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

In the Matter of the Accusation Against:	
Mahmoud Rashidi Naimabadi, M.D.	**Case No. 800-2017-036964**
Physician's and Surgeon's Certificate No. A 87654	
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 September 3, 2020.

IT IS SO ORDERED: August 4, 2020.

MEDICAL BOARD OF CALIFORNIA

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

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

In the Matter of the Accusation Against:

MAHMOUD RASHIDI NAIMABADI, M.D.,

Physician's and Surgeon's Certificate No. A 87654

Respondent.

Case No. 800-2017-036964

OAH No. 2020010610

PROPOSED DECISION

Administrative Law Judge Juliet E. Cox, State of California, Office of Administrative Hearings, heard this matter on June 22, 2020, in Oakland, California.

Supervising Deputy Attorney General Jane Zack Simon represented complainant William J. Prasifka, Executive Director of the Medical Board of California.

Respondent Mahmoud Rashidi Naimabadi, M.D., represented himself and was present for the hearing.

The matter was submitted for decision on June 22, 2020.

FACTUAL FINDINGS

1. The Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. A 87654 to respondent Mahmoud Rashidi Naimabadi, M.D., on June 11, 2004. The certificate is scheduled to expire on January 31, 2022.

2. On November 25, 2019, acting in her official capacity as Interim Executive Director of the Board, Christine J. Lally filed an accusation against respondent. Complainant William J. Prasifka later replaced Lally as the Board's Executive Director. Complainant alleges that respondent acted unprofessionally during two surgeries, and seeks as a consequence to revoke respondent's certificate or place him on probation. Respondent timely requested a hearing.

Respondent's Training and Experience

3. Respondent received his medical education in Iran. He completed a residency in neurosurgery in Canada and has been board-certified in neurological surgery since 2007.

4. Respondent began practicing medicine in the United States in 2002, in Louisiana. He continues to hold a medical license in Louisiana, as well as licenses or certificates in Massachusetts, New Hampshire, and California.

5. Respondent lived in California and practiced neurosurgery between 2004 and 2010, and also between 2012 and 2014. Respondent and his family have lived in New Hampshire since 2014, but respondent continued between 2014 and 2016 to practice neurosurgery part-time in California as well as part-time in Massachusetts and New Hampshire. In part because of the investigation and accusation in this matter,

respondent has not performed surgery since April 2019, although he intends if possible to resume.

6. Respondent also is an author and lecturer on subjects relating to cognitive and emotional influences on physical health.

Spinal Surgery on Patient 1

7. Patient 1, a 71-year-old man, came to the emergency room at Santa Rosa Memorial Hospital (SRMH) on November 10, 2014. He complained of significant lower back pain that had persisted for at least four days, during which time he had not had a bowel movement. He also had been catheterized at a different hospital two days earlier because he could not urinate. Although Patient 1 reported having felt strong enough a week earlier to do landscaping work including tree cutting, he needed support to walk when he arrived at the SRMH emergency room and complained that his legs felt weak. Magnetic resonance imaging (MRI) of Patient 1's spine showed a large disc herniation at the T11/12 junction.

SURGICAL PROCEDURE AND OUTCOME

8. Respondent recommended corrective surgery to Patient 1. Because respondent believed that electrophysiological monitoring of Patient 1's spinal cord during the surgery would be a necessary safety measure to reduce the likelihood of surgical injury to Patient 1's spinal cord, he scheduled the surgery for the following morning when a team to perform this "evoked potential" monitoring would be available.

9. Respondent performed Patient 1's surgery on November 11, 2014. He chose to perform a transpedicular discectomy, a procedure in which the surgeon

positions the patient prone and accesses the vertebral joint from an incision on the patient's back. Although respondent had intended to begin surgery in the morning, he had to wait until afternoon because of other surgical procedures at the hospital.

10. The chart note respondent prepared immediately after Patient 1's surgery states, "I should mention from the beginning, evoked potential monitoring was not getting any signal below L1." In an interview with Board representatives on October 21, 2019, and in his testimony at the hearing, however, respondent clarified that his note meant "from the beginning of the surgery." He explained that evoked potential monitoring had showed normal spinal cord electrical conduction while Patient 1 was supine for surgical preparation and anesthesia, but had stopped showing conduction below the L1 level shortly after the surgical team turned Patient 1 from supine to prone to expose his back for respondent's incision.

11. When evoked potential monitoring ceased to show electrical conduction below Patient 1's L1 vertebra, respondent had not yet made his first surgical incision. He considered pausing to troubleshoot the electrical conduction issue, but worried that any further delay would prolong pressure on Patient 1's spinal cord and perhaps damage it further; he also believed that bringing Patient 1 out of anesthesia would traumatize him (because he would awaken to learn he had not yet had corrective surgery) and also expose him to the further risk of re-anesthesia when surgery resumed. Respondent elected to proceed with the surgery he had planned, reasoning that it would be the fastest way to reduce pressure on Patient 1's spinal cord.

12. Respondent removed parts of Patient 1's T11 and T12 vertebrae and supporting structures in an attempt to reduce pressure on Patient 1's spinal cord. He was unable to remove as much of the herniated disc material as he had expected, but

believed when he concluded the surgery that Patient 1's spinal cord "seems to be decompressed."

13. When Patient 1 awoke from surgery, he had little or no sensation in his legs and was unable to move them. Post-surgical MRI showed "postsurgical edema and hemorrhage in the posterior soft tissues of the back. The hard disc remains . . . , essentially unchanged."

14. Respondent arranged for Patient 1's transfer to the University of California, San Francisco (UCSF) hospital. Patient 1 had further back surgery, but to respondent's knowledge his weakness and paralysis did not improve.

EXPERT OPINION

15. Michael Chan, M.D., reviewed medical records relating to Patient 1, and also reviewed a transcript of the October 2019 interview referenced in Finding 10. Dr. Chan is board-certified in neurological surgery. He has practiced neurological surgery in California since 2011.

16. According to Dr. Chan, a transpedicular posterior approach to a T11/12 discectomy does not offer the surgeon safe access to the damaged disc, because from a posterior approach the spinal cord itself lies between the surgeon and the disc. The surgeon would have to pull the disc material out around the spinal cord, or would have to move the spinal cord aside to reach the disc material; either way, the surgeon would risk damaging the spinal cord.

17. Dr. Chan explained further that to repair or remove a herniated T11/12 disc safely, a surgeon must access the joint either from the patient's front (an "anterior" approach) or side (a "lateral" approach). The anterior approach requires a

thoracic surgeon, because the surgery breaches the patient's pleural space. The lateral approach does not require a thoracic surgeon's participation, because it avoids breaching the patient's pleural space, but it is less common.

18. Respondent was and is familiar with the anterior approach, but he could not use an anterior approach to Patient 1's surgery at SRMH because no thoracic surgeon was available to join respondent for the surgery. Respondent did not believe that the absence of a thoracic surgeon precluded Patient 1 from having surgery at SRMH, however, because he believed a posterior transpedicular surgery would give him adequate, safe access to Patient 1's damaged T11/12 disc. He did not testify at the hearing about considering a lateral surgical approach, but stated in his October 2019 interview with Board representatives that he had known at least one fellow neurosurgeon for whom a lateral approach to similar surgery had gone poorly.

19. In Dr. Chan's opinion, respondent's decision to do a transpedicular discectomy to address Patient 1's T11/12 disc herniation was an extreme departure from the standard of care for neurological surgery. Dr. Chan's opinion that a transpedicular posterior surgical approach to the T11/12 disc is unsafe is more persuasive than respondent's opinion that this approach is safe. For this reason, Dr. Chan's opinion that the transpedicular posterior approach was an extreme departure from the standard of care also is persuasive.

20. Respondent testified that he had offered to arrange Patient 1's transfer to UCSF in the evening on November 10, 2014, but Patient 1 preferred to remain at SRMH for surgery the next day. Respondent did not document how he described the comparative risks and benefits to Patient 1 between transferring to UCSF or remaining at SRMH, or why Patient 1 elected to remain rather than to transfer. In particular, respondent did not state in either his medical records or his testimony that he

explained to Patient 1 that the posterior surgical approach respondent intended to use for Patient 1 at SRMH would be riskier for Patient 1 than the anterior surgical approach that surgeons at UCSF could use.

21. The standard of care in neurological surgery requires a surgeon to discuss all risks and benefits of surgery with the patient, and in particular to document the rationale for choosing a riskier course of action if a safer course potentially is available. In Dr. Chan's opinion, respondent's failure to articulate or to document any medically prudent rationale for failing to transfer Patient 1 to UCSF, despite respondent's inability or unwillingness at SRMH either to recruit a thoracic surgeon to participate in Patient 1's surgery or to perform the surgery laterally, also was an extreme departure from the standard of care. This opinion is persuasive.

22. Finally, Dr. Chan stated that respondent's decision to proceed with Patient 1's surgery (as described in Finding 11) even though evoked potential monitoring had stopped showing electrical conduction below Patient 1's L1 vertebra (as described in Finding 10) was an extreme departure from the standard of care. In Dr. Chan's opinion, a reasonably prudent neurosurgeon under these circumstances would have paused to check whether the lack of electrical conduction was real, or a technical problem; if the lack of conduction were real, a reasonably prudent neurosurgeon would have asked the anesthetist to adjust the patient's anesthesia, asked operating room staff to confirm adequate blood pressure, or returned Patient 1 to the supine position to determine whether conduction resumed. Dr. Chan's opinion is that respondent's decision to press forward with posterior, transpedicular surgery under these circumstances was reckless, and considerably less safe for Patient 1 than any of the available alternatives. This opinion is persuasive.

Craniotomy on Patient 2

23. Patient 2 arrived in the SRMH emergency room at night on November 15, 2015, complaining of a sudden severe headache. Although he was conscious and ambulatory when he arrived, his condition deteriorated rapidly and he became unconscious. Emergency department staff members called respondent for consultation.

24. A scan showed that Patient 2 had a seven-centimeter hematoma on his brain's right parietal lobe, adjacent to a blood vessel malformation. Pressure on Patient 2's brain from the hematoma was causing his acute symptoms, and the blood vessel malformation was the likely cause of the hematoma. Respondent determined that Patient 2 needed immediate surgery at SRMH to remove the hematoma, followed later by surgery at another hospital to correct the blood vessel malformation.[1]

SURGICAL PROCEDURE AND OUTCOME

25. Respondent assembled an operating room team for Patient 2, and the team prepared the room and Patient 2 for surgery. Between preparing the room and the patient and beginning the surgery, the operating room team did not pause for the entire team to confirm that they had prepared and positioned Patient 2 correctly.

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[1] SRMH did not have personnel or facilities for the follow-up surgery to correct Patient 2's blood vessel malformation. Respondent expected that Patient 2 would die if he transferred to another hospital before having the hematoma removed, however.

26. Respondent opened Patient 2's skull on Patient 2's left side. He realized immediately that he had erred, because he saw no hematoma. He reclosed Patient's 2's skull on the left side, and opened Patient 2's skull on Patient 2's right side.

27. Respondent successfully completed Patient 2's surgery. His error (commencing surgery on the incorrect side of Patient 2's skull) caused a delay of between 20 and 30 minutes in removing the hematoma and relieving the pressure it was causing on Patient 2's brain. The evidence did not establish that this delay harmed Patient 2.[2]

28. After the emergency surgery, a helicopter ambulance transferred Patient 2 to a different hospital immediately. Respondent understands that Patient 2 had further treatment there and made a full recovery.

EXPERT OPINION

29. Dr. Chan agreed with respondent that Patient 2's condition was a dire emergency. He disagreed, however, with respondent's assertion that the immediacy and drama inherent in the circumstances excused the operating room team from pausing to confirm which side of Patient 2's head respondent would open. He

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[2] Respondent argued that the delay might have benefited Patient 2. His basis for this argument was plausible in hindsight; but even respondent did not argue that a reasonably prudent physician would have delayed Patient 2's surgery in the hope that delay might improve its outcome. To the contrary, Patient 2's condition was an extreme emergency for which immediate surgery was the only prudent treatment.

characterized this failure as a simple departure from the standard of care, and this opinion is persuasive.

30. In Dr. Chan's opinion, wrong-side surgery such as the left-side craniotomy respondent initially performed on Patient 2 is an extreme departure from the standard of surgical care. This opinion is persuasive.

Additional Evidence

31. Respondent presented no testimony or written references from other physicians describing his skills, prudence, or clinical knowledge.

32. Respondent presented no evidence of any retraining he has undertaken since his surgeries on Patients 1 and 2.

LEGAL CONCLUSIONS

1. The Board may suspend or revoke respondent's physician's and surgeon's certificate if clear and convincing evidence establishes the facts supporting discipline. The factual findings above reflect this standard.

2. Business and Professions Code section 2234 makes a physician's unprofessional conduct grounds for suspension or revocation of the physician's certificate.

3. Unprofessional conduct includes:

a. Gross negligence, connoting an extreme departure from the minimum professionally accepted standard of care (Bus. & Prof. Code, § 2234, subd. (b));

b. Repeated acts of negligence, including multiple simple departures from the minimum professionally accepted standard of care (Bus. & Prof. Code, § 2234, subd. (c)); and

c. Failing to maintain adequate and accurate patient records (*id.*, § 2266).

Cause for Discipline, Patient 1

4. The matters stated in Findings 9 through 12 constitute unprofessional conduct, because the matters stated in Findings 16 through 22 establish that the matters stated in Findings 9 through 12 involved both extreme and repeated departures from the standard of care.

5. The matters stated in Findings 10 and 20 constitute unprofessional conduct, because they represent respondent's failure to record and explain critical medical events and decisions.

Cause for Discipline, Patient 2

6. The matters stated in Findings 25 and 26 constitute unprofessional conduct, because the matters stated in Findings 29 and 30 establish that the matters stated in Findings 25 and 26 involved both extreme and repeated departures from the standard of care.

Disciplinary Considerations

7. The Medical Board has adopted disciplinary guidelines to facilitate consistency among decisions and to protect public welfare. (Cal. Code Regs., tit. 16, § 1361, subd. (a).) These guidelines recommend, as a minimum response to

unprofessional conduct including gross negligence, a period of five years' probation. (Manual of Model Disciplinary Orders and Disciplinary Guidelines, at p. 24.)

8. In this case, both the seriousness of respondent's errors and his failure to acknowledge them or to take corrective action warrant specific probation conditions requiring respondent to undergo a clinical competency assessment, to take a medical record-keeping course, to take other supplemental continuing medical education, and to practice only with review by a practice monitor.

ORDER

Physician's and Surgeon's Certificate No. A 87654, issued to respondent Mahmoud Rashidi Naimabadi, is revoked. The revocation is stayed, however, 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 months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one 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 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. 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 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 that states unequivocally 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 calendar days after being so notified. 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 did not successfully complete the clinical competence assessment program, respondent shall not resume the practice of medicine until a final decision has been rendered on any petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

4. Practice Monitor

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 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 and accusation, and a proposed monitoring plan. Within 15 calendar days of

receipt of the decision, accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the decision and accusation, 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 calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor 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 medical practice, and whether respondent is practicing medicine safely. 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 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.

5. Notification to Hospitals, Other Providers, and Insurance Carriers

Within seven days of the effective date of this decision, respondent shall provide a true copy of the decision and the accusation in this matter 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.

6. Supervision of Physician Assistants and Advanced Practice Nurses

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

7. Obey All Laws

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

8. 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.

9. General Probation Requirements

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit and all terms and conditions of this decision.

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 certificate.

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 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.

10. 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.

11. 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 in California 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. All time spent in an intensive training program which has been approved by the

Board or its designee shall not be considered non-practice. 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 a clinical training 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 years.

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

Periods of non-practice 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 (Condition 7); and General Probation Requirements (Condition 9).

12. 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.

13. 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, or 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.

14. 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 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.

15. 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.

DATE: July 21, 2020

DocuSigned by:
Juliet E. Cox
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JULIET E. COX
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Mahmoud Rashidi Naimabadi, M.D.** PO Box 1210 Santa Rosa, CA 95402-1210 Physician's and Surgeon's Certificate No. A 87654, Respondent.	Case No. 800-2017-036964 **A C C U S A T I O N**

PARTIES

1. Christine J. Lally (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On June 11, 2004, the Medical Board issued Physician's and Surgeon's Certificate Number A 87654 to Mahmoud Rashidi Naimabadi, M.D. (Respondent)[1]. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2020, unless renewed.

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[1] Respondent is frequently referred to as Dr. Rashidi.

JURISDICTION

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

4. Section 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 Board deems proper.

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

"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.

6. Section 2266 of the Code 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.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligent Acts/Inaccurate Records)

Patient 1

7. Respondent is subject to disciplinary action under sections 2234 and/or 2234(b) and/or 2234(c) and/or 2266, in that Respondent engaged in unprofessional conduct and/or was grossly negligent and/or committed repeated acts of negligence in his care and treatment of Patient 1[2] and/or failed to maintain adequate and accurate records. The circumstances are as follows:

[2] Patients are referred to by number to protect privacy.

8. Patient 1 presented to the Santa Rosa Memorial Hospital emergency room on November 10, 2014. Patient 1 complained of five days of lower back and leg pain and difficulty urinating. Imaging studies showed severe spinal stenosis and disc herniation in the thoracic spine at level T11/12.

9. Respondent was called to provide a neurosurgical consultation. He recommended surgery to take place the following morning. His Consultation Report specifically noted that Patient 1 and his family wished to wait until the morning so that spinal monitoring could be utilized to mitigate the risk of spinal cord injury. Respondent's Consultation Report does not mention any discussion with Patient 1 or his family regarding transfer of the patient to a different facility, or of the limitations on the type of surgical procedure that could be performed at Santa Rosa Memorial Hospital.

10. The following morning, Respondent took Patient 1 to the operating room for T11/T12 bilateral laminotomy[3] and a left side discectomy[4]. The surgery was performed using evoked potential monitoring[5]. Respondent performed the procedure using a posterior approach. He explained during an interview with the Board's investigative staff that while he was aware an anterior approach was appropriate, he could not use an anterior approach because no thoracic surgeon was available at the hospital, and for reasons he could not recall, it was not feasible to transfer Patient 1 to another facility. Respondent's medical record does not document any discussion with Patient 1 or his family regarding the limitations on the surgical approach available at Santa Rosa Memorial Hospital, or the possibility of transferring the patient to a different facility.

11. During his Board interview, Respondent stated that there was a positive response to the evoked potential monitoring at the beginning of the procedure. However, the monitored signal was lost when the patient was repositioned during surgery. Respondent elected to

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[3] Laminotomy is a procedure that removes part of the lamina of a vertebral arch in order to relieve pressure in the vertebral canal.

[4] Discectomy is a procedure to remove herniated disc material that is pressing on a nerve root or the spinal cord.

[5] Evoked potential monitoring uses electrical sensory stimulation to alert the surgeon to impending injury during surgical procedures.

continue with the surgery. However, Respondent's Operative Report for the procedure states "from the beginning, evoked potential monitoring was not getting any signal below L1"[6]. The record does not document any issue with loss of monitoring during repositioning, nor does it document any response to the loss of signal.

12. Patient 1 awoke with flaccid paralysis and severe bilateral leg weakness. An MRI showed decompression and signal changes in the spinal cord at the surgical site.

13. Respondent is guilty of unprofessional conduct and Respondent's certificate is subject to discipline pursuant to Sections 2234 and/or 2234(b) and/or 2234(c) of the Code based upon gross negligence and/or repeated negligent acts, including but not limited to the following:

A. Respondent performed a complex surgical procedure at a community hospital with limited resources and expertise, and where he knew that he could not perform the procedure with an anterior approach, instead of arranging to transfer Patient 1 to a facility that could offer a higher level of care.

B. Respondent failed to properly respond when electrical signal was lost on the evoked potential monitoring. Respondent failed to immediately evaluate or assess the plan of care prior to continuing with surgery. There is no indication he checked the leads, adjusted anesthesia, repositioned Patient 1, checked the patient's blood pressure, awakened the patient to perform a physical examination, or took other measures to assess the patient's condition.

C. Respondent performed bilateral laminotomies with discectomy for a midline large thoracic herniated disc with spinal cord compression using a posterior approach which was contraindicated due to high risk of injury to the spinal cord.

14. Respondent is guilty of unprofessional conduct and subject to disciplinary action under sections 2234 and/or 2266 of the Code as follows:

A. Respondent's account of the evoked potential monitoring is inconsistent and incomplete. The Operative Report indicates that evoked potential monitoring did not have a

[6] The anesthesiologist noted that the neuromonitoring technician "never got motor/sensory below L1. Dr. Rashidi OR aware."

signal below L1 throughout the procedure. Respondent stated in his Board interview that the signal was lost during surgery when Patient 1 was repositioned, yet there is no documentation in the Operative Report of this event.

B. Respondent did not document his decision to proceed with surgery using an anterior approach, or that he discussed with Patient 1 or his family, the risks and benefits of performing the surgery with this approach.

C. Respondent did not document a discussion with Patient 1 or his family regarding the possibility of transferring the patient to a facility that could offer a higher level of care.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence/Repeated Negligent Acts)

Patient 2

15. Respondent is subject to disciplinary action under sections 2234 and/or 2234(b) and/or 2234(c) in that Respondent engaged in unprofessional conduct and/or was grossly negligent and/or committed repeated acts of negligence in his care and treatment of Patient 2. The circumstances are as follows:

16. Patient 2, a 27 year old man, presented to the emergency room on August 7, 2017 following an acute onset headache, left sided weakness and seizure. Imaging studies showed a large (7 cm) hematoma in the right posterior parietal lobe, and a large vascular malformation.

17. Respondent evaluated the patient and determined that emergency surgery was necessary. Respondent planned to perform a right craniotomy to evacuate the hematoma. Respondent failed to perform the Universal Protocol, a procedure designed to prevent wrong-site surgery. The Universal Protocol includes a "time out" prior to beginning surgery for clear identification and marking of the surgical site. The record does not indicate whether the surgical site was in fact marked, and Respondent was uncertain during his Board interview whether the surgical site was marked.

18. Respondent performed the craniotomy and opened the dura, and encountered normal brain tissue. He realized he had performed the procedure on the wrong side of the brain, and

repaired and closed the left side. Respondent then proceeded to perform a successful craniotomy on the right side.

19. During his Board interview, Respondent attributed the surgical error to nervousness, haste, and resultant failure to pay attention.

20. Respondent is guilty of unprofessional conduct and Respondent's certificate is subject to discipline pursuant to Sections 2234 and/or 2234(b) and/or 2234(c) of the Code based upon gross negligence and/or repeated negligent acts, including but not limited to the following:

A. Respondent failed to adhere to the requirements of the Uniform Protocol.

B. Respondent operated on the wrong side of Patient 2's brain as a result of haste and inattention, thereby subjecting the patient to the risk of an unnecessary and unplanned surgical procedure and a delay in delivery of care to the right side craniotomy.

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 A87654, issued to Mahmoud Rashidi Naimabadi, M.D.;

2. Revoking, suspending or denying approval of Mahmoud Rashidi Naimabadi, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Mahmoud Rashidi Naimabadi, 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: November 25, 2019

CHRISTINE J. LALLY
Interim Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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