REDACTED

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

In the Matter of the Accusation against:	)	
	)	
WILLIAM HERBERT VEDERMAN, M.D.	)	**OAH No: 2010040615**
	)	
Physician's and Surgeon's Certificate No. G 19049	)	**MBC No: 12-2006-178819**
	)	
	)	
Petitioner.	)	

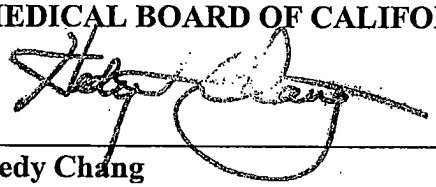
ORDER DENYING PETITION FOR RECONSIDERATION

The Petition for Reconsideration filed by William Herbert Vederman, M.D., of the decision in the above-entitled matter having been reviewed by the Medical Board of California, is hereby denied.

This Decision remains effective at 5:00 p.m. on January 14, 2011.

IT IS SO ORDERED: January 14, 2011

MEDICAL BOARD OF CALIFORNIA



Hedy Chang
Chair Panel B

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

In the Matter of the Accusation Against:	)	
	)	
	)	
WILLIAM HERBERT VEDERMAN, M.D.	)	MBC No. 12-2006-178819
SUNRISE HEALTH MEDICAL GROUP, INC.	)	
	)	
Physician's & Surgeon's	)	
Certificate No. G19049	)	
	)	
	)	
Respondent.	)	

ORDER GRANTING STAY

William Herbert Vederman, M.D., has filed a request for a stay of execution of the Decision in this matter with an effective date of January 5, 2011.

Execution is stayed until January 14, 2011.

This stay is granted solely for the purpose of allowing the Board time to review and consider the Petition for Reconsideration.

DATED: January 4, 2011.

A. Renee Threadgill
Chief of Enforcement
Medical Board of California

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

In the Matter of the Accusation Against:	)	
	)	
	)	
	)	
WILLIAM HERBERT VEDERMAN, M.D.	)	File No. 12-2006-178819
SUNRISE HEALTH MEDICAL GROUP, INC.	)	
	)	
	)	
Physician's and Surgeon's Certificate No. G19049	)	
	)	
	)	
Respondent.	)	
	)	

DECISION

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

This Decision shall become effective at 5:00 p.m. on January 5, 2011.

IT IS SO ORDERED December 6, 2010.

MEDICAL BOARD OF CALIFORNIA

By: _____
Hedy Chang, Chair
Panel B

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

In the Matter of the Accusation Against: WILLIAM HERBERT VEDERMAN, M.D. SUNRISE HEALTH MEDICAL GROUP, INC. Physician's and Surgeon's Certificate No. G19049 Respondent.	Case No. 12 2006 178819 OAH No. 2010040615

PROPOSED DECISION

Administrative Law Judge Mary-Margaret Anderson, Office of Administrative Hearings, State of California, heard this matter on August 10, 11, 12, 16, 17, and 18, 2010, in Oakland, California.

Vivien H. Hara, Deputy Attorney General, represented Complainant Linda K. Whitney, Executive Director of the Medical Board of California.

John H. Dodd, Attorney at Law, represented Respondent William Herbert Vederman, M.D., who was present.

The record was left open at the parties' request to allow them to file written closing argument. The briefs were timely received and marked for identification as follows: Complainant's Closing Argument is Exhibit 47, Respondent's Closing Argument is Exhibit FFF, and Complainant's Rebuttal Closing Argument is Exhibit 48.

The record closed on September 20, 2010.

FACTUAL FINDINGS

1. Complainant Linda K. Whitney issued the Accusation in her official capacity as Executive Director of the Medical Board of California (Board).

2. On August 19, 1970, the Board issued Physician's and Surgeon's Certificate No. G19049 to William Herbert Vederman, M.D. (Respondent). Respondent's certificate will expire on September 30, 2011, unless renewed.

3. The standard of proof applied in making the factual findings in this matter is clear and convincing evidence to a reasonable certainty.

4. In a First Amended Accusation signed August 16, 2010, Complainant alleges unprofessional conduct by Respondent in the medical treatment of obesity offered patients at clinics he operated as Sunrise Health Medical Group. Respondent's practice is alleged to have been grossly negligent, and/or repeatedly negligent, by virtue of his alleged: offer of medical treatment of obesity without a staff of professionals trained and certified in behavior change, exercise and nutrition, and use of diet pills as the primary care provided; failure to provide adequate and appropriate follow-up care by a physician for patients who were prescribed anorectic drugs; failure to keep controlled substances to be dispensed in a secure, locked storage area in violation of the law; dispensing of controlled substances by unlicensed medical assistants and nurses in violation of the law; failure to provide necessary tests, including an EKG and uric acid levels, prior to prescribing anorectic controlled substances; offer of B-12 injections to patients in the absence of a B-12 deficiency; failure to assure adequate and appropriate medical records that document patient progress, including their behavioral, dietary, and exercise progress; and failure to maintain a policy and procedures manual in his practice locations.

Complainant also alleges that Respondent committed unprofessional conduct by violating drug laws. It is alleged that Respondent failed to comply with laws relating to prescribing, labeling, and dispensing controlled substances and dangerous drugs; failed to keep the drugs to be dispensed in a secure, locked storage area; allowed controlled substances to be dispensed by unlicensed medical assistants and nurses; failed to offer a written prescription to the patient in lieu of dispensing the drug; failed to provide the patient with written disclosure that the patient had a choice to obtain the prescription from a dispensing prescriber or pharmacy of the patient's choice; failed to produce records of acquisition and dispensation of drugs to Board investigators on March 13, 2008; and failed to make required weekly reports of dispensation of controlled substances to the CURES program.

Finally, Complainant alleges that Respondent aided and abetted the unlicensed practice of medicine by allowing unlicensed and uncertified medical assistants to note prescriptions in patient records without the approval or prior prescription of a physician and to dispense controlled substances to patients.

5. Respondent attended medical school at the Downstate Medical College, SUNY, in Brooklyn, New York. He completed a mini-residency in occupational medicine at the University of California at San Francisco Medical School in 1981. Respondent has been board certified in occupational medicine since 1985 and was board certified in family practice from 1974 to 1981 and 1982 to 1989. From 1977 until 1991, Respondent focused on emergency medicine. From 1977 until 1983, Respondent was the Medical Director of the

Western Emergency Physicians Medical Group, which supplied physicians to staff hospital emergency departments in California and Nevada.

6. In 1981 Respondent began Sunrise Health Medical Group, Inc., which at one time operated 13 clinics specializing in preventive medicine and the treatment of obesity. Respondent became interested in obesity when he was in medical school as the result of having participated in the treatment of a patient who weighed 700 pounds. Respondent felt that there was more to the problem than overeating. When he was in family practice, many patients would cry and tell him that they eat right but still have weight problems. Respondent could not believe all of these patients were lying. He subsequently learned that certain medications could be effective in helping people lose weight and began Sunrise to fill what he saw as a "niche in an important field."

7. Currently, Respondent operates Sunrise in three locations: Oakland, Concord and Lafayette. He employs two staff persons, whom he refers to as medical assistants: Heidi Andreasen and Angela Panameno. His office manager is Randa Peterson. The clinics are open two days each week at each location. Respondent rarely is in any of the clinics. He employs Albert Mazzie, M.D., on an independent contractor basis, to see patients. Dr. Mazzie rotates between the locations on a part-time schedule. There is not a physician on site at all times that the clinics are open. Respondent describes Sunrise as much more like a business; specifically, a retail weight control business, than a medical practice.

8. The protocol for treating patients at the Sunrise clinics is fairly straightforward. People who call the clinic are given an overview of the program. When they arrive at the clinic, a health history is taken. The patient is weighed and the blood pressure is taken by, for the most part, an unlicensed staff person. A physician performs a physical examination and orally explains the options to the patient. The options primarily concern whether the patient will take medication to aid in appetite control. Although a meal replacement plan is also available, the vast majority of patients opt for the medication regimen. Some counseling takes place. Blood is drawn by a staff person and sent to a laboratory for analysis.

The patient then returns to see a physician again and the lab test results are discussed. If all is well, patients who opt for medication are provided a one-week supply. Written suggested meal plans are provided, along with food diary forms. Patients are directed to return the following week, and it is suggested that they bring their completed food diary for that week. During these subsequent visits, a staff person weighs them and asks how they are doing, looks at their food diary if there is one, listens to their concerns, and provides general support. The patient is then given the next week's supply of medication. This pattern continues on a weekly basis until the patient loses the weight he or she desires to lose. The patients do not see a doctor again until they are close to their goal weight, unless they specifically request an appointment with a doctor.

9. During 2008 and 2009, the initial two visits with a physician, the exam, and the lab work, cost $149, and the weekly visits cost $49 each, whether or not the patient opted to

receive medication. Additional visits with a physician were available on request for an additional cost.

10. The medications prescribed by Respondent through his Sunrise clinics include the following controlled substances:

a. Phentermine hydrochloride. Phentermine is an anorectic which is similar in nature to the prototype drugs used to treat obesity, the amphetamines. It is an appetite suppressant and belongs to a class of drugs called sympathomimetic amines. Phentermine is used as a short-term adjunct along with a doctor-approved, reduced-calorie diet, exercise and behavior change program to help in weight loss. It is used in people who are significantly overweight (obese) and have not been able to lose enough weight with diet and exercise alone. Phentermine is contraindicated in patients with cardiovascular disease, moderate to severe hypertension, advanced arteriosclerosis, or hyperthyroidism. Since Phentermine is related chemically and pharmacologically to the amphetamines, and amphetamines and related stimulant drugs have been extensively abused, the possibility of abuse should be kept in mind when evaluating the desirability of including Phentermine as part of a weight reduction program. Phentermine is a Schedule IV controlled substance under section 11057, subdivision (f)(4), of the Health and Safety Code, and is a dangerous drug as defined by Business and Professions Code section 4022.

b. Phendimetrazine tartrate. Phendimetrazine is a sympathomimetic amine with pharmacological activity similar to the prototype drugs used to treat obesity, the amphetamines. Phendimetrazine is an appetite suppressant and central nervous system stimulant. It stimulates the satiety (feeling of fullness) center in the hypothalamus and limbic regions of the brain. Phendimetrazine must be used in combination with a low calorie diet, behavior modification and regular exercise. Appetite suppressants are not a substitute for proper diet. It is contraindicated in patients with advanced arteriosclerosis, moderate to severe hypertension, symptomatic cardiovascular disease, or hyperthyroidism. Because Phendimetrazine is chemically and pharmacologically related to the amphetamines, and related stimulant drugs have been extensively abused, the possibility of abuse should be kept in mind when evaluating the desirability of using it as part of a weight reduction program. It should only be as a short-term adjunct to weight reduction therapy (a few weeks). Phendimetrazine is a Schedule III controlled substance under section 11056, subdivision (b)(6), of the Health and Safety Code, and a dangerous drug as defined by Business and Professions Code section 4022.

c. Diethylproprion hydrochloride. Diethylproprion is a sympathomimetic amine with pharmacological activity similar to the prototype drugs used to treat obesity, the amphetamines. Diethylproprion is an appetite suppressant and central nervous system stimulant. Diethylproprion is indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on calorie restriction in patients with an initial body mass index of 30 kg/m2 or higher and who have not responded to an appropriate weight reducing regimen (diet and/or exercise) alone. Diethylproprion is contraindicated in patients with severe arteriosclerosis, hyperthyroidism, glaucoma, severe hypertension, or cardiovascular disease. Because Diethylproprion is chemically and

pharmacologically related to the amphetamines, and related drugs have been extensively abused, the possibility of abuse should be kept in mind when evaluating the desirability of using it as part of a weight reduction program. Diethylproprion is a Schedule IV controlled substance under section 11057, subdivision (f)(1), of the Health and Safety Code and a dangerous drug as defined in Business and Professions Code section 4022.

ALLEGATIONS CONCERNING NEGLIGENCE

Undercover operation

11. In May 2008 Board investigator Noelle Holloway was assigned to investigate the Sunrise operation by presenting as a patient in an undercover capacity. She began by telephoning the Hayward clinic and making an appointment using the pseudonym "C[redacted] R[redacted]." At that time, Respondent operated a clinic in Hayward and employed Dr. Jagraj Basi to see patients there. On May 13, 2008, Holloway arrived for her appointment. Holloway brought her own lab report with her that included recent blood chemistry test results. A receptionist asked Holloway to complete a Patient's Identification Information form and a form that requested personal information and health history. She was also given a two-page form entitled "Information About Our Medical Program and Informed Consent," and asked to sign it.

Holloway was then seen by Dr. Basi, who spoke to her about the different weight loss options and asked if she was "ready to start today." Holloway said that she needed to think about the cost and also shared that there were certain drugs that she did not want to take. A staff person came in and discussed the costs with her. She chose a medication program. As she had a coupon worth $10 and brought her own lab test results, the charge for the visit was $139. After the discussion, Dr. Basi returned and physically examined Holloway. He gave her medications for one week, a weekly food diary sheet to fill out and bring back, and a meal plan that included substitute foods. No testing for vitamin B-12 deficiency was done, but Dr. Basi wrote an order for vitamin B-12.

12. Dr. Basi gave Holloway a prescription bottle with a printed label that reads "Sunrise Health Medical Group, William Vederman, M.D." The name C[redacted] R[redacted] and the date are filled in by hand, as are the directions to take one tablet three times a day. The printed label also states that the bottle contains 21 yellow tablets of Phendimetrazine 35 mg.

13. Before leaving, Holloway asked the staff person if she would be able to pick up her medications from a different Sunrise location: the Concord office. She was given a form to fill out concerning transfer of her records to Concord and a schedule of hours for that office.

14. Dr. Basi's notes of the May 13 visit are very limited. Despite the fact that he indicates performing a physical examination, very little detail is provided in the chart.

15. On May 20, 2008, Holloway called the Hayward clinic and made an appointment for her follow-up visit. On May 23, 2008, she appeared for the visit and a staff person took her weight and blood pressure. Holloway had gained a small amount of weight. She then briefly

saw Dr. Basi, and they discussed her meal plan and possible reasons why she had gained, as opposed to lost, weight. Dr. Basi gave Holloway a prescription bottle identical to the one he had given her on May 13. She asked him why Respondent's name was on the bottle, and Dr. Basi said that he was in the process of taking over the clinic and that as soon as he did so the prescriptions would be in his name. Holloway paid $75 for the visit.

16. Dr. Basi's note concerning the May 23 visit contains only Holloway's weight, blood pressure, and pulse. It does not contain information concerning Holloway's progress in any other respect.

17. Holloway was not provided with a written notice that she had a choice between obtaining the prescription from the dispensing prescriber (in this case, Dr. Basi) or from a pharmacy of her choice during either of the May office visits.

18. In May 2008, Dr. Basi worked for Respondent, including working one-half day each week in the Hayward clinic. Dr. Basi subsequently purchased the Hayward clinic from Respondent and began operating it himself on June 1, 2008. Dr. Basi credibly testified about both of Holloway's visits with him, about the protocols he followed when seeing Holloway, and about the chart notes he made of her visits.

19. Dr. Basi described the information he gives patients during their initial visits with him, which is essentially the same information he provided in May 2008. He goes over the program in general, including the following: the side effects of the medications; the risks and the benefits; the fact that drugs are appetite suppressants only; that they do not "burn fat"; that "they are not going to do everything for you – you have to do the hard work"; that they are schedule III or IV narcotics; that "we dispense out of the office but if you want a prescription we can give you one"; that the clinic does not profit from the pills, but rather from the visits; not to drive the first day or so until the patient observes the effects of the medication; that the medication may cause a headache; that "if the jitteriness doesn't go away, there are other options"; and that the medications will show up as amphetamines on a drug test. All of these topics are discussed prior to the initial physical examination.

During the physical exam, Dr. Basi checks the patient's eyes, ears, nose and throat. He conducts basic strength testing, a neurological exam, checks papillary dilation, checks reflexes, and performs cranial nerve testing. If the patient has fasted, lab work is then done. He then goes over diet, exercise, and journaling again in more detail. Dr. Basi tells the patients that their calories are going to be reduced, and tells them the minimum and maximum calories they are to consume, based upon their height and weight and their goal weight. He discusses goal weights, including that some goal weights are unrealistic. Regarding exercise, he recommends high intensity interval training, starting with a slow walk and advancing to faster speeds, working up to five times per week.

After this discussion, a staff person goes over the program again with the patient. They then pay their bill, obtain their medication if they chose medication, and leave.

20. The health history is designed to weed out conditions such as uncontrolled hypertension, glaucoma, any neurological issues, and past addictive history. Dr. Basi notes that there was nothing in the health history that Holloway provided that contraindicated the Sunrise program. His chart notes indicate that everything was within normal limits. Dr. Basi did note that Holloway disclosed a partial thyroidectomy, and he wrote in the chart that this was a benign cyst, 30 years ago. This was of interest to him because of the connection between thyroid conditions and weight.

21. On a form in the chart entitled Routine Physician Orders: Active Program, Dr. Basi wrote that Holloway was to consume a balanced diet of 1200 or 1000-1100 calories per day, and be provided a vitamin B-12 injection and Phendimetrazine tablets.

22. On June 6, 2008, Holloway called the Concord clinic and the call was forwarded to Lafayette. Staff person Heidi Andreasen answered the telephone and told Holloway that the Concord office was closed on Fridays and that Holloway could come to the Lafayette office to pick up her medication. She asked Holloway what medication she was taking and Holloway did not know, so she called Andreasen back. On that call, Andreasen said that she did not have Holloway's chart. Holloway went to the Lafayette location that afternoon. Andreasen asked her to sign in, took her to an exam room, and took her blood pressure and weight. As her chart was not present, it could not be determined how much weight she had lost or gained. Holloway showed Andreasen her food diary, but no note of it or copy was made.

Holloway told Andreasen that she might be relocated to Oakland and need to transfer to that office, but would call on Monday and confirm if this occurred. Holloway paid $49 for the visit. The medication was in a white paper bag stapled shut. No doctor was present at the clinic when Andreasen handed the bag to Holloway. The label on the bottle is one-half blue and one-half white. Under the name Sunrise Health Medical Group, "Mazzi" is written on the doctor line and the Oakland address is pre-printed. "R[redacted]C" is written on the patient line and "6/6/08" on the date line. Andreasen told Holloway that Dr. Mazzi had prepared the medication and had stapled the bag shut. Holloway asked for a blank copy of the meal planner, but one could not be located.

23. On June 9, 2008, Holloway called the Lafayette office and told Andreasen that she wanted to move her records to Oakland and pick up her medication there on June 12. Andreasen agreed. On June 12, 2008, Holloway went to the Oakland office and Andreasen asked her to sign in. Andreasen told Holloway that they did not have her records, and asked her what medication she was taking. Holloway told her that she was taking "little yellow pills," and that she was given 21 at a time. Andreasen took Holloway's blood pressure and weight, and told her that she could not tell her if she had lost weight as she did not have her records. Andreasen told Holloway that they would need to have her records transferred from Hayward, and Holloway told Andreasen that she would follow up on getting that done. Andreasen told Holloway that Respondent and Dr. Basi had officially split the offices, but did not ask Holloway to sign a records release. Holloway paid $49 for the visit and received a small white bag, stapled shut, with a bottle inside. "R[redacted], C[redacted]," and "June 12, 2008" are handwritten on the

label. The bottle has a preprinted yellow label with Respondent's name and the Oakland clinic's address. The name and date are filled in, but not the directions.

24. On June 13, 2008, Holloway telephoned the Hayward office and the call was answered in Stockton by a staff person who identified herself as Joy. She said that the Hayward office was closed. Holloway asked Joy to forward her records from Hayward to Oakland, and Joy said that she would see that it was done.

25. Holloway took completed weekly food diaries with her on each of her visits to a Sunrise clinic. They were discussed with her by a staff person, but never in detail, and she was not given specific advice. Holloway was told to follow the food plan and make substitutions according to the list. Dr. Basi talked about her food diaries with her in more detail. She never saw anyone make a copy of her diary to put in her chart.

26. Prior to starting Holloway on a Sunrise program that included anorectic medications, an EKG was not offered or performed. A uric acid test was not included in the blood chemistry report that Holloway submitted to Dr. Basi. Also, Holloway was not tested for vitamin B-12 deficiency, and yet was offered vitamin B-12 injections as a part of her plan.

Respondent's description of his program and practice

27. Respondent's description of his clinic's program, both in his hearing testimony and interview with the Board, was generally consistent with Holloway's experience. He explained that patients see a doctor first to make sure they do not have any uncontrolled disease. Patients with significant heart disease, uncontrolled diabetes, and similar conditions are not accepted. What the majority of the patients have in common is that they have been to another weight control program; for example, a prior unsuccessful experience with Jenny Craig or NutriSystems. Respondent acknowledges that the patients are coming to Sunrise for medication, because they have tried other methods that have not worked. Nonetheless, in addition to the medication, recommendations are made for changing eating habits, including using portion control to consume fewer calories. Clinic staff looks over the patient's food diary and helps them to confront self-deception in the amount they are eating. Also, patients are encouraged to try to move more to burn more calories; Respondent recalls that he may have at one time advised patients "to go to the Y or whatever." But returning weekly to the clinic to be weighed and receive medication is essential to the treatment plan, as it helps the patient keep on track. As the informed consent sheet that he authored states, drugs alone are not the solution. According to Respondent, the drugs he prescribes are pretty effective in killing appetite, but appetite is often not why people eat.

Despite the protocol, Respondent insists that patients are treated as individuals. His staff is instructed to be very friendly, to be observant, and to offer help. On the other hand, Respondent is adamant that "we don't think our patients are idiots." The patients have heard many times the general guidelines for weight loss: that they need to break bad habits, change their lifestyles, and eat less. Respondent added that "most of what we do could be found in a

book from 1950." But this does not mean that they should not be counseled, and he represented that the patients are counseled.

28. Despite what is found in the medical literature, which he recognizes, Respondent believes the medications he prescribes to be "enormously benign." He represents that he is now the most experienced physician with these medications in Northern California. Respondent relies on staff reports and the patients themselves to recognize when additional doctor visits are warranted, whether connected to the medications or for other medical reasons.

29. Respondent testified that Sunrise has an EKG machine in every office. The tests are done on patients with a heart history or diabetes, although he asserts that studies have shown that EKG's do not reveal any more information than a clinical exam.

30. Although Respondent asserts that a uric acid test "doesn't tell you anything," it is simple to include with the other laboratory tests and is typically included. He does not understand, however, why such a test would be required. Overweight people can have gout and joint problems, but the treatment for gout is to lose weight. Respondent's position in this regard was difficult to understand.

31. Vitamin B-12 is offered to patients primarily because they expect it and they say it helps them feel better. Sunrise does not test for vitamin B-12 deficiency. According to Respondent, certain sources, like the University of Maryland website, state that it is useful to treat fatigue, although "no one knows why." Respondent points out that there is no toxic dose for vitamin B-12.

32. Respondent describes his practice as "very little medical . . . almost like [the] Jenny Craig [program] . . . but over 90 percent of patients are on drugs." Currently, Respondent is "not on the premises very much." He lives with his office manager, however, and so he "hears about the operation every day."

33. Respondent was at times antagonistic and combative while testifying. For example, he more than once referred to the Board's investigators as the "secret police." His demeanor suggested a belief that he is completely in the right and that all who question his opinions and statements are absolutely wrong.

EXPERT OPINION EVIDENCE: NEGLIGENCE

34. Joan Saxon, M.D., is board certified in nephrology and internal medicine. She attended medical school at the University of California at Los Angeles. Dr. Saxon has been on active staff at the California Pacific Medical Center, San Francisco, since 1979. She has served as a Clinical Professor of Medicine at the University of California, San Francisco, since 2002. Dr. Saxon is a specialist in the treatment of obesity, also known as beriatric medicine. She is currently the medical director of the Weight Management Program of San Francisco. The program, which she founded in 1980, primarily treats morbidly obese patients who have been referred by their primary physicians. In the past, she operated similar programs in San Jose and

San Rafael. Based upon her education, training, research, continuing study and clear focus on the risks and benefits of obesity treatment, Dr. Saxon was established as an expert in the medical treatment of obesity. Dr. Saxon is familiar with the standard of practice of beriatric medicine in California.

35. Dr. Saxon's program is quite comprehensive. Patients begin by attending an orientation session where she talks to them for about 30 to 40 minutes about the program. Patients then meet with staff regarding the clinical aspects and schedules. They are screened by giving a health history and submitting to a physical examination that includes a cardiogram and urinalysis. Patients return the following week to receive their results, then attend a group session weekly to learn about making behavior changes, calorie counting, record keeping, general nutrition and other helpful information to aid in fat loss. Dr. Saxon goes over the lab tests with the patients and attends some classes, but in general they are supervised and taught by staff members. Dr. Saxon employs other physicians and nurse practitioners, as well as a behavioral psychologist, a registered dietitian, a part-time exercise physiologist, and a part-time diabetes nurse educator.

36. Approximately 30 percent of Dr. Saxon's patients have medical insurance that covers her program. The screening fee is about $350 and the monthly fee about $390 during the acute phase. The maintenance fee is about $500 for six months.

37. Anorectic medications as used by Respondent are not a part of Dr. Saxon's program. Her opinion as to the efficacy of these medications has changed because of the repeated evidence that the drugs are not very effective. In 2003, she wrote and believed that they were useful adjuncts in an acute weight loss program. Now, she believes that they can help at first, but are not effective in the long run and unless the patient is engaged in long-term changes, they will not be helpful. In addition, there can be side effects, including heart palpitations, elevated blood pressure, cardiac arrhythmia, dry mouth, diarrhea, constipation insomnia, and a "spacey feeling." Dr. Saxon asserts that these medications are more effective in helping to maintain weight than in assisting with initial weight loss. Accordingly, she opined that it is not the standard of practice to use the medications in the acute phase. Instead, more conservative therapies should be tried for approximately six months.

38. Dr. Saxon opined that Respondent's practice, which she described as one that "consists primarily of dispensing diet pills," represents an extreme departure from the standard of practice of a beriatric physician. This is because the practice does not employ trained professionals in affiliated areas who are available to educate and assist patients to lose weight and maintain weight loss. Dr. Saxon believes that patients have the right to receive the resources they need, including the assistance of trained personnel, to help them succeed.

39. Dr. Saxon opined that it is an extreme departure from the standard of practice to prescribe anorectic drugs for a patient and have only two visits with a physician at the beginning of treatment. There are risk factors and a patient may develop side effects. Patients can give the physician information, but the physician needs to question the patient to make sure nothing

is missed. Weekly visits are the minimum at first, and for stable, long-term patients, visits at six or eight-week intervals would be acceptable.

40. Dr. Saxon opined that it is a simple departure from the standard of practice in the treatment of an obese patient to fail to administer an EKG prior to prescribing anorectic medication. Cardiac conditions are not unusual in obese patients and anorectic drugs can create or exacerbate cardiac conditions.

41. Dr. Saxon opined that it is a simple departure from the standard of practice in the treatment of an obese patient to fail to test for uric acid prior to treatment. It is not unusual for obese patients to have elevated levels of uric acid, and this can cause a gout attack. If this is known ahead of time, it can be prevented. In addition, some diet regimens, and weight loss itself, can predispose a patient to gout, even in the absence of anorectic or other medications.

42. Dr. Saxon opined that it is a simple departure from the standard of practice in the treatment of an obese patient to administer vitamin B-12 injections absent proof that the patient is deficient in that vitamin. Dr. Saxon acknowledges that vitamin B-12 is frequently used in beriatric practices, but there is no proof that it is effective.

43. Dr. Saxon opined that it is a simple departure from the standard of practice in the treatment of an obese patient to fail to chart patient progress, including behavioral, dietary, and exercise progress. As an example, she pointed to the chart note concerning Holloway's visit on May 13, 2008. Although Holloway's weight was up three-quarters of a pound, there is no explanation noted as to why she had gained weight and not lost weight after one week on the anorectic medication.

44. Dr. Saxon opined that it is a simple departure from the standard of practice in the treatment of an obese patient to fail to maintain a policy and procedures manual in a medical practice. Such manuals can overlap with an office manual. They describe how the office is run, including how tests are performed and how telephone calls are answered. The job descriptions and tasks of allied health professionals employed in the practice are included. Although the exhibit described by Respondent as his office's manual does have some policies, it does not have protocols for such procedures as taking blood pressures and drawing blood. Thus, it is not sufficient as a policies and procedures manual.

45. Jack Earl Kundin, M.D., is board certified in neurology. He attended medical school at the George Washington University School of Medicine. Dr. Kundin was enrolled in a neurology residency at Jefferson Medical College Hospital in Philadelphia, Pennsylvania, from 1963 to 1964, then at Stanford Medical Center from 1966 to 1968. He was a clinical instructor at Stanford from 1968 until 1972. Dr. Kundin cared for patients with back pain, working with orthopedists, until approximately 2001. He also performed independent medical evaluations for many years, until 2006.

In 2001, Dr. Kundin answered an advertisement and was hired by Ralph Alperin, M.D., who was operating seven medical weight loss clinics in the Bay Area at that time. Previously,

Dr. Kundin was interested in beriatrics only because of obesity's relationship to back pain and strokes. Dr. Kundin worked for Dr. Alperin as an independent contractor. He was told that he had to do things "Dr. Alperin's way," but medical judgments were left up to him. In 2008, Dr. Alperin retired and business was very slow. Nonetheless, Dr. Kundin purchased two clinics in San Jose and operates them as the Northern California Medical Weight Loss Clinics. He works in one clinic and employs another physician to work in the other.

Dr. Kundin has not participated in any research studies in obesity or published in any journals. His sole training and education in beriatrics was received from Dr. Alperin.

46. Dr. Kundin opined that Respondent's program in general and his clinic's treatment of Holloway, was consistent with the standard of practice. He believes that Dr. Saxon's program, while wonderful, represents the "gold standard," and is "not in the real world," especially with the current state of the economy. Despite these statements, Dr. Kundin's practice, although below the level of care that Dr. Saxon provides, appears to be above the level of service provided by Respondent. Dr. Kundin employs one registered nurse for each clinic, and a licensed vocational nurse. He does not employ medical assistants. He and his nurse talk to patients about nutrition and behavioral changes. Dr. Kundin does prescribe, but does not dispense, certain anorectic medications, in 90-day amounts. Blood tests are conducted every 20 pounds of weight loss, and the patient sees a physician at that point and after the first 90 days. Dr. Kundin reviews every patient's chart at least every three weeks.

47. As regards the frequency of physician visits for patients on anorectic medications, Dr. Kundin explained that the medications he prescribes can cause hypertension and rapid heart rate in some people. If he reviews the chart and does not see those problems, he does not see the patient himself. Anytime a patient wants to see him, however, it happens. And his fees include "as many [physician] visits as necessary." He opined, however, that Respondent's practice of seeing the patient twice and then as requested, meets the standard of practice.

48. Dr. Kundin's opinion regarding the simple departures found by Dr. Saxon is similar. An EKG "is a good idea if the patient can afford it, but most people don't need it." He employs the physical examination and history to determine the amount of risk involved in the medications for the patient. Similarly, a uric acid screen is a good idea, but not mandatory and not required by the standard of practice. Dr. Kundin offers vitamin B-12 injections, although they are possibly placebos. He does not charge extra, there is no potential for harm and there is no risk. He believes that it can cause patients to come in to the clinic, which is a good thing.

He reviewed Holloway's chart and found it meets the standard of practice. All that is required in Dr. Kundin's opinion is to note the patient's weight and any side effects. And, the policy manual he was shown is acceptable.

49. Dr. Kundin's opinion that Dr. Saxon's practice represents an irrelevant Cadillac standard was belied by the cost of his own program. Dr. Saxon's initial visit and testing costs

$350. The patient then pays $390 per month until weight loss goal is achieved, when the cost falls to $500 for six months. Dr. Kundin's program costs $500 per month.

50. Dr. Saxon's opinions were overall more persuasive than Dr. Kundin's. Her education, training and experience in beriatric medicine are well established and more extensive than his in all respects. Dr. Kundin qualifications are grounded in his employment by Dr. Alperin and the purchase and operation of his clinics.

Dr. Kundin's practice, however, while less sophisticated than Dr. Saxon's, offers more to patients than Respondent's. Particularly noteworthy is Dr. Kundin's practice surrounding the medication protocols. He prescribes, but does not dispense, and requires patients to return after 90 days for a check-up. Despite this, Dr. Kundin methodically related his opinions that in each alleged instance, Respondent's practice did not fall below the standard. Dr. Kundin's descriptions of his own practice negatively affected his credibility in that regard.

The following findings regarding the negligence allegations are informed by the expert opinion evidence and the above-stated analysis.

FINDINGS RE: GROSS NEGLIGENCE/REPEATED NEGLIGENT ACTS

51. Complainant alleges that Respondent was grossly negligent in that he "offered medical treatment of obesity without a staff of professionals trained and certified in behavior change, exercise, and nutrition, as well as medicine; instead he provided care which consisted primarily of dispensing diet pills." This allegation was not proven. It was not proven that Respondent's clinics primarily dispense diet pills; more services are offered to patients. And it was not proven that the standard of practice requires a staff of professionals as described by Dr. Saxon.

52. Respondent was grossly negligent by failing to provide adequate and appropriate follow-up care by a physician for patients who are prescribed anorectic drugs. Respondent's practice in this regard is striking. What differentiates Respondent's medical practice from the other weight loss programs he compares himself with is that he prescribes dangerous drugs and controlled substances. But despite the numerous contra-indications and possible adverse reactions, patients are left on their own to report what they suspect are problems resulting from the drugs. The only real assistance is from unlicensed staff members, who are expected to note potential problems. The record is unclear about whether the length of time patients are taking the medications is monitored. Further, the payment structure discourages physician appointments, in that after the initial two visits, such appointments cost extra.

53. Respondent was negligent by failing to provide an EKG and uric acid testing for patients prior to prescribing anorectic controlled substances.

54. It was not established that offering vitamin B-12 injections to patients was negligent or violative of the standard of practice of beriatric physicians.

55. Respondent's medical record keeping was negligent and fell below the standard of practice of beriatric physicians.

56. It was not established that Respondent did not maintain a policies and procedures manual for his practice.

ALLEGATIONS CONCERNING DRUG LAW VIOLATIONS

57. On March 13, 2008, investigators for the Board visited the Oakland office of Sunrise. The reason for the visit was to determine if violations of the drug dispensing laws were taking place and, if so, to ask Respondent to come into compliance with the laws. Generally, two investigators conduct such visits, but on this occasion, two additional investigators were present for training purposes. Supervising Investigator Teri Bennett was in charge. With her were Senior Investigator Valerie Baker, Investigator Monica Dimitri, and Investigator Lindsay Barnett (now Lindsay Brierly). When they arrived, there were no patients present. Dr. Albert Mazzie, a physician employee of Respondent, was present but had no contact with the investigators. Heidi Andreasen was present and stated that she was in charge of the office. Another staff person, Angela Panameno, was also there.

58. Bennett interviewed Andreasen, with Dimitri present. Andreasen told her that she works full-time for Respondent in the position of medical assistant, dividing her time between the Oakland and Lafayette offices, and described the treatment procedures. These include that medical assistants such as herself weigh and take the blood pressure of patients. In addition, the assistants who are phlebotomists draw blood for lab tests.

59. Andreasen told Bennett that the medications were kept in two locations: in the front office in a cabinet that is locked only at night, and in a back room in a cabinet that is always locked. The medications include Phentermine, Bontril (Phendimetrazine), Tenuate (Diethylproprion), and Phendimetrazine, which are all controlled substances. A doctor fills the bottles with the medications and places them into bags, which are kept in the front office cabinet. The bags of medication are handed out to the patients by the medical assistants, whether or not a doctor is present. A physician is only present in the mornings, but patients can pick up their medication any time the office is open.

60. The investigators opened a medication bag and found a prescription bottle containing Bontril in 105 mg. tablets. The label on the bottle was handwritten with a patient's name and date, but there were no directions for use on the label.

61. There is a conflict in the evidence concerning how the medications are transferred from the packages they arrive in from the supplier into bottles, and then bags, which are given to patients. During the visit, Andreasen told Bennett and Barnett that "a lot of the medication is received in blister packs from the distributor and the staff puts them into prescription sized bottles. They show the containers to the doctor who approves them and then the staff hands them out to patients." At hearing, Andresen explained that she misspoke when describing the packaging as blister packs. She meant to say shrink-wrapped packaging. A

group of bottles is surrounded by see-through plastic packaging that fits tightly over the bottles. Andreasen stated that the staff does not handle pills, or repackage or reconfigure the bottles. In fact, they are intentionally ordered in pre-packaged doses.

62. Physicians who dispense medications are required by law to keep various records and issue certain reports. One of the reports, the Controlled Substance Utilization Review and Evaluation System (CURES) report, is required to be submitted weekly to the California Department of Justice. On March 13, Board investigators asked Andreasen for the practice's records concerning medications and whether the CURES reporting was done. There is a conflict in the evidence concerning these records and reports.

63. According to Bennett, when she asked Andreasen for the office's drug logs, Andreasen told her that the office did not keep drug logs. Bennett therefore asked for invoices and instructed Dimitri to write down the information so that she could contact the drug companies. Andreasen testified that the office keeps a central logbook which contains an inventory of medications that is called the "Back Office Inventory Book." In this book she records the date received, the quantity, and what is dispensed to the front cabinet. A separate page is maintained for each drug. She testified that when the investigators arrived she gave them this book; they looked at it, and then gave it back to her. She said that they did not ask for invoices, but asked who she ordered drugs from, and she provided that information. In addition, the office maintains a list that shows the name of the patient and the drug prescribed for that patient. Andreasen brought a binder to the hearing that was consistent with her testimony. These two versions cannot be reconciled, and neither witness was more credible on this point. Bennett's request for records may not have been clear or may have been misunderstood by Andreasen.

64. Respondent arrived at Sunrise Oakland at about 11:30 a.m. He questioned the authority of the investigators and was provided with copies of the laws concerning their authority. Bennett advised Respondent that there was a problem in that medical assistants were dispensing controlled substances when no physician was on site. Respondent told her that only doctors dispense medication and that a doctor is present all day. When Bennett advised that she knew this was not the case, Respondent stated that there are times when staff gives medication to patients, but only after it has been checked or approved by a doctor.

65. In her written report, Dimitri described Respondent's demeanor during the drug audit as angry and defensive. She wrote that Respondent "was talking very loudly with a lot of hand gesturing towards SI Bennett." At one point when advised that if he did not come into compliance with the drug laws it could become a criminal matter, Respondent "held out his hands and told SI Bennett to handcuff him now." Andreasen described the exchange between Bennett and Respondent as a heated discussion that became more heated when Bennett made reference to Respondent being like doctors she wanted to "get." Bennett denied any such statement. The investigators left without completing a drug audit, in part because of Respondent's hostile attitude and behavior.

66. Dr. Mazzie worked part-time at the Oakland Sunrise clinic at the time of the investigation. He testified that he did not have knowledge of drug dispensing laws. Dr. Mazzie prepared the bottles of medications given to the patients at the Oakland clinic, but his explanation of the procedure and his role in it was somewhat unclear. He stated that he placed the pills into the bottles, sometimes re-packaging them to provide a lesser dosage at first. The labeling is done by a medical assistant. But he also said that that his role was to check what the medical assistants did against a drug dispensation log. It may be that both methods were employed at different times. He did state that he checked the contents of the bags that the bottles of pills were placed in and stapled the bags shut. In addition, Dr. Mazzie testified both that if he prescribed the drug, his name was on the bottle, and that he thinks that the bottles given to the patients have Respondent's name on them. Dr. Mazzie is aware that the medical assistants dispense medications when he is not on the premises. He does not have keys to the cabinets where the medications are kept; he relies on office staff to open them.

67. Randa Peterson has been the general manager of Sunrise Health since approximately 1989. She has resided with Respondent for about three years. Peterson is in charge of purchasing drugs and ensuring that the proper records are maintained. When she learned that CURES reports were required, Peterson told everyone in the various offices to prepare them and mail them at the end of each month. In 2008 the CURES reports were prepared for each office, printed out monthly, and mailed. They are now done electronically. Part of Peterson's job is to prepare and submit CURES reports, and she uses office records to prepare those reports. Nonetheless, she testified that she does not know if copies of the CURES reports are kept. Peterson asserts that the CURES reports were always submitted timely and complete.

68. A Board investigator obtained a copy of a CURES report for the month during which Dr. Basi prescribed medication for undercover investigator Holloway (May 11, 2008 to June 15, 2008). Hers is the only prescription on the report for that month, despite that fact that the Hayward clinic had many more patients who received medications during that month.

Regarding this fact, Peterson offered the following explanation. Peterson and Respondent discussed whether Holloway's prescription was on the CURES report from the Hayward office, and Peterson recalls that she told him that she was sure it was. But Respondent directed her to submit it again, so she did.

69. Peterson appeared exceptionally nervous while testifying, and her testimony was at times difficult to follow. Her personal relationship with Respondent gives her a reason to be biased. For these reasons, her testimony was accorded limited weight.

70. Peterson testified that Respondent prepared a manual of policies and procedures when he started operating Sunrise and that a copy is kept at each location. Respondent appeared unclear during his interview with the Board and while testifying about the contents of the manual, but was adamant that one was prepared and that it was adequate for the practice. A copy of a document entitled Policy Manual, consisting of 17 pages, was admitted in evidence.

71. Peterson testified that each office has a sign that advises patients of their right to have a prescription that they can fill in a pharmacy. She does not recall what date the signs were put up, but they were present in 2008. Andreasen testified similarly. The Board's investigators who testified stated that such a sign was not present at the Oakland clinic on March 13, 2008. The investigators were on the premises specifically to determine compliance with drug-related laws and regulations, and their testimony in this regard was more credible.

EXPERT OPINION EVIDENCE: DRUG LAWS

72. Orriette A. Quandt earned a doctorate in pharmacy from the University of California at San Francisco in 1972. She worked as a pharmacist until becoming an inspector for the California Board of Pharmacy in 1994. Quandt was employed by Longs Drug Stores from 1999 until 2009, first as Manager of Pharmacy Compliance, then as Chief Pharmacy Compliance Officer. She presently works as a consultant.

Quandt is very familiar with California and federal law regarding the prescribing and dispensing of medications, including controlled substances. She explained that the law clearly differentiates between pharmacies and physicians, in order to protect members of the public from receiving the correct and appropriate medication. When a prescribing physician furnishes the drug, there must be direct contact between the physician and the patient. Exceptions to this rule include only the licensed personnel specified by statute, and these persons do not include medical assistants or even registered nurses.

73. Quandt also opined concerning the storage requirements for physicians who dispense drugs from their offices. California law requires storage in a secure locked area. And federal law requires that controlled substances must be stored in securely locked, substantially built cabinets.

74. The required elements on a prescription bottle label are the patient's name; the license number if the dispenser is a pharmacy; the name of the drug; if generic, the name of the manufacturer; the quantity; strength; directions for use; expiration date; physician's name; and the name and address of the pharmacy or physician. In addition, a description of the contents must be on the bottle and the bottle must be a childproof container.

75. Quandt is clearly an expert in pharmacy and prescriber dispenser laws and regulations and her testimony and opinions were instructive.

FINDINGS RE: DRUG LAW VIOLATIONS

76. Respondent failed to keep controlled substances to be dispensed in a secure, locked storage area.

77. Respondent allowed unlicensed staff members to dispense controlled substances to patients.

78. Respondent failed to comply with laws relating to prescribing, labeling, and dispensing controlled substances and dangerous drugs.

79. Respondent failed, prior to dispensing, to offer undercover patient Holloway a written prescription in lieu of dispensing to her directly.

80. Respondent failed to provide undercover patient Holloway with written disclosure of the right to a written prescription that could be filled at a pharmacy for her choosing.

81. It was not established that on March 13, 2008, Respondent failed to produce records of acquisition and dispensation of drugs for inspection.

82. It was not established that Respondent failed to make weekly reports of dispensation of controlled substances to the CURES program. (No time period was specified in the allegation.)

FINDINGS RE: AIDING AND ABETTING UNLICENSED PRACTICE

83. Respondent aided and abetted the unlicensed practice of medicine in that unlicensed personnel dispensed dangerous drugs or controlled substances to patients when a physician was not present. Thus, despite some conflicting evidence concerning how the bottles were packaged and who put the pills in the bottles, among other things, aiding and abetting was proven.

LEGAL CONCLUSIONS

MOTIONS TO DISMISS THE ACCUSATION

1. Respondent moved for dismissal of the Accusation on the grounds of equitable estoppel and of laches. It is unclear from his argument whether by equitable estoppel he means just that doctrine, or whether he also claims collateral estoppel. Therefore, both types of estoppel will be addressed.

Equitable estoppel

2. In the 1980's and 1990's, there were inspections of Respondent's practice by Medical Board investigators, including of his methods of dispensing medications to his patients. No Board action was instituted as a result of any of these inspections, and Respondent contends that he continued to operate in the same manner "based on the understanding that the Medical Board essentially endorsed the manner in which his practice was being run." Accordingly, he contends that the Board should be estopped from bringing any action against his license that is based upon his method of operating his clinics.

In *Driscoll v. City of Los Angeles* (1967) 67 Cal. 2d 297, the California Supreme Court established the relevant factors to be considered when estoppel is asserted against a public agency. Although *Driscoll* involved estoppel to assert the statute of limitations, the criteria mentioned in *Driscoll* apply with equal force to other situations involving a claim of equitable estoppel against a public entity. Generally, four elements must be present in order to apply the doctrine: (1) the party to be estopped must be apprised of the facts; (2) he must intend that his conduct shall be acted upon, or must so act that the party asserting the estoppel had a right to believe it was so intended; (3) the other party must be ignorant of the true state of facts; and (4) he must rely upon the conduct to his injury. *Driscoll*, *supra* at p. 305; *Ortega v. Pajaro Valley Unified School District* (1998) 64 Cal.App.4th 1023, 1044.

Respondent did not prove the four required elements. He relies upon argument not based in fact and inferences drawn from his unsupported beliefs. The motion to dismiss based upon the general precepts of equitable estoppel is denied.

In addition, Respondent contends that Evidence Code section 623 applies to his situation. It states:

> Whenever a party has, by his own statement or conduct, intentionally and deliberately led another to believe a particular thing true and to act upon such belief, he is not, in any litigation arising out of such statement or conduct, permitted to contradict it.

Respondent did not prove that Complainant "intentionally and deliberately" led him to believe that he was practicing in a legal manner. Accordingly, Evidence Code section 623 does not apply.

Collateral estoppel

3. Collateral estoppel, also known as issue preclusion, prevents the relitigation of issues argued and decided in prior proceedings. In order to establish collateral estoppel, several threshold requirements must be met. First, the issue sought to be precluded must be identical to that decided in a former proceeding. Second, this issue must have been actually litigated in the former proceeding. Third, it must have been necessarily decided in the former proceeding. Fourth, the decision in the former proceeding must be final and on the merits. Finally, the party against whom preclusion is sought must be the same as, or in privity with, the party in the prior proceeding. (*Zapata v. Department of Motor Vehicles* (1991) 2 Cal.App.4th 108, 112.)

There was no prior proceeding; accordingly, collateral estoppel does not apply in this situation and there is no need for further analysis. The motion to dismiss is denied.

Laches

4. The equitable defense of laches requires the moving party to prove unreasonable delay in bringing the action, resulting in prejudice to that party. The defense of laches is

established by a showing of unreasonable pre-accusation delay resulting in prejudice to the licensee in preparing a defense. (*Gates v. DMV* (1979) 94 Cal.App.3d 921, 925.) In a license revocation proceeding, the burden of proof remains with the party asserting laches as a defense. (*Fahmy v. Medical Board* (1995) 38 Cal.App.4th 810, 815; see also *Green v. Board of Dental Examiners* (1996) 47 Cal.App.4th 786, 795.)

Respondent argues that Complainant delayed in bringing the action from the investigations and/or inspections that the Board conducted in the 1980's and 1990's until filing the Accusation in 2009. This is not the relevant time period for a laches analysis. As discussed in the Factual Findings, this action is based upon information gathered by Board investigators in 2008. Respondent was not required to defend against anything he did or do not do prior to that time, and any evidence of his conduct at an earlier time and certainly in the 1980's or 1990's, would have likely been irrelevant. Thus, Respondent failed to establish an unreasonable delay in filing the action and failed to establish that he suffered prejudice in defending against it. The motion to dismiss based upon laches is denied.

CAUSES FOR DISCIPLINE

5. Unprofessional conduct is grounds for discipline of a physician's certificate pursuant to Business and Professions Code section 2234. Unprofessional conduct includes violations, attempted violations, and aiding and abetting violations, of the Medical Practice Act (Bus. & Prof. Code, § 2234, subd. (a)), gross negligence (Bus. & Prof. Code, § 2234, subd. (b)), repeated negligent acts (Bus. & Prof. Code, § 2234, subd. (c)), and violations of federal and state drug laws and regulations (Bus. & Prof. Code, § 2238).

Negligence

6. The evidence established that Respondent committed gross negligence. (Findings 39 and 52.) Cause for license discipline therefore exists pursuant to Business and Professions Code section 2234, subdivision (b).

7. The evidence established that Respondent committed repeated acts of negligence. (Findings 14, 25, 40, 43, 53 and 55.) Cause for license discipline therefore exists pursuant to Business and Professions Code section 2234, subdivision (c).

Drug laws

8. Business and Professions Code section 4172 provides that "a prescriber who dispenses drugs pursuant to Section 4170 shall store all drugs to be dispensed in an area that is secure. The Medical Board of California shall, by regulation, define the term 'secure' for purposes of this section." California Code of Regulations, title 16, section 1356.3, defines "area which is secure," to be "a locked storage area which shall be available only to staff authorized by the physician to have access thereto." Code of Federal Regulations, title 21, section 1301.75, subdivision (b), provides that controlled substances "shall be stored in a securely locked, substantially constructed cabinet." The evidence demonstrated that Respondent failed to meet

the requirements of these provisions. (See Findings 59, 66, 73, and 76.) Cause for license discipline therefore exists pursuant to Business and Professions Code section 4172, as it relates to Business and Professions Code section 2238.

9. Business and Professions Code section 4170, subdivision (a)(1), prohibits a prescriber from dispensing drugs in his office unless they "are dispensed to the prescriber's own patient, and the drugs . . . are not furnished by a nurse or physician attendant." The evidence established that Respondent violated this provision in two respects: drugs were dispensed to another physician's patient and drugs were furnished to patients by office staff. (Findings 12, 15, 22, 59, 64, 66, and 77.) Cause for license discipline therefore exists pursuant to Business and Professions Code section 4170, subdivision (a)(1), as it relates to Business and Professions Code section 2238.

10. Business and Professions Code section 4170, subdivision (a)(4), requires dispensing prescribers to comply with "all of the labeling requirements imposed on pharmacists by Section 4076, all of the recordkeeping requirements of this chapter, and all of the packaging requirements of good pharmaceutical practice . . . ." Business and Professions Code section 4077 contains similar requirements. The evidence demonstrated that Respondent failed to comply with these provisions. (Findings 23, 60, 74, and 78.) Cause for license discipline therefore exists pursuant to Business and Professions Code sections 4170, subdivision (a)(4), and 4077.

11. Business and Professions Code section 4170, subdivision (a)(6), requires dispensing prescribers to offer patients a written prescription before dispensing drugs directly. The evidence demonstrated that Respondent failed to do so. (Findings 17 and 79.) Cause for license discipline therefore exists pursuant to Business and Professions Code section 4170, subdivision (a)(6).

12. Business and Professions Code section 4170, subdivision (a)(7), requires dispensing prescribers to provide patients written disclosures that they have "a choice between obtaining the prescription from the dispensing prescriber or obtaining the prescription at a pharmacy of the patient's choice." The evidence demonstrated that Respondent failed to do so. (Finding 71 and 80.) Cause for license discipline therefore exists pursuant to Business and Professions Code section 4170, subdivision (a)(7).

13. Business and Professions Code section 4081 concerns the records and inventories required to be kept by those authorized to possess dangerous drugs, including physicians. Subdivision (a) provides, in pertinent part, that records of acquisition or disposition of dangerous drugs shall be open to inspection by authorized officers of the law during business hours and be kept for at least three years. A violation of Business and Professions Code section 4081 was not proven.

14. Health and Safety Code section 11190, subdivision (c)(2)(A), requires dispensing prescribers of Schedule II controlled substances to "provide the Department of Justice the information required by this subdivision on a weekly basis in a format set by the Department of

Justice pursuant to regulations." The information required includes the name and address of the patient; the date; the character, including the name, strength, and quantity of the controlled substance; the pathology and purpose for which the controlled substance was administered or prescribed; and other information. (Health & Saf. Code, § 11190, subds. (a) and (b).) A violation of Health and Safety Code section 11190, subdivision (c)(2)(A), was not proven.

Aid and abet

15. Business and Professions Code section 2264 defines unprofessional conduct to include aiding or abetting an unlicensed person to engage in the practice of medicine. The evidence established that Respondent employed unlicensed persons who dispensed dangerous drugs and/or controlled substances. (Finding 22, 23, 83.) Cause for license discipline therefore exists pursuant to Business and Professions Code section 2264.

Other matters

16. Business and Professions Code section 3527 provides for the denial, suspension, or revocation of the authority to supervise physician assistants for unprofessional conduct or a violation of the Medical Practices Act or its corresponding regulations. Cause for such action exists by reason of the above-described violations.

Discussion

17. Respondent contends that he operates Sunrise in accordance with all applicable laws and regulations while at the same time, implying that these same laws and regulations should not apply to him because of the business nature of his practice. But Respondent is not entitled to place himself in some type of third place between a weight loss program and a medical practice. He is a physician and must comply with the laws governing the practice of medicine. The most disturbing aspect of Respondent's position is his cavalier approach to prescribing and dispensing dangerous drugs and controlled substances. It is of serious concern that his model does not contain provisions to affirmatively follow up with patients regarding these medications. The fact that he sees nothing wrong with unlicensed personnel furnishing the drugs to patients is consistent with this overall lax attitude. Respondent argues that the lack of proven patient harm militates against action in this matter. But it is well established that the Board need not wait for a patient to be harmed to take action against a licensee.

18. Despite the serious nature of the violations, Complainant proposes that the public interest will be adequately protected by a five-year term of probation with conditions directed towards remediation. In general, this approach appears reasonable and will be adopted. It is noted, however, that Respondent has demonstrated a lack of interest and even hostility towards the Board's authority. Hopefully, he will avail himself of the opportunities provided by a term of probation so that this case can conclude and his license to practice be fully restored in a timely manner.

ORDER

Physician's and Surgeon's Certificate No. G19049, issued to Respondent William Herbert Vederman, M.D., is revoked; however, revocation is stayed 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, limited to classroom, conference, or seminar settings. 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. Prescribing Practices Course

Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices, at Respondent's expense, approved in advance by the Board or its designee. Failure to successfully complete the course during the first six months of probation is a violation of probation.

A prescribing practices 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. 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, at Respondent's expense, approved in advance by the Board or its designee. Failure to successfully complete the course during the first six months of probation is a violation of probation.

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.

4. Monitoring – Practice

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

The Board or its designee shall provide the approved monitor with copies of the Decision, 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.

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.

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 practice of medicine and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 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 days of the resignation or unavailability of the monitor, Respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within three calendar days after being so notified by the Board or designee.

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, 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.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

5. Notification

Prior to engaging in the practice of medicine Respondent shall provide a true copy of the Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent.

Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities, or insurance carrier.

6. Supervision of Physician Assistants

During probation, Respondent is prohibited from supervising physician assistants.

7. Obey All Laws

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court-ordered criminal probation, payments, and other orders.

8. Quarterly Declarations

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

9. Probation Unit Compliance

Respondent shall comply with the Board's probation unit. Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses. 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).

Respondent shall not engage in the practice of medicine in Respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's certificate.

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

10. Interview with the Board or its Designee

Respondent shall be available in person for interviews either at Respondent's place of business or at the probation unit office, with the Board or its designee upon request at various intervals and either with or without prior notice throughout the term of probation.

11. Residing or Practicing Out-of-State

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. Non-practice is defined as any period of time exceeding 30 calendar days in which Respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Board or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Probation Monitoring Costs.

Respondent's certificate shall be automatically cancelled if Respondent's periods of temporary or permanent residence or practice outside California total two years. However, Respondent's certificate shall not be cancelled as long as Respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two-year period shall begin on the date probation is completed or terminated in that state.

12. Failure to Practice Medicine - California Resident

In the event Respondent resides in the State of California and for any reason Respondent stops practicing medicine in California, Respondent shall notify the Board or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve Respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as

any period of time exceeding 30 calendar days in which Respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Board or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's certificate shall be automatically cancelled if Respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

13. Completion of Probation

Respondent shall comply with all financial obligations (e.g., 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.

14. 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.

15. License Surrender

Following the effective date of this Decision, if Respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request the voluntary surrender of Respondent's license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion 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 card 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

and the surrender of Respondent's license shall be deemed disciplinary action. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. 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. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

DATED: November 9, 2010

MARY-MARGARET ANDERSON
Administrative Law Judge
Office of Administrative Hearings

REDACTED

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO August 16, 2010
BY: [illegible] ANALYST

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

In the Matter of the Accusation Against: **WILLIAM HERBERT VEDERMAN, M.D.** **SUNRISE HEALTH MEDICAL GROUP, INC.** P.O. Box 10165 Oakland CA 94610 Physician and Surgeon's Certificate No. G19049 Respondent.	**Case No. 12-2006-178819** **FIRST AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Linda K. Whitney (Complainant) brings this First Amended Accusation solely in her official capacity as the Executive Director of the Medical Board of California.

2. On or about August 19, 1970, the Medical Board of California ("Board") issued Physician and Surgeon's Certificate No. G19049 to William Herbert Vederman, M.D. ("Respondent"). The certificate was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2011, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Medical Board of California[1], under the authority of the following laws.

4. Section 2227 of the Business and Professions Code ("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 Division of Medical Quality 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 [Chapter 5, the Medical Practice Act].
>
> "(b) Gross negligence.
>
> "© 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."

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1. As used herein, the term "board" means the Medical Board of California. As used herein, "Division of Medical Quality" shall also be deemed to refer to the board.

6. Section 2238 of the Code states:

"A violation of any federal statute or federal regulation or any of the statutes or regulations of this state regulating dangerous drugs or controlled substances constitutes unprofessional conduct."

7. Section 2264 of the Code states that the employing, directly or indirectly, or the aiding, or the abetting of any unlicensed person or any suspended, revoked, or unlicensed practitioner to engaged in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct.

8. In pertinent part, section 4024(b) of the Code defines "dispense" as the furnishing of drugs directly to a patient by a physician or other designated licensee acting within the scope of his or her practice.

9. Section 4026 of the Code defines "furnish" as "to supply by any means, by sale or otherwise.

10. Section 4076(a) of the Code sets forth the requirements for labeling prescriptions, which include, but are not limited to, the following: name of the drug, directions for use of the drug, name of the patient, name of the prescriber, date of issue, prescription number or other means of identifying the prescription, strength of the drug dispensed, quantity of the drug dispensed, expiration date of the drug dispensed, condition for which the drug was prescribed (if requested by the patient or the condition is stated on the prescription), physical description of the drug.

11. Section 4077 of the Code provides that no person shall dispense any dangerous drug except in a container correctly labeled with the information required by section 4076, except that a dispensing physician need not label the container with the prescription number.

12. Section 4081(a) of the Code provides that all records of the sale, acquisition, or disposition of dangerous drugs shall be, at all times during business hours, open to inspection by authorized officers of the law.

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13. Section 4170(a) of the Code provides, in pertinent parts, that no prescriber shall dispense drugs to patients in his or her office or place of business unless all of the following conditions are met:

> "(1) The dangerous drugs or dangerous devices are dispensed to the prescriber's own patient, and the drugs or dangerous devices are not furnished by a nurse or physician assistant.
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> "(2) The dangerous drugs or dangerous devices are necessary in the treatment of the condition for which the prescriber is attending the patient.
>
> "(3) The prescriber does not keep a pharmacy, open shop, or drugstore, advertised or otherwise, for the retailing of dangerous drugs . . . .
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> "(4) The prescriber fulfills all of the labeling requirements imposed upon pharmacists by Section 4076, all of the record keeping requirements of this chapter and all of the packaging requirements of good pharmaceutical practice, including the use of childproof containers.
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> " . . . . .
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> " (6) The prescriber, prior to dispensing, offers to give a written prescription to the patient that the patient may elected to have filled by the prescriber or by any pharmacy.
>
> "(7) The prescriber provides the patient with written disclosure that the patient has a choice between obtaining the prescription from the dispensing prescriber or obtaining the prescription at a pharmacy of the patient's choice."

Section 4170 further provides that the Medical Board shall have authority to ensure enforcement of this chapter with respect to its licensees.

14. Section 4172 of the Code states: "A prescriber who dispenses drugs pursuant to Section 4170 shall store all drugs to be dispensed in an area that is secure. The Medical Board of California shall, by regulation, define the term 'secure' for purposes of this section."

15. Title 16 California Code of Regulations ("CCR") section 1356.3 states: "For purposes of section 4172 of the code, the phrase 'area which is secure' means a locked storage area which shall be available only to staff authorized by the physician to have access thereto."

16. Title 21 Code of Federal Regulations ("CFR") section 1301.75 sets forth federal regulations concerning federal security rules for physicians having controlled substances

on the premises. Section (b) provides that controlled substances listed in Schedules II, III, IV, and V [of the Uniform Controlled Substances Act] shall be stored in a securely locked, substantially constructed cabinet.

17. Section 11150 of the Health and Safety Code provides that no person other than a physician, or such other designated licensees as are stated in the statute, shall write or issue a prescription.

18. Section 11165 of the Health and Safety Code established the Controlled Drug Utilization Review and Evaluation System ("CURES") for the electronic monitoring of Schedule II, Schedule III, and Schedule IV controlled substances in the State of California.

19. Section 11190(c)(1) of the Health and Safety Code provides that for each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance that is dispensed by a prescriber pursuant to section 4170 of the Business and Professions Code, the prescriber shall record and maintain the following information:

> "(A) Full name, address, and the telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the patient.
> "(B) The prescriber's category of licensure and license number; federal controlled substance registration number; and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.
> "(C) Quantity of the controlled substance dispensed.
> "(D) ICD-9 (diagnosis code), if available.
> "(E) Number of refills ordered.
> "(F) Whether the drug was dispensed as a refill of a prescription or as a first-time request.
> "(H) Date of Origin of the prescription."
>
> "(2)(A) Each prescriber that dispenses controlled substances shall provide the Department of Justice the information required by this subdivision on a weekly basis in a format set by the Department of Justice pursuant to regulation."

20. Section 11191 of the Health and Safety Code provides that the records required in section 11190 be preserved for three (3) years.

21. Section 11192 of the Health and Safety Code provides that proof that a defendant has had in his possession at any time a greater amount of controlled substances than is accounted for by any record required by law or that the amount of controlled substances

possessed by a defendant is a lesser amount than is accounted for by any record required by law is prima facie evidence of a violation of section 11190.

22. Section 11200(b) of the Health and Safety Code provides, in pertinent, part, that no prescription for a Schedule III or Schedule IV controlled substance may be refilled more than five times.

DRUGS

23. Respondent, as owner and medical director of Sunrise Health Medical Group, Inc. prescribed, dispensed, or furnished dangerous drugs to patients, including the following controlled substances:

A. Phentermine hydrochloride. Phentermine is an anorectic which is similar in nature to the prototype drugs use to treat obesity, the amphetamines. This medication is an appetite suppressant and belongs to a class of drugs called sympathomimetic amines. Phentermine is used as a short-term adjunct (a few weeks) along with a doctor-approved, reduced-calorie diet, exercise, and behavior change program to help in weight loss. It is used in people who are significantly overweight (obese) and have not been able to lose enough weight with diet and exercise alone. Phentermine is contraindicated in patients with cardiovascular disease, moderate to severe hypertension, advanced arteriosclerosis, or hyperthyroidism. Since phentermine is related chemically and pharmacologically to the amphetamines, and amphetamines and related stimulant drugs have been extensively abused, the possibility of abuse should be kept in mind when evaluating the desirability of including phentermine as part of a weight reduction program. Phentermine is a Schedule IV controlled substance under section 11057(f)(4) of the Health and Safety Code and is a dangerous drug as defined by Business and Professions Code section 4022.

B. Phendimetrazine tartrate. Phendimetrazine is a sympathomimetic amine with pharmacological activity similar to the prototype drugs used to treat obesity, the amphetamines. Phendimetrazine is an appetite suppressant and central nervous system stimulant. It stimulates the satiety (feeling of fullness) center in the hypothalamus and limbic regions of the brain. Phendimetrazine must be used in combination with a low caloric diet, behavior

modification and regular exercise. Appetite suppressants are not a substitute for proper diet. It is contraindicated in patients with advanced arteriosclerosis, moderate to severe hypertension, symptomatic cardiovascular disease, or hyperthyroidism. Because phendimetrazine is chemically and pharmacologically related to the amphetamines, and related stimulant drugs have been extensively abused, the possibility of abuse should be should be kept in mind when evaluating the desirability of using it as part of a weight reduction program. It should only be as a short term adjunct to weight reduction therapy (a few weeks). Phendimetrazine is a Schedule III controlled substance under section 11056(b)(6) of the Health and Safety Code and a dangerous drug as defined by Business and Professions Code section 4022.

C. Diethylproprion hydrochloride. Diethylproprion is a sympathomimetic amine with pharmacological activity similar to the prototype drugs used to treat obesity, the amphetamines. Diethylproprion is an appetite suppressant and central nervous system stimulant. Diethylproprion is indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction in patients with an initial body mass index (BMI) of 30 kg/m^2 or higher and who have not responded to appropriate weight reducing regimen (diet and/or exercise) alone. Diethylproprion is contraindicated in patients with severe arteriosclerosis, hyperthyroidism, glaucoma, severe hypertension, or cardiovascular disease. Because diethylproprion is chemically and pharmacologically related to the amphetamines, and related drugs have been extensively abused, the possibility of abuse should be kept in mind when evaluating the desirability of using it as part of a weight reduction program. Diethylproprion is a Schedule IV controlled substance under section 11057(f)(1) of the Health and Safety Code and a dangerous drug as defined in Business and Professions Code section 4022.

FACTS

24. At all times relevant to this action, respondent owned and operated multiple weight loss clinics under the business name "Sunrise Health Medical Group" (hereinafter referred to as "SHMG") in Alameda and Contra Costa Counties..

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25. Beginning in or about February, 2008, Board investigators ("investigators") placed a series of telephone calls to SHMG in which they posed as potential clinic patients. In response to investigators' inquiries regarding the clinic's weight management plans, clinic staff advised the investigators that Sunrise Health Clinics offered a food replacement (*i.e.*, non-medical) and appetite suppressant (medical) plan. Investigators were advised that a hybrid of the two plans could also be arranged.

26. Investigators were advised by SHMG staff that patients on the medical plan were seen by a physician on the initial two visits and, thereafter, were followed by the staff of medical assistants or licensed vocational nurses (LVN's), who dispensed medications. Investigators were advised that the medications were placed in individual bags, which were then inspected by a physician. The Board's investigators were advised that Vitamin B-12 injections were also available and were "good for energy."

27. On March 13, 2008, investigators for the Board presented to the Oakland office of SHMG, where they interviewed respondent's employee, H.A., regarding the clinic's operation. H.A. advised that the patient's first visit is with a doctor who takes a patient history and performs a physical examination; medical assistants do a blood draw at that time, weigh the patient, and take the patient's blood pressure. H.A. indicated that the clinic offers three weight loss plans, including an 800 cal/day liquid plan, a "Health Management Resource Plan" and a plan where regular food is consumed, with or without appetite suppressants. H.A. stated that the suppressants used at SHMG are: phentermine, Bontril (phendimetrazine), Tenuate (diethylproprion) and phendimetrazine.

28. On March 13, 2008, investigators presented for a pharmacy audit at the Oakland SHMG clinic and inventoried an unlocked cabinet in which the clinic stored Schedule III and Schedule IV controlled substances, including the aforementioned appetite suppressants. H.A. advised that the cabinet and the file in which the finished bags of medication were stored were left unlocked during business hours. Records of acquisition and dispensation of drugs were

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requested by the investigators, but they were advised by H.A. that such records did not exist. Inspection of one medication bag revealed a prescription bottle containing Bontril, 105 mg. tablets, with a handwritten patient's name and a date, but without any directions for use of the drug on the label.

29. Respondent's employee advised that some medications that were received in blister packs and were broken down into prescription bottles by medical assistants. These vials were not in child-proof containers and the labels on the vials did not contain the patient name, the name of the prescribing physician, the date, or the directions for use. Other packaging included prepackaged prescription vials with preprinted labels on the vials, with blanks for the name of the patient, date, and directions for use. The employee then stated that prescription bottles containing patient medications were placed into bags by a physician, on which was written the patient name and a sticker indicating the drug inside, and the bags were stapled shut and filed in a file cabinet by patient name. H.A. told investigators that this filing cabinet remained unlocked during business hours. The employee reported that a physician was at the clinic in the morning only, but that patients could come to the clinic during all business hours, with no appointment, and claim their medications from clinic staff.

30. On March 13, 2008, respondent spoke with the Board's investigators at Oakland SHMG. Initially, respondent claimed that only doctors dispense medication at SHMG and that a doctor was on site all day. After he was advised that the Board was aware that medical assistants were dispensing medications when no doctor was on the premises, respondent admitted that his unlicensed staff would hand out medication, but that "they are only handing over a bag that has been approved by a doctor." Although the name of the drug was clearly printed on bags observed by investigators, respondent insisted that the clinic staff did not know what was contained in each patient's bag and stated that, for all they knew, it could be a bag of candy. At that time, an investigator opened one bag in respondent's presence and verified that it contained a controlled substance.

31. On May 13, 2008, an investigator for the Medical Board presented to respondent's clinic in Hayward, California, in an undercover capacity. She was given the same

information on the available plans as had been provided to the Board's investigators previously. The investigator, who was using the fictitious name "C[redacted]R[redacted] (hereafter "C.R.") received a physical examination by a physician who was not respondent. C.R. was told that a blood would be drawn for a blood test at the first visit, but this was not done, since C.R. brought and submitted a normal blood chemistry test which was dated less than 30 days before her first appointment. No EKG or uric acid test was performed. Thereafter, C.R. was provided with a prescription bottle containing 21 phendimetrazine tablets which designated the drug was prescribed by respondent, even though the prescribing physician was not respondent. C.R. was also given a weekly food dairy, a sample daily meal plan, a food substitution handout and a weekly food diary handout. Respondent's clinic did not provide the investigator with written disclosure that the patient has a choice between obtaining the prescription from the dispensing prescriber or obtaining the prescription at a pharmacy of the patient's choice. The Physician's Order included Vitamin B-12, 0.2 cc, SQ. C.R. gave no history of B-12 deficiency, nor was any test for B-12 deficiency performed. The physician's note for this visit contains no details concerning the information gathered during the examination. When C.R. inquired as to whether she could obtain her medications from other SHMG locations, she was asked to complete what she understood was an authorization to transfer her records to the Concord SHMG.

32. On May 20, 2008, C.R. telephoned the Hayward SHMG and made an appointment for her follow-up physician visit. On May 23, 2008, C.R. returned to the SHMG Hayward clinic, where her weight and her blood pressure were taken and recorded by a medical assistant. She was then seen briefly by a physician, who discussed her meal plan with her. No physical examination was performed. The note for this visit omits any discussion of the patient's progress, including behavioral, dietary, and exercise progress. C.R. was then given a prescription vial containing 21 phendimetrazine tablets, again with respondent's name on the label instead of the dispensing physician's name.

33. On June 6, 2008, the C.R. called the Concord SHMG to request to pick up her medication. She was advised that the Concord clinic was not open that day, that her call had been transferred to an SHMG clinic in Lafayette and, if she wished to obtain her diet medication,

she would have to go to the clinic located in Lafayette. She was further told that the Lafayette clinic did not have her chart and, in order to dispense medication to her, she would need to advise what medication she was taking, and C.R. did so . That afternoon, the investigator presented to the clinic in Lafayette, where a medical assistant took her blood pressure and recorded her weight. The assistant asked the investigator if she had any questions about her diet. She then collected a fee and gave her a bag with a label "Phendimetrazine Tabs," the drug strength and physical description, and the investigator's alias. The investigator was not seen by a physician, and no physician appeared to be on the premises during her visit. A copy of respondent's chart for the undercover investigator does not reflect the patient's progress or response to treatment at the time of this visit, nor is it indicated that a physician signed off on the medication dispensed.

34. On June 9, 2008, C.R. telephoned the Lafayette SHMG and spoke with medical assistant H.A. C.R. indicated that she wanted to move her records to the Oakland SHMG and would pick up her medications at the Oakland SHMG on June 12, 2008. On June 12, 2008, C.R. presented to the SHMG clinic in Oakland, California. At that time, she was seen by a medical assistant and the assistant asked her what medication she was taking. The investigator stated that she was taking "little yellow pills" that had been dispensed in bottles of 21 tablets. The assistant took her blood pressure and weight, collected a fee of $49.00, and dispensed a bag with the label "Phendimetrazine" and C.R.'s name hand-written on the bag.. The investigator was not seen by a physician, and no physician appeared to be on the premises during her visit. A copy of respondent's chart for the undercover investigator does not reflect the patient's progress or response to treatment at the time of this visit, nor is it indicated that a physician signed off on the medication dispensed.

36. On October 2, 2008, respondent was interviewed at the Medical Board District Office. Respondent advised that he was the owner of the SHMG clinics and was in overall charge of the clinics' operations, but that he rarely went to the clinics himself. Respondent stated that medical care at the clinics was provided by a contract physician, who was paid by the hour for "half time" employment. Respondent stated that the clinic dispensed phentermine, phendimetrazine, Bontril and diethylproprion to patients in a one week supply.

When patients returned for their weekly visit they did not need an appointment, but could drop in. At that drop-in visit, respondent stated that a medical assistant or "possibly" an licensed vocational nurse ("LVN") would take the patient's vital signs, weigh the patient, and provide "counseling." Respondent explained that "counseling" included asking "if they are having any adverse reactions if they are on the medication." If a change in medication was required, respondent stated that the contract physician would do that "when he reviews the situation" the following week. Respondent stated that, in addition to obesity, SHMG would provide treatment of other obesity-related medical problems, including Metabolic Syndrome.

37. Subsequent to his interview, respondent provided additional documents to the Board, which showed that his clinics were open for a total of 180 hours per month, during the period March through June. Respondent advised that the contract physician had billed and been paid for medical services ranging from 39 to 51 hours per month, during the same period. Respondent advised that the clinic has no written protocols for patient care.

FIRST CAUSES FOR DISCIPLINE

(Gross Negligence/Repeated Negligent Acts)

38. The allegations of paragraphs 24 through 37, above, are incorporated herein by reference as if fully set forth.

39. Respondent's license is subject to discipline and respondent is guilty of unprofessional conduct in violation of Business and Professions Code §2234, subsection (a) and/or (b) and/or (c) in that respondent was grossly negligent and/or guilty of repeated negligent acts in the medical management of exogenous obesity by reason of the following acts or omissions:

A. Respondent offered medical treatment of obesity without a staff of professionals trained and certified in behavior change, exercise and nutrition, as well as medicine; instead, he provided care which consisted primarily of dispensing diet pills.

B. Respondent failed to provide adequate and appropriate follow up care by a physician for patients who were prescribed anorectic drugs.

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C. Respondent failed to keep controlled substances to be dispensed in a secure, locked storage area in violation of sections 2238 through section 4172 of the Code, 16 CCR section 1356.3 and Title 21 CFR section 1301.75.

D. Respondent allowed unlicensed medical assistants and nurses to dispense controlled substances to patients in violation of sections 2238 and 4170(a)(1) of the Code.

E. Respondent, through his employees, failed to provide necessary tests, including an EKG and uric acid, during the health screening of a patient who was about to receive anorectic controlled substances.

F. Respondent, through his employees, offered B-12 injections to patients absent evidence of B-12 deficiency.

G. Respondent, through his employees, failed to so assure adequate and appropriate medical records which documented patient progress, including behavioral, dietary, and exercise progress;

H. Respondent failed to maintain a policy and procedures manual in his practices.

SECOND CAUSES FOR DISCIPLINE

(Violation of Drug Laws)

40. The allegations of paragraphs 24 through 37, above, are incorporated herein by reference as if fully set forth.

41. Respondent is guilty of unprofessional conduct under section 2238 of the Code and therefore subject to discipline under section 2234 of the Code by reason of the following acts or omissions:

A. Respondent failed to comply with laws relating to prescribing, labeling, and dispensing controlled substances and dangerous drugs in violation of sections 4076, 4077, and 4170(a)(4) of the Code.

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B. Respondent failed to keep drugs to be dispensed in a secure, locked storage area in violation of section 4172 of the Code, 16 CCR section 1356.3 and 21 CFR section 1301.75.

C. Respondent allowed non-prescriber medical assistants or nurses to dispense controlled substances in violation of section 4170(a)(1) of the Code.

D. Respondent failed, prior to dispensing, to offer to give to the patient a written prescription that the patient may elect to have filled by the dispensing prescriber or by any pharmacy in violation of section 4170(a)(6) of the Code.

F. Respondent failed to provide the patient with written disclosure that the patient had a choice between obtaining the prescription from the dispensing prescriber or obtaining a prescription at a pharmacy of the patient's choice in violation of section 4170(a)(7) of the Code.

G. At the drug audit of March 13, 2008, respondent failed to produce for inspection the records of acquisition and dispensation of drugs required to be produced under section 4081 of the Code.

H. Respondent failed to make required weekly reports of dispensation of controlled substances to the CURES program under section 11190(c)(2)(A) of the Health and Safety Code for drugs that had been purchased from wholesalers and delivered to the SHMG clinics under respondent's DEA registration numbers for each clinic.

~~THIRD CAUSE FOR DISCIPLINE~~

(Aiding and Abetting Unlicensed Practice of Medicine)

42. The allegations of paragraphs 24 through 37, above, are incorporated herein by reference as if fully set forth.

43. Respondent allowed unlicensed and uncertified medical assistants to note prescriptions in patient records without approval or prior prescription by a physician. He allowed unlicensed and uncertified medical assistants to dispense controlled substances to patients. He hired only a part time physician, paid by the hour, to constitute the medical staff of his clinics.

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Respondent himself was rarely on clinic premises and failed to monitor the operation of his weight control clinics.

44. Respondent's conduct, as set forth above, constitutes the aiding and abetting of the unlicensed practice of medicine, and therefore cause exists for discipline pursuant to section 2264 and 2234 of the Code.

PRAYER

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

1. Revoking or suspending Physician and surgeon's certificate Number G19049, issued to William Herbert Vederman, M.D..

2. Ordering William Herbert Vederman, M.D., if placed on probation, to pay the reasonable costs of probation monitoring;

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

DATED: August 16, 2010

LINDA K. WHITNEY
Executive Director
Medical Board of California
State of California

Complainant

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