

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

In the Matter of the Accusation
Against:

Pritpal Singh Randhawa, M.D.

Physician's & Surgeon's
Certificate No A 83324

Respondent

Case No. 800-2017-035552

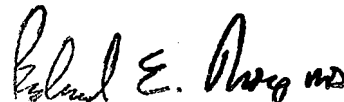
DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on June 16, 2021.

IT IS SO ORDERED May 17, 2021.

MEDICAL BOARD OF CALIFORNIA



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

1 XAVIER BECERRA
Attorney General of California
2 STEVEN D. MUNI
Supervising Deputy Attorney General
3 JOHN S. GATSCHET
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9
10 **BEFORE THE**
11 **MEDICAL BOARD OF CALIFORNIA**
12 **DEPARTMENT OF CONSUMER AFFAIRS**
13 **STATE OF CALIFORNIA**

14 In the Matter of the Accusation Against:

15 **PRITPAL SINGH RANDHAWA, M.D.**
1100 Marshall Way
16 Placerville, CA 95667-6533

17 Physician' and Surgeon's Certificate No. A
83324

18 Respondent.
19

Case No. 800-2017-035552

OAH No. 2020090070

**STIPULATED SETTLEMENT AND
DISCIPLINARY ORDER**

20
21 **IT IS HEREBY STIPULATED AND AGREED** by and between the parties to the above-
22 entitled proceedings that the following matters are true:

23 **PARTIES**

24 1. William Prasifka ("Complainant") is the Executive Director of the Medical Board of
25 California ("Board"). He brought this action solely in his official capacity and is represented in
26 this matter by Xavier Becerra, Attorney General of the State of California, by John S. Gatschet,
27 Deputy Attorney General.

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

3 **C. MEDICAL RECORD KEEPING COURSE.**

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

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

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

25 **D. FAILURE TO COMPLY**

26 If Respondent fails to enroll, participate in, or successfully complete the educational
27 program(s) or course(s) within the designated time period, Respondent shall receive a notification
28 from the Board or its designee to cease the practice of medicine within three (3) calendar days

1 after being so notified. Respondent shall not resume the practice of medicine until enrollment or
2 participation in the educational program(s) or course(s) has been completed as required by the
3 express language of the Decision and Order. In addition, failure to successfully complete the
4 educational program(s) or course(s) outlined above shall also constitute unprofessional conduct
5 and is grounds for further disciplinary action.

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Exhibit A

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

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In the Matter of the Accusation Against:
Pritpal Singh Randhawa, M.D.
1100 Marshall Way
Placerville, CA 95667-6533

Physician's and Surgeon's Certificate No. A 83324,

Respondent.

Case No. 800-2017-035552

A C C U S A T I O N

PARTIES

1. William Prasfika ("Complainant") brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").
2. On or about May 30, 2003, the Medical Board issued Physician's and Surgeon's Certificate Number A 83324 to Pritpal Singh Randhawa, M.D. ("Respondent"). That certificate was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2021, unless renewed.

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 in pertinent part, that a licensee who is found guilty
6 under the Medical Quality Hearing Panel may have his or her license revoked, suspended for a
7 period not to exceed one year, placed on probation and required to pay the costs of probation
8 monitoring, or such other action taken in relation to discipline as the Board deems proper.

9 5. Section 2234 of the Code states, in pertinent part:

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

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

15 (b) Gross negligence.

16 ...

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

18 The failure of a physician and surgeon to maintain adequate and accurate records
19 relating to the provision of services to their patients constitutes unprofessional conduct.

20 **FACTUAL ALLEGATIONS**

21 7. On or about July 16, 2017, at approximately 10:42 p.m., Patient A¹ presented in the
22 emergency department of Mercy Hospital of Folsom. Patient A presented with left-sided chest
23 pain with shortness of breath and a one-week onset of back pain. Patient A reported seeing his
24 primary care physician at the onset of back pain and that he had been given a lidocaine shot.
25 According to the patient, a chest x-ray had previously shown no acute findings but possible lung
26 collapse. Patient A also reported that he had difficulty walking and generalized weakness for the
27 past three hours. Patient A reported he had a history of neuropathy. Patient A reported that he

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

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

3 8. The emergency department staff documented a differential diagnosis of myocardial
4 infarction, atypical chest pain, pneumonia, pleurisy, chest wall pain, dyspnea, chronic obstructive
5 pulmonary disease, and bronchitis. The emergency department staff had Patient A provide a
6 series of labs, and performed an electrocardiogram, a CT² angiogram of Patient A's chest with
7 contrast, and a chest x-ray. The medical imaging indicated the presence of multifocal
8 bronchopneumonia. Following a review of the test results, the emergency department diagnosed
9 that the patient was suffering from bilateral pneumonia, hypertension, and anxiety disorder. The
10 emergency department staff had the patient admitted to the hospital at approximately 3:00 a.m. on
11 or about July 17, 2017. The emergency department did not do a formal neurological evaluation.

12 9. On or about July 17, 2017, at approximately 3:45 a.m.³, Hospitalist B on the
13 overnight shift at Mercy Hospital of Folsom documented an admitting history and physical for
14 Patient A. Hospitalist B documented that Patient A had no significant past medical history apart
15 from anxiety disorder, who presented with chest pressure and difficulty breathing. According to
16 Hospitalist B, Patient A had symptoms starting on July 12, 2017, or July 13, 2017, and had gone
17 to his primary care physician who had previously ordered a chest x-ray. Hospitalist B
18 documented that Patient A reported that the x-ray was not clear and that Patient A's wife stated
19 that Patient A had been told he had a "collapsed lung" but no one referred him to the emergency
20 department. According to Hospitalist B's documentation, Patient A had improved over the next
21 few days but on July 16, 2017, he became acutely short of breath and had difficulty breathing.
22 According to the documentation, Patient A reported that he had a "pressure like sensation" on his
23 chest. Patient denied chest pain, fever, chills, presyncope, nausea, vomiting, or diaphoresis.
24 According to Hospitalist B, Patient A's bloodwork was remarkable for a marked leukocytosis of
25 35.7 with an 85% left shift and an 8% bandemia. In addition, Patient A's D-dimer level was

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

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

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

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

3 11. On or about July 17, 2017, at approximately 2:44 p.m., the Respondent documented
4 in a brief progress note that he had reviewed Patient A's history and physical. The Respondent
5 was the hospitalist on duty and in charge of the patient on July 17, 2017, from 6:00 a.m. to 6:00
6 p.m. The Respondent documented that Patient A was complaining of significant low back pain
7 for the last four days, which was limiting his mobility and was new for the patient. The
8 Respondent also documented that Patient A had significant urinary retention and that a Foley
9 urine catheter had been ordered which did not help with pain. The Respondent documented that
10 Patient A continued to have low back pain and Respondent documented that he would order an
11 MRI⁴ of Patient A's lumbar sacral spine. The Respondent did not document performing a formal
12 neurological examination including specifically indicating whether Patient A was suffering from
13 lower extremity weaknesses, Patient A's reflexes, Patient A's motor strength, and Patient A's
14 sensations in his extremities.

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

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

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

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

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

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1 14. According to Respondent, he next saw Patient A on July 18, 2017, between 10:00
2 a.m. and 11:00 a.m. Respondent drafted and signed a progress note July 18, 2017, at 2:44 p.m.
3 Respondent's progress note documented that Patient A's lumbar spine MRI from July 17, 2017,
4 showed evidence of discitis and that Respondent had obtained an infectious disease consultation
5 and that the specialist was scheduled to see the patient. At the time of Respondent's visit with
6 Patient A on July 18, 2017, between 10:00 and 11:00 a.m., the infectious disease specialist had
7 not yet seen Patient A. At this point more than twelve hours had elapsed since Respondent had
8 received the results of Patient A's lumbar spine MRI. Respondent noted that Patient A's chest
9 CT scan indicated multifocal pneumonia and that blood cultures were presumptive for MSSA⁶.
10 The Respondent documented that Patient A reported that his back pain was better as compared to
11 yesterday. Respondent documented under the neurological examination that there were no
12 complaints of headache or weakness and under the back examination, that Patient A was positive
13 for low back pain. There is no evidence that Respondent performed a comprehensive
14 neurological examination including, whether Patient A was suffering from lower extremity
15 weaknesses, Patient A's reflexes, Patient A's motor strength, and Patient A's sensations in his
16 extremities.

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

28 ⁶ Methicillin-sensitive Staphylococcus aureus.

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

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

19 **FIRST CAUSE FOR DISCIPLINE**

20 **(Gross Negligence)**

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

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

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

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

3 **SECOND CAUSE FOR DISCIPLINE**

4 **(Inadequate and Inaccurate Medical Record Keeping)**

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

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

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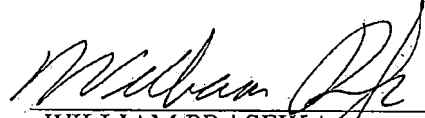
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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 83324, issued to Pritpal Singh Randhawa, M.D.;
2. Revoking, suspending or denying approval of Pritpal Singh Randhawa, M.D.'s authority to supervise physician assistants and advanced practice nurses;
3. Ordering Pritpal Singh Randhawa, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and
4. Taking such other and further action as deemed necessary and proper.

DATED: AUG 11 2020



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

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