Via Rimini Drive** **Fresno, CA 93730-7101** **Physician's and Surgeon's Certificate No. A 53378** Respondent.	Case No. 800-2020-064607 OAH No. 2023030614 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

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

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

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

JURISDICTION

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

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

ADVISEMENT AND WAIVERS

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

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

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

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CULPABILITY

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

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

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

RESERVATION

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

CONTINGENCY

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

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

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

DISCIPLINARY ORDER

A. PUBLIC REPRIMAND

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

B. EDUCATION COURSE

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

C. MEDICAL RECORD KEEPING COURSE

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

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

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

D. INVESTIGATION/ENFORCEMENT COST RECOVERY

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

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

action.

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

E. FUTURE ADMISSIONS CLAUSE

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

F. ENFORCEMENT

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

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Michael F. Ball. 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: 1-19-2024 Tejinder Singh Randhawa

TEJINDER SINGH RANDHAWA, M.D.
Respondent

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

DATED: 01/18/2024

MICHAEL F. BALL
Attorney for Respondent

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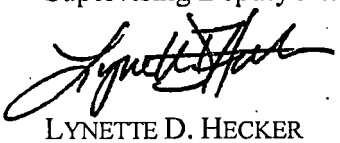
ENDORSEMENT

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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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.** **838 E. Omaha Ave.** **Fresno, CA 93720-2193** **Physician's and Surgeon's Certificate No. A 53378,** Respondent.	Case No. 800-2020-064607 **ACCUSATION**

PARTIES

1. Reji Varghese (Complainant) brings this Accusation solely in his official capacity as the Deputy Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about August 10, 1994, the Board issued Physician's and Surgeon's Certificate Number A 53378 to Tejinder Singh Randhawa, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2024, unless renewed.

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JURISDICTION

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

4. Section 2227 of the Code states:

> (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:
>
> (1) Have his or her license revoked upon order of the board.
>
> (2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.
>
> (3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.
>
> (4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.
>
> (5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.
>
> (b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

STATUTORY PROVISIONS

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

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

. . .

COST RECOVERY

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

DEFINITIONS/TERMS

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

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

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

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

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:

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a. Weight below 2nd percentile on an appropriate growth chart, with decreased velocity of weight gain that is disproportionate to growth in height;

b. Weight decrease of two or more major percentile lines (90th, 75th, 50th, 25th, 10th, 5th);

c. In infants, a daily weight gain that is less than expected for their age; and/or

d. A single measurement showing that weight percentile is markedly discrepant from other parameters (height or head circumference, e.g. when weight-for-height is < 10th percentile).

FACTUAL ALLEGATIONS

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

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

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

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

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

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

[1] "Q2hrs" means every 2 hours.

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

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

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

19. Respondent never saw or examined the infant.

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

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

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

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

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

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

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

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

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

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

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

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

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

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SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

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

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 53378, issued to Tejinder Singh Randhawa, M.D.;

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

3. Ordering Tejinder Singh Randhawa, M.D., to pay the Board the costs of the investigation and enforcement of this case, and if placed on probation, the costs of probation monitoring; and

5. Taking such other and further action as deemed necessary and proper.

DATED: FEB 0 6 2023

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

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