REDACTED

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

In the Matter of the Accusation Against:	)	
	)	
	)	
WILLIAM S. EIDELMAN, M.D.	)	**File No. 06-2000-108619**
	)	
Physician's and Surgeon's Certificate No. G 32011	)	**OAH No. L2001080183**
	)	
	)	
Respondent.	)	
	)	

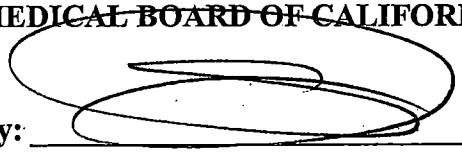
DECISION

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

This Decision shall become effective at 5:00 p.m. on July 6, 2004 **.**

IT IS SO ORDERED June 3, 2004 **.**

MEDICAL BOARD OF CALIFORNIA



By: _____
Steve Alexander, Acting Chair
Panel A
Division of Medical Quality

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

In the Matter of the Accusation Against: **WILLIAM S. EIDELMAN, M.D.** **1223 Wilshire Boulevard, #762** **Santa Monica, CA 90403** **Physician's and Surgeon's Certificate Number G 32011,** **Respondent.**	**Case No. 06-2000-108619** **OAH No. L2001080183**

PROPOSED DECISION

This matter came on regularly for hearing on February 9, 10, 11, 18, 19 and 20, and April 7, 2004 in Los Angeles, California, before H. Stuart Waxman, Administrative Law Judge, Office of Administrative Hearings, State of California.

Complainant, Ron Joseph ("Complainant"), was represented by Rajpal S. Dhillon, Deputy Attorney General.

Respondent, William S. Eidelman, M.D. ("Respondent"), was present and was represented by Richard A. Jaffe, Attorney at Law.

During the hearing, Complainant amended the Second Amended Accusation by striking Paragraphs 26, 27, 28 and 51.

Oral and documentary evidence was received. The parties stipulated that the record would remain open for 20 days. The record would then close and the Proposed Decision would be due 30 days thereafter. The Interim Suspension Order previously imposed on Respondent would remain in effect during that time period. On April 27, 2004, the record was closed and the matter was submitted for decision.

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FACTUAL FINDINGS

The Administrative Law Judge makes the following Factual Findings:

1. Ron Joseph made the Second Amended Accusation in his official capacity as Executive Director of the Medical Board of California ("the Board").

2. On July 1, 1976, the Board issued Physician and Surgeon Certificate No. G 32011 to Respondent. On May 24, 2002, a full Interim Suspension Order was issued, prohibiting Respondent from engaging in the practice of medicine in this State pending the disposition of the instant matter. That Interim Suspension Order remains in effect. Respondent's certificate will expire on February 28, 2005 unless renewed.

Dr. Eidelman

3. Respondent graduated from St. Louis University School of Medicine in 1975. He spent approximately 1½ years in a psychiatric residency program at Highland Hospital in Oakland, California but was dissatisfied with traditional diagnostic and treatment methods and left the program prior to completion. He worked in the General Medicine Clinic at a Kaiser Foundation Hospital in Oakland from 1977 to 1978 and again from 1981 to 1982. From 1979 to 1980, he was engaged in a private psychiatry practice. He returned to that practice in 1983, traveled in Brazil from 1984 to 1985, and then returned to his private psychiatry practice in 1986. In 1991, Respondent began practicing nutritional medicine in addition to his psychiatry practice.

4. Respondent is not board certified with, or board eligible for, any recognized medical specialty board.

5. In 1996, the people of the State of California passed Proposition 215, the "Compassionate Use Act," now codified as Health and Safety Code section 11362.5 ("Prop 215" or "section 11362.5"). Section 11362.5 is designed to insulate a patient from criminal prosecution or sanction for possessing and/or using marijuana for medical purposes "where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief."

6. The following year, Respondent began receiving requests for medical marijuana recommendations from patients. By 2001, almost 100% of his practice was devoted to issuing letters of recommendation for patients' use of medical marijuana.

7. Respondent does not view himself as either a primary care physician or a family practice physician. He describes himself as a "consultant in alternative medicine" and a "medical cannabis consultant." There are approximately twelve medical cannabis consultants in the State of California. (See Finding 14.)

The Expert Witnesses

Jeffrey I. Barke, M.D.

8. Each party offered one expert witness who testified as to the applicable standard of care.

9. Complainant's expert was Jeffrey I. Barke, M.D. Dr. Barke is a Diplomate of the American Board of Family Practice having received his certification in 1991 and re-certification in 1997. He is an Associate Clinical Professor at the University of California, Irvine School of Medicine, Department of Family Practice. He serves on the Medical Executive Committee of Hoag Memorial Hospital Presbyterian where he is a former Chairman of the Department of Family Medicine. He is on the Board of Directors of the Orange County Medical Association, and he is the Medical Director of Brookside Institute, an outpatient chemical dependency treatment center located in Irvine, California. He has also been involved in migraine headache research since 1998. Dr. Barke does not write letters of recommendation for medical marijuana but does not oppose the use of medical marijuana under proper circumstances. Several of his patients are medical marijuana users, having received recommendations from other physicians.

10. Dr. Barke also lectures other physicians on depression from a primary care, family practice perspective, and on migraine headaches, using multi-media presentations. Some of his lectures qualify for CME credit.

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11. Dr. Barke opined that the standard of care for a physician whose patient came to him/her seeking medical marijuana in 2000-2001was the same as that of a primary care, family practice physician. Specifically, the care required of a physician depended on the context under which the patient sought help. A detailed history is critical. In the case of depression, the history should include exploration of the level of depression, whether a specific event triggered it and, if so, the identity of the triggering event, and whether the patient is suicidal. Next a physical examination and review of systems should be performed and laboratory tests should be ordered. In certain cases, the physical examination, review of systems, and laboratory tests may be forgone if the patient has a long-standing medical condition for which he/she has undergone prior medical treatment, and the physician obtains the patient's records from the prior health care provider(s). The risks, benefits and alternative treatments to cannabis should be discussed with the patient. The discussion should include non-drug treatments and remedies such as exercise and abstention from coffee and alcohol. Self-help books may also be recommended. Once the treatment has been decided upon, a follow-up plan should be developed. All of the above should be properly documented because, as Dr. Barke explained, if it is not in the chart, it did not happen.

Tod H. Mikuriya, M.D.

12. Respondent's expert was Tod H. Mikuriya, M.D. Dr. Mikuriya describes his practice as a "medical cannabis consultancy." By that he means that he determines whether patients qualify for the use of medical marijuana under Prop 215. He is a Certified Addiction Medicine Specialist with the American Society of Addiction Medicine and board-eligible with the American Board of Psychiatry and Neurology. He has been, and continues to be, involved in a number of cannabis-oriented groups including the California Cannabis Centers, Oakland Cannabis Buyers Cooperative, Hayward Hempery, Humboldt Medical Cannabis Center, Arcata Cannabis Buyers Center, City of Oakland Medical Marijuana Work Group, Medical Marijuana Task Force-California Society for Addiction Medicine and California Medical Association, International Cannabinoid Research Society, Medical Cannabis Association, and the Editorial and Advisory Board of the Journal of Cannabis Therapeutics. He is a published author on the use of medical marijuana. Dr. Mikuriya was active in drafting Prop 215 and was responsible for the phrase "any other condition" in the statute.

13. Dr. Mikuriya is presently the subject of a disciplinary action by the Board, based on similar charges as alleged against Respondent in the instant case. Dr. Mikuriya's administrative hearing has been held but, at the time of his testimony in the instant case, he was unaware of its result.

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14. Dr. Mikuriya is the President of the California Cannabis Research Medical Group, an organization devoted to cannabis research. The group is composed of approximately 12 physicians in California. It sets minimum practice standards for medical cannabis consultants.

15. Members of the California Cannabis Research Medical Group consider the standard of care for medical cannabis consultants disparate from that of family practice physicians because the medical cannabis consultant serves a much more limited function than a family practice physician. That function is solely to determine whether the patient has a condition that is chronic and is helped by the use of medical cannabis. Making a diagnosis may or may not be part of the evaluation, depending on the situation the patient presents. Medical cannabis consultants do not perform a physical examination on a patient complaining of a psychiatric problem because the patient's complaint is not related to an organic problem. They do not order laboratory tests such as blood work because such tests lie beyond the scope of the question to be answered by the consultation. Minimal practice standards are recordation of the patient's identifying data (name, sex, age, date of birth, and occupation) necessary for the consultant to locate the patient in his/her files, and recordation of a diagnosis under the International Classification of Diseases, Version 9 ("ICM-9") or the Diagnostic and Statistical Manual of the American Psychiatric Association, Version IV ("DSM-IV"), together with notes to support that diagnosis. Nothing more is required. Since "99.9%"[1] of patients who see medical cannabis consultants are self-medicators with marijuana experience, the consultants' task is limited to legitimizing the use of marijuana in order to ensure compliance under section 11362.5. Dr. Mikuriya refers to it as a "get out of jail card" that does not require "bells and whistles." The determination of whether to make the recommendation for medical marijuana use is largely based on chronicity and seriousness[2] of the patient's condition.

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[1] Words and numbers within quotations in this section are those of the testifying witness.

[2] By the term "seriousness," Dr. Mikuriya means how the condition is presented by the patient and whether the condition is consistent and/or intractable.

16. For example, contrary to Dr. Barke, Dr. Mikuriya does not consider it necessary to order an MRI for a patient complaining of migraine headaches because the scan is expensive and not likely to be positive. A physical examination is appropriate only if the medical cannabis consultant performs it as part of his/her general routine and feels comfortable performing it. It is unnecessary to discuss treatment alternatives with patients because the patients have already been through all of the alternatives and know what they want. In fact, because the patient knows what he/she wants at the time of presentation, it is unnecessary to discuss alternatives even if the patient has tried only one other treatment. If the patient is seeking marijuana for the treatment of depression, it is unnecessary for the medical cannabis consultant to inquire into suicidal ideation. It is also unnecessary to perform a physical examination on a patient complaining of depression even though Dr. Mikuriya admits that depression can be a symptom of an organic disorder. It is unnecessary to discuss dosage with a patient because patients have been self-medicating and tell the medical cannabis consultant what his/her needs are. Further, because it is not a prescribed drug, the consultant cannot properly determine a correct dosage for marijuana. Although the consultant cannot determine a minimum effective dose, many patients have determined their own toxic amount from experience and titration. It is also unnecessary to schedule a follow-up appointment after writing a recommendation letter for medical marijuana because the patient must return in one year to obtain another letter. Thus, the issue of whether to provide a letter of recommendation for medical marijuana goes to the basic question of whether the patient has a serious condition which will benefit from medical marijuana.

17. Dr. Mikuriya acknowledges that a diagnosis can be missed under the standard of care endorsed by the California Cannabis Research Medical Group. However, the extent of the risk that a diagnosis might be missed "remains to be seen," and Dr. Mikuriya believes his organization will not have the necessary data to make that determination for another 20 years.

18. Dr. Mikuriya also recognizes that, while the medical cannabis consultant relies almost exclusively on the patient's description of his/her history in determining whether the patient has a condition of sufficient seriousness and/or chronicity to justify a recommendation for medical marijuana, certain patients are far better historians than others, and the quality of their histories varies widely. Therefore, the physician cannot ensure that he/she has taken an accurate history.

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19. All of the above notwithstanding, Dr. Mikuriya utilizes three different forms in his practice. The first is a multi-page patient history form, similar to one he used in 2001. The form, developed by the California Cannabis Research Medical Group, is to be completed by the patient. The second form is one he completes himself. It contains a checklist for a limited physical examination, an area for recordation of five ICD-9 diagnosis codes, an area to record the records he reviewed, a section of check boxes for the treatment plan, recommendations and referrals, and four check boxes for the timing of follow-up ranging from one to twelve months. Dr. Mikuriya's third form is a "Psychiatric Examination & Report." It contains sections for identifying data, chief complaint, present illness, psychiatric history, medical history, personal history, current living situation, current psychotropic medications, mental status, diagnoses (with separate areas for all five diagnostic axes referenced in DSM-IV), and formulation, treatment plan and recommendations. However, Dr. Mikuriya believes a medical cannabis consultant need not know a patient's history with respect to alcohol use, psychoactive drug use, cannabis use, prior surgeries, and family and developmental histories "of interest" before making a medical marijuana recommendation. The patient identification information and diagnosis are recorded on the form the California Cannabis Research Medical Group uses for its research.

20. Not every medical condition is sufficiently serious to qualify for a letter of recommendation for medical marijuana, and Dr. Mikuriya testified he would not issue a recommendation letter to a patient who denied a medical condition but wanted marijuana simply because it made him feel better.

Lester Grinspoon, M.D.

21. Respondent offered the expert testimony of Lester Grinspoon, M.D. Dr. Grinspoon is an Associate Professor of Psychiatry Emeritus at Harvard Medical School in Boston. He is a Diplomate of the National Board of Medical Examiners and the American Board of Psychiatry. He is a recognized expert on marijuana and has written several books on the subject. His most recent book, published in 1993 with a second edition published in 1997, is devoted to marijuana's medicinal uses.

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22. Dr. Grinspoon was not designated as an expert in the standard of care for physicians in California. Rather, his testimony was devoted to an explanation of marijuana's toxicity.[3] He credibly testified that cannabis has "exceedingly limited toxicity" (his expression). The Therapeutic Index is a means of quantifying the risk of taking a particular drug. It is calculated as a ratio of the amount of a drug that would be lethal for 50% of a population divided by the amount required for a therapeutic effect. The lower the number, the greater the toxicity and the greater the risk of taking the drug. For example, the therapeutic indices for various barbiturates range from 3 to 10. The therapeutic index for alcohol is approximately 4. Chemotherapeutic substances for the treatment of cancer are high-risk agents with therapeutic indices ranging between 1.5 and 2. There has never been a human death from a marijuana overdose. Therefore, the therapeutic index for marijuana must be extrapolated from animal data. That extrapolation results in a therapeutic index for marijuana between 20,000 and 40,000.

23. Side effects of marijuana include anxiety, reddened eyes and an initial acceleration of heart rate to a level approximately equivalent to that following a set of tennis. When cannabis is used medicinally, its psychoactive effect may be viewed as a side effect as well. The sophisticated user can recognize that effect and titrate accordingly. In the naïve user, the psychoactive effect can cause anxiety and even paranoia which resolves in a few hours. Therefore, although the recommending physician must provide appropriate guidelines for a new user, the psychoactive effect of medical marijuana is "not something to be concerned about."

24. There is some disagreement over whether cannabis is addicting. Dr. Grinspoon believes dependence, rather than addiction, better describes marijuana's effect on the human body. People are dependent on various substances each day and the issue is the dangerousness of the substance on which the dependence is based. Marijuana is a benign drug which is less dangerous than coffee. Discontinuance of coffee can cause headaches.

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[3] The parties agreed that a finding of patient harm was not necessary in order for a cause for discipline to be established. Dr. Grinspoon's testimony was offered for the purpose of proving marijuana's low toxicity and non-existent mortality rate as a mitigating factor should Respondent's certificate be deemed subject to a disciplinary order.

The Applicable Standard of Care

25. Dr. Barke's testimony regarding the applicable standard of care was more credible than that of Dr. Mikuriya. Dr. Mikuriya made several assumptions about patients seeking medical marijuana without evidence or other justification. Examples of such assumptions are that (1) a physical examination on a patient complaining of a psychiatric problem is unnecessary because the patient's complaint is not related to an organic problem[4]; (2) laboratory tests such as blood work are unnecessary because such tests lie beyond the scope of the question to be answered by the consultation; (3) it is unnecessary to discuss treatment alternatives with patients because the patients have already been through all of the alternatives; and (4) it is unnecessary to discuss dosage with a patient because patients have been self-medicating. Further, the fact (assuming its truth) that an MRI is unlikely to be positive is not a proper reason to avoid its use as a diagnostic tool. It is the negative result of an MRI that assists the physician in ruling out a more serious condition that might underlie the symptoms complained of by the patient. By ruling out a more serious condition, the physician is able to determine the propriety of medical marijuana for treatment of a condition and/or symptoms.

26. The standard of care, as described by Dr. Mikuriya, essentially relieves the physician of all medical responsibility toward his/her patient. The physician may rely on the patient's historical descriptions without knowing either the accuracy or veracity of those descriptions. He/she may accept the patient's opinion of his/her diagnosis without verification. The physician may recommend medical marijuana simply because the patient wants it and need not discuss treatment alternatives or risks. He/she is not required to make any recommendations as to the frequency or amount of marijuana to be ingested or whether it is to be ingested by smoking, vaporization, or digestion. In other words, according to Dr. Mikuriya, the physician performs within the standard of care by recording a patient's identifying data and taking the patient's word that the patient has a serious and/or chronic condition that benefits from the use of marijuana, without ruling out, or even considering, other conditions and/or treatments. One need not be trained in the medical sciences to meet that standard of care. That standard of care can be met by an untrained individual with a patient identification form, a list of conditions amenable to the use of medical marijuana, and a pen.

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[4] As stated above, Dr. Mikuriya admitted that depression can be a symptom of an organic disorder. DSM-IV contains a number of psychiatrically related organic disorders, and DSM-IV's Axis III is the designated axis for the diagnosis of physical disorders.

27. On the final day of hearing, Respondent attacked Barke's credibility by offering the testimony of Stephen Rifkind ("Rifkind"), who had contacted Barke under an assumed name, posing as a potential patient. During a number of telephone conversations, Rifkind informed Barke that he was considering moving to the Newport Beach area with his family in the near future, was seeking a family physician in that area, and was considering Barke in that regard. During the final telephone conversation, he informed Barke that he would come to Barke's office later that week and asked if, in the interim, Barke could telephone in a prescription for four Viagra tablets for him. He informed Barke that he had taken Viagra in the past and had done well with it, but that he was asking Barke for the prescription because he was on poor terms with his former physician. He also requested that the prescription include a few refills. Anticipating a visit from his new patient within the next few days, Barke granted the request and telephoned the prescription to a pharmacy for the "new patient."

28. The evidence is in dispute as to whether Barke sought a medical history from Rifkind before prescribing the Viagra. Rifkind denied it, but Barke's notes indicate that he asked specific questions the answers to which evidenced no contraindications to the medication. The notes are consistent with Rifkind's testimony that he had told Barke he had taken Viagra in the past and "had done fine with it."

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29. Respondent argued that he had practiced more within the standard of care than did Barke because Respondent actually saw his patients before issuing a recommendation for the use of medicinal cannabis. In response to the attack on his credibility, Barke testified that his telephoning the prescription for Viagra for Rifkind was within the standard of care because a physician's decision whether to telephone a prescription to a pharmacy on behalf of a patient he has not yet seen depends on the "context" (Barke's term) in which it is done. Barke chose to do so in this case because Viagra is an innocuous drug that is contraindicated for a very small percentage of patients who have specific medical conditions. Barke ruled out those conditions in Rifkind before prescribing the Viagra for him. In addition, Barke understood that Rifkind was unable to obtain Viagra from his former physician, and that he would be seeing Rifkind in a few days at which time he intended to perform a review of systems and take a more detailed history. He would not have granted Rifkind's request for a telephoned prescription had Rifkind requested Ambien or a narcotic. Barke did not equate prescribing Viagra to recommending marijuana because, even though 200-300 Viagra-related deaths occur annually while no deaths have been attributed to marijuana, marijuana is both addicting and illegal. Barke pointed out that there are ways to harm patients other than by killing them. He also explained that Viagra is used solely for erectile dysfunction[5] while marijuana may be used for a variety of purposes, not all of which are medical conditions. Barke denied having violated Business and Professions Code section 2242 in that Rifkind's physician was unavailable to write the prescription.[6]

30. Rifkind has known Respondent since they were approximately 3 years old. They became close friends on their first day of medical school together. On days other than when he testified, Rifkind was present in the courtroom during part of Respondent's hearing, and he described his relationship with Respondent as "great."

31. Rifkind was previously licensed by the Board as a physician and surgeon in California. His license was revoked in 2000 or 2001 in connection with his drug dependency and his refusal to comply with the requirements of the Board's Diversion Program. His petition for reinstatement of his license is scheduled for hearing on May 18, 2004. Rifkind sat for the California Bar Examination in February of 2003 and received a passing score. He was scheduled to be sworn in as an attorney within a few weeks of the hearing on the instant case.

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[5] Barke testified that a patient may use Viagra for complete erectile dysfunction, for the purpose of increasing potency, or as a "security blanket." All three purposes are considered a type of erectile dysfunction for which Viagra is medically indicated.

[6] In making that assertion, Barke was apparently relying on Business and Professions Code section 2242(b)(1).

32. The fact that Barke telephoned in a prescription for Viagra for a presumed patient without first having taken a complete history and examining him could impact his testimony regarding the standard of care in one of four ways:

a. The standard of care is something other than that to which Barke testified, and both Barke and Respondent acted within it.

b. The standard of care is that to which Barke testified, and he fell below it by issuing the Viagra prescription for Rifkind.

c. The standard of care is that to which Barke testified. Barke fell below it. Respondent did not.

d. The standard of care is that to which Barke testified. Respondent fell below it. Barke did not.

33. Whether Barke fell below the standard of care by issuing the prescription to Rifkind is not properly before the Administrative Law Judge, and no ruling is made on that issue. The only question before the Administrative Law Judge is whether Barke's credibility was sufficiently compromised as to render his testimony regarding the standard of care unreliable. No evidence was offered in connection with the attack on Barke's credibility to show whether the standard of care either is or is not that to which Barke testified. The only proffers of evidence in connection with Barke's credibility were the facts relating to his interactions with Rifkind, and his explanation for his conduct. Barke's explanation that his decision to issue the prescription for Rifkind before meeting and examining him was consistent with his earlier testimony that such decisions must be based on the "context" of the presenting situation. Therefore, the Administrative Law Judge finds that the standard of care is that to which Barke testified. To the extent that Barke may have overstated his position, particularly with respect to the laying on of hands and the necessity of complex tests such as MRIs in almost all cases, that portion of his testimony may be rejected without vitiating the entirety of his testimony or nullifying his overall credibility.[7]

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[7] In Stevens v. Parke Davis & Co. (1973) 9 Cal.3d 51, the court held that the trier of fact may "accept part of the testimony of a witness and reject another part even though the latter contradicts the part accepted." (Id. at 67.)

The Undercover Operations

Kim Wilson – April 6, 2000

34. In and around April of 2000, Respondent was sharing office space with an acupuncturist named Mary Clark and a psychologist named Geoffrey Pfeifer ("Pfeifer"). Pfeifer was not engaged in the practice of psychology but rather performed nutritional consultations for patients by pricking their fingers and examining their blood under a microscope. He and Respondent cross-referred patients to each other.

35. On April 6, 2000, Kim Wilson, a Senior Investigator for the Board ("Wilson"), saw Pfeifer in an undercover operation for the purpose of investigating whether Pfeifer was engaged in the unlicensed practice of medicine. Pfeifer had Wilson fill out a health questionnaire. She complained of being fatigued but unable to sleep. When she was able to sleep, her sleep was restless. She also complained that her immune system was low, that she suffered from cold sores and back-to-back flus and colds, and that she lacked energy. Pfeifer questioned her about her complaints.

36. Wilson asked Pfeifer what was wrong with her. Pfeifer told her he wanted to take a blood sample from her finger. She declined that recommendation but agreed that a blood sample, to be taken and analyzed at a laboratory, would be appropriate. Pfeifer took a pad of Respondent's prescription forms and wrote a prescription for the laboratory work. The prescription was pre-signed with Respondent's signature stamp above the signature line. The printed name at the top of the prescription form was "William S. Eidelman, M.D."

37. Wilson asked Pfeifer about his qualifications. He said he was trained as a psychologist but that studies with a Chinese doctor had led him away from Western medicine.

38. Pfeifer and Wilson discussed the possible use of L-Tryptophan for Wilson's insomnia, but Pfeifer did not have any in stock. He suggested another liquid medication but it was cost prohibitive. Wilson mentioned that she had undergone a physical examination through her HMO a few months before but nothing had been diagnosed and she was dissatisfied with the results. She also mentioned that she was trying to become pregnant but that she would cease those attempts during the time she was taking any medication Pfeifer prescribed.

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39. Pfeifer was unable to write a prescription for medication so he walked Wilson to Respondent's office and summarized his meeting with Wilson to Respondent. Wilson and Respondent briefly discussed the use of L-Tryptophan and Ambien as sleep aids. Respondent did not take Wilson's vital signs or examine her in any way. He did not attempt to verify whether she was pregnant at that time. Wilson said she wanted to pay only her $5.00 co-pay for medication. Respondent wrote a prescription for 50 Ambien tablets and gave it to Wilson. He did not request or suggest a follow-up appointment. Respondent never created a medical chart for Wilson.

40. Wilson received a bill from Pfeifer consisting of $150.00 for a one-hour consult with Pfeifer and $30.00 for a "brief" medical consult with Respondent.

41. At the administrative hearing, Respondent explained that he did not examine Wilson because she had not gone through the usual process for a new patient of having her vital signs taken by someone else in the office and being brought to his office with a chart. He also felt rushed because he was preparing for a lengthy trip to Italy and was in the process of closing his office in Ojai. He gave her a considerably larger number of tablets than usual because he knew he was going to be away from his office for an extended time and because Ambien was expensive and he was trying to assist Wilson in getting her insurance company to pay for it. That testimony lacks credibility in light of his other testimony that (1) his main business was not prescribing sleeping pills, (2) when he did prescribe sleeping pills, it was generally to a patient with a long history of taking them, (3) based on his experience in psychiatry, generally someone who needs a sleeping pill does not need a physical examination, (4) Wilson gave him the "usual story"—the patient was unhappy with her traditional doctor because he had not helped her and came to Respondent seeking alternative treatment, and (5) based on his "internal lie detector" (Respondent's term) which he used on all patients, Wilson seemed like a nice person who did not abuse drugs, and he believed her.

42. Respondent understood Pfeifer to be a nutritional consultant. Respondent was aware that Pfeifer had a pad of Respondent's pre-signed prescriptions and that Pfeifer used them to write prescriptions for laboratory work for Respondent's patients whom Respondent had already seen.

43. The standard of care requires a physician to create a chart for any new patient. It also requires him/her to verify a history received from someone other than a physician (such as Dr. Pfeifer). This is usually done by asking the patient questions pertinent to the reported history. Respondent's failure to create a chart for Kim Wilson, and his failure to verify Kim Wilson's history, as related by Dr. Pfeifer, each constitute a simple departure from the standard of care and incompetence.

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44. Ambien is a relatively benign prescription drug used for temporary sleep relief. It is generally prescribed in sufficient numbers to last 1-2 weeks and never for more than one month. Normal dosage is one 10mg tablet per night. Some patients require two tablets per night, but there was no evidence that Kim Wilson was such a patient. However, even if she were a patient who required two tablets per night, Respondent prescribed more than a three-week supply. An exception to these rules could be made for a patient who had used the product before, who could be trusted to use it correctly and who was going to be away from his/her supplying pharmacy (i.e., away on a trip). Respondent had no basis to believe Kim Wilson qualified for that exception, and by failing to evaluate her underlying problem (the insomnia), Respondent was "prescribing blindly" (Dr. Barke's term). Respondent's prescription of a medically inappropriate number of Ambien tablets to a new patient constituted an extreme departure from the standard of care and incompetence.

45. The standard of care requires a physician to whom a patient is referred by a non-physician to take the patient's vital signs and conduct a limited physical examination before prescribing medication such as Ambien, particularly when the patient has been attempting to become pregnant and it is unknown whether those attempts have been successful. If the patient has been recently worked up by another physician, it is unnecessary to repeat the work up, but the present physician should obtain the patient's previous medical records of the work up. Respondent's failure to take Wilson's vital signs and either conduct a limited physical examination or obtain her previous medical records represents an extreme departure from the standard of care. His care and treatment of Wilson constitutes gross negligence, repeated negligent acts, incompetence and prescribing a dangerous drug without a good faith prior examination. Respondent's allowing Pfeifer to use his pre-signed prescription forms and prescribing Ambien on Pfeifer's recommendation without an independent verification of medical indication constitutes aiding and abetting the unlicensed practice of medicine.

"S[redacted] K[redacted]" – August 1, 2001

46. On August 1, 2001, a detective with the Narcotic Investigations Unit of the Santa Monica Police Department conducted an undercover operation at Respondent's office. She had previously spoken with Respondent by telephone and told him she desired a recommendation for medical marijuana. Respondent told her it would cost her $250.00 in cash.

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47. Using the assumed name of S[redacted] K[redacted] ("K[redacted]"), she and her partner visited Respondent's office for the purpose of obtaining a letter of recommendation for medical marijuana. Alone in the waiting room, they were greeted by Respondent who gave K[redacted] a patient health questionnaire to complete. Respondent took K[redacted] and her partner to a room in the back of the suite. The room contained a desk, chairs, credenza, bookshelf, books, a laptop computer and a printer.[8]

48. K[redacted] told Respondent she had been smoking marijuana since she was 18 and that she had stopped two weeks before her visit to Respondent. She reported suffering from headaches since she stopped smoking marijuana. She told him she was unable to obtain a note recommending medical marijuana at Kaiser, her regular health care provider. She also complained of trouble sleeping and said that marijuana helped her to sleep. Respondent told K[redacted] that, in order for him to give her a recommendation, he had to believe she was actually sick. He then gave her a medical marijuana recommendation letter without taking her vital signs, performing a physical examination or touching her in any manner.

49. K[redacted]'s partner asked Respondent if he too could get a recommendation letter for medical marijuana. Respondent asked the nature of his medical condition, and K[redacted]'s partner denied any medical problem. Respondent was put off by his cavalier attitude but told him he had to have some kind of ailment. K[redacted]'s partner asked for examples of qualifying conditions. Respondent told him he could not tell him that but that he was "pretty liberal" about what constitutes a qualifying medical problem and that K[redacted]'s partner had best remember what was hurting him upon his return. Respondent then suggested to K[redacted]'s partner that he could have migraine headaches or backaches. K[redacted] paid Respondent $250.00 in cash and left with her letter of recommendation. She did not receive a receipt.

50. Respondent does not recall K[redacted] stating that her headaches started after she stopped smoking marijuana. He gave her the recommendation letter on the basis of her insomnia. Respondent admitted that K[redacted] was "low on the seriousness scale" and that her insomnia did not seem like a serious problem. However, Respondent opined that, while Prop 215 was intended for seriously ill individuals, the language of the statute allows for a letter of recommendation for the use of medical marijuana if the recommending physician believes marijuana will help the patient's condition. In K[redacted]'s case, he believed it would help her insomnia and, because she said she had been arrested before, he felt compassion for her.

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[8] This was apparently the same room to which Respondent took each of the undercover officers. Respondent explained at the administrative hearing that his medical examination room was elsewhere in the suite.

51. Respondent created a medical record for K[redacted]'s August 1, 2001 visit. It read, in its entirety, as follows:

"problems falling asleep
headaches
2 months
began having trouble falling asleep,
pot helps sleep

pe 135/85
unremarkable

Diagnosis; (sic) insomnia

Plan: Medical Marijuana as per Prop 215"

52. Dr. Barke[9] opined that the fact that K[redacted]'s headaches began shortly after she stopped smoking marijuana did not relieve Respondent of his responsibility of taking a thorough history and review of systems. In fact, the withdrawal from cannabis only made the treatment for headaches more challenging since there was a strong tendency for the patient to want to return to marijuana in order to stop them. The standard of care required the taking of a thorough history, physical examination and review of systems, including an examination of the back of the eye with an ophthalmoscope. While medicinal cannabis may be considered as a treatment option, all treatment options and their risks and benefits should have been discussed.

53. Respondent's failure to take a thorough medical history on K[redacted], to perform a physical examination and review of systems, and to discuss treatment options, constitutes gross negligence, repeated negligent acts and incompetence.

"D[redacted] C[redacted]" – August 8, 2001

54. On August 8, 2001, an investigator with the San Bernardino County Sheriff's Department conducted an undercover operation at Respondent's office. He had previously spoken with Respondent by telephone and told him he desired a recommendation for medical marijuana. Respondent told C[redacted] he could come in any day after 1:00 p.m. and that he was to bring $250.00 in cash.

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[9] Dr. Mikuriya testified as to the general standard of care but did not address his testimony to specific patients or instances of Respondent's conduct. Dr. Barke testified both with respect to the general standard of care and as to its application to the patients and undercover operations involved in this case. Therefore, some of Dr. Barke's comments are referenced in connection with specific patients and undercover operations while Dr. Mikuriya's are not.

55. Using the assumed name of D[redacted] C[redacted] ("C[redacted]"), the undercover officer posed as a new patient. Upon his arrival, C[redacted] did not see any employees or other patients. Respondent greeted C[redacted] in the empty waiting room and asked him to fill out a patient history form which was 6-8 pages in length. C[redacted] indicated on the form that he had used methamphetamines and marijuana within the previous two years.

56. C[redacted] told Respondent that he did not have a major medical problem but that he was a long-time user of marijuana with a little periodic high blood pressure and occasional temporary muscle aches. Respondent told C[redacted] the law requires a medical reason for a medical marijuana recommendation but that "everybody has got something. You know what I mean." Respondent asked C[redacted] if he has "pain or anything." C[redacted] reported "normal" pain from working out and from physical activity on his job, but that he had gotten used to it. Respondent asked C[redacted] if he ever became depressed, and C[redacted] answered that he did not. Respondent next asked if C[redacted] would get depressed if he did not have marijuana, and C[redacted] answered affirmatively. Respondent then provided C[redacted] with a recommendation letter for medical marijuana.

57. At no time during C[redacted]'s visit did Respondent take C[redacted]'s vital signs, conduct a physical examination, recommend laboratory studies, ask for previous medical records, ask C[redacted] about previous medical treatment, ask C[redacted] about his use of methamphetamines, or discuss any alternatives to marijuana. At the end of the interview, C[redacted] paid Respondent $250.00 and received the recommendation letter for medical marijuana from Respondent.

58. Respondent created a record for C[redacted] Under the date of 8/8/01, that record reads in its entirety:

"difficulty sleeping
anxiety at end of day
without pot, depressed
pot helps sleep, relax, anti-depressant"

59. At the hearing, Respondent claimed he would not have given C[redacted] the letter of recommendation had C[redacted] repeated his statement that he had no medical problems. Respondent also claimed he had made inquiries into C[redacted]'s medical condition to rule out denial. That testimony lacks credibility in light of Respondent's statements and questions to C[redacted] In fact, Respondent never established a medical condition justifying the use of medical marijuana for C[redacted] He only established a probability that C[redacted] would become depressed in the future should a certain event occur. According to C[redacted]'s story, he did not have trouble obtaining marijuana. He only wanted to get it "legally."

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60. Dr. Barke opined that Respondent failed to take a meaningful personal or medical history, failed to perform a review of systems, failed to conduct a physical examination, failed to explore C[redacted]'s symptoms, failed to discuss medical treatment options or medical "red flags," and failed to devise a plan for follow up. Respondent's care and treatment of C[redacted] constituted gross negligence, repeated negligent acts and incompetence.

"S[redacted] J[redacted]" – October 10, 2001

61. On October 10, 2001, a detective with the San Bernardino County Sheriff's Department conducted an undercover operation at Respondent's office. Using the assumed name of S[redacted] J[redacted] ("J[redacted]"), he posed as a new patient. Upon his arrival, Respondent greeted J[redacted] but did not have him fill out a health questionnaire.

62. J[redacted] told Respondent he had obtained Respondent's name at a "smoke out" concert the previous weekend. He said he had smoked marijuana since high school and that he did not "feel very good" when he did not have it, but that he did not have any medical problem of which he was aware. He also told Respondent that he occasionally grew marijuana plants and that he did not want "any of the hassles from the cops . . ." Respondent asked J[redacted] to describe what he meant when he said he did not feel very good when he did not have marijuana. J[redacted] said that marijuana made him calmer and that his temper did not "flare up." The following colloquy then occurred between J[redacted] and Respondent:

> Respondent: "For the purpose of this diagnosis, I have to put down a disease. . . I'm going to say that it sounds like depression. I'm not trying to say that you are depressed or any thing like that, but for medical-legal reasons . . . I have to . . ."
>
> J[redacted]: "You have to have a problem."
>
> Respondent: "Depression can manifest itself in a number of different ways, and just not feeling good is one of them, irritability . . ."
>
> J[redacted] "I know when I don't smoke marijuana I don't feel very good."
>
> Respondent: "I would say that fits in the category of depression . . ., I'm not trying to lay a trip on you or anything like that."

63. Respondent then provided J[redacted] with a letter of recommendation for medical marijuana. He charged Johnson $250.00 in cash and did not provide a receipt.

64. At no time during J[redacted]'s visit to Respondent's office did Respondent conduct a physical examination, take J[redacted]s vital signs, perform a review of systems, order a blood test, or take a history other than as described above. At the hearing, Respondent admitted he could have and should have taken a more detailed history, but that, based on what J[redacted] told him, Respondent still believed he had enough information on which to base the recommendation for medicinal cannabis.

65. Dr. Barke opined that no evidence existed to indicate that J[redacted] was suffering from depression and that, absent the above procedures, Respondent rendered a treatment recommendation without a medical evaluation or diagnosis.

66. Respondent's care and treatment of J[redacted] constituted gross negligence, repeated negligent acts and incompetence.

Matthew Graeff – October 11, 2001

67. On October 9, 2001, Matthew Graeff ("Graeff"), a patrol officer with the Bishop Police Department, on loan to that Department's Narcotics Enforcement Team, telephoned Respondent in connection with one of Respondent's patients who was involved in a criminal matter that was coming to trial. Graeff posed as a new patient and asked Respondent about medical marijuana for treatment of his back pain. Respondent told him he would have to see Graeff personally and that everything involving the letter of recommendation would be covered for a fee of $250.00, preferably in cash.

68. On October 11, 2001, the day after "J[redacted]'s" visit, Graeff saw Respondent at Respondent's office. The purpose of his visit was to determine Respondent's credibility with respect to the thoroughness of his evaluations for medical marijuana recommendations, in connection with the pending criminal matter referred to above. The waiting room was empty upon his arrival. Respondent greeted him and asked him to fill out a health history questionnaire. The only medical condition Graeff disclosed was low to mid back pain.

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69. In response to Respondent's questions, Graeff stated that he had experienced back pain for approximately eight years, that he had seen some chiropractors for it without success and that he had been told he was not a candidate for surgery. He told Respondent he used medical marijuana for relief 2-3 times per week, and 3-4 times per week during a "bad" month. Respondent asked Graeff if he had his medical records. Graeff stated that he did not have them and that he might have trouble obtaining them. Respondent stated that he might need them in the future if questioned by the authorities but that he was not presently concerned about them. Graeff denied taking any other drugs. Respondent did not take Graeff's vital signs or perform any kind of examination on him. He did not ask any other questions concerning Graeff's back pain. Respondent gave Graeff a letter of recommendation for medical marijuana and Graeff paid Respondent $250.00 in cash. Upon Graeff's questioning, Respondent stated that Graeff's could possess 2-3 cannabis plants and 1-2 oz. of dried marijuana. Respondent did not tell Graeff he wanted to see him again to monitor his back pain.

70. Graeff determined that Respondent had not conducted a thorough examination before issuing a recommendation letter for medical marijuana. Therefore, he returned to Respondent's office shortly after exiting and served Respondent with a subpoena for the trial in the pending criminal matter referenced above.

71. Respondent believed Graeff had been sincere in describing his medical condition and had not been concerned that Graeff was not in pain at the time of his visit since a more serious problem would not involve intermittent pain and Graeff's story would have been different.

72. Dr. Barke pointed out that Respondent failed to take a complete current or past medical history, failed to perform a review of systems, failed to conduct a physical examination, failed to ask exploratory questions regarding Graeff's back condition, failed to order diagnostic tests, failed to discuss "medical red flags," failed to discuss treatment options, and failed to prepare a plan for follow up. In the absence of a physical examination, Respondent should at least have obtained his patient's prior medical records.

73. Respondent's care and treatment of Graeff constituted gross negligence, repeated negligent acts and incompetence.

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The Patients

Patient T.A.

74. On March 16, 2000, Respondent saw Patient T.A.,[10] a 29-year-old male, who complained of migraine headaches, insomnia and recurring severe upset stomach. T.A. told Respondent that marijuana helped all three of those conditions.

75. T.A. had not seen a physician for his migraine headaches since 1991. He told Respondent he had experienced the headaches since he was between 7 and 10 years old and that the doctor he saw in 1991 had prescribed Tylenol with codeine but that T.A. didn't like the medication. T.A. said the migraines were an "excruciating pain in the middle of my head, behind my eyes" that "builds up gradually throughout the day . . . becomes severe around sundown," that a particular type of fatigue acted as a prodrome to the migraines, and that, since about age 20, they came in cycles, sometimes three or four days in a row and sometimes once or twice per month.

76. T.A. described his upset stomachs as severe, sometimes related to the headaches and sometimes not. He had tried Zantac, Prilosec, and Carafat. He claimed he had suffered from insomnia since adolescence, both in initially falling asleep and in trying to return to sleep after awakening at 2:00 or 3:00 a.m. Like the migraines, the insomnia was cyclical.

77. The only physical examination Respondent documented in his records read, "Physical Exam BP 125/75 Exam unremarkable." Respondent charted the following diagnosis and plan:

"Diagnosis: 1. Migraine
2. GI disturbance, exact nature unclear
3. Insomnia

Plan: Medicinal Marijuana, as per Prop 215."

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[10] The initials of the patients referenced in this Proposed Decision are used in lieu of their names in order to protect their privacy.

78. Dr. Barke criticized Respondent's care and treatment of Patient T.A. on several grounds. No vital signs were taken except for the blood pressure. The expression "exam unremarkable" cannot be defined based on the chart. One cannot determine from the chart what was done with respect to the patient. No pertinent positive or negative findings are documented, including but not limited to abdominal tenderness. No attempt was made to order tests or to obtain T.A.'s prior medical records. The history is incomplete in that one cannot determine how long T.A. tried the various medications, what happened when he tried them, etc. The plan is not detailed in that the amount and frequency of the marijuana T.A. was supposed to use was not charted and no follow up is indicated. Dr. Barke stressed the importance of charting to assist future health care providers. He agreed with the adage that if it was not charted, it was not done.

79. Respondent believed it was reasonable to make the recommendation for medicinal cannabis because T.A. presented a "clear-cut story of migraine." He did not order tests because the duration T.A.'s history of migraines caused Respondent to believe T.A. did not have a more serious medical condition such as a brain tumor. He had been to other doctors and had tried other medications without relief, and marijuana helped all of his symptoms. Respondent testified that, if he had it to do over again, he would not do anything differently.

80. Respondent missed the point in connection with Patient T.A. A physician does not eschew physical examination and diagnostic testing because they are unlikely to elicit a positive result. It is the negative results of the examination and testing that assist the physician in ruling out more serious conditions. Respondent's history of T.A.'s migraines was more extensive than those for the undercover operatives but was still seriously lacking. His workup for the insomnia and gastrointestinal disorder were virtually non-existent. Respondent's care and treatment of Patient T.A. constituted gross negligence, repeated negligent acts and incompetence.

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Patient S.N.

81. On February 19, 1999, Patient S.N. presented at Respondent's office seeking a letter of recommendation for medical marijuana for treatment of his hypertension. S.N.'s history of hypertension was significant, and he had been treated with medication by his primary care physician at Kaiser. S.N. told Respondent he did not want to take the prescribed medications because of their side effects. At the hearing, Respondent testified that he was uncomfortable with S.N.'s request because marijuana was not the usual treatment for hypertension and S.N. could not document a benefit from it but, when he initially declined the request, S.N. "whined and begged" (Respondent's terms) until Respondent agreed to write the letter. That testimony is contradicted by Respondent's chart notes which read in part: "[H]igh blood pressure, uncontrolled for several years [B]rought literature of effects of cannabis on hbp and would like to try it." The discrepancy between the chart notes and Respondent's testimony was damaging to Respondent's credibility. If his chart note was accurate, he testified falsely at the hearing. If his testimony was true, he falsified the chart.

82. S.N.'s blood pressure was 150/100. Respondent noted in the chart that the physical examination was "otherwise normal" but did not chart what had been done to make that determination. (Neither S.N. nor Respondent described the physical examination when they testified at the hearing.) Respondent and S.N. discussed the seriousness of hypertension and the risks and benefits of treating it with cannabis. Respondent provided a recommendation letter for medical marijuana to S.N. and wrote in the chart: "Plan: Cannabis recommendation as per Prop 215, with caveat to be sure blood pressure is controlled."

83. Respondent told S.N. to call him to let him know the results of the medicinal cannabis use. Respondent did not schedule a follow up appointment for S.N. and did not make a note to himself to follow up on his recommended treatment. S.N. did not call back. At the hearing, Respondent admitted he should have written a note to himself to follow up with S.N. if S.N. failed to telephone him with the results.

84. On October 15, 1999, S.N.'s wife telephoned Respondent and told him S.N. had increased his marijuana use, was becoming lethargic and was withdrawing from his family, preferring to lock himself in a room and smoke marijuana. Respondent spoke by telephone with S.N. who said that he smoked marijuana only in the evenings and that his wife was trying to harass him. However, S.N. admitted that he had not taken his blood pressure and Respondent stressed the importance of controlling his hypertension. Faced with the choice of whether to believe his patient or his patient's wife regarding the amount of marijuana use, Respondent chose to believe his patient.

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85. Respondent next saw S.N. on March 2, 2000, more than a year after S.N.'s initial visit. S.N.'s blood pressure had increased to 180/110. S.N. was anxious and depressed. Respondent gave S.N. a bottle of Carditone, an herbal compound containing a trace amount of reserpine, to control S.N.'s hypertension. He warned S.N. of a slim possibility that the reserpine could exacerbate S.N.'s depression.

86. On March 11, 2000, S.N. requested that Respondent provide him with a letter regarding the necessity of his using medical marijuana. He stated that the letter was to be used in connection with a marital dissolution action between S.N. and his wife. Respondent issued that letter. S.N. told Respondent he had not been taking the Carditone because he feared its side effects. Respondent told him that the possibility of the side effects were slim and that he needed to reduce his blood pressure.

87. No follow up was done for approximately eleven months when, on February 9, 2001, S.N. again presented at Respondent's office. His blood pressure was 220/120 and he was anxious and depressed. He was not taking any medication for his hypertension because he claimed that none of his medications worked. He stated he had taken the Carditone the previous year but it caused him to feel depressed. He also claimed that marijuana improved his affective state by relieving the anxiety and depression. Respondent prescribed Lotensin 10 mg bid, told S.N. to continue the marijuana, to frequently monitor his blood pressure, and to call Respondent the next day with the results of the blood pressure readings. S.N. did not call until February 13, 2001. At that time, he told Respondent the Lotensin had lowered his blood pressure to 160/100 and that the marijuana lowered it another ten points to 150/90. Respondent advised S.N. to see an internist.

88. On February 28, 2001, S.N. reported that the Lotensin had stopped working but that the marijuana had lowered his diastolic pressure from 135 to 120. His internist had changed his medications. On April 17, 2001, Respondent charted that S.N.'s blood pressure was fluctuating but mostly remained in the area of 140/100 without cannabis and 10-15 points lower with it.

89. On August 3, 2001, S.N. was hospitalized with blood pressure of 198/132. Upon his discharge on or about August 7, 2001, he emailed Respondent advising him that his physician had placed him on Zestril, Plendil and Clonidine Hcl, and that the medications had lowered his blood pressure to 150/100 but had left him fatigued, depressed and suffering from dry mouth and headaches. He also wrote:

> "If it weren't for the mmj I would have gone off the deep end a long time ago. Pot is holding me together. Pot reduces my depression, lessens the severity of my headaches, give me an appetite and patience, understanding & the will to deal with my problems. Best of all it has no side-effects."

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90. As with the other individuals to whom Respondent gave letters of recommendation for medicinal cannabis, Dr. Barke did not criticize Respondent's decision to issue the letters to S.N. He did, however, opine that Respondent's work-up and follow-up in connection with S.N. constituted an extreme departure from the standard of care. He explained that a trial of medical marijuana may be acceptable if the physician has taken a history and performed a physical examination and review of systems. In this case, Respondent knew nothing about the patient's work-up at Kaiser other than the patient's statements. Respondent therefore should have obtained the Kaiser records as soon as possible. Dr. Barke's opinion would have been the same even if S.N. had declined to undergo a physical examination and only wanted Respondent to provide the recommendation letter. Dr. Barke opined that Respondent would have no more been relieved of his obligation to render appropriate care in that situation than would an endocrinologist who prescribed medication for diabetes at a patient's request after the patient refused to undergo a physical examination.

91. In addition, Dr. Barke testified that a physician should recommend certain life-style changes to a hypertensive patient, such as elimination or moderation of caffeine, alcohol and salt, and more exercise. The physician should also follow up on the patient every two weeks to two months, or more often depending on the condition's severity, and should order blood work and a urinalysis to rule out organ and kidney damage caused by the hypertension.

92. Dr. Barke also found an extreme departure from the standard of care with respect to Respondent's chart which he found "at best incomplete and at worst potentially dangerous." For example, the note for February 19, 1999 shows no documentation of vital signs except for the blood pressure, no pertinent positive or negative findings, no patient weight, no discussion of the history of symptoms of high blood pressure such as headaches, blurred vision, dizziness or nausea, no discussion regarding non-drug treatment and life-style changes, no discussion of treatment options other than marijuana, no discussion of the amount and frequency of marijuana use or its side effects, and no follow-up plan. There was also no documented attempt to obtain the patient's medical records from other health care providers. Dr. Barke's criticisms were similar for the note on March 2, 2000.

93. Respondent's care and treatment of patient S.N. constituted gross negligence, repeated negligent acts and incompetence.

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Other Patients

94. Respondent offered the testimony of three of his patients, all of whom testified to his caring and dedication, and to the benefits they had derived from the medicinal cannabis Respondent had approved for treatment of their respective serious conditions.[11]

95. The first patient was formerly addicted to the morphene she took to control the pain of sickle cell anemia. Respondent taught her to hang upside-down to clear her lungs instead of going to the emergency room for an IV. The medicinal cannabis he recommended for her not only eased her pain, it also reversed the effects of the disease.[12]

96. The second patient met Respondent when he recommended medicinal cannabis for her husband after he suffered two myocardial infarctions. He continued to be followed by a cardiologist at the same time. The witness became Respondent's patient after she developed severe osteoporosis, cystitis and degenerative disk disease. She had treated at Loma Linda without relief. Her body was not accepting calcium, and she was in great pain. Respondent recommended hydrochloric acid, which she obtained at a health food store, and a QRS machine. Both the hydrochloric acid and the QRS machine greatly helped her condition. She claims to be almost free of osteoporosis now and her vision has improved to the point that she wears only reading glasses instead of the trifocals previously prescribed for her. She believes she has almost completely overcome her cystitis. Respondent also gave her a recommendation for medical marijuana. She does not smoke it, but does make marijuana cookies which she eats at night if she is in extreme pain. She considers Respondent "more than a doctor." He has telephoned when he has found new ways to help her husband's cardiac condition even though her husband is still followed by his cardiologist.

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[11] Respondent was prepared to offer additional patients to testify on his behalf but was limited to three by the court.

[12] No medical evidence was offered to show that the effects of the sickle cell anemia were reversed by the medicinal cannabis. That finding is based solely on the lay witness's testimony.

97. The third patient suffers from migraine headaches. He had treated with a chiropractor following a serious automobile accident in 1994, but the chiropractor was unable to recommend marijuana because he was not a licensed physician. Treatment by two physicians who did not offer medicinal cannabis was ineffective. The patient went to a third physician who gave him a letter of recommendation for medical marijuana, but when the patient returned the following year for another letter, the physician told him he was being investigated and was no longer writing recommendation letters for medical marijuana. He contacted Respondent who told him to come to the office and to bring his medical records with him. The patient brought only his chiropractic records because he was uncomfortable with the others. He and Respondent discussed various treatment options, and Respondent then gave him a letter of recommendation for medical marijuana. The patient then brought 20-25 sick patients to Respondent. Respondent told him to have the new patients bring their medical records with them.

The Fictitious Name

98. On February 15, 2002, Board investigators visited Respondent's medical office. The office directories on the first and second floor of the building in which Respondent's office was located indicated the name, "Center for Natural Healing" next to Respondent's suite number. That fictitious name was also printed on Respondent's business cards. Respondent had previously identified his practice by the fictitious name, "Natural Medicine Center."

99. Respondent has never held a fictitious name permit for either "Center for Natural Healing" or "Natural Medicine Center."

100. Respondent used his own name in conjunction with "Center for Natural Healing" on his office door, the building directories and on his business cards. He did not use the fictitious name in any other manner such as on a bank account. He considered the fictitious name "just kind of a nickname" (Respondent's words).

The Costs

101. Pursuant to Business and Professions Code section 125.3, Complainant's counsel requested that Respondent be ordered to pay to the Board $65,940.57 for its costs of investigation and prosecution of the case. The costs consist of $9,132.04 for investigative services, $11,469.53 for expert witness fees, and $45,339.00 in Attorney General's fees. Those costs are deemed just and reasonable.

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LEGAL CONCLUSIONS

1. Cause exists to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code section 2234(b), for gross negligence, as set forth in Findings 8 through 11, 25, 26, and 33 through 93.

2. Cause exists to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code section 2234(c), for repeated negligent acts, as set forth in Findings 8 through 11, 25, 26, and 33 through 93.

3. Cause exists to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code section 2234(d), for incompetence, as set forth in Findings 8 through 11, 25, 26 and 33 through 93.

4. Cause exists to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code section 2242(a), in conjunction with section 2238, for furnishing dangerous drugs without a good faith examination, as set forth in Findings 8 through 11, 25, 26, and 33 through 93.

5. Cause exists to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code sections 2234(e) and 2261, for dishonesty and false representations, as set forth in Findings 54 and 56.

6. Cause exists to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code section 2264(a), in conjunction with section 2234(a), for aiding and abetting the unlicensed practice of medicine, as set forth in Findings 8 through 11, and 34 through 45.

7. Cause exists to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code section 2266, for failure to maintain adequate and accurate records, as set forth in Findings 8 through 11, 25, 26, and 33 through 93.

8. Cause exists to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code section 2272, for Respondent's failure to use his own name or an approved fictitious name in advertisements regarding the practice of medicine, as set forth in Findings 98 through 100.

9. Cause exists to order Respondent to pay the costs claimed under Business and Professions Code section 125.3, as set forth in Finding 101.

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The standard of proof to be used in these proceedings is "clear and convincing." (Ettinger v. Board of Medical Quality Assurance (1982) 135 Cal.App.3d 853, 856, 185 Cal.Rptr. 601.) This means the burden rests on Complainant to establish the charging allegations by proof that is clear, explicit and unequivocal--so clear as to leave no substantial doubt and sufficiently strong to command the unhesitating assent of every reasonable mind. (In re Marriage of Weaver (1990) 224 Cal.App.3d 478.) Complainant sustained his burden of proof by clear and convincing evidence to a reasonable certainty.

In his Second Amended Accusation, Complainant does not question or criticize, and this Proposed Decision does not address, the curative and/or palliative value of medicinal cannabis. The parameters of this Proposed Decision are defined by the causes for discipline alleged in the Second Amended Accusation, and not on the propriety of medicinal cannabis as a medical treatment. In discussing the role of physicians under Health and Safety Code section 11362.5, the court in Conant v. Walters (2002) 309 F.3d 629, stated:

> "[D]octors are performing their normal function as doctors and, in so doing, are determining who is exempt from punishment under state law. If a doctor abuses this privilege by recommending marijuana without examining the patient, without conducting tests, without considering the patient's medical history or without otherwise following standard medical procedures, he will run afoul of state as well as federal law. But doctors who recommend medical marijuana to patients after complying with accepted medical procedures are not acting as drug dealers; they are acting in their professional role in conformity with the standards of the state where they are licensed to practice medicine."
> (Id. at 647.)

The Standard of Care

In Flowers v. Torrance Memorial Hospital Medical Center (1994) 8 Cal.4th 992, 998, 35 Cal.Rptr.2d 685, the court stated:

> "[T]he standard for professionals is articulated in terms of exercising 'the knowledge, skill and care ordinarily possessed and employed by members of the profession in good standing . . .' (Citation). For example, the law '"demands only that a physician or surgeon have the degree of learning and skill ordinarily possessed by practitioners of the medical profession in the same locality and that he [or she] exercise *ordinary care* in applying such learning and skill to the treatment of [the] patient." [Citation.]' (Citation, italics added.)"

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Health and Safety Code section 11362.5 permits an individual to obtain a letter of recommendation for medical marijuana from any physician licensed in California, without limitation as to the physician's qualifications, skill, education, training or experience. Therefore, in this case, the standard of care must be that in the local medical community, rather than that of a small sub-set of practitioners who limit their practices, in whole or in part, to a finite medical treatment.

It is true that certain medical sub-specialties exist and that the practitioners within those sub-specialties are held to a standard of care specific to their particular area, rather than to one of a larger, encompassing specialty. The purpose for that limitation relates to the degree of special education, training and experience necessary for a physician to work competently (i.e., not negligently) within his/her sub-specialty. Although any licensed physician in this State may practice in a limited, highly specialized area, that physician requires a great degree of training and experience in order to develop the knowledge and skill necessary to competently render care and treatment within that sub-specialty.

Those requisites do not exist for the approximately twelve physicians in California (described by Respondent's expert, Dr. Mikuriya, as members of the California Cannabis Research Medical Group) who limit their practices to writing letters of recommendation for medical marijuana. No special education, training or experience is necessary to write recommendation letters for medical marijuana. On the contrary, medical cannabis consultants seek to severely limit the medical model in their practices by viewing themselves as consultants only who need not examine patients, perform tests, diagnose, offer alternative treatment or exercise any special expertise. As Respondent's expert testified, to meet minimal practice standards, the medical cannabis consultants need only record the patient's identifying data and record a diagnosis and notes supporting the diagnosis. That is a far different standard from physicians whose practice is limited to other narrow specialty areas such as pediatric neurologists, radiation oncologists, or surgeons who limit their practices to surgery of the spine or hand. Therefore, the area of practice occupied by medical cannabis consultants should not be deemed to constitute a sub-specialty with its own standard of care.

The descriptions of a medical cannabis consultant by Respondent and Dr. Mikuriya sound similar to that of a surgical consultant. Neither consultant is considered a patient's primary physician, and the patient sees the consultant for a limited and specified purpose. However, it does not take an expert witness to establish that a surgeon who relies solely on the patient's word for a diagnosis and proper treatment would fall below the standard of care. Yet, this is exactly what Respondent and his expert contend is proper conduct for the medical cannabis consultant.

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Something more is required for the medical cannabis consultant to perform his/her duties within the standard of care. In fact, the analogy to the surgical consultant demonstrates a potentially greater duty for the medical cannabis consultant to perform an adequate workup before recommending marijuana than the surgical consultant who determines if the patient requires surgery. The potential surgical patient comes to the surgeon as a referral from another physician who seeks a consult from a physician with greater expertise, skill and experience in surgical matters. The referring physician has already worked up the patient, taken a history, performed a physical examination, ordered appropriate tests, and has rendered at least a tentative diagnosis. The surgical consultant generally has received and reviewed the patient's medical records. In contrast, many patients seeking medical marijuana self-refer and are not under the care of another physician who may have suggested that medical marijuana might be beneficial, and referred them to the medical cannabis consultant. As Respondent demonstrated with respect to several of the individuals involved in this case, a review of medical records is not a pre-requisite to a recommendation for medical marijuana. Therefore, unless a proper work-up is performed before making the medical marijuana recommendation, a serious condition could be missed with potentially catastrophic results.

As stated above, the evidence established that the proper standard of care for a physician who recommends medicinal cannabis for a new patient is that of a family practitioner. Specifically, the physician must take a detailed history and perform a physical examination and review of systems. If indicated, laboratory and/or other diagnostic tests should be performed and prior medical records should be obtained. The risks and benefits of a proposed treatment should be discussed, as should alternative treatments, and a follow-up plan should be developed.[13] Although some of the above may be forgone depending on the context of the patient's condition and the physician-patient relationship, performance of the above remains the standard of care for even the most benign conditions.[14]

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[13] A follow-up plan is particularly important in the case of medical marijuana recommendations since the written recommendations remain valid for a full year. Although there are no reported deaths from marijuana overdose, other adverse effects such as anxiety, lethargy and dependence have been documented. In addition, follow-up should be performed to ensure that the marijuana is having the intended curative/palliative effect.

[14] For example, Dr. Barke testified that, even for a new patient who complains of symptoms consistent with the common cold, the physician must take a past medical history, including a history of high blood pressure and diabetes in order to avoid recommending an improper over-the-counter medication. He/she must then perform a limited examination to rule out a more serious disorder and establish normal findings. Depending on the circumstances, a follow-up appointment may or may not be necessary.

Dr. Mikuriya testified that the standard of care should be that espoused by his organization, the California Cannabis Research Medical Group (i.e., the taking of the patient's identifying data, a recordation of a diagnosis and the charting of notes to support the diagnosis). Factual Findings Nos. 9 through 20, above, are considered in determining the merits of his position. His position is rejected for the reasons set forth in Factual Findings Nos. 25 and 26.

The standard of care has never been that endorsed by Respondent. (His own expert admitted that a diagnosis could be missed under that purported standard of care and that the extent of that risk will not be known for another 20 years.) To the extent that Respondent was arguing as to what the standard of care should be, as opposed to what the standard of care actually was at the relevant times, Dr. Mikuriya's testimony constituted improper expert opinion. In N.N.V. v. American Assn. of Blood Banks (1999) 75 Cal.App.4th 1358, 1385, 89 Cal.Rptr.2d 885; the Court stated:

> "Under existing law, testimony, including expert testimony, is not admissible to show the standard of care should have been different; an expert is not permitted to '"second-guess an entire profession"' as to what the standard of care should have been. (*Spann v. Irwin Memorial Blood Centers* (1995) 34 Cal.App.4th 644, 655 [40 Cal.Rptr.2d 360].)"

Gross Negligence and Repeated Negligent Acts

Respondent committed extreme departures from the standard of care, both in his treatment of Kim Wilson and in making recommendations for medical marijuana. He performed less in the way of history, examination and charting than even his own expert performs in his practice. In several cases, Respondent did not perform any physical examination at all. In some, the physical examination was limited to only a blood pressure reading. In several cases, his histories were limited to the patients' explanations of why they desired recommendations for medical marijuana. Many of those explanations were insufficient to justify the recommendation. For example, in C[redacted]'s case, Respondent never made any diagnosis of a serious medical condition that could be treated with medicinal cannabis. He only created a prediction of what might occur in the event of a specific condition precedent (i.e., that C[redacted] might become depressed if he did not have marijuana). Some of the patients filled out health history questionnaires. At least two did not (Wilson and J[redacted]

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Health and Safety Code section 11362.5 neither expressly nor impliedly suspends the standard of care for a physician making a recommendation for medicinal cannabis. The statute sets forth the criteria which must be met before the recommendation may be made. Specifically, in order for a recommending physician to avoid punishment or the denial of a right or privilege, he/she must have made the recommendation for medical marijuana "for medical purposes" (Health and Safety Code section 11362.5(c).) The medical purposes are set forth in Health and Safety Code section 11362.5(b)(1)(A) which mandates that the patient must be a "seriously ill" Californian, and the recommending physician must have "determined that the person's health would benefit from the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief." Section 11362.5(b)(2) provides that nothing in the statute is to be "construed to supersede legislation prohibiting persons from engaging in conduct that endangers others, nor to condone the diversion of marijuana for nonmedical purposes."

The term "seriously ill," as used in the statute is not specifically defined except by example. These examples evince a legislative intent that medical marijuana is to be recommended not for any condition for which marijuana might provide some relief, but rather for conditions that cause substantial pain, disability, impairment, handicap, and the like. The expression "any other illness for which marijuana provides relief" means "serious illness" by the use of that term earlier in the same subdivision and as evidenced by the list of major medical conditions used as examples.

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Since Health and Safety Code section 11362.5 was originally passed as an initiative, and because its language did not so permit, it could not be amended by statute [Cal. Const., Art. II, sec. 10(c)]. Therefore, in order to clarify, rather than amend the statute, the Legislature passed SB 420 which became codified as Health and Safety Code section 11362.7 in 2003.[15] Subdivision (h) of Health and Safety Code section 11362.7 states:

> "(h) 'Serious medical condition' means all of the following medical conditions:
>
> (1) Acquired immune deficiency syndrome (AIDS).
> (2) Anorexia.
> (3) Arthritis.
> (4) Cachexia.
> (5) Cancer.
> (6) Chronic pain.
> (7) Glaucoma.
> (8) Migraine.
> (9) Persistent muscle spasms, including, but not limited to, spasms associated with multiple sclerosis.
> (10) Seizures, including, but not limited to, seizures associated with epilepsy.
> (11) Severe nausea.
> (12) Any other chronic or persistent medical symptom that either:
>
> (A) Substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990 (Public Law 101-336).
>
> (B) If not alleviated, may cause serious harm to the patient's safety or physical or mental health."

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[15] Given the date of its passage, Health and Safety Code section 11362.7 is not used as grounds for discipline against Respondent. Rather, it is referenced for the purpose of further demonstrating the original legislative intent behind Health and Safety Code section 11362.5.

With the possible exception of some of the patients who testified on his behalf, Respondent made no attempt to determine whether any of the undercover operatives or patients who sought recommendations for medical marijuana met the statutory criterion of being "seriously ill," and indeed, in several cases, it was very obvious that they did not. Respondent himself admitted to being reluctant to provide the recommendation in some of the cases, but did so anyway without taking any additional steps to ensure that the patients were proper candidates for medical marijuana and that marijuana was a medically indicated treatment for them. By failing to determine the propriety of medicinal cannabis as an indicated medical treatment for each individual patient through proper history, examination and tests, Respondent deviated from the standard of care in the manner consistent with Dr. Barke's testimony.

Health and Safety Code section 11362.5 permits the legal use of medical marijuana if it has been recommended by a physician, and if the other criteria referenced above have been met. In People v. Jones (2003) 112 Cal.App.4th 341, 347, the court discussed and distinguished the terms "recommendation" and "approval" in the context of section 11362.5. The court stated:

> "In People v. Trippet (1997) 56 Cal.App.4th 1532, 1548 [66 Cal.Rptr.2d 559], the court concluded the words 'recommendation' and 'approval' 'mean something slightly different, and ... "approval" connotes a less formal act than a "recommendation."' We agree the two terms have different meanings, but the difference is not simply a matter of the degree of formality. To 'recommend' something is 'to present [it] as worthy of acceptance or trial.' (Merriam-Webster's Collegiate Dict. (10th ed. 2001) p. 974.) To 'approve' something is to 'express a favorable opinion of' it. (*Id.* at p. 57.) The word 'recommendation,' as used in the Compassionate Use Act, suggests the physician has raised the issue of marijuana use and presented it to the patient as a treatment that would benefit the patient's health by providing relief from an illness. The word 'approval,' on the other hand, suggests the patient has raised the issue of marijuana use, and the physician has expressed a favorable opinion of marijuana use as a treatment for the patient. Thus, a physician could *approve* of a patient's suggested use of marijuana without ever *recommending* its use."
> (Emphasis in text.)

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In the instant case, each undercover operative, Patient T.A., and Patient S.N. came to Respondent seeking a recommendation for medical marijuana. In each of those cases, Respondent issued the letter based on his approval rather than his recommendation. In so doing, he disregarded his duty as a physician to diagnose and treat on the basis of a proper history, examination and review of systems, and essentially placed the decisions of diagnosis and treatment in the hands of his patients. By failing to properly diagnose and treat, Respondent was unable to rule out conditions more serious than those reported by his patients, and accordingly potentially placed his patients at great risk.

Respondent also fell below the standard of care in a number of other ways as well (i.e., by failing to medically address patients' complaints that were not treatable with marijuana, by failing to establish and follow a plan for patient follow-up, etc.) The extent of the acts and omissions constituting gross negligence and repeated negligent acts are set forth in the Factual Findings, above, and need not be repeated here.

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Incompetence

> "The technical term 'incompetency' is a relative one generally used in a variety of factual contexts to indicate an absence of qualification, ability or fitness to perform a prescribed duty or function. (Citations.) It is commonly defined to mean a general lack of present ability to perform a given duty as distinguished from inability to perform such duty as a result of mere neglect or omission. (Footnote omitted.) Such an interpretation is totally consistent with the declared legislative objective of public protection by requiring a minimum standard of professional conduct on the part of those licensed to engage in regulated activities. (Citation.) . . . the terms negligence and incompetency are not synonymous; a licensee may be competent or capable of performing a given duty but negligent in performing that duty. This fundamental conceptual distinction has long been recognized in California law (Citations) and in other jurisdictions (Citations.) In defining a similar operative term in the context of an employer's liability for injury caused by an 'incompetent' employee, our state Supreme Court has emphasized that basic distinction in explaining that 'Incompetency connotes the converse of reliability . . .' (Citation) and that 'a single act of negligence . . . may be attributable to remissness in discharging known duties, rather than . . . incompetency respecting the proper performance.' (Citation.) The Legislature has consistently acknowledged that basic distinction in enacting and amending a number of regulatory statutes authorizing sanctions for either incompetence or negligence (Footnote omitted.) Thusly, to construe the one as merely synonymous with the other is inconsistent with general principles of construction requiring that meaning and effect be accorded to all of the statutory parts and that an interpretation of a statute be avoided which renders some of its words surplus. (Citations.)"
> Pollak v. Kinder (1978) 85 Cal.App.3d 833, 837-838, 149 Cal.Rptr. 787.

In addition to deviating from the standard of care as set forth above, Respondent demonstrated a lack of competence in failing to understand the necessity of taking a proper history, conducting a physical examination, correctly charting a patient's history, subjective findings, objective findings, assessment, treatment plan, follow-up and the like. Respondent is neither board certified nor board eligible for any recognized medical specialty board. In fact, he has little medical education beyond medical school and approximately 1½ years in a psychiatric residency program he failed to complete in approximately 1977. He testified that he did not finish his psychiatric residency because he felt his instructors were "going in the wrong direction" and that he was not interested in what they were teaching. He further testified that he wanted to get to the root of a patient's problem and actually heal instead of only treating symptoms. Yet, by limiting his practice almost exclusively to writing recommendation letters for medical marijuana, his practice is concomitantly limited to the treatment of symptoms without healing the patient.

Respondent also testified that he gave letters of recommendation for medical marijuana to some of the undercover operatives, despite their claims that they were not suffering from any major medical conditions, because he believed they might have been in denial. Respondent failed to recognize that patients coming to him seeking marijuana for a medical reason would be motivated to emphasize, rather than deny, their symptoms.

Additional training is necessary in order to increase Respondent's level of competence.

Respondent's Arguments Regarding Negligence and Incompetence

Respondent argued that, because the undercover operatives were not sick, Respondent could not have been negligent or incompetent in treating them by giving them a letter of recommendation for medical marijuana. He is incorrect. It is the fact that he failed to determine that they were not sick that establishes the causes for discipline.

Respondent also argued that he should not be subject to discipline for gross negligence or repeated negligent acts because a "difference of opinion" exists between the parties as to which standard of care applies to his practice. He is incorrect in that regard as well. It is axiomatic that virtually every disputed "standard of care case" involves a difference of opinion either as to the applicable standard of care, or whether the respondent deviated from the standard of care, or both. The standard of care in this case was proven by clear and convincing evidence to a reasonable certainty. The fact that Respondent has a different opinion with respect to the standard makes him no less culpable under Business and Professions Code section 2234, subdivisions (b) and (c).

The Applicability of Business and Professions Code section 2242

Respondent argues that the fourth Cause for Discipline for prescribing dangerous drugs without a good faith examination must fail because he neither prescribed, dispensed nor furnished medicinal cannabis to any patients or undercover operatives, but rather simply issued recommendations for its use. That argument is rejected.

Business and Professions Code section 2242 states in relevant part:

> "(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without a good faith prior examination and medical indication therefore, constitutes unprofessional conduct."

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In order to establish a cause for discipline pursuant to Business and Professions Code section 2242, Complainant had to prove that Respondent prescribed, dispensed or furnished medicinal cannabis to one or more individuals without first conducting a good faith examination.[16] Marijuana (specifically, Tetrahydrocannabinoid) is defined as a Schedule I controlled substance in Health and Safety Code section 11054 and 21 USC 812. The federal statute defines a Schedule I drug as follows:

> "(A) The drug or other substance has a high potential for abuse.
> (B) The drug or other substance has no currently accepted medical use in treatment in the United States.
> (C) There is a lack of accepted safety for use of the drug or other substance under medical supervision."

Business and Professions Code section 4022 defines "dangerous drug" as follows:

> "'Dangerous drug' . . . means any drug . . . unsafe for self-use . . . and includes the following:
>
> (a) Any drug that bears the legend: 'Caution: federal law prohibits dispensing without prescription,' 'Rx only,' or words of similar import.
>
> * * *
>
> (c) Any other drug . . . that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

Business and Professions Code section 4060 states in pertinent part:

> "No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, or veterinarian, or furnished pursuant to a drug order issued by a certified nurse-midwife or a physician assistant pursuant to Section 3502.1."

A physician is not permitted to prescribe a Schedule I controlled substance such as marijuana. (Health and Safety Code section 11164.)

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[16] Respondent's prescription for Ambien which he wrote for Kim Wilson is discussed later in this section.

Business and Professions Code section 4022 presents a two-pronged test to establish whether a drug should be deemed "dangerous": (1) It must be dangerous for self-use and (2) it may not be dispensed except by prescription. Marijuana satisfies those criteria. The first prong of the test is satisfied by the definition of a Schedule I drug in 21 USC 812. The second prong is satisfied pursuant to Business and Professions Code section 4060 and Health and Safety Code section 11164. Therefore, for Respondent to be subject to discipline pursuant to Business and Professions Code section 2242, he must have either prescribed, dispensed or furnished marijuana.

Prescribe

Business and Professions Code section 4040 states:

"(a) 'Prescription' means an oral, written, or electronic transmission order that is both of the following:

(1) Given individually for the person or persons for whom ordered that includes all of the following:

(A) The name or names and address of the patient or patients.

(B) The name and quantity of the drug or device prescribed and the directions for use.

(C) The date of issue.

(D) Either rubber stamped, typed, or printed by hand or typeset, the name, address, and telephone number of the prescriber, his or her license classification, and his or her federal registry number, if a controlled substance is prescribed.

(E) A legible, clear notice of the condition for which the drug is being prescribed, if requested by the patient or patients.

(F) If in writing, signed by the prescriber issuing the order, or the certified nurse-midwife, nurse practitioner, or physician assistant who issues a drug order pursuant to Section 2746.51, 2836.1, or 3502.1.

(2) Issued by a physician, dentist, optometrist, podiatrist, or veterinarian or, if a drug order is issued pursuant to Section 2746.51, 2836.1, or 3502.1, by a certified nurse-midwife, nurse practitioner, or physician assistant licensed in this state.

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(b) Notwithstanding subdivision (a), a written order of the prescriber for a dangerous drug, except for any Schedule II controlled substance, that contains at least the name and signature of the prescriber, the name and address of the patient in a manner consistent with paragraph (3) of subdivision (b) of Section 11164 of the Health and Safety Code, the name and quantity of the drug prescribed, directions for use, and the date of issue may be treated as a prescription by the dispensing pharmacist as long as any additional information required by subdivision (a) is readily retrievable in the pharmacy. In the event of a conflict between this subdivision and Section 11164 of the Health and Safety Code, Section 11164 of the Health and Safety Code shall prevail.

(c) 'Electronic transmission prescription' includes both image and data prescriptions. 'Electronic image transmission prescription' means any prescription order for which a facsimile of the order is received by a pharmacy from a licensed prescriber. 'Electronic data transmission prescription' means any prescription order, other than an electronic image transmission prescription, that is electronically transmitted from a licensed prescriber to a pharmacy."

Dispense

Business and Professions Code section 4024 states:

"(a) Except as provided in subdivision (b), 'dispense' means the furnishing of drugs or devices upon a prescription from a physician, dentist, optometrist, podiatrist, veterinarian, or upon an order to furnish drugs or transmit a prescription from a certified nurse midwife, nurse practitioner, physician assistant, or pharmacist acting within the scope of his or her practice.

(b) 'Dispense' also means and refers to the furnishing of drugs or devices directly to a patient by a physician, dentist, optometrist, podiatrist, or veterinarian, or by a certified nurse midwife, nurse practitioner, or physician assistant acting within the scope of his or her practice."

Furnish

Business and Professions Code section 4026 states:

"'Furnish' means to supply by any means, by sale or otherwise."

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Although Business and Professions Code sections 4022, 4024, 4026, 4040 and 4060 are part of the Pharmacy Law (Business and Professions Code sections 4000 *et seq*), those statutes and Business and Professions Code section 2242 are laws *pari materia*.[17] Thus, they are appropriately used to resolve the issue in question.

The definitions of "prescription," as set forth in Business and Professions Code section 4040 and "dispense," as set forth in Business and Professions Code section 4024, amply demonstrate that Respondent neither prescribed nor dispensed medicinal cannabis to any patient or undercover operative involved in this case.

The same cannot be said for Respondent's "furnishing" medical marijuana. Marijuana is an illegal drug. As a Schedule I controlled substance it cannot be obtained even through a physician's prescription. The only method by which an individual may legally obtain marijuana is via a recommendation by a physician upon his/her satisfaction that the requisites of Health and Safety Code section 11362.5 are met. Since it is the physician, and only the physician, who may make the recommendation, he/she is the sole vehicle through which marijuana may be legally supplied to a patient, and the physician's letter of recommendation serves a purpose analogous to his/her prescription for a Schedule II, III or IV drug. As with a prescription, the letter of recommendation for medicinal cannabis connotes more than a mere approval. It represents the physician's endorsement of medical marijuana as a medically indicated treatment for the patient's condition. (People v. Jones, supra, (2003) 112 Cal.App.4th 341, 347.)

Even if the requisites of Business and Professions Code section 2242 had not been met with respect to Respondent's recommendation letters for medical marijuana, Respondent certainly failed to comply with the statute in connection with the prescription for Ambien he wrote for Kim Wilson. Respondent was not justified in relying on the word of an unlicensed non-physician, trained in psychology and employed to perform nutritional consultations and on a brief conversation with the patient, without a good faith examination or even the creation of a medical record, to write that prescription.

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[17] In fact, Business and Professions Code section 2242(a) specifically calls for one of its terms ("dangerous drugs") to carry the definition set forth in section 4022.

Dishonesty and False Representations

In his Second Amended Accusation, Complainant alleges that Respondent "had been dishonest and made false representations in writing about his care and treatment of several patients." (Second Amended Accusation, page 18, lines 25-26.) Those false representations were contained in the letter Respondent wrote recommending medical marijuana for D[redacted] C[redacted], which states in part:

> "D[redacted] C[redacted] is under my medical care. He reports to me that using marijuana relieves his medical symptoms. I have evaluated the medical risks and benefits of cannabis use with him as a treatment pursuant to Health and Safety Code Section 11362.5 . . ."

At the time he issued the letter of recommendation, Respondent was aware that C[redacted] was not suffering from a serious illness that met the criteria set forth in Health and Safety Code section 11362.5. In fact, it was Respondent himself who suggested a diagnosis of depression to C[redacted] after C[redacted] specifically denied any major medical problems. When C[redacted] denied depression, Respondent suggested the possibility that C[redacted] might become depressed if he was deprived of marijuana. Thus, Respondent issued the letter of recommendation without any diagnosis at all, but only the possibility of a diagnosis if some future event occurred.

Aiding and Abetting the Unlicensed Practice of Medicine

Business and Professions Code section 2264 states in relevant part:

> "The employing, directly or indirectly, the aiding, or the abetting of any unlicensed person . . . to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct."

Respondent could hardly have done more to aid and abet Geoffrey Pfeifer in the unlicensed practice of medicine. As stated above, Pfeifer was an unlicensed non-physician, trained in psychology and employed to perform nutritional consultations. Respondent was well aware of Pfeifer's training, qualifications and clinical status. Yet, he knowingly permitted Pfeifer to maintain and use a pad of his pre-signed prescription forms, and he issued a prescription for an excessive number of tablets to one of Pfeifer's clients (Kim Wilson), whom Respondent had never previously met. Respondent wrote that prescription on the sole basis of Pfeifer's word and a brief interview with Wilson, without properly assessing whether the medication recommended and requested by Pfeifer was medically indicated and without establishing a follow-up plan.

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The Failure to Maintain Adequate and Accurate Records

Proper charting is an essential aspect of good medical practice in that it constitutes a permanent record of the patient's medical history, vital signs, medical conditions, positive and negative findings, test results, diagnoses, treatment plans and treatments, prognoses, follow-up, etc. Those recordations are not only critically important to a physician in his/her subsequent care and treatment of a patient, they also provide a vital source of knowledge and understanding for subsequent treating health care providers. Although patient records need not be lengthy (unless necessary to convey essential information), they must be thorough and complete. Dr. Barke correctly reminded the court and the parties of the adage that if it was not charted, it was not done.

Respondent failed to create any kind of patient chart at all for at least one of the individuals involved in this case and failed to have at least two fill out a patient questionnaire that would remain a permanent part of their charts. His records with respect to the other undercover operatives and patients were extremely limited and incomplete. In at least one case (Patient S.N.), Dr. Barke correctly pointed out that Respondent's record keeping was "at best incomplete and at worst potentially dangerous."

The Fictitious Name Issue

Business and Professions Code section 2272 states:

> "Any advertising of the practice of medicine in which the licensee fails to use his or her own name or approved fictitious name constitutes unprofessional conduct."

The statute is construed in the disjunctive. It calls for advertising to bear either the physician's own name or an approved fictitious name. Complainant did not offer any evidence or authority to show that anything more than an approved fictitious name or a physician's own name is required. Respondent used two unapproved fictitious names—Center for Natural Healing and Natural Medicine Center. He was credible in his testimony that he used his own name wherever the name Center for Natural Healing appeared (his office door, the building directories and his business cards). He offered no such testimony in connection with Natural Medicine Center.

Complainant established a prima facie case for discipline to be imposed pursuant to Business and Professions Code section 2272. Respondent bore the burden of proving an affirmative defense to that charge. (Evidence Code section 500.) He succeeded with respect to Center for Natural Healing. He did not in connection with Natural Medicine Center.

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Defenses and Mitigation

Immunity

In closing argument, Respondent requested the Administrative Law Judge to consider the defenses of absolute and conditional immunity. He based his request on the language of Health and Safety Code section 11362.5(c) which states:

> "Notwithstanding any other provision of law, no physician in this state shall be punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes."

As stated above, Respondent's license is not subject to discipline because he recommended marijuana to patients for medical purposes. It is subject to discipline for a variety of reasons relating to the methods he followed in arriving at his decisions to make the recommendations. However, decisions as to the method, time, location, etc. of performing an act to which one is entitled to an immunity privilege are generally considered "within the scope of the privilege." (Scozzafava v. Lieb (1987) 190 Cal.App.3d 1575; Katsaris v. Cook (1986) 180 Cal.App.3d 256, 266-267.)

Immunity may be either absolute or conditional. Conduct performed under absolute immunity is absolutely privileged against civil action (Saroyan v. Burkett (1962) 57 Cal.2d 706, 708.) Conditional immunity is not. In Katsaris, supra, the Court stated:

> "[U]nder a qualified privilege an actor may be liable for conduct which he undertakes with an improper motive. Likewise a qualified privilege may be lost if the actor engages in conduct outside the scope of the privilege, thus 'abusing' it."
> (Id. at 265.)

Health and Safety Code section 11362.5 requires a recommending physician to ensure that the criteria for a recommendation for medicinal cannabis have been met, specifically, that the cannabis is recommended for a seriously ill Californian, that its medical use is deemed appropriate, and that the patient's health would benefit from its use in the treatment of certain serious conditions.

Further, Health and Safety Code section 11362.5(b)(2) states:

> "Nothing in this section shall be construed to supersede legislation prohibiting persons from engaging in conduct that endangers others, nor to condone the diversion of marijuana for nonmedical purposes."

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Health and Safety Code section 11362.5(b)(2) applies to all "persons" and does not exclude physicians who may issue medical marijuana recommendation letters.

To the extent that physicians are required by the statute to ensure the satisfaction of certain criteria before recommending medical marijuana, and that they are subject to the provisions of Health and Safety Code section 11362.5(b)(2), any immunity granted pursuant to subdivision (c) must be deemed a conditional immunity. It does not protect physicians from license discipline should they deviate from the standard of care, act incompetently, or otherwise violate provisions of the Medical Practice Act in connection with making recommendations for medical marijuana, and their care and treatment of, and decision-making processes regarding, patients for whom the recommendations are and are not made.

Entrapment

Respondent asserts that he was entrapped by the undercover operatives and that the entrapments stand as an affirmative defense in this action.

The use of undercover operations is an accepted and approved method of ascertaining whether a licensee is guilty of such wrongdoing that would subject his/her license to discipline.

> "Where a physician is suspected of improperly prescribing drugs, investigation may be surreptitious and include undercover operatives posing as 'patients' making false representations." Bradley v. Medical Board (1997) 56 Cal.App.4th 445, 65 Cal.Rptr.2d 483.

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However, the courts have set limits on the type and extent of the undercover operation techniques that may be employed. Entrapment was first recognized as a proper defense in an administrative proceeding in Patty v. Board of Medical Examiners (1973) 9 Cal.3d 356, 107 Cal.Rptr. 473. In that case, an investigator for the Board of Medical Examiners sent female part-time investigators to a male physician's office seeking prescriptions for drugs that were not medically indicated. The physician had no prior record, was not predisposed to criminal conduct within his practice. He had been extremely ill and was unable to exercise sound judgment around the time he issued the prescriptions. The Court explained the necessity for the entrapment defense in administrative proceedings as follows:

> "In essence, the courts have concluded that recognition of the defense of entrapment is crucial to the fair administration of justice. If this is true for proceedings before trial courts, it is no less true for proceedings before administrative agencies. 'Sound public policy' and 'good morals' (Citation) are incompatible with entrapment of an innocent person into the commission of a crime in order to revoke his professional license as clearly as they are incompatible with entrapment in order to obtain a criminal conviction. It is as important for the agency, as for a court of law, to observe a 'regard for its own dignity.' (*Id.*) The public's concern with the fair administration of justice attaches equally to administrative as to judicial proceedings. The agency, no less than the court, must 'formulate and apply proper standards' (*id.*) for enforcement of the law; neither should permit its officers 'to consummate illegal or unjust schemes designed to foster rather than prevent and detect crime.' (*Id.*) (Footnote omitted.) The function of the enforcement officials is to investigate, not instigate, crime; to discover, not to promote, crime.
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"Further, to endow an administrative agency which already combines investigatory and adjudicatory powers with the power of entrapment is to invite the appearance and danger of abuse and discrimination. When an administrative body invokes its authority to initiate inquiry, the range of investigation is left largely within the discretion of the agency. (Citation.) The enormous power thus posited in such an agency, as well as the dangers for its abuse, has often been stressed by legal writers. (Footnote omitted.) Abuse is realized when the power of government is 'employed to promote rather than detect crime and to bring about the downfall of those who, left to themselves, might well have obeyed the law.' (Citation.) And the availability of entrapment tactics opens the possibility that an agency will discriminatorily *select* a practitioner, seek out his human weaknesses, and by persuasion and inducement condemn him for professional execution. (Footnote omitted.) Such an abuse of governmental power provides the unconventional practitioner with little protection from the '"likely prejudices of a professional license body."' (Citation.)

"Moreover, the use of entrapment techniques cannot be justified as necessary to a regulatory agency's fulfillment of its investigatory function. The protection of society from criminal elements within a trade or profession is not served by enticing into criminal activity those who have thus far avoided and abstained from wrongdoing. By barring the use of entrapment in administrative proceedings we do not limit legitimate investigation efforts; we only curtail activity which seeks to induce the perpetration of a crime for the sake of punishment." (Id. at 364-366.) (Emphasis in text.)

In Wong v. State Bar (1975) 15 Cal.3d 528, 125 Cal.Rptr. 482, the Court ruled that entrapment is not a defense if the undercover operation was conducted by individuals not employed by the regulatory agency licensing the respondent. In distinguishing Patty, supra, on that basis, the Court stated:

"In Patty . . . the entrapment was committed by the administrative agency's own investigators. Hence that matter involves a situation completely different from the one existing here, and language in Patty clearly implies that we were there concerned with deterring enforcement excesses committed by the agency."

However, in Goldin v. Public Utilities Commission (1979) 23 Cal.3d 638, 153 Cal.Rptr. 802, the Court cited Patty with approval without distinguishing Wong, even though the regulatory agency had not played a role in the alleged entrapment.

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In Douglass v. Board of Medical Quality Assurance (1983) 141 Cal.App.3d 645, 655-656, 190 Cal.Rptr. 506, the Court explained the proper test for determining whether the defense of entrapment may appropriately be raised in an administrative proceeding:

> "[T]he current California test focuses on the law enforcement agent's conduct examined in light of the circumstances surrounding the situation in question. (Citation.) The suspect's predisposition to commit the offense and his subjective intent are irrelevant. (Citation.) Undercover operations and decoys are permissible provided the police agents do not resort to pressure or overbearing conduct 'such as badgering, cajoling, importuning, or other affirmative acts' (Citation) to induce the criminal act. If the police generate ordinary criminal intent, however, the agent's conduct does not constitute entrapment. (Ibid) An individual is presumed to resist the temptation to commit a crime presented by the simple opportunity to act unlawfully. (Ibid) Appeals to friendship or sympathy, or representations or enticements making the act unusually attractive, are impermissible. (Ibid)"

Pursuant to Wong, supra, Respondent's entrapment defense cannot be sustained because only one out of the five undercover operations involved a Board investigator. To the extent that Respondent refers only to the undercover operations involving requests for medical marijuana, the entrapment defense must surely fail since the Board's investigator was involved solely with the Pfeifer matter and had no connection with any medical marijuana operations.

Regardless of whether Wong applies, the evidence did not demonstrate any conduct on the part of any of the undercover operatives that would justify an entrapment defense pursuant to the criteria in Douglass, supra. None of the undercover operatives engaged in conduct that could be construed as "pressure," "overbearing conduct," "badgering," "cajoling," or "other affirmative acts" to induce the conduct that subjected Respondent's license to discipline. Respondent argued that undercover operative C[redacted] "importuned" him into providing a letter of recommendation for medical marijuana. The evidence does not support that claim.

Black's Law Dictionary (6th ed., 1990) defines "importunity" as follows:

> "Pressing solicitation; urgent request: application for a claim or favor which is urged with troublesome frequency or pertinacity." (p. 755.)

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C[redacted] engaged in no such conduct. He made it clear to Respondent that he was a long-time user of marijuana who did not have a major medical problem. He further stated that he experienced occasional high blood pressure and temporary muscle aches. It was Respondent who determined a diagnosis that would justify his issuing a letter of recommendation for marijuana, after he asked C[redacted] if C[redacted] would be depressed if he did not have marijuana. Respondent argued that he was importuned by C[redacted] because C[redacted] did not make it clear, on several occasions rather than just once, that there was nothing wrong with him. That argument does not meet the definition of importunity under any known standard.

This case involves five undercover operations, four of which involved requests for medical marijuana recommendation letters. In each of those four cases, although he was obviously not told the "patients" were undercover operatives, Respondent was told, in advance, the purported purpose of the visits. In each case, he instructed the patient to bring $250.00. In each case, he provided the requested letters without a proper medical work-up and without conduct by the officers that would satisfy the criteria for entrapment described in Douglass, supra.

If Respondent is claiming that he was entrapped on each of the five occasions he was visited, four of which involved very similar scenarios, that claim must be rejected as lacking both reason and logic. In fact, Respondent never testified that he would not have issued the letters of recommendation or the prescription for Ambien but for the overbearing conduct of the undercover operatives. At most, he testified that some of the stories offered by the operatives seemed marginal but still sufficient to justify, in his mind, the issuance of the recommendation letters. At some point, Respondent must take responsibility for his own actions rather than blame others for causing his conduct that was consistent with his general practice.

Lack of Patient Harm

Respondent offered as mitigation evidence the fact that Respondent has been responsible for no patient deaths as a result of his writing recommendation letters for medical marijuana. The evidence, through Dr. Grinspoon's testimony, established that there has never been a death by marijuana overdose. Respondent's argument would have been far more compelling had he been in a position to argue that the treatment he renders to patients is extremely high risk and involves a very high mortality rate, but nonetheless, he has never had a patient death related to his care and treatment. The fact that he has never been responsible for an untoward event that has never occurred offers little in the way of mitigation, particularly in light of Dr. Barke's credible testimony that the problem with marijuana is not death but addiction, and that "there are more ways to harm people than killing them."

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The Discipline

Cause exists to discipline Respondent's medical license. The remaining question is the nature and extent of the discipline to be imposed.

Business and Professions Code section 2229 states:

> "(a) Protection of the public shall be the highest priority for the Division of Medical Quality, the California Board of Podiatric Medicine, and administrative law judges of the Medical Quality Hearing Panel in exercising their disciplinary authority.
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> (b) In exercising his or her disciplinary authority an administrative law judge of the Medical Quality Hearing Panel, the division, or the California Board of Podiatric Medicine, shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of continuing education or other reasons, restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence.
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> (c) It is the intent of the Legislature that the division, the California Board of Podiatric Medicine, and the enforcement program shall seek out those licensees who have demonstrated deficiencies in competency and then take those actions as are indicated, with priority given to those measures, including further education, restrictions from practice, or other means, that will remove those deficiencies. Where rehabilitation and protection are inconsistent, protection shall be paramount."

Respondent admitted he made certain errors in his practice and, if given the chance, will change his practice by upgrading his history taking and performing more focused physical examinations.

In passing Prop 215, the people of California expressed their opinion that marijuana has a specific place in the treatment of serious medical conditions and that Californians suffering with such conditions should not be deprived of that treatment option. Physicians, such as Respondent, who are willing to write letters of recommendation for medical marijuana, provide a valued and valuable service to those who suffer with conditions which marijuana benefits and who desire its palliative effects. To that extent, Respondent should be permitted to continue to deliver that service, provided he can do so competently and within the standard of care.

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Respondent's discipline is based not on the nature of his practice, but on the methods of his practice. Based on the evidence and the reasons set forth above, revocation is not warranted. Pursuant to Business and Professions Code section 2229, Respondent should be permitted to maintain his practice under a properly conditioned probationary order designed to improve his competence and compliance with the standard of care. Such conditions must and shall include, but not be limited to, additional training and practice monitoring.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Certificate No. G 32011, issued to Respondent, William S. Eidelman, M.D., is revoked. However, the revocation is stayed, and Respondent is placed on probation for five (5) years upon the following terms and conditions.

1. Within 15 days after the effective date of this decision, Respondent shall provide the Division, or its designee, proof of service that Respondent has served a true copy of this decision on the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent or at any other facility where Respondent engages in the practice of medicine and on the Chief Executive Officer at every insurance carrier where malpractice insurance coverage is extended to Respondent.

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

2. 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.

3. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, 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.

4. Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of Respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

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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 license.

Respondent shall immediately inform the Division 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.

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

6. In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Division 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 thirty 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 Division 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 Cost Recovery.

Respondent's license shall be automatically cancelled if Respondent's periods of temporary or permanent residence or practice outside California totals two years. However Respondent's license 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.

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7. In the event Respondent resides in the State of California and for any reason Respondent stops practicing medicine in California, Respondent shall notify the Division 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 thirty 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 Division 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 license 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.

8. Within 90 calendar days from the effective date of the Decision or other period agreed to by the Division or its designee, Respondent shall reimburse the Division the amount of $65,940.57 for its investigative and prosecution costs. The filing of bankruptcy or period of non-practice by Respondent shall not relieve Respondent of his obligation to reimburse the Division for its costs.

9. 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 his license. The Division 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 his wallet and wall certificate to the Division 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.

10. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division 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.

11. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Division 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 preferably are 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 Division, 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 Division or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement.

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 Division or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely.

It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Division or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Division 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 3 calendar days after being so notified by the Division 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.

12. 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 Division or its designee. Failure to successfully complete the course during the first 6 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 Division or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Division 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 Division 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.

13. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program").

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of Respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to Respondent's specialty or sub-specialty, and at minimum, a 40 hour program of clinical education in the area of practice in which Respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Division or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

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Based on Respondent's performance and test results in the assessment and clinical education, the Program will advise the Division or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, Respondent shall submit to and pass an examination. The Program's determination whether or not Respondent passed the examination or successfully completed the Program shall be binding.

Respondent shall complete the Program not later than six months after Respondent's initial enrollment unless the Division or its designee agrees in writing to a later time for completion.

Failure to participate in and successfully complete all phases of the clinical training program outlined above is a violation of probation.

14. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Division, 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 Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. Upon successful completion of probation, Respondent's certificate shall be fully restored.

DATED: May 21, 2004

H. Stuart Waxman

H. STUART WAXMAN
Administrative Law Judge
Office of Administrative Hearings

REDACTED

FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO June 28, 2002
BY [signature] ANALYST

BILL LOCKYER, Attorney General
of the State of California
RAJPAL S. DHILLON, State Bar No. 190583
Deputy Attorney General
California Department of Justice
300 South Spring Street, Suite 1702
Los Angeles, California 90013
Telephone: (213) 897-2568
Facsimile: (213) 897-1071

Attorneys for Complainant

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

In the Matter of the Second Amended Accusation Against: WILLIAM S. EIDELMAN, M.D. 1223 Wilshire Boulevard, #762 Santa Monica, CA 90401 Physician and Surgeon's Certificate No. G 32011 Respondent.	Case No. 06-2000-108619 **SECOND AMENDED ACCUSATION**

Complainant alleges:

PARTIES

1. Ron Joseph (Complainant) brings this Second Amended Accusation solely in his official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs.

2. On or about July 1, 1976, the Medical Board of California issued Physician and Surgeon's Certificate Number G 32011 to William S. Eidelman, M.D. (Respondent). The Physician and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on February 28, 2003, unless renewed.

JURISDICTION

3. This Second Amended Accusation is brought before the Division of

Medical Quality, Medical Board of California (Division), under the authority of the following sections of the Business and Professions Code (Code).

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

"(c) Repeated negligent acts."

"(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."

. . . .

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 2242 of the Code states:

"(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without a good faith prior examination and medical indication therefor, constitutes unprofessional conduct."

. . . .

8. Section 2261 of the Code states:

"Knowingly making or signing any certificate or other document directly or indirectly related to the practice of medicine or podiatry which falsely represents the existence or nonexistence of a state of facts, constitutes unprofessional conduct."

9. Section 2264 of the Code states:

"The employing, directly or indirectly, the aiding, or the abetting of any unlicenced person or any suspended, revoked, or unlicenced practitioner to engage in the practice of medicine or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct."

10. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

11. Section 2272 of the Code states:

"Any advertising of the practice of medicine in which the licensee fails to use his or her own name or approved fictitious name constitutes unprofessional conduct."

12. Section 125.3 of the Code provides, in pertinent part, that the Division may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

13. Section 14124.12 of the Welfare and Institutions Code states, in pertinent part:

"(a) Upon receipt of written notice from the Medical Board of California, the Osteopathic Medical Board of California, or the Board of Dental Examiners of California, that a licensee's license has been placed on probation as a result of a disciplinary action, the department may not reimburse any Medi-Cal claim for the type of surgical service or invasive procedure that gave rise to the probation, including any dental surgery or

invasive procedure, that was performed by the licensee on or after the effective date of probation and until the termination of all probationary terms and conditions or until the probationary period has ended, whichever occurs first. This section shall apply except in any case in which the relevant licensing board determines that compelling circumstances warrant the continued reimbursement during the probationary period of any Medi-Cal claim, including any claim for dental services, as so described. In such a case, the department shall continue to reimburse the licensee for all procedures, except for those invasive or surgical procedures for which the licensee was placed on probation."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

14. Respondent is subject to disciplinary action under Code section 2234, subdivision (b), in that he was grossly negligent in the care and treatment of the patients described below. The circumstances are as follows:

PATIENT Senior Investigator K.W.

15. On or about March 26, 2000, Senior Investigator K.W.[1] (hereinafter "K.W.") scheduled an appointment with G.P., a licensed psychologist. The women who answered the phone referred to him as "Dr. P." On April 6, 2000, K.W. was equipped with an electronic monitoring device and traveled to G.P.'s and Respondent's offices. K.W. was escorted to G.P.'s office where she immediately recognized the individual in the office as G.P. since she had been shown his photograph prior to her coming to her appointment. K.W. and G.P. discussed her symptoms. She told him that she was fatigued but sleepless at night. In addition, she told him that she had had multiple colds, sore throats, neck pain and massive amounts of cold sores. She also said nothing seemed to be helping her condition despite the fact that she had altered her diet and taken vitamins.

16. G.P. told K.W. that he worked in association with Respondent. K.W. told

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1. To protect the privacy of the patients and co-worker, only their initials will be used. Respondent knows the full names of these persons and will be provided further information if he requests discovery.

G.P. that she wanted something that would help her sleep at night. G.P. then named several herbs and asked K.W. if she had ever tried them. She said no. He asked her if she had ever used L-tryptophan. Again, she said no. G.P., while not licensed as a physician, proceeded to ask about her digestion, blood type, and whether she would feel comfortable if she received intravenous needles as a form of treatment. G.P. continued to ask questions about her menstrual cycle and she told him she was trying to get pregnant. Finally K.W. asked: "So doctor, what's wrong with me?" G.P. replied that they should take a little drop of blood from her fingertip. Finally, they agreed that she should have her blood drawn by a laboratory. Then K.W. observed G.P. retrieve a prescription form from his desk. She noticed it was blank, but pre-signed with Respondent's signature. K.W. observed G.P. fill in the order for the blood work, and then he handed her the prescription.

17. G.P. then attempted to locate L-tryptophan for K.W. G.P. then picked up a large bottle of liquid and explained that the liquid would give her four hours of sleep. He then explained that he was concerned since she was trying to become pregnant. G.P. then introduced her to Respondent. G.P. told Respondent that K.W. was going through a low immune period, having repeated colds and flues, having trouble sleeping, and was coming off the pill in an attempt to get pregnant. Despite the fact that G.P. was not licensed to practice medicine, Respondent never confirmed any of this information with K.W.

18. K.W. told Respondent that she was not pregnant at the present time. Respondent said that the bottle (referring to the bottle of liquid that G.P. was holding) was probably the safest thing. He said it would knock people out for four hours and then you might wake up and need a second dose.

19. G.P. than stated that the liquid costed $90.00 per bottle. Since K.W. said her insurance would pay for most of it, Respondent offered to write her a prescription for Ambien instead of selling her the bottle. Respondent wrote her a prescription for a 50 day supply. Respondent never performed a physical exam on K.W., nor did he make a separate medical record (apart from that of G.P.) of the interaction between him and K.W. As she was leaving the office, K.W. was handed a receipt for the amount of $180.00 for the visit. The

receipt was apportioned as follows: $150 for the one hour consult with "GP" and $30 for a "brief med consult" with "BE."

20. The following acts and omissions of Respondent during his care, treatment and management of patient K.W., singularly or collectively, constituted extreme departures from the standard of care:

A. He failed to obtain information about K.W.'s condition directly from the patient;

B. He failed to record what he did or did not do in K.W.'s medical record;

C. He failed to perform a physical examination on K.W. despite the fact that he wrote her a prescription; and

D. He failed to prescribe medication to K.W. consistent with a medical need or condition;

PATIENT S.N.

21. On or about February 19, 1999, S.N. was seen for the first time by Respondent. S.N.'s blood pressure was 150/100. Respondent initiated treatment at this time by diagnosing hypertension and by prescribing: "Cannabis recommendation as per Prop 215, with caveat to be sure blood pressure is controlled . . ." No other work up was performed. Nor did Respondent document in S.N.'s medical record any recommendations for nutrition changes, weight loss, cessation of smoking, moderation of alcohol, moderation of caffeine, and regular exercise. In addition, Respondent did not document any recommendation for baseline blood work or an EKG. Furthermore, there was no documentation in the patient record of any attempt to obtain old medical records or communicate with S.N.'s primary care physician. Lastly, there was no documentation of a recommendation of any follow-up plan.

22. On or about October 15, 1999, S.N.'s wife called to complain about his marijuana smoking. S.N.'s wife felt that S.N. was using the marijuana to escape, and that the marijuana was alienating him from his family. S.N. told Respondent via telephone that his wife was only trying to harass S.N. S.N. had a follow-up visit with Respondent on or about March 2,

2000. During this visit, S.N.'s blood pressure was 180/110, which would be classified as "severe" hypertension. Respondent also noted that S.N. was "anxious, depressed." Despite this follow-up visit, Respondent prescribed an herbal remedy which contained the ingredient Reserpine. Reserpine should not be prescribed to those who are at risk for depression. In addition, there are more modern blood pressure medications on the market which have significantly fewer side effects.

23. The following acts and omissions of Respondent during his care, treatment of management of patient S.N., singularly or collectively, constituted extreme departures from the standard of care:

A. He failed to document any change of lifestyle recommendations in the medical record on S.N.'s February 19, 1999 visit;

B. He failed to order or document any recommendations for baseline blood work or an EKG in the medical record on S.N.'s February 19, 1999 visit;

C. He failed to attempt to communicate with S.N.'s primary care physician;

D. He failed to document any follow-up plan in the medical record on S.N.'s February 19, 1999 visit;

E. He prescribed Reserpine to S.N.;

F. He failed to document any recommendations for blood work or an EKG in the medical record on S.N.'s March 2, 2000 visit;

G. He failed to document any recommendations for standard blood pressure medication or non-drug treatment on S.N.'s March 2, 2000 visit; and

H. He failed to document any follow-up plan in the medical record on S.N.'s March 2, 2000 visit;

PATIENT T.A.

24. On or about March 16, 2001, T.A. was seen for the first time by Respondent. T.A. did have a primary care doctor. According to T.A.'s medical record, T.A. told Respondent that marijuana helps his migraine headaches, upset stomach, and insomnia.

Respondent did nothing to confirm T.A.'s assertions that he had a history of diagnoses of migraines, either by attempting to contact the physician who diagnosed the condition or by obtaining or attempting to obtain the medical records. The only notation concerning a physical exam by Respondent was that of a blood pressure of 125/75 and the typed note "exam unremarkable." The diagnosis is 1. Migraine 2. GI disturbance, exact nature unclear. 3. Insomnia. The plan of treatment for T.A., as typed by Respondent on the record was ". . . medicinal marijuana, as per prop 215."

25. The following acts and omissions of Respondent during his care, treatment and management of patient T.A., singularly or collectively, constituted departures from the standard of care:

A. He made a deficient medical record for T.A., which was lacking in headache history;

B. He failed to obtain old medical records to confirm T.A.'s diagnosis of migraines;

C. He failed to perform or document a physical exam for T.A.'s severe upset stomach; and

D. He failed to obtain a detailed history about T.A.'s insomnia and his current lifestyle.

PATIENT P.I.

26. On or about March 2, 2001, Respondent examined P.I. This was P.I.'s first visit to Respondent. P.I. went to see Respondent because he wanted help with his bi-polar disorder and insomnia. When P.I. arrived at Respondent's office, he was asked to fill out a written medical history form which concerned medical complaints, diet, and alcohol usage. Respondent then checked P.I.'s blood pressure, inspected his mouth, checked his height and weight and had him follow his finger with his eyes. Respondent also listened to P.I.'s complaints.

27. The objective or exam portion of Respondent's medical record regarding P.I. reported the following: "BP 115/75, pulse 76

Thin, anxious, high-strung man, exam unremarkable

Diagnosis: Bipolar by hx, Insomnia, Situational anxiety

Plan: Medical marijuana as per prop 215, Marinol 10 mg hs prn #20, Kava Kava recommendation, exercise"

28. The following acts and omissions of Respondent during his care, treatment and management of patient P.I., singularly or collectively, constituted extreme departures from the standard of care:

A. He failed to conduct and/or document in P.I.'s chart a pertinent history, review of systems, or physical exam;

B. He failed to investigate symptoms by ordering important blood tests to look for and rule out identifiable medical illness;

C. He prescribed medication that could worsen the patient's underlying condition; and

D. He failed to arrange and/or document a follow up visit with P.I.

Undercover Deputy Michael French (alias D[redacted] C[redacted])

29. On or about August 8, 2001, Undercover Deputy Michael French (French) (posing as patient D[redacted] C[redacted]) posed as a patient at Respondent's office. French noticed that the inside of the office in which respondent practiced was bare. French did not see any height and weight scales, blood pressure cuffs, thermometers, ears, nose, and throat scopes, no tongue depressors, no Q-tips, nor anything else that would lead a lay person to believe that this was an operational doctor's office. All French observed were two chairs, a table, a lap top computer, and a printer.

30. French asked Respondent for a letter recommending medical marijuana. He told respondent he did not have any major medical problem and had been smoking marijuana since he was a kid. Respondent informed French that he had to have a medical reason to give the recommendation for marijuana. Then Respondent stated: ". . . Well, uh [sic], everybody has got something. You know what I mean." Respondent then suggested to French that if French did not have marijuana that might not he be depressed? French responded that he understood.

31. Respondent did not examine French and he did not draw blood. Respondent did not touch him in any way. Respondent did not take any of French vital signs including temperature, blood pressure, and pulse.

32. French paid Respondent $250 for the visit and, in return, was given the recommendation. Respondent offered no receipt for the services provided.

33. The following acts and omissions of Respondent during his care, treatment and management of patient French, singularly or collectively, constituted extreme departures from the standard of care:

A. He failed to take or conduct a current history, past medical history, review of systems, or physical exam. He failed to lay on hands.

B. The diagnosis and notation in the medical record are not consistent with the doctor-patient encounter as described by French.

C. A treatment recommendation is given without any discussion or basis of a standard medical encounter or diagnosis.

D. He failed to give a discussion as to any medical options for treatment.

E. He failed to explore the patient's symptoms.

F. He failed to evaluate any possible red flags.

G. He failed to make follow-up plans with French.

Undercover Officer Michael E. Wirz (alias S[redacted]J[redacted])

34. On or about October 10, 2001, Undercover Officer Michael E. Wirz (Wirz) (posing as patient S[redacted]J[redacted]) posed as a patient at Respondent's office. Wirz was given no health screening application or history questionnaire at anytime during his visit. Respondent conducted no health screening nor asked any questions regarding Wirz's medical history. Respondent did not conduct a physical exam of Wirz. During the visit, Wirz twice informed respondent that he had no medical problems.

35. Wirz informed Respondent that he wished to get a letter recommending medicinal marijuana to stop police harassment and that marijuana made him feel good and sleep

better. After the recommendation had already been printed, the Respondent stated that he had to have a reason to give the recommendation. Respondent stated that Wirz's statement that he felt better and slept better after smoking marijuana were typical signs of depression. Respondent further stated that the reason for the issuance of the recommendation was that Wirz suffered from depression. There was no questioning regarding symptoms or potential causes of the symptoms of depression. Lastly, Respondent did not discuss treatment options and no follow-up plans were made.

36. Wirz paid Respondent $250 for the visit and, in return, was given the recommendation. Respondent offered no receipt for the services provided.

37. The following acts and omissions of Respondent during his care, treatment and management of patient Wirz, singularly or collectively, constituted extreme departures from the standard of care:

A. He failed to take or conduct a current history, past medical history, review of systems, or physical exam. He failed to lay on hands.

B. The diagnosis and notation in the medical record are not consistent with the doctor-patient encounter as described by Wirz.

C. A treatment recommendation is given without any discussion or basis of a standard medical encounter or diagnosis.

D. No evidence existed on the information given to respondent that Wirz suffered from depression.

E. He failed to ask any exploratory questions regarding depression and he failed to order any blood tests to look for any medical red flags.

F. He failed to discuss any medical options for treatment.

G. He failed to make follow-up plans with Wirz.

Undercover Detective Joan L. Rosario (alias S[redacted] K[redacted]

38. On or about August 1, 2001, Undercover Detective Joan Rosario (Rosario) (posing as patient S[redacted] K[redacted] posed as a patient at Respondent's office. Rosario was accompanied by Undercover Detective Raul Flores (Flores). After she walked in the office she

was greeted by Respondent who told her to fill out an "Initial Patient Health History" questionnaire. Rosario wrote on the questionnaire that she was a long time marijuana user. Rosario told Respondent that she did not have any medical problems.

39. Rosario advised Respondent that she had been smoking since she was sixteen years old and stopped approximately two weeks ago. Rosario told him that she had been experiencing headaches ever since she stopped. At no time was Rosario given a physical exam. However, in his patient record, Respondent recorded a blood pressure reading and indicated, in other respects, that the physical exam was unremarkable.

40. Respondent gave Rosario a letter of recommendation for Marijuana, and Rosario paid Respondent $250. Respondent offered no receipt for the services provided. When Rosario and Flores were getting ready to leave, Flores asked Respondent if he could come back. Respondent told him he could come back and to have his story straight and know what's wrong with him.

41. The following acts and omissions of Respondent during his care, treatment and management of patient Rosario, singularly or collectively, constituted extreme departures from the standard of care:

A. He failed to take or conduct a current history, past medical history, review of systems, or physical exam. He failed to lay on hands.

B. The diagnosis and notation in the medical record are not consistent with the doctor-patient encounter as described by Rosario.

C. A treatment recommendation is given without any discussion or basis of a standard medical encounter or diagnosis.

D. He failed to ask any exploratory questions regarding drug withdrawal nor were there any blood tests ordered.

E. He made a diagnosis of insomnia without any evidence of standard medical practice to substantiate such a diagnosis.

F. He failed to discuss treatment options and failed to make follow-up plans.

Inyo Narcotic Enforcement Team Agent Matthew Graeff

42. On or about October 11, 2001, Inyo Narcotic Enforcement Team Agent Matthew Graeff (Graeff) drove to Respondent's office in Santa Monica. Respondent greeted Graeff and then gave him a health history form to fill out. Graeff indicated on the form that he did not have a serious medical problem other than back pain.

43. After directing Graeff into a room with a desk and two chairs, Respondent began typing on his computer. Respondent asked Graeff how long he had back pain, to which Graeff responded eight years. Graeff also told Respondent that he used marijuana about 2-3 times a week and sometimes, on a bad month, 3-4 times per week. Respondent told him that he did not need medical records at the present time, but he might in case the authorities gave him a hard time.

44. Respondent gave a recommendation for medicinal marijuana to Graeff in exchange for $250.

45. The following acts and omissions of Respondent during his care, treatment and management of patient Graeff, singularly or collectively, constituted extreme departures from the standard of care:

A. He failed to take or conduct a current history, past medical history, review of systems, or physical exam. He failed to lay on hands.

B. The diagnosis and notation in the medical record are not consistent with the doctor-patient encounter as described by Graeff.

C. A treatment recommendation is given without any discussion or basis of a standard medical encounter or diagnosis.

D. He failed to ask exploratory question regarding back pain nor were there any tests ordered.

E. He made a diagnosis of back pain based on an account given by Graeff, without any evidence of standard medical practice to substantiate such a diagnosis.

F. He failed to discuss potential medical red flags.

G. He failed to discuss treatment options and he failed to make follow-up plans.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

46. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that he committed repeated negligent acts. The circumstances are as follows:

47. The facts and circumstances in paragraphs 14 to 45, inclusive, are incorporated here by reference.

48. The following acts and omissions of Respondent during his care, treatment and management of patient K.W., singularly and collectively, constituted departures from the standard of care:

A. He failed to get information about K.W.'s condition directly from the patient;

B. He failed to record what he did or did not do in K.W.'s medical record;

C. He failed to perform a physical examination on K.W. despite the fact that he wrote her a prescription; and

D. He failed to prescribe medication to K.W. consistent with a medical need or condition;

49. The following acts and omissions of Respondent during his care, treatment and management of patient S.N., singularly and collectively, constituted departures from the standard of care:

A. He failed to document any change of lifestyle recommendations in the medical record on S.N.'s February 19, 1999 visit;

B. He failed to order or document any recommendations for baseline blood work or an EKG in the medical record on S.N.'s February 19, 1999 visit;

C. He failed to attempt to communicate with S.N.'s primary care physician;

D. He failed to document any follow-up plan in the medical record on S.N.'s February 19, 1999 visit;

E. He prescribed Reserpine to S.N.;

F. He failed to document any recommendations for blood work or an EKG in the medical record on S.N.'s March 2, 2000 visit;

G. He failed to document any recommendations for standard blood pressure medication or non-drug treatment on S.N.'s March 2, 2000 visit; and

H. He failed to document any follow-up plan in the medical record on S.N.'s March 2, 2000 visit;

50. The following acts and omissions of Respondent during his care, treatment and management of patient T.A., singularly and collectively, constituted departures from the standard of care:

A. He made a deficient medical record for T.A., which was lacking in headache history;

B. He failed to obtain old medical records to confirm T.A.'s diagnosis of migraines;

C. He failed to perform or document a physical exam for T.A.'s severe upset stomach; and

D. He failed to obtain a detailed history about T.A.'s insomnia and his current lifestyle.

51. The following acts and omissions of Respondent during his care, treatment and management of patient P.I., singularly and collectively, constituted departures from the standard of care:

A. He failed to conduct and/or document in P.I.'s chart a pertinent history, review of systems, or physical exam;

B. He failed to investigate symptoms by ordering important blood tests to look for and rule out identifiable medical illness;

C. He prescribed medication that could worsen the patient's

underlying condition; and

D. He failed to arrange and/or document a follow up visit with P.I.

52. The following acts and omissions of Respondent during his care, treatment and management of patient French, singularly and collectively, constituted departures from the standard of care:

A. He failed to take or conduct a current history, past medical history, review of systems, or physical exam. He failed to lay on hands.

B The diagnosis and notation in the medical record are not consistent with the doctor-patient encounter as described by French.

C. A treatment recommendation is given without any discussion or basis of a standard medical encounter or diagnosis.

D. He failed to give a discussion as to any medical options for treatment.

E. He failed to explore the patient's symptoms.

F. He failed to evaluate any possible red flags.

G. He failed to make follow-up plans with French.

53. The following acts and omissions of Respondent during his care, treatment and management of patient Wirz, singularly and collectively, constituted departures from the standard of care:

A. He failed to take or conduct a current history, past medical history, review of systems, or physical exam. He failed to lay on hands.

B. The diagnosis and notation in the medical record are not consistent with the doctor-patient encounter as described by Wirz.

C. A treatment recommendation is given without any discussion or basis of a standard medical encounter or diagnosis.

D. No evidence existed on the information given to respondent that Wirz suffered from depression.

E. He failed to ask any exploratory questions regarding depression

and he failed to order any blood tests to look for any medical red flags.

F. He failed to discuss any medical options for treatment.

G. He failed to make follow-up plans with Wirz.

54. The following acts and omissions of Respondent during his care, treatment and management of patient Rosario, singularly and collectively, constituted departures from the standard of care:

A. He failed to take or conduct a current history, past medical history, review of systems, or physical exam. He failed to lay on hands.

B. The diagnosis and notation in the medical record are not consistent with the doctor-patient encounter as described by Rosario.

C. A treatment recommendation is given without any discussion or basis of a standard medical encounter or diagnosis.

D. He failed to ask any exploratory questions regarding drug withdrawal nor were there any blood tests ordered.

E. He made a diagnosis of insomnia without any evidence of standard medical practice to substantiate such a diagnosis.

F. He failed to discuss treatment options and failed to make follow-up plans.

55. The following acts and omissions of Respondent during his care, treatment and management of patient Graeff, singularly and collectively, constituted departures from the standard of care:

A. He failed to take or conduct a current history, past medical history, review of systems, or physical exam. He failed to lay on hands.

B. The diagnosis and notation in the medical record are not consistent with the doctor-patient encounter as described by Graeff.

C. A treatment recommendation is given without any discussion or basis of a standard medical encounter or diagnosis.

D. He failed to ask exploratory question regarding back pain nor were

there any tests ordered.

E. He made a diagnosis of back pain based on an account given by Graeff, without any evidence of standard medical practice to substantiate such a diagnosis.

F. He failed to discuss potential medical red flags.

G. He failed to discuss treatment options and he failed to make follow-up plans.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

56. Respondent is subject to disciplinary action under Code section 2234, subdivision (d), in that he was incompetent in the care and treatment of several patients. The circumstances are as follows:

57. The facts and allegations in paragraphs 14 to 45, inclusive, are incorporated here by reference.

FOURTH CAUSE FOR DISCIPLINE

(Prescribing Dangerous Drugs Without Good Faith Examination)

58. Respondent is subject to disciplinary action under Code section 2242, subdivision (a), in conjunction with Code section 2238 in that he prescribed dangerous drugs without a good faith examination. The circumstances are as follows:

59. The facts and allegations in paragraphs 14 to 45, inclusive, are incorporated here by reference.

FIFTH CAUSE FOR DISCIPLINE

(Dishonesty and False Representations)

60. Respondent is subject to disciplinary action under Code sections 2234, subdivision (e), and 2261 in that he has been dishonest and made false representations in writing about his care and treatment of several patients. The circumstances are as follows:

61. The facts and allegations in paragraphs 14 to 45, inclusive, are incorporated here by reference.

SIXTH CAUSE FOR DISCIPLINE

(Aiding and Abetting the Unlicensed Practice of Medicine)

62. Respondent is subject to disciplinary action under Code section 2264, in conjunction with Code section 2234, subdivision (a), in that he aided and abetted an unlicensed practitioner, i.e., psychologist G.P., to engage in the practice of medicine. The circumstances are as follows:

63. The facts and allegations in paragraphs 14 to 45, inclusive, are incorporated here by reference.

SEVENTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

64. Respondent is subject to disciplinary action under Code section 2266 in that he failed to maintain adequate and accurate records relating to the provision of services to his patients. The circumstances are as follows:

65. The facts and allegations in paragraphs 14 to 45, inclusive, are incorporated here by reference.

EIGHTH CAUSE FOR DISCIPLINE

(Failure to Use Own Name or Approved Fictitious Name)

66. Respondent is subject to disciplinary action under Code section 2272 in that he failed to use his own name or approved fictitious name in advertisements regarding the practice of medicine. The circumstances are as follows:

67. The facts and allegations in paragraphs 14 to 45, inclusive, are incorporated here by reference.

68. On or about February 12, 2002, Board investigators Salcedo and Gomez went to Dr. Eidelman's office located at 2901 Wilshire Blvd., #311, in the City of Santa Monica. The Board investigators noticed that the directories found in the building lobby and the floor on which Dr. Eidelman's office was located both had the name "Center for Natural Healing" next to his suite number. In addition, the business card that Wirz obtained from Dr. Eidelman also contained the name "Center for Natural Healing."

69. In addition to using the name "Center for Natural Healing," Dr. Eidelman uses the name "Natural Medicine Center" on his initial patient health history forms. Neither "Center for Natural Healing" nor "Natural Medicine Center" are names that have been issued a fictitious name permit by the Board.

PRAYER

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

1. Revoking or suspending Physician and Surgeon's Certificate Number G 32011, issued to William S. Eidelman, M.D.;

2. Revoking, suspending or denying approval of William S. Eidelman, M.D.'s authority to supervise physician's assistants, pursuant to section 3527 of the Code;

3. Ordering William S. Eidelman, M.D. to pay the Division of Medical Quality the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring; and

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

DATED: June 28, 2002.

RON JOSEPH
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant