COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS. Board of Registration in Medicine

Adjudicatory Case No. 2021-023

In the Matter of	)
MAHMOUD RASHIDI-NAIMABADI, M.D.	)

STATEMENT OF ALLEGATIONS

The Board of Registration in Medicine (the "Board") has determined that good cause exists to believe the following acts occurred and constitute a violation for which a licensee may be sanctioned by the Board. The Board therefore alleges that Mahmoud Rashidi-Naimabadi, M.D. (the "Respondent") has practiced medicine in violation of law, regulations, or good and accepted medical practice as set forth herein. The investigative docket number associated with this order to show cause is Docket No. 20-410.

Biographical Information

1. The Respondent was born on January 24, 1965. The Respondent graduated in 1993 from the Kerman University of Medical Sciences in Iran. He has been licensed to practice medicine in Massachusetts under license number 246106 since 2011.

Factual Allegations

2. The Respondent is Board certified in Neurosurgery.

3. On August 4, 2020, the California Medical Board (the "California Board") issued a Final Decision and Order ("California Order") revoking the Respondent's license to practice medicine. The revocation was stayed upon the completion of a five-year probationary term. This

disciplinary action resolved an active case that the California Board opened against him which related to the Respondent's treatment of Patient 1 and 2.

4. With respect to the specific allegations regarding the care of Patient 1:

a. On November 10, 2014, Patient 1 appeared in the emergency room at Santa Rosa Memorial Hospital with lower back pain and weakness in his legs. An MRI showed a large disc herniation at T11/12 junction.

b. The Respondent recommended corrective surgery to Patient 1. The Respondent chose to perform a transpedicular discectomy with the assistance of electrophysiological monitoring. Prior to the surgery, the electrophysiological monitoring showed normal spinal cord conduction. When Patient 1 was switched from the supine to the prone position, the electrophysiological monitoring stopped showing conduction below the L1 level. The Respondent proceeded with the surgery.

c. A post-surgical MRI showed edema and hemorrhage in the posterior soft tissues of the back and the herniated disc remained unchanged. Patient 1 suffered paralysis.

d. The Respondent failed to document how he described the comparative risks and benefits to Patient 1 between the surgical procedure the Respondent would perform and the option to transfer to another hospital for a different surgical approach.

e. The California Board determined that the Respondent's decision to perform a transpedicular discectomy and proceed when electrophysiological monitoring had stopped was an extreme departure from the standard for care for neurological surgery. The Respondents failure to document the rationale for choosing a riskier

course of action when a potentially safer course of action was available at a different hospital was an extreme departure from the standard of care.

5. With respect to the specific allegations regarding Patient 2:

a. On November 15, 2015, Patient 2 arrived at Santa Rosa Memorial Hospital Emergency Room with a severe headache and a rapidly deteriorating condition. A scan showed that a seven-centimeter hematoma on Patient 2's brain on the right parietal lobe. The Respondent determined that Patient 2 needed immediate surgery to remove the hematoma.

b. The Respondent assembled an operating room for Patient 2 and the team prepared the room and Patient 2 for surgery. Prior to beginning the surgery, the Respondent and his team did not pause to confirm the site of the surgery.

c. The Respondent opened the left side of Patient 2's skull. He realized immediately that he had erred because the hematoma was not present. The Respondent rec losed Patient 2's skull on the left side and opened the skull on the right side. The Respondent successfully completed the surgery.

d. The California Board found that the Respondent's failure to pause and check for the correct surgical site was a simple departure from the standard of care. The Board found that the wrong-side surgery was an extreme departure from the standard of surgical care.

6. A true and accurate copy of the California Board Final Decision and Order is enclosed herewith as Attachment A and incorporated herein by reference.

7. On October 22, 2020, the New Hampshire Board of Medicine ("NH Board") issued their Final Decision and Order based on the Medical Board of California's Decision and Order. The NH Board issued a reprimand and placed conditions on the Respondent's medical license.

8. A true and accurate copy of the NH Board Final Decision and Order is enclosed herewith as Attachment B and incorporated herein by reference.

Legal Basis for Proposed Relief

A. Pursuant to 243 CMR 1.03(5)(a)(12), the Board may discipline a physician upon proof satisfactory to a majority of the Board, that said physician has been disciplined in another jurisdiction in any way by the proper licensing authority for reasons substantially the same as those set forth in M.G.L. c. 112, § 5 or 243 CMR 1.03(5). More specifically, in Massachusetts, the Board may discipline a physician upon proof satisfactory to a majority of the Board, that said physician has violated the following statutes, regulations, policies, and/or precedents:

   i. Mass. Gen. Laws c. 112, § 5, ¶ 9(c) and 243 CMR 1.03(5)(a)(3)) ("Conduct which places into question the physician's competence to practice medicine, including but not limited to gross misconduct in the practice of medicine or practicing medicine fraudulently, or beyond its authorized scope, or with gross incompetence, or with gross negligence on a particular occasion or negligence on repeated occasions.");

   ii. 243 CMR 2.07(13)(a), which requires a physician to:

      - maintain a medical record for each patient which is adequate to enable the licensee to provide proper diagnosis and treatment;
      - maintain a patient's medical record in a manner which permits the former patient or a successor physician access to them;

iii. 243 C.M.R. 1.03(5)(a)18: Misconduct in the practice of medicine

iv. Pursuant to *Levy v. Board of Registration in Medicine*, 378 Mass. 519 (1979); *Raymond v. Board of Registration in Medicine*, 387 Mass. 708 (1982), the Board may discipline a physician upon proof satisfactory to a majority of the Board that said physician has engaged in conduct that undermines the public confidence in the integrity of the medical profession.

The Board has jurisdiction over this matter pursuant to G.L. c. 112, §§ 5, 61, and 62. This adjudicatory proceeding will be conducted in accordance with the provisions of G.L. c. 30A and 801 CMR 1.01.

Nature of Relief Sought

The Board is authorized and empowered to order appropriate disciplinary action, which may include revocation of the Respondent's inchoate right to renew his license to practice medicine in Massachusetts.

Order

Wherefore, it is hereby **ORDERED** that the Respondent show cause why the Board should not discipline the Respondent for the conduct described herein.

By the Board of Registration in Medicine,

George M. Abraham, M.D.
Board Chair

Date: May 20, 2021

ATTACHMENT A

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

In the Matter of the Accusation Against: Mahmoud Rashidi Naimabadi, M.D. Physician's and Surgeon's Certificate No. A 87654 Respondent.	Case No. 800-2017-036964

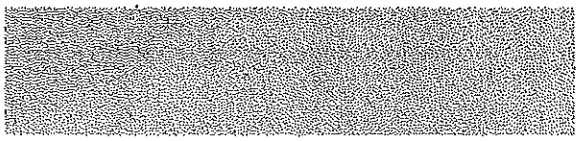
DECISION

The attached Proposed Decision is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on September 3, 2020.

IT IS SO ORDERED: August 4, 2020.

MEDICAL BOARD OF CALIFORNIA



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

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

In the Matter of the Accusation Against:

MAHMOUD RASHIDI NAIMABADI, M.D.,

Physician's and Surgeon's Certificate No. A 87654

Respondent.

Case No. 800-2017-036964

OAH No. 2020010610

PROPOSED DECISION

Administrative Law Judge Juliet E. Cox, State of California, Office of Administrative Hearings, heard this matter on June 22, 2020, in Oakland, California.

Supervising Deputy Attorney General Jane Zack Simon represented complainant William J. Prasifka, Executive Director of the Medical Board of California.

Respondent Mahmoud Rashidi Naimabadi, M.D., represented himself and was present for the hearing.

The matter was submitted for decision on June 22, 2020.

FACTUAL FINDINGS

1. The Medical Board of California (Board) issued Physician's and Surgeon's Certificate No. A 87654 to respondent Mahmoud Rashidi Naimabadi, M.D., on June 11, 2004. The certificate is scheduled to expire on January 31, 2022.

2. On November 25, 2019, acting in her official capacity as Interim Executive Director of the Board, Christine J. Lally filed an accusation against respondent. Complainant William J. Prasifka later replaced Lally as the Board's Executive Director. Complainant alleges that respondent acted unprofessionally during two surgeries, and seeks as a consequence to revoke respondent's certificate or place him on probation. Respondent timely requested a hearing.

Respondent's Training and Experience

3. Respondent received his medical education in Iran. He completed a residency in neurosurgery in Canada and has been board-certified in neurological surgery since 2007.

4. Respondent began practicing medicine in the United States in 2002, in Louisiana. He continues to hold a medical license in Louisiana, as well as licenses or certificates in Massachusetts, New Hampshire, and California.

5. Respondent lived in California and practiced neurosurgery between 2004 and 2010, and also between 2012 and 2014. Respondent and his family have lived in New Hampshire since 2014, but respondent continued between 2014 and 2016 to practice neurosurgery part-time in California as well as part-time in Massachusetts and New Hampshire. In part because of the investigation and accusation in this matter,

respondent has not performed surgery since April 2019, although he intends if possible to resume.

6. Respondent also is an author and lecturer on subjects relating to cognitive and emotional influences on physical health.

Spinal Surgery on Patient 1

7. Patient 1, a 71-year-old man, came to the emergency room at Santa Rosa Memorial Hospital (SRMH) on November 10, 2014. He complained of significant lower back pain that had persisted for at least four days, during which time he had not had a bowel movement. He also had been catheterized at a different hospital two days earlier because he could not urinate. Although Patient 1 reported having felt strong enough a week earlier to do landscaping work including tree cutting, he needed support to walk when he arrived at the SRMH emergency room and complained that his legs felt weak. Magnetic resonance imaging (MRI) of Patient 1's spine showed a large disc herniation at the T11/12 junction.

Surgical Procedure and Outcome

8. Respondent recommended corrective surgery to Patient 1. Because respondent believed that electrophysiological monitoring of Patient 1's spinal cord during the surgery would be a necessary safety measure to reduce the likelihood of surgical injury to Patient 1's spinal cord, he scheduled the surgery for the following morning when a team to perform this "evoked potential" monitoring would be available.

9. Respondent performed Patient 1's surgery on November 11, 2014. He chose to perform a transpedicular discectomy, a procedure in which the surgeon

positions the patient prone and accesses the vertebral joint from an incision on the patient's back. Although respondent had intended to begin surgery in the morning, he had to wait until afternoon because of other surgical procedures at the hospital.

10. The chart note respondent prepared immediately after Patient 1's surgery states, "I should mention from the beginning, evoked potential monitoring was not getting any signal below L1." In an interview with Board representatives on October 21, 2019, and in his testimony at the hearing, however, respondent clarified that his note meant "from the beginning of the surgery." He explained that evoked potential monitoring had showed normal spinal cord electrical conduction while Patient 1 was supine for surgical preparation and anesthesia, but had stopped showing conduction below the L1 level shortly after the surgical team turned Patient 1 from supine to prone to expose his back for respondent's incision.

11. When evoked potential monitoring ceased to show electrical conduction below Patient 1's L1 vertebra, respondent had not yet made his first surgical incision. He considered pausing to troubleshoot the electrical conduction issue, but worried that any further delay would prolong pressure on Patient 1's spinal cord and perhaps damage it further; he also believed that bringing Patient 1 out of anesthesia would traumatize him (because he would awaken to learn he had not yet had corrective surgery) and also expose him to the further risk of re-anesthesia when surgery resumed. Respondent elected to proceed with the surgery he had planned, reasoning that it would be the fastest way to reduce pressure on Patient 1's spinal cord.

12. Respondent removed parts of Patient 1's T11 and T12 vertebrae and supporting structures in an attempt to reduce pressure on Patient 1's spinal cord. He was unable to remove as much of the herniated disc material as he had expected, but

believed when he concluded the surgery that Patient 1's spinal cord "seems to be decompressed."

13. When Patient 1 awoke from surgery, he had little or no sensation in his legs and was unable to move them. Post-surgical MRI showed "postsurgical edema and hemorrhage in the posterior soft tissues of the back. The hard disc remains . . . , essentially unchanged."

14. Respondent arranged for Patient 1's transfer to the University of California, San Francisco (UCSF) hospital. Patient 1 had further back surgery, but to respondent's knowledge his weakness and paralysis did not improve.

EXPERT OPINION

15. Michael Chan, M.D., reviewed medical records relating to Patient 1, and also reviewed a transcript of the October 2019 interview referenced in Finding 10. Dr. Chan is board-certified in neurological surgery. He has practiced neurological surgery in California since 2011.

16. According to Dr. Chan, a transpedicular posterior approach to a T11/12 discectomy does not offer the surgeon safe access to the damaged disc, because from a posterior approach the spinal cord itself lies between the surgeon and the disc. The surgeon would have to pull the disc material out around the spinal cord, or would have to move the spinal cord aside to reach the disc material; either way, the surgeon would risk damaging the spinal cord.

17. Dr. Chan explained further that to repair or remove a herniated T11/12 disc safely, a surgeon must access the joint either from the patient's front (an "anterior" approach) or side (a "lateral" approach). The anterior approach requires a

thoracic surgeon, because the surgery breaches the patient's pleural space. The lateral approach does not require a thoracic surgeon's participation, because it avoids breaching the patient's pleural space, but it is less common.

18. Respondent was and is familiar with the anterior approach, but he could not use an anterior approach to Patient 1's surgery at SRMH because no thoracic surgeon was available to join respondent for the surgery. Respondent did not believe that the absence of a thoracic surgeon precluded Patient 1 from having surgery at SRMH, however, because he believed a posterior transpedicular surgery would give him adequate, safe access to Patient 1's damaged T11/12 disc. He did not testify at the hearing about considering a lateral surgical approach, but stated in his October 2019 interview with Board representatives that he had known at least one fellow neurosurgeon for whom a lateral approach to similar surgery had gone poorly.

19. In Dr. Chan's opinion, respondent's decision to do a transpedicular discectomy to address Patient 1's T11/12 disc herniation was an extreme departure from the standard of care for neurological surgery. Dr. Chan's opinion that a transpedicular posterior surgical approach to the T11/12 disc is unsafe is more persuasive than respondent's opinion that this approach is safe. For this reason, Dr. Chan's opinion that the transpedicular posterior approach was an extreme departure from the standard of care also is persuasive.

20. Respondent testified that he had offered to arrange Patient 1's transfer to UCSF in the evening on November 10, 2014, but Patient 1 preferred to remain at SRMH for surgery the next day. Respondent did not document how he described the comparative risks and benefits to Patient 1 between transferring to UCSF or remaining at SRMH, or why Patient 1 elected to remain rather than to transfer. In particular, respondent did not state in either his medical records or his testimony that he

explained to Patient 1 that the posterior surgical approach respondent intended to use for Patient 1 at SRMH would be riskier for Patient 1 than the anterior surgical approach that surgeons at UCSF could use.

21. The standard of care in neurological surgery requires a surgeon to discuss all risks and benefits of surgery with the patient, and in particular to document the rationale for choosing a riskier course of action if a safer course potentially is available. In Dr. Chan's opinion, respondent's failure to articulate or to document any medically prudent rationale for failing to transfer Patient 1 to UCSF, despite respondent's inability or unwillingness at SRMH either to recruit a thoracic surgeon to participate in Patient 1's surgery or to perform the surgery laterally, also was an extreme departure from the standard of care. This opinion is persuasive.

22. Finally, Dr. Chan stated that respondent's decision to proceed with Patient 1's surgery (as described in Finding 11) even though evoked potential monitoring had stopped showing electrical conduction below Patient 1's L1 vertebra (as described in Finding 10) was an extreme departure from the standard of care. In Dr. Chan's opinion, a reasonably prudent neurosurgeon under these circumstances would have paused to check whether the lack of electrical conduction was real, or a technical problem; if the lack of conduction were real, a reasonably prudent neurosurgeon would have asked the anesthetist to adjust the patient's anesthesia, asked operating room staff to confirm adequate blood pressure, or returned Patient 1 to the supine position to determine whether conduction resumed. Dr. Chan's opinion is that respondent's decision to press forward with posterior, transpedicular surgery under these circumstances was reckless, and considerably less safe for Patient 1 than any of the available alternatives. This opinion is persuasive.

Craniotomy on Patient 2

23. Patient 2 arrived in the SRMH emergency room at night on November 15, 2015, complaining of a sudden severe headache. Although he was conscious and ambulatory when he arrived, his condition deteriorated rapidly and he became unconscious. Emergency department staff members called respondent for consultation.

24. A scan showed that Patient 2 had a seven-centimeter hematoma on his brain's right parietal lobe, adjacent to a blood vessel malformation. Pressure on Patient 2's brain from the hematoma was causing his acute symptoms, and the blood vessel malformation was the likely cause of the hematoma. Respondent determined that Patient 2 needed immediate surgery at SRMH to remove the hematoma, followed later by surgery at another hospital to correct the blood vessel malformation.[1]

Surgical Procedure and Outcome

25. Respondent assembled an operating room team for Patient 2, and the team prepared the room and Patient 2 for surgery. Between preparing the room and the patient and beginning the surgery, the operating room team did not pause for the entire team to confirm that they had prepared and positioned Patient 2 correctly.

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[1] SRMH did not have personnel or facilities for the follow-up surgery to correct Patient 2's blood vessel malformation. Respondent expected that Patient 2 would die if he transferred to another hospital before having the hematoma removed, however.

26. Respondent opened Patient 2's skull on Patient 2's left side. He realized immediately that he had erred, because he saw no hematoma. He reclosed Patient's 2's skull on the left side, and opened Patient 2's skull on Patient 2's right side.

27. Respondent successfully completed Patient 2's surgery. His error (commencing surgery on the incorrect side of Patient 2's skull) caused a delay of between 20 and 30 minutes in removing the hematoma and relieving the pressure it was causing on Patient 2's brain. The evidence did not establish that this delay harmed Patient 2.[2]

28. After the emergency surgery, a helicopter ambulance transferred Patient 2 to a different hospital immediately. Respondent understands that Patient 2 had further treatment there and made a full recovery.

EXPERT OPINION

29. Dr. Chan agreed with respondent that Patient 2's condition was a dire emergency. He disagreed, however, with respondent's assertion that the immediacy and drama inherent in the circumstances excused the operating room team from pausing to confirm which side of Patient 2's head respondent would open. He

[2] Respondent argued that the delay might have benefited Patient 2. His basis for this argument was plausible in hindsight; but even respondent did not argue that a reasonably prudent physician would have delayed Patient 2's surgery in the hope that delay might improve its outcome. To the contrary, Patient 2's condition was an extreme emergency for which immediate surgery was the only prudent treatment.

characterized this failure as a simple departure from the standard of care, and this opinion is persuasive.

30. In Dr. Chan's opinion, wrong-side surgery such as the left-side craniotomy respondent initially performed on Patient 2 is an extreme departure from the standard of surgical care. This opinion is persuasive.

Additional Evidence

31. Respondent presented no testimony or written references from other physicians describing his skills, prudence, or clinical knowledge.

32. Respondent presented no evidence of any retraining he has undertaken since his surgeries on Patients 1 and 2.

LEGAL CONCLUSIONS

1. The Board may suspend or revoke respondent's physician's and surgeon's certificate if clear and convincing evidence establishes the facts supporting discipline. The factual findings above reflect this standard.

2. Business and Professions Code section 2234 makes a physician's unprofessional conduct grounds for suspension or revocation of the physician's certificate.

3. Unprofessional conduct includes:

a. Gross negligence, connoting an extreme departure from the minimum professionally accepted standard of care (Bus. & Prof. Code, § 2234, subd. (b));

b. Repeated acts of negligence, including multiple simple departures from the minimum professionally accepted standard of care (Bus. & Prof. Code, § 2234, subd. (c)); and

c. Failing to maintain adequate and accurate patient records (*id.*, § 2266).

Cause for Discipline, Patient 1

4. The matters stated in Findings 9 through 12 constitute unprofessional conduct, because the matters stated in Findings 16 through 22 establish that the matters stated in Findings 9 through 12 involved both extreme and repeated departures from the standard of care.

5. The matters stated in Findings 10 and 20 constitute unprofessional conduct, because they represent respondent's failure to record and explain critical medical events and decisions.

Cause for Discipline, Patient 2

6. The matters stated in Findings 25 and 26 constitute unprofessional conduct, because the matters stated in Findings 29 and 30 establish that the matters stated in Findings 25 and 26 involved both extreme and repeated departures from the standard of care.

Disciplinary Considerations

7. The Medical Board has adopted disciplinary guidelines to facilitate consistency among decisions and to protect public welfare. (Cal. Code Regs., tit. 16, § 1361, subd. (a).) These guidelines recommend, as a minimum response to

unprofessional conduct including gross negligence, a period of five years' probation. (Manual of Model Disciplinary Orders and Disciplinary Guidelines, at p. 24.)

8. In this case, both the seriousness of respondent's errors and his failure to acknowledge them or to take corrective action warrant specific probation conditions requiring respondent to undergo a clinical competency assessment, to take a medical record-keeping course, to take other supplemental continuing medical education, and to practice only with review by a practice monitor.

ORDER

Physician's and Surgeon's Certificate No. A 87654, issued to respondent Mahmoud Rashidi Naimabadi, is revoked. The revocation is stayed, however, and respondent is placed on probation for five years upon the following terms and conditions:

1. Education Course

Within 60 calendar days of the effective date of this decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational 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 months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the 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. Clinical Competence Assessment Program

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

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

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

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

If respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If respondent did not successfully complete the clinical competence assessment program, respondent shall not resume the practice of medicine until a final decision has been rendered on any petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

4. Practice Monitor

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 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 and accusation, and a proposed monitoring plan. Within 15 calendar days of

receipt of the decision, accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the decision and accusation, 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 calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor 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 medical practice, 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 five 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 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.

5. Notification to Hospitals, Other Providers, and Insurance Carriers

Within seven days of the effective date of this decision, respondent shall provide a true copy of the decision and the accusation in this matter 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, and all rules governing the practice of medicine in California. Respondent shall 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 and all terms and conditions of this decision.

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, subdivision (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 certificate.

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 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 in California 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. All time spent in an intensive training program which has been approved by the

Board or its designee shall not be considered non-practice. 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 a clinical training 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 years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws (Condition 7); and General Probation Requirements (Condition 9).

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 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.

DATE: July 21, 2020

JULIET E. COX

Administrative Law Judge

Office of Administrative Hearings

ATTACHMENT B

Before the
New Hampshire Board of Medicine
Concord, New Hampshire

In the Matter of: **Docket #: 20-MED-0010**
Mahmoud Rashidi-Naimabadi, M.D.
License No.: 14974
(Adjudicatory/Disciplinary Proceeding)

FINAL DECISION AND ORDER

Before the New Hampshire Board of Medicine ("Board") is an adjudicatory/disciplinary proceeding in the matter of Mahmoud Rashidi-Naimabadi, M.D. ("Respondent" or "Dr. Rashidi-Naimabadi") in Docket Number 20-MED-0010.

Background Information

The Board first granted a license to practice medicine in the State of New Hampshire to Dr. Rashidi-Naimabadi on August 4, 2010. Dr. Rashidi-Naimabadi holds license number 14974.

1) On August 4, 2020, the Medical Board of California ("California Board"), issued a Decision and Order ("Order") against Dr. Rashidi-Naimabadi. The Order revokes Dr. Rashidi-Naimabadi's California Physician's and Surgeon's Certificate No. A 87654. However, the revocation was stayed and respondent was placed on probation for five years upon the following terms and conditions:

1. Education Course

Within 60 calendar days of the effective date of this decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational 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 months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the 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. Clinical Competence Assessment Program

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

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

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

respondent's practice of medicine. Respondent shall comply with the program's recommendations.

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

If respondent fails to enroll, participate in, or successfully complete the clinical competence assessment program within the designated time period, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified. Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment program have been completed. If respondent did not successfully complete the clinical competence assessment program, respondent shall not resume the practice of medicine until a final decision has been rendered on any petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

4. Practice Monitor

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 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 and accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the decision, accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the decision and accusation, 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 calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor 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 medical practice, 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 five 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 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.

5. Notification to Hospitals, Other Providers, and Insurance Carriers

Within seven days of the effective date of this decision, respondent shall provide a true copy of the decision and the accusation in this matter 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, and all rules governing the practice of medicine in California. Respondent shall 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 and all terms and conditions of this decision.

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, subdivision (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 certificate.

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 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 in California 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. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. 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 a clinical training 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 years. Periods of non-practice will not apply to the reduction of the probationary term. Periods of non-practice will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws (Condition 7); and General Probation Requirements (Condition 9).

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 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.

This action was based on the California Board's finding that the Respondent exhibited "extreme and repeated departures from the standard of care" and "failure to record and explain critical medical events and decisions."

Pursuant to RSA 329:17-c, when the Board receives "an administratively final order from the licensing authority of another jurisdiction which imposes disciplinary sanctions against a licensee of the board, . . . the board may issue an order directing the licensee to appear and show cause why similar disciplinary sanctions . . . should not be imposed in the state." Accordingly, on September 2, 2020, the Board voted to issue a Notice of Hearing to Show Cause. The purpose of the Show Cause hearing was for Respondent to show cause why disciplinary sanctions similar to those imposed by the California Board should not be imposed in New Hampshire.

On September 9, 2020, the Board issued a Notice of Hearing to Show Cause scheduling the hearing to take place on Wednesday, October 14, 2020 at 10:00 A.M. electronically via real-time, two-way video conferencing through the Office of Professional Licensure and Certification ("OPLC") ZOOM account.

The hearing commenced on October 14, 2020 beginning at approximately 10:15 A.M. The Board members present included:

David C. Conway, M.D., Vice President

Michael Barr, M.D.

Gilbert J. Fanciullo, M.D.

Nina C. Gardner, Public Member

Linda M. Tatarczuch, Public Member

Gilbert J. Fanciullo, M.D., Board Member, served as presiding officer. Dr. Rashidi-Naimabadi appeared and represented himself.

Discussion and Rulings

The presiding officer opened the hearing and offered Dr. Rashidi-Naimabadi five minutes for an opening statement. Dr. Rashidi-Naimabadi declined to issue an opening statement and proceeded to testify on his own behalf. He described to the Board what happened in the two cases that led to the disciplinary action in California and indicated to the Board that he would do things differently now. The Board appreciated Dr. Rashidi-Naimadi's apparent openness and sincerity in answering questions posed to him by Board members; however, the Board remains somewhat concerned about Dr. Rashidi-Naimabadi's judgment and finds that it would be in the public interest to impose certain conditions on his license similar to those imposed by California.

The presiding officer admitted the Board's Exhibit 1 into evidence. The presiding officer closed the hearing at 11:23 A.M.

Disciplinary Sanctions

The issue before the Board is whether Dr. Rashidi-Naimabadi should be subject to disciplinary sanctions similar to those imposed by the California Board pursuant to RSA 329:17-c.

After hearing testimony from Dr. Rashidi-Naimabadi, the Board voted to issue a Reprimand and put the following conditions on Dr. Rashidi-Naimabadi's license:

1) Dr. Rashidi-Naimabadi shall provide the Board with the results of the clinical competence assessment program mandated by the Medical Board of California; and
2) Dr. Rashidi-Naimabadi shall provide the Board with a copy of the continuing medical education required in his California Decision and Order; and
3) Dr. Rashidi-Naimabadi shall provide the New Hampshire Board of Medicine with a copy of the monitor evaluations submitted to the California Board of Medicine; and
4) Should Dr. Rashidi-Naimabadi return to practice medicine in New Hampshire prior to completion of his five-year probation period imposed by California, he will be required to practice under a practice monitor for the remainder of his five-year probation period. The practice monitor, preferably ABMS certified, shall be approved by the Board, and shall meet the following criteria:

a. The 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.

b. The Respondent shall provide the approved monitor with a copy of this Final Decision and Order ("Decision"), and a proposed monitoring plan shall be submitted by Respondent to the Board for approval. Within 15 calendar days of receipt of the Decision, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision, 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.

c. While practicing in New Hampshire under an approved practice 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 monitoring period.

d. The monitor 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 medical practice, 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.

e. If the monitor resigns or is no longer available, Respondent shall, within five calendar days of such resignation or unavailability, submit to the Board, 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 calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

THEREFORE, IT IS ORDERED that the Respondent is **REPRIMANDED**; and

IT IS FURTHER ORDERED that Respondent shall provide the Board with the results of the clinical competence assessment program mandated by the Medical Board of California; and

IT IS FURTHER ORDERED that Dr. Rashidi-Naimabadi shall provide the Board with a copy of the continuing medical education required in his California Decision and Order; and

IT IS FURTHER ORDERED that Dr. Rashidi-Naimabadi shall provide the Board with a copy of the monitor evaluations submitted to the California Board of Medicine; and

IT IS FURTHER ORDERED that, should Dr. Rashidi-Naimabadi return to practice medicine in New Hampshire prior to completion of his five-year probation period imposed by California, he will be required to practice under a practice monitor for the remainder of his five-year probation period. The practice monitor, preferably ABMS certified, shall be approved by the Board, and shall meet the criteria set forth in paragraph 3 (a) through (e) above.

IT IS FURTHER ORDERED that this Final Decision and Order shall become a permanent part of the Respondent's file, which is maintained by the Board as a public document; and

IT IS FURTHER ORDERED that this Final Decision and Order shall take effect as an Order of the Board on the date an authorized representative of the Board signs it.

BY ORDER OF THE BOARD

Dated: 10/22/2020

Penny Taylor

Penny Taylor, Administrator
Authorized Representative of the
New Hampshire Board of Medicine