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

In the Matter of the Accusation Against Roya Elia Dardashti, M.D. Physician's and Surgeon's License No. G83432 Respondent.	Case No. 800-2016-026320

DECISION

The attached Stipulated Settlement and Disciplinary Order 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 October 8, 2020.

IT IS SO ORDERED: September 8, 2020.

MEDICAL BOARD OF CALIFORNIA

Ronald H. Lewis, M.D., Chair
Panel A

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General
VLADIMIR SHALKEVICH
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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ROYA ELIA DARDASHTI, M.D.** **16250 Ventura Blvd., Suite 345** **Encino, CA 91436** **Physician's and Surgeon's Certificate No. G 83432** Respondent.	Case No. 800-2016-026320 OAH No. 2019100196 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

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

PARTIES

1. Christine J. Lally (Complainant) is the Interim Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Vladimir Shalkevich, Deputy Attorney General.

2. Respondent Roya Elia Dardashti, M.D. (Respondent) is represented in this proceeding by attorney Georgeann Hunter Nicol, Esq., whose address is: 10063 Riverside Drive, Unit 2304, Toluca Lake, CA 91610.

3. On or about October 16, 1996, the Board issued Physician's and Surgeon's Certificate No. G 83432 to Roya Elia Dardashti, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2016-026320, and will expire on February 28, 2022, unless renewed.

JURISDICTION

4. Accusation No. 800-2016-026320 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on August 8, 2019. Respondent timely filed her Notice of Defense contesting the Accusation. A copy of Accusation No. 800-2016-026320 is attached as exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2016-026320. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

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

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

CULPABILITY

8. Respondent admits the truth of each and every charge and allegation in Accusation No. 800-2016-026320.

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9. Respondent agrees that her Physician's and Surgeon's Certificate is subject to discipline and she agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

10. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or her counsel. By signing the stipulation, Respondent understands and agrees that she may not withdraw her agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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

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

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. G 83432 issued to Respondent ROYA ELIA DARDASHTI, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for seven (7) years on 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 during each year of probation.

2. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (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. 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 (6) months after Respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

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 successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

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

The program shall consist of a comprehensive assessment of Respondent's physical and mental health and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to Respondent's current or intended area of practice. The program shall take into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require Respondent's on-site participation for a minimum of three (3) and no more than five (5) days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence

assessment program.

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

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

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

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

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall

make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

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

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

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

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

6. PROHIBITED PRACTICE. During probation, Respondent is prohibited from performing any surgical procedure without the presence and participation of an anesthesiologist.

After the effective date of this Decision, all patients being treated by the Respondent shall be notified that the Respondent is prohibited from performing any surgical procedure without the presence and participation of an anesthesiologist. Any new patients must be provided this notification at the time of their initial appointment.

Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; 2) patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. 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.

7. MALPRACTICE LIABILITY COVERAGE. At all times during the period of probation, Respondent shall maintain a policy of liability insurance that is in compliance with Business and Professions Code section 2216.2. Respondent shall provide evidence of malpractice liability coverage on a quarterly basis in conjunction with compliance with condition 11 hereof, or upon demand made by the Board or its designee. If, during the period of probation, Respondent's malpractice liability insurance coverage lapses for any reason, Respondent shall be notified by the Board to cease performing surgical procedures outside of a general acute care hospital. Upon receipt of such a notification, Respondent shall cease performing surgical procedures outside of a general acute care hospital, until Respondent's malpractice liability insurance coverage is restored and verified by the Board or its designee. Respondent shall provide to the Board or its designee the evidence of restored malpractice liability coverage in compliance with Business and Professions Code section 2216.2. The Board or its designee shall verify said liability coverage with the insurer. Upon verification of liability coverage, and delivery of the written notice of acceptance of the proof of coverage to Respondent, Respondent may resume performing surgical procedures outside of a general acute care hospital. The acceptance of the proof of coverage shall be in the sole discretion of the Board or its designee.

8. 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.

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

10. 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.

11. 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.

12. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

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

13. 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.

14. 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 Boards'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, if applicable: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

15. 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.

16. 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.

17. 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.

18. 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.

ACCEPTANCE

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

DATED: 03/10/2020

ROYA ELIA DARDASHTI, M.D.
Respondent

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

DATED: 3/10/2020

GEORGEANN HUNTER NICOL, ESQ.
Attorney for Respondent

ENDORSEMENT

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

DATED: 3/11/20

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
JUDITH T. ALVARADO
Supervising Deputy Attorney General

VLADIMIR SHALKEVICH
Deputy Attorney General
Attorneys for Complainant

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO AUGUST 8 2019
BY ANDREA GERMAN ANALYST

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

In the Matter of the Accusation Against: ROYA ELIA DARDASHTI, M.D. 16250 Ventura Boulevard, Suite 345 Encino, California 91436 Physician's and Surgeon's Certificate No. G 83432, Respondent.	Case No. 800-2016-026320 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California (Board).

2. On October 16, 1996, the Board issued Physician's and Surgeon's Certificate Number G 83432 to Roya Elia Dardashti, M.D. (Respondent). That license was in full force and effect at all times relevant to the charges brought herein and will expire on February 29, 2020, unless renewed.

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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 unless otherwise indicated.

4. Section 2227 of the Code provides:

(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

(1) Have his or her license revoked upon order of the board.

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

5. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

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

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

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

7. Section 2216 of the Code, states, in pertinent part:

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

8. Section 2216.2 of the Code states, in pertinent part:

(a) It is unprofessional conduct for a physician and surgeon to fail to provide adequate security by liability insurance, or by participation in an interindemnity trust, for claims by patients arising out of surgical procedures performed outside of a general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code.

9. Section 2259.8 of the Code states:

"(a) Notwithstanding any other provision of law, an elective cosmetic surgery procedure may not be performed on a patient unless the patient has received, within 30 days prior to the elective cosmetic surgery procedure, and confirmed as up-to-date on the day of the procedure, an appropriate physical examination by, and written clearance for the procedure from, any of the following:

"(1) The physician and surgeon who will be performing the surgery.

"(2) Another licensed physician and surgeon.

"(3) A certified nurse practitioner, in accordance with a certified nurse practitioner's scope of practice, unless limited by protocols or a delegation agreement.

"(4) A licensed physician assistant, in accordance with a licensed physician assistant's scope of practice, unless limited by protocols or a delegation agreement.

"(b) The physical examination described in subdivision (a) shall include the taking of an appropriate medical history.

"(c) An appropriate medical history and physical examination done on the day of the procedure shall be presumed to be in compliance with subdivisions (a) and (b).

"(d) "Elective cosmetic surgery" means an elective surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance, including, but not limited to, liposuction and elective facial cosmetic surgery.

"(e) Section 2314 shall not apply to this section."

10. Health and Safety Code section 1248, states in pertinent part:

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

11. Health and Safety Code section 1248.1 states:

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

"(a) An ambulatory surgical center that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act.

"(b) Any clinic conducted, maintained, or operated by a federally recognized Indian tribe or tribal organization, as defined in Section 450 or 1601 of Title 25 of the United States Code, and located on land recognized as tribal land by the federal government.

"(c) Any clinic directly conducted, maintained, or operated by the United States or by any of its departments, officers, or agencies.

"(d) Any primary care clinic licensed under subdivision (a) and any surgical clinic licensed under subdivision (b) of Section 1204.

"(e) Any health facility licensed as a general acute care hospital under Chapter 2 (commencing with Section 1250).

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"(f) Any outpatient setting to the extent that it is used by a dentist or physician and surgeon in compliance with Article 2.7 (commencing with Section 1646) or Article 2.8 (commencing with Section 1647) of Chapter 4 of Division 2 of the Business and Professions Code.

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

"(h) A setting, including, but not limited to, a mobile van, in which equipment is used to treat patients admitted to a facility described in subdivision (a), (d), or (e), and in which the procedures performed are staffed by the medical staff of, or other healthcare practitioners with clinical privileges at, the facility and are subject to the peer review process of the facility but which setting is not a part of a facility described in subdivision (a), (d), or (e).

Nothing in this section shall relieve an association, corporation, firm, partnership, or person from complying with all other provisions of law that are otherwise applicable.

12. Health and Safety Code section 1248.65 states:

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

FACTUAL ALLEGATIONS

13. At all times relevant to the allegations herein, Respondent has owned and operated a business called Diamond Surgical Institute, located at 16250 Ventura Boulevard, Suite 345, in Encino, California. Diamond Surgical Institute is also known as Diamond Surgical Institute, Inc., and Diamond Surgery Center. Diamond Surgical Institute is an "outpatient setting" as defined by Health and Safety Code section 1248. At no time relevant to the allegations herein was Diamond Surgical Institute accredited, pursuant to the provisions of Health and Safety Code section 1248 et. seq. At no time relevant to the allegations herein did Diamond Surgical Institute fall under any exception specified in Health and Safety Code section 1248.1. Because of this lack of accreditation, it was unlawful for Respondent, while performing surgery at Diamond Surgical Institute, to administer anesthesia in doses that, when administered, have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes. Respondent carried no malpractice insurance and did not participate in interindemnity trust, for claims by

patients arising out of surgical procedures performed outside of a general acute care hospital at the time relevant to the allegations herein.

PATIENT 1

14. Patient 1 underwent cosmetic surgery by Respondent in 2006, at Encino Surgical Medical Center. Seeking additional cosmetic surgery, she returned to see Respondent on March 7, 2014, this time at Diamond Surgical Institute. She was approximately 40 years old at the time of the second surgery. On about March 7, 2014 she filled out Respondent's registration form in Spanish, indicating no medical problems other than that she experienced headaches. Respondent prepared an abbreviated hand-written and barely-legible progress note dated March 7, 2014. Her weight was recorded as 179 lbs during that visit. Respondent later told Medical Board investigators that she used her office manager to translate her interactions with Patient 1, but the fact that a translator was used on March 7, 2014, or at any other time, was not documented in Respondent's records.

15. During her March 7, 2014 appointment, Patient 1 gave blood for a pre-operative complete blood count (CBC), prothrombin time (PT) and partial thromboplastin time (PTT) tests, all of which were normal. However, Respondent did not perform and did not document any other pre-operative laboratory studies that are required by the standard of care, specifically, a Comprehensive Metabolic Panel (CMP), or a chemistry/metabolic panel. Had she done so, Respondent might have been made aware that Patient 1 suffered from health conditions, including uncontrolled diabetes, that may have made Patient 1 an unsuitable candidate for surgery. On March 7, 2014, Patient 1 was also given prescriptions dated March 6, 2014 for Flexeril, Keflex and Percocet.

16. On or about March 13, 2014, Respondent performed liposuction of the abdomen, back, flanks, breast tails, thighs and knees on Patient 1, at Diamond Surgical Institute. On that date Respondent prepared a document she titled "Operative Note," which in its substance was a history and physical form. Respondent recorded a single set of Patient 1's vital signs that included temperature, heart rate, blood pressure and oxygen saturation. The time when these vital signs were taken was not recorded. During her interview with the Board's investigators,

Respondent claimed that during the surgery she watched Patient 1's heart monitor. However, Respondent did not monitor Patient 1's other vital signs and did not make any record of what Patient 1's vital signs were during the two and a half to three hour surgery. During the post-surgical recovery period, Respondent did not monitor and/or made no record of Patient 1's vital signs either.

17. Respondent did not record the patient's weight on March 13, 2014, though Patient 1's weight during the pre-op visit on March 7, 2014 was recorded as 179 lbs. According to the typed operative report, dated March 12, 2014, Patient 1 received 5000 cc of tumescent anesthetic fluid containing 100 cc of Lidocaine 1% plus 1 cc of Epinephrine 1:1000 per liter. If this notation is accurate, the patient received 5000 mg of Lidocaine in the tumescent fluid. Respondent made no record of dosage of Lidocaine as mg/kg of body weight in the operative report, but if Respondent's record entries are correct and the patient's weight remained 179 pounds, the total dose of lidocaine Patient 1 received was potentially toxic and life threatening, at 61.46 mg/kg. The total volume of aspirate was recorded as 5600 cc.

18. During her interview with the Board's investigators Respondent stated that following the surgery Patient 1 was discharged to the care of her boyfriend. There is no documentation of this in the patient's records. Respondent's records do not contain post-operative instructions that advised the patient to ambulate with assistance after she returned home from the surgery. The record also does not contain any information indicating that the patient was contacted by Respondent or by her staff after the operation on March 13, 2014 and before her March 18, 2014, post-operative appointment.

19. Respondent saw Patient 1 for a post-operative appointment on March 18, 2014. The patient presented with severe edema and moderate bruising on upper and lower body, and complained of being uncomfortable, despite wearing a full body compression garment. During her interview with Board investigators, Respondent stated that "when you're putting the garment on it's basically just more of a security blanket than anything else. And the garment is not that tight to begin with. So it is not going to withhold any of the severe swelling."

20. No record notation indicates whether the patient had any difficulty ambulating. Respondent told the Board's investigators that she checked the patient's blood pressure during this post-operative appointment, but she did not record it. Respondent did not weigh the patient. Respondent's hand-written note is illegible and difficult to read, and indicates that the patient was feeling better with decreased pain. During Patient 1's post-operative appointment on March 18, 2014, Respondent advised her to continue antibiotics, and prescribed her Lasix and KDur, a potassium supplement, for swelling. Respondent did not check for Homan's sign, but told the Board investigators during her interview that the patient had no tenderness in her calves, though this fact was not recorded in the medical records.

21. On March 28, 2014 Patient 1 felt short of breath and called 911. Paramedics arrived and found her in respiratory arrest. She was taken to an emergency room at St. Francis Medical Center in Lynwood, California, where she was admitted to the ICU in hypotensive shock. Despite efforts to save her, Patient 1 was pronounced dead due to sequelae of a pulmonary embolism due to deep vein thrombosis in the left leg, at 8:42 a.m. on March 29, 2014.

PATIENT 2

22. Patient 2, a 42- year-old female, consulted with Respondent on November 20, 2015 for liposuction. On the Health History Questionnaire, she stated that she was in good health, and had no medical problems, though she did check the questionnaire form to indicate that she had headaches. Patient 2's surgical history was significant for two prior C-sections, the most recent one having taken place in June, 2015. On her intake information, she indicated that she was not allergic to any medications, nor was she taking any routine medications. She was quoted for liposuction of the back, flanks, posterior thighs and full abdominoplasty.

23. During her appointment on November 20, 2015, Respondent obtained and recorded an illegible history and physical in her handwriting. Respondent noted that Patient 2 had breastfed both of her children for six months, but did not inquire and did not record whether Patient 2 was still breastfeeding the child she delivered in June 2015. The patient was taking multivitamins and birth control pills. She admitted drinking alcohol occasionally, and denied illicit drug and tobacco use. On examination, Respondent noted feeling no masses in the

patient's breast, and noted Patient 2's chest measurements. Respondent noted upper body with severe lipodystrophy of the upper and lower abdomen, bilateral flanks, mid-back and low back; severe upper and lower abdominal skin laxity; muscle diastasis and mild panniculus. Respondent's diagnosis was bilateral mammary ptosis and abdominal wall laxity and lipodystrophy. Respondent's plan was to complete a mammogram and to perform a full abdominoplasty with liposuction of the bilateral flanks, mid back and low back. Respondent also planned to perform bilateral mastopexies, which the patient deferred at the time. Respondent's examination was limited to the areas of interest, and did not include a medical examination, including heart or lungs.

24. Patient 2 returned to see Respondent on November 24, 2015. On this date, she was quoted $5,500 for liposuction of the back, flanks, posterior thighs and full abdominoplasty, plus fat harvesting. Respondent gave Patient 2 undated prescriptions for Keflex, Percocet and Flexeril.

25. Patient 2 gave blood for a pre-operative complete blood count (CBC), prothrombin time (PT) and partial thromboplastin time (PTT) tests, all of which were normal. The patient also had a negative pregnancy test. The dates on these laboratory results show that the samples tested were collected on November 15, 2015, before Respondent saw Patient 2, and were reported on November 25, 2015. Respondent did not perform and did not document any other pre-operative laboratory studies that were required by the standard of care, specifically, a Comprehensive Metabolic Panel (CMP), or a chemistry/metabolic panel. Respondent did not perform and did not document a chest x-ray or an EKG and did not examine the patient's heart or lungs.

26. On or about December 7, 2015, Respondent performed a full abdominoplasty with umbilical transposition, liposuction of bilateral flanks, mid back and low back, as well as fat harvesting, on Patient 2. The patient was provided with discharge instruction before the operation, which did not include instructions for drain care or monitoring the drain output. The patient was instructed to return for post-surgical exam four days after the operation.

27. Pre-operatively, Respondent recorded a single set of the patient's vital signs, before she gave Patient 2 a total of 10 mg of Versed[1] by administering two intramuscular injections 15 minutes apart, followed by a total of .25 mg of Fentanyl[2], administered in two intramuscular injections, 10 minutes apart. This was even though Respondent was, or should have been, aware of the variable absorption of Versed and Fentanyl when given intramuscularly, and that Versed acts synergistically with fentanyl. At the doses administered to Patient 2, this combination of Versed and fentanyl had the probability of placing a patient at risk for loss of life-preserving protective reflexes, and should not have been administered at an unaccredited surgical center. After administering sedation, Respondent left the operating room to scrub. When she returned, Respondent administered several subcutaneous injections "in the upper body regions," amounting to 10 cc of lidocaine, to numb the areas of incisions. During her interview with the Board investigators, Respondent clarified, that these injections were in the patient's flanks and superior umbilical region.

28. The liposuction portion of the surgery involved infiltration of 3000 cc's of tumescent fluid, each liter of which contained lidocaine 1000 mg and epinephrine 1 mg. The total aspirate of fluid and fat was recorded as 1000 cc, containing 300 cc of fat, and estimated blood loss was recorded as 50 cc. The liposuction was followed by a full abdominoplasty.

29. Respondent and her surgical tech monitored the patient's blood pressure, heart rate, temperature and oxygenation, but not CO2 levels, during the surgery. No record of any of the patient's vital signs was made during the surgery. There was no RN or LVN monitoring the patient at any time. At the conclusion of the surgery, Respondent administered 5000 units of Heparin subcutaneously, broke scrub and left the operating room to see another patient, while her surgical tech remained alone with the patient to apply steri-strips and dressings. Shortly thereafter, Respondent was summoned back to the operating room by her office manager, because the patient stopped breathing.

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[1] Versed is a brand name for midazolam, a benzodiazepine sedative that causes relaxation, sleepiness and operative amnesia.

[2] Fentanyl is a potent synthetic opioid.

30. Respondent immediately returned to the operating room and discovered that the patient was not breathing and had no pulse. 911 was called as Respondent began chest compressions, while the surgical tech ventilated the patient with an ambu bag and oxygen. Respondent did not administer any medications to the patient.

31. Paramedics arrived approximately five minutes after the 911 call was made. When the paramedics arrived, the patient was in asystole. CPR was begun and she was given two rounds of epinephrine. She initially had PEA (pulseless electrical activity), and then a pulse and blood pressure were established. She was brought to Encino Hospital Emergency Department.

32. The patient was placed in ICU, where she remained on life support and unresponsive. Neurological examinations at the hospital determined that Patient 2 suffered irreversible loss of brain function and, subsequently, she was pronounced dead on or about December 9, 2015.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence – Both Patients)

33. Respondent Roya Elia Dardashti, M.D. is subject to disciplinary action under Business and Professions Code section 2234, subdivision (b) in that she committed multiple acts of gross negligence. The circumstances are as follows:

34. Allegations of paragraphs 13 through 32 are incorporated herein by reference.

35. Each of the following, whether taken together or separately, constitutes an act of gross negligence:

a) Respondent's failure to obtain a pre-operative Comprehensive Metabolic Panel (CMP), or a chemistry/metabolic panel and an EKG for Patient 1 was an extreme departure from the standard of care.

b) Respondent's failure to record operative vital signs during Patient 1's surgery was an extreme departure from the standard of care.

c) Respondent's dosing of lidocaine tumescent solution for Patient 1 was an extreme departure from the standard of care.

d) Respondent's failure to adequately follow up with Patient 1 prior to her post-operative appointment was an extreme departure from the standard of care.

e) Respondent's treatment of Patient 1's post-operative edema was an extreme departure from the standard of care.

f) Respondent's failure to obtain a pre-operative Comprehensive Metabolic Panel (CMP), or a chemistry/metabolic panel and EKG for Patient 2 was an extreme departure from the standard of care.

g) Respondent's failure to record operative vital signs during Patient 2's surgery was an extreme departure from the standard of care.

h) Respondent's administering Versed and Fentanyl to Patient 2 in the manner alleged herein was an extreme departure from the standard of care.

i) Respondent's failure to plan an adequate follow up with Patient 1 by providing inadequate post-operative instructions was an extreme departure from the standard of care.

j) Respondent's administration of a combination of Versed and Fentanyl, in a dose that was probable to induce the loss of protective reflexes, at a non-accredited surgery center, was an extreme departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts – Both Patients)

36. Respondent Roya Elia Dardashti, M.D. is subject to disciplinary action under Business and Professions Code section 2234, subdivision (c), in that she committed repeated acts of negligence. The circumstances are as follows:

37. The allegations of paragraphs 13 through 32 and paragraph 35 are incorporated herein by reference.

38. In addition to the departures from the standard of care described in paragraph 35, each of the following was a departure from the standard of care:

(a) Respondent's record keeping with regard to the care and treatment she rendered to Patient 1 was a departure from the standard of care; and

(b) Respondent's record keeping with regard to the care and treatment she rendered to Patient 2 was a departure from the standard of care.

THIRD CAUSE FOR DISCIPLINE

(Failure to Perform an Appropriate Physical Examination and Obtain a Written Clearance for Elective Cosmetic Procedures – Both Patients)

39. Respondent Roya Elia Dardashti, M.D. is subject to disciplinary action under Business and Professions Code section 2259.8 because she performed elective cosmetic surgery procedures for two patients without an appropriate physical examination and appropriate history, and failed to obtain a written clearance for the procedures. The circumstances are as follows:

40. Allegations of paragraphs 13 through 32 are incorporated herein by reference.

FOURTH CAUSE FOR DISCIPLINE

(Administering Anesthesia at an Unaccredited Setting – Patient 2)

41. Respondent Roya Elia Dardashti, M.D. is subject to disciplinary action under Business and Professions Code section 2216 and Health and Safety Code section 1248.65 in that she administered a combination of Versed and fentanyl to Patient 2, in a dose that had the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes, at an unaccredited outpatient setting. The circumstances are as follows:

42. Allegations of paragraphs 13 and 21 through 32 are incorporated herein by reference.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Provide Adequate Security – Both Patients)

43. Respondent Roya Elia Dardashti, M.D. is subject to disciplinary action under Business and Professions Code section 2216.2 in that she failed to provide adequate security by liability insurance, or by participation in an interindemnity trust, for claims by patients arising out of surgical procedures performed outside of a general acute care hospital. The circumstances are as follows:

44. Allegations of paragraphs 13 through 32 are incorporated herein by reference.

SIXTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records – Both Patients)

45. Respondent Roya Elia Dardashti, M.D. is subject to disciplinary action under Code Business and Professions Code section 2266 in that she failed to maintain adequate and accurate

medical records in the care and treatment of patients Patient 1 and Patient 2. The circumstances are as follows:

46. The allegations of paragraphs 11 through 30 are incorporated herein by reference.

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 G 83432, issued to Roya Elia Dardashti, M.D.;

2. Revoking, suspending or denying approval of her authority to supervise physician assistants and advanced practice nurses;

3. If placed on probation, ordering her to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: August 8, 2019

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

Complainant

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