



COMMONWEALTH of VIRGINIA

Department of Health Professions

Bernard L. Henderson, Jr.
Director

October 18, 1990

1601 Rolling Hills Drive, Suite 200
Richmond, Virginia 23229-5005
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Manjit R. Bajwa, M.D.
1007 Heather Hill Court
McLean, VA 22101

SERVED BY HAND

Dear Dr. Bajwa:


Pursuant to Sections 54.1-2920, 54.1-110 and 9-6.14:12 of the Code of Virginia (1950), as amended ("Code"), you are hereby given notice that the Virginia Board of Medicine ("Board") will convene a formal administrative hearing to receive and act upon evidence that you may have violated certain laws governing the practice of medicine in Virginia as set forth in the attached Statement of Particulars. Further, you will find enclosed a certified copy of the Board's October 18, 1990 Order of Summary Suspension suspending your license to practice medicine in the Commonwealth of Virginia. As a result of this Order, you may not practice until or unless said suspension is lifted.

The formal administrative hearing will be held pursuant to Section 9-6.14:14.1 of the Code before a Hearing Officer, whose name will be provided to you upon appointment. The above referenced sections of the Code have been enclosed for your convenience. You have been scheduled to appear before the Board on December 5 and December 6, each day at 9:00 a.m. at the offices of the Department of Health Professions, Conference Room 1, 1601 Rolling Hills Drive, Richmond, Virginia.

You may be represented by counsel, summon witnesses on your behalf, present documentary evidence, and cross-examine witnesses. You have the right to have witnesses subpoenaed to be present on your behalf. Should you wish to exercise this right, requests for subpoenas should be made in writing to the Board. If you plan to introduce materials at this meeting, please have five (5) copies of each document available for distribution.

Please indicate, by letter to this office, whether you intend to be present.

Sincerely,


Hilary H. Connor, M.D. *KDW*
Executive Director
Virginia Board of Medicine

KDW:AB1017N1:MED

Notice to Manjit R. Bajwa, M.D.
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Enclosures:

Virginia Code Sections

54.1-110
54.1-2920
9-6.14:12
9-6.14:14.1
54.1-2914
54.1-2915

Statement of Particulars

Attachment I

Order of Summary Suspension

cc: Franklin J. Pepper, M.D., President
Carol Russek, Assistant Attorney General
Karen T. McCaffrey, Legal Assistant
Divison of Investigatons (91-00275)
George Wilbur, Director, Information and Education
Gloria King, Probation Analyst

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: MANJIT R. BAJWA, M.D.

STATEMENT OF PARTICULARS

The Virginia Board of Medicine alleges that Manjit R. Bajwa, M.D. may have violated Sections 54.1-2915.A(4) and (3), as further defined in Sections 54.1-2914.A(10), (13) and (15) of the Code of Virginia (1950), as amended, in that:

1. Between January 1990 and August 21, 1990, during your employment at Prince William Hospital as an anesthesiologist, you conducted your practice in such a manner as to be a danger to the health and welfare of your patients, in that:

 a. On or about February 1990, you ordered morphine sulfate for a 70 year old patient, weighing 50 kilograms, during her recovery from a thoracotomy and lobectomy, without examining the patient. The patient was intubated, on a respirator and very restless. After receiving a report that PO₂ was 60 and the patient was in respiratory acidosis, you again ordered 6 milograms of morphine sulfate without examining the patient.

 b. On or about June 25 1990, you responded to a call for assistance from a nurse anesthetist who was attending Patient A during a hip pinning procedure. The child had been difficult to intubate, the monitor showed increased CO₂ levels and the child's jaw was somewhat stiff. After changing the tube, you left the patient in the care of the nurse anesthetist. Thereafter, the child arrested and died. Although the chart indicates you suspected malignant hypothermia, you failed to provide appropriate supervision and treatment in the care of this patient.

c. Between January 1990 and August 21, 1990, you failed to provide appropriate supervision and treatment to an infant who was difficult to intubate and experiencing a laryngospasm.

d. On or about June 27, 1990, you failed to provide appropriate anesthesia support in the management of Patient B, who was experiencing a pneumothorax.

e. On or about March 13, 1990 during a cholecystectomy you performed a mask induction on Patient C, whose chart indicated a history of difficult IV access, without first establishing an arterial line, thereby placing the patient at risk in the event of emergency.

f. On or about August 15, 1990, you unnecessarily rapidly induced Patient D, who presented for I & D of an abscessed bartholin cyst with a history of seizures as recent as May 1990 and a history of recent cola ingestion.

g. On or about July 20, 1990, while preparing Patient E for bilateral carotid endarterectomies, you were unable to properly position the transducers to calibrate the arterial line monitor.

h. On or about August 6, 1990, you failed to properly administer anesthesia to Patient F, who was undergoing an emergency cholecystectomy, and the patient awoke during the procedure.

2. Between January 1990 and August 21, 1990, during your employment at Prince William Hospital as an anesthesiologist, you engaged in unprofessional conduct and exhibited gross carelessness in your practice in that:

a. You routinely delivered patients to and disappeared from the post-anesthesia room (PAR) without providing the PAR staff any information or report regarding the patients' conditions.

b. You consistently were unavailable or absent when on call and failed to respond to calls or pages by hospital staff. You instructed the hospital staff not to page you on the hospital overhead intercom system.

c. You repeatedly mislabeled or failed to label the controlled substances prepared and/or used by you in your practice and did not use the standard labels of the American Society of Anesthesia. In addition, you misidentified vials or syringes of controlled substances despite labels indicating the contents.

d. You regularly engaged in personal telephone conversations, often of lengthy duration, during procedures in which you were the attending anesthesiologist, thereby compromising your ability to properly monitor and manage your patients and interfering with communications between the operating room staff and the staff of other hospital departments.

e. You regularly brought food and drink into the sterile environment of the operating room.

3. On August 21, 1990, your hospital privileges at Prince William Hospital were terminated by the Executive Committee of the Medical Staff based on your conduct in your practice.

To protect the privacy of the patients referenced above they have been identified by letter only. Please refer to Attachment I of this Statement of Particulars for the identity of Patients A - F.

FOR THE BOARD

Hilary H. Connor, M.D.

Hilary H. Connor, M.D. *KDW*
Executive Director
Virginia Board of Medicine

DATE: 10-19-90

KDW:AB1017N1:MED

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE: MANJIT R. BAJWA, M.D.

ORDER OF SUMMARY SUSPENSION

Pursuant to Sections 54.1-2920 and 54.1-105 of the Code of Virginia (1950), as amended, the Virginia Board of Medicine ("Board") met by telephone conference call on October 18, 1990, after a good faith effort to assemble a quorum of the Board failed and the Executive Committee of the Board unanimously determined that the continued practice of Manjit B. Bajwa, M.D. constituted a substantial danger to the public health or safety. A quorum of the Board was present via telephone to receive and act upon certain investigative information indicating that Manjit B. Bajwa, M.D. has violated certain laws relating to the practice of medicine in the Commonwealth of Virginia. In the judgment of the Board, the continued practice of Manjit B. Bajwa, M.D. constitutes a substantial danger to the public health or safety, in that:

1. Between January 1990 and August 21, 1990, during Dr. Bajwa's employment at Prince William Hospital as an anesthesiologist, she conducted her practice in such a manner as to be a danger to the health and welfare of her patients, in that:

a. On or about February 1990, Dr. Bajwa ordered morphine sulfate for a 70 year old patient, weighing 50 kilograms, during the patient's recovery from a thoracotomy and lobectomy, without examining the patient. The patient was intubated, on a respirator and very restless. After receiving a report that PO2 was 60 and the patient was in respiratory acidosis, Dr. Bajwa again ordered 6 milograms of morphine sulfate without examining the patient.

b. On or about June 25, 1990, Dr. Bajwa responded to a call for assistance from a nurse anesthetist who was attending Patient A, a child, during a

hip pinning procedure. The child had been difficult to intubate, the monitor showed increased CO₂ levels and the child's jaw was somewhat stiff. After changing the tube, Dr. Bajwa left the patient in the care of the nurse anesthetist. Thereafter, the child arrested and died. Although the chart indicates Dr. Bajwa suspected malignant hypothermia, she failed to provide appropriate supervision and treatment in the care of this patient.

c. Between January 1990 and August 21, 1990, Dr. Bajwa failed to provide appropriate supervision and treatment to an infant who was difficult to intubate and experiencing a laryngospasm.

d. On or about June 27, 1990, Dr. Bajwa failed to provide appropriate anesthesia support in the management of Patient B, who was experiencing a pneumothorax.

e. On or about March 13, 1990 during a cholecystectomy Dr. Bajwa performed a mask induction on Patient C, whose chart indicated a history of difficult IV access, without first establishing an arterial line, thereby placing the patient at risk in the event of emergency.

f. On or about August 15, 1990, Dr. Bajwa unnecessarily rapidly induced Patient D, who presented for I & D of an abscessed Bartholin cyst with a history of seizures as recent as May 1990 and a history of recent cola ingestion.

g. On or about July 20, 1990, while preparing Patient E for bilateral carotid endarterectomies, Dr. Bajwa was unable to properly position the transducers to calibrate the arterial line monitor.

h. On or about August 6, 1990, Dr. Bajwa failed to properly administer anesthesia to Patient F, who was undergoing an emergency cholecystectomy, and the patient awoke during the procedure.

2. Between January 1990 and August 21, 1990, during Dr. Bajwa's employment at Prince William Hospital as an anesthesiologist, she engaged in unprofessional conduct and exhibited gross carelessness in her practice in that:

a. Dr. Bajwa routinely delivered patients to and disappeared from the post-anesthesia room (PAR) without providing the PAR staff any information or report regarding the patients' conditions.

b. Dr. Bajwa consistently was unavailable or absent when on call and failed to respond to calls or pages by hospital staff. Dr. Bajwa instructed the hospital staff not to page her on the hospital overhead intercom system.

c. Dr. Bajwa repeatedly mislabeled or failed to label the controlled substances prepared and/or used by her in her practice and did not use the standard labels of the American Society of Anesthesia. In addition, she misidentified vials or syringes of controlled substances despite labels indicating the contents.

d. Dr. Bajwa regularly engaged in personal telephone conversations, often of lengthy duration, during procedures in which she was the attending anesthesiologist, thereby compromising her ability to properly monitor and manage her patients and interfering with communications between the operating room staff and the staff of other hospital departments.

e. Dr. Bajwa regularly brought food and drink into the sterile environment of the operating room.

3. On August 21, 1990, Dr. Bajwa's hospital privileges at Prince William Hospital were terminated by the Executive Committee of the Medical Staff based on her conduct in her practice.

WHEREFORE, it is hereby ORDERED that the license of Manjit B. Bajwa, M.D. to practice medicine in the Commonwealth of Virginia be, and hereby is, SUMMARILY SUSPENDED, simultaneously with the institution of proceedings for a formal administrative hearing in this matter. Said hearing shall be scheduled within a reasonable time from the date of this summary suspension.

Pursuant to Section 9-6.14:14 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record and shall be made available for public inspection and copying upon request.

FOR THE BOARD

Hilary H. Connor, M.D.

Hilary H. Connor, M.D. *KOW*
Executive Director
Virginia Board of Medicine

ENTERED: 10-19-90

RECEIVED: October 19, 1990

Bernard L. Henderson, Jr.

Bernard L. Henderson, Jr., Director
Department of Health Professions

KW:AB1017N1