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

In the Matter of the First Amended Accusation Against: 
Ravi Sham Panjabi, M.D. Case No. 03-2013-229400 
Physician's and Surgeon's Certificate No. A 55600 

Respondent

______________________________

DECISION

The attached Proposed Decision 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 May 4, 2017.

IT IS SO ORDERED: April 4, 2017.

MEDICAL BOARD OF CALIFORNIA

[Signature]
Michelle Anne Bholat, M.D., Chair
Panel B
BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended
Accusation Against: RAVI SHAM PANJABI, M.D.,
Physician’s and Surgeon’s Certificate
No. A55600

Case No. 03-2013-229400
OAH No. 2016100072

Respondent.

PROPOSED DECISION

Administrative Law Judge Jill Schlichtmann, State of California, Office of
Administrative Hearings, heard this matter on February 13, 14 and 15, 2017, in Oakland,
California.

Deputy Attorney General Greg W. Chambers represented complainant Kimberly
Kirchmeyer, Executive Director of the Medical Board of California, Department of Consumer
Affairs.

John Fleer, Attorney at Law, represented respondent Ravi Sham Panjabi, M.D., who
was present throughout the administrative hearing.

The matter was submitted for decision on February 15, 2017.

FACTUAL FINDINGS

Introduction

1. Complainant Kimberly Kirchmeyer is the Executive Director of the Medical
Board of California (Board), Department of Consumer Affairs. She brought the first amended
accusation solely in her official capacity.
2. On January 31, 1996, the Board issued Physician’s and Surgeon’s Certificate No. AS5600 to Ravi Sham Panjabi, M.D. (respondent). The certificate is active and will expire on October 31, 2017, unless renewed.

3. The first amended accusation alleges that respondent’s certificate is subject to discipline as a result of respondent’s: 1) treatment of Patients B.E.\textsuperscript{1} and R.B.; 2) failure to maintain adequate medical records; 3) conviction for driving with a blood alcohol content over 0.15 percent; and, 4) failure to report his conviction to the Board.

Respondent’s Background and Training

4. Respondent graduated in 1984 from Grant Medical College in Bombay, India. He completed a three-year residency in orthopedics at the same institution in 1988. From 1988 to 1989, respondent was the senior registrar in orthopedics at Mahatma Gandhi Memorial Hospital in Bombay. After meeting and marrying his wife, who lived in the United States, respondent moved to this country. He studied for and passed the ECFMG and FLEX examinations in 1990. Respondent completed a clinical base year in general medicine at St. Francis Hospital in Evanston, Illinois, in 1992. From 1992 to 1995, respondent attended a residency in anesthesiology at Loyola University Medical Center in Maywood, Illinois. He attended a fellowship in pain management at the University of Illinois Medical Center from 1995 to 1996. Respondent is licensed in California and Florida. He is board certified in anesthesiology and pain management.


Respondent’s Treatment of Patient B.E.

6. On December 31, 2012, the Board received a report of a settlement in a malpractice action against respondent, pursuant to Business and Professions Code section 801.01. The litigation arose out Patient B.E.’s death following a procedure performed by respondent in his office. Patient B.E. was 66 years old.

7. Respondent had treated Patient B.E. for back pain since June 2003. He had performed various surgical procedures on Patient B.E., including facet joint injections and epidural steroid injections. On May 11, 2010, respondent performed medial branch blocks on Patient B.E. at spinal levels T8, T9, T10, T11 and T12. Patient B.E. reported significant pain

\textsuperscript{1} Patients are referred to by their initials in order to protect their privacy.
relief afterward. Based on Patient B.E.’s response to the procedure, respondent considered him to be an excellent candidate for radiofrequency ablation.2

8. On May 25, 2010, Patient B.E. arrived at respondent’s office at 8:22 a.m., to undergo a radiofrequency ablation at levels T8, T9, T10, T11 and T12. The procedure was to be performed in respondent’s office, which is not an accredited outpatient setting. An unlicensed medical assistant was present during the procedure. No other provider was present. Respondent planned to administer sedation to the patient, monitor his vital signs and perform the procedure himself.

9. Because the procedure is painful and Patient B.E. had anxiety about the undergoing the procedure, respondent provided moderate sedation3 to the patient. Respondent intravenously administered 1.5 mg of Versed,4 50 mcg of Fentanyl,5 and 30 mg of Propofol6 to induce moderate sedation. He applied a pulse oximetry on the patient’s finger, an end-tidal CO2 monitor (to confirm the patient was breathing), and a non-invasive blood pressure cuff. Respondent did not use an EKG7 monitor. Respondent provided oxygen to the patient through a nasal cannula. Local anesthetic was injected in the left thoracic region.

2 Radiofrequency ablation is a procedure used to treat back pain. A needle is inserted at the joint next to the painful nerve. A machine generates a radiofrequency current that heats and damages the nerve tissue, disrupting its ability to send pain signals to the brain.

3 Moderate sedation is defined by the American Society of Anesthesiologists (ASA) in its Position Statement on the Continuum of Depth of Sedation as “conscious sedation” in which responsiveness is defined as a purposeful response to verbal or tactile stimulation (reflex withdrawal from a painful stimulus is not considered a purposeful response); no interventions are required to maintain the airway, spontaneous ventilation is adequate and cardiovascular function is usually maintained.

4 Versed is a trade name for midazolam hydrochloride, a short-acting benzodiazepine central nervous system depressant. It is a dangerous drug as defined in Business and Professions Code section 4022, and a Schedule IV controlled substance as defined in Health and Safety Code section 11057. Intravenous Versed has been associated with respiratory depression and respiratory arrest, especially when used for sedation in noncritical care settings.

5 Fentanyl is a potent narcotic analgesic and is a dangerous drug as defined in section 4022, and a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c)(8). Fentanyl can cause respiratory depression, respiratory arrest and cardiac arrest.

6 Propofol is an intravenously administered sedative-hypnotic agent for use in the induction and maintenance of anesthesia or sedation. It is a dangerous drug as described in Business and Professions Code section 4022.

7 An EKG, or electrocardiogram, records the electrical activity of the heart.
10. As respondent was about to start placing needles for the procedure, Patient B.E. began to complain of pain. Respondent therefore broke sterile field and administered additional medication. He administered 1.5 mg of Versed, 50 mcg of Fentanyl and 20 mg of Propofol. Respondent put on gloves and began to place the ablation needles.

11. A few minutes later, just before beginning the ablation, respondent noticed that Patient B.E.’s oxygen saturation level was dropping. Patient B.E. was in a prone position. Respondent gave the patient a jaw thrust and increased his oxygen through the nasal cannula. Patient B.E. did not respond. Respondent pulled the needles out of his back and turned Patient B.E. over. He again gave the patient a jaw thrust and checked for a pulse. Respondent concluded that the patient had suffered a cardiorespiratory arrest. He asked for an Ambu bag, began cardiopulmonary resuscitation (CPR), and directed his office manager to call 911. Records indicate that 911 was called at 10:19 a.m., and the paramedics arrived at 10:23 a.m. The paramedics continued CPR and placed Patient B.E. on an EKG monitor. Patient B.E. was found to have pulseless electrical activity. He was given epinephrine and atropine. Respondent injected flumazenil to reverse the effect of Versed. The paramedics injected Narcan to reverse the narcotic medication. The patient’s pulse returned. Neither respondent nor the paramedics were successful in their attempts to intubate the patient due to a difficult airway. The paramedics placed an esophageal block tube and he was bag ventilated, then transported to the hospital. In the ambulance, Patient B.E. lost his pulse again. CPR was continued and he was given epinephrine and atropine. His pulse returned and Patient B.E. was taken to the emergency room, intubated, placed on hypothermia protocol and admitted to the intensive care unit. Patient B.E. died on June 11, 2010. An autopsy was performed and the cause of death was determined to be “hypoxic encephalopathy due to cardiopulmonary arrest due to sedation/anesthesia for neural radioablation.”

12. After leaving the hospital, respondent returned to his office. He looked at his “In-Office Procedure Record” for Patient B.E. and saw Patient B.E.’s vital signs and the medication administration had not been documented during the procedure. His medical assistant had documented only the patient’s vital signs before the procedure and the amount of Versed, Fentanyl and Propofol administered. The times and doses of the medication administration were not documented. Respondent wrote in estimated times that the medications were administered and the doses administered. He then decided his entries were incorrect and crossed out and wrote over them, making the record very difficult to read. Respondent then dictated a procedure note report. Respondent added information to indicate that the dosages of Versed, Fentanyl and Propofol were given to Patient B.E. in incremental dosages.

Respondent’s Testimony regarding his Treatment of Patient B.E.

13. Respondent testified that in May 2010, he contracted with a registered nurse to work in his office one day per week to assist with procedures. Respondent states that on the day that Patient B.E. arrived for the radiofrequency ablation, the registered nurse called in sick. Respondent’s medical assistant was not trained in moderate sedation and was not a
qualified provider. Respondent concedes that the standard of care required that a nurse or physician be present during the procedure to monitor the patient. He states that “against his better judgment” he proceeded with the procedure because the patient was in a lot of pain and wanted the treatment. Respondent asserts that because he was so close to the patient, he believed he was able to closely monitor the patient’s breathing and vital signs.

14. At hearing, respondent testified that this was the only time he has performed a procedure involving moderate sedation without a qualified provider present. No individuals who worked with respondent, or nurses employed by him, testified or submitted letters or declarations in support of this assertion. Moreover, at his Board interview, respondent stated he did not know whether the standard of care required that he have a second qualified provider in the room during a procedure with moderate sedation. Respondent did not mention that his nurse called in sick on May 25, 2010, during his deposition or Board interview. During his Board interview, respondent was asked:

When you talked to [Patient B.E.] about the risks of the procedure, um, did you tell him that you would be doing both the procedure and acting as the anesthesiologist?

Respondent replied:

Um, yes. He knew that. Yes.

The interviewer asked:

And did you suggest to him that there might be an increased risk, being you were fulfilling both roles? As a surgeon and the anesthesiologist?

Respondent replied:

Well, no, I – I, uh – I really did not perceive that as an increased risk, given that you know, I’ve been doing this for – I mean I do this once a week for patients for a long time. And I’m very careful about the amount of medication I give, and I make sure they – they are – uh, they don’t lose their reflexes completely.

Later during the Board interview, respondent was asked:

If the procedure is done in a medical center, um, do you perform the surgery the same way? In other words, you – you’re both the anesthesiologist as well as the surgeon?
Respondent replied:

Uh, yes, uh – with the exception that, you know, there is an RN sitting at the table – at the head of the table monitoring the patient.

Respondent’s testimony that he had never before performed this procedure without a qualified provider in the room was not corroborated, was inconsistent with the statements he made at his Board interview, and was not credible.

15. Although respondent was aware that Patient B.E. took 10 to 12 Norco tablets each day, he testified at hearing that did not know if Patient B.E. took any Norco the morning of the surgery, and did not document asking that question of the patient.

16. Respondent performs radiofrequency ablation procedures both in his office and in surgery centers. Respondent earns more money if he performs the procedure in his office. If he determines that there are no significant comorbidities, he prefers to perform procedures in his office and discusses his recommendation with the patient. Respondent did not document having this discussion with Patient B.E. Respondent acknowledges that Patient B.E. was obese, had asthma and was hypertensive that morning. He concluded that the hypertension was the result of anxiety over the procedure. Respondent felt he could safely perform the procedure because he had performed other procedures involving moderate sedation of Patient B.E. in his office without complication. Respondent now acknowledges that he should have cancelled the procedure because he did not have a qualified provider to monitor the patient during the procedure.

17. Respondent agrees that a patient’s vital signs and the administration of medications should be documented in the record in real time. Respondent testified that he instructed, and expected, the medical assistant to document the medical record. He was distraught after returning from the hospital, and was aware that he had not followed the standard of care in that he did not have a nurse there to monitor the patient. Respondent decided to create a medical record by working back from the time the paramedics arrived. He wrote down times in the record, but decided they were incorrect. Instead of making a note of the error, he crossed out the times and wrote over them. He acknowledges that what he did was the opposite of what he was trained to do with regard to recordkeeping.

18. During the deposition taken in the lawsuit initiated by Patient B.E.’s family, respondent testified that he did not use an EKG during the procedure because it was not necessary and that he seldom, if ever, had used an EKG while performing a radiofrequency ablation. At hearing, respondent testified that he did not use an EKG during this procedure.

---

8 Norco is a trade name for hydrocodone bitartrate with acetaminophen, also known as Vicodin. It is a semisynthetic narcotic analgesie, a Schedule II controlled substance and narcotic as defined by Health and Safety Code section 11055, subdivision (b)(1).
because the EKG printer was broken. Respondent acknowledged that an EKG monitor should have been used.

19. Respondent has purchased a new printer for the EKG monitor and he now uses the EKG monitor when administering moderate sedation. Respondent now always has a qualified provider to monitor the patient when administering moderate sedation. Respondent’s medical assistant or nurse documents the patient’s vital signs and medication administration in real time. Respondent reviews the record after the procedure to confirm it is properly documented.

20. Respondent continues to perform procedures in his office, including, epidural injections, medial branch blocks, radiofrequency ablations and trigger point injections. However, he no longer administers Propofol during office procedures.

*Expert Opinions of Respondent’s Treatment of Patient B.E.*

21. Timothy J. Furnish, M.D., testified as an expert witness on behalf of complainant. Dr. Furnish graduated from Jefferson Medical College in Philadelphia, Pennsylvania, in 2005. He attended an anesthesia residency program at the University of California, San Diego (UCSD) from 2006 to 2009. Dr. Furnish completed a fellowship in anesthesiology and interventional pain management at UCSD in 2010. Dr. Furnish is board certified in anesthesiology and pain medicine and is licensed in California. Dr. Furnish has acted as a consultant to the Board for the past three years.

Dr. Furnish has been employed at UCSD since 2010. He is an assistant clinical professor in anesthesia and pain management, the associate fellowship director for pain medicine, the director of inpatient pain consult services and the specialty director of pain management telemedicine. Approximately two-thirds of Dr. Furnish’s time is spent in the clinical setting; one-third of his work is teaching or performing administrative tasks. He treats chronic pain patients with medication management as well as outpatient procedures. Dr. Furnish also treats inpatient patients suffering from acute pain or who are having surgery. Dr. Furnish treats approximately 50 patients each week. Dr. Furnish has performed hundreds of radiofrequency ablations and has at times used moderate sedation to perform the procedure.

22. Dr. Furnish reviewed Patient B.E.’s medical records from respondent’s office and Eden Medical Center where the patient was treated following the procedure. He also reviewed the coroner’s investigation report, Patient B.E.’s death certificate, respondent’s *curriculum vitae*, and respondent’s deposition and interview transcripts, and the audio recording of respondent’s interview. Dr. Furnish also consulted position statements by the ASA on anesthesia care during interventional pain procedures, the continuum of depth of sedation, the guidelines for the safe use of Propofol and a joint statement by the ASA and the American Association of Nurse Anesthetists (AANA) regarding Propofol administration.
23. Dr. Furnish opined that the standard of care requires that a qualified medical provider, whose primary responsibility during the procedure is patient monitoring and administration of sedation, monitor the patient and administer sedation. Respondent agrees with this opinion.

Dr. Furnish also explained that Propofol is generally used to induce anesthesia, or unconsciousness, rather than for moderate sedation. Propofol depresses the respiratory system and can have a synergistic effect when combined with Versed, opioids or benzodiazepines. Versed can diminish a gag reflex in patients. There is a risk of cardiac collapse for a patient who is on opioids, including Norco, and is administered Versed and Propofol. Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Due to the potential for rapid, profound changes in the sedative/anesthetic depth and the lack of antagonistic medications, the use of Propofol requires special attention. The ASA Position Statement on the Safe Use of Propofol recommends against the use of Propofol when administered by the same individual who is performing the surgical procedure. This warning is consistent with the Joint Position Statement by the ASA and AANA. The Joint Position Statement cautions that the failure to follow this recommendation could put patients at increased risk of significant injury or death.

Dr. Furnish opined that respondent committed an extreme departure from the standard of care by performing the radiofrequency ablation on Patient B.E. without a qualified provider present. Having a second qualified provider could have changed the outcome in this case; if the patient had been monitored more closely, efforts to resuscitate may have been initiated sooner.

24. Dr. Furnish explained that patients undergoing moderate sedation should be monitored by continuous pulse oximetry monitoring, EKG-monitoring and blood pressure monitoring. The EKG monitor reports the patient’s heart rate and rhythm. Because Patient B.E. was obese and in a prone position, it would be difficult to watch his chest rise. The pulse oximetry does not monitor heart rate; it would indicate that a patient stopped breathing well after the fact when the oxygen level starts to fall in the patient’s blood. During an ablation, the surgeon is focused on the screen and the procedure in order to insert the needle in the correct position. Inserting the needle in the wrong spot can cause unintended nerve damage or even paralysis; the physician cannot also competently focus on the patient’s vital signs and level of consciousness. Dr. Furnish opined that respondent’s failure to utilize an EKG monitor during the procedure constituted a simple departure from the standard of care. Respondent does not dispute that he should have utilized an EKG monitor.

25. The standard of care requires that patients undergoing moderate sedation be evaluated prior to sedation with a focused history and examination. The physician must examine the patient’s airway, heart and lungs, consider any comorbid conditions that could predispose the patient to adverse outcomes, ask about drug allergies and be aware of current outpatient medications being taken. Dr. Furnish found respondent’s performance of a focused history and physical examination to be cursory but sufficient. However, he found a simple
departure from the standard of care with regard to his documentation of the basics of his findings even when supplemented with the patient's recent clinic visit history. For example, there was no indication of drug allergies or current medications.

26. The standard of care requires real time documentation of intra-procedure vital signs, times and drugs administered. Respondent's intra-procedure record shows vital signs documented every five minutes; however, respondent completed the in-office procedure record and his procedure note record after returning from the hospital. Respondent acknowledges that he was not exact in recording the administration of medications or Patient B.E.'s vital signs; rather, he attempted to reconstruct the record after returning from the hospital and crossed out his entries as his recollection evolved. Dr. Furnish opined that respondent's actions in failing to document the patient's vital signs and the amounts and times medication was administered in real time constituted a simple departure from the standard of care. Respondent does not dispute this opinion.

Ultimate Conclusions regarding Respondent's Treatment of Patient B.E.

27. Respondent did not present expert testimony regarding his treatment of Patient B.E. and did not disagree with the opinions expressed by Dr. Furnish. The testimony of Dr. Furnish was persuasive; it is accepted as establishing the standard of care and respondent's departures therefrom.

Respondent's Treatment of Patient R.B.

28. On September 21, 2012, respondent performed a minimally invasive lumbar decompression (MILD)\(^9\) procedure on Patient R.B., a 77-year-old patient, at ValleyCare Medical Center in Pleasanton, California.

29. The procedure was initially scheduled for August 2012. At a previous preoperative evaluation, it was documented that the patient was allergic to iodine. Iodine is used as a contrast agent in MILD procedures.

30. On September 21, 2012, respondent was unaware of Patient R.B.'s allergy to iodine and had documented in his preoperative history and examination that the patient had no known drug allergies. Patient R.B.'s allergy to iodine was anaphylaxis. A nurse brought the patient's allergy to respondent’s attention while the patient was in the preoperative holding area. Respondent instructed the nurse to contact the pharmacy to deliver an alternative contrast agent. The pharmacy sent “Omniscan” which is the brand name for a gadolinium-based product. Respondent performed the procedure without being aware that Omniscan contained gadolinium or researching whether Omniscan was appropriate for use in a MILD procedure.

\(^9\) A MILD procedure treats pain caused by central canal stenosis. Guided by fluoroscopy, the physician removes fibrous tissue to relieve pressure on the nerves.
31. Following the procedure, respondent left the hospital. He did not designate a back-up surgeon to be available in his absence. In portions of respondent's post-operative note, he inaccurately documented the procedure as taking place at levels L3-4 and L4-5 instead of at levels L2-3 and L3-4.

32. Patient R.B. experienced severe leg pain and exhibited signs of complications following the procedure. Nurses attempted to reach respondent at three different telephone numbers but were unsuccessful. Nurses contacted an orthopedist affiliated with the hospital who admitted Patient R.B. Respondent did not respond to pages and calls for four to six hours.

Suspension of Respondent's Privileges at ValleyCare Health System

33. On October 9, 2012, the ValleyCare Medical Executive Committee (MEC) summarily suspended respondent's privilege to perform MILD procedures based on concerns identified with judgment, technique and management of Patient R.B.'s MILD procedure.

34. On November 7, 2012, the Board received a report from ValleyCare Health System pursuant to Business and Professions Code section 805, stating that respondent's privilege to perform MILD procedures at the facility had been summarily suspended.

35. Respondent appealed the suspension.

36. On November 20, 2012, ValleyCare Health System notified the Board that the MEC had voted to expand the summary suspension to include all privileges involving the use of fluoroscopy with contrast agents. On February 25, 2013, ValleyCare Health System notified the Board that based on respondent's action plan the MEC had lifted the suspension of respondent's clinical privileges to perform fluoroscopy guided procedures using contrast agents. The summary suspension of respondent's privilege to perform MILD procedures remained in place.

37. On June 24, 2013, ValleyCare Health System notified the Board that the MEC had decided to reinstate respondent's privilege to perform MILD procedures subject to pre-procedure concurrence and proctoring requirements in effect for at least 10 cases.

38. Respondent testified at hearing that due to a clerical error by his office staff, his staff privileges with ValleyCare Health System expired, necessitating a new application. He has decided not to reapply.

Respondent's Evidence Regarding his Treatment of Patient R.B.

39. Respondent treated Patient R.B. once per month for at least two years before performing the MILD procedure on September 21, 2012. She suffered from failed back surgery syndrome. She was elderly and frail, but stable on pain medication management until
a flare up six months prior to the procedure. Epidural injections provided temporary relief. Although additional surgery had been recommended by neurosurgeon Lawrence D. Dickinson, M.D., Patient R.B. was reluctant to go forward with major surgery because of the difficult recovery and her preference to avoid general anesthesia. Patient R.B. elected to try the MILD procedure. Respondent had performed the MILD procedure 18 to 20 times previously.

40. Dr. Dickinson had performed surgery on Patient R.B. prior to the MILD procedure and has treated her following the procedure. Dr. Dickinson wrote a letter dated March 27, 2013, in which he reported that Patient R.B. was back to her baseline with respect to ambulation as of early 2013. Dr. Dickinson opined that the MILD procedure performed by respondent, although not beneficial with respect to her pain syndrome, did not cause a permanent adverse outcome.

41. Respondent acknowledges that he was unaware of the patient’s severe allergy to iodine until the patient was in the preoperative holding area. He believes that he performed procedures using iodine on the patient previously. Respondent accepts responsibility for failing to discuss alternatives with the pharmacist and proceeding with the procedure without knowing what Omniscan contained. Gadolinium can be toxic to spinal nerves if injected intrathecally. Although respondent did not intend to have the needle penetrate the dura, due to the mechanical work around the needle during the procedure, inadvertent intrathecal injection is a known complication. If respondent had known Omniscan was gadolinium-based, he would not have gone forward.

42. Respondent acknowledges that he inaccurately documented the procedure in the description section of his post-operative note as taking place at levels L3-4 and L4-5 instead of at L2-3 and L3-4. He correctly identified the levels in the body of his post-operative note.

43. Respondent left the hospital 45 minutes to one hour following the procedure. The patient was stable and he spoke with her. Respondent has a standing agreement with orthopedist Bikram Talwar, M.D., to serve as his backup surgeon if necessary. Respondent concedes that he did not advise Dr. Talwar of this procedure or arrange for him to be available as a backup on September 21, 2012. Respondent did not document that Dr. Talwar was his backup in Patient R.B.’s chart.

Respondent reports that the battery on his cell phone died after the procedure and he participated in a Hindu prayer meeting that afternoon. After recharging his phone and learning that the hospital had tried to reach him, he called in. He provided orders for pain medications and contacted Dr. Talwar to discuss the patient’s condition. Respondent visited the patient in the hospital the next morning and reviewed the patient’s MRI.

Respondent followed the patient until she was discharged to a rehabilitation facility on September 25, 2012. He visited her a few times there. She recovered gradually, but is no longer his patient.
44. Respondent has become more careful with his charting; he reviews it after it is transcribed to confirm accuracy. Respondent no longer relies on nurses to describe medications. He will look at medication bottles if he is unfamiliar with the medication. Respondent is now careful to confirm coverage physicians.

Expert Opinions Regarding Respondent’s Treatment of Patient R.B.

45. Tobias Moeller-Bertram, M.D., testified as an expert witness on behalf of complainant. Dr. Moeller-Bertram graduated from the University of Hamburg Medical School in Germany in 2000. He completed an internship in internal medicine at the Hospital of Saint Rafael, in New Haven, Connecticut in 2001. Dr. Moeller-Bertram completed his residency in anesthesia in 2004, and a pain fellowship in 2005, at UCSD. Dr. Moeller-Bertram earned a masters degree in clinical research at UCSD in 2008. Dr. Moeller-Bertram is board certified in anesthesiology and pain medicine and is licensed in Germany, Hawaii and California. Dr. Moeller-Bertram has acted as a consultant to the Board since 2012.

Dr. Moeller-Bertram was employed by UCSD as an assistant clinical professor in 2005, as an associate professor in the Department of Anesthesiology in 2008, and in the Department of Psychiatry in 2011. Dr. Moeller-Bertram has worked in an anesthesiology/pain management practice associated with the VA Medical Center in San Diego from 2005 to 2012. Since June 2013, Dr. Moeller-Bertram has served as the Medical Director of Desert Clinic Pain & Wellness.

46. Dr. Moeller-Bertram reviewed the Business and Professions Code section 805 reports from ValleyCare Health System, medical records of Patient R.B., respondent’s curriculum vitae, and he listened to the audio recordings of respondent’s Board interviews.

47. Dr. Moeller-Bertram opined that based on the information provided to him, including respondent’s training and expertise, and longstanding patient/physician relationship with Patient R.B., respondent did not depart from the standard of care in performing the MILD procedure on Patient R.B.

48. Dr. Moeller-Bertram found that respondent’s error in identifying levels L3-4 and L4-5 in a portion of his postoperative report constituted a departure from the standard of care. However, because respondent identified the correct levels within the body of the report, he considered the error to constitute a simple departure from the standard of care rather than an extreme departure.

49. Dr. Moeller-Bertram opined that respondent’s failure to arrange for Dr. Talwar to serve as his backup surgeon, and to document that arrangement in the record, constituted a simple departure from the standard of care.

50. Dr. Moeller-Bertram opined that in light of respondent’s explanation that his cell phone battery died and he was away from his home following the surgery, respondent’s
unavailability to hospital staff and failure to respond to calls for four to six hours after the procedure constituted an unfortunate incident, but not a departure from the standard of care.

51. Dr. Moeller-Bertram considers gadolinium to be an accepted alternative to be injected into the epidural space for procedures involving fluoroscopy if iodine cannot be used. However, he noted that in a MILD procedure, where the risk for inadvertent intrathecal injection is high, given the physical manipulation involved in performing the procedure, the risk/benefit ratio is debatable, but not a per se violation of the standard of care.

However, the standard of care requires a physician to have clear knowledge of the nature of a medication before administering it to a patient. Dr. Moeller-Bertram opined that respondent's administration of gadolinium to Patient R.B. constituted a simple departure from the standard of care.

_Ultimate Conclusions Regarding Respondent's Treatment of Patient R.B._

52. Respondent does not dispute that he erred in identifying the levels where the MILD procedure was performed in the postoperative report, that he failed to arrange for and document a backup surgeon, or that he did not understand the nature of the contrast agent he used. The evidence established that respondent committed a series of simple departures from the standard of care.

_Criminal Conviction and Failure to Report_

53. On November 5, 2015, in the Superior Court of California, County of Contra Costa, respondent was convicted of violating Vehicle Code section 23152, subdivision (b) (driving with a blood alcohol content of over 0.08 percent), with an enhancement pursuant to Vehicle Code section 23578 (driving with a blood alcohol content of over 0.15 percent). Imposition of sentence was suspended and respondent was placed on summary probation for a period of three years on conditions that included serving two days in county jail, completing a six-month drinking driver program and paying various fines and fees. Respondent completed the jail time through the Sheriff's Work Alternative Program. He will remain on probation until November 2018.

The factual circumstances underlying the conviction occurred on September 14, 2014. Respondent was pulled over at approximately 8:30 p.m. for driving without headlights illuminated. When the deputy sheriff contacted respondent, he observed respondent to display the objective symptoms of alcohol intoxication. Respondent performed the field sobriety tests poorly and his blood alcohol concentration was measured at the scene at 0.18 and 0.19 percent. One hour later his blood alcohol content was measured at the station at 0.16 percent.

54. Respondent did not report his conviction to the Board.
Respondent’s Evidence

55. Respondent claims that he only consumed two drinks of alcohol on the day of his arrest. Respondent states that since his DUI arrest he rarely drinks alcohol. Respondent pledges never to drive after even one sip of alcohol in the future.

56. Respondent did not report his conviction because the Board was aware of his arrest and he assumed that the Board would also know about his conviction.

57. Respondent successfully completed the drinking driver program on October 28, 2015. The program included 16 hours of education and 30 hours of group meetings. The program coordinator wrote a letter dated January 27, 2017, in which she expressed the opinion that respondent is a social drinker whose arrest was situational. Respondent’s driver’s license is unrestricted now.

58. Respondent provided expert testimony from Martin Williams, Ph.D., on the subject of whether he has a substance abuse disorder. Dr. Williams has been a licensed psychologist in California since 1976. He earned his doctorate in psychology at the University of California, Berkeley in 1975. From 1980 to 2007, Dr. Williams practiced as a clinical psychologist and manager at Kaiser Medical Center in Santa Clara, where he treated patients with substance abuse and psychiatric disorders. Dr. Williams has also maintained a private practice since 1985. Since 1993, Dr. Williams has worked in forensic psychology, evaluating the standard of care and an individual’s fitness for duty or for a security clearance.

Beginning in 2006, he has been a member of the Forensic Evaluation Panel for the Superior Court of California and has offered opinions in criminal cases involving the competency to stand trial, restoration of sanity and sentence mitigation. Since 2011, Dr. Williams has been an approved competency evaluator for the United States Immigration and Customs Enforcement operations. He has also provided forensic assessments for the Board of Parole. Dr. Williams has been active in the American Psychological Association and is a fellow of the organization.

59. Dr. Williams evaluated respondent to determine whether he has a substance abuse disorder and is safe to practice. Dr. Williams conducted a two-hour interview of respondent and administered the MMPI-2RF test. The MMPI-2RF scores indicated the test results were valid, and that respondent was honest and forthcoming during the test.

Based on his clinical interview and the test results, Dr. Williams opined that respondent does not have a substance abuse or mental health disorder. At hearing, Dr. Williams learned that respondent had been arrested for being drunk in public in 2012 and spent the night in custody. No charges were brought following his arrest. This information did not change Dr. Williams’s opinions.
60. Anesthesiologist David Kent Williams, M.D., testified as a character witness for respondent. Dr. Williams completed his training in 2003 and has practiced at 10 to 12 surgery centers in the Bay Area since 2004. Most of his work involves providing sedation or anesthesia for patients undergoing outpatient orthopedic procedures. Dr. Williams met respondent in 2009. He has provided anesthesia services for respondent at surgery centers for patients undergoing pain procedures, including epidurals, radiofrequency ablations and the implementation of spinal stimulators. Dr. Williams estimates that he has worked with respondent at least 50 times.

Dr. Williams considers respondent to be a competent and reliable physician. He would recommend respondent to others. Dr. Williams is aware of the allegations in the first amended accusation; however, the allegations do not affect his opinion of respondent. Dr. Williams is under contract with Empire Anesthesia Group to provide services at Redwood Surgery Center, of which respondent is a part owner.

61. Douglas Abeles, M.D., testified at hearing. Dr. Abeles is an orthopedic surgeon and is licensed in California. Dr. Abeles is partners with respondent at Redwood Surgery Center. Dr. Abeles has known respondent for 20 years. He and respondent refer clients to one another and have a good working relationship. Dr. Abeles has full confidence in respondent’s competence as a pain management physician. He has observed respondent perform surgery and is impressed with his skills. Dr. Abeles also praises respondent’s interactions with his patients and staff. Dr. Abeles and respondent have been business partners for six years and Dr. Abeles considers respondent to be honest and to have integrity.

62. Respondent regularly attends meetings of the American Society of Interventional Pain Physicians, the North American Neuromodulation Society and other professional organizations to keep up-to-date with changes in medicine.

LEGAL CONCLUSIONS

Introduction

1. The purpose of an administrative proceeding concerning licensure is not to punish the respondent, but rather is “to protect the public from dishonest, immoral, disreputable or incompetent practitioners [citations omitted].” (Ettinger v. Board of Medical Quality Assurance (1982) 135 Cal.App.3d 853, 856.) The goal is the prevention of future harm and the improvement and rehabilitation of the licensee. It is far more desirable to impose discipline before a licensee harms any patient than after harm has occurred. (Griffiths v. Superior Court (2002) 96 Cal.App.4th 757, 772.) While the objective, wherever possible, is to take action that is calculated to aid in the rehabilitation of the licensee, protection of the public shall be paramount. (Bus. & Prof. Code, § 2001.1.)
2. The standard of proof regarding the charging allegations is "clear and convincing." (Ettinger v. Board of Medical Quality Assurance, supra, 135 Cal.App.3d at 856.) This means the burden rests on complainant to establish the charging allegations by proof that is clear, explicit and unequivocal – so clear as to leave no substantial doubt, and sufficiently strong to command the unhesitating assent of every reasonable mind. (In re Marriage of Weaver (1990) 224 Cal.App.3d 478.)

Unprofessional Conduct in Treatment of Patient B.E.

GROSS NEGLIGENCE AND REPEATED NEGLIGENCE

3. Business and Professions Code section 2234 authorizes the Board to impose discipline against any licensee who is charged with unprofessional conduct, including an act of gross negligence (subd. (b)), repeated negligent acts (subd. (c)) and/or incompetence (subd. (d)).

Complainant established by clear and convincing evidence that respondent’s treatment of Patient B.E. was grossly negligent and repeatedly negligent. (Factual Findings 21 through 27.) Cause for discipline exists pursuant to Business and Professions Code sections 2234, subdivisions (b) and (c).

Unaccredited Outpatient Setting

4. Business and Professions Code section 2216 places restrictions on the use of anesthesia in an outpatient setting. Section 2216 states in part:

[N]o physician and surgeon shall perform procedures in an outpatient setting using anesthesia, except local anesthesia or peripheral nerve blocks, or both, complying with the community standard of practice, in doses that, when administered, have the probability of placing a patient at risk for loss of the patient’s life-preserving protective reflexes unless the setting is specified in [Health and Safety Code section] 1248.1. Outpatient settings where anxiolytics and analgesics are administered are excluded when administered, in compliance with the community standard of practice, in doses that do not have the probability of placing the patient at risk for loss of the patient’s life-preserving protective reflexes.

Respondent agrees that his office was not accredited pursuant to Health and Safety Code section 1248.1. However, complainant did not present expert testimony regarding the community standard of practice on this issue, or whether in the expert’s opinion, respondent should not have performed the procedure on Patient B.E. in his office based on the doses of medication administered. The evidence did not establish by clear and convincing evidence
that respondent violated Business and Professions Code section 2216.

Unprofessional Conduct in Treatment of Patient R.B.

5. Complainant established by clear and convincing evidence that respondent’s treatment of Patient R.B. was repeatedly negligent as set forth in Factual Findings 45 through 52. Cause for discipline exists pursuant to Business and Professions Code section 2234, subdivision (c).

Failure to Maintain Adequate and Accurate Records

6. Business and Professions Code section 2266 provides that the failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct. Complainant established by clear and convincing evidence that respondent failed to maintain adequate and accurate records of his treatment of Patients B.E. and R.B., as set forth in Factual Findings 22 and 48. Cause for discipline exists pursuant to Business and Professions Code sections 2266 and 2234.

Criminal Conviction and Failure to Report

7. Business and Professions Code section 2236 provides that the conviction of any offense substantially related to the qualifications, functions or duties of a physician and surgeon constitutes unprofessional conduct. Respondent drove with a blood alcohol over twice the legal limit as set forth in Factual Finding 53. The offense is substantially related to the qualifications, functions or duties of a physician and surgeon. Cause for discipline exists pursuant to Business and Professions Code section 2236.

8. Business and Professions Code section 802.1 requires a physician and surgeon to notify the board if he or she is convicted of a misdemeanor within 30 days. Section 802.1 does not provide an exemption from reporting the conviction because a Board employee is aware of the underlying arrest. Respondent failed to report the conviction to the Board. (Factual Finding 54.) Respondent’s failure to report the conviction constitutes cause for discipline pursuant to Business and Professions Code sections 802.1 and 2234.

Disciplinary Considerations

9. Cause for discipline having been established, the issue is the appropriate measure of discipline. When possible, certificates should be placed on probation with conditions, such as completing educational courses, designed to enable rehabilitation and eventual reinstatement.

This matter involves findings of simple and gross negligence in the treatment of two patients, respondent’s conviction for driving with a high blood alcohol content and his failure to report that conviction to the Board. Complainant does not consider respondent to be a
substance abusing licensee. Complainant recommends, however, that respondent’s certificate be revoked, the revocation stayed during a period of probation of nine years with conditions including: a prohibition against solo practice, a practice monitor, a clinical competency assessment program, a professionalism program, a medical record keeping course and an education course, in addition to the standard conditions of probation. Respondent acknowledges discipline is warranted but requests that no more than a public reproof be issued.

Respondent has practiced medicine in this country for over 26 years. This is the first instance of disciplinary action. His treatment of Patient B.E. raises serious concerns; however, it occurred almost seven years ago and respondent has made changes to ensure the safety of his patients, including: the use of an EKG monitor when administering sedation, the presence of a qualified provider when administering sedation, real time documentation of vital signs and medication administration, careful review of documentation and the use of Propofol only in a surgery center or hospital setting.

Respondent’s treatment of Patient R.B. also raises concerns. Again, respondent has made changes to his practices involving more careful documentation, providing a back up surgeon, and a commitment to understanding the nature of any medications administered. Respondent’s treatment of Patient R.B. occurred four years ago.

Although respondent has made important changes to his practice, the numerous instances of departures from the standard of care and his recent conviction for driving under the influence require Board monitoring to ensure that the changes to his practice are followed and his patients are not at risk. Education, professionalism and record keeping courses, a clinical competency assessment program, a practice monitor and a solo practice prohibition are probationary conditions that will ensure the protection of the public, which is the Board’s highest priority. In light of the length of time that has passed since respondent’s treatment of Patients B.E. and R.B., and the changes he has made to his practice, a probationary term of five years is sufficient to provide guidance to respondent and to assure the Board that respondent is safe to practice without monitoring.

ORDER

Certificate No. A55600 issued to respondent Ravi Sham Panjabi, M.D., is revoked; however, the revocation is stayed and respondent is placed on probation for five years upon the following terms and conditions.

1. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, 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 per year, for
each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. 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.

2. 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 CME requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the First Amended 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.

3. Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program that meets the requirements of California Code of Regulations, title 16, section 1358.1. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after respondent’s initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at respondent’s expense and shall be in addition to the CME requirements for renewal of licensure.
A professionalism program taken after the acts that gave rise to the charges in the First Amended 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 program would have been approved by the Board or its designee had the program 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 program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. Clinical Competence Assessment Program

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical competence assessment program approved in advance by the Board or its designee. Respondent shall successfully complete the program not later than six (6) months after respondent’s initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

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

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

Determination as to whether respondent successfully completed the clinical competence assessment program is solely within the program’s jurisdiction.

If respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, respondent shall
receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If respondent does not successfully complete the clinical competence assessment program, respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

Within 60 days after respondent has successfully completed the clinical competence assessment program, respondent shall participate in a professional enhancement program approved in advance by the Board or its designee, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent’s expense during the term of probation, or until the Board or its designee determines that further participation is no longer necessary.

5. Monitoring – Practice

Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in respondent’s field of practice, and must agree to serve as respondent’s monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and First Amended Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), First Amended Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and First Amended Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent’s practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.
If respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent’s performance, indicating whether respondent’s practices are within the standards of practice of medicine, and whether respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within five calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent’s expense during the term of probation.

6. Solo Practice Prohibition

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

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

7. Notification

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

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

8. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

9. Obey All Laws

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

10. Quarterly Declarations

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

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.
11. General Probation Requirements

Compliance with Probation Unit

Respondent shall comply with the Board’s probation unit.

Address Changes

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

Place of Practice

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

License Renewal

Respondent shall maintain a current and renewed California physician’s and surgeon’s license.

Travel or Residence Outside California

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

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

12. Interview with the Board or its Designee

Respondent shall be available in person upon request for interviews either at respondent’s place of business or at the probation unit office, with or without prior notice throughout the term of probation.

13. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar
days of respondent’s return to practice. Non-practice is defined as any period of time respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent’s period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board’s Special Purpose Examination, or, at the Board’s discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board’s “Manual of Model Disciplinary Orders and Disciplinary Guidelines” prior to resuming the practice of medicine. Respondent’s period of non-practice while on probation shall not exceed two (2) years.

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

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

14. Completion of Probation

Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent’s certificate shall be fully restored.

15. Violation of Probation

Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation, petition to revoke probation, or an interim suspension order is filed against respondent during probation, the Board
shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

16. License Surrender

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

17. Probation Monitoring Costs

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

DATED: March 2, 2017

[Signature]
Jill Schlichtmann
Administrative Law Judge
Office of Administrative Hearings
BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against:

Ravi Sham Panjabi, M.D.
19850 Lake Chabot Road
Castro Valley, CA 94546

Physician's & Surgeon's Certificate
No. A55600

Respondent.

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").

2. On or about January 31, 1996, the Medical Board issued Physician's & Surgeon's Certificate Number A55600 to Ravi Sham Panjabi, M.D. ("Respondent"). The Physician's & Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2017, unless renewed.

///

(RAVI SHAM PANJABI, M.D.) FIRST AMENDED ACCUSATION NO. 03-2013-229400
3. This First Amended Accusation is brought before the Medical Board of California ("Board") \(^1\), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

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

5. 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.

\(^1\) The term "Board" means the Medical Board of California. "Division of Medical Quality" shall also be deemed to refer to the Board. (Bus. & Prof. Code, section 2002).
“(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

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

“(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of the proposed registration program described in Section 2052.5.

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

6. Section 2266 of the Code states:

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

7. Section 2216 of the Code states:

“On or after July 1, 1996, no physician and surgeon shall perform procedures in an outpatient setting using anesthesia, except local anesthesia or peripheral nerve blocks, or both, complying with the community standard of practice, in doses that, when administered, have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes, unless the setting is specified in Section 1248.1 [of the Health and Safety Code]. Outpatient settings where anxiolytics and analgesics are administered are excluded when administered, in compliance with the community standard of practice, in doses that do not have the probability of placing the patient at risk for loss of the patient's life-preserving protective reflexes.

“The definition of 'outpatient settings' contained in subdivision (c) of Section 1248 [of the Health and Safety Code] shall apply to this section.”

8. Health and Safety Code section 1248 (b)(1) defines “outpatient setting” as follows:

“Outpatient setting” means any facility, clinic, unlicensed clinic, center, office, or other setting that is not part of a general acute care facility, as defined in Section 1250, and where anesthesia, except local anesthesia or peripheral nerve blocks, or both, is used in compliance with
the community standard of practice, in doses that, when administered have the probability of
placing a patient at risk for loss of the patient's life-preserving protective reflexes.”

9. Health and Safety Code section 1248.1 provides for the requirements for operation
and maintenance of an outpatient setting, including accreditation by an approved accreditation
agency, in pertinent part as follows:

“No association, corporation, firm, partnership, or person shall operate, manage, conduct, or
maintain an outpatient setting in this state, unless the setting is one of the following:

... 

“(g) An outpatient setting accredited by an accreditation agency approved by the division
pursuant to this chapter.”

10. Section 1248.65 of the Health and Safety Code states:

“It shall constitute unprofessional conduct for a physician and surgeon to willfully and
knowingly violate this chapter.”

11. Section 2236 of the Code states:

“(a) The conviction of any offense substantially related to the qualifications, functions, or
duties of a physician and surgeon constitutes unprofessional conduct within the meaning of this
chapter [Chapter 5, the Medical Practice Act]. The record of conviction shall be conclusive
evidence only of the fact that the conviction occurred.

“(b) The district attorney, city attorney, or other prosecuting agency shall notify the
Medical Board of the pendency of an action against a licensee charging a felony or misdemeanor
immediately upon obtaining information that the defendant is a licensee. The notice shall identify
the licensee and describe the crimes charged and the facts alleged. The prosecuting agency shall
also notify the clerk of the court in which the action is pending that the defendant is a licensee,
and the clerk shall record prominently in the file that the defendant holds a license as a physician
and surgeon.

“(c) The clerk of the court in which a licensee is convicted of a crime shall, within 48 hours
after the conviction, transmit a certified copy of the record of conviction to the board. The
division may inquire into the circumstances surrounding the commission of a crime in order to fix
the degree of discipline or to determine if the conviction is of an offense substantially related to the qualifications, functions, or duties of a physician and surgeon.

“(d) A plea or verdict of guilty or a conviction after a plea of nolo contendere is deemed to be a conviction within the meaning of this section and Section 2236.1. The record of conviction shall be conclusive evidence of the fact that the conviction occurred.”

12. Section 802.1 of the Code states:

“(a) (1) A physician and surgeon, osteopathic physician and surgeon, a doctor of podiatric medicine, and a physician assistant shall report either of the following to the entity that issued his or her license:

“(A) The bringing of an indictment or information charging a felony against the licensee.

“(B) The conviction of the licensee, including any verdict of guilty, or plea of guilty or no contest, of any felony or misdemeanor.

“(2) The report required by this subdivision shall be made in writing within 30 days of the date of the bringing of the indictment or information or of the conviction.

“(b) Failure to make a report required by this section shall be a public offense punishable by a fine not to exceed five thousand dollars ($5,000).”

RELEVANT DRUGS

13. Fentanyl is a potent narcotic analgesic. It is a dangerous drug as defined in Code section 4022 and a schedule II controlled substance and narcotic as defined by section 11055, subdivision (c)(8), of the Health and Safety Code. Fentanyl can cause respiratory depression, respiratory arrest and cardiac arrest.

14. Versed, a trade name for midazolam hydrochloride, is a short-acting benzodiazepine central nervous system depressant. It is a dangerous drug as defined in Code section 4022 and a Schedule IV controlled substance as defined by section 11057 of the Health and Safety Code. Intravenous Versed has been associated with respiratory depression and respiratory arrest, especially when used for sedation in noncritical care settings.
15. **Propofol** is an intravenously administered sedative-hypnotic agent for use in the induction and maintenance of anesthesia or sedation. It is a dangerous drug as described in Code section 4022.

**FIRST CAUSE FOR DISCIPLINE**

(Gross Negligence and/or Repeated Negligent Acts and/or Incompetence re Patient B.E.\(^2\))

16. Respondent is subject to disciplinary action for unprofessional conduct under sections 2234(b) and/or 2234(c) and/or 2234(d) of the Code in that Respondent was grossly negligent and/or repeatedly negligent and/or incompetent in his treatment of B.E. The circumstances are as follows:

17. On May 25, 2010, Respondent performed a thoracic radiofrequency ablation on patient B.E., a 66-year old male with a history of back pain. The procedure was performed in Respondent’s medical office, Advanced Pain Management & Rehab Medical Group, Inc., which is not an accredited outpatient setting. A medical assistant was present during the procedure. No other provider was present.

18. Respondent, who is a board-certified anesthesiologist, personally administered IV sedation, including Versed, Fentanyl, and Propofol. Respondent also personally monitored B.E.’s vital signs with pulse oximetry, an end-tidal CO2 monitor, and a non-invasive blood pressure cuff. There was an EKG monitor in the room, but it was not used to monitor B.E.

19. According to Respondent, approximately 30 minutes after being administered with IV sedation, B.E. stopped breathing and went into cardiopulmonary arrest. Respondent initiated CPR, 911 was called, and B.E. was taken to the hospital, where he was placed on hypothermia protocol and life support.

20. B.E. died on June 11, 2010. An autopsy was performed, and the cause of death was determined to be “hypoxic encephalopathy due to cardiopulmonary arrest due to sedation/anesthesia for neural radioablation.”

\(^2\) Patients’ names are kept confidential to protect their privacy but will be identified to Respondent in discovery.
21. Respondent’s medical records include an “In-Office Procedure Record,”
documenting the administration of Versed, Fentanyl, and Propofol. However, there is no
documentation of a focused history or examination conducted prior to administering sedation.
The record also contains numerous handwritten cross-outs of times and dosages of the drugs
administered which are overwritten by different times and dosages, making the record difficult to
decipher.

22. During his physician interview, Respondent acknowledged altering the “In-Office
Procedure Record.” Respondent stated that medical assistant documented only the total amount
of Versed, Fentanyl, and Propofol administered, and did not document the times the drugs were
administered. Respondent stated that when he returned to the office several hours after B.E.’s
cardiac arrest, he wrote down the times the drugs were administered based on his recollection. He
then realized that his recollection was incorrect, and he crossed-out the times he had initially
written and overwrote them with different times. In addition, Respondent added information to
indicate that the dosages of Versed, Fentanyl and Propofol given to B.E. were given in
incremental dosages.

23. Respondent is guilty of unprofessional conduct through gross negligence and/or
repeated negligent acts and/or incompetence, because of the following conduct that constitutes,
jointly and/or separately, departures from the standard of practice:

A. Respondent performed radiofrequency ablation where IV sedation was
administered without having a separate qualified provider administer the sedation and monitor the
patient, which in and of itself constitutes an extreme departure from the standard of practice;

B. Respondent failed to conduct and/or failed to document a focused history and
examination prior to administering IV sedation;

C. Respondent failed to properly record vital signs and sedation drug
administration in real-time; and

D. Respondent inappropriately altered his documentation by writing over original
numbers and notes.
SECOND CAUSE FOR DISCIPLINE
(Unaccredited Outpatient Setting)

24. Paragraphs 16 through 21 are incorporated herein by reference as if fully set forth.

25. Respondent is subject to disciplinary action for unprofessional conduct under Business and Professions Code section 2234(a) and Health and Safety Code section 1248.65 in that Respondent administered IV sedation to patient B.E. at his office, Advanced Pain Management & Rehab Medical Group, Inc., which is an unaccredited outpatient setting, in violation of Business and Professions Code section 2216 and Health and Safety Code section 1248.1.

THIRD CAUSE FOR DISCIPLINE
(Repeated Negligent Acts and/or Incompetence re Patient R.B.)

26. Respondent is subject to disciplinary action for unprofessional conduct under sections 2234(c) and/or 2234(d) of the Code in that Respondent was repeatedly negligent and/or incompetent in his treatment of R.B. The circumstances are as follows:

27. On or about September 21, 2012, Respondent performed a MILD (minimally invasive lumbar decompression) procedure on R.B., a 77-year old patient, at Valley Care Health System Hospital. Respondent’s medical records indicate that R.B. had no known drug allergies. However, immediately prior to the MILD procedure, a preoperative nurse informed Respondent that R.B. was allergic to iodine, which was the contrast agent Respondent planned to use. Respondent asked the nurse to contact the hospital pharmacy for an alternative contrast agent, and Omniscan (gadolinium) was provided. Respondent did not speak to the pharmacist, and he acknowledged that he would not have used Omniscan had he known it was gadolinium, a neurotoxin, because of the risks if used intrathecally.

28. In the operative report, under “Name of Procedures,” Respondent documented that the MILD procedures were performed at levels L3/4 and L4/5, when, in fact, the procedures were at level L2/3 and L3/4.

29. After the procedure, R.B. developed severe postoperative pain and weakness requiring hospitalization. During the initial four to six hours post MILD procedure, Respondent
could not be reached. Respondent also did not designate or identify a back-up surgeon for coverage.

30. Respondent is guilty of unprofessional conduct through repeated negligent acts and/or incompetence, because of the following conduct that constitutes, jointly and/or separately, departures from the standard of practice:

A. Respondent used Omniscan as a contrast agent without knowledge that it is the same as Gadolinium;

B. Respondent could not be reached for four to six hours post-MILD procedure, and he failed to arrange for and identify a back-up surgeon in connection with the procedure; and

C. Respondent incorrectly noted under “Name of Procedures” that MILD procedures were performed at levels L3/4 and L4/5, when, in fact, the procedures were at level L2/3 and L3/4.

FOURTH CAUSE FOR DISCIPLINE
(Repeated Negligent Acts)

31. Paragraphs 16 through 29 are incorporated herein by reference as if fully set forth.

32. Respondent is subject to disciplinary action for unprofessional conduct under section 2234(c) for repeated negligent acts with regard to his care and treatment of patients B.E. and R.B.

FIFTH CAUSE FOR DISCIPLINE
(Failure to Maintain Adequate Records)

33. Paragraphs 16 through 29 are incorporated herein by reference as if fully set forth.

34. Respondent is subject to disciplinary action for unprofessional conduct under Code section 2266 for failure to maintain adequate and accurate records relating to the provision of services to B.E. and R.B.

SIXTH CAUSE FOR DISCIPLINE
(Conviction)

35. Respondent is subject to disciplinary action under section 2236 of the Code in that on or about November 5, 2015, in a criminal proceeding entitled The People of the State of California v. Ravi S. Panjabi in Contra Costa County, Case Number 171186-0, Respondent was

(RAVI SHAM PANJABI, M.D.) FIRST AMENDED ACCUSATION NO. 03-2013-229400
convicted by plea of “no contest” to violating California Vehicle Code section 23152(b), driving
with a blood alcohol content (“BAC”) of 0.08 or more; along with the enhancement of violating
California Vehicle Code section 23578, driving with a BAC of 0.15 or more. The circumstances
are as follows:

a. On or about September 14, 2014, Respondent was pulled over by a police officer in
Danville, California, for driving at night without headlights. At the request of the police officer
involved, Respondent provided two breath samples that recorded 0.182 and 0.191 BAC.
Respondent was arrested for driving unlawfully with a BAC in excess of 0.08.

b. On or about November 5, 2015, Respondent was sentenced as follows: two (2) days
in County jail, probation for three (3) years, a fine of $1,749.00, submit to alcohol testing as
directed by the Court, and required attendance and completion of a six (6) month alcohol
program.

SEVENTH CAUSE FOR DISCIPLINE

(Failure to Report)

36. Respondent is subject to disciplinary action under section 802.1 of the Code in that
Respondent failed to notify the Board that Respondent had been convicted on or about November
5, 2015, of a misdemeanor violation of California Vehicle Code section 23152(b), along with the
enhancement of violating, California Vehicle Code section 23578.

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 & Surgeon's Certificate Number A55600, issued
to Ravi Sham Panjabi, M.D.;

2. Revoking, suspending or denying approval of Ravi Sham Panjabi, M.D.'s authority to
supervise physician assistants, pursuant to section 3527 of the Code;

3. Ordering Ravi Sham Panjabi, 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: March 15, 2016

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

SF2014407736
20823685_3.doc