


Kristina D. Lawson, J.D., Chair
Panel B

1 XAVIER BECERRA
Attorney General of California
2 E. A. JONES III
Supervising Deputy Attorney General
3 CLAUDIA RAMIREZ
Deputy Attorney General
4 State Bar No. 205340
California Department of Justice
5 300 South Spring Street, Suite 1702
Los Angeles, California 90013
6 Telephone: (213) 269-6482
Facsimile: (213) 897-9395
7 *Attorneys for Complainant*

8 **BEFORE THE**
9 **MEDICAL BOARD OF CALIFORNIA**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

11 In the Matter of the First Amended Accusation
12 Against:

13 ARJANG NAIM, M.D.
14 1407 North Vermont Ave., Suite A
Los Angeles, California 90027

15 Physician's and Surgeon's Certificate
No. A 74735,

16 Respondent.

Case Nos. 800-2016-021723; 800-2018-
042780

OAH No. 2017120541

17 **STIPULATED SETTLEMENT AND**
18 **DISCIPLINARY ORDER**

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

20 PARTIES

21 1. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Medical
22 Board of California ("Board"). She brought this action solely in her official capacity and is
23 represented in this matter by Xavier Becerra, Attorney General of the State of California, by
24 Claudia Ramirez, Deputy Attorney General.

25 2. Respondent Arjang Naim, M.D. ("Respondent") is represented in this proceeding by
26 attorney Raymond J. McMahon, Esq., whose address is: 5440 Trabuco Road, Irvine, California
27 92620.

28 3. On or about May 3, 2001, the Board issued Physician's and Surgeon's Certificate

1 No. A 74735 to Respondent. That Certificate was in full force and effect at all times relevant to
2 the charges brought in First Amended Accusation No. 800-2016-021723, and will expire on
3 January 31, 2019, unless renewed.

4 4. The parties hereby agree to the following Stipulated Settlement and Disciplinary
5 Order which will be submitted to the Board for approval and adoption as the final disposition of
6 First Amended Accusation No. 800-2016-021723 and Medical Board of California case number
7 800-2018-042780.

8 JURISDICTION

9 5. First Amended Accusation No. 800-2016-021723 was filed before the Board, and is
10 currently pending against Respondent. The First Amended Accusation and all other statutorily
11 required documents were properly served on Respondent on February 21, 2018. Respondent
12 timely filed his Notice of Defense contesting the First Amended Accusation.

13 6. A copy of First Amended Accusation No. 800-2016-021723 is attached as Exhibit A
14 and incorporated herein by reference.

15 ADVISEMENT AND WAIVERS

16 7. Respondent has carefully read, fully discussed with counsel, and understands the
17 charges and allegations in First Amended Accusation No. 800-2016-021723. Respondent has
18 also carefully read, fully discussed with counsel, and understands the effects of this Stipulated
19 Settlement and Disciplinary Order.

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

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

[illegible]

2
3
4

5
6
7
8

9
0
1
2
3

4
5
6

7

8

9

20
21
22
23

24

25
26
27
28

1 stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek
2 to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails
3 to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary
4 Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal
5 action between the parties, and the Board shall not be disqualified from further action by having
6 considered this matter.

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

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

13 **DISCIPLINARY ORDER**

14 IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 74735 issued
15 to Respondent Arjang Naim, M.D. is revoked. However, the revocation is stayed and Respondent
16 is placed on probation for four (4) years on the following terms and conditions.

17 1. EDUCATION COURSE. Within 60 calendar days of the effective date of this
18 Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee
19 for its prior approval educational program(s) or course(s) which shall not be less than 40 hours
20 per year, for each year of probation. The educational program(s) or course(s) shall be aimed at
21 correcting any areas of deficient practice or knowledge and shall be Category I certified. The
22 educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to
23 the Continuing Medical Education (CME) requirements for renewal of licensure. Following the
24 completion of each course, the Board or its designee may administer an examination to test
25 Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65
26 hours of CME of which 40 hours were in satisfaction of this condition.

27 2. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective
28 date of this Decision, Respondent shall enroll in a course in medical record keeping approved in

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

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

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

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

25 The Board or its designee shall provide the approved monitor with copies of the Decision(s)
26 and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the
27 Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed
28 statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role

1 of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees
2 with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the
3 signed statement for approval by the Board or its designee.

4 Within 60 calendar days of the effective date of this Decision, and continuing throughout
5 probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall
6 make all records available for immediate inspection and copying on the premises by the monitor
7 at all times during business hours and shall retain the records for the entire term of probation.

8 If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective
9 date of this Decision, Respondent shall receive a notification from the Board or its designee to
10 cease the practice of medicine within three (3) calendar days after being so notified. Respondent
11 shall cease the practice of medicine until a monitor is approved to provide monitoring
12 responsibility.

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

19 If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of
20 such resignation or unavailability, submit to the Board or its designee, for prior approval, the
21 name and qualifications of a replacement monitor who will be assuming that responsibility within
22 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60
23 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a
24 notification from the Board or its designee to cease the practice of medicine within three (3)
25 calendar days after being so notified. Respondent shall cease the practice of medicine until a
26 replacement monitor is approved and assumes monitoring responsibility.

27 In lieu of a monitor, Respondent may participate in a professional enhancement program
28 approved in advance by the Board or its designee that includes, at minimum, quarterly chart

1 review, semi-annual practice assessment, and semi-annual review of professional growth and
2 education. Respondent shall participate in the professional enhancement program at
3 Respondent's expense during the term of probation.

4 4. PROHIBITED PRACTICE. During probation, Respondent is prohibited from
5 training interns, residents, or fellows.

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

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

15 6. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE
16 NURSES. During probation, Respondent is prohibited from supervising physician assistants and
17 advanced practice nurses.

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

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

24 Respondent shall submit quarterly declarations not later than 10 calendar days after the end
25 of the preceding quarter.

26 9. GENERAL PROBATION REQUIREMENTS.

27 Compliance with Probation Unit

28 Respondent shall comply with the Board's probation unit.

1 Address Changes

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

7 Place of Practice

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

11 License Renewal

12 Respondent shall maintain a current and renewed California physician's and surgeon's
13 license.

14 Travel or Residence Outside California

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

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

21 10. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be
22 available in person upon request for interviews either at Respondent's place of business or at the
23 probation unit office, with or without prior notice throughout the term of probation.

24 11. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or
25 its designee in writing within 15 calendar days of any periods of non-practice lasting more than
26 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is
27 defined as any period of time Respondent is not practicing medicine as defined in Business and
28 Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct

1 patient care, clinical activity or teaching, or other activity as approved by the Board. If
2 Respondent resides in California and is considered to be in non-practice, Respondent shall
3 comply with all terms and conditions of probation. All time spent in an intensive training
4 program which has been approved by the Board or its designee shall not be considered non-
5 practice and does not relieve Respondent from complying with all the terms and conditions of
6 probation. Practicing medicine in another state of the United States or Federal jurisdiction while
7 on probation with the medical licensing authority of that state or jurisdiction shall not be
8 considered non-practice. A Board-ordered suspension of practice shall not be considered as a
9 period of non-practice.

10 In the event Respondent's period of non-practice while on probation exceeds 18 calendar
11 months, Respondent shall successfully complete the Federation of State Medical Boards's Special
12 Purpose Examination, or, at the Board's discretion, a clinical competence assessment program
13 that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model
14 Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

15 Respondent's period of non-practice while on probation shall not exceed two (2) years.

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

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

22 12. COMPLETION OF PROBATION. Respondent shall comply with all financial
23 obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the
24 completion of probation. Upon successful completion of probation, Respondent's certificate shall
25 be fully restored.

26 13. VIOLATION OF PROBATION. Failure to fully comply with any term or condition
27 of probation is a violation of probation. If Respondent violates probation in any respect, the
28 Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and

1 carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke
2 Probation, or an Interim Suspension Order is filed against Respondent during probation, the
3 Board shall have continuing jurisdiction until the matter is final, and the period of probation shall
4 be extended until the matter is final.

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

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

20 ///

21 ///

22 ///

23 ///

24 ///

25 ///

26 ///

27 ///

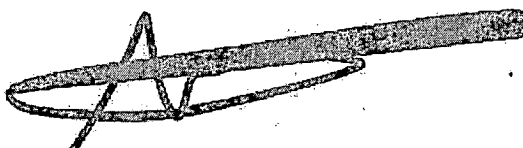
28 ///

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28

ACCEPTANCE

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

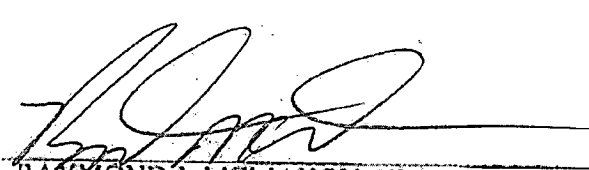
DATED: August 3, 2018



ARJANG NAIM, M.D.
Respondent

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

DATED: August 3, 2018



RAYMOND J. MCMAHON, ESQ.
Attorney for Respondent

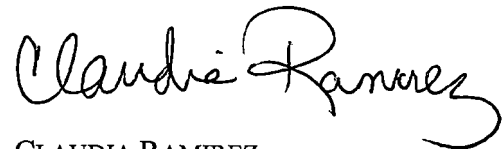
ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 8/13/18

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General



CLAUDIA RAMIREZ
Deputy Attorney General
Attorneys for Complainant

LA2017605117
53007794.doc

Exhibit A

First Amended Accusation No. 800-2016-021723

1 XAVIER BECERRA
Attorney General of California
2 E. A. JONES III
Supervising Deputy Attorney General
3 CLAUDIA RAMIREZ
Deputy Attorney General
4 State Bar No. 205340
California Department of Justice
5 300 South Spring Street, Suite 1702
Los Angeles, California 90013
6 Telephone: (213) 269-6482
Facsimile: (213) 897-9395
7 *Attorneys for Complainant*

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO FEB. 21 20 18
BY Gina Pasion ANALYST

8 **BEFORE THE**
9 **MEDICAL BOARD OF CALIFORNIA**
10 **DEPARTMENT OF CONSUMER AFFAIRS**
11 **STATE OF CALIFORNIA**

11 In the Matter of the First Amended Accusation
12 Against:

Case No. 800-2016-021723

FIRST AMENDED ACCUSATION

13 ARJANG NAIM, M.D.
14 1407 North Vermont Ave., Suite A
Los Angeles, California 90027

15 Physician's and Surgeon's Certificate
No. A 74735,

16 Respondent.

17
18 Complainant alleges:

19 **PARTIES**

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

23 2. On or about May 31, 2001, the Board issued Physician's and Surgeon's Certificate
24 Number A 74735 to Arjang Naim, M.D. ("Respondent"). That Certificate was in full force and
25 effect at all times relevant to the charges brought herein and will expire on January 31, 2019,
26 unless renewed.

27 **JURISDICTION**

28 3. This First Amended Accusation is brought before the Board, under the authority of

1 the following laws. All section references are to the Business and Professions Code unless
2 otherwise indicated.

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

7 5. Section 2234 of the Code states:

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

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

13 “(b) Gross negligence.

14 “(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or
15 omissions. An initial negligent act or omission followed by a separate and distinct departure from
16 the applicable standard of care shall constitute repeated negligent acts.

17 “(1) An initial negligent diagnosis followed by an act or omission medically appropriate
18 for that negligent diagnosis of the Patient shall constitute a single negligent act.

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

24 “(d) Incompetence.

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

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

28 “(g) The practice of medicine from this state into another state or country without meeting

1 the legal requirements of that state or country for the practice of medicine. Section 2314 shall not
2 apply to this subdivision. This subdivision shall become operative upon the implementation of
3 the proposed registration program described in Section 2052.5.

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

7 6. Section 2266 of the Code states: “The failure of a physician and surgeon to maintain
8 adequate and accurate records relating to the provision of services to their patients constitutes
9 unprofessional conduct.”

10 **FIRST CAUSE FOR DISCIPLINE**

11 **(Gross Negligence-Patients 1, 3, 4, and 5)**

12 7. Respondent Arjang Naim, M.D. is subject to disciplinary action under Code section
13 2234, subdivision (b), in that he was grossly negligent with respect to the care and treatment of
14 patients 1, 3, 4, and 5.¹ The circumstances are as follows:

15 Patient 1

16 8. On or about April 12, 2016, Respondent performed a Cesarean section on Patient 1, a
17 then 39-year-old female with a prior Cesarean section. The surgery began at 2:31 p.m. and ended
18 17 minutes later, at 2:48 p.m. Respondent subsequently left the hospital and entrusted Patient 1's
19 care to the obstetrics and gynecology (“OB/GYN”) residents.² Respondent was the attending
20 physician³ and the residents' direct supervisor.

21 9. Beginning at approximately 4:40 p.m., the OB/GYN housestaff (i.e., the residents)
22 and nursing personnel began observing, responding to, and documenting concerning signs of
23 abdominopelvic blood loss. Residents were called to Patient 1's bedside to evaluate her for blood

24 ¹ Patients' names are not used in order to protect their right of privacy.

25 ² Residency is a stage of graduate training. A resident is a physician who practices
26 medicine usually in a hospital or clinic under the direct or indirect supervision of an attending
27 physician. Successful completion of a residency program is a requirement to obtaining an
28 unrestricted license to practice medicine. Residency training may be followed by a fellowship or
sub-specialty training.

³ An attending physician is a physician who has completed residency and practices
medicine in a clinic or hospital, in the specialty learned during residency.

1 noted in the Foley catheter.

2 10. At approximately 4:54 p.m., Dr. K.W. (a second-year resident) evaluated Patient 1 for
3 blood-tinged urine in the Foley catheter, a blood clot the size of a half dollar, and a tender
4 abdomen.

5 11. At approximately 5:24 p.m., Dr. N.E. (a second-year resident) evaluated Patient 1 for
6 a rising fundus and concern for excessive bleeding. The Foley catheter was draining bright red.
7 She telephoned Respondent to discuss Patient 1's condition. The plan was to keep the Foley
8 catheter in its original place, but no other change to the plan of care was made.

9 12. At approximately, 5:45 p.m., Dr. K.W. and Dr. S.M. (a fourth-year resident) re-
10 assessed Patient 1. The Foley catheter was changed in the event that the original catheter had
11 become obstructed by a clot. After the original Foley catheter was replaced, the new one was
12 draining complete red blood. No urine was draining in the Foley catheter. A 6-7 cm mass
13 between the bladder and the anterior uterus was palpable during a pelvic exam. Dr. S.M.
14 telephoned Respondent to discuss Patient 1's condition and plan of care.

15 13. Accordingly, prior to 6:00 p.m., Patient 1's pulse rate had exceeded her systolic blood
16 pressure, she had frank blood⁴ in two different Foley catheters, and she made no urine after 5:00
17 p.m. (until at least 6:30 p.m.). Patient 1 had developed a 6-7 cm mass between the bladder and
18 the anterior uterus which was palpable during a pelvic exam. The OB/GYN house staff and
19 nursing personnel continued to observe, respond to, and document concerning signs of
20 abdominopelvic blood loss.

21 14. At approximately 7:13 p.m., Dr. K.S., a Maternal Fetal Medicine fellow, acting as the
22 OB/GYN attending staff, evaluated Patient 1 after being notified of the patient's status during
23 evening rounds. An ultrasound was repeated. Dr. K.S. explained to Patient 1 and her husband
24 that it appeared Patient 1 had a hematoma⁵ anterior to the uterus, which seemed stable, but it was
25 concerning that there was blood in the Foley catheter with little to no urine output. Her plan was
26 to order imaging of the pelvis and lower urinary tract, order a repeat ultrasound to evaluate the

27 ⁴ Frank blood is used to describe the obvious, visible presence of blood.

28 ⁵ A hematoma is a solid swelling of clotted blood within the tissues.

1 clot, repeat labs, and watch Patient 1 closely.

2 15. By approximately 8:00 p.m., the signs of significant concealed blood loss were even
3 more apparent. Dr. S.C. (a fourth-year resident) evaluated the patient. Patient 1's pulse rate
4 continued to exceed her systolic blood pressure, her hemoglobin dropped to 7.6, and she was
5 severely oliguric⁶ and anuric⁷ (for more than ninety minutes) with frank blood previously coming
6 out of the Foley catheter. Those signs were consistent with massive blood loss and
7 coagulopathy.⁸ Although that is not their only cause, it must be foremost in an OB/GYN's mind,
8 and of the highest priority/urgency, to promptly evaluate and aggressively manage for the
9 possibility of massive concealed hemorrhage until that possibility is excluded.

10 16. Dr. S.C.'s plan was to proceed with two units of packed red blood cells, check the
11 Complete Blood Count⁹ ("CBC") and Basic Metabolic Panel after the transfusion, and proceed
12 with a computed tomography ("CT") urogram to evaluate the kidneys, ureters, and bladder given
13 the frank blood in the Foley catheter. She discussed her plan with Respondent and Dr. K.S., the
14 Maternal Fetal Medicine fellow.

15 17. At approximately 8:07 p.m., Dr. S.C. obtained permission from Patient 1 for a blood
16 transfusion. The resident discussed the risks and benefits with her.

17 18. Respondent returned to the hospital. At approximately 8:47 p.m., he was at Patient
18 1's beside. At approximately 8:57 p.m., he evaluated Patient 1 and wrote a progress note noting,
19 among other things, that she had bloody urine, possible hematoma/stable, and low urine output.
20 His plan was to give two units of packed red blood cells, consider a CT urogram, and re-evaluate
21 the Foley catheter position. Respondent subsequently left the hospital and Patient 1's care in the
22 hands of the residents and Maternal Fetal Medicine fellow.

23
24 ⁶ Oliguria is the low output of urine.

25 ⁷ Anuria means an absence of urine.

26 ⁸ Coagulopathy (also called a bleeding disorder) is a condition in which the blood's ability
27 to coagulate (form clots) is impaired. This condition can cause a tendency toward prolonged or
28 excessive bleeding (bleeding diathesis), which may occur spontaneously or following an injury or
medical and dental procedures.

⁹ A complete blood count is a blood panel requested by a doctor or other medical
professional that gives information about the cells in a Patient's blood, such as the cell count for
each cell type and the concentrations of various proteins and minerals.

1 19. At approximately 11:25 p.m., Dr. S.C. telephoned Respondent and notified him about
2 a concern for active internal bleeding. He was noted to be "en route." Patient 1 gave permission
3 for a laparotomy¹⁰ and possible hysterectomy.

4 20. At approximately 11:42 p.m., Respondent arrived at Patient 1's bedside and evaluated
5 her condition. Respondent wanted to continue the expectant management plan.¹¹ In contrast, Drs.
6 K.S. and S.C. recommended taking the patient back to the operating room for a laparotomy to
7 identify the source of bleeding. When Respondent expressed a desire to continue with the
8 expected management plan, the obstetric in-house team of physicians considered utilizing the
9 chain of command to supersede Respondent's reluctance to proceed directly and promptly to an
10 exploratory laparotomy.

11 21. Respondent wanted to repeat a CBC rather than directly open Patient 1's abdomen.
12 Although the CBC may have made a difference of approximately fifteen minutes, the housestaff
13 and nursing personnel had been observing and responding to concerning signs of abdominopelvic
14 blood loss before 6:00 p.m. (six hours earlier). Although Respondent did not necessarily need to
15 re-operate by 6:00 p.m., he should have become, at or by 6:00 p.m., deeply concerned and directly
16 involved with the ongoing frequent regular assessment of Patient 1's condition. But for his
17 occasional progress note and/or telephone contact, Respondent was inadequately involved in
18 Patient 1's care and treatment.

19 22. Respondent believed Patient 1 looked reasonably well and stable. Patient 1's
20 condition is more a testament of her robust physiologic resilience rather than to her actual clinical
21 condition and intravascular volume status. That "illusionary effect" has been ascribed to youth
22 and the physiologic adaptations of pregnancy. Respondent allowed himself to become lulled into
23 a false sense of security by such compensatory mechanisms.

24 23. Respondent missed approximately four to six hours of opportunity during which
25 Patient 1's condition was clearly compromised, and was further deteriorating, but during which he

26 ¹⁰ A laparotomy is a surgical incision into the abdominal cavity, for diagnosis or in
27 preparation for surgery.

28 ¹¹ The term expectant management is usually defined as watchful waiting or close
monitoring by a physician instead of immediate treatment.

1 failed to recognize and under-responded to Patient 1's deteriorating condition and clearly
2 suggestive signs of ongoing concealed surgical site hemorrhage.

3 24. On or about April 13, 2016, at approximately 12:25 a.m., Patient 1 was transported to
4 the operating room for the exploratory laparotomy and evaluation of the hematoma and
5 hemoperitoneum.¹²

6 25. At approximately 1:15 a.m., Respondent called consultant surgeons. He also engaged
7 the services of the trauma surgery team and a GYN oncologist.

8 26. By 1:15 a.m., Patient 1 had experienced cardiac arrest and was undergoing a massive
9 blood product transfusion protocol. Approximately 3 liters of blood had been removed from her
10 abdominopelvic cavity. She was very unstable and had another cardiac arrest. A hysterectomy
11 procedure had been initiated but could not be completed since the patient continued to have more
12 cardiac arrests.

13 27. Respondent did not actively engage consultant surgeons until after midnight. By
14 then, Patient 1's demise was unpreventable, even in the most expert of hands. A staff surgical
15 consultant would have offered an advantage in being able to communicate staff-to-staff with
16 Respondent to influence and persuade him to operate sooner. In contrast, the obstetrical
17 housestaff who were tending to Patient 1 were trainees under Respondent's attending staff status
18 and supervision and had their hands tied. The maternal fetal medicine specialist was a fellow still
19 in training.

20 28. At approximately 2:20 a.m., Patient 1 was pronounced dead.

21 29. Respondent was grossly negligent with respect to the care and treatment of Patient 1
22 as follows:

23 A. Respondent failed to timely, sufficiently, and attentively evaluate and manage the
24 possibility of Patient 1's ongoing concealed hemorrhage throughout the evening of April 12,
25 2016.

26 ///

27 _____
28 ¹² Hemoperitoneum is the presence of blood in the peritoneal cavity.

Patient 3

30. On or about August 21, 2015, Respondent gave Patient 3, a then thirty-year-old female, a single dose of methotrexate¹³ for presumed ectopic pregnancy.¹⁴ Her quantitative Beta Human Chorionic Gonadotropin ("HCG")¹⁵ was 28,665 mIU/mL. There had been no visualized ectopic or intrauterine pregnancy on an ultrasound done at that time.

31. On or about August 24, 2015, at approximately 3:56 p.m., Patient 3 arrived at the hospital's emergency room in hemorrhagic shock.¹⁶ She was approximately 11 weeks pregnant, with increased pain. Her blood pressure was 82 systolic and she appeared pale and was perspiring profusely. An ultrasound showed she had free fluid in the abdomen. She was hemodynamically unstable.¹⁷ She was admitted to Respondent's care for an emergency exploratory laparotomy and right salpingectomy.¹⁸

32. Respondent found a ruptured right Fallopian tube. Patient 3 had an estimated blood loss of 2,000 mL during the surgery, consisting mostly of hemoperitoneum. She required a transfusion of six units of blood in order to stabilize her in the immediate perioperative¹⁹ and intraoperative period.

33. After the operation, Patient 3 had persistent tachycardia.²⁰ The OB/GYN house staff were concerned that she had a possible pulmonary embolism.²¹ Respondent and the house staff decided not to pursue the workup further. Patient 3 had very low urine output and low

¹³ Methotrexate is an abortifacient and is commonly used to terminate pregnancies during the early stages, generally in combination with misoprostol. It is also used to treat ectopic pregnancies, provided the fallopian tube has not ruptured.

¹⁴ Ectopic pregnancy means a pregnancy in which the fetus develops outside the uterus, typically in a Fallopian tube.

¹⁵ Beta Human Chorionic Gonadotropin (HCG) is a hormone that is produced during pregnancy.

¹⁶ Hemorrhagic shock is a life-threatening condition that results when you lose more than 20 percent (one-fifth) of your body's blood or fluid supply. This severe fluid loss makes it impossible for the heart to pump a sufficient amount of blood to your body.

¹⁷ Hemodynamically unstable means abnormal or unstable blood pressure.

¹⁸ Salpingectomy refers to the surgical removal of a Fallopian tube.

¹⁹ Perioperative generally refers to the three phases of surgery: preoperative, intraoperative, and postoperative.

²⁰ Tachycardia refers to a heart rate that exceeds the normal resting rate.

²¹ Pulmonary embolism occurs when a clump of material, most often a blood clot, gets wedged into an artery in the lungs.

1 hemoglobin/hematocrit values. They considered additional blood transfusion therapy. The
2 OB/GYN house staff authored virtually all of the inpatient orders and physician-generated
3 progress notes concerning Patient 3's life-threatening hemorrhage.

4 34. Throughout the three days following Patient 3's surgery, Respondent failed to
5 personally evaluate her daily, directly, and independently in the hospital. There is no indication
6 that he personally saw her on a daily basis during the three days following her surgery.

7 35. Respondent was grossly negligent with respect to the care and treatment of Patient 3
8 as follows:

9 A. On or about August 21, 2015, Respondent administered methotrexate to Patient 3, as
10 medical management of a presumed ectopic pregnancy, in the face of a quantitative Beta HCG
11 level in excess of 28,000 mIU/mL and a highly suspect ectopic pregnancy.

12 B. On or about August 24, 2015, through on or about August 27, 2015, Respondent
13 failed to personally evaluate Patient 3 daily, directly, and independently during her postoperative
14 inpatient care.

15 Patient 4

16 36. On or about March 14, 2016, at approximately 8:00 p.m., Patient 4, a then thirty-four-
17 year-old female, was admitted to the hospital. She was 16 weeks and four days pregnant. She
18 was in her fifth pregnancy. She had pre-viable preterm premature rupture of membranes.²² After
19 being informed of her options, Patient 4 chose to receive a high dose Cytotec²³ to induce labor.

20 37. On or about March 15, 2016, Patient 4 delivered a non-viable fetus, but the placenta
21 did not pass. As a result, she was given three doses of Hemabate 250 mcg and one dose of
22 Cytotec 800 mcg. Approximately four hours passed since Patient 4 delivered the fetus, but the
23 placenta had still not passed. At approximately 4:50 a.m., an OB/GYN house staff (a fourth-year
24 resident) performed a dilation and curettage.²⁴ Respondent was present for and participated in the

25 ²² Previaible preterm premature rupture of membranes is rupture of membranes prior to 24
26 weeks' pregnancy.

27 ²³ Misoprostol (Cytotec) is medicine used to ripen the cervix and induce labor.

28 ²⁴ Dilation (or dilatation) and curettage (D&C) refers to the dilation (widening/opening) of
the cervix and surgical removal of part of the lining of the uterus and/or contents of the uterus by
scraping and scooping (curettage). It is a therapeutic gynecological procedure as well as the most
(continued...)

1 entire procedure.

2 38. Approximately eight hours after the dilation and curettage, Patient 4's vital signs
3 deteriorated. She became acutely pale with tachycardia and had worsening abdominal
4 pain/distention. On or about March 15, 2016, at approximately 11:22 a.m., Patient 4 underwent
5 an emergency exploratory laparotomy and uterine repair. Her uterus had ruptured along a prior
6 vertical uterine incision. Two liters of hemoperitoneum and a small amount of retained products
7 of conception were noted. Patient 4 received a blood transfusion during and after the surgery.
8 Her postoperative course was uncomplicated.

9 39. Throughout the three days following Patient 4's surgery, Respondent failed to
10 personally evaluate her daily, directly, and independently at the hospital. There is no indication
11 that he personally saw her on a daily basis during the three days following her surgery. There
12 were no progress notes authored by Respondent, the sole attending staff OB/GYN provider during
13 Patient 4's hospitalization.

14 40. Respondent was grossly negligent with respect to the care and treatment of Patient 4
15 as follows:

16 A. On or about March 15, 2016, through on or about March 18, 2016, Respondent failed
17 to personally evaluate Patient 4 daily, directly, and independently during her postoperative
18 inpatient care.

19 Patient 5

20 41. On or about October 2, 2015, Respondent began providing prenatal care to Patient 5,
21 a then thirty-three-year-old female. She was 9 weeks pregnant with her second child. Her first
22 child had been delivered via Cesarean section. Her estimated due date was June 1, 2016.
23 Respondent saw Patient 5 for approximately eleven visits. The last prenatal visit was on May 24,
24 2016. Respondent's handwritten entries in his medical record for Patient 5 are illegible and
25 cursory. The fetal heart rate at each prenatal care visit was absent or illegible.

26 42. Respondent scheduled Patient 5 for a Cesarean section for May 26, 2016 (at 39 weeks
27 (...continued)
28 often used method of first trimester miscarriage or abortion.

1 of pregnancy). However, Patient 5 did not want to undergo a repeat Cesarean section and did not
2 show up for the surgery. Respondent rescheduled the Cesarean section for June 2, 2016.

3 43. However, on or about May 31, 2016, Patient 5 went to the hospital. An ultrasound
4 showed that she was pregnant with one fetus in the breech presentation.²⁵ It further showed an
5 anterior (location of placenta previa) placenta previa²⁶ with placental lacunae (vascular spaces)
6 suspicious for placenta accreta.²⁷ A repeat Cesarean section with preparations in place for
7 massive transfusion and hysterectomy were recommended. Patient 5 agreed to undergo a
8 Cesarean hysterectomy. Respondent was the primary attending surgeon for the Cesarean section.

9 44. Respondent delivered the baby, but his attempt to deliver the placenta was
10 unsuccessful. The uterus was taken out of the abdominal cavity and the placenta was delivered,
11 except for a 4-5 cm area of suspected accreta. The area of suspected accreta was manually
12 removed. While the uterus was being sutured, Patient 5 became pulseless. Chest compressions
13 helped return her heartbeat to normal. Further evaluation revealed that she had lost an additional
14 occult liter of blood. Her vitals were deteriorating. A decision was made to do the hysterectomy.
15 A GYN oncologist was the primary attending surgeon for the hysterectomy, and Respondent was
16 an assistant. After the procedure, Respondent did not participate in the patient's hospital care.

17 45. Respondent was grossly negligent with respect to the care and treatment of Patient 5
18 as follows:

19 A. Respondent's prenatal care and management of Patient 5 is an extreme departure from
20 the standard of care. He failed to identify, address, and manage any and all high-risk factors
21 which complicated Patient 5's pregnancy, either as preexisting or new-onset conditions. There is
22 no indication that Respondent recognized, planned for, or counseled the patient about the
23 possibility of placenta accreta and its potential attendant consequences (e.g., major bleeding and

24 ²⁵ Breech presentation means when a baby is born bottom first instead of head first.

25 ²⁶ Placenta previa occurs when a baby's placenta partially or totally covers the mother's
26 cervix-the outlet for the uterus. Placenta previa can cause severe bleeding during pregnancy and
27 delivery.

28 ²⁷ Placenta accreta is a serious pregnancy condition that occurs when blood vessels and
other parts of the placenta grow too deeply into the uterine wall. Typically, the placenta detaches
from the uterine wall after childbirth. With placenta accreta, part or all of the placenta remains
firmly attached.

possible hysterectomy) when the likelihood of that potential life-threatening possibility was approximately ten percent or more, given her history of a prior Cesarean section in the face of current anterior placenta previa. As a result, he failed to recognize the indication to schedule Patient 5 for a Cesarean section at 34 weeks of pregnancy. Respondent also failed to schedule Patient 5 for Cesarean delivery at 36-37 weeks of pregnancy based upon his well-documented awareness of placenta previa. Furthermore, Respondent's prenatal medical records for Patient 5 mention schizophrenia, history of prior Cesarean delivery, persistent breech presentation, uterine myoma (fibroid), placenta previa, patient desires trial of labor after Cesarean, and bleeding in early pregnancy. However, there is no indication that Respondent addressed each of these issues in sufficient detail.

46. Respondent's acts and/or omissions as set forth in paragraphs 8 through 45, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute grossly negligent acts pursuant to Code section 2234, subdivision (b), with respect to the care and treatment of patients 1, 3, 4, and 5. Therefore, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts-Patients 1, 2, 3, 4, 5, and 6)

47. Respondent Arjang Naim, M.D. is subject to disciplinary action under Code section 2234, subdivision (c), in that he engaged in repeated negligent acts with respect to the care and treatment of patients 1, 2, 3, 4, 5, and 6. The circumstances are as follows:

Patient 1

48. The facts and circumstances are as set forth in paragraphs 8 through 29 above, and are incorporated by reference.

49. Respondent departed from the standard of care with respect to his care and treatment of Patient 1 as follows:

A. Respondent failed to timely, sufficiently, and attentively evaluate and manage the possibility of Patient 1's ongoing massive concealed hemorrhage throughout the evening of April 12, 2016; and

B. Respondent failed to timely engage the services of consultant physicians and surgeons

1 during the post-operative phase of Patient 1's care.

2 Patient 2

3 50. On or about May 25, 2016, Patient 2, a then twenty-seven-year-old female, went to
4 the hospital's emergency department with a three-day history of right-sided pelvic pain. She was
5 admitted to Respondent's care with a presumptive diagnosis of ectopic pregnancy, at nine weeks
6 plus five days' pregnancy. Respondent managed the ectopic pregnancy with single-dose
7 methotrexate. Patient 2's pain improved and an abdominal exam continued to show a non-
8 surgical abdomen.²⁸

9 51. On or about May 26, 2016, Patient 2 was discharged in stable condition with
10 instructions to follow up on day four (May 29, 2016) and day seven (June 1, 2016) in the
11 emergency room.

12 52. Respondent departed from the standard of care with respect to his care and treatment
13 of Patient 2 as follows:

14 A. Respondent's documentation of Patient 2's hospital course was inadequate. Although
15 Respondent was the sole attending staff provider during the hospitalization and was involved in
16 the actual clinical decision-making, he did not author any of the physician-generated notes. As
17 the staff physician, he should have done more than edit or co-sign the OB/GYN house staff's
18 notes.

19 Patient 3

20 53. The facts and circumstances are as set forth in paragraphs 30 through 35 above, and
21 are incorporated by reference.

22 54. Respondent departed from the standard of care with respect to his care and treatment
23 of Patient 3 as follows:

24 A. On or about August 21, 2015, Respondent administered methotrexate to Patient 3, as

25
26 ²⁸ A surgical abdomen is an acute abdomen that requires surgical intervention, as in with
27 acute appendicitis, acute cholecystitis, acute diverticulitis with bowel obstruction, cancer, or acute
28 vascular disease (e.g., infarction, abdominal aortic aneurysm). While acute abdomen and surgical
abdomen are sometimes considered as synonymous, not all acute abdomens are appropriately
treated by surgery.

1 medical management of a presumed ectopic pregnancy, in the face of a quantitative Beta HCG
2 level in excess of 28,000 mIU/mL and a highly suspect ectopic pregnancy.

3 B. On or about August 24, 2015, through on or about August 27, 2015, Respondent
4 failed to personally evaluate Patient 3 daily, directly, and independently during her postoperative
5 inpatient care.

6 C. Respondent's documentation of Patient 3's hospital course was inadequate. Although
7 he was the sole attending staff provider during the hospitalization, Respondent did not author any
8 progress notes. He only authored a few orders. As the staff physician, he should have done more
9 than edit or co-sign the house staff's notes. In light of Patient 3's critical and life-threatening
10 condition upon admission, and her stormy postoperative course, Respondent's direct involvement
11 and documentation was vital.

12 Patient 4

13 55. The facts and circumstances are as set forth in paragraphs 36 through 40 above, and
14 are incorporated by reference.

15 56. Respondent departed from the standard of care with respect to his care and treatment
16 of Patient 4 as follows:

17 A. On or about March 15, 2016, through on or about March 18, 2016, Respondent failed
18 to personally evaluate Patient 4 daily, directly, and independently during her postoperative
19 inpatient care.

20 B. Irrespective of who performed the dilation and curettage procedure, Respondent was
21 the staff OB/GYN solely responsible for the surgical procedure in the teaching/clinical setting
22 such as at the hospital's OB/GYN Department. Respondent's surgical procedure/technique in
23 performing/supervising Patient 4's dilation and curettage constitutes a departure from the standard
24 of care. There is documentation that the OB/GYN house staff used a 12 mm suction curette.
25 However, there is no documentation that he used sequential gentle sharp curettage as a means to
26 assess for any retained products of conception and/or to assure complete evacuation.

27 C. Respondent's documentation of Patient 4's hospital course was inadequate. Although
28 Respondent was the sole attending staff provider during Patient 4's hospitalization, he did not

1 author any of the physician-generated notes. As the staff physician, he should have done more
2 than edit or co-sign the house staff's notes. Given the importance of several critical decision
3 points in Patient 4's management and care (e.g., medical versus dilation and evacuation
4 management, and the acuity of Patient 4's life-threatening condition after her dilation and
5 curettage), direct involvement and documentation by the staff physician is all the more vital at or
6 around such points (but not limited to such points) in Patient 4's inpatient care.

7 Patient 5

8 57. The facts and circumstances are as set forth in paragraphs 41 through 45 above, and
9 are incorporated by reference.

10 58. Respondent departed from the standard of care with respect to his care and treatment
11 of Patient 5 as follows:

12 A. Respondent's prenatal care and management of Patient 5 is a departure from the
13 standard of care. He failed to identify, address, and manage any and all high-risk factors which
14 complicated Patient 5's pregnancy, either as preexisting or new-onset conditions. There is no
15 indication that Respondent recognized, planned for, or counseled the patient about the possibility
16 of placenta accreta and its potential attendant consequences (e.g., major bleeding and possible
17 hysterectomy) when the likelihood of that potential life-threatening possibility was approximately
18 ten percent or more, given her history of a prior Cesarean section in the face of current anterior
19 placenta previa. As a result, he failed to recognize the indication to schedule Patient 5 for a
20 Cesarean section at 34 weeks of pregnancy. Respondent also failed to schedule Patient 5 for
21 Cesarean delivery at 36-37 weeks of pregnancy based upon his well-documented awareness of
22 placenta previa. Furthermore, Respondent's prenatal medical records for Patient 5 mention
23 schizophrenia, history of prior Cesarean delivery, persistent breech presentation, uterine myoma
24 (fibroid), placenta previa, patient desires trial of labor after Cesarean, and bleeding in early
25 pregnancy. However, there is no indication that Respondent addressed each of these issues in
26 sufficient detail.

27 B. Respondent's documentation and medical record keeping of Patient 5's prenatal care
28 was inadequate. His documentation in her medical records, throughout her prenatal care, was

1 cursory and illegible. In light of the details, nature, clinical features, and several important
2 decision points in Patient 5's prenatal care/management (e.g. options for management after
3 previous Cesarean delivery; anterior placenta previa in the face of a prior Cesarean delivery; and
4 breech presentation), direct and vigilant attention to detail and documentation by the staff
5 obstetrician is all the more vital at/around such points (but not limited to such points) in Patient
6 5's prenatal care. Particularly lacking is Respondent's documentation of his consideration of
7 placenta accreta.

8 Patient 6

9 59. On or about September 15, 2015, Respondent saw Patient 6, a then thirty-seven-year-
10 old female who was pregnant with twins. Her estimated due date was October 13, 2015. She
11 received prenatal care in Iran, but she did not provide copies of her prenatal medical records to
12 Respondent.

13 60. On or about September 22, 2015, Patient 6 went to the hospital for a scheduled
14 Cesarean section. She was 37 weeks pregnant. Respondent performed the Cesarean section for a
15 vertex (head first)/breech twin delivery. On September 23, 2015, and September 24, 2015,
16 Respondent evaluated Patient 6 and wrote progress notes in her medical record. His plan was for
17 her to be discharged from the hospital on September 25, 2015. However, on September 25, 2015,
18 the day of Patient 6's discharge, Respondent did not evaluate her or write a progress note. After
19 she was discharged, Patient 6 remained in the hospital until September 26, 2015, presumably as a
20 boarder.

21 61. Respondent departed from the standard of care with respect to his care and treatment
22 of Patient 6 as follows:

23 A. On or about September 22, 2015, Respondent maintained inadequate medical records
24 for Patient 6 for the prenatal/preoperative period. His transcribed preoperative History and
25 Physical was inadequate. He did not address any of the salient clinical concerns inherent in
26 multifetal pregnancies. He did not mention, address, or treat a positive chlamydia test result. He
27 did not document a preoperative physical examination. Of the standard prenatal care laboratory
28 tests that had been reported, he did not address the majority. In the absence of prenatal records

1 having been provided to Respondent, it was unfounded for him to indicate that "OB care in Iran.
2 All being within normal limits." He did not prepare a handwritten History and Physical that
3 would have met the standard of care.

4 B. On or about September 25, 2015, the day Patient 6 was discharged, Respondent failed
5 to evaluate her and write a progress note.

6 62. Respondent's acts and/or omissions as set forth in paragraphs 48 through 61,
7 inclusive above, whether proven individually, jointly, or in any combination thereof, constitute
8 repeated negligent acts pursuant to Code section 2234, subdivision (c), with respect to the care
9 and treatment of patients 1, 2, 3, 4, 5, and 6. Therefore, cause for discipline exists.

10 **THIRD CAUSE FOR DISCIPLINE**

11 **(Inadequate and Inaccurate Medical Recordkeeping-Patients 2, 3, 4, 5, and 6)**

12 63. Respondent Arjang Naim, M.D. is subject to disciplinary action under Code section
13 2266 in that he failed to maintain adequate and accurate medical records with respect to the care
14 and treatment of patients 2, 3, 4, 5, and 6. The circumstances are as follows:

15 64. The facts and allegations in Paragraphs 7 through 62, above, are incorporated by
16 reference and re-alleged as if fully set forth herein.

17 65. Respondent's acts and/or omissions as set forth in paragraph 64, inclusive above,
18 whether proven individually, jointly, or in any combination thereof, constitute inadequate and
19 inaccurate record keeping pursuant to Code section 2266 with respect to the care and treatment of
20 patients 2, 3, 4, 5, and 6. Therefore, cause for discipline exists.

21 **FOURTH CAUSE FOR DISCIPLINE**

22 **(Unprofessional Conduct-Patients 1, 2, 3, 4, 5, and 6)**

23 66. Respondent Arjang Naim, M.D. is subject to disciplinary action under Code section
24 2234 for unprofessional conduct with respect to the care and treatment of patients 1, 2, 3, 4, 5, and
25 6. The circumstances are as follows:

26 67. The facts and circumstances are as set forth in paragraphs 7 through 65, above, and
27 are incorporated by reference.

28 68. Respondent's acts and/or omissions as set forth in paragraph 67, inclusive above,

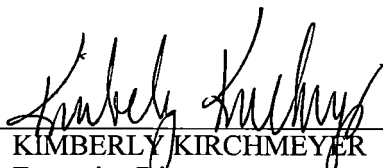
whether proven individually, jointly, or in any combination thereof, constitute unprofessional conduct pursuant to Code section 2234 with respect to the care and treatment of patients 1, 2, 3, 4, 5, and 6. Therefore, cause for discipline exists.

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 74735, issued to Respondent Arjang Naim, M.D.;
2. Revoking, suspending, or denying approval of Respondent Arjang Naim, M.D.'s authority to supervise physician assistants and advanced practice nurses;
3. Ordering Respondent Arjang Naim, 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: February 21, 2018


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

LA2017505253
62635643.doc