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

In the Matter of the Accusation Against:	
Narendra Kantilal Raval, M.D.	**Case No. 800-2019-056631**
Physician's and Surgeon's Certificate No. A 37591	
Respondent.	

DECISION

The attached Stipulate Surrender of License and 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 29, 2022.

IT IS SO ORDERED June 22, 2022.

MEDICAL BOARD OF CALIFORNIA

William Prasifka
Executive Director

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
REBECCA L. SMITH
Deputy Attorney General
State Bar No. 179733
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6475
Facsimile: (916) 731-2117
Attorneys for Complainant

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

In the Matter of the Accusation Against: **NARENDRA KANTILAL RAVAL, M.D.** **10706 Harpenden Avenue** **Bakersfield, CA 93311** **Physician's and Surgeon's Certificate No. A 37591,** Respondent.	Case No. 800-2019-056631 **STIPULATED SURRENDER OF LICENSE AND ORDER**

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

PARTIES

1. William Prasifka (Complainant) is the Executive Director of the Medical Board of California (Board). He brought this action solely in his official capacity and is represented in this matter by Rob Bonta, Attorney General of the State of California, by Rebecca L. Smith, Deputy Attorney General.

2. Narendra Kantilal Raval, M.D. (Respondent) is represented in this proceeding by attorney Dennis Thelan, whose address is 5001 East Commercenter Drive, Suite 300, Bakersfield, California 93309-1687.

3. On or about October 19, 1981, the Board issued Physician's and Surgeon's Certificate No. A 37591 to Respondent. That license expired on October 31, 2019, and has not been

renewed.

JURISDICTION

4. On May 6, 2022, Accusation No. 800-2019-056631 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent. A copy of Accusation No. 800-2019-056631 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2019-056631. Respondent also has carefully read, fully discussed with counsel, and understands the effects of this Stipulated Surrender of License and Order.

6. 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.

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

CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 800-2019-056631, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation and that those charges constitute cause for discipline. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

10. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician's and Surgeon's Certificate without further process.

CONTINGENCY

11. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, 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 Surrender 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.

12. This Stipulated Surrender of License and Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreement of the parties in this above entitled matter.

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

14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 37591, issued to Respondent Narendra Kantilal Raval, M.D., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician's and Surgeon's Certificate and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as an anesthesiologist in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 800-2019-056631 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. Respondent shall pay the agency its costs of investigation and enforcement in the amount of $13,822.25 (thirteen thousand eight hundred twenty-two dollars and twenty-five cents) prior to issuance of a new or reinstated license.

6. 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 agency in the State of California, all of the charges and allegations contained in Accusation, No. 800-2019-056631 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 licensure.

ACCEPTANCE

I have carefully read the above Stipulated Surrender of License and Order and have fully discussed it with my attorney Dennis Thelan. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 5/11/22

NARENDRA KANTILAL RAVAL, M.D.
Respondent

I have read and fully discussed with Respondent Narendra Kantilal Raval, M.D. the terms and conditions and other matters contained in this Stipulated Surrender of License and Order. I approve its form and content.

DATED: 5-12-2022

DENNIS THELEN
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

DATED: 5/12/2022

Respectfully submitted,

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

REBECCA L. SMITH
Deputy Attorney General
Attorneys for Complainant

LA2022600997
65067416.docx

Exhibit A

Accusation No. 800-2019-056631

ROB BONTA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
REBECCA L. SMITH
Deputy Attorney General
State Bar No. 179733
300 South Spring Street, Suite 1702
Los Angeles, CA 90013
Telephone: (213) 269-6475
Facsimile: (916) 731-2117
Attorneys for Complainant

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

In the Matter of the Accusation Against: **NARENDRA KANTILAL RAVAL, M.D.** **10706 Harpenden Avenue** **Bakersfield, CA 93311** **Physician's and Surgeon's Certificate No. A 37591,** Respondent.	Case No. 800-2019-056631 **ACCUSATION**

PARTIES

1. William Prasifka (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 October 19, 1981, the Board issued Physician's and Surgeon's Certificate Number A 37591 to Narendra Kantilal Raval, M.D. (Respondent). That license expired on October 31, 2019, and has not been renewed.

JURISDICTION

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

///

4. Section 118 of the Code states:

(a) The withdrawal of an application for a license after it has been filed with a board in the department shall not, unless the board has consented in writing to such withdrawal, deprive the board of its authority to institute or continue a proceeding against the applicant for the denial of the license upon any ground provided by law or to enter an order denying the license upon any such ground.

(b) The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground.

(c) As used in this section, "board" includes an individual who is authorized by any provision of this code to issue, suspend, or revoke a license, and "license" includes "certificate," "registration," and "permit."

5. Section 2004 of the Code states:

The board shall have the responsibility for the following:

(a) The enforcement of the disciplinary and criminal provisions of the Medical Practice Act.

(b) The administration and hearing of disciplinary actions.

(c) Carrying out disciplinary actions appropriate to findings made by a panel or an administrative law judge.

(d) Suspending, revoking, or otherwise limiting certificates after the conclusion of disciplinary actions.

(e) Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the board.

(f) Approving undergraduate and graduate medical education programs.

(g) Approving clinical clerkship and special programs and hospitals for the programs in subdivision (f).

(h) Issuing licenses and certificates under the board's jurisdiction.

(i) Administering the board's continuing medical education program.

6. 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.

7. Section 2234 of the Code, states:

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.

(d) Incompetence.

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

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

COST RECOVERY

8. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may 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.

(b) In the case of a disciplined licensee that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g) (1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of

the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

9. Respondent is subject to disciplinary action under section 2234, subdivision (b), of the Code, in that he engaged in gross negligence in the care and treatment of Patient 1.[1] The circumstances are as follows:

10. On or about June 6, 2019, the Board received a Code section 805 Health Facility/Peer Review Report from Mercy Hospital (Hospital) that stated that in August of 2018, the Hospital opened an investigation regarding a possible medication error made by Respondent. Respondent was made aware of the investigation, and while the investigation was pending, Respondent resigned his medical staff membership and clinical privileges.

11. On or about August 16, 2018, Patient 1, a 34-year-old female, was admitted to Mercy Hospital at 39 weeks gestation for a scheduled elective repeat Cesarean section. Her past medical history was negative and she was in excellent health.

12. The delivery was performed by obstetrician, Dr. M.T., and assisted by obstetrician, Dr. J.T. Respondent was the anesthesiologist for Patient 1's delivery.

13. Medications in the operating room are kept in an Omnicell (a secure medication dispensing cabinet with various drawers). The planned anesthetic was a spinal injection of Marcaine 0.75%[2]. The Marcaine 0.75% ampules were stored in the back left of drawer number 4 of the Omnicell, which was the anesthesia medication drawer.

14. In the operating room, Patient 1 was placed in a sitting position. Respondent administered a spinal anesthetic which he believed was spinal Marcaine plus Duramorph[3], and then the patient was turned supine. After the spinal injection, the patient did not become numb as

---

[1] The patient herein is referred to as Patient 1 in order to protect her privacy.

[2] Marcaine 0.75% is the brand name of bupivacaine hydrochloride and epinephrine. It is used as local anesthesia, caudal block, epidural block, nerve blocks, and spinal anesthesia.

[3] Duramorph is a systemic narcotic analgesic administered epidurally or intrathecally.

expected. Respondent alleged that he stated that the medication being used had already "expired." Only Respondent examined the expiration date and the ampule. Respondent then injected another dose of the spinal anesthetic medication into the patient - Patient 1 was once again placed in the sitting position, and a repeat spinal anesthetic injection was administered. Within minutes, the patient became numb. The Cesarean section was performed without complication. The infant was presented to the mother in the operating room, and then taken to the neonatal unit for observation. The records for the procedure indicated that the duration of the anesthesia on the case was from 7:26 a.m. to 8:55 a.m., and that the duration of the surgery was from 8:11 a.m. to 8:49 a.m.

15. Following the closure of the Cesarean section incisions, Patient 1 was taken back to her labor and delivery room. At 10:08 a.m., approximately one hour and thirteen minutes after the conclusion of the anesthetic time for the Cesarean section, the patient became unresponsive with dilated pupils. Her oxygen saturation rate was at 99-100%, her heart rate was 130 beats per minute, her systolic blood pressure was 130 to 140 and her respiratory rate was 8 to 10 breaths per minute.

16. Respondent was paged to the patient's beside. He arrived at 10:26 a.m. The Acute Care Team had already administered Narcan intravenously twice with no change in the patient's condition. Respondent confirmed that the patient was unresponsive with dilated pupils. He attempted to place an oral airway but the patient spit it out. He then placed an endotracheal tube for airway protection and management without giving any additional medications. The patient underwent a head CT scan to rule out a possible amniotic fluid embolism and it was interpreted as a normal examination of the head. The patient then had multiple grand mal seizures and was admitted to the intensive care unit (ICU) where she was managed by the hospital's intensivist. The patient was treated with Keppra for the seizures and with propofol and fentanyl for sedation. She had complete paraplegia. Laboratory studies drawn that day revealed evidence of digoxin[4] in the patient's blood. An MRI of the brain showed symmetric edema in the medial aspects of the bilateral temporal lobes, bilateral insular cortices, bilateral frontal lobs, and bilateral basal

[4] Digoxin is used to treat heart failure and abnormal heart rhythms.

ganglia.

17. On or about August 18, 2018, Patient 1 was transferred to the neurology ICU at Memorial Hospital for a higher level of care. She remained obtunded and in the ICU until extubation on or about August 29, 2018. She was discharged home on or about September 11, 2018. Her discharge diagnoses included complete paraplegia, altered mental state, spinal cord inflammation, and brain edema. She was enrolled in a day treatment program at the Center for Neuro Skills, 5-days a week, 6-hours a day, for speech, physical therapy, occupational therapy and counseling. She used a wheelchair for the next year and thereafter began walking with the assistance of a walker.

18. On or about August 16, 2018, the hospital initiated an investigation regarding the digoxin level found in the patient's system. In the sharps container[5] in the operating room, there was no expired Marcaine ampules; however, there was an empty digoxin ampule. The Omnicell record indicated that there were three ampules of digoxin in the machine, but only two ampules were still physically present inside the machine. The digoxin had been stocked in that Omincell in or around October 2017, and no one had used any digoxin from that Omincell since that time. The digoxin ampules were stored in the back left of drawer number 7 of the Omicell (the cardiac drawer) and the spinal Marcaine 0.75% ampules were stored in a similar location in the back left of the anesthesia drawer. The Omincell record dated August 16, 2018 reflects that drawer number 7, the cardiac drawer which contained the digoxin, was accessed at 6:47 a.m. It was determined that Respondent administered digoxin instead of bupivacaine for spinal anesthesia during the patient's cesarean section which likely caused the patient's severe inflammatory response post administration. Respondent denied erroneously administering digoxin.

19. The standard of care for an anesthesia provider requires the selection of the correct medication, and to check that it is the correct medication prior to drawing it into a syringe and injecting it into a patient.

20. On or about August 16, 2016, at the time of Patient 1's cesarean section delivery,

[5] Sharps containers are puncture-resistant containers used to safely dispose of hypodermic needles and other sharp medical instruments.

both the spinal Marcaine and the digoxin ampules were located in similar compartments in different drawers in the Labor and Delivery operating room Omnicell, and Respondent retrieved the wrong medication, digoxin, instead of spinal Marcaine. He failed to read the ampule labelling and did not adequately check the medication. He drew it up into a syringe and injected it into the patient's spinal fluid in error. This is an extreme departure from the standard of care.

21. When there is any question of whether a medication is expired, the standard of care requires that the anesthesia provider save the ampule as evidence that the expired medication was stocked in the anesthesia drawer. Although Respondent alleged that he did not save the alleged "expired" ampule of medication, no such expired ampule was ever discovered or documented. Respondent committed an extreme departure from the standard of care when he failed to save the expired ampule.

22. When the first spinal injection did not result in patient numbness, Respondent should have assessed why it did not work. Respondent failed to double-check the identity of the ampule he had drawn up and administered into the spinal fluid. This is an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

23. Respondent is subject to disciplinary action under section 2234, subdivision (c), of the Code, in that he engaged in repeated acts of negligence in the care and treatment of Patient A. The circumstances are as follows:

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

25. Each of the alleged acts of gross negligence set forth above in the First Cause for Discipline is also a negligent act.

///

///

///

///

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 37591, issued to Respondent Narendra Kantilal Raval, M.D.;

2. Revoking, suspending or denying approval of Respondent Narendra Kantilal Raval, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Narendra Kantilal Raval, 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;

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

DATED: MAY 0 6 2022

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

LA2022600997
65067415.docx