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

11 In the Matter of the Accusation Against:

Case No. 800-2016-021723

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

A C C U S A T I O N

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

Respondent.

17 Complainant alleges:

18 **PARTIES**

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

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

26 **JURISDICTION**

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

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

5 5. Section 2234 of the Code states:

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

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

11 “(b) Gross negligence.

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

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

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

22 “(d) Incompetence.

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

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

26 “(g) The practice of medicine from this state into another state or country without meeting
27 the legal requirements of that state or country for the practice of medicine. Section 2314 shall not
28 apply to this subdivision. This subdivision shall become operative upon the implementation of

1 the proposed registration program described in Section 2052.5.

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

5 **FIRST CAUSE FOR DISCIPLINE**

6 **(Gross Negligence)**

7 6. Respondent is subject to disciplinary action under Code section 2234, subdivision
8 (b), in that he was grossly negligent in the care and treatment of K.D.¹ The circumstances are as
9 follows:

10 7. On or about April 12, 2016, Respondent performed a Cesarean section on K.D., a
11 then 39-year-old female with a prior Cesarean section. The surgery began at 2:31 p.m. and ended
12 17 minutes later, at 2:48 p.m. Respondent subsequently left the hospital and entrusted K.D.’s care
13 to the obstetrics and gynecology (“OB/GYN”) residents.² Respondent was the attending
14 physician³ and the residents’ direct supervisor.

15 8. Beginning at approximately 4:40 p.m., the OB/GYN housestaff (i.e., the residents)
16 and nursing personnel began observing, responding to, and documenting concerning signs of
17 abdominopelvic blood loss. Residents were called to K.D.’s bedside to evaluate her for blood
18 noted in the Foley catheter.

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

22 10. At approximately 5:24 p.m., Dr. N.E. (a second-year resident) evaluated K.D. for a
23 rising fundus and concern for excessive bleeding. The Foley catheter was draining bright red.

24 ¹ The initials of the patient’s name are used to protect her right of privacy.

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

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

1 She telephoned Respondent to discuss K.D.'s condition. The plan was to keep the Foley catheter
2 in its original place, but no other change to the plan of care was made.

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

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

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

22 14. By approximately 8:00 p.m., the signs of significant concealed blood loss were even
23 more apparent. Dr. S.C. (a fourth-year resident) evaluated the patient. K.D.'s pulse rate
24 continued to exceed her systolic blood pressure, her hemoglobin dropped to 7.6, and she was
25 severely oliguric⁶ and anuric⁷ (for more than ninety minutes) with frank blood previously coming

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

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

28 ⁶ Oliguria is the low output of urine.

⁷ Anuria means an absence of urine.

1 out of the Foley catheter. Those signs were consistent with massive blood loss and
2 coagulopathy.⁸ Although that is not their only cause, it must be foremost in an OB/GYN's mind,
3 and of the highest priority/urgency, to promptly evaluate and aggressively manage for the
4 possibility of massive concealed hemorrhage until that possibility is excluded.

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

10 16. At approximately 8:07 p.m., Dr. S.C. obtained permission from K.D. for a blood
11 transfusion. The resident discussed the risks and benefits with her.

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

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

21 19. At approximately 11:42 p.m., Respondent arrived at K.D.'s bedside and evaluated her
22 condition. Respondent wanted to continue the expectant management plan.¹¹ In contrast, Drs.

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

27 ⁹ A complete blood count is a blood panel requested by a doctor or other medical
28 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.

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

(continued...)

1 K.S. and S.C. recommended taking the patient back to the operating room for a laparotomy to
2 identify the source of bleeding. When Respondent expressed a desire to continue with the
3 expected management plan, the obstetric in-house team of physicians considered utilizing the
4 chain of command to supersede Respondent's reluctance to proceed directly and promptly to an
5 exploratory laparotomy.

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

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

19 22. Respondent missed approximately four to six hours of opportunity during which
20 K.D.'s condition was clearly compromised, and was further deteriorating, but during which he
21 failed to recognize and under-responded to K.D.'s deteriorating condition and clearly suggestive
22 signs of ongoing concealed surgical site hemorrhage.

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

26 _____
27 (...continued)
28 monitoring by a physician instead of immediate treatment.

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

1 incorporated by reference.

2 32. Respondent engaged in repeated negligent acts as follows:

3 A. Respondent failed to timely, sufficiently, and attentively evaluate and manage the
4 possibility of K.D.'s ongoing massive concealed hemorrhage throughout the evening of April 12,
5 2016; and

6 B. Respondent failed to timely engage the services of consultant physicians and surgeons
7 during the post-operative phase of K.D.'s care.

8 33. Respondent's acts and/or omissions as set forth in paragraphs 31 through 32,
9 inclusive above, whether proven individually, jointly, or in any combination thereof, constitute
10 repeated negligent acts pursuant to section 2234, subdivision (c), of the Code. Therefore, cause
11 for discipline exists.

12 **THIRD CAUSE FOR DISCIPLINE**

13 **(Unprofessional Conduct)**

14 34. Respondent is subject to disciplinary action under section 2234 of the Code for
15 unprofessional conduct. The circumstances are as follows:

16 35. The facts and circumstances are as set forth in paragraphs 6 through 33 above, and are
17 incorporated by reference.

18 36. Respondent's acts and/or omissions as set forth in paragraph 35, inclusive above,
19 whether proven individually, jointly, or in any combination thereof, constitute unprofessional
20 conduct pursuant to section 2234 of the Code. Therefore, cause for discipline exists.

21 **PRAYER**

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

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

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

28 3. Ordering Respondent Arjang Naim, M.D., if placed on probation, to pay the Board the

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costs of probation monitoring; and

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

DATED: October 26, 2017


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

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