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

In the Matter of the First Amended Accusation Against:	)	
Arjang Naim, M.D.	)	Case No. 800-2016-021723
Physician's and Surgeon's Certificate No. A 74735	)	
Respondent	)	

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 November 9, 2018.

IT IS SO ORDERED: October 10, 2018.

MEDICAL BOARD OF CALIFORNIA

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

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

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

In the Matter of the First Amended Accusation Against: ARJANG NAIM, M.D. 1407 North Vermont Ave., Suite A Los Angeles, California 90027 Physician's and Surgeon's Certificate No. A 74735, Respondent.	Case Nos. 800-2016-021723; 800-2018-042780 OAH No. 2017120541 **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. Kimberly Kirchmeyer ("Complainant") is the 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 Claudia Ramirez, Deputy Attorney General.

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

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

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

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

JURISDICTION

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

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

ADVISEMENT AND WAIVERS

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

8. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the First Amended Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his 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.

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

CULPABILITY

10. Respondent understands and agrees that the charges and allegations in First Amended Accusation No. 800-2016-021723, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

11. For the purpose of resolving the First Amended Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a prima facie case for the charges in the First Amended Accusation, and that Respondent hereby gives up his right to contest those charges.

12. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in First Amended Accusation No. 800-2016-021723 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

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

CIRCUMSTANCES IN MITIGATION

14. Respondent has never been the subject of any disciplinary action.

RESERVATION

15. The admissions made by Respondent herein are only for the purposes of this proceeding, or any other proceedings in which the Medical Board of California or other professional licensing agency is involved, and shall not be admissible in any other criminal or civil proceeding.

CONTINGENCY

16. 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 his counsel. By signing the

stipulation, Respondent understands and agrees that he may not withdraw his 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.

17. 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.

18. 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. A 74735 issued to Respondent Arjang Naim, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) 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.

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. 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, 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. 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.

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

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

7. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, 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 (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.

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 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.

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.

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ACCEPTANCE

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

DATED: August 3, 2018

ARJANG NAIM, M.D.
Respondent

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

DATED: August 3, 2018

RAYMOND J. MCMAHON, ESQ.
Attorney for Respondent

ENDORSEMENT

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

Dated: 8/13/18

Respectfully submitted,

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

CLAUDIA RAMIREZ
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

First Amended Accusation No. 800-2016-021723

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

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO Feb. 21 2018
BY Sara Pacion ANALYST

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

In the Matter of the First Amended Accusation Against: ARJANG NAIM, M.D. 1407 North Vermont Ave., Suite A Los Angeles, California 90027 Physician's and Surgeon's Certificate No. A 74735, Respondent.	Case No. 800-2016-021723 **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

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

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

JURISDICTION

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

5. Section 2234 of the Code states:

"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."

FIRST CAUSE FOR DISCIPLINE

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

7. Respondent Arjang Naim, M.D. is subject to disciplinary action under Code section 2234, subdivision (b), in that he was grossly negligent with respect to the care and treatment of patients 1, 3, 4, and 5.[1] The circumstances are as follows:

Patient 1

8. On or about April 12, 2016, Respondent performed a Cesarean section on Patient 1, a then 39-year-old female with a prior Cesarean section. The surgery began at 2:31 p.m. and ended 17 minutes later, at 2:48 p.m. Respondent subsequently left the hospital and entrusted Patient 1's care to the obstetrics and gynecology ("OB/GYN") residents.[2] Respondent was the attending physician[3] and the residents' direct supervisor.

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

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

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

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

noted in the Foley catheter.

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

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

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

13. Accordingly, prior to 6:00 p.m., Patient 1's pulse rate had exceeded her systolic blood pressure, she had frank blood[4] in two different Foley catheters, and she made no urine after 5:00 p.m. (until at least 6:30 p.m.). Patient 1 had developed a 6-7 cm mass between the bladder and the anterior uterus which was palpable during a pelvic exam. The OB/GYN house staff and nursing personnel continued to observe, respond to, and document concerning signs of abdominopelvic blood loss.

14. At approximately 7:13 p.m., Dr. K.S., a Maternal Fetal Medicine fellow, acting as the OB/GYN attending staff, evaluated Patient 1 after being notified of the patient's status during evening rounds. An ultrasound was repeated. Dr. K.S. explained to Patient 1 and her husband that it appeared Patient 1 had a hematoma[5] anterior to the uterus, which seemed stable, but it was concerning that there was blood in the Foley catheter with little to no urine output. Her plan was to order imaging of the pelvis and lower urinary tract, order a repeat ultrasound to evaluate the

[4] Frank blood is used to describe the obvious, visible presence of blood.
[5] A hematoma is a solid swelling of clotted blood within the tissues.

clot, repeat labs, and watch Patient 1 closely.

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

16. Dr. S.C.'s plan was to proceed with two units of packed red blood cells, check the Complete Blood Count[9] ("CBC") and Basic Metabolic Panel after the transfusion, and proceed with a computed tomography ("CT") urogram to evaluate the kidneys, ureters, and bladder given the frank blood in the Foley catheter. She discussed her plan with Respondent and Dr. K.S., the Maternal Fetal Medicine fellow.

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

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

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[6] Oliguria is the low output of urine.

[7] Anuria means an absence of urine.

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

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

19. At approximately 11:25 p.m., Dr. S.C. telephoned Respondent and notified him about a concern for active internal bleeding. He was noted to be "en route." Patient 1 gave permission for a laparotomy[10] and possible hysterectomy.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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[12] Hemoperitoneum is the presence of blood in the peritoneal cavity.

Patient 3

30. On or about August 21, 2015, Respondent gave Patient 3, a then thirty-year-old female, a single dose of methotrexate[13] for presumed ectopic pregnancy.[14] Her quantitative Beta Human Chorionic Gonadotropin ("HCG")[15] was 28,665 mIU/mL. There had been no visualized ectopic or intrauterine pregnancy on an ultrasound done at that time.

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

32. Respondent found a ruptured right Fallopian tube. Patient 3 had an estimated blood loss of 2,000 mL during the surgery, consisting mostly of hemoperitoneum. She required a transfusion of six units of blood in order to stabilize her in the immediate perioperative[19] and intraoperative period.

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

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

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

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

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

[17] Hemodynamically unstable means abnormal or unstable blood pressure.

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

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

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

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

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

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

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

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

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

Patient 4

36. On or about March 14, 2016, at approximately 8:00 p.m., Patient 4, a then thirty-four-year-old female, was admitted to the hospital. She was 16 weeks and four days pregnant. She was in her fifth pregnancy. She had pre-viable preterm premature rupture of membranes.[22] After being informed of her options, Patient 4 chose to receive a high dose Cytotec[23] to induce labor.

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

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[22] Previable preterm premature rupture of membranes is rupture of membranes prior to 24 weeks' pregnancy.

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

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

entire procedure.

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

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

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

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

Patient 5

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

42. Respondent scheduled Patient 5 for a Cesarean section for May 26, 2016 (at 39 weeks

(...continued)
often used method of first trimester miscarriage or abortion.

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

43. However, on or about May 31, 2016, Patient 5 went to the hospital. An ultrasound showed that she was pregnant with one fetus in the breech presentation.[25] It further showed an anterior (location of placenta previa) placenta previa[26] with placental lacunae (vascular spaces) suspicious for placenta accreta.[27] A repeat Cesarean section with preparations in place for massive transfusion and hysterectomy were recommended. Patient 5 agreed to undergo a Cesarean hysterectomy. Respondent was the primary attending surgeon for the Cesarean section.

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

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

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

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

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

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

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

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

SECOND CAUSE FOR DISCIPLINE

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

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

Patient 1

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

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

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

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

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

Patient 2

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

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

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

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

Patient 3

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

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

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

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

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

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

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

Patient 4

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

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

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

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

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

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

Patient 5

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

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

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

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

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

Patient 6

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

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

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

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

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

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

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

THIRD CAUSE FOR DISCIPLINE

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

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

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

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

FOURTH CAUSE FOR DISCIPLINE

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

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

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

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

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

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 74735, issued to Respondent Arjang Naim, M.D.;

2. Revoking, suspending, or denying approval of Respondent Arjang Naim, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Arjang Naim, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: February 21, 2018

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

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