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

In the Matter of the Accusation Against: **Arjang Naim, M.D.** **Physician's and Surgeon's Certificate No. A 74735** Respondent.	**Case No. 800-2023-098947**

ORDER CORRECTING NUNC PRO TUNC CLERICAL ERROR IN "RESPONDENT NAME" ON PAGE 1, LINE 18 OF THE DECISION

On its own motion, the Medical Board of California (hereafter "Board") finds that there is a clerical error in the Decision in the above-entitled matter and that such clerical error should be corrected so that the Respondents name will conform to the Board's issued decision.

IT IS HEREBY ORDERED that the Respondent name contained on Page 1, line18 of the Proposed Decision in the above-entitled matter be and hereby is amended and corrected nunc pro tunc as of the date of entry of the decision to read as "Arjang Naim."

December 29, 2025

Richard E. Thorp, M.D.
Chair
Panel B

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

In the Matter of the Accusation: Arjang Naim, M.D. Physician's and Surgeon's Certificate No. A 74735 Respondent.	Case No. 800-2023-098947

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 December 24, 2025.

IT IS SO ORDERED November 24, 2025.

MEDICAL BOARD OF CALIFORNIA

Richard E. Thorp, M.D., Chair
Panel B

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

In the Matter of the Accusation Against:

ARJANG NAIM, M.D.

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

Respondent.

Agency Case No. 800-2023-098947

OAH No. 2024120827

PROPOSED DECISION

Administrative Law Judge Deena R. Ghaly, Office of Administrative Hearings (OAH), State of California, heard this matter on July 21 through 23, 2025, by videoconference.

Deputy Attorney General Marsha E. Barr-Fernandez represented complainant Reji Varghese, acting in his official capacity as the Executive Director of the Medical Board of California (Board). Attorney Raymond J. McMahon of Doyle Schafer McMahon, LLP represented respondent Arjang Niam, M.D., who was present throughout the hearing.

Documentary evidence and testimony were received. The record was kept open until September 17, 2025, for the parties to submit written closing briefs and until October 1, 2025, for the parties to submit any responses to each other's closing briefs.

As a transcript of the proceeding had been prepared and used by the parties for their closing briefs, complainant filed it with OAH. The transcript is comprised of three volumes which were marked Exhibits 33, 34, and 35 and included with the record.

Both parties timely filed and served their post-hearing submissions. Complainant's initial closing brief was marked Exhibit 36 and his reply brief was marked Exhibit 37. Respondent's initial closing brief was marked Exhibit W and his reply brief was marked Exhibit X. All post-hearing submissions were included with the record and considered in the preparation of the Proposed Decision.

On October 1, 2025, the record closed and the matter was deemed submitted.

Protective Sealing Order

To protect confidential personal and medical information from disclosure, a Protective Order Sealing Confidential Records will be issued contemporaneously with the Proposed Decision. The order lists exhibits in the matter containing such confidential information and governs the release of any such information to the public. A reviewing court, parties to this matter, their attorneys, and a government agency decision maker or designee under Government Code section 11517 may review the documents subject to the order, provided that such documents are protected from release to the public.

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Respondent's Motion to Exclude Portions of Expert Testimony

PARTIES' ARGUMENTS

During the hearing, complainant introduced a report by, and testimony of, his designated expert, Dr. Gil Bender. During his testimony, Dr. Bender made reference to the role guidelines promulgated by a given medical specialty's governing board, here the American College of Obstetrics and Gynecology (ACOG), play in developing the standards of care associated with the specialty. Respondent's counsel objected to Dr. Bender's testimony about, or reliance upon, ACOG guidelines on the grounds that these materials were not disclosed as required by Business and Professions Code section 2334. (Further statutory cites are to the Business and Professions Code unless otherwise designated.) Complainant argued sufficient disclosure regarding the use of the ACOG guidelines had been made because they and other ethics provisions had been provided during the parties' discovery exchange.

In later portions of Dr. Bender's testimony, he stated his opinions about whether respondent's actions with Patient 1 constituted boundary violations were based on his education, training and experience. Respondent objected again on the basis that the substance of this testimony went beyond what was included in Dr. Bender's report and supplemental report which complainant had submitted to respondent to satisfy section 2334's disclosure requirements. Ruling on both objections were held in abeyance and the parties were directed to provide argument regarding the objections in their post-hearing briefing.

RULING

Section 2334, subdivision (a) requires that parties intending to introduce expert testimony exchange in writing certain information including "(2) A complete expert

witness report, which must include the following: (A) A complete statement of all opinions the expert will express and the bases and reasons for each opinion [and] (B) The facts or data considered by the expert in forming the opinion."

The interpretation and application of a former iteration of section 2334 is the subject of the precedential decision, *In the Matter of the Accusation against Jill Siren Meoni, M.D.*, MBC Case No. 10-2007-185857, OAH No. 2008100753. In the *Meoni* case, complainant brought a motion in limine seeking to exclude the testimony of respondent's expert witnesses because respondent had not met the then-30 day notification requirement under section 2334 and when respondent did make her disclosures, the then-required "brief narrative statement of the general substance of the testimony that the expert is expected to give, including any opinion testimony and its basis" provided by respondent was not sufficiently detailed.

The Board determined that section 2334's disclosure requirements are "self-executing," meaning they apply to all Medical Board cases "whether OAH orders the parties to comply with its provisions or not." (*Meoni*, at p.8.) Further, the Board determined that "[s]ection 2334 governs the entire subject of expert witness disclosure in Medical Board cases, including the penalty to be imposed for failure to comply with the disclosure requirements by the statutory production deadline and therefore Section 2334 prevails over any other provision of law, including provisions of the Administrative Procedure Act." (*Id.* at p. 4.)

Regarding whether respondent's summary met the "brief narrative statement of the general substance of the testimony that the expert is expected to give, including any opinion testimony and its basis" requirement, the *Meoni* decision provides:

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> Merely listing topics or subjects that the expert witness will testify about, without disclosing the general substance of the expert's anticipated testimony, the actual expert opinions he/she will testify to, and the basis for each of those opinions, is plainly insufficient and would clearly violate the statutory requirements of section 2334. A "brief narrative statement" of the "general substance" of the expert's testimony means a short narrative statement that provides the main features of the testimony – the essential nature of the testimony to be proffered. The statement must include any opinion to be presented and the basis for that opinion.

(Id. at p. 10.)

Here, respondent has not argued complainant's expert witness disclosures were untimely, only that the code of conduct referenced in complainant's expert report was not specifically identified during section 2334's disclosure period. As part of the evidence exchange, complainant provided two sources of professional ethics for physicians, the American Medical Association (AMA) Code of Medical Ethics and the American College of Obstetricians and Gynecologists (ACOG) Committee Opinions. During the hearing, official notice was taken of pertinent provisions from both sources. (See Exhs. 22 and 23.)

Given that Dr. Bender's reference to "Code of Ethics" is not specific enough to identify what exactly he is relying upon, respondent's motion to exclude his testimony and report to the extent they rely on a code of ethics is granted. Dr. Bender's testimony to the extent it is based on his knowledge and experience is admitted. Dr.

Bender's ultimate conclusions as reflected in his testimony are not different from or beyond the scope of his analysis in his report.

The AMA Code of Medical Ethics and the ACOG Committee Opinions have been considered in making determinations regarding complainant's first cause for discipline, general unprofessional conduct, which does not require expert testimony.

SUMMARY

Complainant seeks to discipline respondent's physician and surgeon's certificate based on charges of general unprofessional conduct, gross negligence, and repeated negligent acts in his interactions with Patient 1. Specifically, Complainant alleges respondent committed boundary violations with Patient 1, including failing to have a chaperone present when he performed pelvic examinations on her. Complainant also seeks recoupment of investigation and enforcement costs incurred by the Board.

Although complainant failed to establish all the factual allegations made against respondent, clear and convincing evidence established respondent repeatedly breached professional boundaries with Patient 1. Moreover, respondent's own evidence established he has no remorse or insight into his behavior. Under these circumstances, respondent's conduct warrants discipline. He is placed on probation with appropriate terms and conditions. A cost award reduced to reflect respondent used the hearing process to reduce the number of factual allegations established and avoid the most serious disciplinary outcome, revocation, is also granted.

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FACTUAL FINDINGS

Jurisdictional Matters

1. On May 31, 2001, the Board issued to respondent Physician's and Surgeon's Certificate Number A 74735. The certificate will expire on January 31, 2027, unless renewed. Respondent is board-certified in the obstetrics and gynecology (OB/GYN) specialty.

2. On October 26, 2017, complainant filed an accusation against respondent's certificate and on February 21, 2018, complainant filed a first amended accusation for the same matter. The disciplinary matter resolved through a Board decision effective November 9, 2018. Under the terms of the November 2018 Board decision, respondent's certificate was revoked, the revocation stayed for four years and respondent's certificate placed on probation with terms and conditions. Respondent completed probation on November 9, 2022, and his certificate was restored to unrestricted status.

3. On December 3, 2024, complainant signed the operative pleading for this matter, the Accusation. The Accusation charging respondent engaged in general unprofessional conduct, gross negligence, and repeat acts of simple negligence. The allegations are based on respondent's interactions with Patient 1 and failure to provide a chaperone when he performed her pelvic examinations.

4. Respondent timely filed a notice of defense and this matter proceeded to hearing.

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Patient 1's Allegations

October 5, 2021 Office Visit

5. Respondent maintains two offices in Los Angeles, one on Vermont Avenue near Hollywood Hospital and the other on Third Street near Cedars-Sinai Hospital. On October 5, 2021, Patient 1's friend, MB, brought her to respondent's Third Street office. Patient 1 had recently seen another doctor who diagnosed her with human papillomavirus (HPV) and Patient 1 was very upset about this development. MB suggested respondent examine Patient 1 and provide her with a second opinion about the HPV diagnosis. Although Patient 1 did not have an appointment, respondent agreed to examine her, including performing a colposcopy (pelvic exam).

6. During the hearing, Patient 1 testified about events at this first examination, noting she did not remember everything that occurred or was said. Patient 1 stated she did not recall whether a chaperone was at the examination. Patient 1 recalled that, during the examination, respondent told her she was pretty and asked whether she had a boyfriend.

October 13, 2021 Office Visit and Aftermath

7. On October 13, 2021, respondent contacted Patient 1 via text message to let her know the results of her colposcopy had arrived and to arrange another appointment, this time at his Vermont Street office. Respondent and Patient 1 exchanged several texts regarding the time of the visit and other logistics. Patient 1 asked respondent what time would work for an appointment that same day. Respondent replied, 3 pm. Later, Patient 1 texted to let him know traffic was heavy and she anticipated being there at 4 pm. Respondent confirmed the time change would work and advised her not to park on Vermont Street after 4 pm, instructing her several

times to park "in the back," referencing parking spaces behind his clinic, and enter through its back door. (Exhs. 11 and 12.)

8. Patient 1 arrived at respondent's office at approximately 4 pm. Respondent told her the results of the colposcopy from the first appointment confirmed she was HPV positive. She became upset and asked respondent to perform another pelvic exam, which he did. During her testimony, Patient 1 could not remember whether a chaperone accompanied them during the second examination. Patient 1 did recall that during the second examination, respondent repeated she was pretty.

9. Patient 1 further maintained that, after the examination respondent repeatedly asked her to go out for a coffee. She initially refused but, after he continued to press her, she agreed. Respondent directed Patient 1 to drive her car to the hospital parking lot across from his office and ride with him. Together they drove to a coffee shop. There, respondent spoke to her about her HPV diagnosis, telling her it was not serious, then went on to tell her she was strong and pretty, that he would be willing to have sex with her and to provide her with financial support in exchange for sex.

10. Patient 1 recalled becoming increasingly upset at the coffee shop because respondent continually pursued sexualized topics of conversation. She eventually demanded respondent drive her back to her car. There, after they entered the parking lot, Patient 1 stated respondent groped her breast and "wanted" to kiss her.

11. While they were at the coffee shop, Patient 1 stated she posted a picture of a cup of coffee on her Instagram account. After dropping off Patient 1 at her car,

respondent replied to the post, writing "nice" with a "yummy face" emoji followed by "May be [*sic*] you can advise me on mine . . . @ dr.arjangnaim." (Exh. 14, p. A105.) (@dr.arjangnaim is respondent's professional Instragram account.) Patient 1 replied "[n]o because you're unprofessional." (*Ibid.*) During her testimony, Patient 1 stated that she understood respondent's request to help her with his social media account was a request for her to refer her Instagram followers and friends to him. Her response - that no, she would not help him because he was unprofessional - was based on "what had happened between us..... [He] is not somebody that I would have referred my friends to. I thought he wasn't a conscientious person or a righteous person." (Exh. 33, p.A465.) Respondent did not respond to Patient 1's comment that he was unprofessional.

12. On October 18 and 19, 2021, Patient 1 and respondent exchanged several text messages. Patient 1 wrote she was not feeling well because her landlord was evicting her. (Exh. 13, p. A89.) In response, respondent asked where she planned to stay for the night and related questions. In several texted messages, he asked in various ways whether he could come get her and offered her a place to stay. Patient 1 did not accept respondent's offers or elaborate on her circumstances. During the same exchange, respondent offered to provide Patient 1 with medications to help her relax and directed her to come to his office so he could write her a prescription. (Exh. 13, pp. A93-A100.)

13. On October 28 and 29, 2021, Patient 1 and respondent again exchanged text messages. Patient 1 asked for pain medication to treat COVID symptoms. Respondent addressed Patient 1 as "my dear" and "Babe," included the "smiling face with hearts" emoji in his texts, and concluded by writing "I am here for you..... If you need anything, you have me." (Exh. 13, pp. A100-A103.)

14. On February 25, 2022, Patient 1 contacted respondent through Instagram's direct messages feature, requesting a copy of her medical records. Respondent responded with the records and added a message, a two pink hearts emoji, and a note that she looked "lovelier than ever." (Exh. 14, p. A108.)

COMPLAINANT'S EXPERT EVIDENCE

15. Gil Bender, M.D. served as complainant's expert witness. Dr. Bender graduated from Chicago Medical School in 1990. He completed his internship and a residency in OB/GYN at Pennsylvania Hospital, which is affiliated with the University of Pennsylvania. Dr. Bender was board-certified as an obstetrician-gynecologist in 1996 and has been recertified in the specialty every year since then. He is in private practice and serves as the medical director for an independent medical group, Regal Medical Group. He has also served as chair of the OB/GYN group at the hospital with which his practice is affiliated, Tarzana Hospital, where he sits on its medical executive committee. Hospital medical executive committees meet monthly to review any problematic issues that come up with patient care, including potential boundary violations. Prior to his affiliation with Tarzana Hospital, Dr. Bender had privileges at Downey Regional Medical Center, where he also served as OB/GYN chair and member of that hospital's medical executive committee.

16. Dr. Bender opined that the standard of care in all medical procedures an essential lesson of medical education beginning in medical school is to avoid boundary violations. Further, Dr. Bender opined that respecting boundaries is integrally related to providing adequate medical care and that crossing boundaries leaves already vulnerable and often uncomfortable patients with a burden that could interfere with receiving optimal care.

17. The Board retained Dr. Bender to review the investigation files for this case and, based on that review, he opined about whether respondent's conduct violated physician-patient. In forming his opinions, Dr. Bender relied on Patient 1's version of events. Dr. Bender opined that failing to have a chaperone present when performing a colposcopy, taking Patient 1 out for coffee, offering to pick Patient 1 up and help her find housing, and using heart emojis in his communications to her constituted extreme departures from the standard of care and jeopardized patient care.

18. Dr. Bender was asked why such actions violate the standard of care. He responded: "Because this is just blurring the relationship. The patient doesn't understand what is going on. She doesn't know if this is [of] a sexual nature or not. It is getting way beyond patient care and it's very confusing for the patient. And because she's in a very vulnerable position, it puts her in a bad place." (Exh. 34, pp. A600-A601.) Dr. Bender was also asked whether it matters if it is the patient who pursues the relationship. In response, he stated: "It doesn't matter. The physician is still responsible for keeping the appropriate physician-patient relationship in place. Even if it's started by the patient, even if the patient is very aggressive, it doesn't make a difference. The physician is still responsible to keep that relationship professional." (*Id.* at p. A601.)

Respondent's Evidence

19. Respondent denied ever examining Patient 1 without chaperones. He introduced the testimony of Tanya Marguia and Fahimeh "Vida" Shamspoor, both long-time medical aides in respondent's office, to corroborate his testimony. Ms. Shamspoor and Ms. Marguia both stated it was respondent's practice to have one of them serve as a chaperone when he performed colposcopies.

20. Neither Ms. Marguia nor Ms. Shamspoor could remember being present at Patient 1's examinations in October 2021, but both testified they believed one or the other had to have been there, consistent with office practice. Both also stated it was customary for the aide acting as chaperone to record her initials on the patients' charts however, for Patient 1, that had not been done.

21. Respondent denied going out for coffee with Patient 1 or ever assaulting her or making sexually related comments, including offering her money in exchange for sex. Regarding their exchange on Instagram, respondent stated he believed Patient 1's coffee cup post came up spontaneously on his own Instagram account as a result of the platform's algorithm matching his use of her phone number to his Instagram account and he chose to respond to it by way of encouragement of Patient 1's endeavors to become an influencer. Regarding her response, "you're not professional," respondent stated: "I did not know what that meant. I thought – I can tell you what I thought she meant. I thought maybe she said that she has a sugar – she had a baba-ghandi and I asked, is that a sugar daddy, maybe she was – she was unhappy about what I asked her. I don't know. I didn't know what she meant by this." (Exh. 35, p. A876.)

22. During his testimony, respondent stressed that by the second appointment, he began to suspect Patient 1 was unstable and unpredictable. He thus felt the need to communicate with her by text to document their interactions:

> I didn't have a very good vibe on this patient. Sometimes . . . . you just think that somebody is not stable, or . . . because . . . . as a physician, you see . . . many patients a day. And she – besides the fact that she was hysterical, dramatic, emotional, I didn't have a good vibe on her, and I wanted to

> get the text right and calling her to have a stamp of communication with her, to make sure that she might not go crazy and do something crazy. I was saying something, so I kind of insisted of (*sic*) texting her rather than calling her.

(Exh. 35, p. A878.)

23. Regarding his text exchanges about Patient 1's housing issues, respondent maintained he routinely assisted recent immigrants, especially fellow Iranian immigrants, as is Patient 1. Respondent further maintained his communications with Patient 1 and his offers to pick her up, bring her to a place she could stay and the like were all part of the kind of assistance he routinely offered in similar situations. Respondent also stated he works with two rabbis from an organization, Lev Center, and this organization specifically helps recent Iranian immigrants find housing.

24. Respondent offered corroborating evidence of this community work through the testimony of his wife, Karmen Javanizadeh. Ms. Javanizadeh stated she had a specific recollection of Patient 1 because respondent had come home the day he met her and told Ms. Javanizadeh he had a patient who claimed to be supported by a "baba-ghandi," or sugar daddy. According to Ms. Javanizadeh, when Patient 1 texted respondent about being evicted from her apartment, respondent showed her Patient 1's texts after taking care to block her name from Ms. Javanizadeh's sight. Ms. Javanizadeh recalled seeing the heart emojis in respondent's reply texts but did not comment on them to respondent.

25. Ms. Javanizadeh was asked whether she was familiar with respondent's exchange with Patient 1 on Instagram where he commented that Patient 1 looks

lovelier than ever. Ms. Javanizadeh responded she did not talk about that exchange with respondent but "giving compliments to the patients and you look lovely, that happens a lot of times between the physicians and patients." (Exh. 34, p. A757.)

26. Respondent maintained his use of endearments in the Farsi language, in particular "azzis" which translates to "dear," were common ways of addressing others within the Persian community. Regarding the one text where he called Patient 1 "Babe", respondent stated he was trying to write "Baba," another Farsi endearment and the texting program must have autocorrected to "Babe."

27. Respondent maintained he used the heart emoji to signify affection and wrote "you look lovelier than ever" to boost her morale as she was sending him sad face emojis and seemed down.

28. During the hearing, respondent stated he has made some changes in the wake of events with Patient 1. According to respondent, Patient 1's complaint: "definitely changed the way I approach or communicate with my patients, because as far as texting, as far as emojis, and then I will learn not to expose myself to any liability. And if anybody requesting any help, I would refer them off the bat, right, and not get involved with helping them, especially if somebody who might not be stable, but in general." (Exh. 35, p. A915.)

Character Evidence

29. Shahriar Safvati, M.D is board certified in family medicine and practices in Los Angeles. He testified at the hearing as a character witness on respondent's behalf. Dr. Safvati stated he has known respondent for over 15 years and routinely refers patients, including patients who are themselves physicians, to respondent. It is Dr. Safvati's experience that patients are very satisfied with respondent's services and he

has never received any negative feedback about respondent. He has some awareness of Patient 1's allegations against respondent, and finds them hard to reconcile with his own experience with respondent.

30. Shahrokh Kohanim, D.O. is board-certified in emergency medicine and works at Hollywood Presbyterian Hospital. He testified at the hearing as a character witness on respondent's behalf. Dr. Kohanim stated he has known respondent since 2003 or 2004 and interacts with him both socially and professionally when respondent comes to the emergency room to see an OB/GYN patient. Dr. Kohanim stated he has had multiple occasions to see respondent interact with patients in the emergency room and has found respondent to be consistently polite and patient and has never seen him do anything to make a patient feel uncomfortable. Dr. Kohanim is aware of Patient 1's allegations against respondent. Dr. Kohanim wrote a character reference letter consistent with his testimony. (Exh. F.)

31. Respondent introduced other character reference letters from: Social Worker Roya Senobarian; Dr. David Skinner, a general practitioner; Dr. David Razi, a pediatrician; a group letter from the staff at respondent's clinic; Professor Ana Farzindar, a computer science professor at the University of Southern California; Rabbis David and Levy Illulian, the rabbis respondent works with helping Iranians and others in need. These letters uniformly lauded respondent's skills and good works as a physician. They do not reflect knowledge of the allegations against him, however, and are therefore accorded little evidentiary weight.

Analysis

32. Because respondent flatly denies Patient 1's allegations regarding unchaperoned examinations and a meeting at a coffee shop, these allegations' veracity

is at issue. Respondent points to inconsistencies, vagueness, and mistakes in Patient 1's testimony in arguing that she is not a credible witness. Complainant points to the same factors to argue that, given the traumatic circumstances and passage of time, that Patient 1's testimony is not seamless actually buttresses her credibility. Further, complainant argued a lying witness would never admit to gaps in her memory, which Patient 1 did.

33. Complainant's argument in this respect is more convincing. Patient 1 is an imperfect witness; however, her inconsistencies are minor and her gaps in memory explainable by the nature of the events she described and the passage of time. Nonetheless, Patient 1's inconsistencies and uncertainty about two factual allegations set out in the Accusation, whether respondent examined her with a chaperone present and whether respondent tried to kiss her – she only testified he "wanted" to kiss her and did not elaborate on how she came to that conclusion - render the uncorroborated evidence for these allegations insufficient to meet the "clear and convincing" standard of proof applicable to this case.

34. Clear and convincing evidence established the second disputed allegation, that respondent took Patient 1 to a coffee shop where he repeatedly asked her intrusive questions about her private life. Reasonable inferences from respondent's own evidence corroborated her representations about whether respondent took Patient 1 to a coffee shop: First, the texts exchanged between respondent and Patient 1 before the appointment reflect that respondent was not concerned about fitting her between patients or even scheduling her appointment at a time certain. His open-ended invitation for her to come whenever she could and his repeated instructions that she park "in the back," supports a finding that he had no other patients and anticipated Patient 1 staying at the office after business hours. Second, that

respondent saw Patient 1's coffee cup Instagram post only by sheer algorithm happenstance is not believable. The coffee cup picture itself supports Patient 1's assertion that she and respondent had coffee together after her examination. As an "influencer" with followers, it would be standard practice for her to post about whatever she did that day. That respondent saw the post and made comments about it entirely unrelated to her medical care or his alleged interest in her life difficulties support a finding that he was following her Instagram account and believed their relationship had evolved to another level of intimacy consistent with having spent time together outside his clinic. Finally, when she calls him unprofessional, something that should surely have alarmed respondent given the many red flags she purportedly raised in his mind by the second visit, he did not respond at all. Respondent's failure to respond to such an accusation can be understood to be an "adoptive admission." (see Evid. Code § 1221), i.e., that a natural inference from his silence is respondent knew to what Patient 1 was referring when she called him unprofessional and he was not denying it.

35. During the hearing, respondent only further implicated himself when he attempted to explain his understanding of Patient 1's comment that he is unprofessional. Respondent surmised Patient 1's claim he was unprofessional stemmed from his questions about whether she had a baba-ghandi or sugar daddy. This is at least a partial admission to Patient 1's allegation that respondent asked how she supported herself and whether she had a sugar daddy. This probing into Patient 1's private life cannot be linked to any legitimate medical treatment or respondent's alternate explanation for the personal nature of his communications with Patient 1, that he wanted to extend a helping hand to a fellow immigrant.

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36. There is no factual dispute that many text and Instagram messages were exchanged between respondent and Patient 1 over the time they interacted. The only question is whether these communications are sexual in nature and as such, constitute boundary violations. Respondent's assertions that his communications were only intended to provide assistance and comfort to a patient sharing his heritage are belied by his repeatedly calling Patient 1 beautiful and lovelier than ever and his use of heart emojis, as well as the absence of any housing information commonly associated with giving the sort of help respondent purports to give. For instance, respondent never states he works with religious organizations that may be able to find housing for her and never mentions there is a backhouse on his property she may be able to stay in. Instead, respondent only (repeatedly) offers to come get Patient 1 without additional details and once, in a bizarre and truly alarming development, spontaneously offers her medication "to help [her] relax." These attributes support a finding that respondent's communications were sexual in nature and that he even attempted to use his access to prescription drugs as an enticement in his pursuit of a relationship with Patient 1.

37. Respondent's reliance on his shared heritage with Patient 1 and language patterns unique to the Farsi language to explain his use of endearments and patterns of communication with Patient 1 is unavailing. As a licensed physician, he is responsible for treating all patients, regardless of their country of origin, age, marital status etc, with the same adherence to professionalism and best medical practices. In this regard, respondent failed Patient 1. To the extent respondent continues to rationalize his behavior with references to cultural differences and similar excuses, he demonstrates significant lack of self-awareness and accountability. These characteristics raise concerns about his ability to safely practice medicine.

Costs

38. Complainant submitted as evidence of the costs of prosecution of this matter declarations of Deputy Attorney General Marsha A. Barr-Fernandez and supporting billing summary sheets. These documents reflect that the Department of Justice, Office of the Attorney General, billed the Board: $37,165 in prosecution costs through July 20, 2025. Complainant also submitted a Certification of Expert costs for record review and report writing for $2,800 and a Declaration of Investigative Activity with supporting documents reflecting the Board incurred $6,230.00 in investigation costs. The total costs incurred by the Board were $46,195. These costs are deemed reasonable.

LEGAL CONCLUSIONS

General Provisions

1. Pursuant to section 2004, the Board is responsible for enforcing the disciplinary and criminal provisions of the Medical Practice Act.

2. Section 2227 provides that licensees who violates the Medical Practice Act (commencing with section 2000) may have their license revoked, their right to practice suspended for a period not to exceed one year, be placed on probation and required to pay the costs of probation monitoring, be publicly reprimanded by the Board, or have such other action taken in relation to discipline as the Board deems proper.

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Burden and Standard of Proof

3. Complainant bears the burden of proof of establishing the alleged causes for discipline. (Evid. Code, § 500.) The standard of proof in an administrative action seeking to discipline a physician's certificate is clear and convincing evidence. (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856). Clear and convincing evidence requires a finding of high probability, or evidence so clear as to leave no substantial doubt; sufficiently strong evidence to command the unhesitating assent of every reasonable mind. (*Katie v. Superior Court* (2005) 130 Cal.App.4th 586, 594.)

Causes for Discipline

FIRST CAUSE FOR DISCIPLINE – UNPROFESSIONAL CONDUCT

4. As a first cause of discipline, complainant alleged respondent is subject to disciplinary action against his license for committing acts constituting unprofessional conduct in violation of section 2234, subdivision (a), a provision of the Medical Practice Act. Section 2234, subdivision (a), provides unprofessional conduct includes violating or attempting to violate "any provision of [the Medical Practice Act]." Section 2234, a provision of the Medical Practice Act, generally prohibits unprofessional conduct. Although it sets out enumerated conduct constituting unprofessional conduct, the provision states unprofessional conduct includes, but is not limited to, these exemplars.

5. In *Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564, the court addressed what constitutes general unprofessional conduct. In interpreting a former iteration of section 2234, section 2361, the court noted that while the provision does not limit unprofessional conduct to the enumerated conduct, it must be "conduct

which indicates an unfitness to practice medicine." (*Shea*, at p. 575 [citations omitted].) The court went on to define the term as "conduct which breaches the rules or ethical code of a profession, or conduct which is unbecoming a member in good standing of a profession." (*Ibid.* [citations omitted.]

6. Complainant cited AMA Code of Ethics Opinion 1.2.4, which addresses chaperones, and Code of Ethics Opinion 9.1.3, which addresses sexual harassment in the practice of medicine, as of particular relevance to this case. As complainant's allegations regarding chaperones were not established, Code of Ethics Opinion 1.2.4 has not been considered. Code of Ethics Opinion 9.1.3 defines sexual practice in the practice of medicine as "unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature." (Exh. 22, p. A235.) Opinion 9.1.2 goes on to state that sexual harassment in the practice of medicine is unethical, exploitive, and harms patient care. (*Ibid.*)

7. The American College and Obstetricians and Gynecologists Opinion Number 796 (Opinion 796) addresses sexual misconduct in the course of the practice of obstetrics and gynecology. It is particularly instructive in explaining the potential harm from even ambiguous or indirect sexual advances:

> The practice of obstetrics and gynecology includes interactions in times of intense emotion and vulnerability for patients and involves sensitive physical examinations and medically necessary disclosure of private information about symptoms and experiences. The patient-physician relationship is damaged when there is either confusion regarding professional roles and behavior or clear lack of integrity that allows sexual exploitation and harm. Sexual

> misconduct by physicians is an abuse of professional power and a violation of patient trust.

(Exh. 23, p. A236.)

8. Opinion 796 addresses the importance of maintaining appropriate boundaries, noting:

> Regardless of intent, any clinical or nonclinical contact with a patient that may be perceived as a romantic or sexual overture should be avoided. For example, clinical evaluation of a patient outside of a usual clinical setting may blur the boundaries between professional and nonprofessional and therefore is discouraged; however, exceptions may include emergency care or medically indicated home visit[s]. Likewise, obstetrician-gynecologists should strictly avoid sexual innuendo, sexually suggestive humor, and sexually provocative remarks in clinical settings. Nonclinical communications with current patients, including interactions by telephone, e-mail, text-messaging, or social media, should be approached with caution, and professional boundaries should be maintained at all times.

(Exh. 23, p. A239.)

9. Respondent argued ethical standards are not laws created by the legislature and therefore cannot be enforced through a Board disciplinary proceeding. Until the Legislature "speaks" by making ethics code provisions a part of the Medical Practice Act, disciplinary actions cannot be based on ethics code violations.

Respondent's argument is not persuasive. It is the Legislature which crafted an unprofessional conduct provision that expressly avoids an inclusive list of behavior constituting unprofessional conduct. The *Shea* case calls out professional association codes as a source to evaluate whether specific instances of misconduct constitute general unprofessional misconduct. Throughout future iterations of the Medical Practices Act's unprofessional conduct provision since the *Shea* case was published nearly 50 years ago, the non-inclusive list of exemplars remains a defining feature of the provision. *Shea* defines otherwise undefined unprofessional conduct as ethics code violations or the arguably even more ephemeral "conduct becoming." The Legislature has not disturbed the statutory structure underlying *Shea's* interpretation.

10. Clear and convincing evidence established respondent's actions directly implicated and violated the standards set out in the ethics provisions cited by complainant, thereby violating the general unprofessional conduct provision. Respondent's behavior involved inappropriate, sexualized conduct that has no place in the physician-patient relationship and, in the process, blurred relationship lines and endangered patient care.

SECOND AND THIRD CAUSES FOR DISCIPLINE – GROSS AND SIMPLE NEGLIGENCE

11. Gross negligence is "the want of even scant care or an extreme departure from the ordinary standard of care." (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3rd 1040, 1052.) Simple negligence is merely a departure from the standard of care. (*Id.* at 1054.)

12. Complainant proved by clear and convincing evidence that respondent took Patient 1 out for coffee, sent her inappropriate texts and messages including

using heart emojis, used endearments in his communications to her, and offered to pick her up and find her housing. According to Dr. Bender, such conduct constituted extreme departures from the standard of care. His uncontroverted opinions are persuasive. Clear and convincing evidence therefore established respondent committed gross negligence and repeated acts of simple negligence in the course and aftermath of treating Patient 1.

Disposition

13. When exercising its disciplinary authority, the Board is required to give the highest priority to protecting the public as well as to measures to correct the licensee's "demonstrated deficiencies in competency." (§ 2229, subds. (a) & (c).) In addition, the Board "shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee." (*Id.* at subd. (b).) In this sense, the discretion to punish licensees is not unfettered but must be structured to fit within the legislative strictures of the applicable legal provisions.

14. Regulation section 1361, subdivision (a) provides "In reaching a decision on a disciplinary action . . . the [Board] shall consider the disciplinary guidelines entitled "Manual of Model Disciplinary Orders and Disciplinary Guidelines" (12th Edition, 2016) (Guidelines) which provides in part:

> Absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake Board-ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the Board . . . will follow the guidelines, including those imposing

> suspensions. Any proposed decision . . . that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

15. Under the Guidelines, the minimum penalty for violations of section 2234 is stayed revocation and five years' probation with appropriate terms and conditions. The maximum penalty for these violations is license revocation.

16. Here, respondent has not demonstrated any of the factors supporting a deviation from the Guidelines such as early acceptance of responsibility or a willingness to undertake Board-ordered rehabilitation. Further, although the incidents giving rise to the discipline occurred four years ago, a substantial amount of time, respondent's rationales for his actions suggest an ongoing attitude that make recidivism not out of the question. Still, as nothing in the record indicates there have been any similar complaints or disciplinary actions and the Medical Board's statutory schema stresses rehabilitative discipline whenever possible, outright revocation of respondent's license is not appropriate. A lengthy period of probation with appropriate, tailored terms and conditions will give respondent the opportunity to address his deficiencies in understanding boundaries, appropriate professional judgment, and ethics while keeping the public safe.

Costs

17. Pursuant to Business and Professions Code section 125.3, complainant is entitled to recover reasonable costs of investigation and enforcement of this matter in the amount of $46,195. Under *Zuckerman v. State Board of Chiropractic Examiners* (2002) 20 Cal.4th 32, 45, the Board must exercise its discretion to reduce or eliminate cost awards in a manner which will ensure that the cost award statutes do not deter

licensees with potentially meritorious claims or defenses from exercising their right to a hearing. "Thus, the Board may not assess the full costs of investigation and prosecution when to do so will unfairly penalize a [licensee] who has committed some misconduct, but who has used the hearing process to obtain dismissal of other charges or a reduction in the severity of the discipline imposed." (*Ibid.*) The Board, in imposing costs in such situations, must consider the licensee's subjective good faith belief in the merits of his or her position and whether the licensee has raised a colorable defense. The Board must also consider the licensee's ability to make payment.

18. Here, respondent used the hearing process to reduce the number of proven factual allegations made by complainant and to avoid the most serious disciplinary consequence. Under these circumstances, the cost award to the Board is reduced to $35,000.

ORDER

Certificate Number A 74735 issued to respondent Arjang Naim, M.D., is revoked based on determinations of the first, second, and third causes for discipline separately and for all of them. However, revocation is stayed and respondent's certificate 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 programs or courses which shall not be less than 40 hours per year, for each year of probation. The education programs or courses shall be aimed at correcting any areas of deficient practice or knowledge and

shall be Category 1 certified. The educational programs and courses shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for license renewal. 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 attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

2. Professionalism Program (Ethics Course). Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358.1. Respondent shall participate in, and successfully complete, that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but not later than one year after attending the classroom component. The professionalism program shall be at respondent's expense and shall be in addition to the CME requirements for licensure renewal.

A professionalism program 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 program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

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

3. Professional Boundaries Program. Within 60 calendar days from the effective date of this Decision, respondent shall enroll in a professional boundaries program approved in advance by the Board or its designee. Respondent, at the program's discretion, shall undergo and complete the program's assessment of respondent's competency, mental health, and/or neuropsychological performance, and at a minimum, a 24 hour program of interactive education and training in the area of boundaries, which take into account data obtained from the assessment and from the Decision, Accusation, and any other information that the Board or its designee deems relevant. The program shall evaluate respondent at the end of the training and the program shall provide any data from the assessment and training as well as the results of the evaluation to the Board or its designee.

Failure to complete the entire program not later than six months after the respondent's initial enrollment shall constitute a violation of probation unless the Board or its designee agrees in writing to a later time for completion. Based on respondent's performance in and evaluations from the assessment, education, and training, the program shall advise the Board or its designee of its recommendation(s) for additional education, training, psychotherapy and other measures necessary to ensure that respondent can practice medicine safely. Respondent shall comply with program recommendations. At the completion of the program, respondent shall submit to a final evaluation. The program shall provide the results of the evaluation to the Board or its designee.

The professional boundaries program shall be at respondent's expense and shall be in addition to the CME requirements for license renewal. The program has the authority to determine whether or not respondent successfully completed the program.

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A professional boundaries 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 not practice medicine until after he has successfully completed the program and has been so notified by the Board or its designee in writing.

4. Third party chaperone. During probation, respondent shall have a third party chaperone present while consulting, examining or treating patients. Respondent shall, within 30 calendar days of the effective date of the Decision, submit to the Board or its designee for prior approval name(s) of persons who will act as the third party chaperone. If respondent fails to obtain approval of a third party chaperone within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a chaperone is approved to provide monitoring responsibility. Each third party chaperone shall sign (in ink or electronically) and date each patient medical record at the time the chaperone's services are provided. Each third party chaperone shall read the Decision(s) and the Accusation(s), and fully understand the role of the third party chaperone. Respondent shall maintain a log of all patients seen for whom a third party chaperone is required. The log shall contain the: 1) patient initials, address and telephone number; 2) medical record number; and 3) date of service. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term

of probation. Respondent is prohibited from terminating employment of a Board-approved third party chaperone solely because that person provided information as required to the Board or its designee. If the third party chaperone resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name of the person(s) who will act as the third party chaperone. If respondent fails to obtain approval of a replacement chaperone within 30 calendar days of the resignation or unavailability of the chaperone, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement chaperone is approved and assumes monitoring responsibility. Respondent shall provide written notification to respondent's patients that a third party chaperone shall be present during all consultations, examination, or treatment with patients. Respondent shall maintain in the patient's file a copy of the written notification, shall make the notification available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the notification for the entire term of probation.

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

6. Supervision of Physicians 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, all rules governing the practice of medicine in California and 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. Address Changes Respondent shall, at all times, keep the Board informed of respondent's business and residence addresses, email address, 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(b).

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

License Renewal. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California. Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days. In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

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 as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice. In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent

shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine. Respondent's period of non-practice while on probation shall not exceed two (2) years. Periods of non-practice will not apply to the reduction of the probationary term. Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; and Quarterly Declarations.

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 or her license. The Board reserves the right to evaluate respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Board or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

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.

16. Investigation and Enforcement Costs. Within six months of the effective date of this Decision, respondent shall pay to the Board its investigation and enforcement costs associated with the prosecution of this matter in the amount of $35,000.

DATE: 10/31/2025

Deena R. Ghaly
Deena R. Ghaly (Oct 31, 2025 12:15:56 PDT)

DEENA R. GHALY
Administrative Law Judge
Office of Administrative Hearings