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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

[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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