SUPERIOR COURT OF CALIFORNIA

COUNTY OF SAN FRANCISCO

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PETITION FOR WRIT OF MANDATE/ PROHIBITION/ CERTIFICATION

WILLIAMS S EIDELMAN MD VS. MEDICAL BOARD OF CALIFORNIA

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FILED
San Francisco County Superior Court
JAN 04 2019
CLERK OF THE COURT
BY
Deputy Clerk

FAXED

SUPERIOR COURT OF CALIFORNIA,
COUNTY OF SAN FRANCISCO

WILLIAM S. EIDELMAN, M.D. Petitioner, vs. MEDICAL BOARD OF CALIFORNIA, Respondent.	CASE NO. CPF-19-516480 VERIFIED PETITION FOR WRIT OF ADMINISTRATIVE MANDAMUS (§1094.5) AND EX PARTE MOTION FOR ORDER TO STAY DECISION AND LICENSE REVOCATION ORDER Exhibits A to E

PETITION FOR WRIT OF ADMINISTRATIVE MANDATE TO SET ASIDE LICENSE REVOCATION ORDER AND EX PARTE MOTION FOR ORDER TO STAY DECSION AND LICENSE REVOCATION ORDER

Petitioner WILLIAM S. EIDELMAN, M.D. ("EIDELMAN" or "DR. EIDELMAN"), petitions this Court for a writ of administrative mandate pursuant to Code of Civil Procedure section 1094.5, commanding respondent MEDICAL BOARD OF CALIFORNIA to vacate and set aside its Decision dated December 6, 2018, which becomes effective at 5:00 p.m. on January 4, 2019, denominated *In*

the Matter of the Accusation against WILLIAM S. EIDELMAN, M.D., MBC Case No. 8002014010147, OAH No. 2018030645.

Petitioner hereby moves for an order to stay the Medical Board's decision and license revocation order. This motion is made pursuant to CCP §1094.5(h)(1) on the grounds that petitioner is likely to prevail ultimately on the merits in this proceeding, and the public interest would not be hurt by a stay of the operation of respondent's Decision and order pending the outcome of this proceeding in that petitioner's continuing to practice medicine during the course of these proceedings would not represent a danger to his/her patients or to the public.

PETITION

By this petition, petitioner WILLIAM S. EIDELMAN, M.D., respectfully represents:

1. Petitioner is, and all time herein mentioned was, a resident of Los Angeles County, California.

2. Petitioner is now, and at all times was, the holder of a valid physician's and surgeon's certificate duly issued by the Medical Board of California July 1, 1976. Petitioner Eidelman practices functional medicine and specializes in recommending medical cannabis for the amelioration of symptoms stemming from various medical conditions.

3. Petitioner Eidelman has been a consultant in alternative medicine

recommending marijuana for over 20 years, regularly seeing persons with a multitude of medical conditions, including approval of using medical cannabis for psychotherapeutic indications.

4. Respondent is the MEDICAL BOARD OF CALIFORNIA, and is an administrative agency of the State of California charged by law with the duty of implementing the provisions of Business and Professions Code Sections 2220 through 2319 and of investigating and hearing cases of possible unprofessional conduct by holders of the physician's an surgeon's certificate and imposing discipline, including suspension or revocation of the certificate, on holders of the certificate who have been found guilty of unprofessional conduct.

5. Under Business and Professions Code Sections 2004 and 2220, respondent has discretion to determine on the facts whether or not cause exists for imposing discipline on a physician for unprofessional conduct, and particularly whether a licensee has been grossly negligent, repeatedly negligent, and incompetent.

6. Pursuant to Business and Professions Code Section 2230, Government Code Sections 11500 and 11529, and the decisional law of this state, respondent is required to hold a hearing and take evidence in its proceedings for the determination of those facts.

7. On July 11-13, 2018 at Los Angeles, California, a hearing was held to

receive evidence on the issue of whether or not cause exists for disciplining petitioner for unprofessional conduct. Petitioner attended the hearing.

8. On December 6, 2018, Petitioner received respondent's decision and order contending Petitioner guilty of unprofessional conduct on the ground that Petitioner was grossly negligent, repeatedly negligent, and incompetent. Pursuant to its findings of fact, respondent ordered that Petitioner's Physician's and Surgeon's certificate (license) be revoked. A copy of the decision is attached as Exhibit E and incorporated by reference.

9. A verbatim transcript of the record of the hearing, containing the evidence received, is contained in Exhibit B-D. A copy of the administrative record has been requested and will be submitted to this Court upon receipt.

10. Respondent's decision and order are invalid for the reasons contained in this Petition.

A. Venue

11. Venue is proper in San Francisco Superior Court pursuant to Business and Professions Code section 2019, which provides:

"§ 2019. Offices

The office of the board shall be in the City of Sacramento. Suboffices may be established in the Cities of Los Angeles, San Diego, and San Francisco or the environs of such cities. Legal Proceedings against the board

shall be instituted in any one of these four cities . . . ."

The Board referred to is respondent MEDICAL BOARD OF CALIFORNIA. Venue is proper in San Francisco.

B. Procedural Background

12. The Accusation against Petitioner Eidelman was filed on November 22, 2017. (Ex. A at 2-9.), alleging violations of Business and Professions Code section 2234, including subdivisions: (b) Gross Negligence, (c) Repeated Negligent Acts, and (d) Incompetence, as well as General Unprofessional Conduct pursuant to section 2234. (Ex. A to this Petition.) A timely Notice of Defense was filed by Dr. Eidelman.

13. The administrative hearing on the Accusation was held July 11-13, 2018, in Los Angeles, California, before Administrative Law Judge Joseph D. Montoya (ALJ) of the Office of Administrative Hearings. (Exhibits B-D.)

14. Petitioner filed his written closing argument, with appendices and Petitioner's personal addendum on September 14, 2018.

15. Respondent filed its closing argument September 17, 2018.

16. Both Petitioner and Respondent filed reply briefs on October 5, 2018.

17. On November 6, 2018, Judge Montoya issued his proposed decision and mailed it to respondent MEDICAL BOARD. A copy of the Proposed Decision is attached to this petition as Exhibit E.

18. Only Judge Montoya heard the live testimony of the witnesses in this case.

19. On December 6, 2018, respondent MEDICAL BOARD filed its Decision and adopted the Proposed Decision and Order (Ex. E) of Administrative Law Judge Montoya. The Decision and Order of Adoption of Proposed Decision ("Decision") is attached to this Petition as (Ex E. to this Petition.) The BOARD then ordered Dr. Eidelman's license revoked effective January 4, 2019.

C. Petitioner's Contentions

20. The ALJ found that Petitioner was negligent in his care and treatment by misdiagnosing patient with ADHD and Bipolar Disorder, repeatedly misdiagnosing patient, and demonstrated ignorance of the diagnostic criteria for ADHD and Bipolar Disorder, and how the disorders should be diagnosed, and failed to recommend assessment of the patient by a qualified specialist. Respondent does not have the authority to revoke Petitioner's license based on any of these findings because such findings do not show that that Petitioner was grossly negligent, repeatedly negligent, incompetent or generally unprofessional.

21. The evidence received at the hearing does not support the finding for the following reasons: the evidence as to the circumstances surrounding the Board's investigation show that the Board had no authority to open an investigation, filed the accusation against Petitioner beyond the statute of

limitations period, the Board wrongfully rejected petitioner's statutory immunities regarding standards of care for diagnoses applied to making medical cannabis recommendations and practicing alternative medicine.

22. Petitioner Eidelman contends that the action of respondent BOARD on December 6, 2018 rendering its Decision was without, and in excess of its jurisdiction, and was a prejudicial abuse of discretion in that:

a. The BOARD lacked jurisdiction because the BOARD did not receive any legally valid written complaint or mandatory report necessary to confer authority on the BOARD to open an investigation into Dr. Eidelman pursuant to its statutory authority under Business and Professions Code § 2220. The BOARD acted without and in excess of jurisdiction because the BOARD's mandated complaint submission and processing procedures were bypassed when it opened an investigation based on accusations submitted via e-mail which were by definition neither a report or complaint pursuant to California Code of Regulations, title 16, section 1356.2.

b. Procedural irregularities related to the Board's acceptance of an informal "complaint" that bypassed the Board's standardized complaint process contaminated the Board's unwarranted investigation of and discriminatory enforcement action against Dr. Eidelman from the beginning. Such irregularities amount to a prejudicial abuse of discretion by the Board whose unlawful actions

violated Dr. Eidelman's due process rights.

c. The initial investigation by the San Bernardino sheriff's office was illegal. The court in *Conant v. Walters* (2002), 309 F.3d 629 ruled one can not investigate on a marijuana recommendation only. The entire chain of events related to the investigation began because of Petitioner's medical cannabis recommendation. Following the Petitioner's actions, the patient was doing well and responding favorably. The Board's investigation was illegal and proceeded because of a series of discriminatory and biased actions, from initial involvement by the Sheriff through to the ALJ's proposed decision. Detective Wood-Burkhart's entire jumble of papers submitted and accepted as a "complaint" was biased, full of errors, and should not have been considered by the Board. Instead of rejecting the "complaint," the Board perpetuated the discrimination and bias against Petitioner by opening its own investigation solely based on the marijuana recommendation.

While courts have often declined to apply the exclusionary rule in disciplinary proceedings, the application of the exclusionary rule was sanctioned in Elder v. Board of Medical Examiners (1966) 241 Cal.App.2d 246, 260. In Elder, a medical license revocation proceeding, the court held that "the exclusionary rule will apply to an administrative hearing where the proceeding contemplates the deprivation of a license which is recognized as a property right, as is the right to practice medicine." (Elder, 241 Cal.App.2d at 260.) In this case, exclusion of the

complaint and evidence derived as a result thereof is proper to remedy the violation of Petitioner's First Amendment rights.

d. In *Conant*, the Ninth Circuit upheld the district court's order granting a permanent injunction to protect First Amendment rights which specifically enjoined the federal government from "either revoking a physician's license to prescribe controlled substances or conducting an investigation of a physician that might lead to such revocation, where the basis for the government's action is solely the physician's professional 'recommendation' of the use of medical marijuana." (*Id.* at 632.) The government flagrantly violated Petitioner's First Amendment rights by commencing an investigation of him based upon nothing more than the fact that he had engaged in lawful conduct by recommending the medical use of marijuana to patients and the evidence obtained as a result of the illegal police conduct should have been suppressed, not only to protect Petitioner's rights, but also to deter this type of police misconduct, to protect society from the likely erosion of the physician-patient relationship stemming from the chilling effect on speech caused by such constitutional violations and to avoid breeding public distrust in the legal system.

e. The clause in Proposition 215, "Notwithstanding any other provision of law . . ." provides Petitioner with immunity. Health and Safety Code section 11362.5(c). The Board claims the Proposition does not provide immunity from standard of

care. Petitioner's closing addendum provided support for the fact that the phrase "Notwithstanding any other provision of law" protects every aspect of making a cannabis recommendation, including the standard of care. The ALJ rejected Petitioner's claim of immunity without addressing the merits of Petitioner's legal argument whatsoever. There has been no court interpretation or review of the statute serving as the basis for Petitioner's immunity claim. The Board's interpretation was made in error and Petitioner now requests review and interpretation of the immunity claim by this court.

f. The BOARD's decision that Petitioner Eidelman's certificate is subject to discipline pursuant to Section 2234 for gross negligence is not supported by the weight of substantial evidence under the independent jurisdiction test. This trial court must exercise its independent judgment upon the weight of the evidence produced . . . and any evidence which might have been improperly excluded. *Dare v. Bd. Of Medical Examiners* (1943) 21 Cal.2d 790, 799.

g. The ALJ's conclusion that Petitioner is a danger to the public because of an alleged wrongful diagnosis is not supported by the facts or expert witness testimony. The ALJ's contention I contrary to common sense, by concluding that a subsequent diagnosis *consistent* with Petitioner's initial diagnosis is immaterial as related to Petitioner's culpability. Even the Board's own expert, upon realizing the child received a subsequent consistent diagnosis remarked "looks like [Petitioner]

got it right." In light of these facts, the ALJ's revocation of Petitioner's license was without merit and suggests prejudicial bias and an abuse of discretion. The ALJ's bias is further demonstrated by the fact that he erroneously stated on three occasions that Petitioner gave cannabis to the patient's father. Petitioner did not give cannabis to the patient or his father and nothing in the record states otherwise. These are erroneous statements of fact by ALJ are false and show his discriminatory bias based on the cannabis recommendation alone, as well as his fundamental misunderstanding of the facts.

h. Revoking Petitioner's medical license is clearly excessive, the result of the Board's arbitrary and capricious enforcement actions against Dr. Eidelman, and constitutes punishment of Dr. Eidelman that is too severe and not supported by the Board's findings.

23. For the reasons stated in Paragraph 22 of this Petition it is unlikely that respondent will prevail ultimately on the merits in this proceeding, and the public interest would not be hurt by a stay of the operation of respondent's Decision and order pending the outcome of this proceeding in that Petitioner's continuing to practice medicine during the course of these proceedings would not represent a danger to his/her patients or to the public, as such practice has not harmed any patient in his 43 years of practice. Just the opposite, taking away petitioner's ability to practice medicine would cause irreparable harm to his current

patients and the medical community.

D. Petitioner's Beneficial Interest

24. Petitioner Eidelman is the person beneficially interested in the issuance of a peremptory writ of administrative mandate by virtue of the fact that his license to practice medicine in the Sate of California has been subjected to discipline and revocation by the Decision and order of respondent Board.

25. Petitioner Eidelman has a vested property right in his license. *Suckow v. Alderson* (1920) 182 Cal. 247, 250; *Hewitt v. Board of Medical Examiners* (1906) 148 Cal. 590, 592; *Smith v. Board of Medical Quality Assurance* (1988) 202 Cal.App.3d 316, 326.

E. Petitioner's Exhaustion of Administrative Remedies

26. There are no available administrative remedies required to be pursued prior to the filing of this Petition for Writ of Administrative Mandate.

F. There Is No Other Plain, Speedy, or Adequate Remedy Other Than This Petition

27. Petitioner Eidelman has no plain, speedy or adequate remedy to review the decision and order of respondent, other than that provided by way of a petition for a writ of administrative mandate pursuant to Code of Civil Procedure section 1094.5.

G. Petitioner Eidelman Should be Awarded Attorney's Fees

28. This petition is a civil action to review a determination affecting petitioner Eidelman's vested property right in his professional license to practice in the State of California, and such determination was, and is, the result of "arbitrary and capricious action by a public entity or officer thereof in his official capacity." Therefore, pursuant to Government Code section 800, Petitioner Eidelman is entitled to his reasonable attorneys' fees, not to exceed the statutory amount, which he is personally obligated to pay, in the event that he is the prevailing parting in this action. Petitioner Eidelman specifically alleges that he, and no other, is personally obligated to pay the fees of his counsel of record in this matter. The action of respondent is "arbitrary and capricious" in that its decision was not supported for the reasons set forth in the Petitioner's Contentions section of this petition, *supra*.

REQUEST FOR STAY OF RESPONDENT'S DECISION

29. Pursuant to Code of Civil Procedure section 1094.5(h), Petitioner Eidelman seeks a stay of respondent Board's Decision until there has been a final judgment of the court. This stay is not against the public interest and the Petition raises substantial and important issues of law on which Petitioner Eidelman is likely to prevail on the merits.

PRAYER

WHEREFORE, petitioner Eidelman prays that:

1. A stay of respondent Board's decision by operation of law issue until there is a final judgment of this Court on this petition;

2. A peremptory writ of mandate issue after hearing commanding respondent Board to vacate and set aside its Decision dated December 6, 2018, which becomes effective at 5:00 p.m. on January 4, 2019, *In the Matter of the Accusation against WILLIAM S. EIDELMAN, M.D.*, MBC Case No. 8002014010147, OAH No. 2018030645;

3. He be awarded his costs of suit;

4. He be awarded his attorney's fees as authorized by statute; and

5. Such other and further relief as this Court may deem proper.

Dated: January 3, 2018

By: _____

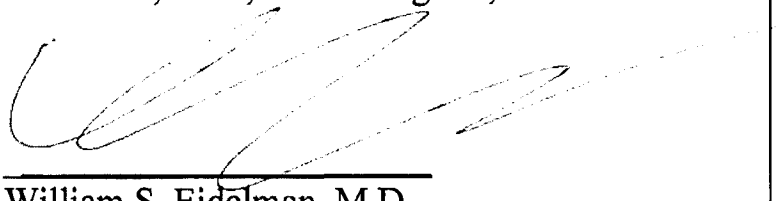
J. RAZA LAWRENCE
Margolin & Lawrence
Attorney for Petitioner
William S. Eidelman, M.D.

VERIFICATION

I, WILLIAM S. EIDELMAN, am the petitioner in this case. I have read the foregoing petition for writ of administrative mandate, and the matters alleged therein are true and correct to the best of my information and belief.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Executed this 28th day of December, 2018, at Los Angeles, California.



William S. Eidelman, M.D.

PROOF OF SERVICE

STATE OF CALIFORNIA— COUNTY OF LOS ANGELES

I am employed in the County of Los Angeles, State of California. I am over the age of 18 and not a party to the within action; my business address is: Margolin and Lawrence Attorneys at Law, 8484 Wilshire Blvd., Ste 440, Beverly Hills, California 90211. My business telephone number is: (323) 653-9700; my business facsimile number is: (323) 653-9709.

On January 3, 2019, I served the foregoing document(s) described as:

VERIFIED PETITION FOR WRIT OF ADMINISTRATIVE MANDAMUS (§1094.5) AND EX PARTE MOTION FOR ORDER TO STAY DECISION AND LICENSE REVOCATION ORDER

on the interested party(ies) in this action by sending service as follows:

By Electronic Service:

Beneth A. Browne
Department of Justice
Beneth.browne@doj.ca.gov
300 S. Spring St.
Suite 1702
Los Angeles, CA 90013

By Mail Service:

Medical Board of California
Discipline Coordination Unit
2005 Evergreen Street
Suite 1200
Sacramento, CA 95815

By Personal Service:

Civic Center Courthouse
400 McAllister Street
Dept. 302
San Francisco, CA 94102

STATE - I declare under penalty of perjury, under the laws of the State of California, that the above is true and correct.

Executed January 3, 2019, at Beverly Hills, California.

Xochilt Gama

Allison B. Margolin (SBN 222370)
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Attorney for Petitioner, WILLIAM S. EIDELMAN, M.D.

SUPERIOR COURT OF CALIFORNIA,
COUNTY OF SAN FRANCISCO

WILLIAM S. EIDELMAN, M.D. Petitioner, vs. MEDICAL BOARD OF CALIFORNIA, Respondent.	CASE NO: EXHIBITS TO VERIFIED PETITION FOR WRIT OF ADMINISTRATIVE MANDAMUS (§1094.5) AND EX PARTE MOTION FOR ORDER TO STAY DECISION AND LICENSE REVOCATION ORDER

EXHIBIT A (Medical Board of California Accusation) 001

EXHIBIT B (Transcript of Proceedings, July 11, 2018, Volume I) 010

EXHIBIT C (Transcript of Proceedings, July 12, 2018, Volume II) 237

EXHIBIT D (Transcript of Proceedings, July 13, 2018, Volume III) 451

EXHIBIT E (Medical Board of California Decision) 728

EXHIBIT A

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO November 22 2017
BY: R. Voong ANALYST

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

In the Matter of the Accusation Against: **William S. Eidelman, M.D.** **1654 N. Cahuenga Blvd.** **Los Angeles, California 90028** **Physician's and Surgeon's Certificate No. G 32011,** Respondent.	Case No. 800-2014-010147 **A C C U S A T I O N**

Complainant alleges:

PARTIES

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

2. On or about July 1, 1976, the Medical Board issued Physician's and Surgeon's Certificate Number G 32011 to William S. Eidelman, M.D. (Respondent). The Physician's 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, 2019, unless renewed.

JURISDICTION

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

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

5. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

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

proposed registration program described in Section 2052.5.

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

6. Section 2262 of the Code states:

AAltering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct.

AIn addition to any other disciplinary action, the Division of Medical Quality[1] or the California Board of Podiatric Medicine may impose a civil penalty of five hundred dollars ($500) for a violation of this section."

7. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

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

9. On or about September 13, 2012, Respondent[2] had an appointment with a four-year-old boy, A.A.[3] During the appointment, the boy and his father, L.T.S., were in the room. Respondent talked with each of them at various times for a total of approximately 20 minutes. Respondent had treated L.T.S. in the past and provided him recommendations for marijuana for medical purposes. The chief complaint for the child was that he had episodes of uncontrollable

---

[1] References to the Division of Medical Quality is deemed by Business and Professions Code section 2002 to refer to the Board.

[2] Respondent indicates that he began practicing nutritional medicine around 1990 and his practice evolved to recommending marijuana for medical purposes around 1997. He has not had privileges at any hospitals or institutions. He is not a specialist in psychiatry, pediatrics or pediatric psychiatry.

[3] The child and his father are identified by random initials to protect their privacy. Respondent will be provided notice of their identities during discovery.

behavior and temper tantrums. Respondent primarily spoke with L.T.S. during the appointment. Respondent noted that the boy was normal appearing, agitated from the stress of the day in school, coming to the doctor, alert, oriented, appropriate, but agitated, and having trouble sitting still. No looseness of association was noted. He was not talkative and answered questions. L.T.S. and an older sibling of A.A. were diagnosed with attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD) and bipolar and were put on drugs for both. They found cannabis more effective.

10. Respondent did not observe the boy having a temper tantrum or uncontrollable behavior, but he did not attempt to contact the school or obtain further information from the school. He did not seek to obtain other medical records of the boy. He did not refer the boy to a pediatrician, psychiatrist or pediatric psychiatrist. Instead, after the twenty to thirty-minute interview with the child and his father, Respondent documented a diagnosis for the boy as a "probable combination of ADD/ADHD or bipolar." Respondent did not document how A.A. met any of the criteria for the attention deficit hyperactivity disorder or bipolar disorder.

11. Respondent documented the plan to "try cannabis in small amounts in cookies." He later indicated that he would let L.T.S. determine the dosage to be given to the boy. Respondent signed a letter that day stating that A.A. is under his medical care and that A.A. reports that cannabis relieves his medical symptoms. In the letter, Respondent indicates that he recommends/approves of his patient's use of cannabis pursuant to the Compassionate Use Act. He indicates he will continue to monitor A.A.'s condition and provide advice on his progress. It indicates that the recommendation letter is valid for one year. Respondent did not try or recommend any standard treatments for ADHD or bipolar disorder, either psychological or psychopharmacological.

12. Respondent's medical records are four pages long and reference the initial appointment described above, two telephone conversations and two in-person visits with a final date of February 20, 2015. Respondent subsequently indicated a lack of familiarity with any peer-reviewed scientific literature regarding the side effects of cannabis use in children and adolescents under the age of 18 years old.

13. Respondent committed gross negligence in his care and treatment of patient A.A. when he diagnosed A.A. with ADD/ADHD and bipolar disorder based on nothing more than a twenty to thirty-minute interview of the child and his father.

14. Respondent committed gross negligence in his care and treatment of patient A.A. when he recommended cannabis as a first-line treatment of ADD/ADHD and bipolar disorder despite evidence of adverse effects of marijuana on the age group.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

15. Respondent is subject to disciplinary action under section 2234, subdivision (c), in that he was negligent in his care and treatment of patient A.A. The circumstances are as follows:

16. Paragraphs 9 through 12 are incorporated here as if set forth in full.

17. Respondent committed negligence in his care and treatment of patient A.A. when he diagnosed A.A. with ADD/ADHD and bipolar disorder based on nothing more than a twenty to thirty-minute interview of the child and his father.

18. Respondent committed negligence in his care and treatment of patient A.A. when he recommended cannabis as a first-line treatment of ADD/ADHD and bipolar disorder despite evidence of adverse effects of marijuana on the age group.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

19. Respondent is subject to disciplinary action under section 2234, subdivision (d), in that he demonstrated incompetence in his care and treatment of patient A.A. and his discussion of same on a subsequent date. The circumstances are as follows:

20. Paragraphs 9 through 12 are incorporated here as if set forth in full.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

21. Respondent is subject to disciplinary action under section 2266 in that he failed to maintain adequate and accurate records pertaining to his care and treatment of patient A.A. The circumstances are as follows:

22. Paragraphs 9 through 12 are incorporated herein as if fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

23. Respondent is subject to disciplinary action under section 2234 in that he committed general unprofessional conduct in his care and treatment of patient A.A. The circumstances are as follows:

24. Paragraphs 8 through 22 are incorporated herein as if fully set forth.

DISCIPLINARY CONSIDERATIONS

25. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about May 24, 2002, an Ex Parte Interim Order of Suspension was issued in a matter entitled *In the Matter of the Petition for Interim Suspension Order Against William S. Eidelman, M.D.*, Case No. 06-2000–108619, due to the risk that Respondent's continued practice of medicine would endanger the public health, safety or welfare. The Order found that in four instances, Respondent had recommended treatment to patients without first obtaining an adequate history, conducting an adequate clinical exam or testing and without obtaining any reliable objective information regarding the patients' medical status. Further, his office lacked even basic medical assessment tools or equipment with which to assess a patient.

26. On or about October 9, 2002, an Interim Order of Suspension was issued in a matter entitled *In the Matter of the Petition for Interim Suspension Order Against William S. Eidelman, M.D.*, Case No. 06-2000–108619, due to the continuing risk that Respondent's practice of medicine would endanger the public health, safety or welfare. The Order made similar findings to the prior Ex Parte Interim Suspension Order issued earlier in the year.

27. On or about June 3, 2004, effective on July 6, 2004, in a prior disciplinary action entitled *In the Matter of the Accusation Against William S. Eidelman, M.D.*, before the Medical Board of California, following a hearing, good cause was found to discipline Respondent's license related to his issuance of recommendations for marijuana for medical purposes.[4] As a

[4] Specifically, he was found to have committed gross negligence and repeated negligent acts by disregarding his duty to diagnose and treat on the basis of a proper history, examination

result, Respondent's license was revoked, the revocation was stayed and Respondent was placed on five (5) years of probation on numerous terms and conditions including: (1) having a practice monitor or participating in a professional enhancement program that includes regular chart review, practice assessment, professional growth and education; (2) successfully completing a course in medical record keeping; and (3) successfully completing within six months from the effective date of the decision a clinical training or education program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California – San Diego School of Medicine. Respondent completed the probation effective October 6, 2009.

28. Following a hearing, effective on October 5, 2009, in a prior disciplinary action entitled *In the Matter of the Accusation and Petition to Revoke Probation Against William S. Eidelman, M.D.*, File No. D1-2000-108619, before the Medical Board of California, the Board found cause to exist to discipline Respondent's license for repeated acts of negligence and failure to maintain adequate and accurate medical records in care and treatment of a patient to whom he recommended marijuana in 2001 and 2005. The Board imposed discipline in the form of public reproval pursuant to Business and Professions Code sections 495 and 2227, subdivision (a)(4).

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number 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 assistants and advanced practice nurses;

---

and review of symptoms, sometimes failing to perform any physical exam at all, essentially placing decisions of diagnosis and treatment in his patients' hands. In several, histories obtained were limited to patients' explanation of why they sought recommendations marijuana for medical purposes. Also, Respondent failed to medically address patients' complaints that were not treatable with marijuana and he failed to establish and follow a plan for follow-up. Additionally, he was found to have made dishonest and false representations; to have aided and abetted the unlicensed practice of medicine, allowing an unlicensed individual to maintain and use a pad of his pre-signed prescription forms; and failing to maintain adequate and accurate records. Last, Respondent was found to be incompetent by 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.

3. Ordering William S. Eidelman, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: November 22, 2017

Christine L. Kelly for Kimberly Kirchmeyer

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

LA2017606142
62612634

EXHIBIT B

BEFORE THE MEDICAL BOARD OF CALIFORNIA

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

JOSEPH MONTOYA, ADMINISTRATIVE LAW JUDGE

In the Matter of the Accusation Against:	Case No. 800-2014-010147
WILLIAM S. EIDELMAN, M.D. 1654 N. Cahuenga Blvd. Los Angeles, California 90028	OAH No. 2018030645 Volume I
Physician's and Surgeon's Certificate No. G 32011, Respondent.	CERTIFIED COPY

TRANSCRIPT OF PROCEEDINGS

Los Angeles, California

Wednesday, July 11, 2018

Reported by:

DONNA ST. CLAIR
CSR No. 14252

Job No.:
191760AH

BEFORE THE MEDICAL BOARD OF CALIFORNIA

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

JOSEPH MONTOYA, ADMINISTRATIVE LAW JUDGE

In the Matter of the Accusation Against:	Case No. 800-2014-010147
WILLIAM S. EIDELMAN, M.D. 1654 N. Cahuenga Blvd. Los Angeles, California 90028	OAH No. 2018030645 Volume I
Physician's and Surgeon's Certificate No. G 32011,	
Respondent.	

TRANSCRIPT OF PROCEEDINGS, taken at 320 West 4th Street, Suite 630, Los Angeles, California, commencing at 9:07 a.m. and concluding at 4:24 p.m. on Wednesday, July 11, 2018, heard before JOSEPH MONTOYA, Administrative Law Judge, reported by DONNA ST. CLAIR, CSR No. 14252. a Certified Shorthand Reporter in and for the State of California.

APPEARANCES:

For the COMPLAINANT: BENETH A. BROWNE
OFFICE OF THE ATTORNEY GENERAL
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Sacramento, California
95814

I N D E X

COMPLAINANT'S Witnesses:	Direct	Cross	Redirect	Recross
KEN BUSCARINO	15	41		
JOHN RAISS, M.D.	82	144	171 185	

E X H I B I T S

DESCRIPTION	MARKED	RECEIVED
1 - Accusation in the Matter of the Accusation Against William S. Eidelman Case No. 800-2014-010147	12	12
2 - Notice of Defense	12	12
3 - Notice of Hearing	12	12
4 - Certificate of Licensure	12	12
5 - Certified Accusation Case No. 06-2000-108619 Filed July 13, 2001	14	14
6 - Certified First Amended Accusation Case No. 06-2000-108619 Filed March 26, 2002	14	14
7 - Certified Ex Parte ISO Case No. 2002050323 Dated May 24, 2002	14	14
8 - Certified Second Amended Accusation Case No. 06-2000-108619	14	14

E X H I B I T S (Continued)

DESCRIPTION	MARKED	RECEIVED
9 - Certified ISO Case No. 06-2000-108619 Dated October 9, 2002	14	14
10 - Certified Decision Case No. 06-2000-108619 Ordered June 3, 2004 Effective July 6, 2004	14	14
11 - Certified Accusation and Petition to Revoke Case No. D1-2000-108619 Filed February 20, 2007	14	14
12 - Certified Decision Case No. D1-2000-108619 Dated September 3, 2009 Effective October 5, 2009	14	14
13 - Certified Order of Restoring License to Clear Status Following Completion of Probation Issued October 30, 2009 Effective October 6, 2009	14	14
14 - Report of Investigation Case No. 800-2014-010147	32	32
15 - Records from Detective Jennifer Wood-Burkhart Date-stamped November 25, 2014 Hand-stamped 1 - 103	35	35
16 - Complainant's Petition for Order Compelling Compliance with Investigational Subpoena Dated February 21, 2017	37	37
17 - Respondent's Opposition to Petition to Compel Compliance with Subpoena	38	38

E X H I B I T S (Continued)

DESCRIPTION	MARKED	RECEIVED
18 - Complainant's Reply Regarding Subpoena Dated May 25, 2017	38	38
19 - Court Order regarding Subpoena Dated June 5, 2017	38	38
20 - Marijuana for Medical Purposes Printed from MBC Website	76	76
21 - Print Page from dreidelman.com Printed on October 28, 2015	74	74
22 - Certified Medical Records	74	74
23 - Addendum to Medical Record of Patient	74	74
24 - Subject Interview: August 7, 2017 A: Transcript B: Audio	75	75
25 - Letter to Expert Briggs	74	74
26 - CV of Expert Briggs	74	74
27 - Expert Report (s) of Dr. Briggs	74	74
28 - Letter of Expert Raiss	74	74
29 - CV of Dr. Raiss	74	74
30 - Expert Report of Dr. Raiss	74	74
32 - Patient Medical Records from Del Amo	72	72

E X H I B I T S (Continued)

DESCRIPTION	MARKED	RECEIVED
33 - CV of Dr. Scherger	72	72
34 - Expert Report of Dr. Scherger	72	72
35 - CV of Dr. Hergenrather	72	72
36 - Expert Report of Dr. Hergenrather	72	72
37 - Article: Academy of Pediatrics	72	72
38 - Article: Esquire	72	72

Los Angeles, California; Wednesday, July 11, 2018

9:07 a.m.

THE COURT: We're here in the matter that's pending before the Medical Board of California an agency in the Department of Consumer Affairs of the State of California.

We're here in the matter of the accusation against William S. Eidelman, M.D. This is the Agency's Case No. 800-2014-010147. It's the Office of Administrative Hearings Case No. 2018030645.

I'm Joseph Douglas Montoya, Administrative Law Judge, Office of Administrative Hearings. I was assigned to hear this case today.

Could I have your appearances, Counsel.

MS. BROWNE: Thank you. I'm Deputy Attorney General Beneth Browne here on behalf of the executive officer of the Medical Board of California.

MR. JAFFE: Richard Jaffe for the Respondent, Dr. William Eidelman.

THE COURT: All right.

Okay. What's up, then, first, ma'am?

MS. BROWNE: Well, Your Honor, it sounds like there is going to be a motion with regard to statute of

limitations. But opposing counsel and I have really kind of worked out a whole game plan. There was no prehearing conference, but we've worked out a plan already for the three days we'll want to present to Your Honor.

THE COURT: All right.

MS. BROWNE: The first item we would like to do is call our witness to the stand, rather than anything else, so we can get our witness out because he has other obligations.

MR. JAFFE: I thought, since there was no prehearing, Your Honor, and the only thing you really have in the case is really the accusation, maybe we could spend just two minutes.

Because there was no pretrial, counsel have worked diligently. You know, subject to your approval, we have some variations of practice that we wanted to run by you in terms of -- in order to make sure there's as little dead time as possible, and thought perhaps what we would do is tell you our basic game plan, because there was no pretrial hearing, and then seek your input just to make sure, you know, you're okay with some of this stuff.

THE COURT: You know, Ms. Browne --

Let's go off the record for a minute.

(Pause in the proceedings)

THE COURT: Back on the record.

The accusation we're operating on today, is that what's behind Tab 1?

MS. BROWNE: Yes, Your Honor.

THE COURT: All of these other accusations, they're just history?

MS. BROWNE: Correct.

THE COURT: So at least I got the Agency's case number correct?

MS. BROWNE: I believe so. Ending in 147?

THE COURT: It's just that there was an amended accusation. When I first saw it, I thought "Did we amend this accusation?" I thought "No, apparently not."

MS. BROWNE: Oh, no.

THE COURT: All right.

Let's go off the record again.

(Discussion off the record)

THE COURT: Let's go back on the record.

We've had some colloquy off the record, and counsel has laid out a proposed schedule that, to be sure, it is not match the normal way things are done, i.e., that the Complainant puts on their case and rests, and then we hear the Respondent's case. Instead, it appears that we're going to get some bits and pieces along the way.

Ms. Browne, are you in agreement with what

Mr. Jaffe has laid out -- that we're going to hear from some of your witnesses today, including this morning, an expert for you folks this afternoon; that your other expert would testify on Thursday afternoon. And Thursday morning, we're going to hear from at least three witnesses pertaining to the patient in question and how they came to be in Dr. Eidelman's office. And then on Friday, we're going to hear from some Respondent experts in the morning and hopefully hear from Dr. Eidelman Friday afternoon.

Is this okay with you, ma'am?

MS. BROWNE: Yes. So the main departure from the standard order of things is, tomorrow, to have at these family witnesses testify in the morning. And we don't have a problem with that schedule-wise, but we do share Your Honor's concern about relevance.

THE COURT: Well, all right. I'll probably allow it so they can make a record. So if somebody disagrees with me if I say it's irrelevant, they've got a record -- or at least an offer of proof. I'm not -- I'll have this afternoon and this evening to think about it.

MS. BROWNE: Understood.

THE COURT: All right. Well, then, let's get some jurisdictional documents in here so we can actually have a hearing.

MS. BROWNE: Okay. And we've provided Your Honor a copy of the original exhibit notebook.

THE COURT: Yep.

MS. BROWNE: The jurisdictional documents are Exhibits 1 through 4. At this time we would like to have -- we would request to have marked for identification -- Exhibit 1 is the accusation in the Matter of the Accusation Against William S. Eidelman, Case No. 800-2014-010147. And subsequent to that there's the accusation packet.

THE COURT: Right. And No. 2 is the Notice of Defense.

MS. BROWNE: Correct.

THE COURT: No. 3 is the Notice of Hearing.

MS. BROWNE: Correct.

THE COURT: No. 4 is a Certificate of Licensure; right?

MS. BROWNE: Correct.

THE COURT: Any objection to 1 through 4?

MR. JAFFE: No, Your Honor.

(Exhibits 1 through 4 were marked for identification by the Court and received in evidence.)

THE COURT: Essentially, 5 through 13 is some history; right?

MS. BROWNE: Yes, Your Honor. Exhibits 5 through 13 are marked in the exhibit list, and they're certified copies of prior disciplinary documents against Respondent.

THE COURT: Is there going to be an objection to these documents?

MR. JAFFE: Not to their admissibility.

THE COURT: All right. We're going to receive 5, which is a Certified Accusation in the Board's case number that ends in -- well, it's 06-2000-108619.

No. 6 is a First Amended Accusation in that same proceeding.

No. 7 is an Ex Parte ISO, May 24, 2002, using an OAH Case No. 2002050323.

No. 8 is a Second Amended Accusation in the case ending in 619.

No. 9 is an interim suspension order -- or Interim Order of Suspension in that same case -- the one that ends in 619.

No. 10 is a Decision in the case ending in 619, it was effective in July 2004, according to the index.

11, certified Accusation and Petition to Revoke Probation, February 2007. It carries the Board's case number 108619, there at the end.

12 is a Decision in that matter, effective

October 5, 2009.

No. 13 is a Order Restoring License to Clear Status Following Completion of Probation; that was from October of 2009.

So we'll take 5 through 13 in.

(Exhibits 5 through 13 were marked for identification by the Court and received in evidence.)

MS. BROWNE: Thank you, Your Honor.

THE COURT: Now then, what's up next, ma'am?

MS. BROWNE: Thank you. We would like to call our first witness to the stand, and that is Supervising Investigator Kenneth Buscarino.

THE COURT: Come on up here, sir.

THE WITNESS: Okay.

THE COURT: Can you raise your right hand.

KENNETH BUSCARINO,

called as a witness and having been first duly sworn by the Court, was examined and testified as follows:

THE WITNESS: I do.

THE COURT: All right. Have a seat, sir. Tell us your name and spell it.

THE WITNESS: Ken Buscarino. Last name is

B-U-S-C-A-R-I-N-O.

THE COURT: You may inquire, ma'am.

MS. BROWNE: May I approach, Your Honor?

THE COURT: Of course.

DIRECT EXAMINATION

BY MS. BROWNE:

Q Thank you for joining us this morning. Could you please tell us your occupation.

A I am a supervising investigator for the State of California, Department of Consumer Affairs, Division of Investigation, Health Quality Investigation Unit. And I work the Glendale field office.

Q Okay. And how long have you held that position?

A I've been an investigator with -- for eight years and a supervisor for three years.

Q And prior to your working for the Division of Investigation, Health Quality Enforcement Unit, did you work for the Medical Board of California?

A The Medical Board of California from -- during that time period -- May 2010 to -- we switched around June -- I think June of 2014.

Q And when you say "switched," what do you mean exactly?

A Well, they transferred us to the Division of

Investigation -- Department of Consumer Affairs, Division of Investigation.

Q And when you say "us," who did they transfer exactly?

A Medical Board investigators.

Q Okay. So since May of 2010, you've been involved with -- at least part of your job has been involved with Medical Board investigations?

A Yes. I was an investigator for the Medical Board for approximately five years.

Q And you promoted to be a supervisor approximately three years ago?

A May of 2014, I think, yes.

Q And as a supervisor --

A I'm sorry. May 2015.

Q May 2015 is when you promoted to be supervisor?

A Yes.

Q Okay. And prior to working for the Health Quality Enforcement Unit for the Division of Investigation and the Medical Board of California, where did you work?

A The Los Angeles Police Department.

Q And when did you work for the Los Angeles Police Department?

A From 1974 to 2009.

Q And could you please tell us what your job responsibilities entailed.
A I was a uniformed police officer, I was a detective, and I was a sergeant.
Q So you promoted through the ranks?
A From police officer to detective to sergeant, yes.
Q Okay. Are you -- if we look at Exhibit 1, are you familiar with what this document is?
A The Accusation?
Q Yes.
A Yes, uh-huh.
Q And if we turn to Exhibit 14, that's the Report of Investigation; correct?
A Yes, uh-huh.
Q And then on the last page of it, page 14 --
A Yes.
Q -- is that your signature at the top?
A That is my signature.
Q Where it says "approved by" -- you approved the document?
A Yes.
Q And what did that signify when you signed?
A Well, it signified that I had read the report and ensured that the attorney general had also approved

the report, and then I signed the report.

Q Okay. And then, at that time, was the investigation transmitted to the Attorney General's office?

A Yes.

Q Okay. Does it -- do you recall or does it appear from the investigative report that there were several investigators assigned to this investigation over time?

A Yes.

Q Okay. And do you recall or does it appear from the investigative report that there were several investigators assigned to this investigation over time?

A Yes.

Q And did that begin with Investigator Fuller, Eric Fuller -- Harold. Sorry.

A Yes.

Q And who was the next investigator after that?

A Investigator Jon Genens.

THE COURT: How do you spell his last name?

THE WITNESS: G-E-N-E-N-S.

BY MS. BROWNE:

Q And then, at some point, the investigation became the responsibility of Investigator Tracy Tu?

A Yes.

THE COURT: And how do we spell her last name?
THE WITNESS: T-U.
THE COURT: I thought you guys might be trying to trick me here.
Okay. So there were three investigators on the case?
THE WITNESS: Yes.
BY MS. BROWNE:
Q Is part of your position as a supervising investigator to ensure that the Report of Investigation accurately reflects the course of the activities in the investigation?
A Yes.
Q Could you tell us when the Medical Board of California, looking at page 2 of the investigative report, received the -- received anything to cause it to open up an investigation?
A Yes. On page 2, under "Investigative Narrative," it says that -- or states "November 25th, 2014, the Medical Board of California received records from the Sheriff's Department."
Q Okay. And is it something that typically gets documented in a Report of Investigation?
A Yes.
Q Okay. And do you know where that -- is that

date documented anywhere else to your knowledge?
A It would be stamped on the initial documents by the Medical Board's CCU unit.
Q Okay. Could we please turn to Exhibit 15.
A Okay.
Q And could you tell us what this is.
A I'm looking at an e-mail. Is that what you're --
Q Right. Could you tell us what the first page appears to be.
A It's an e-mail.
Q Okay. And it has a stamp on it?
A Yes, it does. It says "Received, Medical Board of California, November 25th, 2014."
Q Okay. And I see it also says "Complaint Unit."
A Yes.
Q Is there any significance to that?
A Yes. That's where -- it's a receiving unit for all reports that come to the Medical Board. It's the -- we call it CCU -- complaint unit. They're the first to get it.
Q Okay. And then after they receive something, what is the process? What happens after that -- after they receive --
A They have the reports. They review the reports.

They may send it out to one of their experts. They decide -- the senior person decides whether they can take care of it up there at Sacramento or it needs to be sent out to a field office for investigation.

Q Okay. And when you say, "They review the reports," here it appears it was certainly reports -- police reports that were sent in.

Is it sometimes also in the form of an online complaint?

A Right. Mail in, online, via law enforcement -- they're generated by various sources.

Q Okay. And the date -- the receive date for the Medical Board is -- that's when the CCU unit stamps "received"?

A Yeah, the first unit of the Medical Board received it -- CCU -- and they stamp it.

Q Okay. So, in this case, on the first page, you said it looks like an e-mail. Could you tell us about the e-mail.

A Well, it looks like it's from a Jennifer Burkhart -- I'm assuming San Bernardino County Sheriff's Department -- and it went to the supervisor in San Diego, Eric Ryan. And it said "I had to break this report up into four separate e-mails." So apparently the case -- or something was sent to him regarding the case -- to

Eric Ryan.

Q Okay. And so you know who this Eric Ryan is?

A Yes, I know him.

Q And you're familiar with where he's worked?

A Yes.

Q Are you aware of whether around this time frame in November of 2014 -- did he, like you, work for the Health Quality Enforcement Section of the Division of Investigation?

A Yes. Same job, same position. He's in San Diego; I'm in Glendale.

Q Okay. So after -- you described that around June or July of 2014, there was the changeover where your employer went from being the Medical Board to HQIU; right?

A Yes.

Q So that was the same thing for Supervising Investigator Ryan?

A Yes.

Q Okay. And at this point, then, November 14, 2014, had there already been the change where the employer was no longer the Medical Board; it was the HQIU?

A Yes.

Q And so since this was November of 2014, the

changeover was several months prior?

A I believe it was June of 2014, yes.

Q Okay. Thank you.

So is it your understanding that, even though this -- these reports were initially sent to Supervising Investigator -- for the HQIU -- Ryan, that it actually didn't get received by the Medical Board -- the Medical Board couldn't have discovered it prior to their receipt of it?

MR. JAFFE: I'm going to have to object to that. It's not clear this witness has ever seen this e-mail before today. I'm not sure how he has the basis; there's no -- lack of foundation.

THE COURT: Let me have the question read back.

(Record read)

MR. JAFFE: He's testified at that time he wasn't even an employee of the Medical Board. So what's the foundation?

THE COURT: Well, apparently, there was the person this e-mail has been addressed to.

Do you know whether or not it got to this Mr. Ryan?

THE WITNESS: It looks like it did. I don't know. I mean, I'm assuming it did. I don't work in San Diego to know that, no.

THE COURT: Well, did his e-mail address change?

THE WITNESS: It looks like it's the same.

THE COURT: In other words, his address implies that he's with the Medical Board of California.

THE WITNESS: Well, they never changed the e-mail over to DCA -- the Department of Consumer Affairs. We retained the same e-mails.

THE COURT: So I should infer he would receive this e-mail now and under the aegis of the DCA investigation team, but not under the aegis of the Medical Board of California?

THE WITNESS: We still have the MBC e-mails; it never changed.

THE COURT: Right. But the time he got it, he's not working for the Medical Board.

THE WITNESS: Not working for the Medical Board, but we did retain the same e-mails. I guess they didn't want to change them. They still haven't.

THE COURT: Okay.

Please continue, Ms. Browne.

BY MS. BROWNE:

Q Okay. So and then, also, does it appear that ryan,eric@mbc is the name assigned to an e-mail address, as opposed to being an e-mail address itself?

A It's a business e-mail address, yes.

Q Okay. So it says -- but actually it doesn't even reflect what his actual e-mail address is -- is that right? -- because it doesn't say "@mbc.ca.gov." It just says "@mbc."

A Yeah, "@mbc." And then there's -- yeah, it doesn't go all the way out. It's not complete.

Q Right.

A The "ca.gov" is missing, yeah.

Q So we don't even know what Eric Ryan's address was -- right? -- e-mail address necessarily.

A Yeah, I know his business address. It hasn't changed. We've retained the same e-mail address for years. I don't know if they'll ever change it, even though we don't work for the Medical Board.

Is that what you're --

Q Yeah. Okay. That's fair.

A The other ones that have been, I guess, longer are -- don't have the -- were in the DOI section, but theirs is "dca," not "mbc." There's two different sections, and they just never changed ours.

Q Okay. But notwithstanding the fact that they didn't change it, it is clear that HQIU is separate from the Medical Board?

A Yes. We don't work for the Medical Board.

Q And in this e-mail, do you see any actual

complaint?

A Yes. It says "Complaint Disposition from the Sheriff's Department." And there's a narrative; there's a complaint form.

Q And is -- okay. Primarily, do these attached documents appear to pertain to --

MS. BROWNE: Let me interject for a moment, if I may, Your Honor. Opposing counsel and I have agreed that we will be submitting a request for a sealing order and when we use names, that --

THE COURT: The initials be used?

MS. BROWNE: Correct.

THE COURT: Okay. Ma'am, if this is transcribed, the names of the patients involved -- this will probably apply to some of the people testifying tomorrow -- will be used in their place instead. All right?

THE REPORTER: Yes.

THE COURT: If somebody calls them by their first name or last name, rather than use their initials on the record, we'll just change it.

MS. BROWNE: Thank you, Your Honor.

And then, also, for the record, the way that the accusation is pled, the patient is referred to as A.A., I believe, just for clarification down the line.

THE COURT: All right.

MS. BROWNE: But A.A. equals T.T.
THE COURT: Right.
BY MS. BROWNE:
Q Does it appear that these documents primarily pertain to a T.T.?
A Yes.
Q Okay. Turning back to the Report of Investigation, if we turn to page 12, there's a whole list of attachments and property?
THE COURT: We're still on 15; right?
MR. JAFFE: 14.
MS. BROWNE: I'm sorry. Yes, back to 14. Thank you.
BY MS. BROWNE:
Q So were each of these attachments -- does the Report of Investigation describe how they were obtained?
A Yes.
Q And were these items obtained properly -- as a supervisor, were they obtained properly in the course of the investigation?
MR. JAFFE: I think I would just have to interpose a foundation objection, since he's testified he just signed it as the supervisor -- subject to that.
THE COURT: Well, you may need to lay some foundation about how he might know that, ma'am.
MS. BROWNE: Okay.

BY MS. BROWNE:

Q During the course of this investigation, in your role as supervisor, what did you do exactly?

A In regard to this, I read the report -- after the attorney general had reviewed it, I read it. And it appeared to be in order, and I approved it; I signed it.

Q Okay. And so back during the time frame in question, it looks like the initial -- well, is there a way to tell when this was -- was this at some point transmitted from CCU to a field office?

A Yes.

Q And is there a way to tell when that happened?

A Perhaps in the beginning of the report. It would be on page 6. December 30th, 2014, Investigator Fuller was assigned the case.

Q Okay. So sometime between November 25th, 2014, and December 30th, 2014, this matter was transmitted from the Medical Board to HQIU; is that correct?

A Yes.

Q Okay. And after that time -- after it was transmitted to HQIU, as the supervising investigator, you supervised the course of the events that occurred that are described in the investigative report?

A Yes.

Q And in doing so, do you have -- is there a

protocol to have meetings -- periodic case review meetings?

A Yes.

Q And what does that entail?

A We have quarterly case reviews. An investigator comes in the office -- there's the supervisor, the attorney general, and a commander. We do a short discussion on the cases and see what kind of progress has been made on the case -- suggestions.

Q And when you say the attorney general's --

A The lead attorney general that's assigned to the office.

Q So a lead prosecutor?

A Yes.

Q And that's under the vertical enforcement program?

A Yes.

Q So it's fair to say, over the course of the investigation, you were overseeing what the investigators -- what action was taking place in this investigation; correct?

A We do the best we can with that. Each investigator has about 40 cases, so we do what we can.

MR. JAFFE: And, Your Honor, if I may, since I precipitated this with the foundation thing, we're not

going to contest the authenticity of the document. He signed it; I think that's sufficient for authentication. And if it helps Ms. Browne, I'm not going to object to the general admissibility of the document.

However, I would like to reserve a general objection -- the hearsay objection under this 11513, that any hearsay contained in it would only be used as supplemental evidence and not in and of itself. This document is essentially a summary, and this witness oversaw the preparation, which is fine. We agree it's authentic. I don't have a problem with it being admitted, but you understand my concern.

THE COURT: I understand that you've got an issue that it isn't an official record, I think.

Now, Ms. Browne, are all of the attachments to the report actually here? Because I don't have a feeling they are.

MS. BROWNE: Not all of them, but some of them. And what is our Exhibit --

THE COURT: Does the long list of attachments include some DVDs or CDs or something?

MS. BROWNE: Right. Right. Exactly. Including what was marked as our Exhibit 15. We definitely want to be clear that that came in appropriately, and that document is exactly what it purports to be.

And, yes, there are some CDs and other evidence -- the subject interview.

MR. JAFFE: That are not part of the exhibit list. And we're not even going to complain about that. We're trying to work together, but we want to make sure the record is clear.

THE COURT: Okay. So, for example, despite the hearsay objections, if there's a statement from Dr. Eidelman, that's going to come in under the party admission rule.

MR. JAFFE: Correct.

THE COURT: And some of this other stuff -- the statements by the patient or the patient's family -- could be admissible as administrative hearsay, especially if they're going to testify tomorrow.

MS. BROWNE: Right.

MR. JAFFE: Yes, to supplement. And, again, so as a general rule, I just want to make sure -- and, again, for the purpose of your writing your decision; right? I don't have to tell you obviously. But let it all come in, mindful to a general objection in terms of hearsay, to the extent there are no applicable exceptions -- right? -- like party admissions, like patient testimony -- right? -- and that it's used to support -- supplementing or explaining other evidence, as opposed to

direct evidence, so the Court is clear and the record will be clear that statements contained in this, or any report that contains hearsay, will be used for the appropriate purposes. And as long as that's clear and we make that record clear, I'm fine with the admissibility of the document, if that will help things.

THE COURT: All right. We may have to parse some of that up later. We may have to take that a step at a time.

All right. I'll receive 15.

MS. BROWNE: Thank you, Your Honor.

THE COURT: Without prejudice to Mr. Jaffe here complaining about some of the perceived hearsay.

MR. JAFFE: I think you just admitted 15. I think we had been talking about 14, if we're not mistaken.

THE COURT: I'm sorry. We keep jumping back and forth. 14, meaning the report. Yes, 14.

(Exhibit 14 was marked for identification by the Court and received in evidence.)

MS. BROWNE: So, thank you, Your Honor. Yes, we would move to have identified and marked for the record Exhibit 14.

THE COURT: I knew that's what you were up to, ma'am. I'm a step ahead of you.

MS. BROWNE: Yes, you are. Report of Investigation,

just for the record.

And then, while we're at it, there are other exhibits that are -- that were formerly attachments to the Report of Investigation and property to the Report of Investigation. So perhaps we could identify those items now for the record.

THE COURT: I'm sorry. You want to get into what?

MS. BROWNE: The other items that are attached to the Report of Investigation. Should we go ahead and --

THE COURT: Well, you know, once you pull them off this thing, you're kind of making them stand alone; right?

See, theoretically, this report, in toto, should be what we've got here as 14, along with 30 different attachments and a bunch of property.

MS. BROWNE: Oh, yes, that's a good way to look at it.

THE COURT: If someone wanted a certified copy of this report, and the Board was to produce it -- or DCA was to produce it, it would probably be a lot bigger than what I've got here under Tab 14; right?

MS. BROWNE: Yeah, it would, Your Honor.

THE COURT: So right now I've got 14 in, and it's being treated, I think correctly, as a summary. And to the extent you want some of the attachments to later come

into evidence, I can take that up as that happens.

MS. BROWNE: Okay. So --

THE COURT: In other words, apparently there's an expert report of some kind -- Attachment No. 30.

MS. BROWNE: Right.

MR. JAFFE: Judge, we just -- we have different exhibit numbers for that, just as our convenience. Some of the parts of the Board's case are just separately numbered.

THE COURT: It happens with other agencies too.

MR. JAFFE: Sure.

THE COURT: Sometimes it makes sense and sometimes it doesn't, but we'll pass that for now.

All right. We'll take these other items up as you move them.

What else can this witness tell us, then, that will help me figure out this case.

MS. BROWNE: Right. Well, I mean, we would certainly move to have identified and marked for the record Exhibit 15 -- records from Detective Jennifer Wood-Burkhart, date-stamped 11/25/14, hand-numbered 1 through 103.

MR. JAFFE: And, Your Honor, subject to the same hearsay caveat that I mentioned before, we have no issue with the authenticity or that it be admitted into evidence in this case.

THE COURT: Well, it being a police report, it's probably subject to a rule of Lake vs. Reed.

MS. BROWNE: Correct, Your Honor.

MR. JAFFE: All right.

THE COURT: All right. Well, I'll receive it with that caveat.

(Exhibit 15 was marked for identification by the Court and received in evidence.)

MS. BROWNE: Okay. And -- I guess -- I don't want to waive our right to request for it to come in for more than administrative hearsay, to the extent any exceptions apply.

THE COURT: It can come in for different reasons. It can come in to show why some investigator did what he did. That doesn't necessarily help me decide whether or not Dr. Eidelman here is in violation of the Business and Professions Code.

MS. BROWNE: Right.

THE COURT: It's a lot of hearsay. And, as I said, under Lake vs. Reed, some of it might be used for direct evidence and some of it might not.

MS. BROWNE: Precisely. Thank you, Your Honor.

MR. JAFFE: Right. But I think what we're in agreement upon -- it is, in effect -- even though it's not labeled a complaint -- all she really did was Xerox a

copy of her case records, sent it to this guy Eric, who forwarded it to the Board and says, "Is this enough?"

So as the document that initiated the case, it's certainly admissible for that point, and that's why I feel it is, in effect, the complaint in the case, which precipitated the Accusation. And, indeed, it's instrumental to whatever argument I might have on the statute, since we argue that it runs from November 14 -- or could.

So we have no objection, subject to the Lake issue and subject to the 11153(d).

THE COURT: All right. What else then, ma'am -- that we need this witness for?

MS. BROWNE: Well, we could also lay a foundation for the subsequent -- the following exhibits, right after 15.

THE COURT: Okay. Like what?

MS. BROWNE: So beginning with Exhibit 16.

THE COURT: 16 is some lawsuit you-all started; right?

MS. BROWNE: Yes. We would request to have marked and identified for the record Exhibit 16, which is -- it's the Complainant's Petition for Order Compelling Compliance with Investigational Subpoena and exhibits in support thereof.

THE COURT: All right.

MS. BROWNE: And then, also, some items that are attached and within this document include a Memorandum of Points and Authorities in Support of the Petition -- that begins at page 47.

MR. JAFFE: Judge, if I may just briefly, the bottom line is we filed a motion. We refused to give up the records, pursuant to the subpoena, based on California law. The Board moved to compel. We responded. There were papers back and forth. The Court granted the Motion to Compel.

Documents 16 through 19 are all of the documents and all of the exhibits to the documents -- the motion and the response and the reply -- to that action. They're official records. They say what they say. If the Court finds them helpful, that's fine. I'm not sure the relevance of it, but we have no objection -- to make it easy.

THE COURT: All right. I'll receive them.

(Exhibit 16 was marked for identification by the Court and received in evidence.)

MS. BROWNE: Okay. And so I just -- I did want to point out, because it's significant both for Respondent and for our case, that within -- well, for our case, within Exhibit 16, there is a declaration of an investigator that begins at page 13.

THE COURT: And there's, I'm sure, responses from Dr. Eidelman and witnesses on his behalf; right?

MS. BROWNE: Yes, that's correct. There are three declarations. So they're declarations for -- in Exhibit 16 and 17.

THE COURT: All right. Well, I'll receive them.

MS. BROWNE: Okay. So along those lines, should I also -- if I could request to have marked for identification Exhibit 17, Respondent's Opposition to the Petition to Compel Compliance with the Subpoena?

MR. JAFFE: My response was for 16 through 19. We have no objection to the Court's receipt and use, subject to whatever rules.

THE COURT: I think what she's doing is cleaning up our record a little bit just to identify it numerically.

MR. JAFFE: Okay. I'm sorry.

THE COURT: So 17 is the Respondent's Response to the Petitioner's Motion to Compel.

18 is the Petitioner's reply to that.

And I think 19 is the Court's order telling Dr. Eidelman to give up the documents.

MS. BROWNE: Correct, Your Honor.

MR. JAFFE: No objection, Your Honor.

THE COURT: All right.

(Exhibits 17 through 19 were marked for

identification by the Court and received in evidence.)

MS. BROWNE: And just for the record, yes, the first two pages of Exhibit 19 are the Court's order, and then the actual written tentative decision on the Petition for Order Compelling Compliance with the Investigational Subpoena that was adopted by the Superior Court judge begins at page 3.

THE COURT: All right. I'm sure it will make for fascinating reading.

MS. BROWNE: So I don't know if we've already past this, but we do move to have these documents admitted.

THE COURT: 1 through 19, so far, are in evidence.

MS. BROWNE: Excellent.

THE COURT: Well, maybe excellent for you, but I'm not sure about for Dr. Eidelman.

MS. BROWNE: Okay.

THE COURT: It's excellent that we're making some progress.

MR. JAFFE: And, Judge, that's good enough for us.

THE COURT: All right. Do you have any other questions for this witness, ma'am?

MS. BROWNE: Yes.

BY MS. BROWNE:

Q I guess, just really generally, I want to ask --

did you have a chance to look at the Report of Investigation before you came here today?

A Yes.

Q And did it appear to be -- was there anything improper about it?

A No.

Q And when you signed it, were you -- well, and you signed it; correct?

A Yes.

Q And so some of the attachments and property items that are listed in the Report of Investigation, we're now seeking to admit as evidence here in this case today.

A Yes.

Q And do you have any reason to believe there's anything objectionable --

I guess that's a legal conclusion. Withdrawn.

THE COURT: Yeah. I've got the report. It's in the evidence bin.

MS. BROWNE: Okay.

BY MS. BROWNE:

Q So is there anything else that you recall about this investigation that you think would be important to bring to the judge's attention?

A No.

MS. BROWNE: We thank you very much.

And, Your Honor, if we may --

THE COURT: He's not off the hook yet. Maybe Mr. Jaffe here has a couple of questions.

MR. JAFFE: I've only got a couple.

CROSS-EXAMINATION

BY MR. JAFFE:

Q Exhibit 15, that's the e-mail from -- you testified you know Eric Ryan; right?

A Yes.

Q So do you know why, if he didn't work for the Medical Board of California -- do you have any information as to why the police officer contacted him?

A I don't know. Do you mean do they have a relationship?

Q Yeah. Do you know anything about that?

A No.

Q Let me ask you this. When I read this e-mail -- let me just quote it. This is Exhibit 15, "I had to break the report into four separate e-mails, so here they come (hopefully). Let me know if you get all four attachments. Thanks for taking a look at it!!!!"

What I infer from this e-mail is there was some prior conversations between the two -- some

conversations. Do you get that inference too? Does this seem like a cold e-mail to you?

MS. BROWNE: Objection. Calls for speculation.

MR. JAFFE: Well, I mean, what can you glean as an investigator?

THE COURT: I'll allow it.

BY MR. JAFFE:

Q I mean, doesn't it sound like they've had some communications before?

A Yeah. I don't know anything about this, but I would agree it appears that they knew each other to send this, from what I'm reading.

Q And they not only knew each other, they had some --

A They had conversations --

Q About this case?

A It could have been, yeah.

Q All right. So I'm not going to ask you to speculate. So you don't have any information about why it is that, presumably, having had some communications, she sent it to him, and then he agreed to take a look at it?

A Yeah, he might have had some prior knowledge.

Q Yeah. But you have no prior knowledge about it?

A No, I don't.

Q And let me ask something. If you would have gotten this communication from her --

A You mean I knew her and she --

Q Yeah. If you had know --

THE REPORTER: Can we finish the question and then answer? Thank you.

MR. JAFFE: I'm sorry. I apologize.

BY MR. JAFFE:

Q What would you have done -- based on your experience as an investigator and a supervisor, what would you have done had you received her e-mail with the attachments?

A Would I know her or not know her or what?

Q If you got this complaint, what would you have done -- or these documents, what would you have done, as an investigator for HQIU?

A So this e-mail comes. There's information that there's an issue with a doctor. And I would review it, and then I would send it up to Sacramento to the Medical Board and to CCU and, you know, request to generate a case.

Q How would you send the information, this document, if you had received it? How would you have sent it?

A For the most part, what I do is seek to mail it.

I scan things to the supervisors at CCU -- e-mail scan.

Q And since you're not familiar with this, you don't know -- you don't have personal knowledge of this transaction. You don't know why -- the difference -- it took from November 14th to November 25th for the CCU to stamp this document? You have no information about that time frame?

A No information with their processing -- how their processing works there. I've never been there to look at it.

MS. BROWNE: Your Honor, I would object. Assumes some facts not in evidence, if I understood it correctly.

THE COURT: Well, he just said, at the tail end here, he didn't know all their processes.

MR. JAFFE: Right.

MS. BROWNE: Right. But I guess there's some speculation about when it was even sent there.

THE COURT: Yeah. Well, that might be it. All the document indicates is when it was received at CCU.

MS. BROWNE: Correct.

THE COURT: I don't know if it went by snail mail or e-mail.

MR. JAFFE: Pony Express, if it took 14 days.

THE COURT: Could have been.

///

BY MR. JAFFE:

Q All right. Well, anyway, you don't have any personal knowledge.

One other question: I hear you're retiring from the Agency tomorrow?

A Well, I have worked for LAPD for 35 years, so far 8 years with the State -- too long. But I thought I would try the Department of Insurance for two years, and then I'm done.

Q And today's your last official act with --

A Yeah, with HQIU.

Q Well, you can say you ended on a good note. Thank you very much for your testimony. I appreciate your being here, sir.

A Thank you.

THE COURT: All right. This witness is excused?

MS. BROWNE: Yes, Your Honor.

THE COURT: Goodbye. Good luck.

THE WITNESS: Thank you.

THE COURT: What's next, Ms. Browne? Do you have another witness for this morning, or are we just waiting on your expert this afternoon?

MS. BROWNE: Could we go off the record for a moment?

THE COURT: Sure. Off the record.

(Discussion off the record)

THE COURT: Back on the record.

MR. JAFFE: And also, Judge, just to make things easier, at some point, based on some conversations that counsel has had, I'll read into the record some of the allegations -- the factual allegations in the Accusation that we do not contest.

THE COURT: Okay.

MR. JAFFE: So at some point. We don't have to do it now, but maybe after the opening just to smooth things. We're trying to get back in your graces for not having a pretrial hearing. So we're trying to make this as easy as possible.

THE COURT: Well, it is what it is.

Okay. Ms. Browne, you want to make an opening?

MS. BROWNE: Yes. I should have been prepared for that.

MR. JAFFE: Would you like to take a 10-minute break?

MS. BROWNE: So we did just have a break -- it turned into one.

MR. JAFFE: I didn't realize it was a break.

THE COURT: You've been living with this case for a few weeks, ma'am, at least.

MS. BROWNE: A few years.

THE COURT: So tell me what you expect to prove here.

MS. BROWNE: Okay. Thank you, Your Honor.

We're here today due the Accusation filed against the Respondent in this matter. It's alleged that there are basically three things that the Board is -- will be proving today, and they can be found on -- Exhibit 1 is the Accusation, page 5 -- all three things really.

The first is up in paragraph 13, and that's the allegation that Respondent committed gross negligence in his care and treatment of the minor patient when he diagnosed the patient with ADHD -- or ADD and with bipolar disorder, based on nothing more than a 20- to 30-minute interview of the child and his father.

So with regard to that, we'll have two experts testify that -- experts who are medical professionals; one is a psychiatrist and one is a natural medicine practitioner, which is also what Respondent has stated he does. And they both agree with all of the conclusions and assertions made in the Accusation.

So they'll be explaining that -- the standard of care -- and specifically how the standard of care was violated when Respondent diagnosed this child with these two major psychiatric disorders with insufficient evidence and -- yes, with insufficient evidence and without taking the steps to -- that would be required in order to give such diagnoses.

And the next thing that the Board will be proving will be that Respondent also committed gross negligence in his care and treatment of this patient when he recommended cannabis as a first-line treatment for the disorders he had diagnosed, despite evidence of adverse effects of marijuana on the age group.

And, I believe, at the time of the specific appointment -- September 13th, 2012 -- well, we'll have to look at the date of birth, but I think that the child was four years old and just about to turn five years old, notwithstanding some of the documents referencing him as a five-year-old.

Okay. So the facts are generally undisputed. And the facts are set forth in the Accusation, paragraphs 9 through 12. And there doesn't appear to be very much that Respondent really contests, factually.

THE COURT: He contests the ultimate facts, but he doesn't contest that he saw the child on such and such a date or something; right?

MS. BROWNE: Right. He doesn't believe that the conclusion -- he doesn't believe that he -- it's my understanding so far -- that he did anything wrong in giving these diagnoses and in providing a recommendation for cannabis for this young child.

And the other thing that the Board will be

proving is listed in paragraph 19. And that's essentially alleging, and it will be shown, that Respondent had a lack of knowledge in his care and treatment of the patient.

You will see time and time again in -- well, in the subject interview, which is admitted -- which we will request to be marked and admitted into evidence. We have the subject interview transcript and also the audio, and we'll be requesting that they become Exhibit 24.

And the subject interview is notable for the fact that it puts on full display the allegation in paragraph 19 with regard -- in many regards. And our experts will explain to Your Honor specifically how, and what problems there are with the lack of specificity and the complete lack of understanding, essentially. So when it says "his discussion of same on a subsequent date," that is referring to the subject interview, which was August 7th, 2017.

And then, also in -- okay. In Exhibit 15, there's -- within Exhibit 15, there is a report where a detective Jennifer Wood-Burkhart, from the San Bernardino Police Department, and her colleague, Detective Niles, conducted an interview of Respondent. And that's recorded -- there's no transcript -- and it's described in the report. So we'll see some inconsistencies between

the description of the appointment, then and subsequently, and references to what records existed.

And then, while related, is the Board's allegation of the violation of Business and Professions Code Section 2266, in failing to maintain adequate and accurate records pertaining to his care of the patient. We have got a copy of the medical records. And, I believe as counsel alluded to earlier, the medical records, when first sought, were withheld. And that process is described in the Report of Investigation.

After the -- when the Medical Board -- pardon me, not the Medical Board -- when the Health Quality Enforcement Unit investigators sought to obtain the medical records in this case, there was no consent provided from the father, and, therefore, the Respondent refused to provide the records.

So the -- I'm just going to say Board, with the understanding, of course, which entities are who. So that part was -- part of that investigation was transmitted to the Attorney General's office for the sole purpose of obtaining the medical records. And in that context, a subpoena -- Complainant's Petition to Compel Compliance with the Subpoena was filed. And attached to that, the Board brought -- showed evidence, including declarations from a medical consultant -- a Dr. Pollak,

and an investigator regarding all the steps that they had taken and the suspicion and why it's dangerous -- the risk posed.

THE COURT: The risk posed by not producing records, or the risk posed by recommending marijuana to a four- or five-year-old?

MS. BROWNE: Really, both. And also that -- great point. Also the necessity to obtain the medical records in order to evaluate compliance with the standard of care.

So our expert, Dr. Raiss, will be testifying this afternoon. And he performed a full evaluation of this matter, and the documents -- well, certain documents, which are described in a letter to him, were sent to him, and that's going to be what will be marked as Exhibit 28. And he has extreme -- a lot of expertise. He's been doing his job for a long time. He's extremely knowledgeable, and he prepared an expert report, which has been disclosed. And his expert report, we'll seek to have admitted. And he'll describe specifically why he came to the same conclusions that are alleged in the paragraphs of Accusation -- 13, 14, and 19, essentially.

And then we'll also hear, as I had referenced earlier, from Dr. Briggs, who is a different kind of medical professional, practicing in a different specialty

closer aligned with Respondent's.

Respondent has -- it's my understanding Respondent holds himself out as a natural medicine doctor, but we'll hear from him. He also, as here, does sort of practice in some psychiatry. So either way we look at it, from a natural doctor's perspective or a from a psychiatrist's perspective, the conclusion is really the same.

There are articles that our expert, Raiss, cited in his opinion, and we produced those as Exhibits 39 through 45. Some of those he cited in his report. And then Respondent also provided two expert opinions, which Dr. Raiss, the Board's expert, had an opportunity to review. And when he reviewed those, he did -- we'll hear about -- he did some more research, and the articles that are submitted at 39 -- Exhibits 39 to 45, he'll describe why they support his position and why they refute Respondent's expert's position.

So with all of that, it's -- it really is, Your Honor, a very simple case. We're talking about two counts of gross negligence, incompetence, and the failure to maintain records.

We've got two experts who strongly support the position, and there are not really facts -- or very many facts that appear to be contested. So the Board will be

recommending a proposed decision -- or will be requesting a proposed decision that recommends a penalty -- a disciplinary order consistent with the Board's disciplinary guidelines, which -- with the Board's disciplinary guidelines.

Thank you.

THE COURT: Mr. Jaffe.

MR. JAFFE: Yes, sir.

It's a pleasure to be here. Your reputation precedes you.

THE COURT: You've been misinformed.

MR. JAFFE: I need to explain the context of this case. And I'll talk maybe some about the law later. But let me tell you first a little bit about Dr. Eidelman. Dr. Eidelman is an alternative health practitioner, number one. He spends a lot of time, frankly, writing medical marijuana recommendations for people and other kinds of recommendations, and he also does some other kinds of alternative health, like alpha stimulation and things like that, but his practice is primarily in alternative health. And he views himself as an expert in what the statute and the Board policy talk about -- making medical marijuana recommendations.

Now, it turns out that L.T., the father -- subject to our qualifications for names -- was a patient

of Dr. Eidelman's for several years. Mr. T. has bipolar disease and has obtained a medical marijuana recommendation from Dr. Eidelman successfully for several years. Mr. T. has three or four kids -- four kids, I believe. The older child is also diagnosed with bipolar.

What happened in September of 2012 is L. brings his son T. to the office. And L. explains that the teacher and the principal sat down with him and told him -- this is preschool -- by the way, T.T. was, I think, one day short of five-years-old on the day of the visit. So he's effectively five, and the court records will indicate -- the records will indicate his age, but he was five -- explains that the teacher and the principal said that because T. was too disruptive, they can't let him back in preschool unless he's medicated.

So L., who had previously been on all kinds of psychotropic drugs and had horrible reactions, didn't want T. to go that same route. He figured there was bipolar, or whatever he had, in the family, and he was just adamantly opposed to basic pharmacological. So he brought T. to Dr. Eidelman to see whether he could get a recommendation from Dr. Eidelman.

There is a medical note of the transaction. L., on behalf of T., signed a written informed consent, which outlines various things. That is in the medical records.

It's the first part of the medical records. So we have a written informed consent explaining some of the things about medical marijuana. But you have to understand, Mr. T., as he will testify on Thursday, said he did not want his child to take Ritalin or any kind of other drugs.

Dr. Eidelman observed -- examined the patient. The results of the examination are in the medical records. He observed him, and then he made what's called a probable differential diagnosis.

You're going to hear testimony from our experts that, basically -- what doctors do all the time -- they come up with a probable diagnosis, prescribe or recommend a treatment to see if it's going to have any effect, and then you modify as necessary. There's nothing wrong with that; doctors do that all the time.

And then it really gets interesting. And let me make a prediction, a promise, or a suggestion to you, sir. It is our position and the position of our medical experts that the real problem in this case is how various government agencies overreacted to this condition, which has caused extreme disruption to the family and actual harm to the child. That's a strong statement.

So here's what happens. So they write the recommendation, the father starts giving the medical

marijuana before the child goes to school in some cookie, and, lo and behold, what happens? The problems disappear. Instead of becoming a problem child, he's a model student. The teachers and principal are ecstatic; they're very happy with the results.

The problem is, in the afternoon, the marijuana is wearing off. So the school requests that the father give them another dose of medication for the afternoon -- to bring it to school, so Mr. T., in his absurd naivete, brings the cookie to school, explains what it is -- right? -- because theretofore -- with his letter. He's not hiding anything. He shows the letter. He says, "Here's the cookie. Can you give it to him?" The school theretofore didn't know what it was. They just knew it was working.

They go nuts. They call the child -- the sheriff's department. And I'm not even -- you know, maybe they had to do that; maybe they didn't have to do it. I mean, that's something we don't have to resolve. The sheriff's department gets involved, they get Child Protective Services involved, and then -- well, you already know what the end of the story is. CPS gets an interim order to basically take all the kids away from him.

MS. BROWNE: Your Honor, I've been hesitating. I

forgot to -- and this is my fault -- I forgot to request that Your Honor exclude witnesses from the courtroom during our opening statements.

MR. JAFFE: Do we have a witness?

THE COURT: There's no witness.

AUDIENCE MEMBER: I'm not a witness, no. I'm an attorney.

AUDIENCE MEMBER: I'm not. I'm an --

MR. JAFFE: Observer.

AUDIENCE MEMBER: -- observer.

MS. BROWNE: Oh, it was my understanding that this gentleman was the father.

AUDIENCE MEMBER: No, I'm not, young lady. I'm actually Richard Eastman, an AIDS patient that changed the miracle of medical marijuana.

MR. JAFFE: Thank you. Thank you for your service, sir.

Anyway, he's not a witness.

MS. BROWNE: I'm so sorry for the interruption.

THE COURT: That's all right. I was wondering myself, but I wasn't going to bring it up if you weren't going to.

MR. JAFFE: We're aware of the rule. We're going to preserve the rule for the Court.

THE COURT: All right.

MR. JAFFE: Okay. Child Protective Services gets involved. They get the court order. All right? People who they are, the T.'s don't comply and they actually move out -- the mother takes the kids out of state to Alabama. They reside in Alabama --

THE COURT: Where you can get medical marijuana?

MR. JAFFE: No. At this point they can't even get it. It was just, basically, I assume -- it was just to get away from the kids being taken.

So then they --

THE COURT: And then the sheriffs get involved.

MR. JAFFE: Right. And they pursued L. for child abuse.

THE COURT: All right. I'm not here to try that case.

MR. JAFFE: I understand that. This is just factual background.

At the end of the day, in 2014, the case is dismissed. The CPS case is dismissed with prejudice. It's gone. It's over. Mr. T. is mighty unhappy his life has been disrupted for several years.

THE COURT: He files a lawsuit.

MR. JAFFE: Yes, sir. He files a lawsuit.

Now here's what's interesting. In the reports, it does quote information about L.T., but somehow

somebody forgot to say that, according to L.T., the sheriff's investigator told him that if he filed a lawsuit, they were going to file a complaint against Eidelman. So then he files the lawsuit, and lo and behold, Jennifer Burkhart files this lawsuit against Eidelman.

THE COURT: You know, I'm stuck without how it got here.

MR. JAFFE: I understand. So he eventually settles with the --

THE COURT: L.T. does?

MR. JAFFE: L.T. settles with the State in some undisclosed financial settlement for the harassment. And we're hopeful he's going to be here tomorrow to talk about it. Because the State isn't done with him. Now they're going after him for cultivation. His trial was set for Monday coincidentally. So I expect him to testify on Thursday, along with the other son and grandma. All right? So that's the basic factual scenario.

To recap, all that Dr. Eidelman did was make a probable diagnosis, do a small -- a test, saying, "See if it works." It worked, and then because it was wearing off, L. tells the school what's happening, and then you have the whole series of events. That's the basic facts.

THE COURT: Is this a private school or public school?

MR. JAFFE: It's public school. So maybe they had obligations to report. I'm not even going to go into that.

But this whole thing got, you know, blown up out of proportion because of that. At the end of the day -- and so, the problem with the child is -- Dr. Eidelman can't write any more recommendations for him; the parents refuse to have him undergo Ritalin because, you know, Ritalin, as you're going to hear, is kind of a dangerous drug -- has a lot of side effects. And, unfortunately, the child has gotten a little worse. He was hospitalized at the end of 2016. And what has happened is, under this new DSM-5 and these psychology rules and all that -- you're familiar with all that.

THE COURT: Hang on a second. Because I intend to take notice of DSM-IV TR to inform myself about the evidence in this case.

MR. JAFFE: Good. Okay. Well, under DSM-5, they now have a new diagnostic that's called -- what's it called?

DR. EIDELMAN: Disruptive --

MR. JAFFE: Disruptive mood disorder.

DR. EIDELMAN: -- mood dysregulatory disorder.

MR. JAFFE: Right.

So he was now diagnosed with something which is probably a closer diagnosis to what he really had. And he was diagnosed after a short emergency visit in 2016. We've supplied the medical records. They're also in there -- the Del Amo medical records. So, you know, he's not doing all that well. He can't get medical marijuana. They don't want him to take the drugs, and essentially we're here because Dr. Eidelman made a recommendation to a five-year-old. That's the facts.

At some appropriate point, I will read from the Accusation, for the Court's convenience and Ms. Browne's convenience, what we stipulate to. But she's essentially right. The underlying facts, the medical records -- what Dr. Eidelman did/what he didn't do is not in dispute. What is in dispute is whether what he does is sanctionable under Board law.

Now, we are going to agree that all the expert reports and all the CVs are going to be admitted into evidence because I think that's going to help the Court to supplement the testimony. And I think that the interesting thing you're going to find is that -- we're calling two witnesses. And I think both of them are interesting in different ways. One witness, Dr. Scherger, who is going to testify Friday morning, was formerly at PACE. I'm sure the Court knows what PACE is;

right?

THE COURT: Yes.

MR. JAFFE: Okay. So he used to be at PACE and would evaluate physicians. And Your Honor is also aware of the fact -- Scherger and his expert testimony is listed. And what's really interesting about Scherger -- not only does he evaluate physicians, he was also the Board monitor for Dr. Eidelman as a result of the prior proceedings. So he's very familiar with Dr. Eidelman's practice and how he operates. And the bottom line is, what he's going to say is if he had looked at these medical records as part of his monitoring programming, he would have passed him. You know, Dr. Scherger, who teaches -- he's now at Eisenhower's in Palm Springs -- but he was the teacher and he was the PACE guy -- he was the PACE guy evaluating people.

You know, I don't think -- look, medical marijuana is -- obviously it's not accepted. I mean, it's not standard of care. It's not evidence based. But, you know, the people -- the good people of California, in 1996, allowed doctors to recommend it, even though it's not standard. So he's not going to say -- Scherger's not going to say that he would have given it to the kid -- right? -- because that's not really the issue. The issue is, was it reasonable under

the circumstances? And he's going to say that it is.

But the other expert we have is, like, one of the world's experts on medical marijuana. And he's -- like I say, he's one of the big guys. He treats a lot of young kids. He treats kids as young as one there.

And, undoubtedly, what you're going to hear is a battle of the experts in terms of what the evidence shows about medical marijuana. And we're okay with that. Because if you read Dr. Raiss's opinion and his letter -- it's a very good research project -- I doubt very much -- well, I'm almost certain that he's never given it to anybody because he doesn't believe in it because it's not evidence-based.

So, you know, you've got someone who works in the field, who limits his practice to medical marijuana consulting, who writes in the field, who's familiar with the literature, who uses it on little kids, versus someone who is essentially a psychiatrist, does adults and children, who doesn't believe in it. Okay. He doesn't believe in it. What does that mean? Well, we're going to tell you what that means later on, but that's the principle issue in the case.

And then they have another expert who actually is a -- appears to have some alternative health credentials, but she's a family practitioner. And

typically family practitioners don't treat little kids. And I doubt she does medical marijuana.

So at the end of the day, our view is the issue is not whether either of those experts would have given -- made the recommendation. The issue is whether it's reasonable under the circumstances and in compliance with whatever the rules are with regard to this treatment. And that's really the issue you have to decide.

And, in that regard, I think that the documentary evidence alone is going to justify satisfaction with that. So, like I say, not withstanding this -- so this isn't really a question of whether, you know, Dr. Eidelman followed the so-called standard of care. Marijuana is not standard of care, really, for anything. It can't be because it's called a Schedule 1 drug; right? And a Schedule 1, federally, means that there are no indications for which it be used.

But that's not really the point here. You can use it in California. There are doctors who say that it's helpful for things. There's studies that show what they show. And you can do it here.

So I'm going to encourage you to focus on the real issue in the case, and not whether 99 out of 100 conventional doctors wouldn't have done what he had done.

So I think that's going to be -- and the other thing that you're going to find is there's a big to-do about this 20- or 30-minute visit. We have an article that we've attached -- that were going to have Dr. Eidelman talk about -- from Esquire. And what they refer to is the standard 12-minute visit that a pediatrician makes -- or does in order to make a recommendation for Ritalin.

The problem I have with both of these expert reports is they're very theoretical and not practical -- not in accordance with how the real world works. In the real world, people who are not psychiatrists -- brilliant psychiatrists like Dr. Raiss -- bridge as a functional medicine doctor. Really, doctors -- family practitioners write prescriptions for drugs all the time for kids. And the American Academy of Pediatrics says you can, and we've also attached their guidelines too.

So at the end of the day, what I think you're going to understand is that 20 or 30 minutes is way good enough to write a prescription for Ritalin, which we're going to show you is pretty dangerous and has side effects.

So I think that when you view the evidence in light of the applicable statute and rules, I think the conclusion is going to be inevitable. And, also, my prediction is -- regardless of what the statutes say, I

believe you'll have some empathy with the plight of the family -- what they went through just so they can give the treatment that they wanted to give, especially in light of some of the reactions to conventional treatment to other family members.

So that's it. We'll see how it develops. And, again, I want to thank Ms. Browne because we have spent a lot of time trying to put this case together in a way that's going to make it as efficient as possibly so we can finish it in three days.

THE COURT: All right. I hope so. That would be good.

Anything else this morning?

MS. BROWNE: I guess we were going to try to mark or identify for the record and admit what we could.

MR. JAFFE: Can I suggest -- can I make a statement for the record, which will help you out in terms of what we're going to admit?

MS. BROWNE: Oh, sure.

MR. JAFFE: So if you refer to -- when referring to the Accusation, which is marked as Exhibit 1, and direct our attention to page 3.

THE COURT: Hang on one second.

MR. JAFFE: Yeah, sure. This way we'll get this out, and then we're done.

THE COURT: All right. Now where are we?

MR. JAFFE: Okay. Exhibit 1, which is the Accusation, page 3, paragraph 9. Do you have that in front of you, sir?

THE COURT: Yep.

MR. JAFFE: Okay. We're going to admit that, except that when they -- when they reference to a total of approximately 20 minutes, and a subsequent paragraph, which we're also going to admit, it references 20 to 30. So we take the approximate 20 minutes seriously. It was 20 to 30. Subject to that, Respondent admits the allegations contained in paragraph 9.

THE COURT: All right. Hang on a second.

I'm going to treat all these references in the Accusation of this boy, A.A -- it actually should be T.T.?

MR. JAFFE: Right.

MS. BROWNE: Sure.

THE COURT: You should have a conversation with your paralegal for working it up this way, and you should have a conversation with yourself for letting it slide past.

MS. BROWNE: The directions came from above, Your Honor.

THE COURT: Well, somebody else drafted this? All right.

MS. BROWNE: No, not that. But the directions about -- you'll see in future pleadings maybe A. and B. written, rather than --

THE COURT: Oh, I see. Random initials here in Footnote 3.

MS. BROWNE: Yes.

MR. JAFFE: Makes things confusing.

THE COURT: All right. You guys will admit 9 with the proviso that --

MS. BROWNE: Can I clarify. Does that include the footnotes?

MR. JAFFE: Yes, that includes the footnotes.

MS. BROWNE: Thank you.

THE COURT: All right.

MR. JAFFE: And on page 4, paragraph 10, we admit the allegations in that paragraph 10.

Page 4, paragraph 11, we admit the allegations in paragraph 11.

Page 4, paragraph 12, we admit the first sentence of that paragraph, ending in February 2015. We deny the rest.

And the rest of the complaint is just, you know --

THE COURT: Causes of action.

MR. JAFFE: Right.

So, for the record, we make those admissions to simplify the record and for the convenience of the Court in front of us.

THE COURT: All right.

MR. JAFFE: That concludes everything I have to say.

THE COURT: Right. Have you guys reached any understanding regarding the balance of the exhibits, i.e., 20 through 39 in this binder here?

MS. BROWNE: If I could -- if I could explain one thing about one exhibit. I want to be straightforward about it. First of all, what is marked as -- or what, in our exhibit list, is listed as the Subject Interview, August 7, 2017, (A) transcript and (B) audio CD, and then with regard to Exhibit -- or what's in the exhibit list as Exhibit 31, audio CD, Detective Burkhart-Wood -- those two audio items, it's unclear that -- I don't think that they were -- well, I know that at least one of them was not provided in discovery. It's my understanding that neither of those were provided in discovery to counsel.

THE COURT: You mean the recordings? You got the transcript in 24, but you don't have the recordings?

MS. BROWNE: Exactly.

MR. JAFFE: Just the transcript of the Medical Board interview. There is no transcript of the detective's interview, as far as my understanding.

MS. BROWNE: Correct. So I personally became aware of the issue -- well, I was most concerned just with the Exhibit 31, the audio CD from the detective. Very, very recently I discovered that our office did not appear to have it, and so I inquired with Respondent's counsel, who indicated he didn't have it either.

So I should have asked our investigator to describe, but I was able to obtain -- I'll say, as an officer of the court, I was able to obtain from HQIU, the Glendale field office, yesterday, the audio for -- that we do hope to have admitted as Exhibit 31, from Detective Burkhart-Wood.

THE COURT: Well, have you shared that with Mr. Jaffe yet?

MR. JAFFE: Yeah. Last night.

MS. BROWNE: And then also the CD that we shared, and the CD that will be provided to Your Honor -- it's one CD, but it contains both the audio of the subject interview, Exhibit 24, and also the audio CD of Detective Burkhart-Wood, the San Bernardino police officer who interviewed Respondent, at Exhibit 31.

MR. JAFFE: And you eventually got it to work; right?

MS. BROWNE: Yes. Did you?

MR. JAFFE: No. But we just did the thing. We'll work on it today. We'll get it to work.

THE COURT: All right. So there's some wrinkles there about the recordings?

MR. JAFFE: Can we just defer that? We'd like to take a look at it. We just got it late last night.

THE COURT: Maybe at the break you can get it running on somebody's computer.

MS. BROWNE: Okay.

MR. JAFFE: That's just one exhibit. That's not really...

MS. BROWNE: And so, also, just by way of explanation, the articles that are described in Exhibit -- on the exhibit list as Exhibit 37 and 38, those were provided in discovery by Respondent to us, as well as medical records from Del Amo, which are also Exhibit 32.

And to make everything easier for Your Honor so there's really just one evidence notebook, our office submitted in our notebook what we received in discovery from Respondent, which includes --

THE COURT: 32, 37, and 38.

MS. BROWNE: Yes, exactly.

MR. JAFFE: And 34 and 35 and 33 and 36, which are the expert reports and the CVs. We thought, you know, it would be helpful for the Court and us if you have all that -- all the expert reports and all the CVs.

THE COURT: So, essentially, I've got one big binder instead of two smaller ones.

MR. JAFFE: Correct.

MS. BROWNE: Yeah.

MR. JAFFE: And that was a joint request, and I appreciate that the DAG did that. Because I think that would be easier for all of us -- having one binder.

MS. BROWNE: So that's Exhibits 32 through 38 that were from Respondent.

THE COURT: So, essentially, you're not going to object to those documents, ma'am?

MS. BROWNE: No.

THE COURT: So they can be admitted.

MR. JAFFE: Right.

MS. BROWNE: I mean, for administrative hearsay -- I mean, the normal purposes.

THE COURT: All right. Well, yeah.

(Exhibits 32 through 38 were marked for identification by the Court and received in evidence.)

MS. BROWNE: And then our expert, Raiss, who will testify this afternoon, he cited a lot of articles in his expert opinion -- expert report, and just late last night I received. And now we've included a lot of articles from him that are Exhibits 39 through 45. And those also

relate to Dr. Raiss's opinions, but also they relate to his opinion about Dr. --

MR. JAFFE: Hergenrather? Is it mostly him? He's the guy about the medical marijuana.

MS. BROWNE: Yes. At least one of the experts of Respondent.

MR. JAFFE: I just got this this morning. And what I've done, again, to try to move this along quick, is I sent a copy -- just a picture of this last page 4 of the exhibit list to Hergenrather to see whether he wants to, you know, talk about it or add some more expert reports -- just to try to, you know, speed it along.

THE COURT: All right. So you're going to punt on that issue right now?

MR. JAFFE: Yeah. We can take care of it later, you know. Let's hear the testimony first, and then we'll see. My feeling is as long as we have adequate notice and my witness can talk about it -- you know, we have to do what we have to do in trial, and we have to all make accommodations. I don't have any problem with that. She's been very good.

THE COURT: Well, I've got some of these exhibits that are left over here. Why don't you guys -- let's go off the record.

(Discussion off the record)

THE COURT: Back on the record.

The Respondent's not going to object to 25 through 29, which are expert CVs and reports for the Complainant's experts, so long as they actually testify.

MR. JAFFE: Correct. And that would include 30 as well. So 25 through 30, Respondent has no objection.

(Exhibits 25 through 30 were marked for identification by the Court and received in evidence.)

MR. JAFFE: If I may continue, just to try to expedite this.

Exhibit 21 is a printed page from dreidelman.com; we have no objection to that.

THE COURT: Okay. That will be received then.

(Exhibit 21 was marked for identification by the Court and received in evidence.)

MR. JAFFE: Okay. 22 is the certified medical records of Dr. Eidelman; 23 is the addendum to the medical records. They are Dr. Eidelman's medical records being offered by the Board, I assume.

We have no objection to 22 or 23.

THE COURT: Okay. I'll receive those.

(Exhibits 22 and 23 were marked for identification by the Court and received in evidence.)

MR. JAFFE: Okay. 24 -- it has to do with these -- the subject interview of August 7, 2017, which is the Board's interview of Dr. Eidelman, of which I attended.

I have -- we have no objection to that interview. That would be -- you know, it's party admission.

24, we have no objection.

THE COURT: All right.

(Exhibit 24 was marked for identification by the Court and received in evidence.)

MS. BROWNE: Your Honor, just so we can keep the record really clean and understandable, could we identify the -- well, Exhibits 22 and 23.

THE COURT: He describes them as --

MR. JAFFE: Certified medical records.

THE COURT: -- Respondent's medical records, and the second one as an addendum to his medical records. 22 as his first page of certification of records, apparently signed by Dr. Eidelman.

MR. JAFFE: Correct.

MS. BROWNE: Right. So just to be clear, I put these -- we put these as separate Exhibits, 22 versus 23, although the certification of records actually applies to the whole thing. In other words, the certification of records references 30-some pages, and the purported

records actually included the post-dated addendum. And then, also, as you'll see outlined, References 1, 2, 3, 4 and 5, four of which are articles and one of which is a copy from the DSM-IV.

THE COURT: All right. So what about No. 20? Because I thought I had through 19.

MR. JAFFE: 20 -- it is the Board's policy from the Board's website. That is -- you know, it's maybe judicial notice of the Board's policy on medical marijuana. We certainly have no objection to that.

THE COURT: All right. I'll take notice of that.

(Exhibit 20 was marked for identification by the Court and received in evidence.)

MS. BROWNE: And that was printed out -- I mean, it might be different now. Of course, that was printed out during the course of the investigation, and it is documented in the Report of Investigation.

MR. JAFFE: The one thing I will note, and we already talked about this, Exhibit 20 -- we've got to get a better copy of it. Because the last line of it is actually not there -- or part of it's cut off, and I think the top of it. So, you know, I can't really read it. So maybe between the two of us -- do you see on page 20, the bottom?

THE COURT: Yeah, it looks like something may be cut

off.

MR. JAFFE: And it's not necessarily an important part.

THE COURT: Right. It could be just part of a footer --

MR. JAFFE: It's not a footer.

THE COURT: -- because the last sentence seems to stand by itself. So let's examine that issue.

MR. JAFFE: Anyway, we'll work with that. It is what it is, and I think I have the language.

Okay. So that's -- anything else, Judge?

THE COURT: So I've got 25 through 30.

MR. JAFFE: Yes, Your Honor.

THE COURT: That's about everything for now.

MR. JAFFE: Okay. 33 through 39, and then we've talked about 39 through 45. And then 46 is a stipulation?

MS. BROWNE: Your Honor, opposing counsel and I had discussed making a stipulation as to facts.

MR. JAFFE: I think it's moot.

MS. BROWNE: Yeah.

MR. JAFFE: So, like I said, we're admitting all this stuff. I said what I said about authenticity and hearsay, so I'm good with that. I don't think we need it.

THE COURT: Okay. All right.

MS. BROWNE: Is -- just to clarify, the status of 25 through 30?

MR. JAFFE: We have no objection.

MS. BROWNE: So, I guess, could I move to identify those and then request their admission.

THE COURT: I think I said I would receive them already.

25 is a report from the Division of Investigation for the DCA, Department of Consumer Affairs.

26 and 27 -- 26 is blank.

MR. JAFFE: Is that right?

THE COURT: I've got nothing under 26.

MR. JAFFE: Wait a second. Then we're not right. I'm sorry.

MS. BROWNE: Your Honor, we would request to submit that. It was supposed to be the CV of Expert Briggs who will be testifying tomorrow afternoon.

THE COURT: Okay. So you need to get a copy of the CV.

MS. BROWNE: Okay.

THE COURT: 27 is a report from Briggs to the investigator named Fuller.

28 is another report -- or it's a letter from

somebody at the Division of Investigation to Dr. Raiss.

29 is a CV for Dr. Raiss.

30 is a report by Dr. Raiss -- and that's R-A-I-S-S, by the way.

Right now nothing behind 31. I think that's one of your audios.

And 32 is some medical records that have already been agreed to be received from Del Amo.

33, which has been agreed to be received, is the CV of Dr. Scherger.

34 appears to be a report by Dr. Scherger.

35 is a CV for Jeffrey Hergenrather, who is a medical doctor.

30 appears to be a -- I'm sorry -- 36 appears to be a report by Dr. Hergenrather.

37 is an article about ADHD. Is this one of the -- no, that's the other one.

37 is a publication of the American Academy of Pediatrics regarding "ADHD: "Clinical Practice Guidelines for Diagnosis, Evaluation, and Treatment" of the malady.

38 is an article from Esquire magazine about "The Drugging of the American Boy."

This is a peer-reviewed journal, folks? No.

MR. JAFFE: No, it is not.

THE COURT: 39 is an article about the "Association of Cannabis with Cognitive Functioning in Adolescents and Young Adults." That will make for some scintillating reading on my part.

MS. BROWNE: And, Your Honor, I apologize about the lack of exhibit tabs at this point forward. We will bring those in and provide them.

THE COURT: Okay. We've got a couple of hours to kill here.

So we'll see you at 1:30 with your expert, ma'am.

MS. BROWNE: Yes.

And one quick question. When you described Exhibit 36, my notebook is inaccurate. It doesn't actually contain -- it contains another copy of the CV, rather than the report.

THE COURT: All right.

MS. BROWNE: So I want to know if your notebooks have the same problem.

THE COURT: I've got Hergenrather's report in a letter format.

MS. BROWNE: Oh, good. Okay.

MR. JAFFE: I have two copies of the CV also. So the guy -- the only important guy is him, so you've got the report. I have copies of my report. You don't need

to -- I've copies of this report.

THE COURT: All right. Are you going to be able to get another copy?

MS. BROWNE: Sure. Yeah.

THE COURT: If not, I could burn you one at lunch.

MS. BROWNE: Oh, it would save me a trip back to the office.

THE COURT: Off the record.

(Lunch recess)

THE COURT: Back on the record.

Ms. Browne, you've got another witness; right?

MS. BROWNE: Yes, Your Honor, we do.

We call Dr. John Raiss to the stand.

Oh, and if I may, Your Honor, I've got two exhibits I would like to exchange with yours. These are color copies and have tabs, and I think Your Honor will --

THE COURT: Are they part of this testimony?

MS. BROWNE: Yes, they are.

May I approach?

THE COURT: Yeah.

MS. BROWNE: So I will trade from Exhibit 39 on, if that's okay.

THE COURT: Well, right now I've got something back here.

All I've got is 39.

MS. BROWNE: Well, actually, the problem is there aren't any dividers in there.

THE COURT: Oh, I see.

Okay. There you go.

MS. BROWNE: Thank you.

THE COURT: Have a seat, sir.

Raise your right hand.

JOHN RAISS, M.D.,

called as a witness and having been first duly sworn by the Court, was examined and testified as follows:

THE WITNESS: I do.

THE COURT: All right. Why don't you tell us your name and spell it for the record.

THE WITNESS: John, J-O-H-N. Carl, C-A-R-L. Raiss, spelled R-A-I-double S, as in "Sam," M.D.

THE COURT: Ms. Browne, you may inquire.

MS. BROWNE: Thank you, Your Honor.

DIRECT EXAMINATION

BY MS. BROWNE:

Q Dr. Raiss, thank you for being here this

afternoon.

A Sure.

Q And could we please turn to the book in front of you -- the notebook; it's full of exhibits. And if we could please turn to Tab 29.

Is this your curriculum vitae?

A It is.

Q And was it updated September 3rd, 2017?

A It was.

Q And does it accurately -- is it accurate, to your knowledge?

A It is.

Q Okay. Could you please tell us your educational background.

A I went to Harvard College as an undergraduate. I went then to Baylor College of Medicine for medical school. I then did three years of internship in general psychology residency at Cedars-Sinai and two years of fellowship at Reiss-Davis Child Study Center, and then an additional year of child psychiatry fellowship with -- at UCLA. And then a year of research fellowship at UCLA under the tutelage of Dennis Cantwell.

Q Okay. And so are these listed in reverse chronological order under postgraduate training?

A They are.

I then became board certified in both psychiatry and child psychiatry in 1984.

Q Okay. And have you retained that certification?

A Yes. At that time, there was no expiration date. So there was no need to take an exam every 10 years.

Q Okay. So you remain board certified by the American Board of Psychiatry and Neurology?

A Yes.

Q Okay. So you've had three board certifications -- is that correct? -- psychiatry, child psychiatry, and geriatric psychiatry?

A Yes. I earned the geriatric psychiatry in 1994; that only lasted 10 years. I let it expire in 2004 because I don't do that much geriatric work.

Q Okay. But have you continued doing some child psychiatry work?

A Yes. A considerable amount.

Q Okay. And how long have you seen child -- children patients?

A Well, since the early 1980s in my child psychiatry fellowships, and since about the mid '80s in my private outpatient practice, in, first, Beverly Hills and later Santa Monica. I also, for about 10 or 15 years, did considerable inpatient work of both

adolescents and adults. But right now my practice is purely outpatient.

Q Okay. And as far as your work history, you worked private practice in Beverly Hills, from '81, for 11 years -- 1981?

A Yes. Until 1992 when we moved to -- my wife and I moved to Santa Monica. And then I started working -- got an office in Santa Monica and worked, you know, at St. John's until its psychiatry unit closed in the late '90s. And, you know, I've been practicing there ever since.

Q Okay. So how many years does that add up to? I don't know if you've done the math recently.

A Well, if we date it from the end of my fellowship in '85, so that would be -- 15 plus 18 -- you know, 33 years or 32 years and change.

Q So 32 to 33 years in private practice treating children and adults?

A Yes. And -- yes.

Q And the fellowship that you mentioned -- well, the first -- oh, okay. There are three fellowships that I see under postgraduate training: one starting in 1981 and then one in 1983 and one in 1984. And all three of those related to child psychiatry?

A Yes. The first one was at Reiss-Davis, which

that program is no longer operating. It was one of the last of the, sort of, psychoanalytic child psychiatry fellowships around.

And during that time, I got an interest in psychopharmacology through attending the lectures of Dennis Cantwell. So I decided to do an additional year there, and then subsequently a year of research fellowship after that.

Q Okay. And what is psychopharmacology?

A It's the use of medications in the attempt to help patients with their problems.

Q And does practicing in psychopharmacology imply -- does that imply that you're less likely to do other types of treatments?

A Well, if you bifurcated into psychopharmacology and psychotherapy.

Q Okay.

A The typical psychotherapist will see their patients, say, on a weekly basis -- sometimes more intensively; sometimes a bit less intensively. And the psychopharmacologist will see their patient for an initial evaluation and subsequent follow-ups. So, in general, the psychopharmacologist will see a lot of patients over long periods of time, but less frequently -- the frequency being determined by how

they're doing -- you know, how they're responding to treatment/how they're doing with their medications. And the psychotherapist will see relatively less patients more frequently.

Q Okay. And so -- so have you primarily practiced one or the other?

A Yes. I primarily do psychopharmacology. But it's necessary to do some psychotherapy along with that, in order to understand what's going on with the patient. I mean, the quality of the work really is quite dependent upon the time one spends with the patient to find out what's going on in their lives and make judgments about what their problems are and what, if any, medications might be likely to help them.

Q Okay. So when you say "long periods of time less frequently," approximately how frequently, if you can say? I don't know if that's too general of a question.

A Well, let's say if you're seeing someone who you've diagnosed with ADHD, and you decide to do a stimulant trial, I like to use the protocol that's developed by Jim McGath, who is a professor at UCLA. He's actually written an excellent little book about ADHD, in which one can do about a two-week titration of a medication, starting at a low dose and gradually pulling

it up, to get an idea after two weeks, you know, of the basic questions that a psychopharmacologist asks, which is, number one, how well is this medication working? What are the side effects? And is it worth taking?

A lot depends on the seriousness of the situation. Like if a patient, for example, is having a bipolar mood disorder and going through turbulent times, you might want to see him on a weekly basis or every other week.

Q Even as a psychopharmacologist?

A As a psychopharmacologist. I mean, for example, one bipolar patient that I saw today is having problems with rapid cycling. He made an intervention and decided to do a follow-up in fours weeks, which is actually the way I've been treating him since I began because his condition is not really stable.

Other bipolar patients might be stable enough to see them every three months or six months. It also depends on the side effects and need for testing of the medications that one is using.

Q Okay. And at the end of an appointment, do you document when you anticipate to next see the patient?

A Yes.

Q Do you even sometimes have the next appointment scheduled?

A Depends on the situation. For example, if you need to see someone relatively soon, like two to four weeks, then it probably makes sense to schedule it at the end of the visit. If it's six months or three months, that's a bit harder. And that can be scheduled in advance or it can be scheduled closer to the time that they need it.

Q Okay. And then -- I'm sure this is a completely basic question, so pardon me. But what is being a fellow? What does that mean?

A Well, the hierarchy is internship -- what used to be called internship was the first year out of medical school. And residency is usually one's basic training in the field. So typically there's -- right now, I believe a psychiatry residency is about four years.

If one's going to do child psychiatry, one does the internship years and two years of child psychiatry residency. And then you do two more years of what's termed "fellowship," which is really just an advanced residency.

MR. JAFFE: By the way, Judge, Ms. Browne, if it at all helps, he's an expert. He's an expert in psychiatry. He's an expert, if that in any way helps at all.

THE COURT: All right. Take that into account, Ms. Browne.

MS. BROWNE: I will, Your Honor.
BY MS. BROWNE:
Q I'm just going to ask a few more questions pertaining to your qualifications. And I see on page 2 of your CV it says "List Professional Society Memberships."
A Yes.
Q And I see you have the American Academy of Child and Adolescent Society. Can you tell us what that is.
A Well, that's the main organization for child and adolescent psychiatrists.
Q Okay.
A They publish, you know, the most important journal -- the orange journal. And they have regular annual meetings and multiple meetings through the year to try to keep people educated.
Q Okay. And then the American Psychiatric Association?
A Similarly, that's the main psychiatric organization. And, similarly, they publish the most prestigious journal -- the green journal -- the American Journal of Psychiatry. They have annual meetings.
The American Medical Association publishes what's now called JAMA Psychiatry. It used to be called Archives of General Psychiatry. And that's also one of

the top, you know, two or three journals in the field.

Q Okay. And then, quickly reviewing the professional activities, I notice it says that -- at the bottom of the second page, "Stanford University Physician Assistant Program, Psychiatry Rotation."

Could you tell us what that is.

A Stanford has a local program where they train physician assistants, and they like to have them sit in a doctor's office and see what the practice of various specialties are like. So I've had some of them come to my office and sit by me while I see patients -- I think for about a two-week period for each one.

Q So through the course of two weeks, they'll sit in with every appointment?

A Exactly. And then in between, we'll talk about the cases and ideas. We'll give them references and stuff to read.

Q Excellent. So that was from 2016 to present?

A I believe -- yes, I believe so.

Q Okay. And then turning to the following page, the Rocky Vista University College of Osteopathic Medicine -- what is your involvement there?

A So osteopaths are trained very much like MDs. And, similarly, they like to have -- senior students sometimes like to sit in with a specialist and see what

it's like to be a psychiatrist. So I've had one of them come and sit with me for a couple of weeks.

Q All right. And the "1985 to present, Assistant Clinical Professor of Psychiatry, UCLA, NPI" -- what is that?

A So that's an appointment to the clinical faculty of UCLA. The main thing I do there is teach psychiatry to second-year medical students. There's a class called Problem-Based Learning, in which one works through some of the cases and learns how to try to think about them from differential diagnoses and decide what the next step in treatment is. So I do that on an annual basis for about five or six weeks. We meet twice a week for two hours.

Q Okay. So those are -- the Assistant Clinical Professor of Psychiatry.

And then the next one, 2004 to present, teaching psychiatry to the second-year medical students. What you just described is the latter; correct?

A Yes -- well, actually, they're combined.

Q Okay.

A I mean, one of the duties, if you're on the clinical faculty, you have to do work for the hospital, you know, in one capacity or another, like teaching students or having them come to your office. And in this

case, this is how I fulfill the voluntary clinical faculty work requirement.

Q Okay.

MS. BROWNE: Your Honor, I guess it's already happened, but we would offer that -- request --

THE COURT: He can clearly assist the trier the fact.

Please continue.

MS. BROWNE: Thank you.

BY MS. BROWNE:

Q If we can please turn to Tab No. 1, which is Exhibit 1 in the notebook. And what is your understanding of what that document is?

A Well, I believe this is the Medical Board's accusation of Dr. Eidelman summarized.

Q Okay. So the charging instrument.

And have you reviewed this document before?

A I have.

Q Have you reviewed the specific paragraphs under the causes for discipline -- gross negligence and so forth?

A I have.

Q And did that seem to comport with -- did that comport with your understanding of -- let me back up a little bit and establish some foundation.

So at some point in time, were you hired to

serve as an expert to help evaluate the care and treatment provided by Dr. Eidelman to a patient in an investigation?

A I was.

Q And in doing that, did you receive documents to review?

A Yes, many documents.

Q And if we could turn to Tab 28, is this a letter -- was this a letter sent to you from an investigator with the Health Quality Enforcement Unit?

A Yes. That was Tracy Tu's letter.

Q Okay. And had you arranged with Tracy Tu to review this matter?

A Yes.

Q And do the -- to your recollection, did the attachments written there and the property comport with your recollection of what you received?

A Yes.

Q Okay. And then turning to Exhibit 30, could you tell us what this is.

A That's my report that I submitted regarding Dr. Eidelman, which I mailed to Investigator Tu on or around September 3rd, 2017.

Q Okay. And have you reviewed this report recently?

A I have.

Q And would you swear to this as testimony, if you were so asked?

A Yes.

Q Okay. I'd like to turn our attention to the Accusation, which is Exhibit 1, and we're going to go to page 5, paragraph 13. And the allegation there states -- briefly states that "The Respondent committed gross negligence in his care and treatment of the patient when he diagnosed the patient with ADHD and bipolar disorder, based on nothing more than a 20- to 30-minute interview with the child and his father."

Would that have been -- do you agree with that assessment?

A I do.

Q And with regard to creating a diagnosis for a patient, let's say a pediatric patient, the -- well, you saw that the records -- could you please tell us the standard of care with regard to developing a diagnosis for a patient?

A Sure. Well, you know, it takes time and effort. I mean, probably, if -- for a psychiatrist or a consultant to see a patient, you'd want to spend a minimum of an hour with them, recognizing that, probably, at end of the hour, you're probably not going to have a

definitive answer, but a working answer, possibly, if you're lucky.

And you review the chief complaint, the history of present illness, the history of previous treatment, the medical history, the family history, and the mental status exam.

Now, specifically, for bipolar disorder, there's several things you'd want to -- so this child was brought in by the father -- well, I'll leave it general. For bipolar disorder, you'd want to know what exactly are the symptoms? When did they begin? What was -- I'm sorry.

Q I'm sorry. So let's say a patient comes in, and it's a blank slate; you don't know what you're going to end up diagnosing, if anything, so the standard of care with regard to coming to any diagnosis is what I'd like to be asking you.

A Diagnosis is crucial because diagnosis guides treatment. One can very often go astray by chasing symptoms and ignoring the underlying diagnosis, especially in bipolar mood disorders, where the goal of the treatment is the long-term stability of the patient, which can be easily perturbed by numerous agents, including prescription medication and illegal -- and substances.

Q Okay. And you were -- you listed very quickly,

so I'm going to try to break it down a little bit. But when you first see the patient, you look at their chief complaint, I believe -- was that the first thing you said?

A Yeah. Which usually -- for a child, it's usually going to be the parent who is going to be the reporter.

Q Okay. And so what would a chief complaint, for example, be for a child?

A A common one would be irritability or anger episodes or temper tantrums or having problems with school, achievement. There's so many.

Q Right. Okay. And then the next thing I think that you said was history of present -- maybe you can help me.

A The history of present illness. You know, the crucial thing here is you want to know -- so the chief complaint here was, allegedly, "Kicked out of school by the teacher. You've got to medicate him so he can come back to school."

Q Let me interrupt you. At this point, we just want to stick to more --

A Generalities, not specifics.

Q -- generally. Yeah, the general standard of care.

A So you want to ask lots of questions, like: What are the symptoms? When did they begin? Have they been continuous or episodic? Are there things that make them better? Are there things that make them worse? What situations do they occur in? Are they everywhere or just at home or just at school? And what problems do they cause?

Q Okay.

A And you want descriptions, like: What are the parent's chief complaints? What are the things that bother them the most? What are the things that they want help with?

Q Okay. So that's -- what you just described is the process of obtaining the history of the present illness?

A I mean, there would be much more to it. There's -- what's the sleep like? What's the peer relationships like? And also, you know, what's the history of achievement at school or the history of behavior at school?

Q Okay.

A For example, if the kid has been doing fine, and then all of a sudden you hear a new teacher has problems, you think, "Well, maybe it's something about this particular classroom or this particular teacher, rather

than necessarily a problem with the child."

So the history's a big deal.

Q Okay. And I presume for younger children -- four or five years old -- there would be a lot of context to know about. I mean, some kids -- so you would have to inquire, sort of, about the school -- what it is like?

Or some kids that age, don't even go to school -- right? -- at four.

A Yes. You'd have to inquire about the school, and you'd have to inquire about the home.

Q And what kinds of things would you inquire about the home, for example?

A Well, you'd be, again, probably focused on the chief complaints at first: When did they begin? What is their pattern? You know, how severe are they? How disruptive are they? What's their nature? Are people injured? Do they happen in both home and school or one or the other?

Q And do you also try to get a sense of just the general environment -- like, for example, if all the kids sit down and eat dinner together or do it separately? I mean, I don't know. Does that, kind of, just the everyday life, even separate from the problems -- do you find out just what is, sort of, normal for a particular family?

A Yeah. Everything is important. So you want to know who are the members of the family -- who is there? You want to hear probably from both parents and want to know who are the different -- how many siblings are there. You want to know crucially the family history of the various family members of any psychiatric or medical illnesses. And you want to know about the structure of the home -- do the parents work? Are there babysitters? You know, what's the environment like?

Because everyone -- I mean, every time you see a new psychiatric patient, it's really like entering -- it's almost like space travel. You're on another planet, basically -- a unique world that's completely different than everything else that you've ever seen, and you need to try to make yourself knowledgeable about that world, and that takes time and effort. The better you can do that, the better chance you have of accurately defining the problem and accurately figuring out what medication, if any, might be useful for it.

Q Okay. So going back to the list that you said really quickly, chief complaint was first, history of the present illness was next, and then after that...

A This is just the standard, sort of, medical history format. Past psychiatric history is next. Have there been any previous attempts of treatment with

psychotherapy or medications? Have there been previous problem behaviors that are not present now?

And then there's a medical history. Are there allergies to medications? Have there been surgeries? Are there medical illnesses? Are there infectious diseases? What's the general care? Are the immunizations up to date. And so on.

And then the developmental history. Was the child full-term or premature? Were they breastfed or bottle fed? What were their early years -- how were their developmental milestones; were they on target or delayed? What was the baby's temperament; was it easy or difficult? How did they adjust when they went to preschool, if they did?

Q So it sounds like a lot of information. How long does the first appointment typically last?

A A minimum of an hour and ideally longer, if one has the time. I mean, you know, there's a constant tension in medical practice between one's need to have a practice running and making an income and doing a good job. I mean, ideally, you might want to go two or three hours. But that, for most people, wouldn't be realistic.

So, typically, one does an hour, one covers as much data as one can, one uses rating scales and checklists of stuff like medical conditions and so on to

help one narrow it down.

And then one realizes that you're not going to -- the answer at the and of the hour is a working diagnosis. You may be completely wrong or partially wrong, but that's going to be -- if the patient sticks with you, you try to figure it out over time. But this is your best guess or approximation.

Q And the answers to the questions -- all the questions that you referenced, do those answers get documented in the medical records?

A Ideally, yeah. I mean, you want to take -- I mean, yes. Ideally, I like to sit in front of a patient with a laptop and take notes as we talk, and I've been doing that, you know, for 30-odd years. Because you want to get the details and the quotes. The more detail -- the details are crucial.

Q Okay. And after you have all of that information, you said you come to what you call a working diagnosis?

A Yes.

Q And you document that. Do you include in your documentation the components of what -- well, let me back up a little bit.

Could you tell us what the DSM is.

A It's the Diagnostic and Statistical Manual of

the American Psychiatric Association. It's used to make diagnoses. It underwent a radical change in the 1980s when the DSM-III came out, which for the first time specified diagnostic criteria for the various disorders.

Prior to that, American psychiatry had been primarily influenced by psychoanalysts who weren't much interested in diagnoses. But under the influence of some psychiatrists from the Midwest -- St. Louis at Washington University -- they came up with what was called the research diagnostic criteria, which listed for the major disorders -- like schizophrenia, major depression, bipolar -- specific criteria so that psychiatrists could reliably diagnose so that what one person said was bipolar disorder, someone else would -- hopefully, there would be reliability in making the diagnosis.

And that was developed in 1970s, and then later codified into the DSM-III, which has gone through various modifications and changes since.

THE COURT: We're on the DSM-5 now; right?

THE WITNESS: We are. 2013, I believe.

BY MS. BROWNE:

Q So in 2012, it was the DSM-IV?

THE COURT: TR.

MS. BROWNE: Pardon?

THE COURT: TR for "text revision."

MS. BROWNE: Thank you.

THE COURT: We hold hearings for the regional centers, so we have to have some passing familiarity with it.

BY MS. BROWNE:

Q Okay. So when you are documenting a working diagnosis, do you also make any reference to any of those criteria?

A You might. I mean, in the research world, you would do that very specifically. But in clinical practice, you would try at least. You might not systematically go through every single one, but you would want to hit, at least, what are the pillars of your diagnosis.

I assume you don't want me to get into specifics yet?

Q Right. And then we'll move to that quickly.

A Okay. I mean, specifically, say for a bipolar disorder diagnosis, you would want to know: What is the mood? Is it elevated or irritable? What is the sleep? Is there decreased sleep? What's the speech like? Is there pressure of speech? Is the thinking disorganized or flight of ideas? Is the patient distractible? And does the patient do things that are unusual or very risky, like take over the classroom and tell the teacher,

"I know how to teach better than you" and things like that? The symptoms vary depending on the age of the patient.

Q Okay. And for bipolar disorder, those factors that you just referenced: mood, sleep, speech -- whether pressured --

A Grandiosity.

Q Grandiosity or distractible, doing risky things -- are those related to diagnostic criteria?

A Yeah. I mean, the diagnostic criteria for bipolar is -- it shifted. So there was the DSM-IV TR, and the -- basically, many children of this age were being diagnosed bipolar NOS -- not otherwise specified.

Q And this is at what age?

A In childhood.

Q In childhood. Okay.

And this was at what period of time?

A Before the DSM-5.

Q Okay.

A And so the APA felt that there were too many kids being diagnosed with bipolar, so they created a new category called DMDD, disruptive mood dysregulation disorder, which is like chronic irritability, and which is continuous rather than episodic. Because they thought, "Look. There's just too many kids being

diagnosed bipolar, and that's what psychiatrists are slapping the name on every kid who's irritable, so let's parse it out more and try to figure out what's going on."

Q Okay. So the difference between disruptive mood --

A Dysregulation disorder.

Q -- dysregulation disorder and bipolar has to do with whether the behavior is episodic?

A Well, here's the problem. If you read the literature, you'll find that with young kids and even early adolescents, you don't find the simple patterns that one sometimes observes in adult life, where there's a manic episode followed by a depressive episode.

What you'll sometimes see is what's called rapid or even ultradian cycling. Like, within a day, mood will be up and down. And it can be -- often these things start off with depressions or irritability, and go on and later will either turn into a bipolar disorder -- a classic one -- or not.

It's sort of a complex area. Because even in adult bipolar there's a huge amount of what are called mixed states, where you have depression and mania mixed together, which leads to real complications in treatment.

Q Okay. So the standard of care with regard to reaching a diagnosis for ADHD -- could you tell us what

that is.

A Again, there's nine inattentive and nine hyperactive-impulsive criteria. These haven't changed from DSM-IV TR to DSM-5. The disorder has to be present in more than one place. Like, it can't just be at school. It has to be at home and school. So it's usually very important to get the teacher's opinion. And the most time efficient way to do that is usually to use rating scales, and there's some available rating scales on the Internet that one can get for free.

Q And what is a rating scale?

A Well, a rating scale is a checklist which goes, typically, through the diagnostic criteria, and you have four choices: not at all, little, moderately, or very much. And typically the way these things are usually scored is if something is moderately -- I mean, I'm paraphrasing -- but "moderately" or "very much," that counts as a symptom. And if it's "not at all" or "just a little," it doesn't count.

Q Okay.

A And these things are normed and so on. So you can use it as sort of a crude way of finding out: What do the teachers think? In elementary school -- well, and again, it's hard to make that diagnosis precisely. The younger the child, the more difficult to make the

diagnosis because there's certain developmental distractibility, and that's why they don't teach calculus to five-year-olds -- or most five-year-olds.

Q So in determining whether or not somebody -- a child has a diagnosis or a working diagnosis of ADHD, is it important to understand and be familiar with, developmentally, where a child of a particular age would be?

A Yes. And that's why the teachers are usually thought to be the best judges of that. Because they have classrooms of 10 or 20 or more kids, and they get a pretty good sense of what's normal and what's abnormal.

Q Okay. And you were stating that the criteria for ADHD -- the standard of criteria, there were -- did you say eight?

A Nine.

Q Nine different things. And could you list those for us.

A There's nine inattentive and nine hyperactive/impulsive. And the way the questions are asked varies depending on the age of the person. But, for example, one of the inattentive criteria would be loses things. Like, for a kid, I guess it would be sweaters and books and things like that.

Another is doesn't seem to listen when being

talked to. And so the person will appear to be listening, but they don't retain the information.

Another is a short attention span -- difficulty focusing on some especially difficult material, or material that's considered boring. There's easy distractibility. And there's procrastination -- putting off things -- and so on.

And then there's similar criteria for hyperactivity: impulsivity, difficulty sitting in one's seat, or interrupting -- barging into groups and interrupting them, or asking questions out of turn and not raising one's hand, and so on.

THE COURT: These are laid out in the DSM, I assume?

THE WITNESS: Yes, these are.

BY MS. BROWNE:

Q And then, these things have to be looked at in context; is that right? Like sitting in seat -- there are different kinds of schools that have different rules or protocol for what kids do. I mean, some might let kids run around more, and some might want them to sit in a seat. So in order to see if these criteria apply, do you end up having to learn about the context -- about what the school's like?

A Yes. Because one idea might be -- maybe the kid doesn't need a medication. If they're in a very strict

school that's rigid and academic, maybe it would be better if they moved to a different sort of school, for example.

Q Okay. So that type of thing is something that you look at as a physician?

A You think about it, yes.

Q Okay. So have we covered the standard of care with regard to developing a diagnosis for ADHD, do you feel?

A Again, one has to ask how long -- the questions of: When did this begin? What's the course of this? So ADHD is typically a continuous course, not an episodic course like most classic bipolar disorder. And it's much harder to make the diagnosis in kids of a younger age. You know, you don't want to treat somebody who is doing things that are normal for their developmental age.

Q Right. And for ADHD -- are there any pharmacological treatments for ADHD?

A There are.

Q And are there any risks or side effects to those treatments?

A There are. I mean, in general, if you look at, say, something like UpToDate, you'll notice that for every medication, there's a long, long list of side effects. There's no medication that doesn't have side

effects. And it's important to acquaint, you know, the patient or the parents with the most severe of those.

What's also important is to consider "Is there a medication here that might make a big difference in a patient's life?" Because that, you know -- and that's the real question that the physician's asking: Is there something that can really help, that has manageable side effects, that's worth taking or not? And you never know. Whenever you prescribe, you don't really have a clue as to whether something's going to work or not and what the side effects are going to be.

Q But you advise the patient or the patient's parents, as best you can, about the risks -- or potential?

A You advise them about the risks, and you also schedule a follow-up to ask -- so you see for yourself and hear from the patient and the parents, like, "How well did this stuff work?" "What did it do?" "What was good about it?" "What was bad about it?" "Does the dose need to be adjusted?" "Is it lasting long enough?" -- et cetera.

Q And the feedback that you're talking about with ADHD about the rating skills scales, would that be something that -- when would that happen in the process? Say a five-year-old child comes, and that became

something you were considering as a possible diagnosis. When would that kind of rating scale function --

THE COURT: When would you contact the school?

THE WITNESS: I would probably give that to the parents. I mean, it depends. If it's a simple rating scale, you'd give it to the parents, you'd ask that it be given to the teachers, they would score it, and then the parents would collect it and send it back to you.

If it's a question of a behavioral problem specifically at school, you would want to hear about that from the school directly.

BY MS. BROWNE:

Q Okay. So if it's a behavioral problem, you would want to hear directly from the school. And what was the other? If it's not a behavioral problem --

A If it's a rating scale issue, you would give the -- I mean, in an ideal world, you would give the rating scales to the parents before you even met and have them there at the first visit.

If it's not -- things don't go that smoothly, you could give it to them at the end of the visit, have the teacher score them, and bring them back for a visit a few weeks since.

There's usually not a huge urgency to immediately start a medication. Because, I mean, it's a

long road one's going down. So typically a week or two is not going to make a huge difference.

Q And is there ever an occasion where you, as a physician, would end up contacting the school?

A Yes. You have to get a release of information from the family but, yes, often.

Q Okay. And the release of information -- that would be a signed document by the parent?

A Yes. They release -- "I give so-and-so," you know, "the right to talk to the doctor."

That can be quite helpful -- to hear how the kid is doing in school, what the problems are.

Q And does that happen in your practice?

A Yes.

Q You speak with teachers?

A Speak on the phone, or I find e-mail is even a more efficient way to do it.

Q Okay. You mentioned UpToDate earlier. What is that a reference to?

A So UpToDate is a thing that a physician can subscribe to, or you can -- if you're on the faculty of a school, you can access it as one of the library perks that you get.

It's an up-to-date opinion of every medical specialty with -- and you can look up, say, something

like bipolar disorder or ADHD, or something that you're not familiar with like cardiac problems or, you know, diabetes and learn what is the state of the art of the treatment, the diagnosis, the epidemiology, symptomatology, what are the various -- and you can do it for each medication and so on.

It's a very handy resource because it's rapid, it's fast, you can have it on your laptop, and you can look it up when questions come up.

MS. BROWNE: Your Honor, I wonder if we might take a brief, even just five-minute --

THE COURT: Okay. We want to get this witness done today.

MS. BROWNE: Of course.

THE COURT: We've been wandering around out there in the desert there, and now we need to get to the oasis of his opinion.

MS. BROWNE: Okay. All right. All right.

MR. JAFFE: I know you need to lay some stuff about the standard of care, but --

MS. BROWNE: Yes. All right. Understood.

MR. JAFFE: Actually, it's not a bad -- is there coffee downstairs?

THE COURT: Yeah, they probably still have some coffee.

MR. JAFFE: You're not going to take more than an hour; I'm going to have 10 minutes.

I guarantee you we're going to be done with this witness today.

THE COURT: From your mouth to the good Lord's ear.

THE REPORTER: Can I go off the record now?

THE COURT: Yeah. Let's go off the record.

(Recess)

THE COURT: Back on the record.

MS. BROWNE: Thank you.

BY MS. BROWNE:

Q I would like to return to where we are, which is paragraph 13 of the Accusation, and we just discussed the standard of care with regard to making a diagnosis for a child and, specifically, making a diagnosis for either ADHD or bipolar disorder. And so I think we understand the standard of care.

Now I would like to ask the question -- was that standard of care met in this circumstance? And let me be more specific -- the circumstance of the patient visit between Dr. Eidelman and Patient T.T. that occurred on September 13th, 2012.

A I don't believe it was. I don't believe that there was sufficient documentation of symptomatology, course, and so on, to warrant diagnoses of ADHD and

bipolar disorder. Specifically, the chief complaint related to the school -- the father saying, allegedly, that the school wouldn't let him back unless he was on meds. So that was the biggie. So, therefore, one would want to contact the school and say, "What's up?"

Q Do you find it credible that a school would -- a teacher would say -- would make a statement like that?

MR. JAFFE: Objection. Foundation.

THE COURT: Well, in your experience, sir, would that be unusual?

THE WITNESS: Extremely unusual. And seemingly, to my way of thinking, almost illegal for them to do that.

BY MS. BROWNE:

Q Okay. So let's talk specifically about the diagnosis of ADD or ADHD. How was the standard of care violated with regard to making that particular diagnosis?

A By not documenting criteria, by not getting -- using rating scales, by not getting information from the school.

Q Okay. And the amount of information that you had talked about obtaining earlier when you were discussing the standard of care, could that even happen in a -- say, a 20- to 30-minute appointment?

A If it had been solely focused on ADHD, if you had come pre-equipped with rating scales from home and

school and took a very efficient history, it's possible.

Q Okay. But more commonly, the time frame that you described earlier would be required?

A Yes. And also here there were no rating scales, there was no word from the school, so, no.

Q Okay. And so when I asked is that credible, and then His Honor referenced "in your experience" -- is part of what you do sometimes require you to make a judgment call about somebody's credibility?

A Yes.

Q Please describe.

A Well, people have different views -- are you speaking specifically here to this case?

Q Yes, yes. Let's speak to this case.

A So all the history comes from the father, who says that he has bipolar disorder, and he has a son with bipolar disorder. So bipolar disorder is sort of a wildly overused term in our culture. So one would want to ask, "What do you mean you have bipolar? What does that mean?"

And if you hear, "Well, I've been hospitalized three times for manic episodes, and I've had trials of lithium and Depakote, and I'm currently maintained on such-and-such," that would be stronger evidence. But just to say, "I have bipolar" is insufficient, in my

opinion.

Also all the -- I mean, the father is the sole reporter. And to quote Dr. Eidelman's attorney from during the hearing with the Medical Board, he is suspect.

Q Let me interrupt you there. Do you mean -- the subject interview transcript, are you referencing?

A Yes.

Q Okay. Thank you.

A You know, he apparently -- I mean, and these are in the words of the attorney -- sued the State when the State, you know, closed down his marijuana clinic. And, I mean, they were asking, "Well, why didn't you do an IEP" -- an individualized education plan?

And he says, "Well, the father's not the kind of guy who would do an IEP."

You know, so the father is not the most solid basis on which one wants to base a diagnosis. I mean, he may be correct, or he may not be. But he is suspect, I would say. His reports are of uncertain validity. So one would want to get corroborating evidence from, say, the mother or, say, the school.

Q And it sounds like the father had been a patient of Respondent previously. Would any information from -- from that doctor-patient relationship be relevant?

A Yes. Again, depending on the level of

documentation. I mean, if one is merely looking -- the question is, does the patient merely bring in a diagnostic label and say, "I have X," and that gets affixed to them, then leading to a prescription? Or does the doctor inquire about details that would lead the doctor and other doctors reviewing a case or hearing it to go, "Yeah, this guy probably has bipolar disorder"?

Q Okay. And so we've shifted over from ADHD to bipolar disorder. What are the -- well, what are the criteria that were documented on in the medical records, which are at Exhibit 22 -- Tab 22, page 3?

A So "Episodes of uncontrollable behavior, temper tantrums can come at a moment, when it's seemingly normal, and bipolar disorder runs in the family. Father and brother both on psychiatric drugs as children, both diagnosed with ADHD and bipolar, put on drugs for both. Father found cannabis more effective. Older son lives in another state, where he takes drugs for ADHD and bipolar -- Risperdal -- and is even on disability for it and receives an SSI check. When the older son visits California, the father has, under the Compassionate Use Act, given cannabis to him with good results."

So here, what do we learn? "Uncontrollable behavior" -- what does that mean? We don't know. "Temper tantrums" -- okay? -- "that can come on rapidly;

manageable at home, not at school." So there's outbursts of anger.

Now, that can be many different things. That could be bipolar disorder, it could be depression, it could be psychosis, it could be oppositional defiance disorder, it could be a reaction to a difficult teacher. You know, that's not sufficient. I mean, if you subsume it to episodes of irritability or uncontrollable behavior, it's just not -- you know, it's not enough to form a diagnosis.

Q Did you say "irritability"?

A The temper tantrums.

Q Oh, okay.

A So you can say, "Well, mood is" -- I mean, say the temper tantrums -- "Mood is irritable at times. There's episodes of it, and they come on rapidly."

The mental status doesn't give us much help -- "Alert, oriented appropriate, but agitated talking, trouble sitting still." He's being seen at the end of a school day. Most kids are not happy campers at that time. They're hungry; they're tired.

"No looseness of association. Not talkative." So there's no pressured speech. "Answers questions." So there's no irritability seen in the office. There's no pressured speech. There's no disorganized thoughts seen

at that moment.

Q So, of this, what really does, if anything, relate to a bipolar diagnosis?

A You mean if one wanted to stretch this and say, "How could this conceivably be?" you could argue, "Well, there's this irritability; there's these temper tantrums; that maybe this is DMDD form." Or, you know, as described in the literature at that time, "Childhood onset often is continuous, not episodic. It's dysphoric, it's irritable, rather than euphoric or manic."

So it's conceivable that bipolar disorder could be a diagnosis. It's just insufficiently documented to, you know, stick a label on it and make treatment decisions.

Q Okay. And as far as understanding what the -- what the context is or being more specific than what you referenced -- "uncontrollable behavior and temper tantrums" -- did you -- I'm not sure. Were you provided the audio of the subject interview?

A Yes.

Q Okay. Did you listen to it?

A I believe I did, yes.

Q And did you also have the transcript?

A I did.

Q Okay. And you read the transcript?

A Yes.

Q And when you listened and/or read, did you find anything -- was Respondent, when asked in the subject interview, able to provide anything more specific than what is written in this medical report on page 3?

A Well, my sense, to paraphrase what the Respondent said in the subject interview, was that he really doesn't care about psychiatric diagnoses -- they're artificial constructs; they're not that relevant. He just wants -- and he provided an article about ADHD, arguing that it's overdiagnosed or the diagnoses are influenced by the pharmaceutical industry, and that he's not really that interested in documenting a rigorous diagnosis, in part, because the treatment is always the same: It's cannabis.

So, really, rather than going through this in detail looking for "Does this kid -- is he bipolar? Is he ADHD? Is he ODD? Is he depressed? Is it family dysfunction? What's going on?" it's sort of like, "Let's find a label so we can provide marijuana," which is the one treatment that's always used.

Q And when you say "the one treatment that's always used," do you -- based on what? What are you referring to? You're talking about the one treatment that's -- that always appeared to be used by Respondent?

A Yes. That he specializes in the compassionate use of cannabis, and this is what the patients are there to see him for, and that's the prescription. That's what they're there for. That's what -- certainly in this case where the father got a cannabis letter, and he's looking for one for his son.

Q Right. And, in fact, here, was it your understanding that the father brought the son in and was asking -- was not saying, "What's the diagnosis here, Doc?" but was asking for a medical marijuana recommendation?

A That was my sense. He's saying, "It worked for me. It worked for his older brother. Let's give it to him."

Q So when you reviewed the subject interview transcript, were you -- did you read that and listen to it with an open mind to try to understand where Respondent was coming from?

A That's my sense of what the Board wants from its medical experts. They don't want them to be, like, paid to do one side or the other, but just to look at the case as if they themselves were treating it and ask, "What do I think?"

Q Right. So your sense is the Board wants just an objective understanding?

A Honesty and objectivity.
Q Okay. And do you feel, in writing your report, you maintained that objectivity?
A I believe so.
Q And do you prescribe or -- pardon me. Do you recommend medical marijuana?
A I do not. But I ask my patients about it, and I occasionally observe some of them experiencing benefit from it.
Q Okay.
A It's increasingly being used now, you know, due to the recent changes in the law.
Q Okay. So during the subject interview, did you notice that -- did it appear that Respondent was asked some pretty tough questions?
A Well, could you --
MR. JAFFE: Maybe that's a little vague. Maybe you can help him.
MS. BROWNE: Yes.
THE COURT: Maybe I'll end up reading that interview myself.
MR. JAFFE: Right.
THE COURT: I just want to know what his opinions are, based on that information or something else.
MR. JAFFE: Yeah, I'm not sure -- I mean, I'll object

to the relevance of his opining on the --

MS. BROWNE: The question is withdrawn.

Thank you, Your Honor.

BY MS. BROWNE:

Q So now I would like to turn to paragraph 14 of the Accusation, which describes the recommendation. So it's your understanding that the Respondent wrote a recommendation for the child for medical marijuana; is that correct?

A Yes.

Q And did you ever, by the way, find any letter -- such a letter in the medical records?

A I don't recall. I presume there was one, but I don't recall reading it.

Q And if there were one, is that something that should be maintained in the medical records -- a copy of it?

A You mean if a physician recommends medical marijuana in that time which requires a letter, should it be in the medical records?

Q Correct.

A I presume so, yes.

Q Okay. So the Accusation talks about "There is evidence of adverse effects of marijuana on the age group -- a 4-year-old just about to turn five."

Is that accurate?

A No. I think the adverse evidence -- the strongest quality of adverse evidence is with adolescents because nobody's ever studied kids smoking -- or using marijuana/cannabis, to my knowledge, systematically. I think it's been used for specific things -- you know, specific medical conditions, but not for the treatment of psychiatric disorders.

Q Okay. So --

A So the evidence comes from the big studies. Like the big prospective studies, like the Dunedin Study from New Zealand, are mainly on adolescents.

Q Okay. And did you reference any such study in your expert opinion report?

A I did.

Q Okay. And then did you have an opportunity to subsequently review -- subsequently review any other expert opinions pertaining to this case?

A Pertaining to the Dunedin Study?

THE COURT: No. Pertaining to this particular case.

BY MS. BROWNE:

Q This Accusation -- proceeding regarding Dr. Eidelman.

A Oh. Did I read the other experts' reports?

Q Yes. And, specifically, did you read two other

experts' reports, including Dr. Scherger and Dr. Hergenrather?

A I did.

Q Okay. And were you provided those recently?

A Yes.

Q And were you requested to opine on that to -- did I talk with you about that?

A Yes.

Q Okay. And did you -- did you thereafter -- or what was your critique? Let's take a look at Exhibit 33. What was your critique, if any, of -- pardon me. That would be Exhibit 34.

THE COURT: 34 is -- let's back up.

Did you write any further reports after reviewing the reports generated by the Respondent's experts.

THE WITNESS: Not a formal report.

THE COURT: Okay. You reviewed their reports?

THE WITNESS: I did.

THE COURT: Okay. So 34 is the report generated by Dr. Scherger.

THE WITNESS: That was not the one I wrote about. I wrote about Dr. Hergenrather's report -- or discussed it.

MS. BROWNE: Okay.

THE COURT: That's 36, I believe.

MS. BROWNE: Thanks.
THE WITNESS: Actually, I don't believe --
MR. JAFFE: It could be your copy has the CV too.
THE COURT: Here. Let me show you 36, sir.
THE WITNESS: Thank you.
MR. JAFFE: It's a problem we addressed yesterday.
THE COURT: There's even a little "36" scribbled on the first page. Does that look familiar to you?
THE WITNESS: It does.
So there was one particular part that I thought was quite interesting. Okay. Here we go. Should I read the relevant part?
THE COURT: Hold on. What page are you on?
THE WITNESS: Page 5.
BY MS. BROWNE:
Q And where on the page -- at the top or bottom?
A The top of the first paragraph -- the top paragraph.
Q Okay.
A "After over 35 years of my practice" -- well, you know, let's go -- "Furthermore, the assertions of harm of cannabis that are promulgated by the National Institute on Drug Abuse, NIDA, are focused on abuse rather than therapeutic opportunities."
MR. JAFFE: I'm sorry. Where are you reading from?

Page 5?

THE WITNESS: Page 5, first paragraph.

MR. JAFFE: First full paragraph?

THE WITNESS: First full paragraph.

MR. JAFFE: Okay. Thank you.

THE WITNESS: "In many cases the assertions of harm are not supported by the evidence. For example, Nora Volkow, M.D., a naturalized American psychiatrist and director of NIDA, often quotes a surmised neurotoxic effect of cannabis on the developing brain that permanently lowers IQ. The Dunedin Study that she is referring to, also referred to in the review by John C. Raiss, M.D., was reviewed at the University of Oxford to find that these conclusions are premature in light of likely confounding from socioeconomic status, Rogelberg [sic], 2012."

Q And did you have an occasion to look for an article by Rogelberg?

A Well, it turns out that his name is Rogeberg -- there's no "L" -- and it turns out he's a Norwegian economist, whose report was reviewed and edited by an Oxford psychiatrist, Leslie Iverson. But, yes, I found that report and read it.

Q Okay. And if you could look at the exhibit list.

A If I might just give it a tiny bit of context.

Q Please. Thank you.

A So it's hard to get fine, well-done, long-term studies. They're expensive, and they take decades to run. Many studies are often short-term.

Now, when you're studying something like marijuana, you can't do a double-blind -- well, in 2012, you couldn't do a double-blind, placebo-controlled trial, especially in a young age group, because of the perception that that would be unethical due to the possibility of harm. So what you can do instead is do what's called a long-term prospective study.

So the Dunedin Study in New Zealand, which was run by Duke, was a birth cohort of about a thousand kids who were born in New Zealand in 1979, who were followed for 40-odd years. They measured their neuropsych status about age 13 and tested them again around age 40. And basically what they found was that people who smoked marijuana heavily daily had neuropsychological deficits that didn't improve with abstinence, and they estimated there was an average IQ drop of six to eight points. So this was adolescents.

Now, what Dr. Rogeberg said was, "Well, that could have been based on socioeconomic status." That is, you took poor kids, you took them out of the jungle, you

put them in school, their IQs went up. After school, they drifted back to their tribal homes, and their IQs went down. And he gives sample graphs, based on showing, you know, if this was the case, this is what it would look like.

I then researched the literature and found that there was a reply to that by Terrie Moffitt at Duke, who was involved in the Dunedin Study, saying, That's all very well, but what the actual data shows is several things. One, regardless of the socioeconomic status, IQ stayed stable throughout. It wasn't like the SES kids went up and then went down. They were stable for whether low, middle or high -- their IQs stayed stable over the years.

Secondly, the marijuana users did not primarily come from the low SES group. And it was related to -- the drop in IQ points was specifically related to daily marijuana use over years, dropping the IQ and causing neuropsych benefits -- I mean, neuropsych deficits.

Q And is that -- the reply article that you're talking about, is that Exhibit 44?

A Yes.

Q Okay. And the article to which that is a reply -- which exhibit, if one of these, is that?

A I'm not sure if it's in here.

Q Okay.
A It's cited -- it would be under Exhibit 44. I'm sorry. I'm wrong. It's Exhibit 43 that's the Rogeberg article.
Q So that's the main article that you were talking about a few minutes ago?
A No. The main article was Exhibit 42 --
THE COURT: The New Zealand study.
THE WITNESS: -- which was reviewed in that same issue by James Swanson. Because this was sort of a big deal study. And then the Rogeberg article said "Maybe it's wrong. Maybe it's just based on their SES."
BY MS. BROWNE:
Q Rogeberg is 43?
A Yes.
THE COURT: SES being "socioeconomic status."
THE WITNESS: I'm sorry?
THE COURT: You said "based on their SES." That's an acronym for socioeconomic status?
THE WITNESS: Yes.
BY MS. BROWNE:
Q So we've got -- 42 was the main article, and then 43 followed. And then 44 was the reply that you referenced?
A Yes.

Q Okay. Thank you. I just wanted to put the exhibits in there for context -- or for the record, actually, for later.

A This article was published, you know, about a month or two before T.T. was seen. And, in my opinion, it would cause pause -- or should have caused pause in the idea of putting a young child on regular, daily cannabis, or at least one would have wanted to inform the father that there's a possibility that this might impair his neuropsychological status and drop his IQ.

THE COURT: His IQ is supposed to be stable absent some intervening incident or insult; right? I mean, I've had that testimony. Does that make sense to you? So if I fall off my bike and hurt my head, it's probably going to cause me to lose some IQ score.

THE WITNESS: If there's an injury.

THE COURT: And otherwise?

THE WITNESS: Otherwise it usually stays stable. And I think that's what they're implying in the original article -- that this is a trauma or has a negative toxic effect when started when they're young.

There was a subsequent article from UpToDate in April of 2018, which --

BY MS. BROWNE:

Q Do we have that here?

MR. JAFFE: 39.

THE WITNESS: -- stated -- not based on long-term studies but relatively short-term studies -- arguing that actually there doesn't -- if you take -- even if they start in adolescence, if you take them off of the marijuana for a while, there's initially a mild to moderate decrement in their performance. If you take them off the marijuana, that decreases.

THE COURT: The rate decreases?

THE WITNESS: Their ability to improve closer to their baseline. The problem is if you're using marijuana as a mood stabilizer, you can't really take somebody off for days or weeks because then they're going to destabilize. So it has to be used continuously, so I'm not sure that helps that much. I mean, I think common use would argue, anybody who's smoked marijuana, it makes cognitive work difficult to do, especially arduous.

BY MS. BROWNE:

Q Okay. Well, so that's about the 2018 article. But you're saying the standard of care was -- with regard to one to provide medicinal marijuana recommendation at the time in question -- at the date of the visit, in September of 2012, was your opinion based on the standard of care at that time?

A Yes.

Q And if we turn to the Report of Investigation at Exhibit 14, it seems to suggest -- so Exhibit 14, at page 10, the investigator documented receiving your expert report in September of 2017 and then e-mailing you for a clarification. And then at the bottom of that page, it says "Dr. Raiss provided the following."

Do you see where that is?

A Yes.

Q And is that accurate? Did you -- because we don't have a separate exhibit that says that -- you know, where you signed this. But is this accurate -- what it states that you stated?

A Yes. I mean, the other main -- so the first concern from the Dunedin Study was the drop in the IQ points and the neuropsych damage.

The other big concern is that there can be an increased risk of psychosis in youngsters who take cannabis. And so there was a 2007 Lancet review of increased risk of young people who take cannabis.

Q Okay. So were you asked or -- if you recall, were you asked by the investigator whether or not the standard of care that you described in your written report would be the same or different whether -- in September of 2012 versus when you wrote your report? Do you understand what I'm asking?

A The standard of care with respect to efficacy of cannabis or harmful effects of cannabis?

Q With respect to anything in your written report.

A I mean, there's new data that have come out since then.

THE COURT: But what about in 2012?

THE WITNESS: At that time, this didn't exist. So the notion would be that this could be harmful in two main respects: dropping IQ and increasing the risk of psychosis -- and I believe mood disorder as well.

BY MS. BROWNE:

Q So looking at the Report of Investigation at page 11, it has -- so it has what appears to be a quote from you after the investigator asked you for clarification. And so it's indented from page 10, about a third of the way up from the bottom, and then -- suggesting that that's a quote of what you wrote or maybe sent her an e-mail saying.

A On which paragraph?

Q So on page 10, where it says "On October 10th, 2017, I e-mailed Dr. Raiss requesting clarification of his report. Dr. Raiss provided the following."

Is it your understanding that that is what you wrote?

A Yes.

Q I mean -- okay. So you can verify for us that that is -- what is quoted there, as your writing, is what you wrote?

A It is.

Q Okay. And at the -- on the next page, halfway down, it says -- you wrote "In summary, there is no difference in the standard of care from 2012 to the present. Instead, additional evidence has accumulated to support the notion that cannabis is harmful to children's cognitive and emotional development."

A That's accurate.

Q Okay. Is there any other way in which you believe the standard of care was violated by the medicinal marijuana recommendation that Dr. Eidelman provided to patient T.T.?

A Well, so there were sort of three basic ideas: the failure to do an adequate diagnostic write-up, failure to discuss the potential harm of cannabis, and also failure to discuss the treatments that were available that had a considerable evidence base behind them for efficacy in treating either ADHD or bipolar disorder.

Q Okay. And what you're saying is, even assuming that, if there were an accurate diagnosis of ADHD or bipolar, there's still -- in addition, there's the

problem you just talked about?

A Yeah. I mean, like if I was contemplating discussing this with a parent or something, you would say to them, "Look. I think your kid has ADHD/bipolar, and the standard treatment for it is this and this and this, and they're documented by double-blind, placebo-controlled, random-based trials, which is the highest level of evidence. You know, and they seem to have considerable efficacy; they also have these side effects. The evidence for the positive effects of cannabis is limited to case reports and often is adjunct, rather than the primary care. And case reports are usually thought to be the lowest level of evidence -- sort of the lowest randomized controlled trials." So, I mean, you need to say that to them.

Q Okay. And in reviewing the subject interview transcript and listening to the audio of the subject interview, did you believe that there was any demonstration that Dr. Eidelman lacked knowledge -- had a knowledge deficit in his care and treatment of the patient?

A Yes.

Q Please describe.

A Well, he didn't seem to be aware that there were any, I mean, adverse effects to cannabis treatment. He

didn't seem to be aware of the diagnostic criteria for bipolar disorder. He didn't seem to be aware of the evidence for efficacy of the standard treatments, which I've -- I mean, as I was -- prior to our meeting today, I reviewed, you know, placebo -- randomized double-blind, placebo-controlled trials prior to 2012 for the second-generation antipsychotics in bipolar disorder. There's 10 of them for about four or five different medicines.

I mean, he was saying, "Either no medications have efficacy or they have terrible side effects." It's true that all medications have side effects, including cannabis. But there was a huge evidence base that was sort of ignored.

I mean, marijuana or cannabis is viewed as a panacea that works for everything without side effects, and common sense tells us that everything has side effects.

MS. BROWNE: One moment, please.

BY MS. BROWNE:

Q Just in summary, are there -- in looking and listening to the subject interview, reading the subject interview transcript, and reviewing the documents that you were provided in this matter, is there any other comment you would like to make about -- or opinion that

you have with regard to the care that was provided by Dr. Eidelman to the patient?

A Well, I mean, it strikes me that there's a difference in the stance of the typical physician to a patient, which is to try and do as thorough a diagnostic work-up as time permits, to come to a working diagnosis, to start treatment, to have the humility to realize that treatment is uncertain, and to schedule a follow-up visit to see how things are going. Because is the medicine working? Do there need to be adjustments in dose, et cetera? Is it not working? Should it be switched?

Here, the purpose seems to be more to affix a diagnostic label, get a letter, and come back in a year.

And rather than -- I mean, one interesting thing about this case was that the patient, according to the reports of the father -- again, it might be suspect -- said that in the first week or so, there was a tremendous response to the cannabis. That he was doing -- according to the father, he was doing better than anyone in the class.

And then problems with the duration of the marijuana. And they asked, "Well, bring a midday dose," which led to the -- when the midday dose turned out to be a cookie, the school went ballistic and apparently everything was dropped.

Now that was a promising, interesting finding, which, if further studied, would be quite interesting. And if Respondent had met with the father and said, "Look. You can't bring cannabis to school. The school's going to go ballistic. But why don't we use a longer-acting formulation in the morning or try to dose it -- try to do some variations in dose to try to make it last through the day, and let's see if the benefits persist."

Because with patients in general and mood disorders in particular, often you'll see initial efficacy, and the drug will poop out. This happens with antidepressants and bipolar all the time. You know, the question is: Was he onto something? Or was this just a temporary lull, and then the drug lost its efficacy? That's unclear. But that would have been a promising thing to follow up on and to report on perhaps.

Q Okay. And it looks like the next appointment, after that main appointment that we're talking about here today, wasn't until -- actually, to the day -- a year later. But prior to then, there are two telephone discussions on Exhibit 22, page 4?

A Yes.

Q And do those -- do those help show that Respondent was following up on the recommendation?

A Well, for the telephone conversation of September 20th, there would be no real follow-up necessary for that one. Things are going great.

For October 12th, big problem. I mean, you know, the symptoms were recurring in the afternoon; the duration of action is insufficient. So that would have been a time -- if one really, you know, thought "Gee, the cannabis was helping. We just need to get it to last longer -- to try to inquire, "How can we make it last longer without giving him a midday dose?"

I mean, if one believes that cannabis is helpful or potentially helpful, and there seems to be evidence of that, one would wonder "Is this for real or is this just a temporary thing?" Or "Is this something we could improve just by needing a longer-acting medicine?"

Much the way that short-acting stimulants will last for four hours, you know, you have to take another dose midday, whereas long-acting lasts all day, could something similar have been discovered with the cannabis?

The problem is it seems like the dad wasn't really so much coming for a doctor-patient relationship, where there's going to be ongoing treatment and follow-up. It's just, "Give me the letter, and I'll see you in a year." And certainly the dad should have brought him back, or perhaps Respondent could have asked

the father to bring him back and said, "Look. Maybe there's a way we can work this out."

Q And what you're talking about now is presuming that the --

A Assuming efficacy.

Q Assuming efficacy, but is that also presuming that the efficacy is toward treatment toward an actual disorder or an actual diagnosis?

A Assuming there's some disorder that's being -- you know, it's called a school behavior problem --

Q Right.

A -- that is being helped by this treatment.

Q Right. Were you provided a copy of any of the -- well, we can see in the letter that describes what attachments and property were sent to you, and in your report where you describe the same. But it appears that you were not sent any of the documents pertaining to the Respondent's disciplinary history; is that correct?

A I was sent them recently.

Q You were sent them more recently?

A But not at the time of the report.

Q So did you review them more recently?

A I did.

Q And did you find anything -- or did you notice any patterns or find anything --

MR. JAFFE: I'm going to object to that. I don't see how --

THE COURT: Yeah. I'm going to sustain the objection.

MS. BROWNE: Okay.

BY MS. BROWNE:

Q So as you reviewed paragraphs 13 and 14 of the Accusation, you agree with those assessments?

MR. JAFFE: I'll let her ask for emphasis, but I think he's already --

THE COURT: We've covered both of those, ma'am.

MS. BROWNE: I have no further questions. Thank you.

THE COURT: Mr. Jaffe.

MR. JAFFE: Yes, sir.

CROSS-EXAMINATION

BY MR. JAFFE:

Q Dr. Raiss, my name is Richard Jaffe. Let me just ask you -- I'm not going to tie you up too long.

First, so the bottom line is you're a board-certified psychiatrist; correct?

A Yes.

Q And all the testimony that you've given here is based on your experience as a board-certified psychiatrist?

A Yes.
Q You're not here to opine on the standard of care, say, of what a family practitioner or general practitioner would do, are you?
A No.
Q Okay. And as I understand your testimony, you do not make -- you don't prescribe or recommend medical marijuana yourself personally, do you, in your practice?
A No. But I document when my patients are taking it and observe the positive and negative effects and the type they're using and the method of ingestion and so on.
Q So you have some familiarity with it, but it is not something that you -- you do not write medical marijuana recommendations; correct?
A Correct. And I believe they're no longer necessary, if I'm correct on the law at the present time.
Q I don't know. Well, that's above my pay grade. There's been this proposition and all, but I'm not sure that's the case for minors. But, you know, I'm not an expert on that. And I guess the point is neither are you in terms of -- let me ask something. Do you consider yourself an expert as to what the law requires to write these medical marijuana recommendations?
A You mean previously, before -- around 2012?
Q Sure. Sure. Yeah, forget about the fact that,

by this new proposition, supposedly recreational use is okay.

A I've reviewed those. I think they're somewhere in here. And my quick summary of it is that basically they're saying to the physician, "You need to consider marijuana just like it's any other medication. You need to document what you're treating. You need to consider what are the benefits of marijuana, what are the adverse effects, and what are the alternative treatments. And you need to discuss that with the patient."

Q Okay. And that's your -- all right. That's your understanding of what's required under the law. And by the --

A There are many other points, but I think those are the heart of it.

Q And, by the way, a couple of things on your expert report. You know, on page 14 of your report -- what exhibit is that? -- 24?

Let me just read something.

THE COURT: Hold on a second.

No, it's not 24. It's 30.

MR. JAFFE: 30?

BY MR. JAFFE:

Q So what -- is the reason you don't recommend marijuana -- just to ask you flat out -- is because you

don't think there's sufficient evidence? You're an evidence-based medicine guy -- right? -- a psychiatrist/pharmacologist. And you only use things that are evidence based with sufficient scientific studies; right? That's essentially your practice?

MS. BROWNE: Objection. Assumes facts not in evidence.

THE COURT: Well, I'll allow him to answer it.

THE WITNESS: Yeah. I mean, for example, in, I think, February of this year, there was an article -- I believe it was in the American Journal of Psychology -- documenting the use of CBD as an adjunct in treating schizophrenic patients who are maintained on their medications, and CBD was used as an adjunct.

THE COURT: CBD?

MR. JAFFE: Cannabinoid oil -- CBD oil.

THE WITNESS: So, in other words, that's the part of the marijuana plant that's not the hallucinogenic part, but an extract without hallucinogenic properties. That was found, when combined with the standard antipsychotic drugs for the patient, to be of benefit.

BY MR. JAFFE:

Q So that's evidence based -- that would be evidence based, in your opinion?

A Correct. And, I mean, I have a patient with --

well, let's leave it.

Q Right. But still, the point is, the only thing you're going to use -- recommend to a patient is something that's evidence based?

A I try.

Q Okay. And that's really -- and the conclusion of your report on page 18, I want to quote, "To prescribe marijuana" -- well, first, you understand that marijuana can't be prescribed? That was just a -- do you understand that?

A To write a letter.

Q Okay. I understand. I make that mistake all the time.

But "To prescribe marijuana as a treatment for bipolar disorder/ADHD, without first trying standard treatments, both psychological and psychopharmacological, is an extreme departure from the standard of care."

So the bottom line is, at least one of the things you find wrong is that the marijuana recommendation was the first-line treatment rather than trying something else first; right?

A Yeah. My understanding of the regulations were that you don't have to exhaustively try every single one, but it implied that you want to try one or two and see how they work out before you go there -- before you go to

cannabis.

Q Okay. So your understanding of the regs -- and that's good to know because maybe they're unclear; maybe they're clear. Your understanding of the regs is that it can't be a first-line treatment -- essentially, is what you're saying? I think I'm just paraphrasing what you just said.

A You know, I would probable hedge that and say that if you want to make it a first-line treatment, you have to explicitly document to the patient, "Here's the evidence. Here's the treatments with far more evidence base that I would like for you to consider" and document their understanding and refusal of that.

Q How about if the patient -- or, in this case, the father, just doesn't want to take Ritalin, for example -- or whatever the drug would be. Because, for whatever reason, he's against it -- he had a bad reaction. Are you allowed to accommodate the patient or the family?

A You'd probably want to, one, interview the school and see what's going on. Is there some nonmedication way you can treat this? Get the mom involved, since she has a 50 percent stake in what happens to the kid, and see what her view is. And prior to -- and also really consider the harms. You see, the

harms here weren't mentioned -- the potential for giving a five-year-old cannabis and that that could, if we believe the Dunedin Study, damage their brain.

Q Well, okay. Let's talk a little bit about that. First, you mention this Exhibit 39 -- you talk about this Exhibit 39, which we just took a look at. Here's what I can't figure out. I'm not -- I'm barely -- I can't even say I'm literate at this stuff. But this Exhibit 39, "Association of Cannabis with Cognitive Thinking in Adolescents and Young Adults" -- well, actually, the first thing I want to ask you, when they do these studies, are the people using cannabis using medical cannabis pursuant to a doctor's recommendation and being followed by the doctor, or are they basically just people who smoke dope?

A So in this study you're referencing, the JAMA Psychiatry one from April, that's a meta-analysis of many, many, many studies. And I would assume that it's not prescribed -- or a medical letter of marijuana; that this is marijuana use in the course of their adolescent lives.

Q Right. And isn't that really the problem with all of the studies that show harm or no harm for marijuana -- is that the marijuana group, they're people who are basically marijuana users -- right?

A Correct.

Q And isn't it also true that people that use marijuana typically are more likely to use other negative drugs, like alcohol or even more stronger drugs; right? I mean, who's to say they're only using marijuana?

A Well, there's statistical ways to remove the effects of the alcohol. For example, there was a recent article published by an English group -- a prospective follow-up that was published in 2018, saying that marijuana use -- and they parsed out the other things: depression, psychosis, and alcohol -- was associated with an increased risk of hypomania and bipolar by about a factor of two. So that can be -- in the individual study you can assess that. It can be statistically removed so you can see -- you can try to focus on "Well, what is the cannabis doing by itself?"

Q In this meta-study in 2018, again, I think -- I mean, the judge is going to enjoy reading this, but let me just read you the conclusion on the first page and see if I got this right. "Conclusion and relevance" -- I'm reading from the first page of 39 -- "Associations between cannabis use and cognitive functioning in cross-sectional studies of adolescents and young adults are small and may be of questionable clinical importance for most individuals"; right?

Am I missing something, or is this saying that there's really not much of a difference, even an association or a causal, between people that use marijuana and cognitive functioning? I mean, isn't that what they're saying in this meta-analysis -- there's not much of a clinical importance -- difference the crucial word in the sentence you quoted is "cross-sectional." So we're taking a slice of adolescents at a certain point in time.

Let's look at pages 7 and 8 -- sorry -- pages 7 of 11 and 8. So near the bottom of the page, about halfway down, the last paragraph.

Q What page is this -- 7?

THE COURT: 7 of 11.

THE WITNESS: Yeah. And in the journal it's 591. Beginning with the line: "Furthermore, our data do not address associations between cannabis use and cognitive function over longer periods. Although, some included studies did examine chronic cannabis users and outcomes after prospective abstinence. Consideration of effects from longitudinal studies offers conflicting evidence regarding long-term trajectories and cognitive function in cannabis users, especially after abstinence. Strong evidence for cognitive dysfunction associated with adolescent onset, long-term, frequent cannabis use, comes

from a longitudinal study of the Dunedin cohort, showing that individuals with adolescent-onset, daily cannabis use, who continued heavy use throughout adulthood, showed declines in IQ and poor cognitive functioning at age 38 years, even after adjusting from multiple relevant areas.

However, the sample size of this specific subgroup was small, which raises questions about generalized ability. Further, other longitudinal studies argue against the strength of persistence of deficits over shorter periods, especially in studies where abstinence was carefully monitored."

BY MR. JAFFE:

Q So explain it. So what does that mean? I mean, what do you think that means? There's one study -- does it mean there's one study that shows some deficit -- this Dunedin Study?

A The single best study, where they followed them out 40 years, shows that, "Whoa, they're losing IQ points when you follow them long term." Now, this is not just adolescent use, but this is daily use into adult life.

So this -- and the 64-dollar question is, "Yeah, but what if you started at age four or five?" We know that when the fetus is exposed to alcohol, there's more damage done than when you or I have a glass of wine with our dinner.

So, you know, this makes it look risky long term. And the thing we don't know/we don't have any data about is, "But what if you use it as a medicine and you give it to a five-year-old? What's that going to do?" There's no data.

Q There's no data. All right.

But, actually, what you're saying -- none of what you're saying is accepted by the NIH, is it? I mean, you're taking this article, this study, and that study, but that's not really the NIH's position about any of this stuff, is it?

A How do you see NIH's position?

Q Okay. Let me ask you another question.

MS. BROWNE: Objection. Vague. We'll just put that on the record.

THE COURT: Well, he's going to try another question.

MR. JAFFE: I'm going to try another question.

BY MR. JAFFE:

Q You're familiar with the National Institute of Drug Abuse?

A Yes.

Q Okay. And I'm not going to ask you what it is, but they have something to do with studying drugs and its long-term effect?

A Administered by Nora Volkow, "a naturalized

American citizen," to quote from your other expert.

Q Touché.

A Implying perhaps she's suspect because she naturalized, and she's not a genuine American citizen.

Q Right. Right. Let me --

THE COURT: Or maybe she's naturalized because she practices natural medicine.

THE WITNESS: In which case, she should be a supporter.

THE COURT: Okay.

BY MR. JAFFE:

Q Let me just read you something. And tell -- let me just first ask whether you agree or disagree. There's an article from the National Institute of Drug Abuse: "What are marijuana's long-term effects on the brain?" Here's the statement, and tell me if you agree, "The ability to draw definitive conclusions about marijuana's long-term impact on the human brain from past studies is often limited by the fact that study participants use multiple substances, and there is often limited data about the participants' health or mental functioning prior to the study."

And then it goes "Over the next decade, National Institute of Health is funding brain/cognitive development, ABCD Study, a major longitudinal study that

will track a large sample of young Americans from late childhood, before first use of drugs, to early adulthood." They're going to use neuroimaging.

Do you agree with the basic idea that you can't draw definitive conclusions because of the fact the participants use multiple substances, and often there is limited data about the participants' health and mental functioning prior to the study?

MS. BROWNE: Objection. Vague as to context.

THE COURT: No. Overruled.

MR. JAFFE: You know what, may I approach and just hand him this?

THE COURT: Sure.

MR. JAFFE: Just for context, can he just take a look at the whole document?

THE COURT: Sure.

MS. BROWNE: I don't know -- is there a document in evidence?

MR. JAFFE: Well, it's not in evidence yet.

THE COURT: Hang on a second.

Are you familiar with this document before this afternoon?

THE WITNESS: No. But it looks pretty simple. It looks like it's from the NIDA website -- what's their view of marijuana.

THE COURT: And the NIDA -- that organization -- who is that?

THE WITNESS: The National Institute on Drug Abuse.

MR. JAFFE: And that's a subpart of the National Institute of Health, a federal government agency for the NIH.

THE COURT: So my friend would say about somebody, "Hey, he's a citizen." Meaning, he's a stand-up.

This is a recognized organization; right?

THE WITNESS: Very much so.

THE COURT: Fox Mulder's not chasing him around; right?

THE WITNESS: Who's not chasing him?

THE COURT: Fox Mulder, The X-Files. He's not chasing him around; right?

THE WITNESS: Not to my knowledge.

THE COURT: Okay.

BY MR. JAFFE:

Q So, anyway, it seems to me that NIDA -- now that I have this new acronym -- is saying that you can't really know -- you know, there's some -- it sounds like what they're saying is there's some defects in the -- you can't really reach a conclusion because there are confounding variables with the arm that's the marijuana users because, I mean, let's be clear -- they're drug

addicts. You're studying drug addicts and trying to make conclusions about one of the drugs that they may be using. Isn't that really the issue?

A Not necessarily drug addicts. Because, as I mentioned, there's a range of use. And there's, I mean, people who have a glass of wine with dinner -- well, I guess what they're saying here is you can't be definitively sure.

And also another factor is every human is different to how they respond to medications or to marijuana. So there's probably some people who can smoke and not be harmed and others who will be. And that has to be determined on a case-by-case basis.

THE COURT: But isn't this really just saying, based on the current studies, it's difficult to draw too much from them? -- if I understood the quote correctly. So we need more studies, and that's why they're going to fund another study; right?

THE WITNESS: Yeah. There's a paragraph above here -- let's see -- where they're referencing the Dunedin. Yeah. I mean, so they're saying, "We don't really fully know."

But, nonetheless, I mean, you can imagine that if on the west side of Los Angeles, if one were to suggest to a parent that they prescribe cannabis to their

child at the age of five, there would be -- I think the general -- most people -- a large proportion of the people, when spoke to, would be extremely alarmed and go, "What?"

BY MR. JAFFE:

Q Okay. I mean, that's your opinion. I mean, I respect it.

Now, let me ask you this. Here's another thing from NIDA, and the title of this one is: "Is there a link between marijuana use and psychiatric disorders?"

And here's what they say "Research using longitudinal data from the National Epidemiologic Survey on Alcohol and Related Conditions examined associations between marijuana use, mood, and anxiety disorders and substance use disorder."

And here's the punch line: "After adjusting for various confounding factors, no association between marijuana use and mood and anxiety disorders was found. The only significant associations were increased risk of alcohol-use disorders, nicotine dependence, marijuana-use disorders and other drug disorders."

I'll give you this too.

A Do you know the date that you got that?

Q This is, like, in February of this year. This is current.

A There was a study that came out later than that arguing differently -- the big prospective one from England that I mentioned. You know, in a way, this -- I mean, our discussion here mirrors, sort of, what's going on with psychiatry diagnostically. Are diagnoses categorical, yes or no, or are they dimensional, where you have some of this and some of this and some of this?

And, similarly, responses to a medication -- one can't say definitively it will do this for every single patient. It's a bowl about probabilities. So you wonder, "Well, what percent of people are going to do well on a given med or poorly?"

Q Right. And actually --

THE COURT: Look what oxycodone has done for everybody; right?

MR. JAFFE: Oh, God.

THE COURT: Well, hang on a second.

Right? Because it will kill some pain, but it can have some side effects, like addiction; right?

THE WITNESS: And it was helped by the FDA saying that it's a long-acting drug, so it will be safer and less habit forming than a short-acting drug. It was helped by the Purdue Pharma contributors, hosting doctors and funding their prescription, and by pill mills where doctors would dispense it and Xanax bars for $250 a

visit.

THE COURT: They're a part of my business too -- and the pharmacies.

THE WITNESS: And the pharmacies.

BY MR. JAFFE:

Q Right. And, actually, that's consistent with what you testified before, which is -- I thought that was, you know, an apropos quote. You don't really know what the drug is going to do or what the side effects are going to be. You give it and then see what happens; right?

A And you educate the patient, like, "If I give you Lamictal, you could get this terrible rash -- this Stevens-Johnson syndrome." "If I give you olanzapine, you could gain a lot of weight and become diabetic." "If I give you marijuana, it could increase the risk of psychotic symptoms down the road. It could dull your cognitive capacity and, you know, cause you to lose IQ points. These are the risks."

Q Well, but the problem with the IQ points is, you know, I mean, as these two quotes indicate, I mean, you can't really draw those conclusions. You don't even know because -- you know, isn't one of the problems that they don't really study marijuana in most of these studies? It's all about drug abuse; it's NIDA. It's not the

National Institute of Health on evaluating effective treatments for bipolar disorder. I mean, from my understanding, there's not many studies like that -- right? -- that evaluate medical marijuana in the context of a therapy for medical conditions?

A That's the beauty of the prospective cohort studies, and they study everybody. They take a sample of everybody who was born in 1979, and they follow them. And then they ask questions like, "So compared to the people who did X, how did they turn out compared to the people who didn't?"

Q Right. Right.

THE COURT: Hang on a second.

So in that study they could also be looking for other things; right?

THE WITNESS: Yeah. They say if they did X --

THE COURT: Cardiac problems.

THE WITNESS: -- so take out the effects of Y and Z -- yeah, they've done articles on pulmonary function in cannabis users, and so on.

BY MR. JAFFE:

Q Right. But to the best of your knowledge, they haven't really done any studies in terms of evaluating the therapeutic effectiveness of medical marijuana, certainly not in bipolar or other psychiatric conditions;

right?

A That's just beginning to be explored. I mean, as with the hallucinogens and with ketamine -- I mean, that's a whole new interesting area that not -- you know, quite a bit has been learned about ketamine, some about the hallucinogens, probably relatively less about marijuana. But hopefully the research will increase so we can find out what's good about it and what's bad about it.

Q Right. And until that research is there, I mean, either you're a doctor like you, who doesn't prescribe it or recommend it because it's not evidence based, or --

A Well, let me give you an example. So I have one patient who says, "Look. When I take -- when I vape cannabis of a specific type" -- I forget quite what the mix is -- half indica and half sativa -- "When I take four or five puffs at night, it relaxes me, it allows me to sleep better, and I can reduce my dose use of Seroquel."

Q So you told him to keep doing it; right?

A No. I made a note of it, and I said, "This sounds reasonable. It seems to be making you better." Plus, his overall course and trajectory was going well. This is a very bright, insightful patient. That sounded

like reasonable -- what he was doing.

I have other people who say, "I smoke all day long. I'm not getting anywhere with my life. I'm not doing anything." That doesn't sound helpful.

Q Right. But at least in that one case, the comment you made -- you're not that bold. But -- you weren't going to write in your notes "Continue doing it," but you were just going to record it because you --

A If the patient finds it of benefit -- and, you know, here he's doing it very careful, treating it like a medication, dosing it appropriately, and noticing observable benefits.

Q Right. But you weren't going to make that recommendation in you -- you weren't going to actually say, "Patient continued to do it on my doctor's recommendation"?

A No. I'd just say, "That sounds reasonable."

Q Right. Okay. I have a question. You're familiar -- you've seen the Del Amo hospital records for the patient for the admission?

A Yes.

Q He was eventually -- I mean, I think he was evaluated initially, I assume by the ER docs, with disruptive mood dysregulation disorder. That's the kind of thing -- that's what you were talking about before?

A Yeah. That was, you know, that chronically irritable thing that was sort of carved out of what was previously called bipolar NOS.

Q Right. And do you have any beef or dispute with that diagnosis for this kid? Do you think that would be a better diagnosis, which was only created in 2013? Can you opine on that? Does your gut tell you that that's probably a better -- more reasonable diagnosis?

A Maybe. It's not very well documented either. I mean, you know, you don't have the data in there and the criteria you need, in terms of duration or so on.

So it's another rough-and-ready, typical three-day-hospital-stay diagnosis.

Q So let me ask you about that because I think that's important. I think that's important. So you've looked at this record. And when you were testifying about all that's got to be in the medical records -- I'm looking at this Del Amo record, which is Exhibit -- what? -- 32? And I'm thinking "Man, none of what he's saying here is in there."

I mean, that's kind of what you're saying -- is you don't find the record of this hospital admission adequate to support the diagnosis of dysfunctional mood -- whatever; right? I mean, you have some criticism of this diagnosis too; right?

MS. BROWNE: Objection.

THE COURT: Hang on a second.

I don't think he has said that. If you want to ask him if he does --

MR. JAFFE: I'm sorry? He hasn't said that?

THE COURT: He hasn't said it yet.

MR. JAFFE: Let's back up. I'll ask the question, and then you can object.

BY MR. JAFFE:

Q Do you think that Exhibit 32, which is the record of the involuntary hospitalization for this patient, which finds a diagnosis of disruptive mood dysregulation disorder -- does that meet the standards that you articulated during your testimony about what it takes in terms of the diagnostic process and the recording of the information? Does that meet the standard that you articulated?

A It's better. If we read the reason for admission in the initial psychiatric eval, it states "The patient has been acting out for months with younger siblings, punching them, intimidating younger siblings, defiant, raging, and refusing to go to bed.

According to the social worker, patient attempted to smother his younger 4-year-old brother during a monitored visit this week and told his

grandmother that he wanted to hurt himself. Patient presents very angry and refuses to speak to me at first. Patient wants to run away from home and into the street.

In speaking with the patient today, patient is hostile, labile, impulsive, agitated, unpredictable at this point in time, and gets aggressive. Denies any frank suicidal ideation, but according to the grandmother, he is very out of control. He denies any psychosis. There's quite a bit of mood lability, impulsivity, agitation, and unpredictability. He requires much redirection on the unit. He impulsively wants to strike out at others."

And regarding the family history, drug use runs on both sides of the family, especially the parents. So this is better. There's far more detail in here. I mean, you know, it's not a research-unit level, but there's considerable detail in there.

Q Right. It seems to me -- I mean, tell me if I'm wrong here -- but it seems to me, all of this information is being given by one source, which is the grandmother -- only one source.

A And the doctor who is interviewing the patient and hearing what the patient has to say.

Q Well, but he's interviewing the patient, and he's talking to the grandmother. I mean, there's no

second --

A And observing the patient's behavior on the unit.

Q Well, that's -- Dr. Eidelman observed the patient and talked to the father.

This ER doctor talked to the patient and talked to the grandmother; right? And you seem to suggest that what he had to do was talk to the other parent, who has a 50 percent stake in. But I guess what I'm pointing out is, it doesn't seem like this doctor felt the need to contact the other parent -- or either of the parents. This is the grandmother.

MS. BROWNE: Objection. Misstates the testimony.

MR. JAFFE: I think the record will reflect that this witness said that --

THE COURT: He's starting to argue with the witness, is the problem.

MR. JAFFE: Okay. I understand.

I'll withdraw that and ask another question.

BY MR. JAFFE:

Q All right. In any event, is there any indication in this record that the doctor spoke to a family member, other than the grandparent -- grandmother?

A No. Not that can I see.

Q Okay. That's fine.

A In general, with psychiatric data, it's the more the merrier. More is better. I mean --

Q And is it fair to say that if L.T. came to you with T. -- and we can use their names and the court reporter is going to take out the names, so you don't have to worry about -- and if you did whatever standard treatment or evaluation -- you did, say, an hour -- would he have left with a prescription for anything? Or would you simply say that, "You know, there's no rush, and we've got to do this follow-up."

Do you think you would have prescribed anything for him in this first visit?

A I think, given the context of this particular case, I would have said, "Before we do anything, let me talk to the school and see what they have to say and try to get some understanding of what's going on here."

Q And if L.T. says, "Look. He's not going back to school until you do it," you would just say, "I need to talk to the school"?

A I would say, "Well, let's call them right now then."

Q Okay. All right. That's -- give me a minute.

Do you understand why there was no -- you've read a lot of the records in the case; right?

A Yes.

Q You understand what happened in this case; right? That the sheriff's department was called, Child Protective Services was called, and they got a temporary order of custody -- removal?

A So that he was removed from the home?

Q Well, that was the order and then the parents -- the mother fled to Alabama with the kids. You understand that's why --

A Yes.

Q -- there was no --

A So there could be no follow-up.

Q Right. You remember that from the records; right?

A Yes.

Q Okay. Thank you.

A Could I say, the scientifically interesting question would be: How much did they actually use marijuana in the intervening years with him -- and I know the record says that they didn't -- and what effect did it have?

Q Maybe we're going to find that out Thursday. I don't know. We have Mr. T. coming to testify.

A There was a quote from the hospital record --

Q That he wasn't on it.

THE COURT: There's a quote from grandmother saying,

"At one point he took marijuana, and it seemed to help."

MR. JAFFE: Right. That was the reference -- that short period of time.

THE COURT: But at that time, grandmother is claiming that she and grandfather have full custody --

MR. JAFFE: Right.

THE COURT: -- not the father, not the mother, not DCFS. That's here on page 7.

MR. JAFFE: Right. And that's, in effect, what happened. Because, as we pointed out, the case was terminated in '14.

THE COURT: Well, you know, a lot of that backstory is not really relevant. It's a practical matter because it's not going to help me to decide what's going to happen here.

MR. JAFFE: Right. I understand.

Thank you very much for your testimony, Dr. Raiss.

THE COURT: Dr. Raiss, maybe Ms. Browne has a couple more questions.

REDIRECT EXAMINATION

BY MS. BROWNE:

Q Is there a difference between what happens at a -- when there's an involuntary hospitalization of a

child patient versus what happens at an initial appointment with a physician, such as yourself?

A Yes. I mean, for an involuntary hospitalization, the child would first have to be evaluated probably -- presumably outside of the facility to have been brought there. So there would have been a 5150, a 72-hour hold written, which would contain data. There would also be nurses' notes and other data that one could reference, and laboratory studies and an evaluation. So it's a very different process.

Q Okay. And in asking you what would you have done, are some of these questions -- some of these hypothetical questions hard to answer because you wouldn't have even gotten there in the first place? If I understand your testimony correctly, there was no basis for an ADHD and/or bipolar diagnosis, so --

A Well, let's say I called the school, and they said, "Yeah, something has to be done. He goes ballistic. He disrupts the classroom. He hit kids or the teachers. He has to be calmed down, or else he's going to be sent out to another school."

If you were facing that scenario, what I would say is, "Look. The way to go here is with a second-generation antipsychotic."

If the dad said, "Forget it. I want you to

prescribe medical marijuana," I don't think I could, in good conscience, do that, knowing what I know.

Q You couldn't in good conscience do what?

A Prescribe medical marijuana, in this instance, if I had ascertained that there is a huge, let's call it, anger management, irritability, DMDD kind of problem.

Q Okay. So could you prescribe anything? I mean, does that -- do you -- without a diagnosis -- isn't part of the problem here that, what is in our Accusation, paragraph 13, that we first talked about, which is, you know, the inadequate determination of what was the problem, whether it's --

A But I'm assuming you've done additional work, you've talked to the school, you've found there is a big anger management problem. He disrupts the classroom. He's assaultive, aggressive. "We can't manage him here. If you don't do something to get this kid under control, he can't come back to school. He's going to have to go elsewhere."

Q Okay. So just to be clear for the judge, who is going to be deciding this, you're assuming a lot. Like, you're making a lot of assumptions by some of your answers to the hypothetical questions?

A Yes, many assumptions. But then the question is, "Okay. So what are you going to do about it?"

And I think I would say to the dad, "Look. I can show you 10 randomized double-blind, placebo-controlled studies for the atypicals that argue they will rapidly -- there's a high probability that they will rapidly and efficiently assist you in this situation."

And if he said, "No. Forget it. I don't want to do that. I want to do cannabis," I think I would say, "I just don't feel like I can do that in good conscience. I think the evidence for efficacy is too weak, and the evidence for harm is too strong to give that to a five-year-old kid. So I wouldn't be comfortable with doing that in my practice. I'm sure there are many doctors who will do that for you, but I don't -- not from me."

Q And there have been questions asked about "What would you do," and that's -- that's interesting. But, I mean, the point here --

THE COURT: What is the community of practitioners going to do?

MS. BROWNE: Yes.

BY MS. BROWNE:

Q Of course, what the judge is going to be looking at is what is the standard of care and was there a violation or not. The standard of care is not what you

would do, not to be mean.

A One thing I would like to say to patients is "Look. If we had a hundred psychiatrists observing us in some 19th century amphitheater, commenting on what we were doing, what would they think about this?"

And if I said, "Okay, guys. Here's the choices: Try a second-generation drug" -- you'd probably get 95, 98, 99 percent saying, "Yes, obviously"; and "Try cannabis," I think you'd be lucky to get one as your first-line thing.

Q But that wouldn't even be a scenario, if I understand right, because of what you said about the harm and the nonefficacy; right?

A Those would be included -- I mean, "Given all the information, what are you going to do? Here's your choices: Prescribe a second-generation drug, prescribe Depakote; prescribe behavioral or management" -- actually, it probably wouldn't be 98 or 99.

Probably some people would say, "Why don't you do behavioral stuff first, before you prescribe any medication. Maybe he needs to go to a different school. Maybe it's a poor fit with the teacher. Don't be too quick to prescribe. Try to gain more information and figure out what's going on here."

Q Okay. And is that the same concept with --

yeah, with any medication? Recommending medical marijuana or like you said --

A Yeah. Because it's so risky, and you never know how things are going to turn out. It could be -- you could hit a home run ball deep into center field, or you could strike out. So you never know what's going to happen.

Q Okay. And to your knowledge, was the patient -- prior to the appointment in question, was the patient ever taken somewhere else, and that somewhere else recommended medication?

A Not to my knowledge.

Q There wasn't any evidence that you saw that that even happened?

A You mean, that he was taken to another practitioner who recommended that he be prescribed certain medications?

Q Correct.

THE COURT: Or gave the diagnoses?

THE WITNESS: Not that I recall, unless I missed something.

MR. JAFFE: You didn't.

BY MS. BROWNE:

Q Is it really fair to draw any conclusions from medical records so many years later? We were looking at

the Del Amo medical records, which are in -- well, December, just on the eve of 2017, whereas what this case pertains to is September of 2012. Is it even helpful for the judge to consider?

A I think so because, I mean, like I say, the more data, the better. And what this suggests to me is that the Respondent's diagnosis, even though it was quick and dirty and insufficiently documented and investigated -- probably if you called it -- instead of bipolar disorder -- bipolar NOS, which is what they called DMDD back in 2012, may have been on the money, given what's reported subsequently in the Del Amo records.

Q Okay. So you're inferring though. But just to be clear so Your Honor doesn't get the wrong impression --

THE COURT: No, I think I understand.

BY MS. BROWNE:

Q Okay. All right. And there is also an issue of cause and effect. I mean, we don't know any of the intervening circumstances that led to this New Year's Eve situation. There are lots of possibilities.

A That's true.

Q Okay. So your understanding with regard to recommending medical marijuana is that -- is kind of that it's like any other medicine, and it needs to be treated

as such?

A With the problem that, because of its legal status, it's actually unlike FDA-approved meds, in that it's been inadequately investigated. So the studies haven't been done to find out when it's used as a -- with some exceptions, like -- but not for psychiatric conditions -- can be used for nausea with chemotherapy, and so on. But it hasn't been adequately investigated -- to know, you know, what's good about it and what's bad about it -- in the way that other medications are investigated. So that's just starting to be done right now.

THE COURT: Despite its continued federal status as Class 1.

THE WITNESS: Is that right?

THE COURT: Well, if you continue to be classified by the feds, it's Class 1.

THE WITNESS: I believe so.

MR. JAFFE: No medical use.

THE WITNESS: That means it's like heroin or LSD, which, of course, now you're seeing articles about those appearing in the literature.

THE COURT: I didn't see that damage anybody in my younger days.

MR. JAFFE: So you've been told.

THE COURT: No, I've seen it. I grew up with a guy that had too much "L." He was done before I was in college.

THE WITNESS: I think hallucinogens definitely have the potential to open one's eyes to things. Cannabis, however, with regular use, I think for some people, can interfere with academic performance.

THE COURT: You all need to understand, I base the evidence on my experience and training. I know enough to know that what I know can be dangerous, so I'll be sparing with that.

BY MS. BROWNE:

Q Was it your understanding that the parent had provided the child patient in this case marijuana prior to obtaining the recommendation from Respondent?

A I'm not sure that's clear.

Q Okay.

A He had certainly given it to the older brother, and I'm not sure if he had given the child a test dose or not. I don't remember whether that was documented or not. Probably not because that would have been, sort of, evidence, like, "I gave him a test dose and he went to school that day and the teacher said he was amazing. He was great." If that would have been done prospectively, that would have been useful to know.

MS. BROWNE: We have no more questions.

MR. JAFFE: Just a couple.

Do you have any questions, Judge?

THE COURT: Yeah. Doctor, that DSM-IV TR, when you go to the bipolar section, there's two bipolars. There's I and there's II. Can you tell what one Dr. Eidelman thought -- which one they had here?

THE WITNESS: I would say, based on the data, neither because they both require episodes. I mean, they're episodic disorders. You need to have a manic episode for I or a hypomanic episode for II. The duration criteria: seven days for I; four days for II. No evidence that was met.

Usually kid-bipolar is more -- much tougher to diagnose because it's more like every day up and down, every day with big time irritability often. So I don't -- I would imagine he would have probably called it bipolar NOS if he wanted to be more specific.

THE COURT: And the differential diagnosis, you're saying, would be more difficult in a child; right?

THE WITNESS: Definitely.

THE COURT: And for bipolar I, the DSM-IV teaches that the average onset is 20 years of age; right?

THE WITNESS: Yes.

THE COURT: So this early onset is problematic.

THE WITNESS: I think the map, somewhere in my report -- I think three out of a thousand kids would have onset before the age of six. So very, very low probability of that.

THE COURT: ADHD -- you can often respond to that with behavioral interventions; right?

THE WITNESS: That's what's recommended for kids under six, rather than meds, to start with.

THE COURT: And in theory, if this child's in a public school, they might need to provide that as special education; right?

THE WITNESS: You'd probably have to pull their teeth to do an IEP -- to get them to do it, but, yeah.

THE COURT: And so the notion that "We're going to kick your kid out of school," if it's public school, is problematic if the kid has a disability that is interfering with his access to his education -- right? -- in your experience.

THE WITNESS: Yes. I mean, I suppose they'd move him to -- they might move him to a Special Ed class or to a different school, maybe. But you would think there would be some sort of due process within the school system before that took effect.

THE COURT: Yeah, I'd think so too, since I've done some Special Education hearings in my time.

And can you really diagnose ADHD without talking to the schools?

THE WITNESS: I don't -- well, I don't think so, especially not at this age. I mean, maybe if they're a teenager, and you could look at a bunch of school report cards and read the teachers' comments, hear about the course.

THE COURT: And what about comorbidity of ADHD and bipolar?

THE WITNESS: They're huge. I mean, bipolar, anxiety disorders, substance disorders, ADHD -- there's many, many comorbid diagnoses.

THE COURT: So putting those two together in and of itself doesn't jump out at you as a problem?

THE WITNESS: I think -- not really, no. I mean, they're quite common. I mean, but again --

THE COURT: But ADHD is comorbid with a lot of things.

THE WITNESS: True.

THE COURT: Autism.

THE WITNESS: Yep.

THE COURT: All of these other things you just mentioned.

THE WITNESS: Which, actually, that would be another thing on the diagnosis. I mean, is there some sort of

spectrum disorder going on?

I mean, it's complex. Especially when you see a little kid early on, it really -- you just don't know, and you're never going to make a definitive diagnosis, even if you spend an hour, an hour and a half with him.

THE COURT: Well, as a practical matter, if you suspected autism, you would want to get a specialist involved; right?

THE WITNESS: Psych testing, yeah. There doesn't seem to be much evidence of that, from what I see.

THE COURT: No, it's not looking familiar to me there either, but I've only held a couple hundred eligibility hearings for resource centers, so I've got an idea of what it looks like.

THE WITNESS: Similar treatment for disruptive behavior disorder and autistic kids.

THE COURT: Well, it's back to behavioral.

So if we don't know what all the negative -- or if it's not pinned down if there are negative repercussions for medical marijuana, especially in children, is there anything out there in the science, if you will, that supports its use?

THE WITNESS: There's case reports in adults -- I detailed some of those in my reports, something by Lester Grinspoon, who was a Harvard psychiatrist, wrote in the

late '70s or '80s -- in some patients who had bipolar who didn't respond well to their meds, where he used it as an adjunctive to their meds.

You know, the problem is its legal status inhibits doing the kind of research studies that are strong.

THE COURT: And then the problem is it would be -- isn't that a species of anecdotal evidence?

THE WITNESS: Exactly.

THE COURT: So Cary Grant said LSD helped him feel better, so is that proof?

THE WITNESS: About the same level of microdosing work on hallucinogen data. You hear patients come in and say, "When I microdose this, it's helped me write a really good screenplay after years of struggling," and so on and forth so.

THE COURT: And then you've got to worry about like that scene from Woodstock where the guy's on the stage telling people, "Look out for the brown acid. It's bad."

THE WITNESS: That's another issue, is purity -- what's in it, you know, breaking down the components.

THE COURT: A problem being faced by the newly established industry as we speak.

Anything else for this witness?

MS. BROWNE: One question, Your Honor.

THE COURT: Yes.

FURTHER REDIRECT EXAMINATION

BY MS. BROWNE:

Q I had forgotten to ask this before. Respondent's counsel had asked you about the standard of care -- applying it with regard to being a psychiatrist, as you are, and said -- then stated, if I recall, something similar to, "That wouldn't apply to just a regular family practitioner." And I believe your answer was, "Yes." So I just want to clarify.

A That's an important point because, I mean, if you reference a busy family practitioner who sees -- or internist who sees patients quickly, that's one thing. But this is a consultant on medical marijuana. A specialist who is charging 250 bucks, which, you know, is more than, say, a managed care company will pay for a psychiatric diagnostic evaluation of an hour.

So I think consultants are expected to do detailed reports. And it's sort of like a different -- like if you're going to see a specialist in endocrinology or rheumatology or whatever, you'd expect a big report and a write-up for you and some time spent.

So I think the fair comparison would be -- rather than with a busy family practitioner or internist

or pediatrician would be, "Well, what about a subspecialist consultant?" You know, that would be really what this is.

Q So with regard to your understanding of the standard of care, were you -- when you made your determination that is written in your report, were you taking into account the specific type of practice that Respondent has?

A Yes, I think so. I mean, it would be a different matter, yes, if he was a pediatrician seeing a follow-up patient every 20 minutes.

MR. JAFFE: I'm going to object to that in terms of foundation. I mean, this witness is a psychiatrist. I mean, I think he's an expert in psychiatry, but he's never given a medical marijuana recommendation. So I'm not sure he can --

THE COURT: He's licensed by the State of California to do everything from fix my toenail to drill in my head. He maybe shouldn't do that; that would get into some standard of care issues. But that physician's and surgeon's certificate is pretty broad. And under the Act, he can write those recommendations if he wants.

I'm going to overrule the objection.

THE WITNESS: It's like if a patient comes to you for a second opinion consultation -- "What do you think?

What should I do?"
BY MS. BROWNE:
Q So the standard -- you're talking about the standard of care that applies -- that you were describing, it applies not just to a psychiatrist; it applies in the situation that was here. Right?
A Yeah. It's the more leisurely approach that a consultation has. For a consultation, you can take more time and think things through -- more so than a busy practitioner who is running and seeing a bunch of patients every hour.
Q But are you saying that you're holding Respondent to a higher standard because he isn't super busy? I just want to make sure.
A No. I would say this is just the basic standard for doing a consult, basically.
Q For doing a consult with regard to a medical marijuana recommendation?
A Which is, you know, a drug like any other. It needs to be taken seriously.
Q Right. And this did involve making mental health diagnoses -- psychiatric diagnoses. So if that were done by a different kind of practitioner, does it still need to meet the same criteria that you outlined for the standard of care?

A Yeah, it's just basic medicine -- diagnostic, evaluation, and then treatment recommendations.

MS. BROWNE: Okay. Thank you.

THE COURT: Anything else over there, Mr. Jaffe?

MR. JAFFE: No, Your Honor.

THE COURT: May this witness be excused, Ms. Browne?

MS. BROWNE: Yes, Your Honor.

THE WITNESS: Thank you, Your Honor.

THE COURT: Okay. 9:00 o'clock tomorrow?

MR. JAFFE: Yes, sir.

THE COURT: All right. We're going to hear from the family people; right?

MR. JAFFE: Correct.

THE COURT: Off the record.

(Proceedings concluded at 4:24 p.m.)

REPORTER'S CERTIFICATION

I, the undersigned, a Certified Shorthand Reporter of the State of California, do hereby certify:

That the foregoing proceedings were taken before me at the time and place herein set forth; that any witnesses in the foregoing proceedings, prior to testifying, were duly sworn; that a record of the proceedings was made by me using machine shorthand, which was thereafter transcribed under my direction; that the foregoing transcript is a true record of the testimony given.

Further, that, if the foregoing pertains to the original transcript of a deposition in a federal case, before completion of the proceedings, review of the transcript [] was [] was not requested.

I further certify I am neither financially interested in the action nor a relative or employee of any attorney or party to this action.

IN WITNESS WHEREOF, I have this date subscribed my name.

Dated: August 23, 2018

Donna St. Clair, CSR No. 14252
Certified Shorthand Reporter
For The State Of California

DONNA ST. CLAIR, CSR NO. 14252

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EXHIBIT C

BEFORE THE MEDICAL BOARD OF CALIFORNIA

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

JOSEPH MONTOYA, ADMINISTRATIVE LAW JUDGE

In the Matter of the Accusation Against:	Case No. 800-2014-010147
WILLIAM S. EIDELMAN, M.D. 1654 N. Cahuenga Blvd. Los Angeles, California 90028	OAH No. 2018030645 Volume II
Physician's and Surgeon's Certificate No. G 32011, Respondent.	CERTIFIED COPY

TRANSCRIPT OF PROCEEDINGS

Los Angeles, California

Thursday, July 12, 2018

Reported by:

DONNA ST. CLAIR
CSR No. 14252

Job No.:
19191OAH

BEFORE THE MEDICAL BOARD OF CALIFORNIA

DEPARTMENT OF CONSUMER AFFAIRS

STATE OF CALIFORNIA

JOSEPH MONTOYA, ADMINISTRATIVE LAW JUDGE

In the Matter of the Accusation Against:	Case No. 800-2014-010147
WILLIAM S. EIDELMAN, M.D.	OAH No. 2018030645
1654 N. Cahuenga Blvd. Los Angeles, California 90028	Volume II
Physician's and Surgeon's Certificate No. G 32011,	
Respondent.	

TRANSCRIPT OF PROCEEDINGS, taken at 320 West 4th Street, Suite 630, Los Angeles, California, commencing at 9:07 a.m. and concluding at 4:25 p.m. on Thursday, July 12, 2018, heard before JOSEPH MONTOYA, Administrative Law Judge, reported by DONNA ST. CLAIR, CSR No. 14252, a Certified Shorthand Reporter in and for the State of California.

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I N D E X

COMPLAINANT'S Witness:	Direct	Cross	Redirect	Recross
Bridget Briggs, M.D.	95	115	144	156
RESPONDENT'S Witnesses:				
L.T.	7	51		
William Eidelman, M.D.	159			

E X H I B I T S

(None)

Los Angeles, California; Thursday, July 12, 2018

9:07 a.m.

THE COURT: Okay. Let's go back on the record in the Eidelman matter. Respondent is present; counsel are present. I'm going to take some witnesses out of order.

Your documents getting away from you there, Mr. Jaffe?

MR. JAFFE: Yes, sir.

THE COURT: All right. Your first witness, sir.

MR. JAFFE: Yes, sir.

Just for the Court's information, I took to heart what you said yesterday. We're only going to call L.T. today, not the grandma or the son.

THE COURT: Okay.

MR. JAFFE: So I suspect we'll have an early morning. And our plan will be we'll break relatively early and then come back for the Board's second expert, if that's all right.

THE COURT: All right.

MR. JAFFE: If possible, if it's okay with each of you, we might start Dr. Eidelman's direct, at least on the general matters. Because tomorrow's going to be a tight day -- a big day. We'll just see how it goes.

THE COURT: All right. Good idea.
MR. JAFFE: Thank you, Your Honor.
We'd like to call L.T. to the stand.
THE COURT: Come on up here, sir.
MR. JAFFE: And, just because it was an issue yesterday, this individual here is not a witness.
THE COURT: All right. Just a member of the John Q. Public?
MR. JAFFE: Yes, sir.
THE COURT: All right. These are open hearings after all.
Sir, would you raise your right hand.

L.T.,
called as a witness and having been first duly sworn by the Court, was examined and testified as follows:

THE WITNESS: I do.
THE COURT: All right. Would you tell us your name and spell it for us.
THE WITNESS: L.T.
THE COURT: Okay. Keep your voice up for the court reporter. These lawyers will get their questions done, and we'll get you out of here as soon as we can.
Counsel.

MR. JAFFE: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. JAFFE:

Q And I'm going to call you L. Do you mind if I call you L.?

A Yeah, that's fine.

Q L., just as a preface, you're the father of T.T., the subject of this investigation; correct?

A Yes.

Q Could you just tell us a little bit about, first of all, just your educational background. Just briefly, what's the last grade of school you went to?

A Probably, like, 11th or 12th.

Q Okay. You're not a high school graduate?

A No.

Q What about your work experience, just generally, so the Court gets an understanding of what you've done in your life.

A I've done subcontracting for installation -- doing construction. I've owned a salvage business -- recycling business. I've also worked in -- had co-ops for medical marijuana for AIDS and cancer patients.

Q Oh, really? And when did you do that?

A It was probably back in, maybe, 2012/2013.

Q Okay. And have you lived most of your life in California?
A Yes.
Q And where else have you lived?
A Tennessee and Georgia.
Q Okay. And I've already --
MR. JAFFE: Your Honor, there's not going to be a HIPAA issue, and his medical history is relevant and I've already inquired about that.
BY MR. JAFFE:
Q So I'm going to ask you some questions about your medical history, and you've already indicated to me you don't mind sharing that with the Court?
A No, I don't care.
Q Thank you.
Have you ever been diagnosed with any kind of mental/behavioral condition?
A Yes, hyperactivity/ADHD.
Q And approximately when were you diagnosed with that?
A Since I was a kid.
Q Like, a young kid?
A Probably -- I don't know, at least eight.
Q Eight.
And you went to see doctors; right?

A Yeah.
Q All right. What, if any, medications were you prescribed to treat your ADHD?
A Pretty much, like, Ritalin, Risperdal. So many drugs I can't remember.
Q Why so many drugs?
A Because none of the drugs really worked, or they had side effects and stuff. I had to do blood tests, everything else.
Q What kind of side effects did you have?
A Either not sleeping, sweats -- like today, still, one of the long-term effects from it, I still get sores in my nose all the time ever since one of the medications they gave me as a teenager.
Q And is it your understanding that that's the side effect of some drug?
A Yeah. Because I didn't start having that trouble until one of the medications they gave me.
Q Right. You say you've been on Risperdal, Ritalin --
A I've been on so many drugs. The only way I can probably pretty much describe it is I was used, pretty much like every other kid that gets psychiatric drugs -- use them as a guinea pig. Something not work, we'll try something else.

Q And from what period of time do you think, to the best of your recollection, did you start using psychoactive drugs? -- I'll just call them. And did there come a time that you stopped using them?

A Probably when I got around, like, 18 -- when I became an adult.

Q All right. And that's when you stopped using them. Why did you stop using them?

A Because they weren't doing no good. I couldn't work on them. I couldn't function on them.

Q Right. And, again, I'm going to ask you a personal question, but you've already indicated that you'll answer it. Did you -- were you a recreational user of marijuana?

A No.

Q When you were a youth, you didn't use marijuana?

A No.

Q Why not?

A I just don't believe in drugs.

Q Well, of course, you were on prescription drugs. By "drugs," do you mean, like, illegal drugs?

A Yeah. I don't like using prescription drugs either, so...

Q Right. So you didn't use marijuana as a kid?

A No.

Q Okay. So you weren't taking any drugs from the time you were 18 to -- how old are you now, sir?

A 38.

Q Okay. So you're 38. So you haven't taken any drugs since the time you were 18. Did there come a time that you thought about getting back on some kind of medication for whatever your medical condition is?

A Yeah. Actually, a friend of mine was trying to convince me about the medical marijuana -- that it was a lot safer to use and everything else.

MR. JAFFE: Judge, just for Beneth's point of view and Your Honor's, we have no more fact witnesses. I don't know who these people are, but they're not -- I don't intend to call them.

THE COURT: Okay.

MS. BROWNE: No expert witness is here either?

MR. JAFFE: Tomorrow.

MS. BROWNE: Right. I mean today.

Okay. Thank you.

MR. JAFFE: Just so you know, this is our only fact witness. Anybody who comes in --

THE COURT: Is not your witness.

MR. JAFFE: -- is not my witness. And there might be members of the public because of some general interest in this.

Okay. So I don't have to say that anymore?

MS. BROWNE: Sure. Thank you.

BY MR. JAFFE:

Q All right. So I think we left off at some -- a friend recommended medical marijuana. Why did they recommend it to you? Were you having some kind of episodes or something?

A I was having trouble sleeping and stuff on it, and then at the same time on it --

Q On what?

A The -- what now?

Q Let's affix a time first. Do you remember approximately when -- what decade -- how old you were that your friend recommended you might try medical marijuana?

A Probably early 30s.

MS. BROWNE: Objection. Assumes facts not in evidence -- that a friend recommended it.

THE COURT: That's what he testified to a couple minutes back.

MS. BROWNE: He did? Okay. Thanks. I missed that.

BY MR. JAFFE:

Q Okay. So your early 30s?

THE COURT: "A friend tried to convince me to use marijuana."

MR. JAFFE: Right.

BY MR. JAFFE:

Q And the time frame was your early 30s?

A Yes.

Q And the reason for that was, you say, because you were having trouble sleeping?

A I was having trouble sleeping, and then also, at the same time, I was getting pushed to check into it -- into the medical marijuana by -- through Family Preservation, which was a program through the Los Angeles County Department of Children and Family Services at the time.

Q I'm sorry? I didn't hear that. You're saying family services --

A Los Angeles County Department of Children and Family Services.

Q You're saying that someone there told you --

A Through Family Preservation.

Q What is Family Preservation?

A It's one of the programs they offer where they have counselors come in your home and try to take care of if you need any resources to help get the case closed and stuff on it.

So they knew I was having trouble sleeping on it and that I had ADHD on it, so they, kind of, recommended

trying to check into that because of new breakthroughs with that.

Q So a friend and CFS suggested medical marijuana. What did you do about that?

A Actually, I got referred to Dr. Eidelman, and I went and talked to Dr. Eidelman about it.

Q And that was, like, what? How long ago was that?

A Probably 18 years ago.

Q Okay. So you went to see Dr. Eidelman, and then you had an office visit with him; right?

A Yes.

Q And at some point did he issue you a medical marijuana recommendation?

A Yes.

Q Okay. And what effect, if any, did it have on the conditions that you've just told the Court about?

A Basically, it helped me sleep at night. It helped me calm down and relax. So I was using it during the day on it, but eventually I got used to where I didn't have to have it. So that was the good thing about the marijuana -- I didn't have to have it all day long.

Q You didn't have to have it all day long?

A Yeah. It helped me control my symptoms on it where I could control them to get off of it. So now I

just use it at night now.

Q What were you doing at that time? Were you working?

A I was running a salvage business.

Q Salvage business?

A Yes.

Q Did you have employees?

A Yes.

Q Did you have a policy about smoking dope at your company?

A Beforehand, yeah. I would actually fire anybody that failed a drug test -- even marijuana.

Q Why is that?

A Just a stigma that everybody has against marijuana. I didn't know nothing about it, and I was always told that it was a drug and it was always bad for you. So that was my insight on it until I had other people start trying to convince me to get into it.

Q Okay. All right. So you get the recommendation. You take it. It seems to have done something to you.

Did there come a time when some other child of yours -- well, can you just tell me, how many kids do you have?

A I have six kids.

Q You have six kids?
A Yes.
Q Okay. Did there come a time when you brought another one of your children to see Dr. Eidelman?
A Yes.
Q And which child was that?
A S.T.
Q All right. And how old was S. at the time you brought him to Dr. Eidelman, just to the best of your recollection, in general?
A Probably -- around 12 probably.
Q Okay. And what was S.'s problems?
A He had bipolar and ADHD.
Q And how do you know he had bipolar and ADHD?
A And -- because he was diagnosed in Georgia, and he gets a disability check from Georgia on it. His mom was taking care of all of that.
Q Oh, so he was formally diagnosed and government-stamped as having this condition; right?
A Yes.
Q All right. And when he was in Georgia, after he was diagnosed, did he take any prescription drugs for his condition?
A Basically, the, kind of, same thing with me on it. Kept trying different medications and using him as a

guinea pig.

Q Right. And what effect -- did you have an opportunity to observe him on these pharmacological agents?

A Yeah. A lot of times he was pretty much like a zombie and all drugged up and couldn't really function or anything.

Q So, in your opinion, as a father, the pharmaceuticals -- were they working or were they not working?

A Not working.

Q Okay. And I gather he's in Georgia, and at some point, he --

A When he was out here on it -- working with me on it, I went and seen him with Eidelman and went over the stuff with Eidelman -- his medical history and everything -- and Eidelman gave him a recommendation to try it.

Q Okay. And this was about when he was 12. How old is he now?

A He's 18.

Q Okay. All right. So what effect, if any, did you observe that the marijuana had with him?

A Pretty much immediately, so...

Q For the good or the bad?

A For good on it.

His mother -- when she gave up custody and let me have him out here on it, we came pretty close on it with the help of Eidelman and working with the medical marijuana. He was just pretty much almost going to be out of special ed.

Q Okay. Let's back up a little bit. Because we don't have that issue on the record yet. So at some point, because of his condition, did he have some kind of educational program?

A He was in special ed.

Q He was in special ed. And that's because of his medical condition?

A Yeah. His behavior and medical conditions.

Q All right. And I think you said you almost had him off on the medical marijuana. How did that happen?

A We almost -- his behavior got better being on it. So pretty much almost through the whole school year on it, he started out from the rock bottom, and we got him where we could take him out of special ed.

Q Are you -- you seem to be implying -- and let me just ask you a couple questions about it because I don't know anything about this. Are there different levels of special ed or something?

A Yeah. You can have the all-day special ed on

there, and then you can start doing mainstreaming to go out into the regular classes and stuff to be with the regular kids.

Q So are you suggesting there was some change in his level of special ed?

A Yeah. We actually got him from all-day special ed on it with all the restrictions and everything else, and, pretty much, we were at the last step to where he was not going to be in special ed.

Q So this is -- these are formal -- and, again, I think the judge knows something about this. I just don't.

They're different gradations, and they're just formal things -- you go, like, different levels. And you got him from some lower level to some higher level; right?

A Back to -- I guess what we can call it is basically normal kids going to regular classes and stuff on it. So if you have behavioral problems or you have learning problems, then it's pretty much -- they'll put you in special ed. But if you get so bad on it, then you're in all-day special ed.

Q Okay. But he never got to "normal." Why is that? What happened?

A His mother took him back to Georgia.

Q Oh, I see. And took him to continue school there?

A Yeah. Took him back there. She had full custody, so...

Q Okay. And they didn't -- in Georgia, was he taking medical marijuana?

A No.

Q What, if any, medications was he taking instead of marijuana?

A They put him back on the same medication and everything.

Q What effect did it have on him?

A While he was back there, he never finished high school.

Q He's never finished high school?

A Never finished. He hasn't finished high school on in and in special ed.

Q Still in special ed?

A Yeah.

Q What level?

A Down at the bottom again.

Q He's down at the bottom again.

A So what control I had, whenever he came out here -- when he showed up on the plane or whatever else with a bag full of pills, I just threw them straight in

the trash and put him back on his medical marijuana.

Q And then what would happen?

A Get him better again on it until he went back to his mother again.

Q All right. Now, let's -- I'm going to turn our attention to T., the subject of this case.

Let me start with -- did there come a time that you became aware that he was having issues in school?

A Yeah.

Q And let me just ask you a general question that may make it easier. Tell us what happened -- first, tell us how it all started -- this whole -- why we're here, why you faced what you've faced -- and we'll get into that. In your own words, just tell us what happened.

A Basically, we put T. in school on it because we already knew there was some behavioral problems out of T. And so --

Q Well, start from the beginning. So he starts --

THE COURT: Hang on a second.

MR. JAFFE: I'm sorry.

THE COURT: You put him in school. Did you put him in a public school?

THE WITNESS: Yes.

THE COURT: How old was he?

THE WITNESS: I believe around five at that time.

THE COURT: You said you knew he had behavioral issues?

THE WITNESS: Yeah, we were having some trouble at home with him and stuff.

THE COURT: Please continue, Counsel.

BY MR. JAFFE:

Q Okay. So what kind of trouble were you having with him at home?

A Having some tantrums, like adjustment disorder. His environment got changed and stuff like that. He just couldn't handle it.

Q Really? But he was home. So you weren't -- you didn't do anything about it?

A We had the time to focus on him and try to handle him.

Q Right. But then, at some point, he starts, I guess, kindergarten?

A Kindergarten at Eagle Ranch.

Q Okay. Public school?

A Public school.

Q Okay. And where is the public school with relation to your house?

A Pretty much, almost, right across the street.

Q Okay. How would T. get to and from school?

A Me or my wife would walk him over to the school.

Q Okay. Were other of your children going to the same school?

A Yes.

Q Which children?

A It would be L.H., Jr., and it would be E., my daughter.

Q Okay. So I gather you or your wife would walk your three kids to the elementary school, and then you would pick them up afterwards -- right? -- or someone would -- you or your wife; right?

A Yes.

Q And that would occur every day?

A Yes.

Q Now, did there come a time when someone from the school raised some issues regarding L.'s [sic] behavior?

A You're talking about T.'s behavior?

Q I'm sorry. T.'s behavior. Thank you.

A Yes.

Q And could you explain it -- first of all, time frames. So he goes to school -- when do you guys start school out here? Like, end of August or something?

A I think it's probably the beginning over there.

Q What -- with respect to -- without asking you a date or so -- with respect to when he started school, when did someone from the school first communicate to you

that there was some problems?

A Pretty much immediately. It was T.'s teacher.

Q T.'s teacher.

And just so we'll set the picture, what are the circumstances for the communication? Where was it? When was it? Who was there? Just tell us how this first communication about --

A Pretty much, because it's kindergarten on it, the kindergarten teacher will walk the kids out to the gate. So it's pretty much we have to pick up our kid there, so we pretty much have communication. And all the kids met right there at the gate.

Q So pretty much from the beginning, outside the school -- all the kids are around there?

A Yeah.

Q Okay. And you said it was the teacher?

A Yes.

Q So, to the best of your recollection -- and this is early on -- to the best of your recollection, what did the teacher -- and your other kids were there when the teacher's talking to you?

A Yes.

Q Right next to him, because you're all kind of bunched together?

A Yeah. Other parents are there.

Q Okay. What did the teacher tell you, to the best of your recollection?

A She was having trouble with T. concentrating, throwing tantrums, disrupting his whole class on there. And it was taking a lot of her time to focus on him, and she couldn't focus on the other kids.

Q Right. And this is early on. Did that happen again early on?

A Probably after, probably, two or three weeks on it, I guess.

Q How many times did she --

A Pretty much it was almost a daily basis.

Q A daily basis she would tell you what?

A About T. acting up in the class, doing something, not doing his homework -- I mean, doing his schoolwork, and stuff like that.

Q And what was your response during all these?

A Well, we knew we had to do something about it.

Q All right. Well, did you tell her -- okay. So this goes on for roughly -- these conversations -- for a period of time?

A Probably at least two to three weeks, probably.

Q Okay. Did there come a time when there was something -- a communication more than just, what I'll call, a complaint, and more than just with your teacher?

And, if so, can you explain that interaction with whomever it was.

First, did there come a time when there was something more that happened?

A Yeah. Probably after two or three weeks on it, then the principal met up with me when I was picking up the kids -- and the teacher.

Q So the principal and the teacher. And still the same thing, where you're all kind of outside, after everyone's there and picking up their kids and all that?

A Yes.

Q Okay. And, to the best of your recollection, take us through this communication because this might be important. So I really want you to focus on it and, you know, figure out and tell us who said what and even, kind of, details.

I mean, there was obviously no court reporter and it was a long time ago, but, to the best of your recollection, give the Court the details of what happened during that conversation.

A I can't remember the exact details, but I do -- we were discussing on it, and the teacher could not handle T. in his class. They were trying to figure out to do something with T.'s behavior and stuff on it. And the principal pretty much gave me -- pretty much, I

needed to either put him in homeschool or go see about getting him medication for his behavior in class.

Q And you say the principal told you that?

A Yes.

Q And you say "pretty much." I mean, what did she say -- or did you have an impression of what would happen if you didn't do either of those?

A No. They only had two options. Either go see him get medication or to put him in homeschool. There was no other options.

Q What about -- did she mention anything about special ed -- some kind of disability or special ed or anything?

A No. Not at that time, no.

Q Let me just say, there's been some skepticism regarding whether a school -- do you have any idea, yourself, whether it's legal for someone in a school to tell you that at the time?

A At the time on it, I wasn't warned about whether it was legal or not. There was a problem with T., so I wasn't looking at it as legal or not. I was more looking at the problem to help my kid out. I wasn't worried about fighting a legal issue on there. I knew there was a problem with T., and something needed to be done about it. And he probably did need medication.

Q Now, at that communication with the principal, were any of your children -- did any of your children overhear it, to the best of your recollection?

A Yeah. It would probably be H. and E., my daughter.

THE COURT: H. is L., Jr., and you call him H.; right?

THE WITNESS: Yes, sir. Sorry.

THE COURT: No, I'm just making sure.

MR. JAFFE: And, actually, we'll make an offer of proof. Again, we could call H., and he would probably confirm it, but he's 14. I take what you said yesterday seriously.

BY MR. JAFFE:

Q So there were other children -- other of your children who, you're testifying, heard what the principal said; right?

A Yes.

Q Okay. And you're sure about this? Could it be that you misunderstood?

A No. Because there was no other -- they gave me no other options. Either homeschool him or take him to a doctor and see about getting medication.

Q And what was your response?

A With past history of me with the medical

marijuana, the past history with S., I kind of -- I didn't really dispute it because I kind of knew he needed some kind of medication on it.

Q Okay. Well, let me ask you this. I wasn't asking the right question.

At the time of that interaction, what was your response to the principal? Did you tell her say -- did you say anything? Did you say you'd think about it? Did you say you'd do it? I mean, what did you tell the principal?

A I told him I was going to go carry him to go get seen for medication on it. Because I believed he did need medication at the time.

Q So you're saying you didn't have a problem with what he was telling you because you agreed with him?

A Yeah. It wasn't like it was a dispute. It was, basically, this is what T. needed.

Q Okay.

A So I wasn't trying to make it a legal issue. I mean, I wasn't worried about that because at the time the issue was T.

Q Okay. You were concerned about your son?

A Yeah. It wasn't a legal issue. I mean, T. needed help.

Q Right. You wanted to get your son help; right?

A Yes.

Q Okay. Well, let me ask you this. How come you didn't take him to a child psychiatrist and get Ritalin or Risperdal?

A Because I didn't want him used as a guinea pig. And if the medical marijuana was working on me and was working on S. great, I'm not screwing up my kid's liver with all these pills that they don't even know what they're doing. Just like Risperdal is coming out now -- you know what I mean? -- after they crammed it down my throat -- gynecomastia. It's all over the TV getting -- I mean, all the bad side effects. It's everywhere.

Q Which you experienced personally?

A Yeah. It's just like, "Oh" -- the doctor sees you, "Here's a pill. Oh, it don't work? Here's another pill."

I wasn't going to put my kids through that. It worked great on S., so we tried it on -- that's why I took him to Dr. Eidelman.

Q So at some point -- let me ask you this. To the best of your recollection, how soon after you had this conversation with the principal did you take him to see Dr. Eidelman?

A Probably within a day.

Q Okay. So you take him to Dr. Eidelman, and --

so approximately just how long do you think you were in his office?

A Probably at least, like, 30 minutes waiting and probably at least 30, 45 minutes in his office.

Q Okay. And to the best of your recollection, can you just tell us a little bit about what -- first, you've had -- I think you testified -- you testified that you had a consultation yourself. And, by the way, I guess you had taken it in 2008 -- you had a couple consultations with Dr. Eidelman? You had seen him a few times; right?

A Yes. And then with S. -- I seen him with S. too.

Q Okay. Do you have any specific recollection about what you talked about? Because I know -- and I apologize, because there's a bunch of meetings or interviews. Do you remember anything about this particular event?

A We compared -- talked about comparing the symptoms with me that T. had similar with me on it, the conditions that kind of matched of with S., so there was a pattern that we discussed on it. And then we discussed -- talked about the school behavior and how T. was doing and everything else.

Q Right. Do you feel that based on your

background with -- experience with drugs, that you had a reasonable understanding about the benefits and risks of basic drugs like Ritalin and Risperdal?

A Yeah, the side effects are horrible.

Q Right. So you didn't feel like you were suffering from any kind of lack of information about conventional drugs, did you?

A No, because I experienced firsthand.

Q Firsthand. All right.

And was this around the time -- you mentioned that you were running this cannabis thing for patients around, you said --

A Around after I got into it, I started growing my own medical marijuana for me, and then I started growing it for S. And then, at the time T. was getting on it, I actually had a medical co-op.

Q You had a medical co-op?

A Yes.

Q So you're not just the typical medical marijuana recommendation recipient. I mean, you were sort of in the business?

A Well, I got out of it -- after I seen the benefits how it was used with me, I started getting around people and seeing the benefits of what it actually was doing and everything else, I started changing my

career and started changing my lifestyle to actually go help people and get them the medication. Because it was hard to get access to medication on it. There's some drugs on it -- you can get marijuana with pesticides and everything else, so it was safer to grow it and get it to the people that actually need it without chemicals or anything else in it.

Q And that became kind of -- I guess what you're saying is that it became --

A It became more of a passion on it, basically -- something that I loved doing to help people out and to get them their marijuana that they needed.

Q Okay. So you had a pretty good understanding of medical marijuana yourself -- right? -- based on your personal experience, experience with S., and in your business?

A Well, it wasn't really a business. I mean, I was feeding my family -- taking care of my family, but I wasn't getting rich or anything. I was putting food on the table.

Q Okay. So you get the medical marijuana recommendation from Dr. Eidelman maybe within a day of the teacher, the principal telling you what they tell you.

And then what happens next? Did you eventually

start providing T. with medical marijuana, and, if so, how?

A I got it -- I actually went to one of the dispensaries right afterwards because I didn't have the right type to give T.

Q What do you mean the "right type"? I don't know that much about it.

A I was going to get him more of a sativa than more of an indica.

Q What is the significance of that?

A The best way to describe it is sativa is more of a daytime on there, and then indica is more of a nighttime.

Q And that's because a daytime doesn't make you as drowsy or something?

A It don't make you as drowsy as much on it, and then I wanted something that was very low in THC.

Q And why was that?

A Because we were mainly going after the CBD -- the lower CBD.

Q Right. We talked about that yesterday -- what that is. So the judge is fully aware of that.

So you were looking at a low THC?

A Yeah. I wasn't looking to get my kid high or stoned or be a druggie.

Q You wanted -- I believe it's called cannabinoids?

A Cannabinoids on it.

Q So you basically looked for some kind of product that was the least, I guess, hallucinogenic and the most -- just the other non-THC cannabinoids?

A Yes.

Q Okay. Did you manage to find such a product?

A Yeah. They actually had a product there that was in the peanut butter form because they were using it for other kids.

Q Oh, really? So you actually bought the medical marijuana in peanut butter form, premade?

A Yeah. It was tested with what was the amount that was in there and everything else.

Q Oh, it was tested?

A Yes.

Q So they actually put on a label, like, what percent of whatever it is?

A Yes.

Q Is this like under 1.5 percent THC?

A I know it's pretty low.

Q Okay. All right. So, anyway, I gather that at some point you gave him this peanut butter medical marijuana for school pretty much, I gather -- for school;

right?

A Yes.

Q Okay. So he goes to school. And every day you're still walking him there and walking him back?

A Yes.

Q Did there come a point where you got feedback as to T.'s behavior after you gave him the peanut butter medical marijuana? And, if so, describe when -- how soon it occurred after you gave him the first dose, and describe the interaction you had -- with whom and what they said.

A It was mainly with his teacher on it, and I had told her that we put him on -- that a doctor put him on medication, to let me know any feedback.

Q Oh, you let her know, like, walking to the school, that you put him on medication?

A Yeah.

Q And you asked her to give you feedback as to how it was going to affect his behavior?

A Yeah. If it's working or if there's any side effects or anything like that.

Q Okay. And at some point did she give you feedback? And let's affix a time, if we can, as to how long after you gave it to him to when she gave you the feedback.

A Probably within a week on there.
Q Okay.
A I mean, she would give me, you know, a little bit every day on it --
Q Okay. Every day -- it sounds like it's a little feedback every day.
THE COURT: Counsel, you've got to stop cutting him off before he's done answering his question.
MR. JAFFE: I apologize. Sorry.
THE COURT: And try not to lead him. This will be more credible if he's testifying.
MR. JAFFE: Okay.
BY MR. JAFFE:
Q Can you describe the initial feedback -- the first time teacher gave you feedback, what did she say?
A It's going to be, basically, on it that he was better in class. And probably about -- after getting feedback that he was doing good on it, probably after not even a week on it, she confronted me on it -- and I do remember this on it -- she actually goes, "I'm surprised the doctor actually got the medication right for the first time on it, and it's actually working." She was actually shocked.
Q Did she explain why she was shocked?
A Because he became the best student pretty much

overnight. In class, he was the best student doing his work, everything else.

Q Did she explain why she was shocked that he got it right?

A Because a lot of other kids that she's dealt with on, doctors are always switching their medications. And I guess she was always having problems with other kids -- putting them on medication and the medication not working, or they have to change it or change the dosage or stuff like that.

Q Okay. So she tells you that he's doing good -- best in the class -- and she's surprised. What other feedback, if any, did you get from her? So that happens. What happens next? Let me ask you this -- withdrawn.

At some point, did you tell the teacher what the drug was?

A Yeah. In that conversation, when she was shocked and everything else with the medication being right, I told her what it was.

Q And what was her response?

A She wasn't too shocked on it. She was more concerned about how people were going to react to it.

Q And did she give you any suggestions or advice?

A She told me to keep it quiet on there -- about me giving it to him -- so people don't freak out about

it. Because people aren't used to the marijuana.

Q Okay. What happened next?

A She did come back to me and told me that it was wearing off around lunchtime.

Q And did she -- what, if any, suggestion did she make to you with respect to that issue?

A Possibly -- to try to hide it, to try to either pick him up at lunchtime or bring it to him -- the peanut butter sandwich to him at lunchtime.

Q Meaning, another dose?

A Another dose, yes.

Q Okay. After you received that advice from the teacher, what, if anything, did you do?

A Actually, went to -- so this was going on for probably about two weeks. So I actually went to the principal with the recommendation from Dr. Eidelman and with T.'s dose for the next day in a peanut butter sandwich form.

Q And what did you tell the principal?

A I told him that T. was a medical marijuana patient on there, and I demanded the school to treat him the same as any other patient that gets medication. I said, "Have the nurse give it to him -- have him come in at lunchtime to have him get his medication."

Q Why didn't you just bring him home at lunch and

give it to him there?

A Because the school is -- I mean, the way I seen it on it, I mean, if a kid can get Risperdal, Vicodin, everything else at school, there's no difference to the medical marijuana. If the nurse is giving it to him on it, it's safe; it's away from the other kids. And that should be the school's job anyways -- to give him the medication -- whatever type it is -- if the doctor is recommending it.

Q What, if any, response did the principal give after you --

A She was going to get back with me about the -- how to get with the school board to see how to handle the situation.

Q Anything else she say as to why?

A They didn't know how to handle it with a kid being with medical marijuana because they never had it before.

Q And what else? Did she indicate to you in any way that there was a problem?

A No. I don't know. She was just going to get with the board to see how to handle the situation.

Q And how did you leave it?

A She was supposed to be getting back with me. So as soon as she figured out how to handle it, she was

supposed to be getting back with me.

Q Okay. And then you obviously don't know initially what -- what happened next from your -- what happened next?

A Pretty much, I guess they made a referral to the Department of Children Services for me giving my kid medical marijuana.

Q And so they made the referral. Then what happened with Children Services?

A They showed up on there. As soon as they showed up on it, I didn't let them talk to my kids on it -- on there. I discussed the issue with them on it, and I just didn't let them talk to my kids on it -- is basically what happened.

Because their mentality of freaking out over the marijuana and everything else on it and threatening to remove them from me, so I just kept my kids hid from them. And I tried to talk to them for over a week or two over the phone with them.

Q And then what happened?

A Pretty much, I hid my kids on it, and then everything got, pretty much, quiet. Pretty much, everything just went away.

Q For what period of time?

A Probably at least over -- probably almost a year

and a half.

Q And the kids are still -- they're still in California?

A They were in California, for the most part, until we put them back in school -- I think it was the next school year. And my wife went back to her family in Alabama.

Q At some point, did your kids move to Alabama?

A Yeah.

Q And could you tell us a little bit about that. I don't want to lead you, but just tell us the circumstances.

A They were in school for probably, I would say, over half of the school year -- maybe three-quarters of the school year.

Q In Alabama?

A In Alabama.

Q Why did they go to Alabama?

A Because of the medical marijuana out here. I just didn't want that to be a problem on it.

Q Can you use medical marijuana in Alabama?

A They do have a program back there for medical marijuana.

Q Oh, they do?

A Yes. The CBD oils.

Q CBD oils?
A Yes.
Q Okay. So what happens next? Was there some kind of criminal prosecution to you?
A I had -- my medical co-op was raided by the San Bernardino County Sheriff's Department.
Q When was that?
A Probably about three years ago, four years.
Q All right. Whatever happened to this -- so you testified -- at some point, did the Child Family Services get some kind of court order or something?
A Since they raided the co-op -- how it got started, since they raided the co-op on it, I immediately had my lawyer call them and demand for all the marijuana back.
Q I'm asking about Child Family Services. Was there some kind of court proceeding with regard to Child Family Services?
A Yeah. Afterwards, yeah.
Q Okay. What was the end result of the court proceeding -- the final, final result?
A Everything was dismissed with prejudice. There was no signs of neglect or abuse by giving my kid medical marijuana.
Q Right. And, actually, you gave -- you have

documentation for that, which I've provided.

But, anyway, your testimony is all the charges were dismissed.

A Yeah. They brought it against me that I failed to adequately provide medical care and proper diagnosis to T.T.

Q Do you have any information about whether or not Dr. Eidelman's recommendation was at issue in that case?

A They brought up -- the way they attacked me wasn't, I guess, to do with the recommendation. It was actually to do with more of the standard of care of Dr. Eidelman prescribing the medical marijuana.

Q They attacked you for what he did -- what Dr. Eidelman did?

A Yeah. The way it is on it -- so they had Dr. Amy Young and a couple of other experts testify that Dr. Eidelman violated the standard of care on there; and, therefore, I neglected my kids for not getting them properly diagnosed.

Q What was the result of --

A It was not founded, and it was dismissed with prejudice.

Q Including that allegation?

A Yes, all the allegations.

MR. JAFFE: All right. And, Judge, for your

information, a lot of this -- the reports are already in evidence.

THE COURT: All right. But whatever happened in that court case isn't binding here.

MR. JAFFE: Correct. Just background information.

BY MR. JAFFE:

Q Okay. Now there's no more Child Protective Services case. Now, as we sit here today, who has legal custody of your children?

A I do.

Q Full custody?

A Full custody.

Q Okay. Other than S.

A S. is in Georgia.

Q But T. -- that would be T., H. --

A E., T., J., S.

MR. JAFFE: Okay. Hold on one second.

BY MR. JAFFE:

Q Let me just ask you, you understand why we're here today, and I thank you for coming here to testify on Dr. Eidelman's behalf.

Just generally, in case I missed anything, is there anything else that you feel that might be relevant to Dr. Eidelman's case that maybe I've missed because of -- you know, I've missed it. Is there anything else

you might want to address?

A I mean, I don't know what this Court is looking for on it -- for standard of care on it, but the level that Eidelman provides his, I guess, customer service on it is better than anybody else you can go to.

Q Right. So you don't have any complaints with the treatment?

A No. If I actually -- even if I don't have symptoms related to, like, the medical marijuana or whatever else, I can call Dr. Eidelman and ask him questions on it.

He's always there if I need to get ahold of him if I have a problem with T.'s behavior or whatever else. And then Eidelman checks up at least once a month -- calls to see how T. is doing and everything else.

Q So how would you characterize Dr. Eidelman, to the extent that it's relevant in this proceeding, in terms of the level of care?

A I think it's going to be hard to find a doctor on it that you can actually -- you know what I mean? -- that you can actually call and get ahold of -- you know what I mean? You don't have to wait for days and weeks for appointments or anything else, and that he actually calls and checks up.

Q Okay. Anything else you might want to tell the

judge? You might be done. I'm just asking in case I forgot something or you have something else to say.

A I think that's about it.

Q Okay. Thank you. So now I'm done, and now Ms. Browne gets to ask you some questions.

MS. BROWNE: Your Honor, would it be possible to take a brief recess?

MR. JAFFE: I have no objection.

THE COURT: Sure. Come back in 10 minutes.

Off the record.

(Recess)

THE COURT: Back on the record.

Before we get into your cross-examination, Ms. Browne, folks here -- any of you with the press?

THE WITNESS: We're all patients.

THE COURT: I reckoned that was probably the case, but I have to ask now. What you all have to understand is that there's a protective order in place to keep confidential the identity of this boy here. We're using names here in the hearing, but the court reporter is under an order, if there's a transcript prepared, to put initials in place. The problem is I can't have you all running around and talking about this boy because, again, we don't want his business in the street.

AUDIENCE MEMBER: Yes, sir.

AUDIENCE MEMBER: Yes, sir.

THE COURT: Ms. Browne, do you have some questions?

MR. JAFFE: Your Honor, if I may -- just one thing. I mentioned this -- the dismissal from the Child and Family Services. Ms. Browne was kind enough to make copies of them.

So I would like to offer them into evidence just, basically, to support what he said -- that all the charges have been dismissed against him.

Ms. Browne was kind enough to make copies.

MS. BROWNE: Let's give the judge this one.

Did you write that (indicating)?

MR. JAFFE: I did.

MS. BROWNE: Oh, okay.

MR. JAFFE: 46.

THE COURT: Are you going to have any objection to this document, ma'am?

MS. BROWNE: No, Your Honor. But we are going to request that it goes under seal.

MR. JAFFE: For sure. Yes. Because it has names. We would concur with that request.

THE COURT: Okay. Ms. Browne.

MS. BROWNE: I'm just going to turn my phone off.

THE COURT: Good plan.

MS. BROWNE: Except for it's turning on.

THE COURT: Your problems with your phone tend to incite my Luddite tendencies. I have an ongoing dispute with a lot of technology.

MS. BROWNE: I don't know what to do. I feel like I should put it outside of the room.

MR. JAFFE: Can you just silence it?

MS. BROWNE: We're not on the record, are we?

THE REPORTER: We are on the record.

MR. JAFFE: No, we don't have to go off the record. Can you just, like, turn it on silent so you don't connect?

THE REPORTER: Would you like me to go off the record while we figure this out?

THE COURT: Yeah, we'll go off the record.

(Pause in the proceedings)

THE COURT: Back on the record.

Ms. Browne raised the issue that she may have to get into some rather private information of the kind that's sometimes covered in juvenile court proceedings, and -- which those proceedings tend to be highly confidential.

And then that jogged my memory that there's a provision of the -- I think it's Welfare and Institutions Code that makes those proceedings confidential. And while I don't have a background in juvenile court

matters, it latches on to us here once in a while, either in proceedings regarding the Department of Social Services -- but more recently, I've got a case pending for the Behavioral Sciences Board, where, to get a transcript of a licensee's testimony in a juvenile court proceeding, the Attorney General's office had to file a petition with the juvenile court because the list of people who can get juvenile court records it not very long, and Joe Montoya's name is not on it.

So what this means, Mr. Jaffe, is 46 here -- I don't even know if I can receive it under seal. I'm going to have to take a look at this after the lunch hour.

MR. JAFFE: Okay. We've offered it. You'll make a ruling based on further research.

THE COURT: And where are you going with this, Ms. Browne, in this issue, before you get your cross under way?

MS. BROWNE: I'm sorry. Your question was?

THE COURT: Well, you've raised a confidentiality issue, and then you're going to have to get into some rather private information.

MS. BROWNE: Right. And I'm not going to be asking about circumstances. I'm going to be asking somewhat indirect questions. But it was highly personal. I don't

know that the witness would want --

THE COURT: Well, you want me to close this part of the proceeding? Is that where you're heading with this?

MS. BROWNE: I think that might be the witness's preference.

THE COURT: Well, he's been willing to be pretty forthcoming here. That being said, I don't know exactly where your exam is going to go.

Folks, I think I'm going to ask you all to leave for a while until we're done with this witness. Down across the hall, you can find our lovely attorney-client waiting room with all the amenities of old magazines to look at. There's a little coffee shop downstairs; you can get a snack or cup of coffee.

MR. JAFFE: By the way, he's our last witness for the morning, so you're kind of free until 1:30.

THE COURT: You can wander around the new, improved Grand Central Market if you like.

MR. JAFFE: Thank you, Judge.

THE COURT: All right, Ms. Browne.

CROSS-EXAMINATION

BY MS. BROWNE:

Q It was stated on direct that --

MS. BROWNE: May I proceed, Your Honor?

THE COURT: You may.
BY MS. BROWNE:
Q It was stated on direct exam that you had been diagnosed with bipolar and ADHD. Are those the two diagnoses you have?
A Mine is going to be ADHD.
Q You were diagnosed with ADHD?
A ADHD and hyperactivity.
Q And any other diagnoses that you know of?
A Not with me, no.
Q Okay.
A Learning disability.
Q Pardon me?
A Just a learning disability.
Q Okay. And do you remember when that was?
A Probably since -- probably around -- my guess, around eight.
Q Okay. Eight years old?
A Yeah.
Q Which is about third grade -- I'm sorry. I'll speak up. Which is about third grade?
(Interruption in the proceedings)
THE COURT: Please continue, ma'am.
BY MS. BROWNE:
Q So about eight years old -- is that about third

grade?

A I guess. It's been, like, 30 years.

Q Yeah. So do you remember the process -- like, how were you diagnosed and by whom?

A I just went and talked to a doctor -- talked to a doctor for a few minutes, and then they prescribed me some pills.

Q And your parents took you to a doctor?

A A doctor, yeah.

Q Okay. And that was when -- you were raised in Los Angeles?

A Los Angles County, yeah. Lancaster.

Q All right. Did the -- do you know if there was, sort of, a similar situation where the school had recommended that you go to a doctor or receive medication?

A I don't recall.

Q Okay. Can you tell us when you started taking any -- when you were prescribed and when you took any medication? -- like how old you were.

A Right around eight years old.

Q Okay. And do you recall the first medication that you were provided?

A No. The only thing I remember over the years that I took the most was Ritalin, Risperdal, and I think

there was lithium. I don't know. There was too many of them to even keep track of. I didn't even know what I was getting when I was kid.

Q Okay. Did you live with your parents?

A Yeah, my parents.

Q And were both of your parents involved or was one of them involved with taking you to get treatment?

A I would probably say -- I know my dad worked a lot, so probably it was mostly -- probably a lot of it was something to do with my mom.

THE COURT: Just stop for one second.

(Interruption in the proceedings)

THE COURT: Have her come in for a moment.

MR. JAFFE: I'm sorry?

THE COURT: Have her come in for a moment.

MR. JAFFE: Come here for a second.

THE COURT: Ma'am --

AUDIENCE MEMBER: Yes, sir.

THE COURT: These are normally public hearings, but an issue got raised here about this man's personal and confidential information, and Ms. Browne might have to get deep into it. So I thought it was best to close the hearing for the rest of the morning.

AUDIENCE MEMBER: Yes, sir.

THE COURT: And there will be another expert witness

this afternoon if you want to come watch that.

AUDIENCE MEMBER: Thank you, sir.

MR. JAFFE: I'm sorry for overreacting.

AUDIENCE MEMBER: No worries.

Thank you, sir.

THE COURT: I figured it would be best if she heard it from me.

MR. JAFFE: Thank you, Judge.

THE COURT: Okay. Why don't we start that question over, Ms. Browne.

BY MS. BROWNE:

Q Okay. So you were diagnosed with ADHD when you were about eight years old, and you were prescribed Ritalin. Was that the first medication?

A I can't recall. The only way that I can describe it was the doctors would treat me -- and what the average medical people do still today is they treat kids like a guinea pig.

I mean, that's basically how many different drugs I've been on. "It don't work? Oh, here's something else." "It don't work? Here's something else. Cram it down his throat."

I mean, that's basically all it is. I mean, that's what my firsthand experience is and that's what I've seen with a lot of doctors. That's all they do in

psychiatrics.

Q So how frequently did you go see a doctor?

A Probably at least -- probably once a month at least. I've been hospitalized several times too.

Q Okay. So beginning when you were about eight, you'd see a doctor about once a month?

A Yeah, roughly.

Q And was it -- do you know, was it a psychiatrist or what kind of physician?

A Not exactly, no.

Q Okay. And then did you ever receive any other diagnosis or any other mental health-type issue?

A I believe not.

Q Just the ADHD?

A Yeah, hyperactivity stuff.

Q Okay. Well, did the doctors -- you were a kid, so did the doctor or your parents share with you this information?

A No.

Q Okay. But at some point you learned that your only diagnosis was ADHD?

A Yeah, as far as I know.

Q Okay. And what were your symptoms of ADHD?

A Just having trouble concentrating, behavioral problems.

Q Okay. So the trouble concentrating -- that began in about third grade or at eight years old?

A I guess, yeah. I can't remember.

Q Okay. So what was school like for you?

A Kicked out of school all the time, kicked out of classes.

Q At what age were you kicked out of school or kicked out of classes?

A Probably since the beginning. Probably, I'm going to guess, around eight. But I can't remember that far back.

THE COURT: Sir, how old are you now?

THE WITNESS: 38.

THE COURT: Please continue, ma'am.

MS. BROWNE: Okay.

BY MS. BROWNE:

Q Do you remember -- approximately how many times were you kicked out of a class, for example?

A Fifty, a hundred.

Q And this began when you were in elementary school?

A Yeah.

Q Okay. And what was the reason given that you were kicked out of class or school?

A Mainly had to do a lot with my behavior -- not

sitting still in class, goofing around, and not doing my work.

Q So the symptoms of not sitting still in class, goofing around, not doing your work -- usually those aren't things that I would think of as getting somebody kicked out of class or school, but that happened fifty to a hundred times?

A Yeah. Behavioral -- you know what I mean? Not doing what I'm supposed to be doing in class. I mean, that's over the course of my -- you know, over my school.

Q Okay. Were you ever violent?

A Not too much on it. I didn't really go get in fights or anything too much.

Q When you say "on it," do you mean while on a medication? Or just while --

A Just in general, I guess.

Q -- in school?

A While I was in school. I didn't go bullying, trying to start fights. It was more of me just trying to sit still in my class, getting into trouble -- basically doing stuff I ain't supposed to be doing.

Q Okay. But were you ever violent toward any other child?

A No.

Q Okay. Did you believe that you had a mental

disorder or ADHD or needed any kind of medication?
A At that time, I mean, I was a kid. So I didn't really know if I needed it or not.
Q Okay.
A I guess rebelling too, so -- I guess.
Q And when you went to the doctor approximately every month, was that all the way through high school?
A When I, kind of, got in high school I didn't go to the doctor as much. I started getting off of them, but they kept putting me on and off.
Q You started getting what?
A They started taking me on and off, so sometimes I wouldn't go because I would run away from home or whatever, and then I wouldn't have the medications and stuff.
Q So sometimes you would be trying a medication, but you'd run away from home, and then would you --
A Yeah, I would stop.
Q You would stop because you didn't have the medication?
A Yeah. And I didn't want it anyways. I didn't like all the side effects. It made me feel like I'm drugged up all the time.
Q Okay. When did you start noticing side effects -- like, feeling like you were being drugged?

A I mean, I had side effects probably from the beginning. I don't know which drug exactly.

Q And so what specifically -- like, what was the side effect? You felt like you were drugged up, so you felt like you --

A Drowsy at times on it. Sometimes sick/throwing up. I used to get sores in my nose all the time on there. I still do today -- whatever medication they gave me when I was younger on it.

Q Sores on top of your nose?

A Inside my nose and stuff.

Q Okay. And how frequently did that happen?

A I still get them today, probably at least -- probably once or once every two months.

Q And what makes you think that that's related to a medication?

A Because I didn't have that problem until I got that one medication that I started having those side effects from. And then they switched me off of that one -- whichever one that was.

Q So you were on a medication, and then it caused a side effect, and then they switched you off of it to something else?

A Yeah.

Q And do you remember when that was?

A Through me growing up.
Q Well, just do you remember when it was that you got the sores in your nose?
A Probably when I was about 10 or 11 -- probably. I'm guessing.
Q Okay. And then how long were you on the medication? How long did you have that happen?
A I think they probably switched it maybe -- I guess maybe about a month, they switched me to something else.
Q But you feel that the continuing problem relates to that medication?
A Yeah.
Q And when did you first start taking -- using marijuana? You said you were how old?
A Probably -- I can't remember when I went to Eidelman. Probably 28, 30 -- probably 10 years ago when I first started seeing Dr. Eidelman.
Q And at that time, were you still having the same symptoms?
A I was having -- basically, the problems that I was having then was having some trouble with my anger, concentrating, having trouble sleeping at night -- I couldn't go to sleep at night.
Q Anything else? Any other symptoms?

A I guess, probably -- I would probably say one of them -- I think it was someone from the Department of Children Services -- to help me relax more -- maybe being more -- getting agitated easy.

Q Okay. So that was recommended to you by the Child and Family Services -- they recommended marijuana?

A Yeah, through the Family Preservation on it. They wrote it up as -- I think it was -- gave me information about newer medications related to bipolar, because that's what they always referred to it as in dependency court. ADHD -- they always refer to it as bipolar for some reason.

Q Your understanding is they're the same thing?

A I know they're two different things, but that's what they always -- that's what they always filed it against me.

Q They filed it against you? Did you feel like they were taking action because you just had a diagnosis?

A That's just how the dependency court is. Like, they get a little bit of information and then they twist it around and they file stuff.

Q Okay. And you said that you -- one symptom was trouble with your anger. How did that manifest itself -- like, what happened?

A Through the marriage and everything else, I

started having domestic violence issues and stuff like that.

Q Okay. And when you say "domestic violence issues," what specifically --

A With my wife.

Q Okay. So what does that mean -- like, what happened specifically?

THE COURT: Let's not get any further into this, Ms. Browne. It starts raising Fifth Amendment problems.

MS. BROWNE: Okay.

BY MS. BROWNE:

Q Was there ever any violence towards any of your kids?

A No.

Q Did any of your kids ever witness you being violent with your wife?

A I think arguing with her, I believe.

Q But any -- what about violence?

A I believe not. I don't think they were present when I hit my wife.

Q Okay. So you talked about the -- so when you started using marijuana, can you tell us how that helped your symptoms?

A Yeah. It pretty much eliminated the domestic violence and me controlling my anger and stuff on it. So

I haven't had a domestic violence issue and a physical altercation on it. Even though I had a lot of trouble and I'm divorced now on it, but there was no physical violence afterwards on there. I get to sleep at night and wake up the next morning and work. I concentrate better, focus better.

Q You had a felony conviction for burglary in another state; is that right?

A Yes. That was when I was 18.

Q Okay. So you were asked by counsel what your employment had been through the years, and I didn't hear -- at that point I didn't hear you mention a co-op or anything to do with marijuana. But when did you start having a business related to marijuana?

MR. JAFFE: Just for the record, I believe there is testimony on that.

THE COURT: There was. But if she missed it trying to keep up with her notes, I'll allow it.

THE WITNESS: I believe it was, like, probably two years after I started using the medical marijuana. I started growing it for myself and growing it for my kid.

BY MS. BROWNE:

Q Okay. And you were -- two years after you started using it. And you started using it when you were...

A I don't recall. I've been on it probably for about 10 years with Dr. Eidelman.

Q Okay. So about eight years ago is when you got involved with the business?

A Roughly, I guess.

Q Okay. And how did you ingest -- or how did you take marijuana?

A I usually smoked it at night and then took edibles for the day.

Q And did your wife join you? I mean, did she use marijuana as well?

A At one point she did. She started using it for other symptoms on there -- for PMS symptoms and back pain and stuff like that whenever she needed it. So she would hardly take it all the time on it.

Q And she started doing that about 10 years ago when you started?

A Probably, roughly. Yeah, I would say so.

Q Okay. And she would take it by smoking it as well?

A Smoking it or edibles.

Q Okay. And did any of your kids -- did they ever see you smoking marijuana?

A Nope.

Q You sound pretty confident.

A No. I'll lose my kids over that. It's already been litigated I don't know how many times on it. And my kids have been intensely investigated on that issue. But the State wants to keep bringing it up in other departments. My kids are no where around it. They don't know anything about marijuana, except for T. knows that it as medication.

Q Okay. And S. also knows it as medication?

A Yeah. Well, I mean, now he knows it was medical marijuana because he's older.

Q Did they know what marijuana was -- that it was illegal -- do you think?

A Well, how I always taught my kids on it -- I always told them it was illegal -- any of the drugs. Because I had a zero tolerance in my house to have that even around my life.

Q Okay. So you mentioned, in general, different departments and that they would try to -- they would get involved if the kids saw --

A Ever since I got T. on them -- ever since that came into light with giving T. the medical marijuana on there, it's been like -- one incident will come up after another on it. It will get twisted for revenge or whatever else. And then there's a malicious prosecution case, one after the other.

Q Okay. But the first time that happened was when T. -- when you gave T. the marijuana?

A With regards to what now? The first CPS case or the --

Q Yes.

A The first one was 10 years ago or longer. That was where I had Family Preservation on it.

Q I'm not familiar with Family Preservation -- with what that is.

A That's part of a program where they have counselors come out through Penny Lane.

Q Is Penny Lane like -- what is Penny Lane?

A It's like counseling. It's one of your government programs.

THE COURT: I think they're a private vendor with services. I've run across them in some regional center cases.

MS. BROWNE: Okay.

BY MS. BROWNE:

Q So let's talk for a minute about S. You first -- you started S. on medical marijuana; right?

A Yes.

Q Okay. And about how old was he?

A I'm going to guess maybe 12.

Q Okay. And did S. have any kind of diagnosis?

A Yeah. ADHD, bipolar.
Q And did you notice that S. had any symptoms?
A What do you mean?
Q Any symptoms of any kind of problem -- of any mental disorder.
A Yeah. S. had a bunch of problems.
Q And when did he have problems?
A Ever since -- I believe, probably since he was around probably five years old.
Q Okay. And what kind of problems did he have starting at five years old?
A I believe behavior issues, not listening, having trouble in school.
Q Did he get kicked out of school ever?
A Yeah. He's been kicked out of school several times in Georgia, not up here with me.
Q And how does that happen? When a child gets kicked -- or when you did or your kids -- when they get kicked out of school, how does that happen?
A It's for the behavior issues. But I didn't have that trouble with S. out here.
Q Okay. And when did S. come out here?
A Probably around when he was 12, I believe -- probably somewhere around there. His mom was going to let me take him for the -- she was having too much

problems back there with him with school and everything else, so she was supposedly going to sign over custody. So I had him for almost a whole year out here.

Q And when was that?

A Back when he was about 12 probably.

Q Okay.

A That's when he started the medical marijuana.

Q Okay. So you had him around the time you started the medical marijuana business -- I mean, you had custody of him?

A I didn't have custody. He was out here. The mother still had custody, but she allowed me to have him for the year because she could not handle him anymore. She was going through a divorce, or whatever she was doing. She couldn't handle him.

Q Okay. And when was it that you and your wife separated?

A We separated like two years -- are you talking about S.'s mom?

Q S.'s mom. Sorry.

A S.'s mom -- we've been separated since he was probably two or three years old.

THE COURT: He's 18 now?

THE WITNESS: 18, yeah.

I'm sorry. I can't remember all these dates.

THE COURT: I understand. I don't want you guessing, but we're entitled to your best estimate. So sometimes that can be, "Well, I know it was around Christmas," or "I know it was after Thanksgiving and before Christmas." That would be the kind of estimate that would be reasonable. Okay?

So when you say, "He was two or three," one of the reasons I ask you how old he is now is so I can do the arithmetic and figure out --

THE WITNESS: I'm trying to take a guess too because I can't remember. There was too many incidents.

THE COURT: I understand. A lot of water under the bridge; right?

BY MS. BROWNE:

Q So from about two to three years old, when you and S.'s mom separated, at that time -- between two and three years old up to twelve years old, where was S.

A With his mom.

Q Okay. And did you see him during that time frame?

A Yeah.

Q How frequently?

A It depends. Sometimes on it I lived out here, so I didn't get to see him for four or five or six months. Or if I was living back there at the time, I got

to see him every other weekend or every week.

Q So when you lived out here, every four or five or six months he would come visit?

A I would say probably -- when he was out there and he was kind of getting older, it would be, like, once a year he would come out for the summer and stuff.

Q When he was getting about what age?

A He started coming out here probably when he was around 12 or whatever.

Q Okay. But between, like, 3 years old and 12 years old, it would be -- between 3 and 12, before he started coming out once a year, about how frequently would you see him?

A If I was living back there at the time on it, then I got to see him almost every week on there.

Q Okay. And when did you live back there?

A I moved around a lot, so it's kind of hard to say. I moved back there, stayed back there a while, and then I would move back here. So I traveled a lot.

Q Did you live anywhere else other than here and --

A I lived in Tennessee. I lived in Virginia. I lived in Alabama, Illinois.

When I was younger I did construction work for the union and stuff, so I traveled. I went after the

money. So I subcontracted a lot. Wherever I could go grab quick, easy money, I would grab the money. That's why I ended up moving around a lot.

Q Okay. And that was during the time frame between when he was about 3 and 12 -- is when you moved around a lot?

A Yeah.

Q Okay. And then how did you -- how often did you talk to his mom about him?

A I mean, I probably talked to her once a week or every two weeks.

Q Okay.

A I mean, we still communicated. Even if I wasn't around or whatever, I still called her or she called me.

Q So you knew that, throughout that time, that S. was having difficulty?

A Yeah.

Q And he -- I'm sorry. I don't want to cover old ground, but he was diagnosed -- he got his diagnosis about what age?

A Around five.

Q And it was -- so it was the doctors back in Georgia --

A Georgia, yeah.

Q -- who prescribed him medication?

A Yes.
Q Okay. And then he had bad side effects?
A Yeah. I don't know all the details of the side effects -- the problems -- you know what I mean? I just know he was constantly switched from one medication to the next just like I was when I was a kid.
Q Okay. And do you know if he ever did well on any of those medications -- improved?
A No.
Q No, you don't know? Or, no, he didn't improve?
A He didn't improve at all. The only time he improved was when he was out here on it. Actually, Georgia don't have medical marijuana. And, actually, I wish they had it back there personally. Because it was actually working out here, and then when he got back there, they had to put him on the medication that wasn't working.
Q Okay. So when he moved out here, he had -- was he in -- well, sorry.
First, back there, was he in special education?
A Yeah. He's always been in special ed.
Q Okay. So in special ed, do you know if he had an IEP plan -- or an IEP or any kind of plan?
A I know they were done, but I wasn't a part of it. The mother was taking care of it.

Q And when he came out here when he was 12, did you get the school records showing any documentation about --

A Yeah. All his records were transferred out here to the school when I enrolled him.

Q Okay. What about his medical records?

A Yeah, I had his medical records.

Q And the medical records -- did they go to the school? Or they went to you?

A I think they went to me.

Q Okay. So you had his medical records at 12 years old when he moved out here. Did you take him to a doctor aside from Dr. Eidelman?

A No.

Q Okay. And how long was he out here?

A I know the one period when he first started -- when we first put him on the medical marijuana, I had him out here for the whole school year.

Q Okay. So how long -- if you remember, how long was he out here before you tried the medical marijuana?

A I pretty much did it almost immediately.

Q Okay. And --

A I knew none of the pills worked on me. None of the pills were doing any good on it. It was kind of helping me with my symptoms on it. It's a lot safer than

all the other drugs goofing up your liver or anything else. I mean, marijuana is natural. It's already in everybody's body.

Q It's in everybody's body?

A Yeah. Whatever the chemical is. I'm not a doctor, but I know it's the chemical that your body produces on it. THC breaks down, so it's naturally -- it's in everybody's body. That's why if you go look at a drug test on it, there's a certain level of scale before you actually become positive because you already have that naturally in your body.

Q Okay. I see.

A However you guys do the stuff on it. So that's the little bit of research I know about it.

Q And when he came out here, was he taking any medication?

A Yeah. A bag full of pills.

Q Do you remember anything more specific about, like --

A Ritalin, Risperdal, lithium. I mean, you should already know this. You're from the Medical Board, and this is how psychiatrists do this every single day.

Q Prescribe a bag of pills?

A Yeah. "Oh, this don't work? Let's try something else."

You guys do this as a daily practice -- doing all manmade drugs and cramming them down kids' throats and adults' and everything else. And you don't even know what you're giving them.

Q Okay. So you try -- what symptoms did he have when he came out here?

A Anger, behavior issues.

Q And when you say anger and behavior issues what --

A Throwing stuff, losing his temper and stuff like that, not sitting still, not concentrating, not sleeping at night.

Q Okay. And when he acted in anger, was there like -- was there any kind of reason that you could see? I mean, was he angry about something in particular, or he would just start out of nowhere?

A Sometimes it would be in particular; sometimes he would just snap like a light switching on -- go into a rage.

Q Okay. And so did you -- when he came out here, did you take him to any other doctor than Dr. Eidelman?

A No. I mean, he's already been to a bunch of doctors. The pills wasn't, obviously, working. The medical marijuana was working on me, with no side effects, and it relieved my symptoms on it.

And I've seen where a lot of kids are taking the medical marijuana, a lot of adults for ADHD. It's over in Israel -- it's in their hospitals all over there -- treating all these symptoms, everything else. So I had him evaluated by Eidelman to get him off the pills, to get him the medical marijuana.

Q Okay. So when you took him to Eidelman, it was to get him on --

A To get him off all those others drugs that was poisoning his body and everything else and see how the medical marijuana would work.

Q And did you take to Dr. Eidelman -- did you take the medical records that you had gotten?

A Yeah.

Q So did Dr. Eidelman review those records?

A Yeah.

Q And did he agree with any of the diagnoses? Or what did he say about the mental disorder?

A I think he agreed with all the diagnoses on it. I just -- he didn't agree with the medication, I don't believe -- with all the different medications on it. None of them were working. And it was pretty much like a guinea pig -- just one after another.

Q Did he refer you to another physician --

A No.

Q -- for S.
A No.
Q Okay. So was he kind of operating as S.'s primary doctor?
A Yeah, I guess so.
Q Did you ever -- after you came out here, did you -- well, he had problems in school, it sounds like?
A Yeah.
Q He was throwing things.
Did the school -- I'm sorry. I keep losing my train of thought.
MR. JAFFE: Could we just affix a time? Is she talking about Georgia, or is she talking about California? I'm not sure.
THE COURT: I think she's asking about California schooling -- or she was starting to.
BY MS. BROWNE:
Q So did Dr. Eidelman ever ask -- like, give you any documents to take to the teachers to ask for -- did Dr. Eidelman ever talk to S.'s teachers?
A No, I don't think he talked to the teachers. Because I brought the records that came from Georgia -- the medical records, the school records. I have all that. Because it's all in the medical records of his behavior and everything. I know the file was huge.

Q Okay. After S. started using the marijuana -- well, first of all, in what form did he use it?

A Edible.

Q Okay. And after he started using it, how did he respond?

A Basically, his behavior improved on it. And, actually, out of that whole school year, until his mom goofed up on it -- I wish he could have stayed out here longer -- at the end of the school year on it, they were talking about pulling him out of special ed altogether and just kind of do mainly -- only on some of the subjects put him in special ed. So, basically, he would be a mainstream student, just pulled out necessarily just for extra resources or whatever else.

Q And do you know -- was he in special ed just because of the emotional/behavioral problems or was there any kind of learning disability?

A I think he also had a learning disability a little bit too.

Q Okay.

A I think the biggest concern was the behavior; that was the biggest problem.

Q Okay. So did he -- his behavior changed. So was he not angry anymore?

A No. Pretty much after he was on it, I pretty

much had hardly no behavioral issues out of him on there.

Q He just got pretty mellow?

A Yeah. He was mellowed out. He was doing his schoolwork on it. I mean, you could tell what it was doing. I mean, one year in school on it, and they're trying to pull him out of special ed.

Q Okay.

A I mean, that's the results that it was. It's just, unfortunately, I didn't have custody of him to keep him out here and get him all the way through school because of the mother on it, unfortunately.

Q And did he stop losing his temper?

A Yeah, up here. But when he went back, everything went back down the toilet again.

Q And was the school aware that he was taking the marijuana?

A No, I don't think so. Because they never requested it at lunchtime or anything else, so I was giving it in the morning and in the evening.

Q Okay. But they knew he was on some kind of medication?

A Yeah. Because of his records and everything else. It never got brought up with the school about that issue because they never asked for it -- to have it at lunchtime or anything else. He was already in special

ed, was already on all the medication. So it was never an issue to be discussed if he needed medication or not medication.

Q So when he started school, did you have a meeting with his school to talk about the --

A To put him in the classes and special ed because they were transferring everything out here.

Q So they made a plan?

A Well, they have to follow the IEP that was already done back there.

Q Oh, okay.

A So no matter if you're transferring schools, all the IEPs -- all the schools across the country have to recognize all the IEPs.

Q Okay. Got it. And after that one year, how did S. do?

A They were going to pull him out of special ed. The next year, he was going to be out of special ed.

Q But he ended up going back to Georgia?

A Georgia, yeah.

THE COURT: Okay. I've got this part figured out, folks.

MS. BROWNE: Okay.

BY MS. BROWNE:

Q S is doing well now?

A Since he's 18 now on it, he's actually doing better. I mean, he's in Georgia on it. He's still using the marijuana illegally. But, I mean, he started on the marijuana after he turned 18 on it, so now he's starting to get his life together. He's trying to get back into school and stuff.

He's using it illegally against the law back there. And now he's starting to improve. So even though he's doing it illegally on it, I hope he gets his life straightened out, whether it's illegally back there or not. I can't condone it. I don't want him to go to jail or anything else, but, I mean, he actually needs it.

He's actually in a relationship. He's engaged to get married since he's been on there. So he's got a good relationship going with his fiancee, so I mean...

Q After he went back there, did he keep using the marijuana illegally?

A I don't think he -- not when he was a kid, as far as I know, no.

Q But just later at some point?

A He didn't want to be stuck on all those pills on it. So when he had a choice when he was 18 on it, he stopped taking all the pills and went back to the marijuana.

Q So when he -- he came here at 12 and he did well

on the marijuana and then he went back to Georgia?

A Yeah.

THE COURT: And then he didn't do well. And he's now 18, and he uses marijuana illegally, and it seems to be making him better in the opinion of the witness. That's the witness's story, and he seems to be sticking to it.

MS. BROWNE: Okay. Your Honor, I was just trying to figure out if he was using marijuana between 13 years old and 18.

THE COURT: I don't know how much that's going to help me decide this case.

MS. BROWNE: Yeah. Okay.

BY MS. BROWNE:

Q So let's talk about T. And what symptoms did you first notice with T.?

A T. always had the -- had problems since he's been born because of the CPS case -- the one that they recommended me with medical marijuana with -- that CPS case. He was taken out of the hospital when he was a newborn, so by the time we got him back -- being thrown from different foster homes on it -- so he was already having emotional problems already.

Q And his mom -- during -- from his birth through his childhood, were you with his mom?

A Yes.

Q So he was in a family unit with you and his mom?
A Yes. Until like two years ago.
THE COURT: Hang on a second.
You said something about CPS taking him from the hospital.
THE WITNESS: When he was a newborn. That was the first CPS case.
THE COURT: And they did that why?
THE WITNESS: Because I got into a altercation with the doctor. They were supposed to discharge him from the hospital after he was born, and then there was a shift change and a new doctor came in and said he wasn't ready to be discharged on there.
And the doctor tried to give me an excuse as far as something that was going to take two weeks or whatever -- the standard testing they do when a kid is born or whatever they send off -- the DNA or whatever they do. I forgot that one special test, honestly, so I don't really know.
Anyways, so I was going to sign against medical advice and be discharged on it, and we were going to plan on moving back East at the time on it. So the doctor reported it on it, and the DFS came in and did their investigation on it. And then --
THE COURT: How long was the child away from you and

your wife after the child was born?

THE WITNESS: Probably at least six to eight months -- maybe a year.

THE COURT: So T.'s less than a year old, and he's put back in the custody of you and your wife?

THE WITNESS: Yes.

THE COURT: Okay. Let's pick it up from there.

BY MS. BROWNE:

Q And then were there -- was there ever any intervention between six to eight months when he returned up until the incident with the school when he just turned five?

A We had trouble with him acting out at home and stuff. Change of environment -- if we moved from one place to the other on it, he would have trouble adjusting to it and stuff like that.

Q Change in environment -- you mean like going to the grocery store or a different place, or like moving or something?

A Like, moving for a stable environment -- he had to have a more structured environment. So if we moved from one house to another or -- kind of like the incident when he got brought into school was a change of environment. So it just kind of exploded.

THE COURT: Sometimes a symptom of autism, my man.

We'll pass that for now.
BY MS. BROWNE:
Q Okay. And so when he acted out before he went to school, was there ever any other involvement with Child and Family Services?
A No. We didn't have that until we got the medical marijuana with T.; that was the next case.
Q Okay. So with T., did you ever take him to a doctor, other than Dr. Eidelman?
A For routine exam, physical, or whatever. My wife was the one who did all of that at the time.
Q Okay. And so did she talk with the doctors about the problems that you saw -- his acting out when there's a changed environment?
A I don't know. She was going to the doctor. So she probably brought it up. I don't know if she did or didn't.
Q Do you know if a doctor ever diagnosed him with any kind of condition?
A I don't think so, no.
Q Do you know if a doctor ever prescribed anything to him before?
A He never had nothing ever prescribed to him on there for behavioral issues or anything like that.
Q Okay. So when was the first time that you gave

him a sample or tried out medical marijuana with him?

A After I got the recommendation from Dr. Eidelman.

Q Okay. So why didn't you -- when he was born, why didn't you want him to stay in the hospital? The doctors recommended --

A I already had the discharge paperwork in my hand, and we just don't have a regular, like you keep asking, primary care physician on it. We never really had the best at it anyways -- you know what I mean? -- because we move around. So we just end up -- when they need to go to the doctor or their yearly physical, we just find -- if we don't have insurance or if we have a different insurance or Medi-Cal, we have to go to a different doctor. So with us moving around, we just never had a primary care physician.

So, basically, that's was what it was when we -- when my wife had him at Cedars-Sinai. They were going to discharge him on it, and then whoever they have the -- the fill-in doctors, because we didn't have the regular doctor. So the next doctor came in and didn't want to approve him on it. I think she was, kind of, more biased towards us because we were actually going to be moving, you know, with a newborn, and she didn't really like that. So she was trying to use the excuse that they were

waiting for one of the tests to come back or whatever else, and I got into it with the doctor over it.

MR. JAFFE: Judge, I think we've heard this before.

THE COURT: Ms. Browne, this history is not helping me.

MS. BROWNE: Okay.

THE COURT: I've got some discrete charges here that -- this is tangential.

MS. BROWNE: Yes.

BY MS. BROWNE:

Q Could you tell me about the appointment when you took T. to see Dr. Eidelman. Could you just tell me everything you remember about it.

A Talked to him on it. We kind of talked about T., and we talked about T.'s symptoms on it, how my symptoms are -- were kind of similar to his -- the symptoms that S. was having on it compared to T. Went over, basically, the family history.

Q So the symptoms that S. was having on it -- like, what specifically did you talk about with him?

A Well, like S.'s behavior in class, S. not concentrating.

Q So the behavior in class based on what the teacher told you?

A Based on T.'s teacher, yeah.

Q Right. Okay.

A And then what we were experiencing at home -- what we were seeing on there. So basically T. on it. We already had a family history that we have with S., everything else. The marijuana's working with me; the marijuana is working with S. All these pills ain't working.

"You know what? He has some of the symptoms of S., some of the symptoms of you. You know what? Let's try it and see because it's not hurting. It's safe, it's not a dangerous drug on it, and it's working great. It works great with other kids was ADHD." So that's why he prescribed it.

Q Okay. And when you say the pills he was taking weren't working, did you give him any of the pills? I mean, I think you said --

A Not with T., no. Because, I mean, I was used as a guinea pig; my son was used as a guinea pig. The marijuana works great on me; the marijuana works great on S. Why am I going to sit there and carry my kid to go to another doctor that's going to do the same thing as common practice? "Oh, let's cram some pills down his throat and let's see if it works."

MR. JAFFE: I think we've heard this too.

THE COURT: Yeah. It's getting like a --

MR. JAFFE: You know what? Maybe it's time that I say something, and maybe we can just move on.

MS. BROWNE: I just have one more question.

MR. JAFFE: It's the fourth time we've heard the same testimony. I apologize, but I feel like I'm not doing my job because I should be, you know, objecting.

MS. BROWNE: I'm sorry. My next question was just going to be about whether -- or what Dr. --

THE COURT: Let me try to summarize here. Before you took T. to Dr. Eidelman here, you had not taken him to any other doctors to get a diagnosis about what was driving his behaviors. Am I right about that?

THE WITNESS: Yes. Correct.

THE COURT: And is one reason you did not go to such other doctors is because you presumed that they would want to medicate your son in the manner that you had been medicated?

THE WITNESS: Yes.

THE COURT: And you don't find that to be a good way of dealing with it; right?

THE WITNESS: Yes.

THE COURT: Okay. Now let's get back to this visit with Dr. Eidelman, Ms. Browne.

BY MS. BROWNE:

Q Were there any side effects that Dr. Eidelman

warned you about in using marijuana for the child?

A It can be over -- too much on it can make him oversleep on it. There's some -- maybe overeating on there.

Q Did he ever talk to you about any other options?

A He suggested to maybe see someone about the pills -- about trying the pills first on it, which I was against on there. I believe it's more natural to -- with the marijuana. I think that's why he made a recommendation too. Because we compared the pills -- how it does in general with everybody else -- the pills with me and how they didn't work; the pills with S. didn't work; the marijuana worked. So we weighed out all them options -- what was best for T.

Q He advised you to go see another doctor first?

A I mean, he -- you know what I mean? -- he pretty much, I guess -- we discussed the issues with the pills and, if I wanted to look at that option, to go to another doctor.

I mean, I guess not necessarily advise. But, I mean, that was an option too. So the option was kind of left up to me if I was going to be in agreement to the pills or no pills on it. But we both pretty much came to the conclusion that the marijuana was going to be the best option after weighing out all the options and the

symptoms and everything else.

Q Was one of the options considered counseling or therapy?

A He recommended to also put him -- get him in counseling and stuff --

Q Okay.

A -- along with the medical marijuana --

Q Okay.

A -- to help deal with some of the behavior issues and stuff like that.

Q Did he refer you to a therapist to do counseling?

A He suggested for me to do it, so I found someone up there where we were going -- up there. I found someone up there afterwards.

Q So when did he -- he did begin counseling?

A Well, probably -- after the whole incident, and all, blew up and we got resettled. So it took, like, probably three or four months to get him in counseling. We were moving around, so we went to a counselor for a month or two or whatever else, and then we moved and we had to start back over again.

Q Was the counseling -- did you go do that on the doctor's recommendation, or was that because CFS got involved?

A No, it wasn't because they got involved. It was actually because of Eidelman's recommendation -- along with using the medical marijuana, to go also to counseling.

MS. BROWNE: Okay. We have no more questions.

Thank you.

MR. JAFFE: I don't have anything else.

One minute, Your Honor.

No, Your Honor.

Your Honor, do you have any questions for this witness?

THE COURT: No, I don't think so.

You're excused.

MR. JAFFE: Thank you very much for coming. Good luck to you and your family, sir.

MR. JAFFE: And, Your Honor, per our earlier discussion, I think we're done for the morning. And then, in the afternoon, Ms. Browne is going to resume her case.

And I think that's your last witness, other than what you may have as rebuttal or something; correct?

MS. BROWNE: Correct.

THE COURT: All right. 1:30, then, folks.

(Lunch recess)

THE COURT: Back on the record.

Ms. Browne, you have another witness?

MS. BROWNE: Yes, we do, Your Honor.

I need to place -- there's one page that's missing from the exhibit --

THE COURT: Go ahead. I trust your moving around my courtroom.

MS. BROWNE: Your Honor, do you have a hole punch right now?

THE COURT: No, I don't.

So I assume this lady sitting in the front row there is our next witness?

MS. BROWNE: Correct. At this time we would like to call Dr. Briggs to the stand.

THE COURT: All right. Come on up here, ma'am. Could you raise your right hand, please.

BRIDGET BRIGGS, M.D.,

called as a witness and having been first duly sworn by the Court, was examined and testified as follows:

THE WITNESS: Absolutely.

THE COURT: All right. Could you tell us your name and spell it for the record, please.

THE WITNESS: My name is Bridget Briggs, B-R-I-D-G-E-T; Briggs, B-R-I-G-G-S.

THE COURT: All right. You may inquire, madam.

MS. BROWNE: Thank you, Your Honor. I'll note that we have a witness in the courtroom.

THE COURT: Well, he's done witnessing, so if he wants to witness what we do here now, he can.

MS. BROWNE: Okay.

DIRECT EXAMINATION

BY MS. BROWNE:

Q Thank you for being here, Dr. Briggs. Could you please tell us your specific profession.

A I am a board-certified family medicine practitioner. I'm also a board-certified functional medicine provider through two different ports: the Institute of Internal Medicine and the American Board of Integrative Holistic Medicine.

Q And can you tell us what that means -- the latter?

A The latter for being board certified by family medicine, or the other two boards?

Q The last one, I meant to say.

A Sure. So to be board certified through The Institute for Functional Medicine, which is primarily recognized by the American Board of Physicians, it's a three-year-long course of additional studies, almost like

a secondary residency, for which, at the end of the three-year-long course, there is a board certification that you sit for.

Same thing with the American Board of Integrative Holistic Medicine. It's a course that you take. Once again, you have to sit for the boards.

Q Okay. So the Institute of Functional Medicine and then the Board of Integrative Holistic Medicine. Any other board certifications?

A American Board of Family Medicine.

Q And that's ABFM?

A Yeah.

Q And how long have you been practicing?

A I've been practicing since 2001, full-time.

Q Okay. And your type of practice?

A I'm a traditional family medicine doctor, but my practice is essentially completely functional medicine.

Q Okay. And could you describe any changes, through time, of your practice.

A Sure. I had a son with brain cancer. So when my son was diagnosed with brain cancer, that's what triggered me to, basically, maneuver from a traditional family medicine doctor with advances in obstetrics and gynecology -- I have a fellowship in OB-GYN.

At that point, while we were going through his

sickness, I went and sought out functional medicine and integrative medicine and traditional medicine. So on or around, I would say, 2005 and forward, that's when I began to seek out the certification process to have a better understanding of traditional medicine.

Q Have you reviewed the materials in this case?

A Yes, I have.

Q Okay. And "in this case," of course, I'm referring to Dr. Eidelman. You're an expert reviewer for the Board?

A Yes.

Q Okay. And the -- if we could please turn to exhibit -- Exhibit 27. The witness's copy is tabbed with pink at the bottom. Do you recognize this document?

A Yes.

Q Could you tell us what it is.

A This is my review and my write-up for the Medical Board of California after the review of the case.

Q Okay. And have you had an opportunity to review this lately?

A Yes, I did.

Q Okay. And the items that are listed on the first page, are those the items that you reviewed in connection with this case?

A I just reviewed my summary, since I don't have

the rest of the --

Q Oh, okay. So back when the Board -- the Board sent you certain materials to review and look at -- records and whatnot?

A Yes. These are the records that I looked at.

Q Okay. All right. And you've got a factual summary on the second page of the opinion.

And turning to the third page, you made a conclusion that -- about the diagnostic process, the diagnoses that were made, and the treatment plan.

A Yes.

Q And then, also, pertaining to seeking expertise from someone who is more specialized, could you describe your conclusion?

A Yes. After reviewing the case, I felt, number one, that the diagnosis of bipolar in a five-year-old is incredibly uncommon, nor do most children at the age of five exhibit the typical signs and symptoms attributed to bipolar. So since this was such an uncommon and rare diagnosis, I felt that that was probably not likely to be the truth in this case or at least was a premature diagnosis.

And I felt -- you know, usually the person that's going to be best at making these types of diagnoses is going to be a specialist in the field, and

it's going to take a number of clinical appointments, appropriate questionnaires, observations, IEPs, 504s -- all that to come up with such a severe diagnosis, not to mention the ADHD. The ADHD is not uncommon whatsoever, but the one that bothered me the most was the bipolar diagnosis.

Q Were you aware, from your review, that Dr. Eidelman actually has studied psychiatry?

A Yes. I was under the understanding that he did a partial residency, that he did not complete the residency. And, my understanding -- that was in general psychiatry, not pediatric psychiatry, which is a completely different field.

Q Okay. And did you see any indication that -- there was a reference at one point that Dr. Eidelman talked about treating the symptoms -- and that that was generally what happens -- as being more important, really, than making a diagnosis. Do you have any opinion about that concept of just treating the symptoms?

A Absolutely. First of all, the symptoms of bipolar, if you actually look -- number one, to be diagnosed with bipolar, the child or the person has to exhibit signs and symptoms of depression. That is one of the core parts of the diagnosis of bipolar.

So at no time, in any of the chart notes, did I

look and see any treatment of pediatric depression. I didn't see any depression scales asked; I didn't see any mania scales asked. So, definitely, treating the symptoms is 100 percent core in treating bipolar, but I didn't see any of those questions asked.

The clinical appointment -- there were two essential clinical appointments one year apart. And, generally speaking, there's going to have to be some feedback from the parent if the child can't communicate episodes of mania, duration of mania, episodes of depression, effects of the depression, the effects on food intake, concentration, sleep patterns -- absolutely none of that was diagnosed in any of the charts.

So treating the symptoms -- I would like to know what symptoms were being treated, because it's not exhibited in the chart notes.

Q Okay. Here at Exhibit 22, we have the certified medical records. Could we take a look at those.

So -- and I should point out Exhibit 22 and Exhibit 23 are both part of the 35 pages of medical records that were submitted. And I believe what's numbered as page 3 of 5 is -- that's for the first appointment.

So, I mean, this is a page long, so isn't this sufficient?

A Absolutely not.

Q Please describe -- explain.

A This is really, in my mind, the father kind of giving some background history, which is valuable. No question. I want to know what the father has had in his own previous diagnosis, the medicines that he has tried, the side effects -- because there's a definitive genetic component to many of these psychiatric illnesses, and even drug metabolism -- there's a very strong genetic connection to being a hypermetabolizer or a slow metabolizer, for which I don't really get the details here, in terms of which medications has the family been on and has failed.

There is a single listed medicine here, Risperdal, for the son -- or for the brother, is my understanding. But I don't really hear any detail here specifically, other than the child has uncontrollable behavior, temper tantrums, and moments when it's occurring, seemingly, at normal times. Those are not the diagnoses -- or the phrases of diagnoses -- or searching for the diagnosis of bipolar, nor even ADHD, to be honest. We have scales that are provided to us to go through and ask very detailed questions. That is not anywhere in the medical record here.

It feels like a five-minute conversation, where

the dad is walking in saying, "Hey, this works for me. It works for my other son, so I feel like we should give it to my five-year-old." And I feel like it's a patient-driven approach. It's a patient-driven -- kind of the patient telling the doctor what to do, and maybe the doctor not taking the mandatory steps to make sure that, in a pediatric undeveloped brain, that we're making the most well-researched and safest mode of action before we jump into something as severe as cannabis, not even just something as clean as CBD -- you know what I mean?

There's great value to some of these nutraceuticals, and I'm a big proponent of these nutraceuticals. But the research on omega-3s and inositol and amino acid therapy -- there's so much that could have been implemented long before this huge leap into cannabis with a -- really there's -- the physical here isn't even detailed enough. Beyond the physical, there is no psychiatric questionnaires asking the child not one question. I hear the history of the dad. But I don't see anything, other than the child is agitated from the stress of the day in school, coming to the doctor. I'm sorry. What five-year-old isn't agitated? What five-year-old do you know that doesn't have temper tantrums?

I mean, I have five kids. They're all

different. They all have different temperaments. But I wouldn't say that a child with uncontrollable behavior would lead me to give the diagnosis of bipolar. I would not be completely swayed by a parent; I would want to see my own observation, my own questionnaires. I would like to see the teacher's notes; I would like to see a formal neuropsychiatric evaluation of the child before I would be willing to jump in and give something that, according to the literature, can change their neurochem development for the rest of their life.

Q And isn't the case also for -- or is that the case also for some of the other medications that are prescribed if the patient did have bipolar disorder at this age?

A Every single medicine prescribed out there has its risks and its benefits. And we know, especially when you're dealing with children, that their response to medicines can be so dangerous that it could lead a child to perform suicidal behavior -- that we all know, as primary care doctors, to proceed with caution.

In other words, even the first appointment may not elicit a drug prescription. It may require further testing or counseling or one-on-one, you know, at school, you know, where the child is removed from the normal classroom and put into an SDC class, because our desire

is to use first-line medications for either ADHD or bipolar. None of us want to do that to a virginal brain. I mean, this child is five.

And some of his behaviors -- they oftentimes outgrow many of these excitotoxic behaviors. So it takes time to see and observe and to really ascertain if your diagnosis -- you can have inclinations that this child has bipolar, but that still doesn't justify the leap of a controlled substance.

Because once you change his neurochem -- and most people will tell you this that use marijuana -- they're hooked. It's an addictive drug. It changes the neurochems. The synthesis and the degradation of those remote transmitters are changed, and it is very difficult to completely withdraw that medicine and be able to function on a day-to-day basis.

So we're asking a child, who, according to the medical records, was given medical marijuana, and by the afternoon needed to have another cookie to step back into alignment. So we're already seeing a very early case of a child's brain who is already now becoming dependent. That bothers me.

Q Are there any different types of -- well, you referenced CBC?

A CBD.

Q Could you tell us what CBD is.

A CBD is the cannabinoid aspect of the marijuana plant. CBD has several levels of success and intervention in neurochem. But the beauty of the CBD is it doesn't contain the THC aspect of the marijuana plant; therefore, we don't have the risk of psychoactive element.

CBD is available over the counter. CBD is available as topicals. It's available as various forms of ingestion at all ages. CBD is credibly efficacious in ADHD, in excitotoxicity, in learning, in anxiety and depression. There are multiple cases of CBD, without the psychoactive aspect of the THC, that is completely therapeutic in most excitotoxic kids -- from cerebral palsy to autism to Asperger's.

So I don't care the severity of the child we're looking at. I am not anti-CBD. It is benign. It doesn't mean it works for everybody, but it can certainly change and protect the potential psychoactive or the potential of the THC aspect creating a schizophrenic outbreak or break of stability.

Q So you're familiar with some literature on the subject?

A Yes, ma'am.

Q Even if not articles by name, you're familiar

with the literature?

A Yes.

Q So is there any literature that you know of that relates to cannabis being given for bipolar?

A Yes.

Q To a child?

A To a child, no. No. Most of the literature is limited in pediatric experience using anything but THC. We are taught to proceed with caution.

There are life-threatening conditions like epilepsy -- I mean, there are cases where -- you know, the infamous case of Charlotte's Web, where the child was sent home from the hospital after living in the hospital for a prolonged period of time, 25 seizures a day. There was nothing -- no seizure medicine out there that would control her seizures, and so she was sent home to, basically, pass away, because epilepsy does kill.

And in this particular case, the father was able to design his own liquid oil form of the CBD-THC blend -- they coined it Charlotte's Web -- and it has been very successful in certain cases of epilepsy.

In these cases, it's kind of like the last-end resort, where everything else was tried first-line. And, you know, in the literature at the same time, where we've seen successful cases in adult medicine and in teenager

medicine or preteen medicine, that CBD in combination with diluted forms of THC have been effective in some mood stability elements.

But it is also written in the literature that using marijuana in teenagers who may be predisposed to bipolar or schizophrenia can actually elicit the very first manic episode or schizophrenic outbreak.

So I would say to you that there isn't enough in the research to give me the flippant ability to give a five-year-old CBD with THC, in a single twenty-minute-long appointment without any true psychiatric evaluation or having failed any of the natural nutrients that are available to us over the counter. Omega-3s are over the counter, inositol.

I mean, look at the research of Dr. Scott Shannon. He's a pediatric psychiatrist. He travels worldwide. He is not anti-CBD whatsoever. He's not even anti-CBD with THC in the worst-case scenario, but he says very frankly in his research: "Not under the age of 24 in a developing brain." Because it makes permanent changes of their neurocognitive pathways that are irreversible. We can't fix them and change them. I'm not willing to take on that accountability as a practitioner.

Q Thank you.

And then the other aspect -- you referenced that there should have been a referral given because of limited knowledge of pediatric psychiatry. Could you tell us about that.

A Most children that are having problems at school, generally speaking, the school will ask for a neuropsychiatric exam. It's typically a three-day exam, where the child either goes through their physician and does three days of intensive investigation to really come up with the appropriate cognitive defect -- if it's emotional; if it's attention; is it dyslexia? I mean, imagine a child at age five, who may not be able to read or auditorily process -- that they wouldn't act out.

So you want to make sure that you've made the appropriate assessment before you come up with a label, like a diagnosis of bipolar or ADHD, especially as this is his first academic year. So, generally, the physician, at this point, will participate by adding their feedback to the neuropsychiatrist. And the school, the doctor, and the neuropsychiatrist work together as a team, whether it's through the IEP or the 504, to discuss the best intervention academically for the child. And usually that academic intervention begins with some more hands-on observation at the school.

So most of these schools don't just kick out a

five-year-old. I mean, imagine the legality issues. But the parents and the doctors have to follow the protocols that are there that segregate the children that may be struggling. And there are special day classes and one-on-one aides that are designed to basically give an interventional approach and feedback so that we know how to meet the child's needs.

Q And what is the significance of making an accurate diagnosis?

A Well, twofold. One, the child becomes labeled; two, the child, in this particular case, was removed academically from school altogether. So the parents had the burden of homeschooling, is my understanding.

This further impairs the child's ability to do appropriate social integration and learning how to interact with other children and learning to self-soothe and learning different strategies for paying attention and -- I mean, that's just some of the harmful natures.

Not to mention, we talked about the harmful effects, potentially, of administering the THC component of the CBD. I literally think the CBD was not a bad option. I've seen phenomenal, phenomenal successful stories of children using CBD. It's the THC element, to me, that was so premature. There might become a time that is necessary. I mean, risk versus benefits. You

know, I'm not saying that it would never be right to use. What I'm saying is the appropriate steps and the utilization of the school and other neuropsychiatrists or just a specific pediatric psychiatrist -- really use our subspecialty networking to make sure that we are appropriately meeting this child's needs.

Q Is there any change to your opinion based on the fact that medical marijuana had been given to the patient's older brother, apparently successfully -- reportedly successfully?

A So two things bothered me after I read the case. Number one -- it affected me, number one, that the father came in and said that he had a 13-year-old son -- forgive me if my age is incorrect -- that lived in another state, and when the son came in, the father was also administering marijuana to the sibling. So this is like a parent giving their kid drugs. I'm sorry. It's not right. It wasn't prescribed for the child, so this makes me question the father. I don't take my medicines -- I don't take my drugs out of cupboard, even as a doctor, and hand them to my children. I do not do that.

So if the parent came to me and opened up and voiced to me that he was giving his drugs -- they're prescription; I understand -- to their child, that would already make me take a step back and say, "Do I trust

this parent to be the dispenser of a controlled substance," number one.

Two, the child was not prescribed a specific dose. The instruction to the father was, you know, "Just pass out a little bit and let's see if we can figure out the dose." Because, I'm sorry, Dr. Eidelman didn't know the dose for a five-year-old. Well, why would you? We're not typically given any type of instruction about the dosing of a five-year-old.

Now, I'll give you an example. My sister has ovarian cancer right now -- excuse me -- cervical cancer. And you can go on these little websites and get a face-to-face interview through Skype with a doctor who knows how to make a great fund of money on the side, and they will prescribe you medical marijuana, and they will tell you it is a two-to-one -- or excuse me -- a ten-to-one ratio of CBD to THC, not enough to make you go schizophrenic or psychoactive. And this happened after the case, so it did not influence my reading of this case.

And my sister is her own being, but I happen to be her doctor. And she tried this pain medicine -- which she has debilitating pain -- and, in these cases, we know that there's great efficacy using CBD and THC combination for pain. And she went completely schizo; she lost her

mind. The family called me. She was pretending like she was possessed; she was freaking out.

In something that was an uncontrolled substance at the time, a small amount of THC. But the element is this, if you're participating in functional medicine, and you're skilled enough to do genetic testing, which is what we do, there are genes for OCD; there are genes for bipolar; there are genes for ADHD. Knowing the right neurochemical/neurotransmitter that's out of balance and how to go and intervene with something -- a natural or lifestyle medicine -- is certainly a whole lot less risky than even if you have a severe case.

Okay. She'll never touch it again. But it's my limited amount of exposure to somebody that is using it for a severe case like pain. This could have happened to this child. You know, it's fortunate it didn't happen. But when do you not -- when are you going to take that risk that it's going to happen? If you gave it successfully to one five-year-old, what are you going to do to the next five-year-old?

When a five-year-old comes into my clinic, and the mother tells me that this child is exhibiting cases of ADHD or excitotoxicity -- because parents don't generally know to use the word "bipolar" -- the first thing we do is we do metabolic labs. We look at their

neurochem; we measure the metabolites of dopamine; we measure the metabolites of serotonin; we measure the metabolites of noradrenaline and global methylation; we look at the genes for MAOB. Do they have an inability to detoxify or metabolize catecholamines, which are things like adrenalin?

So imagine when you're over-adrenalized. This child is excitotoxic, the child is brought to school, the child is jumping out of his skin. Is the answer CBD and THC? Or is the answer a low amine diet? Is the answer something that breaks down histamine or catecholamine? Is the answer something like 5-HTP that would increase serotonin?

When you're talking about functional medicine or integrational medicine, you have duties to do the right steps. And if you're trained in functional medicine, I would expect that, before the drug that has the potential of having permanent effects. More importantly is now this child is going to be on this for -- what? His whole life? Is he going to launch? Is he going to get a career? Is he going to be educated?

When you look at what happens to pediatric neurochem when damage occurs -- Dr. Loudon at CHOC hospital -- he is a pediatric neurosurgeon. His specialty is curing kids with cancer. What do they do to

these brains? They radiate the brain; they give chemotherapy to the brain. And at the end of the story, these kids are living through cancer. But 50 percent of these children, because of a neurochemical hit to the brain, do not launch. 50 percent of these kids don't get a career, they don't marry, they are a burden to society.

So do we want to just start changing the brains of these kids when we have no research out there? What is the long-term neurochemical side effect to what we're doing? We're not saving lives like cancer, but what are we doing when we're giving kids this instead of typical ADHD meds? Ritalin (methylphenidate) is the treatment for ADHD. Does it have side effects? Yes, it does have side effects. How do you combat the side effects? You either modify the medication, or you use things that control the excitotoxicity -- omega-3s, inositol, phosphatidylserine/choline. Or, instead of using the drug, in functional medicine, we would use methylfolate or methyl B-12. Do the work? They 100 percent work without using a drug.

I'm not saying that this would never lead to the final case of using a mixture of CBD and THC. But there's no way, if that was my child -- if I was your wife, and you brought my child home on a brownie, I would not feel confident in you, and I would not feel confident

in the doctor, nor would I stay in the state. I would run and change states before anybody tried to permanently change my child.

And saying that a tantrum is abnormal -- or acting out -- who said that every child in kindergarten is not allowed to have a temper tantrum or act out? Who said that? Because I'm going to tell you, there's a big percentage of these kids that are acting out in school today. Things that are excitotoxic -- MSG, red dye, yellow dye. How about changing the diet before we give them a controlled substance?

MS. BROWNE: We have no more questions, Your Honor.

THE COURT: Counsel.

MR. JAFFE: Thank you.

CROSS-EXAMINATION

BY MR. JAFFE:

Q So it sounds like you don't make any recommendations for medical marijuana; is that true?

A No, that's not true.

Q So you do recommend it?

A I don't prescribe medical marijuana because, federally, doctors are under the federal law, which says we are not allowed to prescribe marijuana. In the state of California, it may be legal, but doctors must comply

with federal laws. There are doctors that do prescribe medical marijuana, but it is not federally acknowledged or recommended; so I do not prescribe medical marijuana.

When patients have cancer, they're in pain, they're dying, there are times that patients come in, they have their marijuana card, and I have nothing negative to say about that. I do think it holds its place. Some of the fastest growing prescriptions right now in all of pharmaceuticals stem from CBD basically, and, potentially, complements of THC. But that's federally regulated and researched and controlled. In adult medicine, I do think that marijuana has its value for pain, nausea -- severe cases.

Q So as I understand it, the reason you don't prescribe it is because you think it's illegal federally?

A It's illegal for doctors, if you follow federal laws, to prescribe it. I don't prescribe it, just like I don't prescribe specific cardiothoracic drugs. I'm not a cardiothoracic surgeon. I know my field. I'm not anti-marijuana in certain special situations. It's been well researched. It is now legalized in California, so when my patients are using it, I don't have a problem with it.

Q Marijuana, you're referring to?

A Yeah, marijuana.

I have a problem with giving it to children.

Q So you're under the understanding that you, as a California physician, are not allowed to prescribe or recommend medical marijuana; that's your understanding?

A My understanding is there's a dichotomy currently in the state of California. The dichotomy is it's legal in California, but federally it's not legal.

So you do have to acknowledge that there is a dichotomy going on, and, should you practice the prescribing of medical marijuana, you may be looked at more thoroughly in terms of your safety of your practices. I think that it's new, and anything new comes along with that type of observation.

Q So if there are any medical marijuana guidelines that the Medical Board has put out, I gather you're not really familiar with them?

A I am familiar with them.

Q With the medical marijuana guidelines?

A Yes. But I just don't prescribe it. I'm not a pain specialist. Many of the pain specialist doctors, they do prescribe medical marijuana. But I do not prescribe medical marijuana, nor do I prescribe every other drug out there. You prescribe according to your level of expertise.

Q And you don't have any expertise, as you call

it, prescribing medical marijuana?

A Absolutely not.

Q Okay. And did you hear the distinction between recommending marijuana and prescribing it? Does that ring a bell to you?

A Yes.

Q And what is your understanding of the difference and what the different legal implications are?

A What I say to my patients if they ask me about medical marijuana, I say exactly those words. I do not prescribe medical marijuana, but I will not be against you using medical marijuana for a specific medical reason, such as pain.

Q But, in any event, you don't feel you're an expert in the conditions for which medical marijuana could be prescribed, according to you?

A I do not believe that I am an expert in prescribing marijuana, the doses of marijuana, and what would be appropriate for a child versus an adult.

Q Okay. And so let me ask you this -- and I think I know the answer to this because I know a little bit about functional medicine. How much Ritalin do you prescribe in your practice?

A You mean how many a month, per se?

Q No. I mean do you prescribe Ritalin to your

patients?
A Yes.
Q And you treat young kids under six?
A Absolutely. We are full functional medicine, from babies -- I've delivered babies since I came out of residency. So from the birth to geriatrics, we treat all ages.
Q Do you prescribe Ritalin as a first-line therapy for ADHD?
A No.
Q Because I know you're a functional medicine doctor. So you prefer a functional medicine approach, which is basically supplements and food; right?
A First line is nutrition first, prescription second.
Q Okay.
A But that doesn't mean we don't prescribe Adderall, Vyvanse, Ritalin -- everything.
Q But not first line?
A No.
Q All right. So you would -- your treatment approach would be different than, say, a medical doctor/psychiatrist who calls himself a psychopharmacologist whose first line is drugs?
A I agree.

Q Okay. And in this particular case, I gather from what you're saying, you wouldn't even have recommended this patient Ritalin or Adderall as first-line therapy -- right? -- if he was going to get anything.

A I would have done a combination of both. As I said, we know that, for example, one of the biggest side effects of Ritalin is the drop-off at 3:00. So the kids are great at school; by the time they come home the medicine has worn off and their excitotoxicity becomes significant. So to enhance the ability of the patient to take the Ritalin, you would do something that is neurocognitively anti-inflammatory, like DHA.

So it's not that you're anti the drug, but you're trying to subdue the medication side effects, for which, it's clear in this case, the father had had several side effects from other psychotropic medicines that he had been on, apparently that the young child -- the teenagers had been on, and so they were looking for something that was completely the other direction. We would try to enhance the medicine by helping with some of the side effects that can occur as a side effect of the medicine.

Q Right. And just to be clear, all of these -- you engaged in a pretty lengthy analysis of some of the

things that you would have done -- mentioned all kinds of chemicals and diagnostic tests and treatment.

It's fair to say, that is basically your functional medicine hat talking; right?

A Yes.

Q Okay. Functional medicine, wonderful as it is, that's considered complementary and alternative medicine in California; isn't it?

A Yes.

Q And a regular medical doctor, assuming they would understand what you're even talking about and the test you were talking about, they wouldn't really share your opinion as to all the tests and all the treatment that you would recommend to treat, say, the side effects of the Ritalin or whatnot. I mean, this is unconventional, even what you're suggesting?

A I do agree that most primary care doctors or pediatricians would just prescribe the Ritalin and just keep changing the drug.

Q And that happens fairly frequently? What happens is you start with a drug and then you change it?

A It wouldn't happen that quickly in a five-year-old. What make this is so uncommon is the age of the child. He basically -- five is kindergarten. It's how quickly the diagnosis was placed on this child

without any criteria having been met, except for the word of a father who is not educated enough to make that conclusion.

No appropriate ADHD questionnaire is asked here, no bipolar. So, to me, it's unlikely that you would have ever walked into any appointment with any pediatrician psychiatrist and have been given any drug at this point. I think it would have instigated a formal treating period, like the three-day neuropsychiatric test. You see what I'm saying?

Q Right.

A But there's not many five-year-olds that I've ever seen prescribed Ritalin or Adderall.

Q Right. And actually -- well, let me get to that. So do you diagnose bipolar in your clinic?

A Yes, we do.

Q All right. And even though you're not -- so you're comfortable -- so you're not taking the position that you have to be a psychiatrist -- a pediatric psychiatrist to diagnose bipolar?

A My undergraduate major was psychobiology, so I have an extensive knowledge of neuropsych. Just because of my undergraduate major, I did do research in pediatric psychology. My -- again, my Institute for Functional Medicine background has a very strong neurochemical

background, and I do genetic studies. So genetic studies can help to elucidate, and then we do urinary neurotransmitter studies. So do I feel skilled enough to diagnose bipolar? Yes. In a child? Never.

Q In a child, never?

A Never would I diagnose a child with bipolar. That would never come from me. That would absolutely require a pediatric psychiatrist with extensive experience. I would never feel qualified to do that. I'm not even sure I believe that that's the correct diagnosis. That is just so outlandish.

Q Well, let me ask something. Are you aware of the fact that under the DSM -- we had testimony yesterday from a Dr. Raiss, another Board expert. And as I understand it, he testified that what happened is -- is that prior to 2013, a lot of kids -- young kids were being diagnosed with ADHD/bipolar disorder, and that was a problem. And so as a result, they came up with a different diagnosis because that combination -- ADHD/bipolar was being overutilized by primary care physicians. And that diagnosis --

A As a combination?

THE COURT: So I think his testimony was as to bipolar. The gist of it was that they broke out bipolar NOS, and it's got a new name.

MR. JAFFE: And what's it called?

THE COURT: Disruptive mood dysregulatory [sic] disorder.

BY MR. JAFFE:

Q Disruptive mood dysregulatory disorder under DSM-5. Is that something you may have heard of?

A No, not that code. Sorry.

Q So you have no knowledge that, as a result of the fact that primary care physicians were, supposedly, overdiagnosing bipolar, they came up with some new nonbipolar diagnosis in 2013?

A I can tell you, in the new DSM, they took many of the traditional terminology for almost every term we've used, and they changed the terms. So there's tons of new terms, but the reality is they're describing bipolar. They're just creating new terms for it.

Q Okay. All right.

A And just as an observation, as a primary care doctor who sees 30 patients a day, and in our clinic we see about 450 to 500 patients a month, the amount of bipolar diagnoses that are given under the age of 18, they tend to be around the ages of 15 and 16 and 17, after puberty.

And if you understand -- the reason that's relevant is because the reduction of hormones, especially

testosterone and estrogen, is tightly regulated by two enzymes that are regulating also the metabolism of your catecholamines. This is why it's so unusual to diagnose a child with bipolar -- because they have not significant enough testosterone and significant estrogen for there to be an interaction with the COMT enzyme and MAOB enzyme.

So it is logical to see, with the onset of puberty, maybe the early signs of bipolar. And this is why it's required that you have to diagnose a child with coding of ADHD prior to the age of seven. So ADHD under the age of seven is commonly diagnosed. Bipolar is traditionally not diagnosed until after the onset of puberty.

Q And all that talk about the acetylcholine -- or whatever choline you're talking about -- that's all functional medicine stuff; right?

A You can open up American Academy of Family Medicine and look up the COMT gene, the COMT enzyme -- it's called the warrior gene. It metabolizes your estrogen and it metabolizes your dopamine. That is standard medicine. That is not functional medicine. And understanding the metabolism of your neurotransmitters and how it's affected by puberty should be standard medicine.

Q Is it standard medicine?

A It is absolutely standard medicine.

Q I just wanted to get your --

A It's coined "the warrior gene." So sometime you just Google the words "the warrior gene," and you'll find all the literature on bipolar tendencies and schizophrenia tendencies as associated with these family-hereditary forms of bipolar and schizophrenia.

Q Okay. Thank you for that.

What is, basically -- so we talked a little bit about the literature -- well, you know what? Let me talk a little bit about your report first, and that would be Exhibit 27.

And I want to just go slow and have you read -- start from page 3 and just -- let's look at page 3, at the "Medical Issues." And the first -- I think it's "Inappropriate level of expertise in the diagnosis and treatment of a pediatric patient."

And if I can just ask you to read that first paragraph under "Standard of Care" to yourself.

A Okay.

Q So are you basically saying here in your analysis that Dr. Eidelman -- or he shouldn't have made a provisional diagnosis of ADHD/bipolar?

A Yes, bipolar. I don't think he should have made any of those diagnoses without the appropriate

questionnaires at least having been performed. There isn't enough meat in his first appointment to justify those two diagnoses.

Q Okay. Let's start from the beginning. When a patient comes in, under California law, you have to have a medical note; right?

A Yes.

Q Okay. And I think what you're taught in law [sic] school -- there's a word called SOAP. Are you familiar with SOAP notes?

A In med school, we're taught that.

Q Okay. And SOAP stands for subjective, objective, assessment, and plan; right?

A Yes.

Q Would you agree that, because this patient and her -- and his father came to his office for medical advice, he had to create a SOAP note; right?

A 100 percent.

Q Okay. So SOAP note -- the first thing is subjective, and I guess that's -- what? -- the patient complaint?

A Uh-huh.

Q And then the next thing is objective, and that could be vital signs or stuff like that or --

DR. EIDELMAN: A physical exam.

MR. JAFFE: I'm sorry?
DR. EIDELMAN: A physical exam.
BY MR. JAFFE:
Q A physical exam -- objective. I'm sorry.
And then would that include lab tests or something also?
A Uh-huh.
THE COURT: Is that a yes, ma'am?
THE WITNESS: Yes.
BY MR. JAFFE:
Q And then --
A And your questionnaires. That's typically -- most EMRs now automatically have all the pull-downs. So you should be able to have your ADHD pull-downs -- click, click, click -- ask your questions. It has your depression -- click, click. I mean, it's very simple. The questionnaires take maybe a total of 20 minutes, depending on which questionnaire you're focusing your time on. But almost every EMR has it right in front of your face.
THE COURT: What's an EMR?
THE WITNESS: Electronic medical records.
We are, by law, required to be on electronic medical records. This one was not. I don't know why. But we are required by law, and we find specific

standards, like your Mini-mental State Exam. It's a standardized test.

BY MR. JAFFE:

Q So is it your understanding that all physicians in California have to have an EMR?

A Yes.

Q Really?

THE COURT: When did that go into effect?

THE WITNESS: I want to say it was recommended in 2011. I don't know when the penalties come into play at this point, but your financial reimbursability is affected whether you carry EMR or not.

So this would be a case of -- I mean, I get penalized every year by Medicare. If certain criteria are not in your charts because you're not following EMR, you do get penalized. So I'm assuming you get penalized too.

BY MR. JAFFE:

Q Actually, if I -- let me throw this out to you. There's no requirement for EMR unless you go for reimbursement.

A Yes, reimbursement.

Q So if you don't do reimbursement, then -- you'll agree -- you don't have to do EMR. Not every physician in California has to have electronic medical records. It

depends on whether you participate in this reimbursement.

A I apologize. You're right.

Q I understand. We're just clarifying the record.

A I forget. I am -- I take insurance.

Q Right. Because you and most of the physicians you deal with, they fill out insurance forms. So all of them have to do that.

A Yes, sir.

Q All right. So let's assume -- there's no indication in this case that he has EMR. All right? So doctor has to do an assessment. All right? An assessment is -- I mean, an assessment is what? You've got to give an opinion as to what you think; right?

And that opinion oftentimes is -- they have a word for this in medicine -- what's the word? -- differential diagnosis -- right? -- or probable diagnosis; right? And what that means is "I don't know. Here's what I'm thinking so far"; right? That's what it means. You're taking a guess. That's what an assessment is. Here's the information I've got. Here's what I think it might be; right?

A Uh-huh.

Q And, actually, you've seen Dr. Eidelman's medical notes, and that's what he says -- "probable"; right? That's what he says -- "probable." In 22, it

says "Probable combination ADHD" -- and ADHD is first, I believe -- "bipolar."

A Uh-huh.

Q All right. So he's required to have an assessment; right? So he says, based on what he's done, it -- you know, looks like it might be ADHD/bipolar.

Now, he has to put something in there; right?

THE COURT: Does he?

MR. JAFFE: I'm sorry?

THE COURT: That's pretty argumentative. If he doesn't know, maybe he should say, "I can't tell what this is."

BY MR. JAFFE:

Q So he could say -- let me just take the judge's questions. He could say, "I have no idea," or he could say, "I don't know. See somebody else"; right?

A I can tell you that, when you bill insurance, if somebody comes in and you think they're a diabetic, you are not allowed to write "diabetes" until you can prove that they have diabetes. So you can say "metabolic syndrome"; you can say "hyperglycemia."

There are several psychiatric codes you could put besides using the word "bipolar." Not to mention the appropriate questions were not asked to say bipolar.

Q I understand. But, again, Dr. Eidelman

doesn't --

A Bill insurance. So I don't know what to say. I'm trying to follow the normal standard practice. I mean, I'm not a concierge doctor. Maybe concierge doctors don't have standardization. So maybe this is a whole moot point. I mean, I come from the standard of medicine.

Q Standard of functional medicine?

A No. I'm a normal primary care doctor. I'm not a concierge doctor. I don't do this for a cash price. I have to follow the standard of medicine as the American Board of Family Medicine requires; as Medicare.

Q Medicare -- you have to follow Medicare; right?

A It is intense criteria for billing and coding and diagnosis. It's intense. I mean, you're affecting people's life insurance. Codes are important. I mean, you can't just flippantly pass a code to people. It has to be accurate.

Q Right. So do you feel -- I mean, now that you bring this up, do you feel that all this insurance stuff that you're doing -- that kind of drives, in part, how you treat patients or how you fill out the forms? Is that what you're saying?

A Yes. We all need structure and standardization so that we're practicing reliable medicine.

Q Because of insurance, are you saying? I mean, because you seem to be tying that because of insurance.

A Because you follow law with standards. You don't make your own law. You follow the standards that you're taught and raised on. Otherwise, why would you go to the doctor and ask my opinion? Well, who taught me? Somebody had to teach me the -- you know, the fund of knowledge that I am delivering and the approach that I am prescribing. There needs to be standardization to that. It can't just be whatever I feel.

THE COURT: I think his question boils down to -- is the standard of care being driven, in part, by Medicare or health insurance policies or other.

THE WITNESS: CMS -- California Medical Society, yes. I mean, it's not just insurance. It's the basics of where you're trained from. The Medical Board of California, CMS -- I mean, they work together as an entity to govern the way doctors practice medicine. It's not comfortable for any of us, but it creates structure.

MR. JAFFE: Thank you, Judge.

BY MR. JAFFE:

Q So your conclusion -- read your conclusion. So the conclusion is "There was severe departure from the standard of care for the failure of the practitioner, who acknowledges limited expertise in the field of pediatric

psychiatry, and the need to consult with an expert in the field to provide an accurate diagnosis and treatment plan for the pediatric patient."

I notice you also used "severe." You don't really mean severe. What did you mean by "severe"?

A It's a very not appropriate way to diagnose and treat a child of this age group. It wasn't an appropriate diagnosis, I thought, or an appropriate utilization of skills that, I feel, should have been the skills of an expert.

Q And what kind of expert would that be?

A Pediatric psychiatrist or neuropsychiatrist, based on several studies and testing and intervention, combined with the school and people that are working with this child. It requires more than a parent and a parent's opinion. It requires a group of people to make sure the diagnosis of this child was accurate.

Q And the fact -- suppose I told you that the older son was diagnosed with bipolar disorder at age five; would that change your opinion?

A It would be, I would think, important in my decision-making, absolutely. But I would like to say, "Based on what behavior?" It's not just somebody diagnosed it. I want to say, "What was the behavior of the child to justify that diagnosis?"

Q So you wouldn't even accept the fact that, in the family history, that an older child was diagnosed with bipolar?

A I would always take that into play and the dad's diagnosis. I would take that into play, but I still wouldn't be comfortable, as a sole entity, to give that diagnosis. I would ask for the integration of multiple specialties, including school, school testing, psychologists, everybody, to make sure that there was a solid understanding of the behavior and what it was related to.

Q Okay. And I would like you to assume -- there's been testimony in the case that the principal of the school gave the father an ultimatum. Now, we're not going to -- really, just for the sake of this, whether it happened or not, we don't know. But assume that to be the case -- that the principal said, "Either medicate the kid, or he's not coming back to school."

If someone had come to you with that, what would you have done in that initial visit?

A I would have contacted the school.

Q Okay. And let's say the school said, "Yes, that's true. We want him medicated."

What would you do then?

A I would do exactly what we talked about just

five seconds prior. I would ask for neuropsychiatric testing that is paid for by the school. I would ask to be a part of the 504, because of it's a medical condition. And I would ask for a one-on-one for my child. I would ask for SDC classes for my child. But I would ask, first and foremost, for nonmedication intervention first-mode.

I have never -- I mean, I have worked with several schools in our district. I have to write 504s for kids, I have to participate in IEPs for these children. It always takes a doctor's intervention. Many of our kids who have ADD or ADHD -- we participate in their care through the school. So it's not unheard of for the doctor to be working with the school.

Q So the bottom line -- you wouldn't give the child any treatment on the first visit?

A No. Not in a 20-minute -- no.

Q How about a one-hour visit?

A Medicine, no. Not for a five-year-old.

Q Nothing?

A I would do blood, I would check thyroid, I would check inflammatory labs, I would check for celiac disease. I mean, I would do something, but I wouldn't prescribe drugs. Nothing's going to happen by taking the time to do a second appointment -- not a year later, but

how about two weeks later to do some metabolic tests to make sure you have at least ruled out really common things that are fixable, like thyroid disease.

Q Who do you use -- just out of curiosity, who do you use for these metabolic labs? Do you use Doctor's Data or Genova labs -- or something like that?

A LabCorp, West Pacific, Quest. They all do every one of those tests.

Q How about the genetic testing? What would you do for that?

A There is a genomic company in Murrieta called Murrieta Genomics.

Q Right. What would be the cost of that kind of assessment? You know, let's say someone comes in to you, and you say, "Here's what you need to do before I'm going to treat the patient." Five grand?

A It $103.

Q For each test?

A For the complete -- over 100 genes tested. It's 103 genes.

Q A CBC costs what?

A A CBC, $25.

Q So you're saying all the testing, all the charges you would charge --

A Are you asking me what is the cost of a genetic

test?

Q The whole thing. What does a workup cost that you just described?

MS. BROWNE: Objection. Vague.

THE COURT: Well, hang on.

You just described a number of things you could check with blood tests, genetic tests, and this that. So approximately what would that cost, cash money?

THE WITNESS: If I did a complete thyroid, it's $40. I mean, I'm just going to tell you, if I have a cash patient and a cash patient has no health insurance, which is -- with Covered California, you make sure every child has health insurance. So I have no understanding of a child not having health insurance.

BY MR. JAFFE:

Q So you don't think children in California -- there's some children who don't have health insurance?

A It's a simple signup.

THE COURT: But we're talking about 2012.

THE WITNESS: Okay. So in any case, if you can afford to pay a concierge doctor cash, then you should be able to afford a general thyroid panel, a TSH, a CBC, a chemistry. I have a nanny that I pay cash, $100, for her basic blood.

///

BY MR. JAFFE:

Q That reminds me. The CBC -- you understand this patient was treated in 2012; right?

A Yes.

Q Right now CBC [sic] is quite popular, isn't it?

A CBC?

Q CBD oil.

A Yes.

Q But it wasn't really that available in 2012?

A True.

Q And it's exploded in the last two or three years; right?

A Uh-huh.

Q So fair to say, it wasn't really an option back in 2012 because it just wasn't really being done. I mean, you had only a few manufacturers.

By the way, is your understanding the CBD oil --

THE COURT: Each question you're going to want her to answer.

MR. JAFFE: Okay.

BY MR. JAFFE:

Q Do you think that CBD oil is legal right now?

A It is.

Q What makes you think that?

A It's available at Sprouts.

Q Right. Do you know what a Schedule 1 drug is? Do you know that CBD oil is a Schedule 1 drug?

A So is Prevacid, but it's over the counter.

Q You think Prevacid is a Schedule 1 drug?

A It's a pharmaceutical drug. It's available over the counter.

Q Okay. All right. I'm just asking you about your understanding.

But you think CBD -- do you have an opinion as to whether or not it's called an FDA Schedule 1 drug -- CBD?

A I didn't know that until you said it to me right now. I just simply know it is readily over the counter so we don't really even consider it as a controlled substance because it's readily available.

Q Okay. I mean, that's -- I think you're right. It is available over the counter, but it is, I think, FDA considered a Schedule 1.

A Okay.

Q All right. Now, if I tell you that probably the standard --

I'm sorry?

THE COURT: I think we're going to take a 10-minute break.

(Recess)

THE COURT: Let's go back on the record.

MS. BROWNE: Your Honor, in my copy, I didn't have Dr. Briggs's CV.

THE COURT: Yeah, I've got a blank spot in my volume.

MS. BROWNE: Pardon?

THE COURT: I don't have one either.

Does counsel have one?

MR. JAFFE: No.

THE COURT: Is this the only one you've got?

MS. BROWNE: No.

THE COURT: Okay. You've got to share, just like in kindergarten.

Okay. Some more questions on direct -- cross, I mean?

MR. JAFFE: Very briefly.

BY MR. JAFFE:

Q I think you were given this part of the medical records -- I hope you were -- the hospital admission at Del Amo Hospital for the child in 2016. Are you familiar with that?

A No.

Q Okay. Can I direct your attention to Tab 32?

A Sure.

Q And let me represent to you that this is the hospital record for the child. He was hospitalized

12/31/2016. If you take a look at the second page on the -- there's something called an "Admitting Diagnosis." What's an admitting diagnosis?

A Was this a psychiatric facility or a hospital?

Q Actually, I think it's a behavioral facility.

THE COURT: It's a psychiatric hospital.

THE WITNESS: Yeah. So it's an admitting diagnosis.

BY MR. JAFFE:

Q So that means what the doctors thought he had when he first came in?

A Correct.

Q And that's -- the diagnosis is disruptive mood dysregulation disorder. That's kind of what we were talking about before.

A Uh-huh.

MR. JAFFE: And that's a "yes," for the court reporter.

BY MR. JAFFE:

Q And that -- I think what you said is that that's essentially like bipolar?

A Okay.

THE COURT: No, I don't think she said that. I was telling her that that was the testimony -- or the summary of some testimony we've received already.

MR. JAFFE: All right.

BY MR. JAFFE:

Q Do you know what the difference is between disruptive mood dysregulation disorder and bipolar?

A No. I told you this is literally the first time I've heard that.

Q Oh, the term?

A Uh-huh.

Q Okay. All right. But, I mean, it's fair to say because there was an admitting diagnosis, they didn't do all of your -- I mean, there's no record here that they did all that stuff that you talked about with the pull-down menus and whatnot. I mean, it seems to me what somebody did -- correct me if I'm wrong -- is somebody took a look at the patient for some period of time and came up with an initial admitting starting diagnosis; right?

A Oftentimes, in these types of hospitalizations, the parents say, "He has been diagnosed with this." So it's often per the parent.

Q Right. So you can't tell if it came from the parent or the doctor made this differential diagnosis?

A Right.

Q Right. And just so you know, because you haven't looked at it, it looks like the next day he had a psyche evaluation, 1/1/17, and then the final diagnosis

was the same thing later on. So it looks like they stuck with the same diagnosis.

But anyway -- all right. If you don't know anything about this condition, then that's all I have. Thank you for coming here.

THE COURT: Any redirect, Ms. Browne?

MS. BROWNE: Yes, Your Honor.

Now that we have the CV, is it okay if I --

THE COURT: Sure. Ask her some question about it.

I don't want you reading things to her. She's a good reader, I bet.

THE COURT: Doctor, did you go to medical school at U.C. San Diego?

THE WITNESS: Yes, I did.

THE COURT: Okay. That's what I was inferring, but I wanted to be sure.

MR. JAFFE: I'm done, by the way.

THE COURT: Okay. Do you have anything else, Ms. Browne?

MS. BROWNE: Yes, Your Honor.

REDIRECT EXAMINATION

BY MS. BROWNE:

Q You used earlier the expression "concierge doctor," and I've also heard the phrase "functional

medicine." Functional medicine and concierge doctor -- is that the same thing? Or what are those terms?

A They're very different terms. A functional medicine doctor could be a concierge doctor. A functional medicine doctor could be a normal-practicing insurance physician. So I think we come in various forms. I'm a functional medicine doctor, but I do standard medicine, I bill insurance, I take normal insurance rates. So I don't receive cash appointments. So you govern me a little bit differently.

Q So is that what a concierge is? Was the definition that they take cash patients?

A Typically, concierge doctors -- there's a number of different styles, but oftentimes they receive cash for their appointments. Some of them are part of a network where you can pay a fee for $1,800 a year and be able to tap into that resource as often as is needed. So they're not necessarily paying per appointment, but, generally speaking, it's a cash based type of practice where they don't use insurance.

Some doctors actually do both. They'll charge a cash price, like $1,800 a year, and then still take fee for service, which is PPO medicine. That's very popular in my Valley. So, I mean, generally these doctors have a smaller subset of patients. They usually don't have as

many, you know, patients to juggle, and they can be a little bit more independent and kind of beat to their own drum. So there's various forms of concierges.

Q Okay. So when you say "standard medicine," I want to make sure that we're talking apples and apples. When you were talking about standard medicine -- that you practice standard medicine and the insurance billing, that's not one and the -- is that the same thing? Were you equating the two? Do you understand my question?

A The only difference, I want to say, that I've ever known was -- I mean, traditionally, if you're board certified by the American board of whatever you're in, we're all governed by those same laws -- whatever they're pertaining to: prescribing, ordering. I mean, generally, we're all under the same category.

When you also take insurance, you are having to keep in mind the cost of things. Because, for example, if I were to write a PSA in a Medicare patient, it's not covered. So that's going to be at the risk of the patient to pay that.

Q What is PSA?

A Prostate-specific antigen.

So you can't just do whatever you want in standard medicine. A lot of times you have to follow the bylaws of California Medical Society or Blue Cross or

Medicare. So we have a little bit more regulations. You can actually order anything you want, but at the risk to the patient cost-wise. So you have to be a little bit more mindful of how you spend the patient's money.

Q So is it possible that you're holding Respondent to a higher standard? Because of your board certifications and the insurance that you take, you have to meet other certain standards. Is it possible that you're holding Respondent to a higher standard of care?

A I think so. For example, one of the things that's very common is if I were to see a patient -- let's say I said this patient had bipolar -- and Blue Cross will pull my chart. And let's say I used this code bipolar, and I ordered this blood test. Blue Cross will randomly pull charts, they'll review your charts, and they'll look at the review of systems; they'll look at your documentation; was there enough meat in the subjective and the objective -- the assessment and the plan -- or they'll fail to cover the appointment if they don't feel that you've met their standard of the appropriate assessment/diagnosis -- ordering labs, what have you. So it is -- it requires a lot more conscious medicine, or you risk the patient not getting the labs covered.

That's different for a concierge doctor because

if you're not billing insurance, you don't have somebody breathing, you know, around your neck making sure you crossed your t's and dotted your i's. But I think it puts a safety network in there to make sure that you do that extra labor.

I mean, I still see 27 patients a day. I do 20-minute appointments, and there's only so much you can do in 20 minutes. It takes more appointments to be really thorough, which is why we don't rush into giving big diagnoses before we've been able to collect the data, and because we are regulated by the insurance companies and CMS.

Q So I don't think I was --

A Am I not answering your question right?

Q Oh, no, no. I didn't phrase it right, so give me another opportunity here.

When the Board sends you the expert package -- when they sent you the items that you reviewed in order to come up -- to write your report, they ask you to -- you wrote it in a very prescribed format. And one of the things -- the first thing for each issue is the standard of care.

So I want to make sure that -- when you analyzed the standard of care, I want to make sure that you were talking about the standard of care generally applicable

that a reasonable doctor would do -- the regular definition of what standard of care is.

A Yes. My point of saying -- following the standard of care simply means -- when you are a traditional doctor, and you have a lot move governing bodies, you're less likely to deviate from the standard of care because you're babysat. You know your charts will be pulled at a blink. Medicare walks into your clinic once or twice a year, so you better be having the standard of medicine and care and accuracy of your charts and everything. You will dot your i's and cross your t's.

In concierge medicine, it's a little bit easier to get away with your own style of medicine and to deviate from the standard of care. I'm not saying it's right or wrong. I'm just saying that sometimes that freedom that is necessary at times -- I mean, I am a functional medicine doctor because I heartfully believe that standard medicine doesn't work for everybody. It's sometimes the worst thing we can offer to anybody. So I am, by no means, disrespecting or disregarding the style of medicine. I think it's extremely valuable.

Q So when you're an expert and you are reviewing patient care, for a concierge doctor who just takes cash only versus another doctor who takes insurance and is

board certified and has to follow the extra requirements that you were talking about -- when you're analyzing those two different cases, are you talking about the standard of care -- here, in your expert opinion, are you talking about the standard of care for insurance or for a doctor even if they don't take insurance?

MR. JAFFE: Judge, may I say, I think we understand what's going on here. This is now the third time the Board attorney is trying to elicit the same testimony.

THE COURT: Yeah. We've been going over this ground. I'll sustain an objection to it.

MR. JAFFE: So asked and answered. Cumulative.

THE COURT: Okay. Sustained.

BY MS. BROWNE:

Q Do you recall whether you were asked to submit an amendment or an explanation to your expert opinion by the Board in this case?

A Yes, I was.

Q And did their asking that have to do with the label that you had put on -- in your conclusions?

A Yes.

Q And do you recall they wanted it changed so that -- do you recall specifically anything about that?

A Yes. I think the gentleman alluded towards I had said "severe," and it was supposed to be extreme. So

I used the wrong verbiage when I was typing too quickly. Apologies. I'm sorry.

Q No problem. But when you did that, you read the Board's guidelines about doing an expert review, and when you said "severe," you meant extreme?

A Extreme, correct. And I did fix it. I think you just don't have the right copy in there.

Q Yes, that's true.

Excellent. Thank you. Just a couple of other things. Your CV is -- can be found at --

THE COURT: 26.

BY MS. BROWNE:

Q -- 26, Exhibit 26. And I wonder if you can take a moment to look that over. If you could take a moment to review it, please.

Does that -- is there anything else that's in your CV that is significant in helping to see that you did a good job analyzing this case?

THE COURT: You mean that she's qualified to do it?

What would the CV tell me about whether or not she did a good or bad job here?

MS. BROWNE: Thank you, Your Honor.

BY MS. BROWNE:

Q I guess I'm just trying to ask if I missed anything that the CV brings to mind.

A I mean, I can tell you that I feel like the CV is clearly not updated. My office manager faxed it over today.

So, in any case, I speak worldwide -- I speak in Taiwan; I speak in Australia. I am a regular speaker for multiple pharmaceutical companies and nutraceutical companies. I have a teaching course in genomics that I teach. I mean, I hope that I'm qualified. I mean, I could go on and on, but it really doesn't matter.

THE COURT: Doctor, you're licensed to practice medicine.

THE WITNESS: Thank you.

THE COURT: That qualifies you to assist me in determining what's what in the field.

MR. JAFFE: And, Judge, she's a big deal in the functional medicine -- in the field. She's a big deal.

THE COURT: All right.

BY MS. BROWNE:

Q Okay. So if we could please turn to Exhibit 34.

MR. JAFFE: And can I inquire -- are you going to ask some questions about another expert?

34 is Dr. Scherger's opinion.

MS. BROWNE: Right.

MR. JAFFE: I'm going to object to that. Beyond the scope of cross.

THE COURT: Yeah, it's kind of out of the scope, ma'am. That's why we relax the rule about the scope of cross once we get to redirect. I think I have to sustain the objection.

MS. BROWNE: Okay. Your Honor, we were hoping to avoid needing a rebuttal witness.

THE COURT: Well, you should hope that because the rule on a rebuttal witness is that they're only there to -- they're not there to put on things that should have been in your case in chief. This witness is part of your case in chief, providing evidence that you hope is going to convince me that the Respondent here has in some way violated the standard of care, and, therefore, there should be some kind of disciplinary result.

I expect that there's going to be disagreement between the experts on your side and the Respondent's side. And if we go down that road, then they would have to come back with their experts to try to rebut what your rebuttal is, and we're not going to do it that way.

MS. BROWNE: Thank you, Your Honor.

THE COURT: I do have one question, ma'am. Have you run across Dr. Scherger there when you were in San Diego?

THE WITNESS: No, I didn't.

THE COURT: It must be a big hospital down there in

San Diego.

THE WITNESS: There's lots of them.

MR. JAFFE: I think Scherger was at PACE.

THE COURT: His CV indicates he was teaching at the school down there, not just part of the PACE. But we're past that.

THE WITNESS: It was after me.

THE COURT: There seems to be some overlap here, '92 to '93.

In any event, is there any other question for this witness, Ms. Browne, to tie in with her direct or cross.

MS. BROWNE: Yes, Your Honor. If we could turn quickly to Exhibit 22, page 4.

THE COURT: 22?

MR. JAFFE: That would be his medical notes -- Dr. Eidelman's medical notes, page 4?

And I'm hoping this is going to be within the scope of cross.

THE COURT: Well, I don't know.

MS. BROWNE: I'll ask my question and --

THE COURT: We'll see what happens.

MS. BROWNE: Okay. And I believe this is my last question.

///

BY MS. BROWNE:

Q I wanted to ask -- what is the importance of follow-up care?

A Simply, in this particular case, the standard of care is usually, if you are going to use something of label, which we do all the time as doctors, that you would have a much closer follow-up to assess in your own eyes, rather than solely in the eyes of the parent -- but was the child having an improvement in signs and symptoms of ADHD or bipolar.

So my concern was -- you know, the initial visit was in 2012, and there wasn't a face-to-face appointment for almost exactly a year. And I understand he wasn't on the marijuana the entire time. But, I mean, generally you would want to keep assessing the child and confirming that, even if he wasn't using one modality, that he wasn't being completely ignored and, again, try to prevent the hospitalization that eventually did ensue.

So, you know, if we were using something, especially in pediatrics, there's always -- you don't walk out the door without a follow-up appointment within a very short period of time -- two weeks, four weeks -- especially neuorcognitively-wise. It's a pretty short follow-up traditionally.

MS. BROWNE: Thank you. No more questions.

MR. JAFFE: I just have a couple redirect, hopefully on point, to follow mine up.

THE COURT: It's okay.

RECROSS-EXAMINATION

BY MR. JAFFE:

Q Just to be clear, when you talk about insurance and, you know, concierges and all -- let me throw out a term and see if this might help you refine your thinking a little bit.

Have you ever heard the term "defensive medicine"?

A No.

Q You've never heard of doing things just to CYA? You never learned in medical school about defensive medicine?

A (No audible response)

Q No? Okay.

A Sorry.

Q And as I understand your testimony, you treat -- you see around 26 patients a day?

A Uh-huh.

Q For an average of --

THE REPORTER: Was that an "uh-huh"?

MR. JAFFE: Yes.

THE WITNESS: Yes.

MR. JAFFE: That was a "yes." We can translate her.

BY MR. JAFFE:

Q And your average patient time is 20 minutes?

A It's about 20 minutes. But it's between my nurse practitioner and I. So sometimes she'll start the patient, and I'll wrap up the patient.

Q And that's 20 minutes total, you think?

A Right.

Q Right. So the nurse practitioner will do the initial workup, and then you'll come in and review the electronic medical records and give your input and all that?

A Yes, sir.

Q And that entire transaction is 20 minutes. And you have EMR, so everything is right at your fingertips.

A Absolutely.

MR. JAFFE: Thank you very much. I really appreciate your coming here.

THE WITNESS: Thank you.

THE COURT: All right. You're excused. Thank you.

THE WITNESS: Thank you.

MR. JAFFE: Judge.

THE COURT: Yeah.

MR. JAFFE: Anyway, it's 3:30. At your pleasure --

can we go off the record for a little bit?

THE COURT: Yeah.

Off the record.

(Discussion off the record)

THE COURT: Back on the record. We'll start some direct with Dr. Eidelman until 4:30. I've got to stop at 4:30 because I've got to be someplace. If I'm not there on time, my wife will be unhappy.

MR. JAFFE: There might be an appropriate time to stop even a little bit before that. That's the hard deadline -- 4:30?

THE COURT: Yeah.

MR. JAFFE: Okay. I'll figure out an appropriate time.

THE COURT: All right. Come on up here, Doctor. We'll get you sworn in too.

Raise your right hand, sir.

WILLIAM EIDELMAN, M.D.,

called as a witness and having been first duly sworn by the Court, was examined and testified as follows:

THE WITNESS: Yes, Your Honor.

THE COURT: Okay. Keep your voice up, sir, because, otherwise, Donna won't be able to hear you, and we won't

have a clear record, and that would be bad.

Counsel.

MR. JAFFE: Thank you, Your Honor.

DIRECT EXAMINATION

BY MR. JAFFE:

Q Dr. Eidelman, how old are you?

A 69 1/2.

Q Okay. Can you give --

MR. JAFFE: I'm not sure I've got his CV in the record.

BY MR. JAFFE:

Q Could you give, just briefly, your CV starting with your college, medical school, and then training. And then go into your -- what you've done, you know, since you graduated and where and whatnot.

A Okay. I went undergraduate to UCLA. I went to medical school at St. Louis University. I did --

Q And when did you graduate, sir?

A I graduated from UCLA in 1970 -- December of 1970. I graduated from St. Louis University in June of '75. I did -- back in the day, they used to have a combined internship/residency in psychiatry, and so I started in that, and I did a year and a half.

But I dropped out at that point for the purpose

of going into alternative medicine because I felt that the conventional medicine was on the wrong track and didn't know it, and I didn't want to be on that train; so I was looking for other directions.

And so the first part -- I mean, I did some work as a general practitioner at Highland -- sorry -- at Kaiser hospital in Oakland. So I did some, you know, ordinary GP work on and off for about four or five years.

Q In the late '70s?

A In the late '70s, early '80s.

And then I was also studying what I now call alternative psychiatry that's based, in a way, on Eastern meditation practices and philosophy.

Q Tell me a little bit about that. So what kind of Eastern practices in medicine, and what kind of treatments would that involve?

A Well, what it boils down to is that, deep down, we're born healthy. And mental health -- you should be feeling good and happy, positive. And most people I've met -- there's mental illness, which, you know, is a diagnosable disease where you are sick. But even people who aren't necessarily diagnosed with mental illness, people aren't necessarily that happy, don't feel good, and aren't really living good lives.

And so my orientation was to go into, really, a

positive state of mental health as opposed to just getting rid of your misery and still being basically, you know, going from severe misery/mental illness to the normal misery that everybody's living in.

Q Well, that's a little --

A Well, I mean, you know, basically, most people aren't exactly living joyful, blissful lives.

Q And that's kind of what you're referring to as alternative psychiatry?

A So my alternative psychiatry was to be how to move from the, sort of, normal, not really positive/happy, you know, grinding through your life to how to be more joyful and ecstatic and loving.

Q And that was your -- part of your medical practice?

A No. That was what I call -- well, later came to call alternative psychiatry. But it involves using meditation techniques and awareness. I mean, Freud was the first Westerner to talk about that we are mainly unconscious. And most people didn't and still don't understand that.

But my work was how to become conscious. And once you're conscious and awake, then you're just naturally joyful and loving. And so I worked with different techniques involving that concept and process

until around 1990.

Q So basically throughout the '80s?

A Throughout the '80s.

Q Okay.

A And I did learn that technique that involves -- well, let's say that it turns out -- and this isn't known by most doctors -- that the body is literally a liquid crystal with the same type of solid-state electromagnetism as modern technology. So we're basically full -- literally, full of energy, but Western medicine and scientists have been taught that the body is electrochemical but not electromagnetic, and people still believe that.

But it turns out the body is electromagnetic and full of energy in a variety of different harmonics and types, and that it turns out that you can use different aspects of energy in different ways to stimulate the healing process. And one of them involves the use of your hands. So I actually was doing this kind of practicing and teaching -- a kind of hands-on energy healing that was very effective.

I mean, it's not -- I wouldn't ever say that I cured anyone of cancer with it, but many simple things. People come in feeling bad, and they would leave feeling better. And in the workshops that I gave, people would

feel better and be able to do that to other people.

And so in combination with the meditation and all that -- I was doing that until around 1990. And then in 1990, I was introduced to the work of Jonathan Wright and Alan Gaby, founders and initiators of what now we're calling functional medicine. And so from Jonathan Wright and Alan Gaby -- they gave, basically, a four-day, very intensive course of nutritional medicine, going through all the nutrients and all the diseases and what you can use to treat -- you know, which nutrients for which diseases and how to apply them sometimes intravenously. And I, overnight, changed to that kind of a practice.

Q And what kind of a practice was that?

A What they're now calling functional medicine.

Q But that was before it was called --

A That was before it was called functional medicine. So nutritional medicine -- they called it nutritional medicine for the '90s when I took the course in 1990. So nutritional medicine.

But it also included the energy medicine, and so energy medicine and nutritional medicine. And so I did that until around -- or I continue to do that to this day. And then in 1996 -- November of 1996, the Compassionate Use Act passed and went into effect in '97.

Q The marijuana thing; right?

THE COURT: What we call medical marijuana.

THE WITNESS: Right. So then in 1997, one of the, sort of, leading cannabis activists came to me and asked me if I would write him the letter. And I initially balked at it, and he kind of tried to talk me into it. And part of trying to talk me into it was, "Look. Read the law. 11362.5, Section C, says, 'Notwithstanding any other provision of law, no physician in the state shall be punished or lose privileges for recommending marijuana for medical purposes.'" He said to me, "Look. You're safe. You're protected by the law." So based on that, I started writing the letters.

Q Based on what?

A That I thought that I wouldn't get in any trouble for doing it -- that it was safe; I was protected. The law protects me.

Q Okay.

A So I began writing the medical cannabis -- well, he started then sending people to me, and it turned out that there were a few other doctors in Northern California who were already writing the letters in 1997.

Q Like -- one of them was Tod Mikuriya?

A Like Dr. Mikuriya and Dr. Hergenrather, who we're going to meet tomorrow. But I was the first one in Southern California.

And so this first patient that I had written it for told other people, and the word spread. People would ask me, "Is it okay -- can I send people to you?"

And at the time, I said, "Well, only if they're seriously ill. Don't send me people who aren't seriously ill."

So I got a lot of people who were seriously ill. And then in the -- in the process, you know, people would come in for medical cannabis. I'm a functional medicine doctor, so they would come in with arthritis, and so I would say, "Well, look, arthritis is an inflammatory process, and cannabis is a known anti-inflammatory, but here's a long list of other things you can do, both with your actual diet -- because foods can be pro-inflammatory. Here's nutritional supplements that are anti-inflammatory or have been known to help in your condition for whatever reason." And then also the energy-medicine part.

So, basically, I would continue to do my nutritional medicine or functional medicine practice, and then cannabis was just a part of it. And it's true, that, after a while, most people were walking in the door for cannabis, but I would always tell them about these other things. Now, a lot of times they weren't interested, but a lot of times they were.

And in November of 2004, I began using this microelectric current device called the Alpha-Stim, which is amazingly effective. Their biggest customer now is the military because it's so effective for stress reduction. And it was rumored that it works for addiction, but the company is not allowed to say what it knows because of FDA regulations. But I thought, "Wouldn't it be cool if it worked?" But I put it on my desk, and if patients would come in and they're anxious or they're depressed or they have headaches, I would give them the treatment while we were doing the consultation.

THE COURT: And this is called what?

THE WITNESS: The Alpha-Stim.

THE COURT: I thought that's what you said, but I wanted to get it right.

THE WITNESS: And I was really shocked at how effective it was. People would get relaxed. They would go into a deep state of relaxation in two minutes nearly every time. Well, the ones who wouldn't get relaxed in two minutes, they would get relaxed in five or ten minutes, and maybe 1 out of 10 would take longer and not get the effect, and 1 out of 1,000 would say they didn't like it; "Please take it off."

And then after a year and a half, in June of '06, someone came in addicted to methamphetamine, wants

to get off of it today, and can I help her. So I hook her up to the Alpha-Stim, her craving ends immediately, and she gets off of it like a piece of cake. Now, granted, she was motivated, but it worked.

So I think "Oh, wow. It really works. Let's see what it does on cigarettes." So then cannabis patients come in, and I say to them, "Well, do you smoke cigarettes?"

"Yes."

"Do you want one now?"

"Yes."

"Can I hook you up just for fun to see what happens?"

And they would usually go, "Okay."

And two minutes later the craving is gone every time. And I kept track of it and wrote it down, and after -- well, basically, it completely, 100 percent, takes away any interest in a cigarette 94 percent of the time. And then 6 percent of the time, they would say, "Oh, I want one, but less."

And then after about 400 of these people, because I was keeping track, something happened that made me realize that if I asked them at the beginning, "You can feel the craving physically -- right? -- it's not just mental." And they would pretty much always agree.

And then in the 6 percent who would say, "Oh, I still want one, but less," I would say, "Yeah, but if you check into the physical part, is it still there?"

And then they go, "No."

So then it would -- for taking away the physical, it became 100 percent pretty much. And for taking away all of it, it still remained about 94 percent. So I've continued to do it now since 2006 and --

Q You ever write anything up about it?

A I do have an article published in a publication called the "Townsend Letter" that was published in '09.

Q So the Alpha-Stim -- do you still do this Alpha-Stim?

A Oh, yes, absolutely.

Q That's part of your practice?

A That's part of my practice.

Q Okay. Well, let's focus, you know, on the medical marijuana part of it.

So you start doing this in '97 and '98. And what kind of patients do you see in terms of medical marijuana? Can you characterize your patient population?

A Well, it's basically every type of person and condition that you can think of. Because cannabis really does -- well, it treats the symptoms of many different

diseases. It's known to be anti-inflammatory, and most diseases are inflammation related. So, of course, it's going to reduce inflammation, and they're going to feel better.

So an example would be like, let's say, a patient who's got something like lupus or rheumatoid arthritis or that family of disease, and then if they begin as a novice -- or virgin, if you will -- taking the cannabis, they feel better right away when they take it. It wears off; they don't feel as good. But if they continue taking it, the anti-inflammatory effect takes about three months to maximize.

So then after three months, even after the acute effect of the medication wears off after some hours -- depending on if they do it orally or if they do it by mouth -- then, after they've been doing it for three months, they feel much better than they did after they've done it for a week.

And then somebody who like, let's say, for whatever reason -- it might be they moved to an area where they can't use it, or maybe they get put in jail and they can't use, then it takes three months for the anti-inflammatory effect to wear off.

Q What other effects have you noticed in terms of medical marijuana, aside from anti-inflammatory?

A Well, I mean, it's usually antidepressant. I mean, the intoxication effect is often referred to as getting high. And if someone starts out low and gets high, it might not get them really high, but bring them back to normal, so that's why the antidepressant. Does that make sense?

Q All right. Just, again, let's focus on -- so what kinds of -- so what do you -- what kind of practitioner do you consider yourself to be? I mean, because we've had a psychiatrist who basically does drugs, and we've had a family physician who calls herself a functional doctor. What are you? What do you refer to yourself as?

A Well, I refer to myself as a consultant in alternative medicine. I could call myself a functional medicine doctor. I practice -- basically, I do the same things as most functional medicine doctors do. Although, of course, there's a wide range of things that people would do under that name.

Q Well, what about -- medical marijuana isn't part of functional medicine, is it?

A Well, I think that if you had Dr. Jeffrey Bland here, who is really the founder of functional medicine, he would say it is.

Q Oh, really?

A Yeah.
Q Because it's a plant?
A It's an herb.
Q And functional medicine deals a lot with herbs?
A Anything natural.
Q Anything natural.

All right. So how do you view yourself in terms of -- there was some testimony from Dr. Raiss yesterday that you're a consultant, super specialist as opposed to -- I don't know -- like some general internist or something.

Talk to me about what you think you do.

A Well, in a way, it got created artificially by the law to begin with.
Q How so?
A Well, when cannabis was illegal, nobody recommended or prescribed it. You couldn't really talk about it -- you wouldn't think about talking about it to your patients because it's just illegal.

And then once the Compassion Use Act passed, and then by law you could, and the patients need the letter to use it. I mean, it's -- up until, like, last year -- Prop 64 -- you couldn't just go and get it without talking to the doctor. So it created this specialty of doctors writing the notes. Because the normal,

conventional doctors wouldn't do it because they were too afraid. But then a doctor, who is either stupid or courageous, would write the letters, and they became the specialists, which I'm one of them.

And there's a group that -- it had a different name to start with, but the current name is the Society of Cannabis Clinicians, of which Tod Mikuriya was the founder, and Dr. Jeff Hergenrather has been the director of it since Dr. Tod died. And that's a group of cannabis specialists that's been growing and growing over the years. And now that other states have approved it, then it's even interstate and international.

Q Okay. And you understand that part of the record in this case are the prior proceedings involving the Medical Board?

A Yes, very well. Thank you.

Q Just because it's part of the record and, perhaps, Ms. Browne will ask, I would like to just go over a little bit because it is -- I wouldn't normally do it, but it is part of the record, so it's fair game.

So can you just briefly go into the prior proceedings, from your perspective, starting -- I think there were two prior proceedings?

A Well, there were three really. The first proceeding was the one where I wasn't really allowed to

defend myself. It was an interim suspension order hearing. No witnesses were presented. Just the Board presented their expert witnesses, and I wasn't allowed to rebut them at all.

Q Were you there?

A I was there, but I wasn't allowed to rebut them. I wasn't allowed to defend myself in the slightest.

Q You couldn't testify?

A No. My attorney made a little written thing of why we should be able to wait for the full hearing on the merits before the suspension, but I got suspended.

Q All right. But you didn't put on any witnesses?

A No. And I wasn't allowed to confront my accusers.

Q So you didn't -- there was no cross-examination of the Board?

A Absolutely not.

Q So as a result of that temporary suspension, your license was suspended. And that was -- what? -- 2003?

A That was May of 2002.

Q 2002.

A Right.

Q And then, at some point, did there become a formal Board action?

A So then, there was a settlement agreement that I made that I wasn't happy with, but I made it. And then the Board rejected it.

Q So you and -- not the Board, but you and the Attorney General's office?

A The DAG at the time made a settlement agreement with me; the Board rejected it.

So then I had a hearing and Your Honor -- Judge Montoya might even remember a meeting that he had with me.

Do you remember that, Your Honor?

THE COURT: I don't want to get into any settlement conferences, because that's what it would have been.

THE WITNESS: This was after the settlement conference when the hearing was scheduled.

THE COURT: So I wasn't on the medical panel at the time.

THE WITNESS: But you made a very nice talk to me that day to feel confident in the ALJs -- that they're not rubber stamps for the Board.

THE COURT: Yep, that's how it is.

THE WITNESS: So, anyways, I did have the hearing.

BY MR. JAFFE:

Q The full hearing?

A The full hearing on the merits, which you were

my attorney.

Q Right. Right.

A And although they did -- Judge Waxman did find me -- I don't know if the word is guilty. What's the right word?

Q Liable.

A But in the process, he did make the statement that's on page 58 or whatever the ruling, that I provide a valued and valuable service and should be allowed to continue, so I was under administrative probation. So I went through five years of administrative probation.

Q Tell me, what did that involve? Because that's going to be relevant. So what was the administrative probation? What were the terms?

A Well, I mean, I had to go through some processes with PACE, which I did -- some courses at PACE and an evaluation at PACE. So I went through the evaluation at PACE, the couple of courses that I had to do. And then I was supposed to have a practice monitor, and then the Board rejected, like, several of the practice monitors I proposed. And then it defaulted back to PACE, and PACE -- so PACE --

Q Assigned someone?

A -- assigned a practice monitor, and that was Dr. Scherger.

Q Dr. Scherger -- Dr. Joseph Scherger.

MR. JAFFE: Judge, he's going to testify tomorrow.

THE COURT: That's what I thought was going to happen tomorrow.

MR. JAFFE: He's going to be the first witness.

BY MR. JAFFE:

Q So Dr. Scherger was appointed as your practice monitor. And just to affix a time, when was that? 2005-ish or something?

A By the time he came on board, it was probably shortly into 2005.

Q Okay. And what was your role?

MR. JAFFE: And, Judge, I'll ask this witness about it so I don't have to ask Dr. Scherger in detail. So hopefully we're only going to hear this testimony once.

BY MR. JAFFE:

Q What was his responsibility as the practice monitor?

A He would come and visit my office four times a year. And then I would send him a list of patients by initials, and they would randomly pick out seven patients a month, and I would send in the medical records of these seven patients, and he would evaluate them.

Q And did he do, like, a written report of the evaluation?

A And he would do a written report every -- I forget how often -- once a year or something.
Q Right. And then would he give you a copy of that written report?
A Yes.
Q And give a copy to the Board?
A Yes.
Q And that went on for five years?
A Yes.
Q So he saw -- 7 times four, times five -- whatever that number is, roughly?
A You mean in terms of the number of patients that he saw?
Q Yeah.
A Well, 7 a month times 12 is 84 a year, and times five years, so 440 patients -- or 420 patients.
Q So he reviewed the charts of roughly 400 patients over that five-year period of time?
A That's 400 a year.
Q 400 a year?
A 400 a year times four years, so 1,600.
THE COURT: No. It's 84 a year. It's 12 times 7 per year. Every month --
THE WITNESS: Yeah, you're right.
THE COURT: It's a total of 400-plus over the five

years.

THE WITNESS: Excuse me.

Anyway, he looked at a lot of the patient records, and --

BY MR. JAFFE:

Q Did he ever have suggestions for you?

A At the beginning, I think he made some suggestions that I followed.

THE COURT: This is because there was a recordkeeping issue in that prior proceeding; am I right?

THE WITNESS: That's right.

BY MR. JAFFE:

Q So one of the things he was worried about is records?

A That's right.

Q Now, he actually worked with PACE; right?

A He was -- yeah, he was at PACE in a high-up position, but I don't remember what.

Q Okay. We'll ask him about that.

Okay. He looks at about 400 records. He does these reports to the Board. And then, I guess, at some point, did you come off the probation, and, if so, when?

A Well, during the course of probation, there was a parole officer that made a complaint to the Medical Board about a letter I had written to a patient who was

on parole. And, again, I made a settlement that I didn't like, but I agreed to it.

Q There was another accusation?

A There was another accusation.

Q And that would be in 2009-ish or something?

A Well, 2008/2009, somewhere in there.

Q Okay.

A And so I agreed to a settlement that I didn't really agree to, but I agreed to it. And the Board rejected it, and it came to another hearing.

THE COURT: And that's the one with Sam Reyes; is that correct?

THE WITNESS: That's the one with Sam Reyes.

And they gave me a reprimand for not having -- basically, not doing his blood pressure, but otherwise rejected the Board's accusations.

But when that decision was finalized, that was -- well, my probation could not end until that proceeding ended. So the probation ended up lasting two or three months longer than it would have if it wasn't for that.

BY MS. BROWNE:

Q Because of the pendency of the decision in the second administrative case?

A That's right. So it would have ended in July of

'09, but it actually ended in October of '09 when the final ruling came in in my favor, except for the reprimand -- the public reprimand.

THE COURT: And that's because the standard probation terms say that probation is extended if there's a filing of a proceeding during the probation.

THE WITNESS: Right. Right.

THE COURT: So there you go.

So that brings us to October '09, and it brings us to about 4:25.

MR. JAFFE: It's a good time to stop, Judge.

THE COURT: Well, I'm listening. I've got that whole history in the record here.

MR. JAFFE: Right.

THE COURT: Now you're stuck with me because Sam Reyes retired recently.

And he said, "Joe, why don't you get in the saddle?"

I said, "Okay. I'll do a turn in the barrel here." So here I am.

All right. 9:00 o'clock tomorrow.

Off the record.

(Proceedings concluded at 4:25 p.m.)

REPORTER'S CERTIFICATION

I, the undersigned, a Certified Shorthand Reporter of the State of California, do hereby certify:

That the foregoing proceedings were taken before me at the time and place herein set forth; that any witnesses in the foregoing proceedings, prior to testifying, were duly sworn; that a record of the proceedings was made by me using machine shorthand, which was thereafter transcribed under my direction; that the foregoing transcript is a true record of the testimony given.

Further, that, if the foregoing pertains to the original transcript of a deposition in a federal case, before completion of the proceedings, review of the transcript [] was [] was not requested.

I further certify I am neither financially interested in the action nor a relative or employee of any attorney or party to this action.

IN WITNESS WHEREOF, I have this date subscribed my name.

Dated: August 23, 2018

Donna St. Clair, CSR No. 14252
Certified Shorthand Reporter
For The State Of California

DONNA ST. CLAIR, CSR NO. 14252

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EXHIBIT D

BEFORE THE

MEDICAL BOARD OF CALIFORNIA

STATE OF CALIFORNIA

JOSEPH D. MONTOYA, ADMINISTRATIVE LAW JUDGE

CERTIFIED COPY

In the Matter of the Accusation Against:	
WILLIAM EIDELMAN, M.D. 1654 N. CAHUENGA BLVD Los Angeles, CA 90028	Case No. 800-2014-010147 OAH No. 2018030645 Volume III
Respondent.	

TRANSCRIPT OF PROCEEDINGS

Los Angeles, California

Friday, July 13, 2018

Reported by:

MARCENA M. MUNGUIA,
CSR No. 10420

Job No.:
19216OAH

BEFORE THE

MEDICAL BOARD OF CALIFORNIA

STATE OF CALIFORNIA

JOSEPH D. MONTOYA, ADMINISTRATIVE LAW JUDGE

In the Matter of the Accusation Against:	
WILLIAM EIDELMAN, M.D. 1654 N. CAHUENGA BLVD Los Angeles, CA 90028 Respondent.	Case No. 800-2014-010147 OAH No. 2018030645 Volume III

TRANSCRIPT OF PROCEEDINGS, taken at 320 West Fourth Street, Suite 630, Los Angeles, California, commencing at 9:10 a.m. on Friday, July 13, 2018, heard before JOSEPH D. MONTOYA, Administrative Law Judge, reported by MARCENA M. MUNGUIA, CSR No. 10420, a Certified Shorthand Reporter in and for the State of California.

APPEARANCES:

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For the RESPONDENT: RICHARD JAFFE, ESQ.
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I N D E X

RESPONDENT'S Witnesses:	Direct	Cross	Redirect	Recross
Joseph Scherger, M.D.	7	65		
Jeffrey Hergenrather, M.D.	91	147		
William Eidelman, M.D.	196	216	227	

E X H I B I T S

RESPONDENT'S:	Marked for identification	Received in evidence
47 - Abstracts	126	126

Los Angeles, California, Friday, July 13, 2018

9:10 a.m.

THE COURT: Let's go back on the record in the matter. All counsel are present. Respondent is present.

MR. JAFFE: Yes.

THE COURT: There's a witness sitting in the front row.

MR. JAFFE: Yes.

THE COURT: Get him in the box.

MR. JAFFE: Sir, would you take the stand.

THE COURT: Have a seat.

MR. JAFFE: One preliminary matter, Judge.

THE COURT: Yes.

MR. JAFFE: That exhibit, the CPS summary --

THE COURT: Yes.

MR. JAFFE: -- I thought about it some more. It was really just to confirm the witness's testimony. You indicated that it might be problematic for some reason.

THE COURT: Yeah.

MR. JAFFE: I'm going to withdraw it. I think it's not worth the effort. You indicated that it's not a major --

THE COURT: 46?

MR. JAFFE: Yes, sir. I withdraw.

THE COURT: All right. I'm going to hand it back to you.

MS. BROWNE: We would move to admit it if possible.

MR. JAFFE: You would move to what?

THE COURT: Admit it?

MS. BROWNE: Admit. That's the word.

THE COURT: I tell you what. I'm going to handle this thing. I did not have a chance to stick my head into that 827 issue. I'm concerned about it. If I'm correct, this is not going to be admitted. It's going to be sealed and that's going to be the end of that and I'll caution you both.

MR. JAFFE: In any event, I just wanted to make it as easy as possible since it seems like it's not a major issue.

DR. EIDELMAN: There's a related question. They made a comment about the violence.

MR. JAFFE: No. No.

THE COURT: All right. I'll table the Exhibit 46 issue.

MR. JAFFE: But do whatever you want to do and if -- now, if the government wants to admit it, I mean, you can admit it or not admit it, depending which one you do. I just wanted to make things a little simpler.

MS. BROWNE: We both need to submit a sealing order, your Honor.

THE COURT: Sir, would you raise your right hand.

JOSEPH EDWARD SCHERGER, M.D.,

called as a Witness, and having been first duly sworn by the Court, was examined and testified as follows:

THE WITNESS: I do.

THE COURT: Okay. Tell us your name and spell it, please.

THE WITNESS: Joseph Edward Scherger, S-c-h-e-r-g-e-r.

THE COURT: All right. Counsel?

MR. JAFFE: Thank you, your Honor.

THE COURT: You may inquire.

DIRECT EXAMINATION

BY MR. JAFFE:

Q Dr. Scherger, before you is an exhibit book and I think I've opened it up to Tab 33, which is your C.V. It's already admitted into evidence. Just please confirm this is your C.V.

A Yes.

Q And Tab 34 would be the expert report you submitted in this case; is that correct, sir?

A Yes.

Q The first thing I'd like to do is have you talk about your -- you're a licensed medical doctor in the state of California, sir?

A Yes.

Q Could you briefly give the Court your educational background and then -- first your education and then we'll go into the professional background, both teaching and clinical practice. What's your educational background?

A I'm a native of Ohio. I attended the University of Dayton in Dayton, Ohio and then I attended UCLA School of Medicine, graduated in 1975. I did a family medicine residency at the University of Washington in Seattle along with a Master's of Public Health in Seattle.

Q Okay. And what about any -- any training after that, the Master's in health and then the residency in Seattle? What did you do then?

A Well, I've been in clinical practice ever since 1978, completing my training. I've done lots of continuing education, both teaching it and attending it. I was a national fellow in Kellogg Foundation for three years, but I participated in a variety of adult learning type activities but no formal education.

Q Okay. And from your resume, it appears that you

both have -- you have extensive experience in teaching as well as clinical practice?

A Correct.

Q Could you go into -- could you give the judge kind of a summary of your -- let's focus on your teaching over the years. What education foundations did you work for and what did you do for how long and whatnot?

A Well, I've always been a teacher, even as a resident in training. I was a teacher, but when I started clinical practice in Northern California, I was a volunteer at a National Health Service Corps as a migrant health doctor in the town of Dixon. We also covered a clinic in the Capay Valley in the town of Esparto and a clinic in the Delta in the town of Walnut Grove.

So for two years, I was one of two doctors taking care of the people in those clinics with a couple nurse practitioners. But during that time, I had medical students from U.C. Davis and I trained a nurse practitioner during those two years. I liked the area. We stayed living in Davis and I started a private practice in the town of Dixon in 1980, but at the same time, I joined the faculty in the Department of Family Practice at U.C. Davis, in charge of medical student education that would happen off campus.

So I began a series of part-time teaching and

practice and I did that for 12 years at U.C. Davis, mostly focusing on medical student education, but every Wednesday I supervised the residents in Sacramento. So both students and residents.

I was -- we moved to San Diego in 1992, so -- for me to become the vice president for primary care education at Sharp HealthCare where I started a family medicine residency program in three different locations in San Diego.

Q So you administered the family medicine program --

A Yes.

Q -- for resident students?

A Yes. I started a faculty medical group and we developed programs and became accredited and trained residents. So pretty much that summarizes what I've been doing in various places.

Sharp started losing money in the late '90s. They decided that medical education wasn't their primary mission, so they were starting to cut the programs that I had started four years earlier and I went to U.C. Irvine as Chair of Family Medicine and Associate Dean for Primary Care. So in that time I had a clinical practice, I administered a department, and was on the executive committee in the medical school and did some teaching and

I did that for five years.

I was recruited to be the founding dean of the Florida State College of Medicine in 2001, so I moved to Tallahassee, saw patients a half day a week, but the rest of the time was spent developing and getting that medical school accredited. That job only lasted two years.

We moved to San Diego, where I joined the faculty at the University of California San Diego for six years.

Q When was that? '90 --

A That was in 2003. That's when I became a member of the physician assessment program called PACE Program.

Q We'll get into that. I want to ask you specifically about that.

A At U.C. Davis I would teach residents and students on a weekly basis, see patients; again, always the combination of clinical practice and teaching and running programs, and I did that for six years until 2009.

In 2008, I took a consulting job at Eisenhower Medical Center in Rancho Mirage because they wanted to develop new models of patient-centered medical home models of primary care and they wanted to become a teaching hospital, two of my expertise. So after talking to them for a year, they gave me a great offer to come as

Vice President for Primary Care and the head of medical education. We've developed a group that's now more than 70 doctors. I have my own practice and we developed a family medicine residency and internal medicine residency and we're about to launch an emergency medicine residency. So both -- we now have a hundred residents at Eisenhower, where before there were none. So that program, the primary care practice, my own practice, it's been a good ten-year run for me.

Q And so currently you're at Eisenhower --

A Yes.

Q -- at Rancho Mirage?

A Well, that's where the hospital is. My practice is in La Quinta. You know, the valley is nine communities.

THE COURT: The valley's always hot.

MR. JAFFE: Well, he lives in Palm Desert, so that's --

THE WITNESS: This time of year -- it's seven months we have great weather but not now.

THE COURT: It's a dry heat though; right?

THE WITNESS: We've had a monsoon condition. We've had rain the past few days, so it hasn't been all that dry.

THE COURT: All right. I'm getting sidetracked here.

BY MR. JAFFE:

Q What kind of courses would you teach over the years?

A Oh, goodness. It varies. You know, first of all, I really would teach comprehensive primary care. I delivered babies 18 years. If you look at my C.V., there were lots of publications on the management of normal childbirth. I was very proud of having a very low C-section rate. I did a lot of teaching around maternity care, but at the same time I taught a lot of hospice care and palliative care and before that was invented, per se, as a training area. I've always been an athlete, a long-distance runner. I did a lot of sports medicine teaching through the years. I've done writing in that area and so, you know, the beauty of family medicine is that, you know, we're a jack-of-all-trades and a master of everything that's common. So it's -- you know, it lets you evolve.

Now, I'm pretty much a geriatrician and do a lot of -- you know, there's a lot of interesting applications. I've got a paper coming out on the importance of vitamin D in seniors that's under-appreciated, for example. Alternative medicine's been another area of interest.

Q And what have you done in alternative medicine?

A Well, when I was at U.C. Irvine, I was very involved with a family, Henry and Susan Samueli, who were very involved. Henry Samueli was a founder of Broadcom and Susan was very interested in alternative medicine, so the Dean asked me to lead the effort to establish what has become the Susan Samueli Center for Complementary and Alternative Medicine, now Integrative Medicine. And so we -- you know, we were looking, we were working with the California Chiropractic -- the Los Angeles College of Chiropractic around their work. They had a research arm that was credible and we started looking at the benefits of a variety of different treatments.

Q Okay. And you mentioned PACE. I think the judge has indicated that he knows what PACE is, but can you explain what you did at PACE and how you got involved?

A Well, a colleague, Bill Norcross, a family doctor colleague who's a great guy, was founder of a family medicine residency there. He developed the PACE Program because he was a consultant to the Medical Board and he saw that, you know, the Medical Board would have all these doctors who were being disciplined, but they didn't know whether they were competent or not. I mean, should they take their license away or should they not? Could there be some rehabilitation? It sure would be

nice to assess the doctors.

So seeing that need, he developed the Physician Assessment Clinical Education Program, or PACE, which has become the largest in the country. There's about 11 of those programs, but PACE I think is larger than all the other ones combined and serves not only the Medical Board of California but the Medical Board of a variety of other states.

Q I'm from Texas and PACE is standard. That's all we refer to.

A So Phase I would be, you know, comprehensive assessment of the knowledge and basic skills of the doctor. Is he a personally competent doctor, no matter what their specialty is, so we would test them. And then Phase II would be are they competent in their own specialty? So Bill needed help. He needed help evaluating. They got a grant for all the physicians to do all the State prison doctors based on their need, but he also, because of my Irvine experience, asked me to look into doctors who did alternative medicine because of my background. So I kind of became the PACE expert for alternative medicine doctors.

Q And how long were you there?

A I was at U.C. San Diego for six years. I worked for PACE for about four years.

Q And what did you do? Just how did you -- can you just explain to the judge what you did exactly as the CAM, Complementary and Alternative Medicine, PACE doctor? What would your duties include?

A Well, I became the practice monitor. So they all went through PACE and if they basically -- if they survived the Phase I and Phase II that they were a competent doctor, usually the Medical Board would put the doctor on probation for a period of time, requiring a practice monitor.

Now, they would have their own practice monitor who was not a clinician, but then PACE would offer a doctor to visit the office every three months, review the records, interview the doctor, get a sense for how the office was working and whether or not they were really complying with the standard of care. So I was in charge of, you know, several doctors who were there because of alternative medicine and one of them was Dr. Eidelman.

Q So during the four-year period, if someone had an alternative -- if a physician had an alternative medicine benefit and there was a Board order for a PACE evaluation, you'd be the person?

A I would participate in the PACE evaluation and that was done by the whole team of us, but I would then become their practice monitor. So that's a single job, a

single responsibility, to do the practice monitoring.

Q On how many occasions do you think you did that roughly over the course of your four-year term with PACE?

A Oh, between five and ten physicians I did the practice monitor work.

Q And I think you testified that's how you met Dr. Eidelman?

A Correct.

Q And anything else about your teaching experience you think might be relevant to this case?

A I mean, I think that covers it. I am involved with the Society of Teachers of Family Medicine, the academic organization of my field, and we have a whole study section on that. I've recently actually been trained -- not certified but trained in the new area of functional medicine.

Q Oh, really?

A And functional medicine uses intensive lifestyle modification to get to the root cause of chronic illness so you can reverse it. So we've -- I work actively in our Eisenhower Wellness Program where we're reversing diabetes, getting people off of drugs. We're reversing high blood pressure, hyperemia, any chronic disease in which lifestyle, especially diet, could reverse the disease. We're doing that. I've got a book called Lean

and Fit that's in its second edition. I've got a website leanandfitlife.com, so probably my biggest area of teaching right now is healthy nutrition, lifestyle and wellness.

Q I see. And just to conclude on the teaching and education part of your background, can you give us a rough idea of how many medical students and residents you've worked with over your, I guess, 40-year career?

A I've never counted them, but several hundred residents and probably, you know, up to a thousand medical students I've spent some intensive time with in terms of being a teacher, you know; lecturing in front of a lot more, but I wouldn't count those as direct mentoring type of teaching.

Q Okay. And in terms of your clinical practice, I think you went over the various aspects. Anything to add in terms of your clinical experience? You said general family practice?

A Yeah. I do family medicine, so it's all ages, although almost all my patients are adults now. I did see two young kids the other day, but -- and it's mostly in geriatrics. The desert is a unique place to work because by and large people want to be healthy. They're there to be healthy. I just had my 45th wedding anniversary and I was talking about it in the community

and I heard a new line that Coachella Valley is the place that old people go to visit their parents. It's just a remarkable place for healthy seniors.

Q Now, I just want to ask you a couple of questions about have you ever worked as an expert witness in cases?

A Yes.

Q Okay. Can you tell us a little bit about your background apart from PACE in terms of your experience as an expert witness?

A Since the 1980s, late, I think it was around '86, I started doing medical malpractice expert witness work. There was a defense firm in Sacramento that actually defended me in two cases that popped up in 1986 and they liked me and asked me if I'd be an expert witness. I was a lot younger of course then and so since then, I've done that; no advertising, just on the side, if you will, and never more than about 5 percent of my work. But I've done, you know -- you know, usually about 20 active cases a year. Most of them go from one year to the next for a variety of firms that like to use me. At any point in time, it's about 80 to 90 percent defense, but I do do plaintiff work also.

Q And sometimes Board work as well?

A Yeah. There's a firm particularly in Sacramento

that does a lot of Medical Board-related defense and they send me usually two or three cases a year.

Q Okay. And how often do you have to testify in these cases?

A Not very often. I mean, more often than not, I tell them to settle, that this isn't really defensible. I mean, most of them have been through inappropriate prescribing and some of these doctors really shouldn't be prescribing opioids or they should go through the PACE Program, prescribing program. So a lot of them I've really kind of helped not go to the hearing level, but I have gone to the hearing level.

There was, I remember, a doctor up in Woodley Clinic who was really I thought quite a good doctor and wasn't being treated fairly. It was kind of a misinterpretation of him. He was from Asia and it just wasn't right and so we defended him, for example, but -- so I've had a few hearings through the years, but by and large have been able to just review and give recommendations and avoided going to that level.

Q Are you saying that the lawyers basically tend to follow your recommendations?

A Yeah. They know I'm not a hired gun. I'm a straight shooter, so anybody that hires me, I will tell them, Hey, you know, I think on the plaintiffs' side --

and it's why some plaintiffs' firms like to use me -- is probably more than 50 percent of the time I tell them, you know, "This isn't going to go anywhere. I can't support what you're doing."

Q Okay. I'd like to now -- I'm finished. Do you have anything else about your education, training?

A I think we've covered it.

Q Okay. Thank you. And I appreciate your -- I'm just going to ask you in case I missed something --

A Sure.

Q I want to ask you some questions before we even get into the particular case, I mean, based on your experience, training many hundreds of medical doctors, a couple hundred residents, lecturing, PACE, central issue in this case is diagnose. How do you diagnose? How do you come up with a diagnosis? I'm going to ask you just some general questions. I wonder if you can give your opinion and your expertise about what are the fundamentals of diagnosis? I notice -- let me -- I noticed in your resume that there's a book that you participated in. It's called like "The 10-Minute Diagnosis."

A Right.

Q Is that -- so can you tell the Court based on your experience in teaching and the real world, how does

a doctor -- how do you teach students -- how's a doctor supposed to diagnose a patient? What do you do?

A Well, the central issue in this case and the central issue of diagnosis is clinical judgment and doctors need to do that in a matter of minutes.

Q Why is that?

A Well, first of all, they can. You know, doctors are really trained. Like, for example, in pediatrics when kids come in with respiratory infections and they're sick, the first thing the doctor does is he looks at the whole child and can determine within 30 seconds is this a toxic child or is it a child with a cold or, you know, a fever or whatever? I mean, is this a sick kid or isn't it in our kind of work?

Q 30 seconds?

A Yeah. You have to. I mean, it's all about eye contact and behavior and you can pretty much tell a toxic child from a nontoxic child. So that kind of clinical judgment is vital.

You know, the -- I've studied medical anthropology and I don't want to belabor this, but diagnoses actually don't exist in the real world. They're nothing but contrived labels.

Q Really? What do you mean by that?

A Well, they're -- the point is every person is

unique and every illness, which is a person's experience of not being well, is actually unique and what we do is we create -- in our medicine, we've created a bunch of labels that help us aggregate a group of people, you know, in the same general category and we call that a disease so we have some sense of how to treat the disease, but it's very important to realize that the disease isn't the reality. It's the person and everybody is going to be somewhat different.

So your clinical judgment from Osler, It is more important to know the patient with the problem than what problem the patient has. I mean, you need to get a sense of how you can help this patient. So diagnosis is important.

Now, some areas of medicine, diagnoses are very, very precise. I have a strep throat. I have a bladder infection. Some areas of medicine, the diagnoses are really not precise at all and I would say mental health is classic for that. We have a bunch of labels in mental health as these things that really exist as in cookie cutter one after the another. Like bipolar is one of them. I mean, these labels are general groupings that let us organize our thinking around them, but there's tremendous variation within a label.

Rheumatology, like all these rheumatoid

arthritis, lupus and all this kind of stuff, those labels, you know, cover a whole lot of very, very different people and you've got to treat the people. So it's around -- and history is 80 percent of it.

Q 80 percent of the diagnosis?

A Is history. It's information. And we're trained to ask the right questions efficiently, beginning with an open-ended question and letting the person talk, and there's an old saying in medicine, "If you want to know the patient's diagnosis, ask them because usually they'll tell you." And so it's -- you take a history and then you do physical and lab to really validate your clinical impression of what is going on.

Q Is there any lab for bipolar?

A No. So it's judgment. It's clinical judgment and it's -- I mean, for example, I'll mention -- I mean, this case, we know this child had a behavior problem. I mean, you could give it all -- I don't think the labels -- you know, I couldn't tell you whether the child had bipolar or not from the record. He had a family history, so it kind of hints he may be headed in that direction; but, you know, that's just a label. He had a behavior problem. Whether -- I mean, is it bipolar or is it some sort of disruptive behavior problem? I mean, you know, in the world of psychiatry, every few years they

come out with a whole new psychiatric classification of problems and they keep changing the names every time.

It just goes to show it's a moving target. The bottom line when you're taking care of somebody is, What's the nature here? We're dealing with a disruptive child and is it nature or nurture? That is, is it genetics or is it the home environment? How much of each?

For a child like this with his family history, there certainly would seem to be a biologic basis to his problem, not just home environment, but both of them are always coming into play.

Q Why is that? Why do you think there seems to be a biologic basis? Because of the --

A The family history. I think the severity of his symptoms, how young they're manifesting, but you don't know. You don't know. This child could have been traumatized at two or three in a way that's done that. It's kind of immaterial. You really don't know for sure, but with a strong family history of mental illness, you do suspect that there's probably some genetic or biologic component to it, but clearly there's always going to be the environmental component to it.

I mean, we're now -- we now have this term "epigenetics," which is the role of the environment

impacting our genes, and we're sort of realizing that everything is epigenetic to some degree or not, but the reality is you've got this disruptive child to deal with and you're going to use your -- you're going to realize, yeah, this is clearly -- this isn't a normal child.

The history is pretty clear. How can I help this disruptive child and this family be better? And that's really what was presented to Dr. Eidelman with a background of a father and an older brother and a request to try an unorthodox therapy to help the child.

So, you know, he's there with his clinical judgment which, you know, from my own assessment of him through the years, I think he has -- I think he's very smart and he uses good, careful clinical judgment. His clinical judgment is -- it was worth a try and probably safer than these drugs that we give to people for these behavior problems, which, you know, psychiatrists tend to really like, but we family doctors are left with the obesity, the diabetes, the -- you know, like the zombie-like effects that they have and, you know, it's not a pretty picture right now.

You know, the whole world of mental health drugs, we tend to believe that cognitive behavioral therapy and sometimes alternative treatments, you know, are going to be less toxic in the long run to a child

than heavy-duty psychiatric drugs, but again, that's all about clinical judgment. Everybody's different. Some people really need those drugs and some people really -- the drugs are really helpful, but in general you want to help a person with the least toxic therapy in the way that's likely to have long-term positive benefit.

Q Okay. So I guess the question is how -- I mean, is there some -- in your opinion, some kind of minimum time -- well, let me -- in your experience, how -- how much time does the average practitioner spend with a patient, let's say, family practitioner?

A Well, in our practice, we make sure the doctors have at least 20 minutes instead of the 10 or 15 minutes.

Q Talk about this 10 or 15 minutes. You're implying that that's more the norm?

A Well, the norm of productivity in primary care and in specialty care. I mean, my cardiologists see 30 patients a day. They'll see -- the orthopedists, you know, are you going to see four people an hour or are you going to see six people an hour or are you going to see three people an hour? But pretty much all doctors in office practice today occasionally might have more time with a new patient, but by and large the productivity standards for almost every office practice is somewhere between three and six patients an hour.

Q So that would be 20 to 10 minutes?

A Yeah.

Q And let me ask you this. Based on your experience teaching, I mean, during this 10- to 20-minute encounter, is it normal to come up with some kind of assessment and plan in that 10 or 20 minutes?

A Sure. I mean, that's really what we're trained and skilled to do and, again, you know -- you know, there are -- the beauty is if you have more time, you're not going to interrupt people. I mean, studies show that doctors interrupt patients within less than a minute of the beginning of the encounter. If you give a doctor more time, we can train them not to interrupt the patient and if you don't interrupt the patient, you have a better chance of getting to know who the patient is and you can probably be better at actually helping them out and so, you know -- but you can -- it does not take long to determine what the problem is or the problems are and what you need to do to help them.

So the clinical, the way medicine is practiced, unlike a lot of other helping professions, is pretty -- pretty rapid, pretty intense based on intense observation and clinical judgment.

Q Over a relatively short period of time?

A Correct.

Q There's been testimony yesterday that for ADHD, I mean, there's all kinds of pull-out charts in American -- you know, electronic medical records and you have these forms and questionnaires and all that. What role does that have, if any?

A Well, they can have a role and school psychologists and, you know, some professionals will do a more formal type evaluation that way and I'm not saying that's bad and it can be confirmatory, but the truth of the matter is throughout my career, I have used my clinical judgment in relatively brief visits to diagnose attention deficit hyperactivity disorder. It's not rocket science at all. Usually what's going on at home and at school and others, that's clearly going on and I will move to treatment without -- it's not practical to try to refer everybody to that kind of formal testing.

Q Why not?

A Well, first of all, there is not enough of that available. There's no reimbursement system to cover it. It's not -- most importantly, it's just not necessary.

Q Your opinion is it's not necessary?

A No. No. No. I mean, you know, any -- just bring the child into this room and watch them for a few minutes and they wouldn't be sitting still listening to this. They'd be, "Mom, can I get out of here?" And

they'd be restless in a minute. I mean, it's not hard to make those diagnoses and then if you use treatment -- I currently use a lot of nutrition treatment. I get them off sugar and it's amazing when you get a kid off sugar how their behavior changes, but sometimes if it requires a Ritalin or one of those related drugs, they can be incredibly helpful.

Q But between the history and observation, you're saying that's enough?

A Sure. Well, that's reality. I mean, that's what all -- I would say the vast majority of cases of, you know, diagnosed ADHD are made in brief visits. That's the reality of clinical practice and it works.

Q And that's consistent with what you've taught all your medical students?

A Yes. I can't remember in 40 years -- and I've had hundreds of cases. I can't remember one patient, one child with ADHD, that I referred for the more formal elaborate test.

Q Not one?

A Not one.

Q And you made the diagnosis on the initial 10- or 20-minute --

A That's correct. I mean, there may be a couple cases where the school actually pulled out their protocol

and followed kind of a binder checklist and confirmed it, which was nice. It's nice to always have validation, but I never needed that to make the diagnosis.

Q Let me ask you this. I mean, your resume is full of societies where you're the president of and family practice this and family practice that. It sounds like you've been well connected over the last 40 years with all these organizations.

A Right.

Q Yeah. What you're describing now, is that -- is that just the way you work? Are you mainstream in this regard or are you just way out there?

A No. I'm mainstream. I'm clearly mainstream.

Q Right.

A I mean, I've worked hard to get communication with patients online and to expand the communication access. I do believe in longer visits than 10-minute visits. I would never practice in an area that didn't give me at least 20 minutes with patients. I believe in not interrupting patients when you ask them a question and you've gotta have enough time to do that. And so I do believe that time is very important in healing, but it doesn't require hours, if you will. I mean, in a clinical encounter, 20 minutes is kind of a luxury to primary care.

Q Really?

A Yeah.

Q So 20 minutes is a long time for you guys?

A Yeah. The system doesn't make enough -- we don't get paid well enough to see only three people an hour so, you know, Eisenhower believes in health care as it should be and is willing to subsidize primary care. We don't earn our salaries. They're willing to subsidize primary care because it expands our market share and it helps the seasonal people decide to get their primary care at Eisenhower and not in Seattle where they have their summer home; and if they get their primary care at Eisenhower, they'll probably get their hip replacement at Eisenhower, too.

Q It's an investment, like a lost leader almost.

A One of the lost leaders. But the reason I went to Eisenhower is they wanted primary care the way it should be, not the productivity model. I still remember the CEO wagging his finger and I said, "I forbid you to develop the high-productivity model of care. I want this to be the best primary care the people have ever seen," and that's why I went because that's what I believe in. But, again, it doesn't take a lot of time.

Q And operatively -- am I correct in assuming you're saying that means 20 minutes instead of 10

minutes?

A Correct. That extra five minutes means a lot.

Q Okay. And, again, as far as -- is it fair to say, as far as you understand, your colleagues agree with that, your approach?

A Oh, yeah. Yeah. We have no burnout. 40 percent of primary care doctors burn out. 50 percent of residents get depressed. We've never had a depressed resident. In ten years, we've never had a burnout doctor and we don't lose doctors unless for personal reasons. They have to move away or they decided to retire. But no. We're doing it the way we should be.

You know, Dr. Eidelman has a practice that he doesn't feel the pressure to see more than like three people an hour or so and it gives him, you know, a quality, relaxed practice. You know, he's not, you know, writing off prescriptions every five or ten minutes to people without sitting down and finding out who they are and what their problems are. It's just not his style.

Q So you're saying three an hour is a relaxed practice?

A That's right.

Q Based on your experience, you don't consider yourself a medical marijuana expert, do you?

A No.

Q We're going to have one later, but based on your experience in 40 years, have you ever made a medical marijuana recommendation?

A Yes.

Q And have you observed the patients? Have you had to record notes where a patient says they're on medical marijuana?

A Yes.

Q Do you have -- at least as, you know, based on your experience in family practice, do you have a general sense of where marijuana falls in terms of safety, you know, in the world of drugs? Have you developed such a sense?

A Yes.

Q Could you tell the Court how you view as a family practitioner medical marijuana in the context of psychiatric -- other -- other stimulants like Ritalin to antipsychotics and whatnot? Give us your perspective.

MS. BROWNE: We're going to object, your Honor. We just heard testimony that he's not an expert with regard to medical marijuana.

THE COURT: I'm going to overrule the objection.

THE WITNESS: Well, marijuana's a natural substance. Cannabis is a natural substance. You know, you can almost call it like an herbal like therapy. Now, it does

have serious -- significant, I should say, you know, mental health effects on a person and it should be used carefully and cautiously and I don't go out and recommend people developing a marijuana habit. I don't think we'll keep up with China if we become a nation of potheads, for example.

It's just a casual thing to say, but marijuana relaxes people. You know, it's way safer than cigarettes. It's in many ways safer than alcohol. It's less addicting than those. It's really not addicting in the same way that those things have become addicting. It can be, but it's a therapy that -- that has benefits that, you know, are somewhat mild. I consider it a safer and in some ways more natural therapy than developed prescription drugs which I think really do alter people's brains and alter their brain chemistry.

BY MR. JAFFE:

Q Like Ritalin?

A Ritalin is a good example and the stimulants of Ritalin, Adderal, I mean, those drugs, we know what they do and they are clearly stimulants, although paradoxically in children with ADHD it calms them down. So it's a paradoxical effect, but I'm more thinking of the antipsychotics, especially the new antipsychotics that the drug industry is promoting and making great

profit from and wining and dining the whole psychiatric world.

You know, the whole -- I've been in medicine long enough with the original antipsychotic drugs and the original ones and, quite honestly, the new drugs, while they help some people, and I'm not dismissing them, by and large, have been, you know, put upon us in a way that has not been terribly productive and therapeutic and for -- I personally would much -- if a patient can get improvement and relief from cannabis, I would consider that way better than writing a prescription for a psychiatric drug.

Q Really? Even as a first-line therapy?

A Absolutely.

Q Just because of what?

A Well, because it's -- the lack of side-effect profile that, you know, if used appropriately, it can be relaxing. If it's going to give me pain relief, I mean, I've gotten people using way less opioids or they've gotten off their opioids because of cannabis and that's a victory.

Q Can you explain -- so you're saying you have patients that you -- you're saying you wean them off or something? Can you explain that to the judge, what you mean by that?

A Well, what's going on now that my patients don't need a prescription from me, I have two or three patients a week that are coming in saying, "Doc, I don't need the Oxycodone anymore. I'm using cannabis and it works well" and I go, "That's great." And so, you know, for pain, for relaxation, if they're using less prescription drugs, the cannabis is a therapy -- I mean, the patients will tell you, "This is working for me." And end-of-life care, cancer, you know, the role of cannabis as an herbal, more natural way of helping people with problems is pretty much by and large at this point a success story.

Colleagues that I know well in Colorado and other states, I mean, there are issues of some emergency room visits due to cannabis and a few things happening, but by and large, the doom and gloom or "Oh, my God. What's going to happen to our state" has not materialized at all. I think the net benefit has actually been positive.

Q All right. And just to make clear, you're not some big medical marijuana proponent?

A No. I'm just a primary care doc observing -- you know, this is in my primary care tool kit, so I've always had the ability to prescribe medical marijuana and I've done it on occasion, you know, a limited number of

times, a few times a year; but now it's -- it's getting more common and we're learning -- we're getting more experience with the use of cannabis, particularly in things like an oral form.

Q Okay. Now, that's in general. Let's talk about its use in children. What, if any, special concerns would that -- do you think that would present to someone like you?

A Well, first of all, we don't know. I mean, it really has never been tested, studied. The use in a child would be kind of a little bit of a new frontier, if you will.

Q As a therapy?

A As a therapy. But, you know, it's the kind of therapy that wouldn't scare me. It wouldn't scare me nearly as much as a lot of the antipsychotic drugs.

Q Really?

A Oh, gosh, no, because they change people in ways that cannabis really doesn't change a person. I mean, it can if you overdose on it or you get it continuously. But you know, these drugs, you know, kind of really -- you sort of have to say, "Is the benefit worth the risk for this?" And, you know, I've had two cases of medical malpractice using Lamictal, which is a common drug for bipolar disorder, in which it destroyed a person. I

mean, they almost died and have permanent side effects as a result of using this widely used drug.

Q What was the malpractice? I'm sorry to interrupt.

A Well, they developed -- they were never warned or they weren't put on the -- you know, it's a drug that is very dangerous, causes a lethal or life-changing condition called Stevens-Johnson syndrome if you give too much too quickly. It's a drug you've got to start at 25 milligrams and over the course of eight weeks, you work up to 200 milligrams very, very carefully. Well, doctors who aren't as familiar with all that, you know, did not follow the guidelines, escalated the drug very quickly, and the patient was in the intensive care unit for an extended period of time and will never be the same. I mean, those cases are not defensible, but that's different.

I mean, that's what can happen with these heavy-duty prescription drugs which we're really not even trained to give. I would have to -- I would personally refer someone to a psychiatrist, child psychiatrist, to use any of those antipsychotic drugs; but as a primary care physician, I think if I were in the situation that Dr. Eidelman was in with that request, you know, my response would be try it. It may be very helpful. I

really don't see much downside in a child that's being really disruptive like this.

Q Really. So that's really your bottom line? You would have made the same recommendation?

A Yeah. We use off-label treatment all the time. So, I mean, the reality is when you go to a doctor, I mean, the truth of the matter is the drugs get approved by the FDA based on enormous amounts of studies for one condition and then we find that it helps other conditions, but the cost of getting an FDA-approved for every condition we're using it for -- I mean, we're using Cialis now for improving circulation for peripheral vascular disease, we're using it for the prostate, all these uses that the drug reps aren't allowed to talk about because they're only allowed to talk about whatever's FDA approved, but we know it helps for a variety of things and we're using it for it with good effects.

So doctors do what's called off-label uses of medicine. Again, you know, first do no harm and then act in the best interest of the patient, stay safe, but we do a lot of things that you would call unorthodox.

Q Okay. Now, so just to follow up -- I mean, the child was only five. Let me represent to you that between the Board expert reports and -- you've seen the

Medical Board's expert reports; right?

A (No audible response)

Q And?

THE COURT: Have you, sir?

THE WITNESS: Yes. Yeah. I read the whole thing.

MR. JAFFE: Thank you.

BY MR. JAFFE:

Q And let me represent to you that they were -- both experts were highly critical of Dr. Eidelman for his recommendation for a child so young. The child was five years old. The fact that the child was five years old, would that -- even with such a young child, you would still maintain that it -- that that would be appropriate for someone in a child that young?

A I think a cannabis cookie tried in a very disruptive five-year-old child in which you've manipulated the diet and, you know, you had things in which it seemed like we've gotta give this child something and a family asked me, Could we try a cannabis cookie over, you know, a psychiatric drug or this or that, I would -- my instinct would be, Sure. I mean, we use -- I use alcohol in newborns to do a circumcision. You know, that's --

Q That's not FDA approved.

A No. That's in the nurturing. We give them

alcohol to calm them down and do a circumcision on them so we don't have to give them stronger anesthetics. I mean, we will use substances that will calm down and relax a child. And, again, it's risk-benefit ratio and reasonable clinical judgment and I think that's what happened in this case and I think that the experts on the other side totally overreacted and, you know, didn't really benefit the child, which is really the important person here, is this child.

Q Actually, from your expert report, you seem to be somewhat critical of the reaction of the school and the authorities. Can you explain that?

A Yeah. I think they clearly overreacted, didn't talk to Dr. Eidelman, which is really what they should have done. I mean, I can see that they would have raised an alarm. I mean --

MS. BROWNE: We're going to object, your Honor, for relevance.

THE COURT: Yeah. I'm not here to try this. I understand your issue with the circumstances. I'll note that from what I've seen so far that the authorities out there in San Bernardino consulted a couple of physicians or psychiatrists and were told that nah, this is outside the standard of care. So obviously reasonable medical minds might differ about what happened here, so I don't

want to get into this --

MR. JAFFE: Okay.

THE COURT: -- too far.

Let me just say this. As I told you, I've got some experience here in this special education arena and dealing with people who may or may not have developmental disabilities, which also ends up having me on the periphery of the special education system. So I have to note that nothing got done there and so how that's going to fit into my analysis in the end, I don't know, but I don't want to right now get too far into the reaction of the school people.

MR. JAFFE: I understand. I'll withdraw the question and ask -- can I just ask you to clarify your comment that nothing got done there? I didn't understand what you said, what you meant by that.

THE COURT: Well, in other words, dad's testimony is they told him medicate or get out of town.

MR. JAFFE: Right.

THE COURT: If that's true, and that's a bunch of hearsay, it appears to me that the school is in violation of some obligations they have under federal and state law because if they have child find obligations, they're supposed to be reaching out for people who might need special education services and the schools can provide

special education services to people with ADHD. That's unlike the regional centers which have a narrower, tighter aperture for assistance. So right away, there's an allegation that the schools didn't do their duty.

This gets into an issue that this witness has raised about -- and our witness yesterday afternoon raised about the school's involvement. They can help tie down that diagnosis of ADHD and maybe even bipolar. Your position at the center of this thing is the diagnosis. Out in that world, people would be looking for some further assessment. Okay? These are concerns I have. You need to understand this.

MR. JAFFE: And that's why I'm asking, your Honor, because I think that's an important point --

THE COURT: Well --

MR. JAFFE: -- and I think the problem I have --

THE COURT: -- so the problem you've got is the allegations made by the experts for the Board that there should have been some contact with the school. What did Dr. Briggs say yesterday? "Did they tell you this? Call the school right now." You know, it's -- this was not an emergent situation, was it, Doctor?

THE WITNESS: No.

THE COURT: So that's a concern I've got.

MR. JAFFE: Well, let's address that right now.

Judge, I greatly appreciate your giving your thoughts on this. I think it's helpful now.

THE COURT: They're not set in stone.

MR. JAFFE: I understand that.

THE COURT: But I point it out to you that under the APA, I'm entitled to evaluate evidence based on my experience and training. The Medical Board has over a period of time tried to provide us some training, as they're obligated to do under the Procedure Act; but I've got a fair amount of, if you will, both on-the-job and other training for dealing with these situations that arise from us conducting hearings for 10 of the 21 regional centers.

You know, I was on the ground floor when we took over Special Education hearings before we set up a special division to do it and so, you know, my first reaction listening to the dad's testimony yesterday was, Well, if this is true, that makes for a pretty good lawsuit if it's true, but it's a lot of hearsay.

Dad says -- and there wasn't an objection to it -- but dad says teacher says; dad says principal says; and I don't think it's -- you know, I've got problems with the notion that you want to make how the school behaved a certain amount of line of defense here, okay, because it's related to the concept of, Who's the

grown-up? It came up a few times when I was trying to raise children and they don't give you an instruction manual, but one thing I figured out was who's the grown-up.

Well, who's the doctor? Dr. Eidelman here. Just because the patient's telling you something or the school's telling you something -- I think this is something you're going to want to address in closing -- how far do -- where's the professional obligation come in on the physician and surgeon's part to say, Well, let's slow down here?

But let's find out what's going on because I also have testimony, Doctor, that properly to do an ADHD diagnosis, you've got to see that it's happening across zones, if you will. So that's another reason you contact the school and verify the behavior, because dad's only working off the hearsay that he's getting from the teacher, and who knows what report of bias is going on there, and there's some stuff going on in the home and -- but there was one behavior dad spoke to that's the kind that I pointed out yesterday sometimes that's associated with autism. From the little I've heard here, it's probably not autism, but if there's a child that has problems adjusting to changes in the environment, that's one of those that comes up on the dashboard as at least a

yellow warning light. H'm, do we have that? And that gets into the inexactitude of diagnosis working across the -- out of either of the DSMs more recently and that's why you've got to read that stuff about differential diagnosis that they have in each one and the chapter and the information about comorbidity.

THE WITNESS: I resonate with everything you're saying and, you know, this -- Dr. Eidelman took a risk. You know, was his treatment the standard of care? No. But he took a risk to try to help this child and he felt like he had enough information, but you could clearly argue that he could have had more, and over time, because it's -- you know, clinical medicine is not one visit, you know. There's a continuity of care that's vitally important and over time we would have known, but it's -- yeah. I mean, it is all -- again, it boils down to, Is this faulty clinical judgment? And I can see where many, many outsiders looking at this will jump on him to say, This isn't the standard of care. You know, this is, you know, clearly not something that could or should be done; but, you know, I've done that many times in my practice for -- I will always do what I think is right for the patient even if I'm out on a limb.

THE COURT: I get that.

THE WITNESS: We go out on a limb all the time as

doctors and we can defend it usually pretty well because we've acted in the best interest of the patient and the patient is part of it, but we also do things that are really not dangerous and I don't think what was done here was going to be what I'd call dangerous.

THE COURT: Okay. But when you're using that alcohol on the circumcision, if you have to choose bourbon over John Jameson's Irish whiskey, I mean, reasonable doctors might disagree over which kind you used; right?

MS. BROWNE: Your Honor, that calls for expert testimony.

THE COURT: Well, he's an expert. All right.

BY MR. JAFFE:

Q Well, let's -- this is the judge --

MR. JAFFE: Judge, again, thank you.

THE COURT: Your Direct is not finished, I gather?

MR. JAFFE: Correct. And, Judge, I --

THE COURT: Get back onto it.

MR. JAFFE: I just thank -- I want to thank you for surfacing your concerns. That is very helpful I think to the process. Thank you, sir.

THE COURT: Maybe it's going to come back and bite me. I don't want to buy a writ.

BY MR. JAFFE:

Q Let's work further on this and let's dig deeper.

So an issue that the judge raised that was raised here was the fact that Dr. Eidelman didn't make the call before he made the recommendation. That's one of their big complaints.

The woman testified yesterday, Pick up the phone. I guess the question is, was that necessary in order to make the recommendation? If not, why not? Give us your opinion in terms of all this stuff about clinical judgment because I think that's probably the heart of the case.

A Sure. Well, I wasn't there, so I'm only speaking from what I see in the record and what was represented. But in the reality of clinical practice, again, when you're seeing three people an hour on a full day's schedule or whatever, you've got to do what's reasonable and practical.

Now, if I see a child or I get a story that is clear and I get a believable parent describing what's going on at school, I mean, you know, a lot of times the parent's saying, "Look, I can't even keep my kids in school. They're going to throw them out unless I put them on major drugs" or --

Q Let me just interrupt you there. Is that something you've heard before?

A Many times.

Q Is that right? Really?

A Sure.

Q Because there's also some skepticism whether that could even possibly happen. You heard the judge just say --

THE COURT: Well, hang on a second. That the school might have, if we believe dad, said essentially they were going to violate the law, okay, that's something that the family's got to deal with and it sounds like Dr. Briggs is better informed on this because her reaction right away was -- it was actually Dr. Reyes, "This doesn't sound legal" and so that could get into how much experience you've got. Certainly if my friend or neighbor came to me and said, "The school told me this," I'd say, "Let me find you somebody who will straighten them out."

Now, if in this physician's experience, they've had parents come out and say this kind of thing, he's not a lawyer, so I don't know if he should tell them, "Go find a lawyer that knows this part of the law." But that's why I wanted to pin down, this is a public school.

THE WITNESS: Let me make a clarification.

My son's a high school teacher in Santa Ana High School, a tough place to work. There are kids that he cannot tolerate in his classroom and he's had to

dismiss from his classroom. Now, the school has to deal with the child --

THE COURT: Yep.

THE WITNESS: -- legally, but an individual teacher doesn't have to deal with someone who prevents the other kids from learning. So usually these are not cases that they're not going to be able to go to school. It's just that they're not going to be able to stay in their classroom with their peers and we try to salvage that if it's salvageable.

So I'm not trying to speak in terms of the global responsibility of Special Ed. That's not my area. I'm just trying to keep kids in the normal path because once a kid is labeled as "abnormal," that's going to haunt them the rest of their life.

THE COURT: I've seen that movie from both sides of it because you get some parents that don't want to recognize that the kid has a problem.

THE WITNESS: And I agree. I get it. I'm not into mainstreaming everybody, but if I've got a child behavior problem, which is a huge area -- and a lot of it is our society; we don't have places where the kids can run in the woods anymore and burn off steam like we used to. It's a big problem. But I'm trying to keep kids healthy and normal whenever possible and use, you know, the least

amount of risk and practical ways of doing it.

And I think in this case, Dr. Eidelman was painted a picture that allowed him to act without having to do further research. That would be my argument, but I can certainly understand where experts in this area would demand, I mean, that he do it. I mean, I hear that all the time: the primary care should have referred. And sometimes they should have, but in general we're there to try to help people whenever we can within reason and within good -- within good standard of primary care, and a lot of times that has us treating mental health problems.

I mean, most mental health treatment is treated at the primary care level and I think Dr. Eidelman is similar to that, although he's a specialist in the use of cannabis.

BY MR. JAFFE:

Q So to be clear, you're saying that what you thought -- that Dr. Eidelman on this particular case wasn't required to call the school and it wasn't necessary in order to make the provisional diagnosis and make the recommendation; correct?

A Yes. I think he had enough information.

Q Right. And then he -- the medical record notes the family history of issues. Can you -- what would --

could you outline, 'cause I think the judge obviously is going to -- he's given us hints. Could you --

MS. BROWNE: We're going to object to that statement as assuming facts not in evidence.

MR. JAFFE: I withdraw that. I apologize.

THE COURT: No. Look, one reason I'm glad to have 30 days to write a proposed decision is because it gives me some time to think about things because in every case, licensing case, I have the public welfare on one hand and some individual's future on the other and I don't want to act precipitously and experience has taught us around here, everybody that's held hearings here since I've been here has sat down thinking they're going to end up one place when they start to write a decision and by the time they're done, they're somewhere else. And so, you know, I'm going to end up going through that process, but to the extent I'm voicing my concerns and letting you know how my experience has put a lens on this.

MR. JAFFE: Let me thank you again.

THE COURT: I'd like you to take that into account. That gets into some other legal philosophical issues I don't want to bore you with.

MR. JAFFE: I'm not worried about that, but I do appreciate it. As a practitioner, I can't ask for anything more. Thank you, sir.

BY MR. JAFFE:

Q So --

THE COURT: Your -- the witness's bottom line is he thinks Dr. Eidelman had enough information on that day in 2012 to recommend some medical marijuana to this child.

Is that fair to sum you up, sir?

THE WITNESS: Yes.

THE COURT: Okay.

BY MR. JAFFE:

Q And you might have done the same thing faced with the circumstances?

A Yes.

Q And do you think -- as a family practitioner, do you think your opinion is outside the norm based on your experience teaching students for 40 years and being in all these organizations?

A No.

Q Now, let's just -- if I can just refer you to the medical records, 'cause we haven't really spent much time in the medical records, that would be Tab 22. I just want to ask you a few questions.

MR. JAFFE: And, Judge, I'm not going to be much longer.

THE COURT: Okay.

//

BY MR. JAFFE:

Q Now, in this case, you know, you're the monitor of Dr. Eidelman. You understand he uses a Release of Liability form?

A Yes.

Q And you've seen that before?

A Yes.

Q Could it be that you might have been involved in the preparing or the helping him write or review this?

A Yes.

Q You were?

A Yes.

Q Do you have any information about whether or not the Medical Board of California has seen this before and approved it?

A I don't know.

Q But at least you looked it over before?

A Yes. I -- you know, we were two people, one from the Medical Board, one from PACE, and I believe both of us -- it's been a long time, but I think both were happy with this form.

Q Okay. And if you take a look at the next page, page three of five, the first sentence:

"Chief complaint: episodes of uncontrollable behavior, temper tantrums can

come in a moment when seems normal."

That's a description of the conduct of the behavior. Then the next sentence is:

"At home it is tolerable and they are able to deal with it. In school, the teacher could not accept it."

What do you glean from -- what can you tell us about what Dr. Eidelman viewed as how many -- what's the word -- social areas that involved?

A How many? Well, at home and school. Two.

Q Two, home and school. And does that have any significance in terms of making any kind of diagnosis for ADHD, as far as you know?

A Well, what they're saying is that the child does have these problems at home. He's not an angel at home and disruptive at school. But at home where they're dealing on a limited basis, they don't have a whole classroom of kids, they are able to tolerate it and deal with it, but at school it's disrupting the school. So, you know, it's -- the behavior is in both places, but in one it's so disruptive that something needs to be done.

Q Okay. Now, if you can just -- the note is only one page long for this initial visit. Okay? Could you just take a quick look at it? I know you've seen it before.

A Right.

Q Where it says "Diagnosis: probable combination ADHD/bipolar," what does that -- what does that convey to you, the word "probable" diagnosis?

A Well, again, I think that shows that all these diagnoses are clinical judgment and I think Dr. Eidelman is wise enough to not say, Oh, I know exactly what this is. So you make a -- I mean, that's really good initial care is that it's a presumptive diagnosis at this point, which is -- you act on that.

Q And you glean that from the word "probable"; right?

A Exactly.

Q He's not sure what it is?

A It's not -- it's not cast in stone at this point, but that's probably -- you know -- you know, it's probably what's going on and it's what we call a presumptive diagnosis, but you treat it -- evaluate and treat on a presumptive diagnosis.

Q And the "Plan: Try cannabis in small amounts in cookies." Let me ask, you're generally familiar with the medical marijuana policy in the state of California?

A Yes.

Q So let me ask you this. In your opinion, looking at this medical -- does this note evidence a

sufficient history and an appropriate prior examination of the patient for the purpose of California law of medical marijuana policy?

A Yes.

Q Does this note evidence sufficient development of a treatment plan with objectives?

A Yes.

Q From -- if you turn the page, you'll see some follow-up notes.

MS. BROWNE: Your Honor, we're going really quickly. Could I object retrospectively?

THE COURT: Okay.

MS. BROWNE: I would say objection; calls for a legal conclusion with regard to medical malpractice laws.

THE COURT: Did he say "medical malpractice" or the "medical marijuana policy" that I believe the Board has published at some point? Which were you referring to, Mr. Jaffe?

MR. JAFFE: I'm only referring to the exhibit attached --

DR. EIDELMAN: When you said medical marijuana, she thought you said "malpractice."

MR. JAFFE: I didn't say "malpractice."

MS. BROWNE: Thank you. Thank you for the clarification.

THE COURT: You were moving to page four?

MR. JAFFE: Yes.

BY MR. JAFFE:

Q If you can look at pages four and five, just briefly scan that. Now, again, just -- I apologize. Page two, we've already talked about the Release of Liability. So do you think that based on the medical record, including the Release of Liability, that Dr. Eidelman's conduct provided the appropriate consent, including the discussion of side effects?

A Yes.

Q Okay. Based on the notes on four and five, do you think that that was an adequate review of the treatment efficacy?

A Yes.

Q And in general, if you take a look at Exhibit 22, page two through five, and -- you know something about recordkeeping, sir?

A Yes.

Q You've taught about it before?

A Yes.

Q You review doctors who are accused and have problems recordkeeping?

A Yes.

Q You consider yourself an expert in

recordkeeping, don't you, sir?

A Yes.

Q Do you think this record, Exhibit 22, is -- meets the standard of a reasonable physician in the state of California?

A Yes.

MR. JAFFE: Give me a minute.

(Pause in the proceedings)

BY MR. JAFFE:

Q So based on your testimony that you were Dr. Eidelman's monitor, can you give the Court some idea what your understanding of the nature of his practice is?

MS. BROWNE: Objection; lacks foundation.

MR. JAFFE: Well, I just put it in my question.

MS. BROWNE: Well, as far as referencing a time frame.

THE COURT: That's more a valid point.

MR. JAFFE: Okay.

THE COURT: In other words, you were the monitor several years ago; right?

THE WITNESS: Yeah, in the decade prior to this happening.

MR. JAFFE: That's a fair point.

THE COURT: I'm inclined to sustain the objection.

//

BY MR. JAFFE:

Q Okay. Do you have any information about -- how would you characterize, at least based on your experience with Dr. Eidelman -- and have you had any conversations in the recent past with him?

A Yes.

Q And has he told you a little bit about what he's doing now?

A Yes.

Q How would you -- from your lens as a teacher in medicine and/or author, how would you characterize his practice based on your monitoring and based on all the conversations you've had with him? How do you -- what kind of practice practitioner is he?

A Well, I think he's a specialized doctor out in the front line, which means he doesn't only -- he doesn't -- people don't have to be referred to him like a specialist, but he provides -- the core -- the crux -- the core of his practice is medical marijuana in which he sees people, he interviews them; tries to -- you know, gets an objective picture of what's going on and decides whether or not medical marijuana is appropriate or not. So he makes that decision with most of his patients.

He does a variety of other things that he's interested in, like smoking cessation through electrical

stimulation. He was starting that work when I was his practice monitor. So he has other interests and he sees people with kind of chronic health problems; again, mostly medical marijuana, but he does some other alternative therapies that he reads about and is trying in his office again in the same consent way.

Q All right. Okay. Can you -- in your opinion, looking at the record, did the recommendation of medical marijuana in this case cause the patient any -- any harm due to the taking of the product?

A No.

Q Can you tell from the record or any information you have about the case, did it have any positive or beneficial effect?

A Well, we have documentation that it was helpful. You know, the first response on September 20th was really very positive and the follow-up response the next month was it's working, but it's wearing off in the long school day, so could we try a second treatment at lunch, essentially, which would be a reasonable thing to do.

Q Why do you think it would be a reasonable thing to do?

A Well, I mean, that's quite common. When I deal with ADHD kids, you know, we start with a low dose once a day and find out if that dose is adequate and is once a

day adequate, and I would say quite often a second dose is necessary for treating this problem because it will wear off and the problem will burst forward again.

So I think -- you know, I mean, this is a typical time course for treating this problem and a typical thing. It's just the therapy was unorthodox for the time and place it was given and had the negative response, which, you know -- but there was not a problem. Certainly the therapy was not causing the child to be disruptive or bad or making him ill. As a matter of fact, the data is just the opposite.

Q Right. There's been -- let me represent to you there's been some testimony that the fact that he needed a second dose in the afternoon was indicative -- was evidence that his brain was changing. Does that -- does that make any sense to you?

A No.

Q Okay.

MS. BROWNE: We'd object retrospectively again as misstating the record.

THE COURT: I think the testimony was closer to that it's a sign that the child is becoming rapidly dependent on the marijuana product.

BY MR. JAFFE:

Q I would ask you to consider what the judge said

and ask you whether that even makes any sense after two weeks.

A Well, I guess I don't want to evaluate what makes sense and -- what makes sense to me is that a dose of a medicine given I'm assuming reasonably early in the morning like 7:30 or 8:00 in the morning would wear off by noon. Drugs do. Whenever you have a drug in the body, there's what's called tachyphylaxis. Your body gets used to the drug and it tends to wear off quicker. Opioids are classic examples of that. So -- but drugs will do that. So it's really -- I mean, I think it would be premature to say that the child has gotten addicted or habituated to the drug in a negative way. That's way premature in this case.

I think that, you know, cannabis is not a long-acting substance. We really don't understand its pharmacotherapy that much, but I think it's pretty reasonable in this early stage to say sure, let's try two.

Now, if I came back and someone said, "This child needs it every three hours," I'd say, "Wait a second." You know, that's not -- now I think we've entered into a realm of overuse or abuse. But to use it twice instead of once in a day would not really get there yet in terms of being a sign of a negative effect on him

or that. I mean, I think that's just a reasonable need.

MR. JAFFE: Okay. Give me a minute.

I'd pass the witness for the benefit of my colleague. I'm wondering if we can take a break. We've been going an hour and a half and for the court reporter --

THE COURT: Especially for her. We'll take a ten-minute break.

(Recess)

THE COURT: All right. Let's go back on the record.

Ms. Browne, "You may fire when ready, Gridley."

MS. BROWNE: Thank you.

CROSS-EXAMINATION

BY MS. BROWNE:

Q I just have a few questions for you.

Do you feel that Dr. Eidelman had sufficient -- I want to confirm, do you feel that Dr. Eidelman had sufficient information in order to make the diagnosis and take the action that he did?

A Yes.

Q And you stated -- on the nature versus nurture controversy, is there one direction that you tend to come out on?

A In this child, I think both are weighing

heavily, so it's not a clear -- I would never say it's purely genetic or nature. On the other hand, I think that both are in play here, which would mean using a medicine rather than just counseling is probably necessary.

Q And on what basis -- on what basis do you state that?

A The family history.

Q And what is your understanding of the family history?

A That the father and the older brother have mental health problems. I believe they were both diagnosed with bipolar disorder.

Q Okay. So that goes toward the nature or the nuture?

A The nature, that there would be a genetic component to the problem.

Q Okay. But you also said that there's a nurturing problem in this case, did you say?

A Well, there almost always is going to be in terms of the household and, you know, how well the child is raised, I mean, and so you can usually assume in a child behavior problem that there could be or is likely to be an environmental concern also, but you don't know.

Q Is that something that should be explored in --

should that have been explored here?

A Well, Dr. Eidelman is not the pediatrician for the child. He's not in charge of the child's comprehensive care. He does a specific service that he was requested to do. So in the limited capacity or the limited focus that Dr. Eidelman had, he's not a person that is referring to counselors and things like that. That would be the role for the pediatrician and the family doctor.

Q And in this case, do you know whether there was a pediatrician, a family doctor?

A No.

Q No, you don't know or no, there was not?

A I don't know.

Q Should that be something that's important to know?

A That is an important thing and Dr. Eidelman's consent form makes it very clear that he's not providing primary care and that they should have a primary care doctor.

Q So you believe sufficient information was provided by way of the release that you had looked at in prior years?

A Yes.

Q This -- you talked about only 50 -- well,

outside of your program, the program that you had, you had generally 50 percent of residents get depressed, but that was not the case in your program. Does -- is that a marker of doing well, of success in your program?

A We certainly think so. The success also means they're well trained and become good doctors, but we consider that an important marker of success.

Q Okay. And when you say "well trained and become good doctors," all up to the standards of care that you hold?

A Yes. For example, all of our resident graduates have passed their board exams and have gone into good jobs and the only evidence so far is that they're doing a good job in those good jobs. We've hired about one-third of our graduates and they're doing a real good job for us.

Q And do you -- I presume you teach your patients -- not your patients -- your residents this -- this standard of care which you apply; correct?

A Yes.

Q Are you familiar with the DSM-IV characteristics of ADHD?

A Yes.

Q Could you please tell us what they are?

A I would have to go back and look at it for the

exact wording. I mean, I'm familiar with it, but do I have it memorized? No.

Q Oh, okay. So not the exact wording. Just could you just give us your understanding?

A Well, for ADHD, which is different than ADD -- ADD is Attention Deficit Disorder and would be someone who's having trouble concentrating, staying focused, ability to either learn or do their job. With ADHD, you have the attention deficit and the hyperactivity component. Usually it refers to children and it's a combination of not keeping their attention for proper learning and their hyperactivity is disruptive.

Q Just thinking about the DSM, I'm not asking for you to use the exact wording by any means, but are there any other criteria that you can think of for ADHD or ADD?

A Well, I think it's important that it's observed in multiple settings, that it isn't just in the situation of one context or with one person, but it's a behavior pretty much across the span of the child's day and the environments that they're in.

Q And here I believe you testified that it appeared that there were sufficient problems at home and in school to warrant the diagnosis of ADHD or ADD; is that correct?

A Yes.

Q And would you agree that in making that determination of whether there's sufficient -- that in making that determination by not calling the school that Dr. Eidelman was relying on the father?

A Yes.

Q And do you think it's appropriate for the doctor to rely on the father?

A Yes.

Q And were you aware that Dr. Eidelman had previously treated the father?

A No. I wasn't aware of that.

Q And does the fact that the father -- strike that.

You said that the DSM changes frequently and it calls the same things different things in different editions. Did I say that correctly?

A That's correct. I mean, "frequently" means once or twice a decade and --

Q Right.

A But, yeah, the labels have evolved over time, been changed, reflecting -- I mean, I don't think the mental health problems themselves have changed. It's just that the labels have evolved.

Q And why do you think the labels evolve?

A Well, it's a consensus of expert opinion feeling

like the label isn't as precise as it should be or that, you know -- I mean, mental health science evolves and I think we get a better understanding of mental health problems all the time and it's often argued, you know, that the label, you know, isn't up to date with science. So they want to change the label to reflect the science.

Q Okay.

THE COURT: In other words, it's not just semantics. There's some scientific change behind it?

THE WITNESS: Yeah. They've got good reasons, I mean --

THE COURT: Okay.

THE WITNESS: -- to make the changes.

BY MS. BROWNE:

Q And are you aware of any change in the diagnosis from the DSM to the DSM-V of bipolar disorder?

A I have not studied that, no.

Q And if there were a change, would you -- well, I'm sorry. Have you diagnosed anyone with bipolar?

A Yes, I have.

Q Okay. So would a change in the label -- in that it's based somewhat on science, would that be important to study?

A If would be. I look stuff up all the time and in a teaching environment, I'd say if we're going to make

a diagnosis of bipolar, let's look at the current criteria for the diagnosis, so we'd look it up.

Q Are you aware in this case of whether or not Dr. Eidelman looked up the criteria for bipolar?

A No.

Q No, you're not aware or no, he didn't look it up?

A I'm not aware that he looked it up. He may have looked it up, but, you know, the notes are just the summary of the case. I think my sense is that the diagnosis was there because of the family history.

Q Okay. You said if a patient can get improvement and relief from cannabis that that's a good thing that makes it -- that makes it beneficial. Is -- could you define what "improvement" means in this case?

A Well, in this case, it would mean that the child was less disruptive at school, was capable of being in the classroom hopefully learning and -- but certainly wasn't having a negative impact on the teacher's ability to maintain order in the classroom. So that would be a positive response.

Q Okay. And that's positive why? Because why? How is that positive?

A Well, that's -- that's the problem you're trying to treat is to keep the kid in the classroom and to deal

with a teacher who's saying he's very disruptive. So if you fix that, that's a positive response.

Q Okay. And are there any -- well, I guess you already said this. There's -- you said there's a lack of a side-effect profile for cannabis?

A I think we're still learning about those. I mean, clearly -- I mean, I think we all would appreciate there are side effects. I wouldn't want somebody driving right after taking cannabis cookies, for example, but I think you've gotta respect the side effects that are there which are going to vary from one person to another.

Q Okay. And do you have any concern about the dosing of medical marijuana when it's prescribed?

A Well, I think he points out that to use it is as little dose as possible. The trouble for us doctors with medical marijuana is we can't write a milligram prescription because we don't know how much is in any given product exactly and so it's -- it's pretty loose right now. When you use marijuana, you've got to trust the manufacturer, you trust the purity, and you hopefully -- I mean, it would -- you know, for example, you know, one cookie, that seems like a reasonable thing to do, you'd want to do, but not have the child eat five cookies or something like that. It would be clearly a risky thing to do.

Q So the -- so the dosing was probably okay just because he just started with one cookie in the morning before school?

A Correct.

Q Okay. And then you believe it was reasonable to provide, you know -- would it have been reasonable to provide a second dose of another cookie at -- you know, at lunchtime?

A Yes. Given the long school day for a child, I think that was certainly reasonable.

Q Uh-huh. Other than the release which you talked about, are you aware whether or not there were any other warnings about side effects, things to watch for that Dr. Eidelman stated to the patient's father?

A I'm only aware of what's in the note.

Q Okay. But what's in the note and the release seems sufficient?

A Yes.

Q You stated that you have a concern with atypical antipsychotics because they can change people?

A Yes.

Q What do you mean by "change people"?

A Well, it's a vague statement. I apologize for that. Mental health drugs alter mental health and behavior and all mental health drugs cause a change in a

person, whether it be their personality or their ability to learn or various things, and the antipsychotic drugs are what we call major mental health drugs in that they have a major effect on a person, and I think when that's -- when that's done where lesser therapies might be used, it's an unfortunate thing.

Q And why is it unfortunate?

A Well, I don't think we doctors should change people's personalities or behaviors or cause any more impact on them than we need to to treat the problem, so I think any time -- for example, a famous physician, Maimonides, once said that any illness that can be treated with diet should not be treated any other way, which is a powerful statement which I wish we lived by in American medicine because we so quickly go to drugs. But using -- if nutrition alone is not going to be adequate, if you're going to choose a therapy, you want to use the least toxic therapy that could be effective.

Q Okay. With the statement anything that can be changed by diet should be changed -- diet alone should be changed by diet? Was that what you said?

A The statement of Maimonides, who's a 12th Century physician. So it's a long time ago. He certainly emphasized that a first line of therapy should be nutrition wherever possible. Hippocrates felt the

same way.

Now, I do an enormous amount of teaching along those lines with people, so I actually stop more drugs than I start in my practice of medicine.

Q Okay. And that is -- what you just described, is that part of the standard of care?

A Yes. As a matter of fact, geriatricians -- and I know geriatrics well. I was in charge of the geriatrics program at Irvine. Every good geriatrician stops more drugs than they start because seniors are suffering from polypharmacy.

Q And what do you mean "polypharmacy"?

A It's defined as someone being on five or more drugs. We know if a person is taking five or more drugs, they actually are suffering because of taking five or more drugs. It's an additional problem on top of the problems that you're treating, so you try to avoid -- if you're taking care of the whole patient as a primary care geriatrician, you realize that you want to get the patient on the least number of drugs possible.

Q So otherwise it creates an additional problem?

A That's correct.

Q Then what is the -- what is the problem if they're effective?

A The side effects of the drugs that interact with

each other. I mean, in American medicine, we're often giving drugs to treat the side effects of other drugs we're giving.

Q Okay.

A So it's a problem. Being -- people don't live as long and do as well if they take a lot of drugs.

Q Sure.

A I mean, I just had a patient pass away at 106 and she'd only taken one drug in her entire life and that was an antibiotic.

Q Now, in counting the number of drugs, would marijuana count as a drug since it's natural?

A Oh, sure. Yes. Marijuana is a drug. Medical cannabis is a drug.

Q So before trying medical marijuana, then, for the same reason, you'd want to try nutritional changes?

A The primary care physician will in the care of this child. Now, you know, Dr. Eidelman in his specialty provides a certain therapy on request and so for him, people come to him to get medical marijuana if he feels it's a reasonable treatment option. So that's what he does essentially.

Q Okay. Do you think that Dr. Eidelman should obtain records from the primary care physician?

A I don't think it's always necessary, again, for

the limited scope that he's providing. I think it's important for the patient to let the primary care physician know what he does, but he doesn't need to -- again, he's not taking responsibility for the care of the whole child.

Q Okay. Well, here, do you know whether Dr. Eidelman made contact with the primary care physician?

A I don't know. The record doesn't show that he did.

Q Well, in teaching medical recordkeeping, is that -- is it true that if it's not documented, it didn't happen?

A Correct.

Q So --

THE COURT: I take your point, ma'am. Move on.

MS. BROWNE: Okay.

BY MS. BROWNE:

Q So one of the findings -- I'm sorry. One of the statements in the Accusation -- do you know what the Accusation is?

A Yes.

Q Okay. One of the allegations in the Accusation is that references -- and if you want to look at it, it's Exhibit 1, but otherwise, I can tell you what it says.

A I read it.

Q Okay. So paragraph 14 where it says -- it accuses Respondent of committing or of being negligent, grossly negligent when he recommended cannabis as a first-line treatment. Do you have any concerns about that it was the first choice?

A Well, I don't agree. First of all, I don't agree with the statement. Again, the patient is guiding what they want to do and whether it be the first thing that's ever been done for this child or not. Again, we don't know. The child's had five years of life, but they come to Dr. Eidelman for a specific request and he has to use his judgment to decide whether that request is reasonable, whether it be the first line or the fifth line or whatever and I think that his judgment is that it was a reasonable request and that it could be tried.

Q You said we don't know if it's first line or not because were there other things that had been tried?

A You know, as a doctor, you're not thinking -- again, you're not thinking about is this first line or whatever. Your judgment is what's the problem and how could I help this patient and is the request the patient is making reasonable? And I think using cannabis as a first-line treatment in this case if it were the first-line treatment I think is completely reasonable.

Q Okay. So there's no duty to get all the past history to see if any other treatments have been tried?

A No.

Q So it sounds like there's -- is there a difference in the standard of care when you apply it to the primary care physician versus a specialist in marijuana?

A Every specialty has its standards of care, but when it comes to the patient and their medical problem, there really is just one overall standard of care. It's just that different specialties practice differently.

Q And so here, are you applying the standard of care that applies to a family practitioner?

A Well, I'm applying a standard of care for Dr. Eidelman because, you know, Dr. Eidelman is a specialist in this and I'm very familiar with his practice. I think he knows the use of cannabis very, very well; but even if this were a family practitioner having done this, or I may have done it myself, but if a family practitioner did this and documented in the way Dr. Eidelman did, I would defend them as being a reasonable and appropriate treatment.

Q Okay. Do you think you might be biased at all given that you do have the prior experience working with Dr. Eidelman and teaching him?

A I'm not sure I would call it a bias. It's just that I'm more informed. I'm more familiar with his practice. I've spent hours talking to him so I know who he is. I know what kind of a doctor he is. I have a sense of how intelligent he is, how thoughtful and careful he is and what his goals of practice are. I mean, some docs I monitor, it's very obvious that it's kind of a racket. They're in it for the money, they're churning people and I'm pretty critical of them in my evaluation. None of that applied to Dr. Eidelman.

Q Are you aware Dr. Eidelman doesn't take insurance --

A Yes.

Q -- so the patients pay in cash?

A Yes.

Q Are you aware how much?

A Well, I think at the time I was monitoring him, the cost for the visit and the letter was about $250. I don't know if it's changed or not. I imagine it might have.

Q Okay. At that time, was 250 a fair price?

A Yeah. I thought he was very reasonable.

Q So I want to ask you a couple things. I just want to ask you a few things hypothetically that if they're true, whether it would change your opinion in the

case.

A Okay.

Q Well, actually, before I do that, do you have any problem with the fact that the medication is given in cookies, sugar cookies?

A Well, no. It kind of reinforces that this is sort of a natural method of treatment. I have patients now taking cannabis cookies on their own for a variety of problems that they're coming to tell me about, that it's usually been a positive thing that they're telling me about and I don't say, you know, I wish you didn't do that or you're doing something wrong. I mean, if they're on less medication because they're using cannabis cookies and even better if they're feeling better, I think that's a positive thing. So that's just the way oral cannabis is given.

Q But it's got sugar in it. Is that --

A Yeah --

Q -- worth the --

A -- but a single cookie is not too bad.

Q So if somebody takes cannabis and it helps them to take less medication, that's a good thing; right?

A In my opinion, yes.

Q But isn't cannabis a medication?

THE COURT: We've done this loop already.

MS. BROWNE: Okay. All right.
BY MS. BROWNE:
Q So let me move on to what I was going to move on to, which is to say I want to ask you a few things hypothetically and see if that changes your opinion.
Would it change your opinion about any of this if the father in this case had been -- was a convicted felon?
A No.
Q Would it change your opinion in this case if you knew that the Department of Child and Family Services had been extensively involved with this family of multiple kids and some allegations against the father had been substantiated?
MR. JAFFE: Objection; misstates the record. The entire matter was dismissed. We have it --
THE COURT: Well, there were two matters apparently and I don't necessarily put that much in the substantiated business, ma'am.
MS. BROWNE: Okay.
THE COURT: We hold hearings for the Department of Social Services and they'll come in and say, "Our people substantiated this" and I'll say, "Why am I here?" Truth is, times I find that what they substantiated hasn't been established by a preponderance of the evidence so we're

going to stay out of this.

MS. BROWNE: Fair enough.

THE COURT: And another reason is you've got no evidence that the Respondent knows anything about all of this.

MS. BROWNE: Right. Okay. Thank you. I withdraw the question because, yeah, we don't want to tie that into this.

BY MS. BROWNE:

Q So let me stick to a different question is do you think -- would your opinion be the same if you knew that the father had an anger problem, a history of having an anger problem?

A It would be the same.

Q What about if the father had engaged in domestic violence?

A It wouldn't change my opinion in the circumstance of the case.

THE COURT: Is that because you might expect that behavior if the father's bipolar?

THE WITNESS: Yes.

MS. BROWNE: And in this case, we know the father was bipolar.

THE COURT: No. That's what Dr. Eidelman believed.

MS. BROWNE: Right.

THE COURT: The father's testimony yesterday was that he's ADHD and he made some statements to the effect that he actually has not been diagnosed with bipolar, but everyone puts that label on him. I believe that was the gist of his testimony.

MR. JAFFE: I would agree. I think that's correct, your Honor.

MS. BROWNE: Thank you, your Honor.

THE COURT: It just adds another little layer for me to work with.

BY MS. BROWNE:

Q If we could please turn to page 22 -- sorry, Exhibit 22 --

MR. JAFFE: The medical records?

MS. BROWNE: Correct.

BY MS. BROWNE:

Q -- and page three. So in this second paragraph, the family history, it says:

"Bipolar disorder runs in family. Father and brother both on psychiatric drugs as children. Both were diagnosed with ADD/ADHD and bipolar, put on drugs for both."

So in the medical record, it says "bipolar" -- I forgot what my question was -- I just -- would it make a

difference in your opinion, I mean, considering that Dr. Eidelman apparently did think that the father was diagnosed with and the brother were diagnosed with ADHD and bipolar?

A It wouldn't change it. It just tells me the mental illness runs in this family.

Q Okay.

A I take the labels with a grain of salt and I'm not their doctor in this case, but those are the labels they were given, but it's clear that mental illness runs in the family and they've been treated with psychiatric drugs.

Q And the labels that were given here, are you aware whether -- strike that.

You've already answered it. I don't want to cover the same ground.

In this case, could you assume that Dr. Eidelman -- well, are you aware of whether Dr. Eidelman had prescribed medical marijuana -- not prescribed -- offered a -- provided a recommendation letter to the father for medical marijuana?

A Wasn't aware.

Q Okay. Does that -- is that significant to know?

A It only -- if it were true, it lets me know that he has some background with this family and it isn't the

first time he's dealt with the family, which would add to his -- this, but it's immaterial to his treatment of the child on that day. I mean, it's not a significant factor --

Q Okay.

A -- but it would be worth noting, but I don't think he needed to put it in the note because it's about the child.

Q Okay. And you think that Dr. Eidelman is qualified enough to make a diagnosis of ADHD or bipolar?

A Yes.

Q So do you think it's Dr. Eidelman's -- well, I guess -- it sounds like you don't. I think I know your answer to this question, but I'm going to ask it just in case. Do you think that Dr. Eidelman should have just trusted the father to give adequate information and to know enough to say that his child should be given the medical marijuana?

A Yes.

Q Did he have any duty to look further into the family history more than just the fact that that label had been put on the older brother and the father?

A No.

Q No, he had no duty to let --

A No. I don't think he had to go further than he

did to give the treatment a try.

Q Okay. And -- okay. At this -- earlier I heard you say when asked -- oh, you weren't asked, but you said when -- was this treatment the standard of care and then you said no.

A Well, we don't have a standard of care yet in the use of cannabis in children, so there is no standard of care.

Q Okay.

A It just doesn't exist. So right now, we're working on best clinical judgment.

Q Okay. If the -- if the -- if Respondent had treated the dad, should he take into account his experience and knowledge about the dad when making an assessment of the child and the nature versus nuture --

A Sure.

Q -- evaluation?

A Yes.

Q And is it sufficient that there was a diagnosis of ADD and bipolar? Does that make any difference in your opinion?

A No.

Q If it were just ADD or just bipolar, it would be the same?

A Yes.

Q Okay. When you mentioned that you prescribed medication for ADHD and then usually it ends up wearing off so then you end up saying you'd do a second dose later, did I understand that right?

A Yes.

Q Do you prescribe the XR?

A I do also. The XR usually does not require a second dose --

Q Okay.

A -- but there can be what's called a breakthrough that sometimes requires a second dose even with the XR product, but usually once a day is sufficient. XR products have tended to be more expensive, so sometimes patients can't afford the XR and you use the shorter acting.

Q Is it important to offer the patient the extended release first to see if they could afford it and if they can't, then talk -- then move toward the --

A Usually I try the drug without the XR to see if it's effective.

MR. JAFFE: I think we're getting a little far afield, Judge.

THE COURT: Yeah. Well, I think she's entitled to inquire into other treatment modalities --

MR. JAFFE: Okay.

THE COURT: -- for these conditions.

MS. BROWNE: And, same thing, I don't want to cover old ground, so I have no more questions for you. Thank you.

MR. JAFFE: Judge, I have no Redirect. Do you have any further questions of this witness, your Honor?

THE COURT: No.

You're excused, sir. Thank you.

THE WITNESS: Thank you.

MR. JAFFE: Judge, can we take another little break?

THE COURT: Yes.

MR. JAFFE: And just -- we can go off the record.

THE COURT: Yes.

(Recess)

THE COURT: We have another witness. Let's go back on the record, see what we can accomplish.

MR. JAFFE: And, Judge, this will be our final expert witness and then we'll go back to Dr. Eidelman and that will be the end of our case.

THE COURT: Sir, have a seat. Raise your right hand.

JEFFREY YATES HERGENRATHER, M.D.,

called as a Witness, and having been first duly sworn by the Court, was examined and testified as follows:

THE WITNESS: I do.

THE COURT: All right. Will you tell us your name and spell it.

THE WITNESS: Jeffrey Hergenrather, J-e-f-f-r-e-y. Middle name is Yates, Y-a-t-e-s. Last name Hergenrather, H-e-r-g-e-n-r-a-t-h-e-r.

THE COURT: All right. Counsel?

MR. JAFFE: Thank you, your Honor.

DIRECT EXAMINATION

BY MR. JAFFE:

Q Doctor Hergenrather, can you briefly give us you your educational background?

And let me just note for the record and for you, sir, that your resume, which is in Tab 35, which I believe is before you in the exhibit book, and your expert report, which is Tab 36, are already in evidence, so feel free to refer to it. The Court is familiar with it and might be asking you some questions about it, but it is in evidence and you should feel free to refer to it.

A Fine.

Q Can you give us briefly your educational background, sir?

A I graduated from high school right here in Los Angeles County back in 1966. I spent one year in

general education in Boulder, Colorado at University of Colorado. Then I transferred back into the Bay Area to Berkeley, California, where I went to University of California, Berkeley and completed by B.A. degree in 1970, and from there I went on to medical school in the fall of 1970. I was in the first class in the medical program at Brown with our graduating year 1995, so we graduated -- I'm sorry. 1975 -- where'd those 20 years go? All right.

So that was '75. I graduated from medical school and then I went on to a rotating internship in South Carolina and then I went on into general practice following that year of rotating internship.

Q And where was that general practice?

A General practice initially in northern Idaho where I spent one year and then I went on down to Tennessee where I was on -- in an intentional community known as The Farm in Tennessee.

Q Intentionally, you say, I-n-t-e-n-t-i- --

A Yes. It was a big commune and I became the physician at that commune. There were 600 people when I arrived in 1977 and then my wife and I and family stayed until 1982. So about five and a half years later, we left that community and moved to California, and I've been practicing in California since 1982.

Q In Northern California?

A One year in Southern California where I was involved in emergency medicine and then we moved north to Northern California in Sebastopol in 1983 and I've got a private practice in Sebastopol since 1983, mostly doing E.R. work for 26 years during the period of time when my wife and I were raising four children; but then after our kids were grown and gone from the house, I opened a practice in cannabinoid medicine. I've been a cannabis specialist with an office devoted specifically to doing cannabis medicine since 1999.

Q 1999. All right. Let's talk about -- okay. So you worked it says here '89 to '92. You're an E.R. doc at Warrick Hospital, Santa Rosa?

A Yes. That's correct.

Q And that was your full-time job?

A Yes, it was.

Q How big of a hospital was it?

A Oh, gosh. We had probably fewer than a hundred beds, I think. It was a busy 24-hour E.R., the third E.R. in the town of Santa Rosa. We had bigger hospitals with bigger E.R.s, but we would have a particular catchment area in the southeast quadrant of Santa Rosa. So --

Q Geographic catchment you're talking about?

A Yes. That's right.

Q And so you spent a lot of time doing that. Basically, what kind of cases? You'd receive basic E.R. stuff? Can you describe the nature of your practice back then?

A Basically, E.R. stuff from little, you know, sick children and infants all the way through quite a big population of elder care, geriatric care. We had a few nursing facilities near our community hospital there and of course get to know the local medical staff and serve the needs of those folks as well. So we would receive ambulances. Some of the more difficult cases with multiple organ involvement, serious traumas, would often bypass our hospital on to the trauma center in Santa Rosa. We got a wide range of general medical emergency medicine cases.

Q All right. Just out of curiosity, how long would your average patient encounter that you would be at the E.R. room -- a patient comes in and then maybe they're worked up, but when you see the patient, how much time do you spend with the patient?

A Well, on an average, I would say probably initially about 15 minutes and then order whatever needed to be ordered as far as lab imaging studies or whatever might need to be done and then return to visit with the

patient to figure out a disposition plan. If there was a trauma case and I was putting on casts or splints or doing something of that nature, I might spend a bit more time doing whatever needed immobilizing. If it was cardiac care, I might take the patient right on into the intensive care unit, establish lines, and -- meaning I.V.s, and medications until the cardiologist arrived to pass the case off to the specialist.

So it was quite a range from 15 minutes was maybe the shortest case, but that was the range, from 15 minutes to as much as an hour intermittently with the patient. It wasn't full-time over that period of time.

Q At some point would you have to write some type of SOAP note?

A Absolutely. That was the method of documenting the illusory injury and then writing prescriptions as needed and then establishing a follow-up care plan.

We also had an occupational medicine division of this E.R., so we did see some occupational medicine cases and have them back again as far as their follow-up care.

Q Okay. And that would include like an assessment or basically what the patient had, what you thought the patient was -- had?

A That's correct.

Q And that could be done even -- would you have to

do something? You'd have to put something in there after you see the patient if you had any idea?

A Well, I'm not sure of the question.

Q Okay. That's all right.

Let me -- so -- all right. You did this emergency room for 12 years, a wide variety of practice, and --

MS. BROWNE: Objection; misstates the record.

MR. JAFFE: Well, that's really not the question.

MS. BROWNE: The amount of years, did I hear 12?

MR. JAFFE: '89 to 2002?

THE WITNESS: In this facility, that is correct. It was continuous with 26 years --

MS. BROWNE: Yeah. That's what I wrote.

THE WITNESS: -- in emergency medicine.

BY MR. JAFFE:

Q Then you switched to another hospital?

A Prior to --

Q Oh, prior to that --

A -- I had been at Healdsburg General Hospital and then prior to that I directed the E.R. at Ross Hospital and prior to that I was the E.R. director in the Woodland Memorial Hospital. So this goes back through those earlier years. The first hospital I was in in California was at the Palo Verde Hospital in Blythe, California.

Q So 26 years as an E.R. doc?
A That's correct.
Q Okay. I understand.
What -- what made you to get into -- and I think you said that it was 1999 you opened a private practice for medical marijuana? Was that also when your were also being an E.R. doc at this Warrick?
A Warrick Hospital? That's correct. I did open my practice in '99 as I made about a two- or three-year transition out of the E.R. The practice was a little slow initially, but as it picked up, I could continue with the sufficient income to cover mortgages and -- or a mortgage, I should say, and then I moved out of the Warrick E.R. and into this as a full-time practice.
Q What got you interested in cannabis?
A You know, I was interested from college years in recognizing that this was a very interesting herbal medicine or substance. I studied it in -- as an undergraduate. When I went off to medical school, I went to the medical library and although it wasn't part of the curriculum, I was interested in cannabis enough to go to the library and see what literature was there and I was kind of taken aback even in 1970 as to the polarized information. You know, it's one way or the other, it seemed, and in defining what the risks or benefits of

cannabis use was.

So because medical school is so rigorous, I didn't really spend much time with that in my medical training; but as I left my residency in rotating internship, I was quite interested in cannabis and I followed up with a group of people that I had met in San Francisco in the '60s when I was an undergraduate at Berkeley and that was what formed this community in Tennessee. It started from San Francisco. School buses and trucks and vans, people caravanned around the country, ended back in San Francisco in 1971 and then took off again in '72 and founded this community in Tennessee.

So it was under way and I had told them as I went off to medical school in 1970, "I'll catch up with you after I get done with my medical training."

THE COURT: So was Kesey and Cassidy involved in this or was it --

MR. JAFFE: I was about to say the Electric Kool-Aid Acid Test.

THE WITNESS: Well, we knew all of what was going on around the country and met Ken Kesey and others in that era. Tennessee was its own scene. We were -- we were -- I spoke of it as an intentional community. You could call it a commune, but it was unusual. It was huge. It

started out with 200 people and then they would come from all over the world to visit and see what we were doing.

By the time we got there in 1977, there were 15,000 visitors a year to the community and so we would take care of them, put them up, let them help out on the crews, whether it was the medical crew or the farming crew or the construction crew, wherever they would fit in, and then basically after a few days we'd say, "Okay, three days or the rest of your life. Are you going to throw in with us or not?"

So we shared all things. We did not have our own wallets, so to speak. If we wanted something, we'd go to the bank lady and see if there was funds to support our needs, whether it was a trip home for family needs or a pair of shoes. We would go and see if there was funds for those needs and --

BY MR. JAFFE:

Q You didn't feel -- they didn't film the Easy Rider in your bus, did they?

A No, but I certainly remember it well.

THE COURT: All right.

BY MR. JAFFE:

Q All right.

THE COURT: I shouldn't have started that detour.

THE WITNESS: Down that path.

BY MR. JAFFE:

Q Now, so marijuana was -- cannabis was an interest of yours and then this is 1999, so this is after the compassionate use?

A Yes, three years after compassionate use passed, though I might mention that coming out of Tennessee or actually being in Tennessee from '77 to '82, marijuana was not a legal drug or herb at that time anywhere in the country, but patients would come to me on a daily basis and explain to me what cannabis was doing for them. And although I never handled it, it was never in the clinic, if somebody was using it as a medicine for a seizure disorder, an autoimmune disease, a mood disorder, pain, whatever the particular problem was, I was being taught by my patients what cannabis was offering to them and then if I gave a nod to a midwife and then said, "This person is really benefiting with the use of cannabis," generally the midwives would do whatever was necessary to help that patient find the cannabis to continue using it medicinally.

So I was peripherally involved in that, but certainly my education in this community was rich with learning from patients what cannabis could do long before the science was understood.

Q Okay. So tell us about the evolution of your

practice from '99. And basically it's been continuous from '99 to the present time private practice? You're the only doctor --

A Yes.

Q -- that --

A Yes. I'm a solo practitioner. I opened a practice and began seeing patients for the medicinal use of cannabis and I must say at that time, probably 99 percent of the patients that I saw were coming to me already using cannabis, but they needed to be legalized in California. So I had a role of seeing patients and evaluating them and then writing an approval letter for them at the conclusion of those initial visits, setting up a follow-up visit in six months or whatever the need was, sometimes less time between visits. But in other cases, six months was pretty common initially and then that gradually extended out to about a year. The Medical Board of California was recommending that doctors follow up with medical marijuana patients at least on an annual basis and so I was doing that or more frequently as needed.

So that changed over the years and really by I would say 2010, 2012, in that range, I was seeing more and more patients that weren't really using cannabis but were interested in using it for a variety of needs, and

this began to extend into patients that -- like I say, probably the majority of the patients were not using cannabis when they came to see me following I would say 2012 or '13.

Q Unlike your earlier practice where basically your role was giving a letter to someone using it to make it legal?

A That's correct. So the acuity continued to go up, as the needs were very serious in many cases. The range of patients that I was seeing, whereas before it was probably -- well, I know for fact that the mean age of my patients in that earlier time was 48 years of age, I saw a few teenagers, very few children, but I did see some, and then it tapered off into old age where I was seeing folks in their 70s and a few patients in their 80s. So basically a bell curve centered at about 48 years.

Now, by 2013, Sanjay Gupta, our CNN correspondent medical doctor and neurosurgeon, was -- went on the air to say that he apologized to the American people for his not understanding or not respecting the medical uses of cannabis. He thought that there was no medical use of cannabis and it changed him to see a child using cannabis for a seizure disorder in Colorado. That was in 2013, and I'd have to say that there was a

significant change in my practice at about that time to where more and more people were asking and talking about it and interested for childhood illnesses as well as illnesses of the elderly.

Q What kind of childhood illnesses, if you can --

A Well, probably the first were seizure disorders and cancers, but there were also some autoimmune diseases and some mood disorders, a variety of mood disorders, mostly ADD, ADHD, and, oh, that was -- probably the first wave of kids were those cases, mood disorders, cancers, autoimmune diseases.

So I really got established in seeing more pediatric cases and seizure disorders, as I mentioned. Those were the first kids that I began to see medicinally and some genetic disorders. So I have seen kids as young as one year of age with genetic disorders and usually seizures accompany that or some other medical problem where you realize that this kid is destined for more and more medical problems and intervention and medications and we would see if cannabis would be able to reduce any of the seizures or prevent the seizures altogether.

So that was kind of the nature of it. And then the population curve of my patients really broadened from children all the way to -- well, the oldest is 103 that I'm still seeing. So we do see quite old people at this

point as well. I do, I should say, rather than "we." It's still a solo practice in cannabis medicine.

Q Now, do you have any research projects with cannabis that you're currently interested in?

A Well, I am, and one of the things that occurred when I began to see patients in 1999 for the use of cannabis was I was approached by my mentor, one of my mentors, Dr. Todd Mikuriya, M-i-k-u-r-i-y-a, and Todd invited me to begin to come to quarterly meetings of what was at that time called the California Cannabis Research Medical Group. We changed our name in 2003 or '04 to the Society of Cannabis Clinicians to broaden this to more of a national or even an international name because we were seeing docs coming in from all over the country.

So I began to go to those quarterly meetings and begin to participate. Soon after I got started, I was asked to be secretary of the group and so I was involved in helping find presenters for our meetings who would come and give us some education about their use of cannabis in their medical practice and then I went on to become the president of that group about a year after Dr. Mikuriya died and I've been a president of this Society of Cannabis Clinicians since 2008. So that has become a bigger and bigger role in my practice to run a group of docs as -- in the specialty of cannabinoid

medicine.

Q How many docs do you have in your group?

A I think about somewhere between 150 and 200 doctors and over 300 members in the organization. It's really growing much more rapidly now. We have a sister group in Australia and some European doctors joining us as well, some Canadians doctors, and some really from all over the -- well, not the Mediterranean. I mean the Caribbean and South American countries as well. So there's a small sprinkling of doctors from around the world at this point as members of the organization, mostly American docs, U.S. docs, and of those, probably still the majority are in California.

Q And are you generally familiar with the literature on marijuana, the safety and efficacy or harm, potential harm? You've done some research on that?

A Yes, I am, and have been doing that. I became a member of the ICRS, the International Cannabinoid Research Society, in 2003. Dr. Mikuriya asked me to participate in presenting papers to the ICRS in 2002, so I had already begun to write some about our -- my cases, but also to stay up to date with all the literature that I could find starting in about 2003.

So subsequently, I joined the IACM, another organization, the International Association for

Cannabinoids in Medicine, and that's a -- founded in Germany and is more of a European group of physicians. So I've been a speaker there a couple times now and attend those conferences regularly as well.

So these two groups were the first, I would say, worldwide that were really exploring more and more the use of cannabis as medicine. So we were studying the basic pharmacology, physiology. You know, the cannabinoid science really took off in about the mid 1980s when the cannabinoid receptor was discovered and I can talk more about that later, but this has been a real key part of the Society of Cannabis Clinicians is education and research.

So we are involved in research projects. And among those that I'm involved in right now, a study of pain and opioids so that I am seeing, for example, patients discontinuing use of opioids or diminishing use of opioids as they use cannabis as medicine. Another project that I'm involved in is use of cannabis in a nursing facility that specializes in dementia. So we're using cannabis in patients with Alzheimer's disease. So that's an active area of research that I'm involved in. I've been active in studying Crohn's disease as a particular disease that benefits greatly with the use of cannabis and so that's another area that I've written in

and spoken about.

So -- and there are really many other areas with the opportunity now to look at the genes in people. We are able to design studies where we are about to endeavor asking the doctors of the society to bring us their patients with a mood disorder and then we'll look at the genes to see how they compare and we're finding clustering of the genes of the cannabinoid receptors with various diseases. So it's very interesting to see how we're wired, so to speak. So --

Q And you're -- and you -- the presentations and lectures, they're outlined in your C.V. on pages two and three; right?

A Yes.

Q Okay. We don't need to go into that.

A No, that's fine.

Q Okay. So you do some research and you do some lectures?

MR. JAFFE: And, Judge, I'd like to know, just so I'll know when to find a good place to break, what's your thinking on that?

THE COURT: Why don't we break now and come back at 1:15.

MR. JAFFE: Okay. Good. Thank you, your Honor. Thank you.

(Recess)

THE COURT: Let's go back on the record.

BY MR. JAFFE:

Q Doctor, in your opinion, based on your years of experience using cannabis, is it generally a safe medication?

A Yes. It is remarkably safe.

Q What kind of information or explanation would you need to give to the Court in order to explain your opinion that cannabis is a generally safe medication? What type of explanation, I'm asking.

A I would want the Court to understand that this is a -- cannabis works in our bodies in a system in the body, augmenting a natural system that's already there.

Q What's that system called?

A That system is called the endocannabinoid system.

Q What is the function of the endocannabinoid system? And you're saying in humans?

A Well, it's not only in humans. The endocannabinoid system is seen throughout the animal kingdom, so it's seen -- probably excluding insects, but it's seen all the way into the oceans, in primitive creatures, hydra, sea squirts, and when you look at the genes of these animals, you can see that they have an

endocannabinoid system. The system is there to bring the body into balance, to modulate the body, to help it to come into balance. So it's really what fits the word homeostasis. The endocannabinoid system brings us into homeostasis.

Q What are the components of that system, I guess, physiologically?

A It's based on a receptor, which is like a socket, and molecules that fit in that socket called the endocannabinoids. So these are small molecules that fit into the protein receptors. These receptors reside in two areas of the body. One is in the brain and in the nervous system and the other is in the immune system. So wherever they are in the body and in the -- in the brain and in the immune system, they modulate the way that these systems work.

Q "Systems" meaning what system?

A The nervous system and the immune system. They modulate the way these systems work in the bodies, so they bring them into balance. Otherwise, the body would tend to go haywire, literally, overactivated if you get nervous, and the nerves can't turn off again. Then you burn up nerves. You literally damage the nerves. So the endocannabinoid system is there to protect the body, to protect the brain, and to protect and modulate the way

the immune system works as well.

So it's a very key system. It's been evolving along for -- it's thought to be for 600 million years along with the evolution of all these sea creatures through the animal kingdom, the amphibians, and the reptiles and the mammals. We see this system in these animals and we know that the natural cannabinoids are responsible for bringing that system, that body, back into balance.

So its main roles are to help us eat and to sleep and to relax, which is both mental and physically relaxing, and to forget in a helpful kind of a way, but it does have a role in helping forget or -- I'll talk more about that -- and to protect, and the protective role is very interesting because there are mobile endocannabinoids in this immune system that are circulating cells and they are going around the body looking for problems, either abnormal cells or cells that are cancerous, and when they come upon them, they program the cell death of those cells and rid them from the body. So they're key to the health of an organism of a human, to have a healthy endocannabinoid system working in the body.

Q And from your answer, just to be clear, because this is like a physiology thing, the body -- you're

implying that the body produces these endocannabinoids?

A That's correct. These are molecules that are mimicked by the cannabis molecules, so we know of THC and CBD. There's some molecules we hear about in the press. There are actually over a hundred cannabinoids in the cannabis plant and these cannabinoids are uniquely similar, almost identical, in shape to the natural endocannabinoids.

Q Produced by the body?

A Produced by the body. They're produced on demand as a response to a stress, as a response to something needing correcting. And so the natural cannabinoids are produced, they activate the receptors, they bring the body back into balance, and then they're broken down again.

So here's cannabis that comes along. The same shape molecule from the cannabis plant fits into these receptors and in being there, in activating these receptors, we're augmenting the natural cannabinoid tone of the body and in this way we're helping the body to come back into balance.

Q What you call homeostasis?

A What I would call homeostasis.

Q Why -- if the body produces these natural cannabinoids that fit these receptors, why would you ever

need to what you call augment the system?

A Perfect question. The reason is that not all receptors are the same. The cannabinoids are the same we think between all animals and humans, but these receptors are a little bit different. The ones in the brain are 472 amino acids long. It clumps into a socket. The ones in the circulating cells are 360 amino acids long, a little shorter, but they're the mobile ones and they go floating around the body in the bloodstream.

So these receptors, with one change of an amino acid, you can measure that this endocannabinoid system isn't working as well. So many human conditions are now being recognized as endocannabinoid deficiency syndromes.

Q Really? Like what? What kind of conditions now do you think are --

A Migraine, fibromyalgia, M.S., mood disorders.

Q How are they recognized? Because that's relevant to our case. Talk about how mood disorders are now becoming recognized as an endocannabinoid --

A Deficiency.

Q -- deficiency.

A This is simply because we can see in the genes that these are not the same from person to person. There was a clever test done by a Japanese researcher called Matsunaga a few years ago and he looked at -- he tested

people for happiness and he gave them a questionnaire and those that tested very happy in their outlook on life, he looked at their genes and they all have the same endocannabinoid genes, a similar polymorphism, a similar shape of their cannabinoid receptor.

Similarly, we're able to look at the genes with people with depression or other mood disorders and these other diseases that I've spoken of and many, many others and we can see schizophrenia as well is one of those conditions considered to be an endocannabinoid deficiency.

So by augmenting the natural system, we're basically helping the body to bring itself back into homeostasis where it's having a hard time doing it with its natural receptor and cannabinoids.

Q Okay. So let's tie this in. How does that explanation of our endocannabinoid system and the lock and key, how does that help the Court understand your testimony about why cannabis is a relatively safe drug? So tie it up and then we'll move on, because I'm sure the judge is going to want to move on.

A Sure. Well, we're looking at -- we have a situation here where the body is in need of coming in to balance and so in mood disorders and anxiety disorder, it just -- a person tends to be anxious. In PTSD, you tend

to dwell on aversive memories; in depression and so forth, there's a tendency in various mood disorders to not be able to really recover very well and so we see family histories of mood disorders. The same family will have depressive disorders. The same family will have anxiety disorders or bipolar disorders and so forth.

We see that in the families and now we're actually able to look at the genes of these people and understand this in a different way, in a better way. So these molecules and cannabis mimicking the natural cannabinoids are, in fact, bringing us into balance and helping to cure these -- not cure, but to pharmacologically improve the situation for these -- for these individuals, and we really -- the clinicians doing cannabis medicine see this every day and it's very impressive to be able to use cannabinoids and modulate these diseases and bring them into control with an herb.

So it's rather remarkable. These aren't synthetic molecules which have proven to be dangerous. They're plant cannabinoids. They've evolved along for -- the cannabis plant has supposedly been on earth for 60 million years. It's been around and been used by human beings for probably 100,000 years, maybe 5,000 where we actually have evidence of it in the literature, but this plant has been used for many, many years, eons as far as

a plant that seems to have gained a great deal of use and a degree of safety that is rather remarkable.

It's only in the synthetic molecules that are manufactured that we actually see problems where people get into trouble and even have died with synthetic molecules.

Q Does this explanation shed any -- do you have an opinion as to whether medical marijuana cannabis is safer than psychoactive drugs or is that a reasonable question?

A It is a reasonable question and, quite honestly, I have people coming to me because they have tried conventional drugs and the side effects have just been horrible and they don't want to continue use of those drugs.

Q Okay. I'm going to ask a more refined question now, which is that is there something in the explanation in terms of the biochemistry that you just explained that would lead you to conclude why cannabinoids natural would be inherently safer than antipsychotics or stimulants or Ritalin? I mean, what about your explanation might help explain the fact that -- I don't know -- an earlier witness said that it's a safer drug than some of the other antipsychotics, because now we can get to the biochemistry as you explained and tie it in all together, briefly, very briefly.

THE COURT: Can you do that?

THE WITNESS: I think I can do that.

THE COURT: All right.

THE WITNESS: Well, from the side of the question of pharmacologic drugs that are very commonly used, many of them, especially in the antipsychotic division of these drugs, have boxed warnings on the drugs.

BY MR. JAFFE:

Q Black box, you mean?

A Black box warnings. They are in some cases dangerous drugs that may result in deaths and that's why the black box warning is there. These are drugs that commonly have fairly significant side effects. They're not tolerated by people very well and at least in my patient population, which is to some degree self-selected because they want to come and see if cannabis will work, they've tried conventional drugs and they're not working. They are looking to cannabis to see if this herbal medicine can modulate their mood disorder, their mental disorder, and keep them from needing conventional drugs.

And quite honestly, this is a mix in my practice. Some people use cannabis only, quite successfully, and other people rely on both cannabis and conventional drugs to be able to maintain a good mental health. So it's not necessarily going to work in

everybody. Some people don't like the feeling of using cannabis as a medicine, so they'll move along and try something else.

Q Okay. And unless there's some other thing I missed about the biochemistry in all this stuff, I'm going to move on. Do you think I'm --

A Briefly, we all hear about neurotransmitters such as dopamine and serotonin and adrenalin. These are common neurotransmitters in the brain. What the cannabinoids are doing is they're modulating all of the neurotransmitter systems in the brain. They're there as a retrograde messenger in the synapses of the brain to calm the system down.

So if in -- let's say in an anxiety, for example, if the nerve impulses are firing away and you're very anxious, cannabinoids have an ability to turn this neurotransmitter down or off to where it relieves the anxiety or whatever the problem is. It can be a movement disorder where dopamine is involved. It can be a mood disorder where serotonin is involved. It can be an anxiety neurotransmitter where adrenalin might be involved. In any of these neurotransmitters, the cannabinoids are there to modulate the way the brain works and so it's good across the spectrum of many diseases as an effective and safe medicine.

Q And does that, what you're talking about, have anything -- make it more or less likely that the cannabis would alter the brain chemistry or the personality of the patient? Is that a relevant -- is that related in any way?

A Well, it is related but in a way that I think I should make a comment about because since we know that these cannabinoids in the plant can turn the brain down a notch to bring it into balance to down-regulate it to reduce the neurotransmission, it has an effect on the brain.

Q Okay.

A There's no question about that. It does alter the brain while those molecules are active in the system and once they're metabolized -- in the case of most of these molecules, they're largely metabolized when they're inhaled over the course of three hours and when they're ingested, they're metabolized over the period of about eight to ten hours -- and then the effects may linger for a few more hours or even a few more days before they've finally worn off, but then the brain goes back to its natural state, unaltered, by having had these plant cannabinoids.

Q Okay. Let's zone in now on that issue but on kids because the patient in this case was a child and

there's been discussion about how this cannabis can harm the patient. Let's continue just on the biochem- -- the physiology and biology and the receptors. What effect -- how does -- is there increased risk of harm in cannabis in light of the fact that it's a child and, if so, what's the harm or what's the reason there is no harm? Because that's really what we're talking about in this case, because there's been testimony about some of these issues.

A I see. Well, in a word, it is not a harmful substance. Just in a one phrase, it is not a harmful substance. Granted, it's not for everybody, but it does not harm the brain. It alters the brain while the active molecules are there, but it doesn't harm anything.

Q And why -- how about in kids? I mean, why do you say -- what's the basis, a biological basis, you're thinking it wouldn't harm the kids? Doesn't it like kill receptors or something like that?

A No, it actually doesn't. It does articulate with the receptor. It activates the receptor. It increases the natural cannabinoids to work better for the child. You know, in a six-year-old that came to Dr. Mikuriya with a terrible cancer, by the time he was nine years old, he was dying of a neuroblastoma. He had had multiple operations to debulk the tumor. The kid was

depressed. This kid was dying and his parents came to Mikuriya and said, "Can you help us?" The University of San Francisco had long since given up. They had no more treatments. They would do surgery and debulk the tumor.

Q Can I ask you to just cut to the chase, because we have to end this case.

A I apologize.

Q I apologize, but I'm going to do what I can with the judge's permission to direct things.

A The child came under control with cannabis. It relieved his depression and actually the tumor disappeared when he was 13 years of age.

Q Do children have as many of these receptors, these ethno -- endocannabinoids?

A They're born with fewer --

Q Do children have as many of these receptors, endocannabinoids receptors?

A They're born with fewer and through the earlier years of life, these cannabinoid receptors in the brain increase in population. When we use cannabis as medicine, this population of receptors diminishes in response to having this added load of natural -- of plant cannabinoid.

Q Isn't that a bad thing?

A No, because the cannabinoids that are there as

plant cannabinoids and natural cannabinoids are providing a better ability to respond to whatever the stress is.

Q Okay. Okay. Now what I want to do is change the lens, move up a dimension --

A Sure.

Q -- and briefly -- and I apologize to you, but I'm going to inform the judge that I'm going to move a lot quicker than I might ordinarily just for time issues. I want to talk about the medical literature, because it's come up a couple times.

A Sure.

Q And I'm going to ask you some summary questions. You're familiar with the medical literature on the safety and efficacy of cannabis?

A Yes, quite a lot. I try to read everything.

Q Can you give me some of your basic conclusions about what the literature shows and then I'll ask you a couple detailed questions about what it means or why that's the case.

A You can choose what you want to read. This literature is extensive. There are tens of thousands of papers on cannabinoids and physiological and pharmacological effects. This is probably beyond -- beyond opioids, the most studied medicine ever. There's a vast amount of information. Most all of the research

in the United States, not entirely, but very nearly all of the United States research is done through the National Institute on Drug Abuse and so --

Q NIDA?

A NIDA.

Q NIDA. We've talked about that.

A It's only looked upon as a drug of abuse. You can go to NIDA with an elegant study and want to study it for use as a medicine and they'll say, "Sorry, it's outside of our mission. We do not study beneficial uses of cannabis. We only look at it as a drug of abuse."

So the literature coming through the federal government is aimed at looking at cannabis as a drug of abuse and a dangerous drug and that's where the money goes. So we have a lot of literature that may suggest or assert that cannabis is harming the nervous system or harming the brain or harming the immune system, but when it comes to clinical medicine, it's simply not the case. We do not see what -- basically what is being asserted.

So if we look at the evidence, and I would be glad to look at some of this evidence, we do see that cannabinoids, plant cannabinoids, are remarkably safe and effective in doing what they're able to do.

Q Let me hand you what I've -- what you've --

A Yes.

MR. JAFFE: Judge, can I give you this (indicating)?
THE COURT: Did you show this to Ms. Browne?
MR. JAFFE: Yes, sir.
THE WITNESS: This is a spare. I've got the same in front of me.
BY MR. JAFFE:
Q And in response -- at some point I sent you some articles that an expert witness provided?
A Yes. That's right. I'm familiar with those articles as well.
Q And I asked you to prepare additional articles that you might want to talk about?
A That's correct.
Q And is this document the list of --
A This is overlapping with those other exhibits.
Q Okay.
A It includes some of them that are shown in that other --
Q Right. Is there anything in particular --
THE REPORTER: I'm sorry. You're both talking at the same time. "It includes some of them that are shown in that other," and then I didn't get the rest of your answer before you started.
THE WITNESS: -- that were entered into court as a list of exhibits. This exhibit list that I sent to

Dr. Eidelman's attorney was in some ways overlapping with that same list.

BY MR. JAFFE:

Q Is there anything -- mindful of just severe time limits we have, is there anything you want to draw attention to to the judge that you think is particularly important in terms of the literature?

A Well, of course there is and some of these things I think are -- really should be heard because they dispel some of the assertions of harm. These are -- these are the research papers that we all get to read and some people will dismiss them as pro cannabis and other people will focus on the literature that is deprecating and looks like it's harmful, but this -- some of these papers are really dispelling those assertions of harm and I think they're relevant to this discussion.

So among them, we have -- here's what's called a meta-analysis on neurocog- -- "Residual effects of cannabis use on neurocognitive performance." So what this means is it's looking at a lot of papers, 33 papers in this number two.

> "33 studies met inclusion criteria. Results indicated no significant effect of cannabis use on global neurocognitive performance or any effect on the eight

assessed domains. Overall, these meta-analyses demonstrate that any negative residual effects on neurocognitive performance attributable to either cannabis residue or withdrawal symptoms are limited to the first 25 days of abstinence."

Q So let me just interrupt you there.

A Is this beyond what you want?

Q No. So the point is this: This is a list so your Honor will understand it. Just to short-circuit this, this is a list of articles that overlaps from the list of the other doctor --

A Yes, it does.

Q -- that you think gives a view of some -- a reasonable view of the literature, of the state of the literature?

A I think so. I believe so. You know, if you're looking at grade point averages or if you're looking at I.Q., these papers show that if you control for other drugs, if you control for alcohol and tobacco, you do not see harm in I.Q. and harm in other cognitive issues when controlling for tobacco and alcohol.

Q And that would be your opinion, wouldn't it?

A Absolutely that would be my opinion.

MR. JAFFE: Judge, at this point -- I might do things

differently if we had a lot of time -- I'd like to offer this into evidence as just an expansion of his testimony. I would note that there was no problem doing the supplemental articles that Dr. Raiss did and this is just something he did in response and I think that will assist the trier of fact and that once this is admitted, I'm going to move on to the patient.

THE COURT: Ms. Browne?

MS. BROWNE: We have no objection as administrative hearsay, your Honor.

THE COURT: All right.

MR. JAFFE: What number is this? Would this be 48?

THE COURT: Good question.

MS. BROWNE: What's 47 then?

MR. JAFFE: Was that that withdrawn exhibit I did?

THE COURT: 46 was that one.

MR. JAFFE: Okay. So this is 47 then?

THE COURT: Okay. We'll label this 47.

MR. JAFFE: Okay. 47. Thank you.

(Respondent's Exhibit 47 was marked for identification by the Court and received in evidence.)

THE WITNESS: If I may --

BY MR. JAFFE:

Q Yeah.

A -- it's been ten years ago when research was looking at brain subcortical structures and suggesting that cannabis was altering them, altering the development of the adolescent brain, and the initial research was suggesting that yes, it did alter the brain; and then in subsequent years, this has changed so that by the time we got to I believe it was 2014 -- I would have to look to be sure -- it's either 2014 or 2015, there was a paper that said yep, it altered the brain, but then parenthetically they added that the patients that were the subjects that were smoking marijuana also were drinking more alcohol than were the controlled subjects. So a year later, National Institute on Drug Abuse, NIDA, funded another study in which they controlled for alcohol in a way that they hadn't controlled before and now the research comes back with 50 adolescents, regular pot smokers, cannabis smokers, and they found that there were no alterations in brain structures when you controlled for alcohol.

So there's a common belief that cannabis is altering the brain and the further we look and control for drugs and alcohol and tobacco, we don't see that to be the case.

So there's an assumption that cannabis is damaging the brain and from my standpoint as both a

scientist and somebody who's studying these articles but also a clinician who is seeing these people, these kids, I am not seeing anything like that. I am not seeing any brain damage to these kids whatsoever.

Q Okay.

A They're thriving.

Q Let's talk about that a little bit. We're done now with the research. Let me just ask you in terms of your experience with children and then we're going to move right on to the -- right on to this case.

A Good.

Q What is your experience recommending medical marijuana in kids, in kids?

A I've probably treated about I'm going to guess about 25 kids, something in that range.

Q What's the youngest child you've ever treated?

A One year old.

Q One year old?

A Yes. The next was a 16-month-old. The one-year-old had a genetic disorder with a seizure, so we started him on cannabinoids and it calmed the seizure. The second patient is a 16-month-old and he had a large -- a very large brain tumor and the parents talked to the surgeon, that they could cut it out -- no, they can't cut it out. It's too big and to deep. They talked

to the chemo docs and radiation docs, "We've got a treatment for you," but the patient's family was told it's going to damage the brain to do these treatments and that we're not going to kill the tumor anyway.

Q So what did you treat the patient with?

A We treated the patient with concentrated cannabis, just like a tincture but even more concentrated, an oil on his pacifier. The tumor disappeared and the child is thriving in school.

Q Okay. What about other young children? What about other --

A And I might add that as this child goes into the second grade, his I.Q.'s been tested at 135. So there's no evidence that we see, that I see, that the parents see, that it's actually harming his brain development.

Q That particular child?

A That particular child.

Q What about other early, very young children? Who else?

A I'm treating other mood disorders in children, depression and anxiety. By the time I get to teenagers, I see bipolar as a diagnosis, not commonly used as a diagnosis in younger children, although they do fall somewhere in the range of maybe ADD or maybe autistic spectrum. The diagnosis isn't so important as much as it

is controlling the problem, controlling the symptoms.

Q Expand on that, please, because that's a, you know, important issue in this case.

A Well, I just see that the diagnoses -- you know, we're basically dealing with bad behaviors in kids. Sometimes it's violence. Sometimes it's just severe agitation. Sometimes it's extreme anxiety. There's a variety of symptoms that we're trying to control and if we go back to the physiology, cannabinoids are down-regulating these problems.

So the cannabinoids are very effective in dealing with those kinds of symptoms. It doesn't matter to me what the diagnosis is. I can make a diagnosis based on my interview with the child and his family. Usually but not always, the child comes with a diagnosis made somewhere else, over at Kaiser or some other institute.

Q I'm sorry. You said you could make the diagnosis just on the basis of interviewing --

A Of the interview with the family and hearing about the symptom complex, yes. I'm a G.P. I treat anyone from childhood to old age.

Q And you've been practicing medicine for how long? 30 years?

A No. It's more than that. It's 42.

THE COURT: I've got it. He's been a doc for a long time.

BY MR. JAFFE:

Q A long time, and you have occasion to talk to other doctors?

A Yes. That's part and parcel with what this cannabinoid society is, this Society of Cannabinoid Clinicians. We get together and talk about our cases.

Q Do you think you're the only -- do you have some special X-ray vision or special skills that allow you to make a diagnosis just based on an interview with a family? Is that uncommon in your field?

A You know, a G.P. and a family doc are trained to make their best diagnosis. If you don't know what's going on, you refer to another doctor. You give a treatment effort. If you control the symptoms and the behavior is improved, you're doing just fine. If you can't control it, you use pharmacologic drugs as well. If you're having trouble, you might go on to refer to a specialist, but the G.P.s and the family docs make these diagnoses and make treatment plans right from the get-go.

Q Even just based on the interview --

A That's correct.

Q -- and history and physical and --

A And observing the child in an initial visit.

Q In an initial visit?
A Yes.
Q Okay. So in general, what kind of side effects -- if you can characterize the side effects and first side effects of your -- you say 20, 25 kid patients, you said?
A 25.
Q What kind of side effects have you seen in your childhood -- children patients?
A Very little in children. The younger they are, the fewer side effects they seem to have.
Q Why is that do you think? Do you know?
A I think it's because the cannabinoid receptors are still developing and the cannabinoid receptors in the brain are the ones that "get you high."
Q Interesting.
A So when they're not developed, the children don't seem to be altered in the way that an adult or an old person would. Old people are the hardest people to treat because they're much more fixed in what they're able to tolerate. So if you give somebody who's 70 or 80 years old cannabinoids, you've got to be very gentle and start with nonpsychoactive products and then ease into the THC and other molecules that may improve the quality of the medicine considerably, but you have to be wary of

the fact that older people are going to have more side effects. The kids just don't show much side effects, and that's common for me and my practice is to not see side effects in the kids.

Q Do you have any information --

A Maybe they fall asleep a little bit.

Q Do you have any information of whether that's also common in your colleagues in your society?

A Yes, it is true. We talk about this and we find that the kids generally are quite easy to treat. We give it to a lot of kids with seizure disorders. This is a very common use of cannabis at this point and is finally approved by the FDA. CBD is a treatment for seizure disorders.

Q Okay. Give me a minute. All right. Thank you.

We're going to move on to the case now and we're going to move pretty quickly --

A Sure.

Q -- because I think that -- can I just direct your attention to the medical record in the case, which would be Exhibit 22, in your tab, starting with 22, and if you can just take a look at the first -- the first -- the visit that's essentially the subject of the case is on page three of five in Exhibit 22. Can you just take a look at that?

A I'm looking at page three of five in section 22.
Q All right. 9/3/12, that's the entry?
A 9/13/12.
Q Correct. Yeah. I'm sorry.
Now, you're familiar with the basic facts of the case and you've written a report about this; right?
A Yes, that's correct.
Q I'll ask you some general questions, but let me get to the meat of the issue and the thing of which I think is most concerning to certain people in the case.
Do you think Dr. Eidelman was required to contact the school before making the recommendation, yes or no?
A No.
Q And can you explain your answer? Why do you think that he was not required to contact the school?
A Well, in part, it's a privacy issue. I think, you know, to share the diagnosis and the medical problem is not anybody else's business but the child and his family. I see -- I've got a case very much like this, so I can relate to this quite well.
Q Oh, really? Just -- similar to like a young --
A A six-year-old was brought to me by his parents and bad behavior, extreme anxiety, temper tantrums, couldn't control him. They were trying to keep him in

school and it was really not going well. It was hard and they had to, you know, start to make appointments to put him in a special school. They were trying to keep him in a regular school program and I started this child on cannabis and he eventually came under very good control.

I had an interview with him a couple months ago. He's now nine years old in the third grade and doing very well and communicated extremely well with me. When he came in as a six-year-old, he was like a caged raccoon in my office. He was in the corner of the room with his face away from me. He was tearing the table paper off and chewing it and throwing it; just terrible.

Q Can I ask you did you -- was that child having school problems, too?

A Yes, he was, extreme school problems.

Q Did you feel the need to call the school to verify that?

A No. I did not. I talked to the parents about our treatment plan. They started the treatment and immediately the family said -- actually, the school counselor said, "What did you do?" And mother said, "Well, I guess it was just a good day or a good week." She didn't want to tell what was going on and still hasn't revealed, and for actually a couple years she wouldn't even tell her parents or her friends. She kept

it private between me and the family as to what we were doing as far as treating him with cannabis. We did not feel a need to communicate with the school. The school was asking what did you do because they were so impressed with the change in the behavior, but we did not reveal what we were doing.

Q H'm. And in your experience in all the years of your practice, I mean, how common is it during a patient interaction to pick up the phone and call, I don't know, the school, like you can get ahold of somebody in the school? Is that common or uncommon?

A Uncommon. I've never done it.

Q Never?

A Never. I've talked to CPS people. I've had a few talks with law enforcement when they call me, but as far as calling schools, this isn't part of my practice. It's not that I wouldn't. If I felt like I needed to administer medicine through a school nurse, then I would be obliged to do that, but if I don't have to, if the child can take his medicine before school and again after school --

THE COURT: The issue here, Doctor, is that there's been testimony and other information to the effect that if you want to diagnose ADHD, the practitioner should contact the school and get some information from them as

to what the behaviors are like at the school.

THE WITNESS: You know, I do have documents in my records on children with ADD and ADHD showing that these behaviors are problematic, so I know that the school has recognized the problem and documented the problem.

THE COURT: And if you don't have that documentation from the school, somebody didn't fill out a Conners or something like that, I mean, it may not be, according to some of the evidence I've got, a proper approach to assessing and diagnosing ADHD in a child. So, I mean, that's some of the evidence I've got.

THE WITNESS: I see. Well, we're trying to do no harm and if we can use medicine and --

THE COURT: Well, I'm not talking about the medicine end at this point.

THE WITNESS: We're talking about the diagnosis.

THE COURT: We're talking about the diagnosis, what's wrong with this child and how are we going to try to get the best diagnostic stand that we can get. Recognize I've heard all about how diagnosis is not exactly an exact science in every case but being able to tease out, Well, we've got autism here. We've got ADHD. Do we have a comorbidity in both of those? Do we have a learning disorder, all those things that are going into a child's school career --

THE WITNESS: That's right.
THE COURT: -- for me.
THE WITNESS: I see it from the side of the school telling the parents that we have a problem and this child cannot be in the classroom with these behavioral issues and so that often is documented and something that I'm --
THE COURT: So the parents may show up to you and say, Hey, this is what we got from the school.
THE WITNESS: That's correct.
THE COURT: Maybe they've already been through some process through the school about assessment for Special Education services?
THE WITNESS: Exactly. And in many cases, they're trying their best to keep the kid in a normal school program in hopes that this is going to be a normal kid.
THE COURT: Legally, they're supposed to put him in the least restrictive environment.
THE WITNESS: Yes. I have cases just like that.
THE COURT: Let's continue, Counsel.
BY MR. JAFFE:
Q Well, let's follow up with the judge. What happens if you don't have information? Does that mean you can't make the recommendation?
A No. It's not that I can't make the recommendation. I think to use an herbal medicine to see

if it's going to alleviate the problem considerably and keep this child on a good learning path is reason enough, that this symptom complex is controlled with cannabis. This is what we're really trying to achieve. These are constructs that we develop with various names of these conditions and the names change. One day it's bipolar and another day it's something else. One day it's ADD and ADHD and another day it's autistic spectrum, and so the diagnoses actually change over my practice.

Q Right. Then I guess then let's go back to this. So you've told the judge that you've had cases where the parents walk in with documents from the school; right?

A That's correct.

Q Have you had cases where the parents walk in with nothing, where it's just the observation, with just the information from the patients?

A Well, that's true as well.

Q You've had those kinds of cases?

A I have.

MS. BROWNE: Objection; vague. "The patients" being the child?

THE COURT: I think he means the parents.

BY MR. JAFFE:

Q The parents basically come in and tell you what the problem is; right?

A They do.
Q And --
A That's correct.
Q -- in those kinds of cases, have you not written a recommendation because you didn't have either a document from the school or make a phone call? Have you refrained from making the recommendation because you didn't have some document from the school?
A No. I would go ahead and make the recommendation.
Q Even if you didn't have a document from the school and even if you -- and you say you never called the school, so that's --
A That's correct. I never have called a school.
Q All right. So there are -- so with respect to the cases where the only thing you're relying on is what the parents tell you and your observations --
A And my observation of the child and this clinical picture that is in front of me.
Q Right. And do you feel -- in your practice and your experience, you've made the same kind of -- you've made the recommendation, based -- is it fair to say the same kind of information presented and recorded by Dr. Eidelman in his notes, you yourself?
A Yes, I have.

Q On more than one occasion?
A On more than one occasion.
Q Are you familiar with whether any members of this society have made similar recommendations on this kind of --
A You know -- I'm sorry to interrupt.
Q I'm sorry -- basically relying on the parents? Is that something that you've ever heard about before from other society members, observation and --
A Yes, we do rely on the parents' story of what's going on at home and in the child's needs for, you know, trying to enter into an educational system and the worst problems, we may have kids that just can't get into the educational system at all with severe autism. It's just they don't thrive. But this is turned around as well. Well, they don't thrive in a normal school.
Q Okay.
A They may thrive in the Special Ed classes. They do okay.
Q So if you -- so your testimony is you've done it and -- what I'm referring to --
A And my colleagues have done it in the society.
Q And that's what's evidenced and Dr. Eidelman relied on, the family history and essentially his observations. So what is your opinion to a reasonable

degree of medical certainty whether it's in -- within the standard of care of at least medical marijuana practitioners to rely on the observation -- the physician's observation of the parent and the history as related by the parents to make a medical marijuana recommendation for a small child? Do you have an opinion as to whether what Dr. Eidelman did in this case was within the standard of care of your specialty?

A In my specialty, Dr. Eidelman is performing within the standard of care. When we deal with people that are going into a university setting, it's quite a different deal and you have some specialties and subspecialties and people are going to get pages of diagnostic information and testing and that's all valuable and when -- many of the kids that I have treated that have serious mental problems have, in fact, had these more like university-based evaluations, but no one has given cannabis as a trial in the university setting. Those doctors haven't ever had an education about cannabinoid medicine. It may be discouraged or forbidden by the institution, so they know nothing about it.

Q Right. And so the following page on four and five, there's some other notes and I'm sure you've seen them before.

A Yes.

Q But they seem to be what I guess you people would call follow-up?

A Yes. We call it follow-up and I've been impressed with the fact that Dr. Eidelman made phone calls, called the family back. So I'm going to recheck in. This is a good standard of care. This is what I do in my own practice and I think it's appropriate. It is the standard of care. Granted, it's outside of what you might call conventional practicing medicine, but the California public ask us to do this in voting for Proposition 215, the Compassionate Use Act. They want the physicians to be able to try cannabis as a medicine and that's what we're doing.

Q From the medical notes in terms of the follow-up, can you ascertain whether or not the recommendation was having a positive or negative effect?

A Well, it seemed quite clear from the father's contact that the child was improved with cannabis. It also appears that it was wearing off during the day and either dad needed to get some more medicine or give another dose. I might handle it a little bit different in terms of selecting a cannabis strain or something with more CBD or whatever. There are ways that I can get some more hours out of the day before this kid's going to be treated again with the next dose.

Q Can I ask you, have you ever encountered this with your treatment of children where they -- a dose wears off?

A Yes.

Q Is that uncommon?

A Not uncommon.

Q Let me ask something. There's been some testimony in the case that the fact that the person -- that the child needed another dose is indicative of either that the brain was changing or that he was becoming addicted or dependent on the drug. Would you agree or disagree with that?

A I would disagree with that.

Q Why is that?

A We know that these cannabinoids are metabolized anywhere from five hours and they're gone to about ten hours and they're gone. This is unique to the metabolic pathways in the liver. It's all the Cytochrome P450 metabolic pathways. So everybody's metabolic machinery is slightly different. So in some people, these cannabinoids are going to be gone after about five hours and in other kids they may be effective for ten hours, so we have to coach the families into understanding that we don't know yet if your son or daughter is a fast or a slow metabolizer. We're going to adjust the treatment

accordingly.

Q Let me just be clear. If you -- let's assume that this were your patient and you had treated the father and the son and father told you what's written in here. Would you have called the school before issuing a recommendation?

MS. BROWNE: Objection; vague as to reference to "here."

BY MR. JAFFE:

Q She's right. Let me ask a better question.

Assuming that you had treated the patient, treated the father, written down what Dr. Eidelman had written down; right?

A Yes.

Q Would you have called the school during your visit with the patient?

A Probably not.

Q Because you've never called the school, from what you're telling me?

A Well, that's true.

Q Okay.

A It's not that I wouldn't be working to improve our treatment plan, but this is the nature of cannabinoid medicine. It's a little different for everybody. You have to adjust.

Q Well, I meant call the school initially before making the recommendation.

A No, I would not be.

Q You would not?

A No, I would not do that.

Q Do you know anybody in your society that would make a call to a school?

A Nobody comes to mind. I can't say that it hasn't been done, but this is not common --

Q Thank you.

A -- in part because the Medical Board has gone after doctors treating kids and both families and the doctors keep this private between themselves and their patients. That's the truth of the matter.

MR. JAFFE: Okay. Thank you very much.

Pass the witness. Want to take a break, Judge, or I'm ready -- whatever you want. Up to the court reporter?

MS. BROWNE: Break.

THE COURT: About ten minutes.

(Recess)

THE COURT: Let's go back on the record.

Ms. Browne.

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CROSS-EXAMINATION

BY MS. BROWNE:

Q There is no evidence of marijuana's efficacy for the treatment of bipolar disorder or ADHD in children; is that correct?

A I would not say that's correct. There are some papers -- I would have to pull out my computer to tell you which ones they are, but there have been some -- some efforts to look at cannabis as a treatment for those conditions. I would defer to my notes to be able to provide those to you if needed.

Q Did you provide them to counsel?

A No. I did not, not in that particular evidence as I think they were adult patients, not children.

Q Oh, so -- but my question was there's no evidence of marijuana's efficacy for the treatment of bipolar disorder or ADHD in children.

A In children, not to my knowledge.

Q Are you aware that there are other rigorously tested FDA approved medications which do have the potential to treat ADHD or bipolar?

A Yes, I am aware of those. I usually see them in the context of people either using them or having tried them and finding them either ineffective or having too many adverse effects to continue.

Q But you are aware of -- notwithstanding whether or not there are side effects, you're aware that there are several FDA-tested and approved medications which have been shown to help these conditions?

A Yes, I'm aware of those.

Q And did you consider that in coming to the conclusion that you reached here today?

A My clinical experience brings me to the conclusion that there are -- there is an opportunity to try herbal cannabis as a first-line drug or in response to drugs that have failed, to use herbal cannabis in treating these conditions.

Q When you have treated patients in a similar manner to the patient here, T.T., and you have done that and then made a similar recommendation; correct?

A That is correct.

Q In those cases, did you provide the parents of the patients or -- yeah, the parents of the patients any information about potential side effects of it?

A Yes. That is part of the initial evaluation. Additionally, I typically give the patients my e-mail address as well as my office line so that they can call in if they were having any problems or questions.

Q And what side effects do you advise them of at the initial evaluation?

A Well, somnolence is typical early on because cannabis is now regulating and has this sleep-inducing quality when people are getting used to it. Unless you start with very low doses, you may have some somnolence initially. Typically the patients get over that within several days or within the first few weeks, it subsides as they get a change in their receptor population and no longer exhibit that problem. After somnolence, certainly dry mouth in mucous membranes is common and, rarely, a hyperemesis syndrome, which is reported in the cannabis literature but is quite rare in my experience.

THE COURT: And what is that syndrome?

THE WITNESS: It's a Cannabis Hyperemesis Syndrome wherein using cannabis on a daily basis, some patients will begin to have intractable vomiting, which is a bit counterintuitive because cannabis treats vomiting; but when that happens, the pattern clinically is that they find comfort in getting in a hot shower. This is well documented in the literature.

They often will go to an E.R. for other antiemetics and fluid administration and then after about a day, the condition subsides and in many cases they can resume cannabis therapy soon after, but there is effectively a reset of the cannabinoid receptors when you metabolize the cannabis and it's gone from the receptors.

Then the vomiting stops. So it's -- I've seen it six times in 3,000 cases. Maybe E.R.s see it fairly regularly. It's not uncommon to see somebody come in with cannabis hyperemesis, so I do tell them about that as one of the potential precautions or adverse effects of cannabis use.

BY MS. BROWNE:

Q So you advise the parents of these patients somnolence, dry mouth, mucous membranes?

A Uh-huh.

Q What about the mucous membranes?

A Dryness of the mucous membranes, mouth, eyes.

Q And the rare occurrence of the syndrome you just described?

A That's correct.

Q Is there anything else that you describe to them?

A Not so much in the children, but in older patients I would talk about loss of balance and also about a short-term memory loss as you're getting used to cannabis use. It's a therapeutic effect of cannabis, but it also is problematic for particularly adults. Children don't seem to be complaining of such a problem, short-term memory loss.

THE COURT: What is it? Okay.

THE WITNESS: Got me.

THE COURT: All right.

BY MS. BROWNE:

Q So with regard to the short-term memory loss, you said the children don't complain. Is it something that it occurs less frequently with kids or you just don't -- it's not a problem?

A I think probably both are true. I don't think it occurs so often in children and it isn't expressed as a problem. Mostly I think folks would mention the somnolence is something seen early in cannabis therapy until tolerance develops and once tolerance develops, people get back to normal behavior and sleep patterns.

Q And how long does it take until tolerance develops?

A Usually about a week unless you're going very slowly on dose and then it may occur farther down the line, but if you start right off on a recommended dose, tolerance usually develops in about a week.

Q Okay. And so you advise them about the potential side effect of somnolence and do you give them that information as well?

A I do. I usually use a PowerPoint slide presentation and have these enumerated for them to read and look at. Sometimes I'll send them the PowerPoint

slides and let them have it at home so they can refer to it.

Q That's interesting. About how long is the PowerPoint? How many slides?

A About 50 slides.

Q A lot of information?

A A lot of information. It's like a college course, unfortunately not taught in medical school.

Q Looking at Exhibit 22 -- well, is there any documentation of advising the parent, the father of the patient, about any potential side effects?

A Give me a moment and I'll check it out here again. There's some suggestion in the fourth paragraph on page three.

> "We discussed the different drug options, none of which are really approved for this condition, but nonetheless which are widely prescribed. We described nutritional factors. Father requested the trial of cannabis."

MR. JAFFE: Your Honor --

THE WITNESS: It's not really.

MR. JAFFE: Can I -- he's not really looking at the right page.

THE COURT: Well, he's looking at a page.

MR. JAFFE: Right.

THE COURT: I recognize that everybody has some information there a little bit different than what he's been talking about.

MR. JAFFE: Right. But, I mean, I don't know how to do this.

THE COURT: Well, if there's an absence of something there, I don't think we need to --

MR. JAFFE: But I think he's looking at the medical note, not of the release.

THE COURT: Yeah, I think you're correct, but that indicates that there was some discussion between the Respondent and dad.

MR. JAFFE: Right.

THE WITNESS: I do also see in this Release of Liability, page two of five, where it speaks of "Cannabis may affect coordination and cognition." These are issues common in beginning cannabis therapy. "Impairing ability to drive/operate machine," obviously not an issue for children. But, you know, you do want to be discussing details as they pertain to the patient, and the father signed this. I believe -- well, I don't know that that's the father's signature. I presume that it may be. Well, yes, it is.

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BY MS. BROWNE:

Q Yes.

A It is the father. So there are some adverse effects described in this document.

THE COURT: It doesn't warn of the old cotton mouth, does it?

THE WITNESS: Part of the deal.

BY MS. BROWNE:

Q Do you think it's part of the standard of care to advise a parent of these side effects that you discussed?

A I don't know that everybody does that. I try to make a point of doing it myself.

Q But is it part of the standard of care to discuss any of them?

A Well, not necessarily. It may save a phone call or an e-mail if you do discuss potential adverse effects, but they are relatively minor and there's no significant harm with being somnolent and falling asleep or getting a dry mouth, so it may not be the standard of care. I think it's a good idea.

MR. JAFFE: Your Honor, I'm going to object. I think there's going to be -- there's already been testimony, but there's going to be testimony this is a form approved by the Board as part of the probation, so I'm not sure

it's permissible for -- for the Board to take the position that the Board-approved form is inadequate.

THE COURT: Well, I don't know that she's saying the form is inadequate. She's just talking about all the communication between the doctor and the patient/patient representative in this case, the parent.

MR. JAFFE: Okay. I stand corrected. But, again, there will be -- I promise you there will be testimony on this particular form.

THE COURT: Well, there's your offer of proof.

MR. JAFFE: Yeah.

BY MS. BROWNE:

Q Does having this form -- is that a sufficient form of -- or is that a sufficient form of communication of any side effects, this form?

A This form is a form very much like what I am currently using. I think it's adequate. I have recently written a form that we are going to ask the Medical Board of California to include as an agreement with the patient which will further describe some of the possibilities of adverse effects. So this is older and identical to mine or very close to the same one I have used for 19 years; but having said that, I think today it could be improved upon.

Q So this is a Release of Liability, which

basically means you can't be sued, or do you look at this as more -- is that how you look at this, as a function of this document?

A And to clarify points about the doctor's role, we're not providing a medicine, so that's not a Release of Liability issue. It's just informing the patient as to our role in taking on this person as a patient.

Q So with regard to obtaining -- well, do you think it's appropriate to obtain informed consent from a parent before providing them a recommendation for their four- to five-year-old child for marijuana?

A I think it is a good idea.

Q And in obtaining an informed consent, what information -- how should the patient or patient's parent be informed?

A If you would like me to open up my computer and read the one that I've just created, I would give you those details, but we are going to present it to the Medical Board probably within the next week because I think it should be included in the physician-patient relationship.

Q Are you aware of whether or not in this case Respondent provided any of that information to the father independent of what's in this form on page two?

A Nothing that I've read further defines those

other possible informed consent issues, but I don't know the answer to that question.

Q Okay. Are you aware of whether or not the child had tried any other medications?

A To my knowledge, the child had not tried conventional medications.

Q Would it be important to describe -- describe other conventional medications?

A If used, yes, it would be appropriate to do that.

Q If -- I'm sorry. If marijuana were used or if the other medications were used?

A If other medications had been used.

Q Okay. But in prescribing the marijuana, it's -- are you saying it's not necessary to explain alternative treatments including possible other pharmacologic medications?

A Well, just by way of correction, we're not prescribing. We're recommending.

THE COURT: Everyone keeps using the word "prescribing," Doctor, and I'm just letting it flow with the tide.

MS. BROWNE: Could we -- thank you for bringing that up. If I use the word "prescribe," could you just interpret that --

THE COURT: That's what we've all been doing pretty much.

THE WITNESS: Really? All right.

MS. BROWNE: That's what I mean. Thanks for bringing that up.

THE WITNESS: Yeah. I think it was clear that other drug options were discussed, which means something other than cannabis would have been discussed, and that was clear to me in page three, paragraph four.

BY MS. BROWNE:

Q Okay. We discussed -- which says, quote:

"We discussed the different drug options, none of which are really approved for his condition, but which are nonetheless widely prescribed."

A Uh-huh.

Q Okay. How do you interpret that, that they discussed what? To you, what do you read that? What does that reference? Like, for example, what other medications is this referencing, if you understand this?

A I think I understand it. I know that drugs used in ADD are relatives of adrenaline. Drugs commonly used in the bipolar commonly are -- the antipsychotics are employed. Both of these have -- you know, they may be tolerated well, but at the same time may be fraught with

considerable adverse effects. So if you've talked about different drug options, to me, this would mean you've looked at some of the possibilities based on the working diagnosis.

Q Okay. And are there any other drugs that you imagine that this is referencing?

A Benzodiazepines are not uncommonly employed, although they too are rather addictive and problematic for long-term use.

Q So they're not uncommonly employed for these conditions?

A For anxiety, and ADD would be commonly employing the sympathomimetic means and for bipolar not uncommonly using the antipsychotic drugs.

Q So -- but the Benzodiazepines, that's a drug for ADD or ADHD?

A It could be used in both of these conditions. Doctors will use it in many of the mood disorders.

Q Okay. Are there any other medications that might be used to treat any of these conditions?

A There are antiepileptic drugs such as Lamotrigine that is not uncommonly used. They do have some mood-stabilizing effects. That covers the main ones.

Q Okay. When you said for ADD drugs "relatives of

adrenaline," could you be more specific?

A Adderal, for example.

Q Okay.

A And others, Concerta. I'd have to -- I'm not prescribing these, so I would have to look at the book and run down the list, but usually patients have either tried them and found them --

THE COURT: Problematic?

THE WITNESS: -- problematic. Thank you.

BY MS. BROWNE:

Q And when you say "usually patients have tried them and found them problematic," which patients are you talking about?

A Patients with these particular mood disorders.

Q Your patients or not your patients?

A They may include my patients. That's right.

Q Okay. So is -- is your experience your patients -- are you talking about solely your patients or yours and others generally?

A Both.

Q Okay. And is that -- do you feel you have sufficient knowledge to -- to rule -- to rule these things out?

A I don't think "rule out" is the right word. I would say that I'm not writing prescriptions for those

medicines. I would defer to somebody else to write those prescriptions.

Q And with the antipsychotics that are employed, is that the standard first-line treatment for bipolar disorder?

A It is one of the first-line treatments for bipolar disorder. That is correct. It's not alone. I would again defer to a doc who is writing those prescriptions as to his or her choice, but antipsychotics are definitely used and psychotic breaks are a typical problem, a typical problem with bipolar disorder.

Q And when we say "bipolar disorder," do you know whether it's bipolar 1 or 2?

A No, not without knowing more about the case or if it's been diagnosed by some other professional.

Q So do you think there's enough information in the record to make a bipolar diagnosis?

A For myself, no.

Q For the standard of care?

A I don't know that I can comment on that.

Q And same question for ADHD or ADD: Is there enough documentation in the record to justify a diagnosis for ADD?

A It seems that there is.

Q And what generally are the -- what are the

requirements under the DSM, not specifically the language, but generally for ADHD, the diagnosis?

A I would -- I don't feel that I can answer that question.

Q Okay. What are any of the symptoms or do you know any of the DSM criteria for ADHD?

A I'm not an expert in DSM, but I can tell you that ADD/ADHD, the patients with this disorder have a very difficult time focusing their attention. That's probably the single most important element to it. There is also issues about uncontrolled behavior; in this case, temper tantrums as well. I don't know what the DSM criteria are and I would have to defer to a list if I were to recite those.

Q And are you familiar with ADHD inattentive type?

A Inattentive type?

Q Correct.

A I'm not sure where we're going with this, but inattentive patients, yes, I am.

Q And do you know what the difference is between the inattentive type versus the other type?

A No. You'd have to be more specific and I would probably again defer to another resource to be able to recite those.

Q Okay. Okay. Did you review any of the articles

that are in Exhibits 39 through 45?

A I did. I think I have those here inside the book, or maybe not. I did review the articles that were listed.

MR. JAFFE: It should be in your book. It's not in your book, that big book? Doesn't his copy have these articles?

MS. BROWNE: Yes.

THE WITNESS: Okay. Maybe you can -- oh, here they are (indicating).

MR. JAFFE: That's the exhibit. I think we have -- Ms. Beneth Browne was kind enough to add all these articles starting on 39, so these are here.

THE WITNESS: There they are. Yes, I recognize these papers.

BY MS. BROWNE:

Q You're familiar with each of them?

A Yes, I am.

Q And they are consistent with your testimony today?

A An aspect of my testimony has been that there is -- many studies are funded by institutions looking for harm and other studies are not focused on harm and so what I would say, I'm familiar with these studies, I don't necessarily agree with their conclusions.

Q Well, don't some of them have different conclusions?

A Yes. Do you want to get into those?

MR. JAFFE: Well, let her ask the questions. She'll ask you the question she wants to ask you.

BY MS. BROWNE:

Q Do you think that's a relevant focus, to focus on harm, whether or not a medication or a product, a use -- whether or not marijuana does cause any harm?

A I'm not quite sure of your question.

Q Well, I mean, it sounded like the -- it sounded like a criticism possibly of some studies is that they're funded by somebody who's looking for harm, kind of focused on that rather than benefits, possible benefits. Is looking for harm, is that a worthwhile endeavor?

A Absolutely. Yeah. We all want to avoid harm, so yes, it's appropriate to look for harmful consequences.

Q Okay. Okay. And have you studied and are you familiar with potential harmful consequences?

A Of?

Q Of marijuana in a four- to five-year-old.

A There are very few studies looking at four- and five-year-olds as far as their use of cannabis. I would have to dig deep to find articles that are addressing

cannabis as medicine in that age group other than to say that when we're looking at I.Q., when we're dealing with a five-year-old, we don't have grade point averages. So I'm looking at a behavior and whether they're succeeding in school. The I.Q. is problematic in testing. We certainly have evidence that cannabis does alter cognitive abilities and I think no one's -- I don't believe anybody's argued that. I think cognitive -- neurocognitive effects of cannabis do occur, but when you're not under the influence of the cannabis, they are no longer an issue. Executive functioning and memory return to normal after you discontinue use of cannabis or I might say also become tolerant of cannabis. They are two different things, but if you're treating with cannabis, you can expect some cognitive changes until a patient gets tolerant of it.

Q Which happens after about a week, you said?

A I said a week. It could be more, but it just depends on the clinical situation and the quantity of cannabis being utilized.

Q Okay.

A And really more than that, we're talking about ratios of cannabinoids, so different medicines affect different people in ways. A CBD strain of cannabis may have very little impact on cognitive abilities and

memory.

Q Okay. Now, is executive functioning related to the -- well, you said that nobody would debate the neurocognitive effects that do occur.

A Yes.

Q Did I state that right?

A Yes, I did state that.

Q Okay. Which is a way of saying cognitive abilities decrease when under the influence of marijuana; correct?

A Yes, that is correct, and I'm only hesitant in saying that because many people in -- adults using cannabis on a regular basis have very responsible positions in our society and you would not see a cognitive deficit in those people, but you could test for it and demonstrate it. I'm not sure you could do that, but people that run corporations -- I've got patients who are law enforcement officers, superior court judges. Many people in very -- doctors, lawyers, many people in very high-functioning positions are cannabis users and they are not suffering from neurocognitive deficits.

So I think it's fair to say that there is a neurocognitive effect of cannabis use, but whether it's impairing or not is quite another question.

Q Okay. In evaluating whether there's a

neurocognitive effect or a change of somebody over time, isn't it important to know -- to have a baseline? In other words, if there's a child whose -- who has been using cannabis over a period of time, let's say a couple years, and that child has a high I.Q., does that help show the safety of cannabis?

A Probably, although the naysayer might say, "Gee, the I.Q. might have been higher had you not been using cannabis."

Q That's my question. A naysayer would say that. I mean, do you see that as a problem in making an assessment about whether there are neurocognitive effects?

A You know, I think we have to look at risk/benefits across different classes of medicines and if you can normalize a person's life, keep them in school, learning well, I'm -- I think it's great to be able to test people, but I don't think it's a requirement of good medical care to be doing such testing.

Q I didn't mean to imply -- oh, you mean for the physician to be doing such testing?

A Or ordering it or expecting it to be done, that's correct.

Q Okay. So what I meant is based on studies --

A Uh-huh.

MS. BROWNE: Just a moment, please.

(Pause in the proceedings)

BY MS. BROWNE:

Q So there's -- I'm going to make a statement. I think I know your answer, but I wanted to know whether this is -- whether you agree with this statement. "There is considerable evidence for cognitive impairment while under the influence of cannabis." Is that an accurate statement?

A In some cases, that is true.

Q Just in some cases?

A That's correct.

Q Okay. And then here's the other statement. Same thing, please let me know if this is correct or not. "There is considerable evidence for" -- "that there is long-term damage with sustained early-onset use of cannabis."

A I would disagree with that strongly.

Q Would you say that there's any evidence?

A Under my elbow, I have a paper written in 2016 about I.Q. and educational outcome in teens --

Q Okay.

A -- and this paper says that those who used cannabis 50 times or more did not differ from never users on either I.Q. or educational performance, so it really

depends on who you're looking at and what you're trying to demonstrate. So I don't think a broad-brush stroke of saying that there are significant impairments for cannabis use is accurate.

Q So -- but my -- I don't know that I used the word "significant."

A Okay.

Q I had said "considerable evidence," so a lot of evidence, that there's long-term damage with sustained early-onset use of marijuana.

A I don't believe that's true.

Q Okay. And what was the -- what was it under your elbow that you were just referencing for us?

A The Mokrysz paper published in the Journal of Psychopharmacology, 2016.

MR. JAFFE: And that would be that exhibit -- just to clarify for the record, that's the exhibit that we've just introduced.

THE WITNESS: That's correct.

MR. JAFFE: What number, just for the judge?

THE WITNESS: It's number 5.

MR. JAFFE: Number 5.

BY MS. BROWNE:

Q So Exhibit 47, number 5?

A That's correct. It includes:

"These findings suggest that adolescent cannabis use is not associated with I.Q. or educational performance once adjustment is made for potential confounds, in particular adolescent cigarette use. Modest cannabis use in teenagers may have less cognitive impact than epidemiological surveys of older cohorts have previously suggested," which is to say that the literature is rich in studies indicating that there's harm in the damage to the brain and when further studies have come along, it dispels some of those assertions of harm and points to other confounds, in this case tobacco, in other cases alcohol. Concurrent use of these other products may be, in fact, where the problem lies and not in the cannabis. Cannabis gets lumped with these other --

THE COURT: Does some of the stuff out there show how much is being used? There's this community in a New Zealand cohort study that's been bandied about and I don't know whether somebody's smoking a little every day for years or whether they're keeping up with the two-joint song and --

THE WITNESS: Uh-huh.

THE COURT: -- smoking early and often.

THE WITNESS: You know, I would really want to go

to -- it's a huge cohort. There's a couple thousand people in that cohort at this point and everybody's a little bit different in their cannabis use. We're not controlling for either the kind of cannabis or the quantity of cannabis or the frequency of its use, the strength of it, the ratios. It just is not easy to summarize it. I think --

THE COURT: That gets into the whole dosage issue generally with cannabis; right? Because it's kind of hard to -- I don't got how many milligrams this is. This is different than the pills produced by the pharmaceutical company where there's 10 milligrams of this and we used one milligram per 20 pounds of body weight, blah, blah, blah.

THE WITNESS: Correct.

THE COURT: It sounds like you folks are kind of using some Kentucky wind to just try to make this shot go, Well, let's try a couple nibbles here.

THE WITNESS: The nature of cannabis medicine here is to titrate for an effective dose and in the last decade we've been able to select strains that have less psychoactive THC so we often employ these in our treatment plans to something with greater than CBD, cannabidiol. So we have an opportunity to adjust our treatment plans to make a, let's just say, a better, more

logical perhaps, treatment plan.

It's still trial and error, but in the end -- it's trial and error and some people -- I would have to say that in many people that I initially laid out a treatment plan, I'll learn a week later or a month later or a year later, well, they tried that but went on to something else because they had the opportunity to try something different and they got a better response from it. So we make a good, educated guess.

THE COURT: So now we've got a certain amount of self-medication?

THE WITNESS: Absolutely. That's part of the deal with an herbal medicine.

BY MS. BROWNE:

Q So let's talk about that, the CBD. What does that stand for?

A Cannabidiol, C-a-n-n-a-b-i-d-i-o-l.

Q Okay. And that is --

A It's a natural constituent in marijuana --

Q Okay.

A -- in all marijuana but in different ratios.

Q And if -- what is the other constituent? In other words, if there's less CBD, what is there more of?

A Generally there's more THC when there's less CBD, but the latest laboratory evidence shows that there

are 100 to 144 cannabinoids in a cannabis plant, depending on what part of the world it's coming from. So there are a lot of other cannabinoids. Granted, they can be kind of lumped into different groups so there are some that are more like CBD and some that are more like THC and so forth, but there are a lot of different constituents of the cannabinoids, and that's not even the whole picture because we also are utilizing a fraction of the plant called the terpenes and the terpenes also have pharmacologic properties, pain relieving, anxiety reducing, and so forth.

So we are getting to a point when laboratory and analyzed cannabis will give us an opportunity to do more selections as to what might work best for somebody.

Q So in this case, do you see any -- is there any reference to --

A No, not in Dr. Eidelman's notes. But, you know, quite honestly, even my practice with this knowledge that I've got about cannabinoids, it's really not any different. We start somewhere and we make adjustments as needed in order to optimize our treatment.

Q And do you -- when you're starting a patient on somewhere --

A Uh-huh.

Q -- what would be an example of where you would

start a patient or a young child, for example?

A I like to use THC and I say that because it's a stronger medicine. If you go to a high CBD strain, which might be 20 parts CBD to one part THC, you're going to have a medicine that's very low psycho activity. It may work well for anxiety, but it may not work well for many other problems such as seizures. THC is a great anticonvulsant. THC is a great pain reliever. THC works for many conditions. So when we mix these cannabinoids into something more of a balanced ratio, we may have a better-tolerated better medicine, but this is something that we're kind of in the early stages of figuring out.

So now that we can measure these cannabinoids, we can direct somebody to the lab or to the dispensary and say, Try a balanced THC/CBD product and see how that works for you.

Q And when you say -- if, say, somebody went to the -- wherever they get marijuana and said, "Could I get a balanced blend?" --

A Yes.

Q -- would they be -- I mean, are you -- would that be consistent with what you're saying? I mean, should you specify a certain amount and should they specify a balance when they're buying it?

A This is a good point and this is quite the

reason why California law is now, as of July 1st, you've got to repackage and relabel your medicines so we know how many milligrams per milliliter or per product of these cannabinoids, dominant cannabinoids, are present. So that gives us a better idea as to how to direct a patient.

We haven't had that opportunity until now and even still we're not measuring and requiring terpenes to be listed and we're only looking at dominant cannabinoids and that really isn't enough to know in order to know whether you're going to find the right medicine.

THE COURT: The first time.

THE WITNESS: The first time. Exactly. So we're still at a trial-and-error kind of a pattern of deciding on a treatment plan.

BY MS. BROWNE:

Q And do you specify a certain dosage, as in how much?

A I do.

Q And how do you do that? Like an ounce or do you say a measurement or --

A I would typically aim a family with a child to use an oral product.

Q Okay. So in this case -- let's say that.

A In this case, similar to this case --

Q Okay.

A -- it could be prepared as a cookie or a gummy or some edible product or it might be a tincture or an oil or even a capsule. These products are being developed as we speak. It's changing every day.

Q Okay.

A So these medicines are coming to be available and we do know more about them than we have known in the past, but because there are so many variables with 140 cannabinoids and 150 terpenes, we don't know where we're going to end up. A family is directed by me to keep trying if they find something isn't working. So I might start with a tenth of a milligram per kilogram per day.

Q Okay. Wait. Could you say that again? A tenth --

A One tenth of a milligram of THC per kilogram of body weight per day. And for my own practice, I'll write this down. And so we translate that into how many milligrams of THC they may be using as my advice to them when they go out the door.

Q Okay. And is talking about a dose or prescribing a specific dose part of the standard of care or was it in 2012?

A This is changing. It will -- I think it will become the standard of care, but we have so much to

learn, I don't think we can expect doctors to know what they're doing yet because we don't really know the best treatment plan for any condition.

Q So in advising a patient of a dose --

A Yes.

Q -- should -- is that the way you just said that, one tenth of a milligram of THC per kilogram per --

A Day.

Q -- day, is that the format of a dose --

A It depends on --

Q -- no matter what the dose is?

A -- the condition. It depends on the condition.

THE COURT: You're talking over each other.

THE WITNESS: I'm sorry.

BY MS. BROWNE:

Q And in order --

A So that dose might be typical in sending somebody out with anxiety.

Q Okay. And what about with this patient?

A Would I use something different from dad preparing a cookie with marijuana? Not necessarily. I mean, people use what they are able to access. The world is changing in cannabis medicine to where we can direct people to more specific products than ever before. The standard of care has not been what I'm describing. The

standard of care has been make a little bit of medicine, give your child a wee bit and increase the dose two or three -- you know, by a certain amount at a certain interval. So that may be the best we can do at this point.

Q But -- so I'm just -- I want to try to stay focused just on this case --

A Okay.

Q -- which is my fault because I was asking you more broad questions. So I'm talking to myself here.

In this case, should there have been more specific dosing instructions?

A No. I don't think so. I think this is adequate to get somebody started.

Q Okay.

A And you look for the results and when the results come back that "father reports program working very well, gave cookie at breakfast, teacher says he's doing great," what more could we ask for?

Q Okay. But do you -- father would like to --

THE COURT: What more?

BY MS. BROWNE:

Q This small amount of cannabis in a cookie, is that a measurable amount?

A It will be a measurable amount, but it hasn't

been for millennium.

MR. JAFFE: Meaning because it will in the future?

THE WITNESS: I think it will in the future, but because people's receptors are different, because conditions are different and require different amounts of medicine, it's just an educated guess.

BY MS. BROWNE:

Q But there should be a guess by the doctor, by the physician; is that correct?

MR. JAFFE: Objection. No. I'm sorry. I withdraw the objection.

BY MS. BROWNE:

Q There should be -- should the doctor be involved in the dosaging? I mean, it sounds like you certainly are. Is that part of the standard of care?

A Probably not.

Q Okay.

A Probably it's simply an approval. If you go online and get an approval from a doctor for a medical treatment in California, you are not going to get a dosing recommendation would be my guess.

Q So that means it's not part of the standard of care?

A That's probably true.

Q What's true?

A That it is not part of the standard of care --

Q Okay.

A -- that the doctor is pinpointing a dose to be taken at a particular interval. There's a range and so we might aim somebody at what you're going to start to do and then go from there as to what the results are.

Q Okay.

A Fortunately, it's such safe medicine, worst scenario, you're going to fall asleep. With an extremely large overdose, you might sleep for a half a day, but you're not going to hurt somebody, whereas the next line of therapy to use conventional pharmaceuticals, you run the risk of a lot more dangerous adverse effects.

Q And is your opinion that you've expressed in this case in accord with generally accepted science?

MR. JAFFE: I'm not sure -- that seems a little vague, but I guess if you -- it's a lot of opinions and generally --

THE COURT: Yeah. I'm not running a Kelly-Frye hearing.

THE WITNESS: I'm not sure if I can answer that.

BY MS. BROWNE:

Q Okay.

A I teach people about metabolism and how fast these molecules are going to be metabolized by their

livers. I tell people the frequency of dosing that they might find to be a best choice and I might direct them to a ratio of cannabinoids that might be the best choice, but these are I would not say the standard of practice at this time. They may become the standard of practice, but I wouldn't say they're the standard of practice today.

Q Okay. The articles that you have documented, these are abstracts that are written out in Exhibit 47?

A Yes, and the title and source of those journals are right at the tops of the abstracts.

Q And the abstracts -- you didn't write the abstracts based on reading the paper. They're published somewhere?

A These are the abstracts of these papers.

Q Gotcha. Okay. And so do these -- what you've submitted here, do these -- are these in accord with your understanding? Do you agree with these?

A Well, no, I don't. For example, the conclusions for number 6 show that -- this says that -- "Regional Brain Abnormalities Associated With Long-term Heavy Cannabis Use" and the conclusion is:

> "These findings indicate that heavy daily cannabis use across protracted periods exerts harmful effects on brain tissue and mental health."

I don't agree with this paper.

Q And based on what don't you agree with this paper?

A Mostly in that you're not controlling for the variables.

Q And have you read this -- have you read this paper, not just the abstract?

A I have, but I didn't print the whole thing here for lack of room. I mean, it might be a five- or ten-page paper.

THE COURT: I've got enough paper.

THE WITNESS: I wanted to contrast it by showing this paper with another paper that came out after it. So this paper came out in 2008 and by 2014, it's quite a different conclusion and in 2015, it's a different conclusion still.

BY MS. BROWNE:

Q Okay. So which is the conclusion that you -- and I don't mean to -- which conclusions do you agree with, if any, that -- in what you have provided in Exhibit 47?

A I think it's quite telling to look at the difference between paper number 7 and paper number 8.

Q Which --

A They were both funded by NIDA. They were both

looking at changes in brain structures and the reason I didn't agree with or concur with the findings of paper number 7 was because they didn't control for alcohol. They said they did in the early part of the paper, but as they got to the end of the paper, they said:

> "Marijuana users reported drinking a greater number of alcoholic drinks per week than control participants."

So the follow-up paper a year later funded by NIDA controlled for alcohol and then --

Q Number 8?

A Number 8.

Q Okay. So they -- the same institution did -- they corrected what you thought was wrong with it?

A Yes, they did.

Q Okay. And what was the conclusion? You said --

A The conclusion was that there was:

> "No statistically significant differences found between daily users and nonusers" --

Q Okay?

A -- "on volume or shape in the regions" of the brain "of interest."

So whereas earlier they were saying, Look, it's damaging the brain, this is causing harm, this is

damaging the brain, in the paper a year later they said nope, no evidence of any brain differences between the users and the nonusers.

Q Now, is looking at the volume and shape of the brain or a certain portion of the brain, is that how you measure whether there's harm?

A That's how these papers --

THE COURT: You're really taking me out here in the weeds and I don't know if I want to --

MS. BROWNE: Thanks.

THE COURT: I don't know how much of a trial in the science we can have here. I can tell you this. It seems like every time I turn around there's a report of a new paper telling me whether all that coffee I drink is good or bad.

MR. JAFFE: It's good. It's good, isn't it?

THE COURT: The latest story is, It's good, Joe. It's good. But I don't know. I'm reminded of that bit from Sleeper when Woody Allen wakes up and then they say --

MR. JAFFE: Steak and chocolate.

THE COURT: -- steak and chocolate. So I might be showing my cynicism here a little bit --

MS. BROWNE: I appreciate it, your Honor.

MR. JAFFE: And it is 3:25 and I guarantee I'm

getting you out of here at 4:30, Judge.

THE COURT: Well, Ms. Browne's got to do her thing.

BY MS. BROWNE:

Q So I will wrap it up. So our expert Dr. Raiss --

A Yes, I did read his testimony.

Q Right. And then you wrote in your opinion that we have as an exhibit here, you wrote that you criticize something about it and then he explained basically why his position was correct. Did you have a chance to look at his explanation?

A I think we're talking about the Dunedin study and how the Oxford University group felt that there may be some socioeconomic status, having maybe an explanation for the differences in these outcomes.

Personally, I feel that if I want an expert opinion about something statistical, I'm happy to ask an accountant or a statistician to evaluate it. It doesn't require an M.D. to be able to look at evidence and I think Dr. Raiss, or Raiss, was saying that this is done -- this is a judgment by a nonM.D. and I'm thinking, so what?

Q What was a judgment by a nonM.D.?

A Well, you brought the subject up.

THE COURT: It's the Oxford paper.

THE WITNESS: The Oxford paper.

MS. BROWNE: Okay. Okay.

BY MS. BROWNE:

Q So of the documents that you've presented, that you brought for us --

A Yes.

Q -- the abstracts in Exhibit 47, do you -- you subscribe to the eighth one and is that the only one?

A Oh --

Q I just want to make it easy for the judge to know what your position is.

A No. Actually, more of these papers, I would concur with. Here is a paper out of the Netherlands, number 9. I concur with that one.

Q Okay. Thanks. Could you tell me which ones you agree with and which ones you don't?

THE COURT: He says number 9.

THE WITNESS: I agreed with number 9.

BY MS. BROWNE:

Q Okay.

A Number 10 is "Cannabis and schizophrenia." I agree with number 10 and number 11. Both of these papers in concert showed that in conclusion, the studies did not find any evidence of increasing schizophrenia or psychosis in the general population from 1996 to 2005. I

agree with that paper.

Q Okay. So --

A Number 12, I agree with that paper.

Q 12?

A Number 13, I agree with Judge Francis Young's Administrative Law Judge opinions.

Q Okay. And which other ones do you agree with?

A I agree with the abstract of Drs. Kunos and Pacher at number 14:

"Modulating endocannabinoid activity may have therapeutic potential in almost all diseases affecting humans, including obesity/metabolic syndrome, diabetes and diabetic complications" --

THE REPORTER: Diabetes and diabetic what?

THE WITNESS: It is in my document that has been admitted.

"Obesity/metabolic syndrome, diabetes and diabetic complications, neurodegenerative, inflammatory, cardiovascular, liver, gastrointestinal, skin diseases, pain, psychiatric disorders, cachexia" --

THE COURT: So according to this guy, this will cure what ails you.

THE WITNESS: This is out of NIH.

And after -- the last one, "chemotherapy-induced nausea and vomiting among many others." So I agree with that abstract. I see it in my practice every day.

BY MS. BROWNE:

Q So just in the interest of time, could you just tell me the numbers? We've already covered most of them.

THE COURT: We've got 9 through 14.

MR. JAFFE: What about the earlier ones to start?

THE WITNESS: Okay. I concur with number 1 and number 2 and number 3 and number 4 and number 5, not number 6 and I think the rest of them I concurred with.

BY MS. BROWNE:

Q Number 7, you said no?

A No on number 7. Let me be sure I was right about that number.

THE COURT: Yeah. 7 you said was the one that was repeated. Number 8, when they factored in the alcohol use, it gave what you believe was a more accurate picture.

THE WITNESS: Yes, that's correct. They controlled for alcohol and changes in the brain disappeared.

BY MS. BROWNE:

Q So is this -- this represents -- when you were making this list, it's -- this represents what goes

toward analysis of T.T.?

A I'm sorry. What does that mean?

Q I'm sorry. I'm getting astray. I'm withdrawing that question and I might not have any more questions. Let me check.

THE COURT: See, Doctor, there's this saying among attorneys that they make their best questions and make their best arguments in the car after leaving a hearing. I'm sure Ms. Browne is trying to avoid that situation there while she goes through her notes.

MR. JAFFE: That's right.

BY MS. BROWNE:

Q I think most of the questions I was going to ask, you've already answered really clearly.

The statement in the -- on the first page of your opinion, it says in your conclusion, a conclusion, it looks like:

> "Dr. Eidelman appropriately recommended an ingestible form of cannabis as a safe and effective medication to calm the nervous system of this child so that, among other things, he could remain in normal school."

When you say "safe and effective medication," that's -- is that based on what you've testified about here today?

A Yes, it is.
Q Okay. Of the patients who come to you, I understand you're a specialist in medical marijuana -- right?
A Right.
Q So patients come to you knowing what they want, what they would like to get; right?
A Well, I don't know what you mean by knowing what they'd like to get. I guess they want to have a consultation about the use of cannabis and see if it's appropriate for their condition.
Q Okay. Of the patients who come to you, what percentage do you end up providing them a recommendation?
A Probably nearly all.
Q Okay.
A I remember one that I did not, but I would say nearly all.
Q In using medical marijuana, is there ever a concern that it might mask the symptoms of an illness rather than --
A That's possible. I mean, if somebody presents with pain, which is not what we're talking about here, and you're using cannabis as a pain reliever and what you are dealing with is an abdominal aneurysm, yes, it could mask those symptoms. So it's -- it's important to do an

examination and appropriate studies.

So, again, we're trying to avoid harm and make a good, appropriate judgment and referral. It's not to say cannabis wouldn't be useful, but having an appropriate workup and evaluation is key to good medical care.

Q Okay. And in following up on a patient such as -- in following up on this patient, how soon -- what frequency of follow-up should there have been?

A I think what Dr. Eidelman did with his follow-up phone call a week after the initial visit is excellent. I think that's beyond what most doctors do. Most cannabis doctors don't do that and so I think that's a very good and responsible thing to do.

A month later or about three weeks later, he did again have a follow-up. I think that's again beyond what most doctors would do who give cannabis recommendations, so I think that's excellent. And then a year after, eleven months later, he followed up and I think that that too is appropriate. Unfortunately, this child did not enjoy the benefits of cannabis for much of this time because of the complications with this case and the school and the Medical Board, so he came off of medication and had to go on without using it for some time, which I think is unfortunate.

So I think these -- Dr. Eidelman exceeded a

normal standard of care of a cannabis clinician or physician.

Q With regard to follow-up specifically?

A Yes, I do believe that's true.

Q So you have testified cannabis is generally a safe medication and then in this case found it to be appropriate for ADHD and bipolar disorder combined conditions and --

A Yes.

Q And did you -- and my question is also you said for mood disorders --

A Yes.

Q -- which -- so would that include depression?

A Yes. It would include depression.

Q Okay.

A Major depression as well as anxiety with depression. That's ICD, not -- ICD-10 F41.8. So any depressive disorder may benefit from cannabis, but some people say no, it didn't really help for depression. So it's variable.

Q Are there risks of any -- like some people -- not everybody responds the same; correct?

A That's correct.

Q So are there risks of having a negative reaction?

A I have only seen people get into behaviors that were frightening with suicidal attempts when they're using conventional medicines. I have never seen this with cannabis alone in my years of experience.

Q So -- so -- but with due respect, that doesn't answer my question.

A I'm sorry.

Q Are there risks of negative results?

A Well, that certainly would be the biggest of the negative results, would be suicide, and I don't see that with cannabis.

THE COURT: That would be bad.

BY MS. BROWNE:

Q That would be bad. There's no denying that would be bad. Is there a risk of any other negative -- maybe not quite that negative, but any other negative consequences?

A No significant negative effects. Remarkably safe.

Q Okay. And an insignificant negative effect, so you're --

THE COURT: I don't need to hear about insignificant things.

MS. BROWNE: Okay. Excellent.

//

BY MS. BROWNE:

Q And did you think that the family history was significant in Dr. Eidelman's determination whether to recommend?

A Yes. I think it is a significant family history and it fits well with my understanding of what are now being called, as I mentioned earlier, clinical endocannabinoid deficiency syndromes. In looking at this family history, I think that's probably what we're dealing with is a genetically inherited abnormality of endocannabinoids and to use supplemental cannabinoids in the form of plant cannabis is very helpful and I think is an excellent first-line approach to this kind of a condition.

Q Do you see any problem with sending -- well, you referenced that you agree with item one?

A Yes.

Q And do you see any problem with sending a four- to five-year-old to school with -- while giving them something that causes cognitive impairment?

A No, I don't. And as I mentioned, too, cognitive impairment is something that can -- may be measured with certain kinds of tests, but if you can calm the nervous system and have somebody stay in the seat and listen to the teacher and learn how to read and write, et cetera,

et cetera, that's a success, whereas if you go to -- you know, I don't -- I would have to look at these, the neurocognitive testing and see what is exactly being tested and is it relevant to the clinical case.

So we have to look at the risks and benefits of cannabis use and if the risks are greater than the -- or the benefits are greater than the risks, then I think whatever cognitive impairment may occur under the acute influence of cannabis may very well be worthwhile.

MS. BROWNE: Thank you so much.

THE WITNESS: Thank you. Thank you, your Honor.

MR. JAFFE: I have no further questions.

Judge, do you have any further questions of this witness?

THE COURT: No.

Thank you, sir.

MR. JAFFE: Thank you. And the witness is -- I think I've arranged to be the witness's ride. So if you don't mind, the witness has already testified, so he's going to stay.

THE COURT: All right. He can stay there in the peanut gallery.

MR. JAFFE: And now we'd like to call Dr. Eidelman to the stand briefly -- or recall him.

THE COURT: There you go.

MR. JAFFE: And he's still under oath.

THE COURT: Yep.

WILLIAM EIDELMAN, M.D.,

recalled as a Witness, and having been previously duly sworn by the Court, was examined and testified as follows:

DIRECT EXAMINATION (Continued)

BY MR. JAFFE:

Q Okay. Let's continue. I'm going to do a couple of things to short-circuit this.

You heard the testimony of Dr. Scherger with respect to his concern about drugs used Ritalin, Risperdal and antipsychotics. Do you recall that testimony --

A Yes.

Q -- and his concerns?

A Yes.

Q Do you agree with those concerns?

A Yes.

Q And let me ask you this. In your practice, do you make initial -- do you ever write any prescriptions for Ritalin or any kind of psychoactive drug for kids?

A Well, not for kids.

Q Initial prescriptions, first of all?
A No.
Q How about refills?
A I've done refills on Ritalin and Adderal for adults.
Q But not for kids?
A Well, they don't come to me. I don't see them.
Q And not initially?
A And not initially.
Q Okay. Let's turn to your medical records. I just want to get some testimony on Exhibit 22, page two, the consent form. All right? I'm sure you're familiar with the consent form; right?
A Yeah.
Q Let me ask you this. Do you have any information about whether the Medical Board of California has seen or reviewed this form?
A Well, when I was on administrative probation and Dr. Scherger was working with me, the probation officer was present during the development of this and did approve it.
Q The probation officer, the Medical Board --
A The Medical Board.
Q And they were -- they approved it and they wanted you to give this form to every patient?

A That's right.
Q And that was your agreement, that you were going to keep doing it; right?
A Yes.
Q Okay. Did the Board ever tell you that it was insufficient for --
A Never.
Q Now --
MS. BROWNE: Objection; vague, insufficient for --
BY MR. JAFFE:
Q In any fashion that it was inadequate?
A No.
Q Okay. All right. Let's move on to the case and we are going to be brief since I think the relevant facts of the case are well known, and of course you heard the testimony of Ms. Lloyd. Anything -- anything to add? Let me just ask you this: I mean, you have the medical record. Does your medical record of 9/13/12 accurately depict what transpired during that interaction?
A I believe so.
Q And you observed the patient?
A Yes.
Q And your note says, "At home, it is tolerable and they're able to deal with it" and then it says, "In school, the teacher could not accept it." I think that

it's pretty clear, but in case it isn't clear, what did you mean by that? I mean, what information were you recording for the father with regard to the locations or social context that the patient was having a problem with?

A Well, the father told me that the teacher told him that he had two options: either put him on some medication or home school, just like he testified.

Q And you understood that the child was having problems in school; right?

A That's right.

Q And by this note, are you saying that he also -- you were also told that he had problems at home?

A That's correct.

Q What is your -- you heard the doctor's testimony that he specializes in medical cannabis recommendations. Is that one of the things you do?

A That's the main reason most people walk into the office.

Q To do what specifically?

A To consult about medical cannabis.

Q Are these people that just want the treatment and they want to know if they qualify? Is that --

A Well, they're hoping to become legal, yes.

Q And what do you view your job as once they come

in? What's -- what's your function?

A Well, I'm a physician. I'm trying to help people get better and they're coming in asking about cannabis, but they've got a problem. So I take the history and do a physical exam on them and then there's going to be a number of different things probably that they'll need to get better and cannabis probably is one of them because as we've just seen, it worked for so many different things, and then I'll usually go into other natural things whether it's nutrition in terms of diet or supplements and I'll often offer them an energy therapy treatment of one kind or another and show them a variety of different ways they can get better and then they end up walking out the door with a cannabis letter and a lot of other knowledge that many -- that not everybody puts to use.

Q Okay. And how many -- how long is your average patient visit with these cannabis treatment recommendations?

A Well, it can be anywhere from 20 minutes to even an hour.

Q Depending on what?

A Well, partly depending on how many people are in the waiting room and partly depending on the nature of the problem and how deep we need to go into it and how

much they're interested in hearing about the other things that they could or should do.

Q Like what?

A Diet, nutrition, supplements, energy medicine.

Q And do you offer those kinds of things, too?

A I offer those kinds of things.

Q And how long have you been writing these medical marijuana recommendations?

A Since sometime in 1997. I don't remember the exact date that I started.

Q So that's --

A The law went into effect in January of '97 and at some time during '97, I started writing the letters.

Q So upwards of 20 years?

A Yeah.

Q How many patients do you think you've seen for this condition?

A Thousands.

Q Thousands?

A (No audible response)

Q All right. And how do you view -- when you write like you did in this case "Diagnosis: Probable combination of ADHD/bipolar," what do you mean by that when you're saying "probable"?

A Well, you know, as was testified earlier that

you can't know for sure in the thing like that, it always starts out as a working diagnosis. So you look at the situation, you evaluate the situation, you come up with your initial impression, and then you work from there. So it's a working diagnosis. It's a preliminary diagnosis, like in the hospital they have the admitting diagnosis and the discharge diagnosis. So it's tantamount to that. You've gotta give something. I mean, you could say I guess, "I don't know what it is," but in general you do have an idea of what it is. So that's why I said "probable," because I couldn't be certain. I mean, you can never be certain anyway, but to me it looked like that was the likely situation.

The father, even though he himself claimed not to have bipolar, he talked about having been prescribed lithium and Respiradol, which are only prescribed for bipolar, not ADHD, so he clearly had been diagnosed as bipolar, and the son had the same thing, you know, had been given the same medication. So he clearly had been diagnosed as bipolar.

Q So you had two family members that are --

A Two family members with the bipolar and the kid exhibiting the same symptoms, it's extremely likely that he's got the same diagnosis --

Q Right, but --

A -- but it's not certain, so that's why I said "probable."

Q And bipolar, is there any genetic element to bipolar?

A Well, there is a genetic element to it, sure.

Q And that's why family history is important?

A Yes, I mean, and there are other things, too, because even if it's not genetic, it could be epigenetic in the sense that families engage in the same behaviors and food choices that will affect the genes. So it might not be -- it might be epigenetic more than genetic, and I didn't know it at the time about the -- about the patient in question being basically taken away at birth from the parents; but that's another reason, you know, there could be an issue, as a cause of why he's bipolar or has these symptoms.

Q All right. And -- I'm sorry. I just lost my train of thought just for a second.

Let me -- let's get into what may be a big issue in the case. You've been criticized for not I guess during this visit picking up the phone and somehow calling somebody at school. "Call the school." Okay? That's the criticism. Let's take it head on. Did you -- do you normally -- would you normally -- in this normal situation, would you call --

A I'm not normally seeing kids of that age. This is a completely unique situation that I never encountered -- that I've encountered only one time, nothing even resembling it ever.

Q What makes it unique, if I can interrupt you?

A Well, I mean, a five-year-old child being brought in because of the -- what seemed to me like an emergency or urgency of needing something to get back to school and, you know, a five-year-old child in general with that type of behavioral problem. I had -- no one had ever come in like that before or since and -- but the main reason I wouldn't have called the school are privacy issues.

Q What do you mean by that? That hasn't really come up yet.

A Well, Dr. Hergenrather mentioned it, but people have the right to privacy and especially around these kinds of issues. You know, they don't necessarily want everybody to know what's going on or what they're thinking of doing therapeutically.

Q Okay. So did you feel -- I mean, obviously from the fact you gave it, you didn't feel it was necessary to call the school?

A That's right.

Q Why is that?

MS. BROWNE: I --

THE WITNESS: Privacy issues. Plus, I didn't think I needed any more information at that moment.

BY MR. JAFFE:

Q What was the information that you thought was sufficient in order for you to make the recommendation?

A Well, between the family history and the description of the father -- by the father of the problem, it was enough.

Q Okay. And just so -- 'cause you talked about it, what percentage of your practice is children?

A Well, very, very, very small.

Q All right. So you don't consider yourself a pediatrician?

A No, I'm not a -- well, I'm a consultant in alternative medicine and I do occasionally work with children but rarely, not that often, and not always around cannabis. You know, sometimes people will call me up, Oh, my kid is this or that. Can you help us in some way that's not cannabis related? And I'll do it.

Q Right. Now, the patient -- the father was a patient of yours; right?

A That's right.

Q And the older son was a patient?

A That's right.

Q Let me ask you a hypothetical. Somebody walked in off the street telling the story that Lloyd told you. Would you have done anything differently?

A Someone I didn't know?

Q Someone you didn't know?

A I probably wouldn't have written the letter.

Q Why not?

A That's a question of trust. You know, I knew Lloyd and I trusted what he said and I knew him enough to, you know, know he really had the problem himself and the older brother has the problem himself. It's just natural that the kid has it and somebody walking in cold off the street, I probably wouldn't do that.

Q Let me ask you this. Suppose Lloyd had come to you and told you everything, the situation, but hadn't told you that he got kicked out of his school, right, that he had this choice --

A Uh-huh.

Q -- of not going to school -- of not taking medication, not going to school, not taking medication. It's kind of a hypothetical, but would that have changed anything based on your observations or history? What would you have done differently, if anything?

A Well, I mean, I probably would have advised him to try some of these other like dietary changes first.

You know, I wouldn't have been so quick to issue the letter. Let's put it that way.

Q But you felt it was urgency, again?

A Yes.

MS. BROWNE: I'm sorry. I couldn't hear. I couldn't hear.

MR. JAFFE: You want me to repeat it?

MS. BROWNE: Objection to the question and the answer. I didn't hear and I don't know if the court reporter did.

(Record read)

MR. JAFFE: Urgency, again.

BY MR. JAFFE:

Q Is that correct?

A Yes.

Q Let me ask you this: You've been here the whole time. You heard the testimony of Dr. Raiss. Any comment -- I want to give you the opportunity at least because you have a right to confront your accusers.

A Right.

Q Any comment you want, anything you want to say to the judge about Dr. Raiss's testimony?

A Well, he's a psychopharmacologist with no experience really whatsoever with cannabis or cannabis patients, so he really has no clue what he's talking

about in the context. He could talk about psychopharmacology and very blithely referred to how wonderful the psychopharmacological drugs are and he very, very, very much downplayed the negative effects, and the negative effects are horrendous. They cause all kinds of long-lasting diseases.

I have a patient who's now 30 years old who when she was maybe in her young teens was given something like Risperdal and it caused the side effect of like a tic, like a huge tic in her neck where she's got a constant spasm on her neck and she has to be on something like valium for the rest of her life because they gave her one of these drugs as a kid. That's just one small example. These drugs have tremendous side effects and they are horrible. Maybe they help in some way and maybe not everybody has the horrendous side effects, but enough of the large percentage do.

I mean, I had a patient, you know, in the last couple years -- it wasn't a child, but an adult who was given an antipsychotic and she came back after a couple of years that I hadn't seen her and she was shaking crazy and "What's wrong with you?" "Oh, I got Parkinson's Disease" and it turns out somebody -- and she had been to three doctors who had given her three different antiParkinson's. She was on three antiParkinson's drugs

and it wasn't working. She's still shaking like a leaf all over and I said, "Well, did anybody ask about the antipsychotic drugs?" "No." "Well, did anyone say that the antipsychotic drugs might be causing this shaking?" "No." "Well, I think you'd better stop the antipsychotic drugs." And then a couple of weeks later, a month later, I'm in the grocery store and somebody comes up to me that I didn't recognize. It was her. The shaking was completely gone. "Thank you, Doctor. You saved my life by telling me to stop the antipsychotics."

Q So you're not a big fan of them?

A So I'm a big antifan of them.

Q Anything else about Dr. Raiss here that you recall?

A Well, all of his stuff about the dangers of cannabis I think is highly exaggerated and I think that Dr. Hergenrather has gone over most of that material.

Q I think we've -- we've got that.

A So I think that it's -- the safety of cannabis has been well demonstrated and that the -- all of these -- the evidence of harm is basically to the degree that there is harm or could be harm, that we're talking about teenage or adult abusers, and nothing -- no studies ever have been done on that order with people using it medically in the right way.

Q Okay. Just in one or two sentences, you've treated thousands of patients. You say -- what kind of side effects have you seen? Are they similar to what Dr. Hergenrather testified to?

A Basically you have dry mouth. You might get sleepy. You might have some short-term memory loss when you're acutely intoxicated and it wears off.

Q Okay. Anything else about Raiss, Dr. Raiss?

A Not that I can think of right now.

Q Okay. Same opportunity for Dr. Briggs, to confront your accusers. Well, what do you have to say about that?

A I thought -- I sure wish I would have written this stuff down. I thought you were going to ask a more direct question.

Q What about when she testified she would have picked up the phone in her seven minutes out of the 20 minutes? Do you think that's realistic?

A Probably not, but --

MS. BROWNE: Objection; misstates the facts in the record, your Honor.

THE COURT: Well, let me just cut across it.

Look, it was clear to me that Dr. Briggs has a -- is much attune to that whole Special Ed business. She knew about 504 reports. She knew about IEPs. So she

knew if what dad was saying is true that something potentially funky was going on with the school.

MR. JAFFE: What do you do about it is really what --

THE COURT: Well, to the extent that she says, "I want information from the school," she's going to find a way to get it, which begs the question here, "Dad, give me a release so I can get some information from the school. Get a release so I can send a questionnaire to the teacher." There's an argument to be made here, now, the Respondent should have slowed this process down. Now he's saying there's some urgency here and I've got to take that into account. There's an argument to be made. Now, a good defensive back will keep it in front of you for a little while.

MR. JAFFE: I appreciate that. Understood.

THE COURT: That's a concern I've got here.

MR. JAFFE: Again, I appreciate that.

BY MR. JAFFE:

Q All right. So I'm still going to ask you that question and put you on the spot. Anything else about Briggs? This is your opportunity.

A Well, she talked about that she did 20-minute visits of which the majority of the visit was done by the nurse practitioner and she comes in at the end. So her idea of, you know, you've got to spend longer and you

can't make -- it just doesn't make any sense. And the whole idea of making the bipolar diagnosis, I mean, okay, granted, look, if I'm going to prescribe Respiradol, I'd better be pretty damn clear that -- sorry -- that it's really bipolar, but I'm not giving something that's ridiculously dangerous. I'm giving something that's amazingly safe in my opinion and other people's opinions and that actually worked.

So I think the other thing that Raiss said at the end was that when he realized that the kid had been diagnosed with a disregulatory -- disruptive mood disregulatory disorder, his words were, "Well, it looks like Dr. Eidelman got it right. Maybe he's onto something." So I think that --

THE COURT: That's not quite how he put it, but -- I think he thinks you stumbled into it, but we'll pass that.

THE WITNESS: Well, no, but Dr. Scherger points out that a doctor who either has the good clinical judgment or doesn't should be able to make the assessment pretty fast, within a few minutes. You may change your mind later. I put "probable" as a working diagnosis. If I didn't have to put down a diagnosis for the record because I'm recommending cannabis, I probably wouldn't have put that down, but it's a working diagnosis that

later proved true.

THE COURT: Yeah, but you've probably got to have a working diagnosis to tell him to go get some Nyquil for the night.

THE WITNESS: Well -- okay.

BY MR. JAFFE:

Q But I guess isn't that the point? If it's just Nyquil or marijuana, you don't necessarily need -- I think that's what the judge is saying. You don't necessarily need to have assays and contact the school and documen- -- all that documentation. I think -- is that what you're saying, as opposed to Respiradol --

A Right.

Q -- where because of the side effects, you'd want a lot more?

A Yes.

Q So are you saying it depends on the drug you're prescribing?

A Sure, and what you're trying to do as the treatment.

Q Right. I don't know. I mean, let me just ask, anything else you want to address? I hate to keep it open-ended, but I'm doing this --

A I mean, there are various legal concerns that I have that we've discussed and that you'd rather I not

bring up, but I have to bring it up.

Q Okay. Could you briefly --

A Can I look at some notes that I have?

Q Sure.

MR. JAFFE: Briefly, very briefly. We're getting the judge out of here at 4:30.

THE COURT: Ms. Browne's got to have an opportunity here.

MS. BROWNE: We have no objection, your Honor. We can be quick or do it in writing.

MR. JAFFE: Quickly.

BY MR. JAFFE:

Q Very quickly, what's your concerns, legal concerns?

A Legal concerns, that, you know, I'm being charged with 2234 subcategories for various things and I believe that I'm in a safe harbor under 2234.1.

Q And I guess we're going to address that at closing, the legal arguments.

A But I just wanted to bring it up and mention it. I'm not going to go into it.

I'm going to mention a couple other things I'm not going to go into, but we also discussed the statute of limitations issue, 2230.5, and even though the Department of Investigation is now a separate thing from

the Medical Board, maybe in a legal sort of a way, that in a realistic way, they still -- the section of --

Q Investigations?

A -- the investigation that the HQIU or whatever it is that's part of the D.O.I. instead of the Medical Board still is the Medical Board Investigatory Unit and for all practical purposes is still part of the Medical Board.

THE COURT: Well, I tell you what. I think your lawyer ought to cover this in some briefs.

THE WITNESS: Okay. And then just two more real quick things: That there is the Government Code 10101, which states the Accusation provided for by Section 11503 shall be filed no later than three years after the date of the incident in question and although that conflicts with 2230.5, there's nothing in the law itself that says that it wouldn't, that you couldn't use it in this situation.

THE COURT: The Board -- hang on a second. The Board's specific provisions are going to control over the general provisions, so --

MR. JAFFE: Move on, Dr. Eidelman.

THE WITNESS: And so last but not least is the -- notwithstanding any other provision of law, is the Compassionate Use Act, part C, that even if we say it's a

qualified immunity that if you qualify, it should give you immunity and I believe I qualify, so it's not standard of care.

BY MR. JAFFE:

Q Anything else you want to mention before you're cross-examined?

A That's it.

MR. JAFFE: Thank you. I pass the witness.

Ms. Browne.

CROSS-EXAMINATION

BY MS. BROWNE:

Q So how does the Compassionate Use Act -- how are you saying that that -- and I'm not asking you as a legal question. I'm just asking you as a doctor and your understanding and how -- what you meant. How does this Compassionate Use Act help you in this case? I mean, how does -- does that basically set the standard of care? Is that what you're saying?

A No. I'm not sure what you're asking.

Q Well, I guess I'm curious exact -- more clearly, what do you mean when you say that the Compassionate Use Act, something about --

THE COURT: It provides you some protection.

MS. BROWNE: Yeah. Yes.

BY MS. BROWNE:

Q -- it provides you qualified immunity?

A I think I've been asked to save that for another situation.

MR. JAFFE: No. She's asking you a question.

THE WITNESS: Well, it says, "Notwithstanding any other provision of law, no physician in the state shall be punished or lose rights or privileges for recommending marijuana for medical purposes" and "notwithstanding any other provision of law" is known to be a broad coverage of protection. It's meant that like the -- well, in the precedent, like with these, they were claiming it wouldn't apply to McCrea (phonetic) or me because it's saying that the public needs to be protected from all the various problems that can arise and then -- but then -- that's B, and then C says, "But notwithstanding any of the other provision of law, then no physician shall be punished."

So I think that the physician is supposed to be protected and that under that protection that you can't go about saying, Oh, the way he did it was the wrong way; that I believe the law states that the physician is protected. I don't think I did anything wrong, but I think I would be protected even if I had. I didn't, but I'm protected.

THE COURT: Okay. I think I understand your point.

THE WITNESS: Okay. Thank you.

BY MS. BROWNE:

Q Did hearing the testimony of Dr. Raiss and/or Dr. Briggs make you reconsider anything about your care and treatment of patient T.T. in this matter?

A No. Now, as far as future situations, if I ever faced a future situation, I no doubt would take different actions, including calling the school, but -- just because of being in this situation, but a -- and I think that maybe, you know, the Medical Board did pass some rules regarding prescriptions of these other kind of dangerous drugs that we were just talking about.

I don't know if your Honor is aware that there was a problem in San Bernardino, the same place that this happened, of children under protective care like under foster care being prescribed excess dangerous, you know, these kinds of drugs, and it was a big scandal in the newspaper and I think that there is an article about that in the exhibit.

And then a couple of years ago, the Medical Board passed a rule that in order to prescribe these kind of drugs to these kind of people, you have to go through some serious hoops, including court approval, and maybe the Medical Board should do something like that with

cannabis in kids, but they haven't yet.

Q And are you -- when you say that, are you talking about -- if you could turn to Exhibit 23, the first page of Exhibit 23, this is your addendum to the medical record?

A Right. That's right.

Q And so this was dated June 12, 2017. Is that when you wrote this addendum?

A That's right.

Q Okay. And is that the same day that you certified the records that you were -- the medical records that you were providing to the Board?

A Possibly. I'm not sure.

Q Well --

MR. JAFFE: If not the same day, close in time.

MS. BROWNE: Okay.

BY MS. BROWNE:

Q And is what you wrote in your addendum -- do you think that was appropriate to be part of your medical record or -- just sort of "yes" or "no" is what I'm looking for.

A Yes.

Q And is the -- and was -- were the articles referenced one, two, three and four, are those appropriately part -- and five, appropriately part of the

medical records?

A I'm not sure what you mean by "appropriately."

Q Well, it seems like maybe those were just trying to provide a defense to the Board, knowing if the records were subpoenaed, I'm going to get into the medical records some defensive items that the Board can consider. Is that a fair statement?

A Yes.

Q Okay. And is the article that you referred to about the issue you were talking about, the treatment with drugs, heavy use of drugs to treat abused children, is that at page 19 of reference 5, Exhibit 23?

A Yes. Thank you for finding that.

Q You're welcome.

So I asked you earlier about if after listening to the testimony of Dr. Raiss and Dr. Briggs if that would -- if that would cause you to reconsider how you treated patient T.T. in this matter and it sounds like in the future you would call the school?

A In that identical situation --

Q Okay.

A -- probably.

Q Okay. And then I have the same question with regard to hearing the testimony. And, also, did you have a chance to look at the exhibits in this case?

A I looked at most of them as well as I could.

Q Did you remember looking at the ones the Child and Family Services -- the first attachment to the Report of Investigation?

A Yes, I do. Yes.

Q Okay. So in light of that document and in light of the testimony that you heard from the father, the father of patient T.T., is there anything that you would do differently in this case in your care and treatment of patient T.T.?

A Well, I mean, the things that were put in that exhibit that you're currently talking about are -- basically were all thrown out in the child court with prejudice, every single one of them, and the only thing that wasn't put in there was the final report, that they were all tossed out.

THE WITNESS: So, you know, your Honor, I hate to say it. My lawyer doesn't want -- didn't want to go this --

THE COURT: I think you ought to -- you ought to listen to your lawyer, sir. He's a smart fellow and you're paying him good money, I assume.

THE WITNESS: Yes, but still --

THE COURT: And --

THE WITNESS: -- the issue is we can't believe -- your Honor, I know it's hard to believe and the two other

experts for the Board couldn't believe that this San Bernardino School District would do anything illegal.

THE COURT: No. No. No. No. You misunderstand. Maybe they did do something illegal. You think in all my years here dealing with government agencies I haven't seen some of them mess up? No. No. No. No. You're wrong.

THE WITNESS: Okay. All right. But anyway, you know, I won't really go into the details, but they put a lot of dirt into this and, you know, to the -- you know, that evidence shouldn't have been there. It was thrown out and they basically neglected the most important thing, that it all got tossed out.

THE COURT: Well, but some of that is written before it got tossed out.

THE WITNESS: No. Well, but that's part of the thing, too, that she dated the report 11/12 as if it was before it got thrown out, but it was really 11/14, not 11/12. So the --

THE COURT: Well, okay. Let me just cut you off here. How this ends up getting here isn't especially relevant. Okay?

THE WITNESS: Right.

MR. JAFFE: Well, if it may, your Honor --

THE COURT: Because now I've gotta decide whether you

should be here.

MS. BROWNE: My question's much more limited. I'm not asking the truth of it. I'm not going there at all. My question was in light of what you read because he testified he read these and he read what we've now introduced as Exhibit 46, that it was tossed out. In light of hearing the testimony of the father and reading these documents, the two documents, the initial -- what was the initial functional complaint and Exhibit 46, I believe his testimony -- I wanted to know -- I'm sorry -- I was stating the question, whether or not that would change -- make him question the father's judgment or do anything differently in this case.

MR. JAFFE: Right, and I think he testified it wouldn't because all of these allegations were thrown out in that, per his testimony, verified by the first two pages of that report that we're not taking into evidence -- well, you may or may not.

THE WITNESS: Well, you see, your Honor, the question part of the thing is should I be here, was that initially the father refused to release the medical records. So the Medical Board goes in to superior court to petition to compel me to release the records; but in that compelling, they leave out the -- when they're like talking to all these other doctors, they left out the

part about the teacher insisting that the kid be on medication, which would change the story. It might not have changed their decision, but it's a different part of the story.

And the other thing, which there's the CD of the police officer's interview with me in my office where she states that I said I didn't have medical records, of which I did not say that, and she told that to the different people that she, you know, got their opinion from and, Oh, well, we need to see the records to see if you have records, but --

MR. JAFFE: Doctor, I'm pretty sure the judge isn't going to consider that in terms of this case.

THE WITNESS: Well, he raised the question of should I be here and I'm saying that I shouldn't be here because there's so much dishonesty in the case.

MR. JAFFE: But I'm pretty sure that this judge -- and he's clearly and thankfully indicated what he thinks is important of the case. I'm pretty sure that whole story of how they got the records isn't part of it, so I think we should just move on according to my recommendation.

THE WITNESS: I said what it was. It's finished.

BY MS. BROWNE:

Q Did you have an opportunity to provide a

declaration in opposition to the subpoena that you're referencing?

A We did present an opposition.

Q And the medical records that are at Exhibit 22 and 23, you certified those on or around June 16th, 2017; is that correct?

A I'm not aware of the date.

Q Oh --

A It's okay.

Q The first page of Exhibit 22.

A Okay.

Q Okay. So you signed that on June 12th, 2017; right?

A Yeah.

Q And that was also the date of your addendum?

A Yes.

Q And what -- did you have a physical file folder of patient T.T.'s medical records in this case?

A No. It's on the computer. This is a printout of the file on the computer.

Q Okay. So when you maintain your medical records in EMR -- you maintain EMR? Is that --

A Well, I couldn't call it an EMR. It's just a file on the computer. That's different than electronic medical record.

Q What kind of file? WordPerfect file?
A Microsoft Word.
Q Microsoft Word. So it's -- does each patient have a file --
A Each patient has a separate file.
Q I see. So at the time that you spoke with the San Bernardino detective that we've been referencing here, had you typed in every single thing that you had -- that is included on page three?
A Yes.
Q Okay. And when did you -- if you recall, when did you type the next entry on the next page?
A The date that it happened.
Q Okay. And is that the same for the next two?
A Yeah.
Q Okay. And in 2013, did you write another cannabis letter?
A Yes.
Q Oh, okay. I guess it says that. Does that say that at the bottom of page four, "cannabis letter reissued"?
A Yes.
Q Okay. And so -- and you -- there is not a dispute, I believe, that you issued a cannabis letter the year prior; correct?

A Right.

Q Is the cannabis letter -- is there -- is that in the file?

A No, it's not.

Q It's not maintained in the medical records?

A No.

MS. BROWNE: We have no more questions. Thank you.

THE WITNESS: Thank you.

REDIRECT EXAMINATION

BY MR. JAFFE:

Q Just -- you know what the concept of defensive medicine is?

A Yes.

Q When you say if the exact circumstances were to occur again, you would call the school, why would you call the school?

A Well, exactly that, because of defensive medicine. I did not practice defensive medicine the first time that he was here.

MS. BROWNE: The first time --

THE WITNESS: The first time the patient came in.

BY MR. JAFFE:

Q But to be clear, as we speak, you're not saying -- you're not saying that you thought you did

anything wrong; right? But you would -- you don't want to be here again?

A Defensive medicine, as I understand it, means you do more than what you necessarily think you should just so somebody else looking at it would say, "Oh, you're okay."

THE COURT: There's an analog in the legal practice, sir.

MR. JAFFE: What would that be? CYA?

THE COURT: Take some more depos just to make sure no one can criticize you. Sure.

MR. JAFFE: No further questions.

THE COURT: And you'd better have a good letter to your client about how we're not going to take some of these depos and this is why.

Thank you, Doctor.

THE WITNESS: Thank you.

You don't have any questions, your Honor?

THE COURT: No. The question's about how I'm going to figure this all out.

MR. JAFFE: And, Judge, I just want the record to reflect it's 4:26. Ms. Browne and I have done what we promised we would do for you.

THE COURT: You'll be rewarded in heaven. Let's go off the record.

(Discussion off the record)

THE COURT: Ms. Browne plans to order a transcript, so she needs more time than she might to come up with a closing argument that's in writing. The parties have stipulated that they'll file concurrent closing briefs by September 7th of this year and there further will be a stipulation that if I want to have some colloquy with counsel after we get those briefs that if I deem it necessary, I'll reopen the record and set a telephonic conference/argument that will be electronically recorded.

Is that acceptable to you, Mr. Jaffe?

MR. JAFFE: Yes, it is your.

THE COURT: And you, Ms. Browne?

MS. BROWNE: Like I mentioned, we'd prefer a court reporter, your Honor.

THE COURT: Okay. Well, you guys are paying. We'll get a court reporter, too, if necessary.

MS. BROWNE: Thank you.

THE COURT: Okay. I have to have a stipulation to do something telephonically or not or use a reporter.

MS. BROWNE: Thank you.

THE COURT: There's a couple of agencies who seem to try to read it differently, but they're wrong.

MS. BROWNE: One question. Will there be a chance for a reply brief?

THE COURT: I don't know. It may just gum things up and it may be something I take up if there's some oral argument.

MS. BROWNE: Because the reason I bring it up is because usually since we have the burden of proof, we would say our closing argument and then Respondent would say his closing argument and then we'd get to --

THE COURT: I'll tell you what --

MS. BROWNE: -- have the last word, so to speak.

THE COURT: Since we're doing this concurrently, anyone who wants to make any replies, you get to the 14th of September. That's our new date. The 7th for your main briefs. If you want to make a brief reply, the 14th.

MR. JAFFE: So at any time, any discussion will be after the 14th?

THE COURT: And it may not. I may read these things and say, "Fine. I'm going to write this decision." All I'm saying it's come up more than once in my experience that after I get the briefs, I should want to get into some conversations.

So 9/7, equal briefs. 9/14, replies. Stip for telephonic.

MR. JAFFE: You're going to issue a written order on the stips?

THE COURT: No. It's on the record.

All right. Now, you're going to get them those documents and we're all going to get out of here.

Doctor, look, I tell every Respondent at the end of a case in a perfect world, we're never going to see each other again because it will mean you've either got legal grief or I need your help and we don't want to be in those situations. Right?

Okay. Now we're off the record.

(Proceedings concluded at 4:35 p.m.)

REPORTER'S CERTIFICATION

I, the undersigned, a Certified Shorthand Reporter of the State of California, do hereby certify:

That the foregoing proceedings were taken before me at the time and place herein set forth; that any witnesses in the foregoing proceedings, prior to testifying, were duly sworn; that a record of the proceedings was made by me using machine shorthand, which was thereafter transcribed under my direction; that the foregoing transcript is a true record of the testimony given.

Further, that if the foregoing pertains to the original transcript of a deposition in a federal case, before completion of the proceedings, review of the transcript was not requested.

I further certify I am neither financially interested in the action nor a relative or employee of any attorney or party to this action.

IN WITNESS WHEREOF, I have this date subscribed my name.

Dated: August 6, 2018

Marcena M. Munguia, CSR No. 10420
Certified Shorthand Reporter
For The State Of California

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EXHIBIT E

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

In the Matter of the Accusation Against:	
WILLIAM S. EIDELMAN, M.D.	**Case No. 8002014010147**
Physician's and Surgeon's Certificate No. G32011	OAH No. 2018030645
Respondent	

DECISION

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

This Decision shall become effective at 5:00 p.m. on January 4, 2019.

IT IS SO ORDERED December 6, 2018.

MEDICAL BOARD OF CALIFORNIA

By: _____
Ronald H. Lewis, MD, Chair
Panel A

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

In the Matter of the Accusation Against: WILLIAM S. EIDELMAN, M.D., Physician's and Surgeon's Certificate No. G 32011, Respondent.	Case No. 800-2014-010147 OAH No. 2018030645

PROPOSED DECISION

The hearing in this matter took place at Los Angeles, California on July 11 through 13, 2018, before Joseph D. Montoya, Administrative Law Judge (ALJ), Office of Administrative Hearings.

Complainant Kimberly Kirchmeyer, Executive Director of the Medical Board of California (Board), was represented by Beneth A. Browne, Deputy Attorney General.

Respondent William S. Eidelman, M.D., appeared at the hearing and was represented by Richard Jaffe.

The parties agreed to file closing briefs, and reply briefs, and the record was therefore held open for that purpose. Each party's opening brief was to be submitted by September 7, 2018, and reply briefs were due on September 14, 2018. On September 6, 2018, the parties submitted a joint request to extend the deadlines by one week, so that opening briefs would be due on September 14, and reply briefs would be due by September 21. That request was granted.

On September 14, 2018, Respondent filed his written closing argument, with appendices and with Respondent's personal addendum. Those documents are collectively identified as exhibit 48.

On September 17, 2018, Complainant's closing argument was received, without objection, and it is marked as exhibit 49.

On September 18, 2018, Complainant submitted a request to extend the deadline to file reply papers, to which Respondent had no objection. Because Complainant's counsel had medical issues, the deadline was extended to October 10, 2018.

On October 5, 2018, each party submitted a reply brief. Complainant's is marked for identification as exhibit 50, and Respondent's is marked as exhibit 51.

The Accusation against Respondent identified the child patient, and his father, by random initials, instead of by their actual initials. However, they were at times referred to during the hearing by their names or initials, the court reporter being instructed to use initials in transcripts. Their real initials or status are used in this Proposed Decision, i.e., L.T. or father for the parent of the child patient, and T.T. or the child for the young patient.

By a separate protective order, a number of documents shall be sealed, as they reference the patient and parent by name, and it was impractical to redact the names from the documents.

The matter was submitted for decision on October 5, 2018.

The ALJ hereby makes his factual findings, legal conclusions, and order.

SUMMARY OF THE CASE

Respondent is a physician who labels himself as a consultant in alternative medicine. A substantial amount of his practice involves providing medical marijuana recommendations to patients. In September 2012, one of his a patients, L.T., brought the patient's then five-year-old son (T.T) to Respondent for an examination and a medical marijuana recommendation. The child's father had obtained such recommendations from Respondent for himself and an older child in years prior, due to the father and older sibling carrying a diagnosis of Bipolar Disorder and Attention Deficit Hyperactivity Disorder, or ADHD.

The father told Respondent that the boy had had episodes of uncontrollable behavior and temper tantrums, and that this was causing trouble in school. Respondent met with father and son for 20 to 30 minutes, and no tantrums or unusual behavior was observed. Respondent diagnosed the boy as having a "probable combination" of ADHD and Bipolar Disorder. He then recommended that the boy be given small quantities of cannabis in cookies.

The child was given cannabis by his father, and his father reported improvements in the child's behavior to Respondent soon after the initial visit. Thereafter, the boy's school became aware that the child was being given cannabis, which then triggered an investigation by child protective services and law enforcement. That led to a referral to the Board.

Complainant asserts that Respondent committed gross negligence, repeated negligent acts, and demonstrated incompetence and general unprofessional conduct in his diagnosis and his cannabis recommendation. She also asserts that his medical records for this patient were inadequate.

Respondent asserts that his diagnosis was sound, and that cannabis is appropriate as a response to the diagnosed condition. He also asserted that the applicable statute of limitations had run, and that he should be immune from discipline under the Compassionate Use Act.

FACTUAL FINDINGS

The Parties and Jurisdiction

1. Complainant brought and maintained the Accusation while acting in her official capacity.

2. On July 1, 1976, the Board issued Physician's and Surgeon's Certificate number G 32011 to Respondent. At the times relevant to this matter, it was valid. The Certificate is due to expire on February 28, 2019.

3. Respondent graduated from St. Louis University Medical School in 1975. He spent approximately one and one-half years in a combined internship/residency program in psychiatry; that was approximately one-half of the program's duration. He was then a general practitioner for approximately five years. In the 1980's he became interested in alternative medicine, and practiced it. In 1990 he was introduced to nutritional medicine, now known as functional medicine. In 1997, following passage of the Compassionate Use Act, he began providing medical marijuana recommendations. Although he still practices functional medicine, and he uses other treatment modalities, much of his practice is provision of medical marijuana recommendations.

4. Respondent's certificate was previously disciplined, as described hereafter.

5. The Accusation was filed on November 22, 2017. (Ex. 1, p. 1.) After it was served on Respondent he filed a timely Notice of Defense, requesting a hearing. This proceeding ensued. All jurisdictional requirements have been met.

Respondent's Admissions

6. Near the outset of the hearing, Respondent admitted that a number of the allegations in the Accusation were true. The admissions pertain to allegations found in paragraphs 9, 10, 11, and part of 12, with an exception to one sentence in paragraph 10.

Thus, Respondent admits the following, including the statements in the footnotes that are tied to the aforementioned paragraphs of the Accusation[1]:

> 9. On or about September 13, 2012, Respondent[2] had an appointment with a four-year-old boy, A.A.[3] During the appointment, the boy and his father, L.T.S. were in the room. Respondent talked with each of them at various times . . . . Respondent had treated L.T.S. in the past and provided him recommendations for marijuana for medical purposes. The chief complaint for the child was that he had episodes of uncontrollable behavior and temper tantrums. Respondent primarily spoke with L.T.S. during the appointment. Respondent noted that the boy was normal appearing, agitated from the stress of the day in school, coming to the doctor, alert, oriented, appropriate, but agitated, and having trouble sitting still. No looseness of association was noted. He was not talkative and answered questions. L.T.S. and an older sibling of A.A. were diagnosed with attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD) and bipolar and were put on drugs for both. They found cannabis more effective.
>
> 10. Respondent did not observe the boy having a temper tantrum or uncontrollable behavior, but he did not attempt to contact the school or obtain further information from the school. He did not seek to obtain other medical records for the boy. He did not refer the boy to a pediatrician, psychiatrist or pediatric psychiatrist. Instead, after a twenty to thirty-minute interview with the child and his father, Respondent documented a diagnosis for the boy as a "probable combination of ADD/ADHD or bipolar." Respondent did not document any of the criteria for the attention deficit hyper activity disorder or bipolar disorder.
>
> 11. Respondent documented the plan to "try cannabis in small amounts in cookies." He later indicated he would let L.T.S. determine the dosage to be given to the boy. Respondent signed a letter that day stating that A.A. is under his medical care and that A.A. reports that

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[1] Ellipses indicate an allegation not admitted, or in the case of the second footnote, omission of extraneous material.

[2] "Respondent indicates that he began practicing nutritional medicine around 1990 and his practice evolved to recommending marijuana for medical purposes around 1997. He has not had privileges at any hospitals or institutions. He is not a specialist in psychiatry, pediatrics, or pediatric psychiatry."

[3] "The child and his father are identified by random initials to protect their privacy. . . ."

> cannabis relieves his medical symptoms. In the letter, Respondent indicates that he recommends/approves of his patient's use of cannabis pursuant to the Compassionate Use Act. He indicates he will continue to monitor A.A.'s condition and provide advice on his progress. It indicates that the recommendation letter is valid for one year. Respondent did not try or recommend any standard treatments for ADHD or bipolar disorder, either psychological or psychopharmacological.
>
> 12. Respondent's medical records are four pages long and reference the initial appointment described above, two telephone conversation and to in-person visits with the final date of February 15, 2015. . . .

(Ex. 1, pp. 3-4.)

Other Findings Pertaining to the Diagnosis and Recommendation, and Subsequent Events

7. (A) The child's father testified that he was motivated to obtain marijuana for his child because of his personal experience with drugs given to him as a child for ADHD or Bipolar Disorder, and his experience with treatment for such conditions of his older child, mentioned above. Father testified that as a child, he was diagnosed with ADHD, and various medications were used on him, one after the other, and that they did not ameliorate his condition, and often had negative side effects. He described himself as a human guinea pig, describing how various medications were tried, and their dosage manipulated, and when they were not efficacious, a new drug would be tried, with the same results: manipulation of dosage, negative side effects, little benefit to L.T.

(B) L.T. testified that he did not suffer from Bipolar Disorder, but stated that is what his condition was often called, and that this was the result of misinformation being imported into Dependency Court proceedings.[4]

8. According to father, for many years he was against using any nonprescription drugs or illegal substances, but as an adult was convinced to try medical marijuana, which he obtained from Respondent some ten years ago. He found that it managed his symptoms, and he was convinced of its efficacy. He attested that it calmed him, allowed him to sleep, and that he could get up in the morning and work. He testified that he had exhibited anger towards his wife, but once he used marijuana, his angry behaviors toward his wife ceased.

9. An older son has been also diagnosed with ADHD and Bipolar Disorder. Father testified that none of the standard drugs tried on his older child helped, but when the child was an adolescent Father obtained medical marijuana for him, from Respondent, and it had a positive effect. According to father, the effect was such that in a relatively short period of time, the older boy was going to exit the special education program at his school.

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[4] Respondent believed L.T. had Bipolar Disorder because of the types of drugs that had been given to him before he consulted with Respondent.

However, the boy moved out of state with his mother, could not obtain medical marijuana in his new state, and he regressed.

10. Father testified that much of the impetus to seeing Respondent was the behavioral problems his child was having in school. He said that the boy's teacher told him he needed to get the child medicated, or he would be excluded from school.

11. After obtaining the medical marijuana medication from Respondent, Father was giving small amounts of the cannabis to T.T.in the morning, in the form of a cookie. He testified that it was having a positive effect on reducing poor behavior. He learned that in the afternoon, however, the behavior returned. Father wanted to give T.T. another small amount of the cannabis at lunch, and went to the school nurse to have her administer it. She turned the matter over to the school administration, which in turn led to efforts by the local child protective services and law enforcement to intervene.

12. Father's testimony is that the cannabis he gave T.T. helped manage the child's behavior, and he perceived no negative effects while he was able to provide it. However, due to the efforts of his local child protective services to take custody of his children, his wife took T.T. and the other children out of state, where medical marijuana was not available.

13. Respondent, after providing the recommendation to L.T., contacted him a week later to find out how things were progressing. On September 20, 2012, Respondent was told that the program was going well, and that T.T. "functions normally and correctly!" (Ex. 22, p. 4 of 5.) On October 12, 2012, Respondent learned of the school's negative reaction to the use of cannabis, that there were efforts by child protective services to take the child and his siblings from L.T. and his wife, and that the mother had left the state with T.T.

14. According to his medical record for T.T., Respondent saw him on September 13, 2013. He learned that there had been a year of problems with child protective services, that the child had not been back to school, and that they had stopped giving him cannabis, because his mother was fearful of more problems with the authorities. According to the chart notes,

> "He [T.T.] is doing relatively well, not in school so demand for drug is not there. PE: 90/60, pulse 95. Mental Status: alert, oriented, calm, smiling. Not talkative. Aware of situation with school and authorities, accepts situation. Diagnosis: ADD/BiPolar."

(Ex. 22, p. 4 of 5.)

15. Respondent's records indicate that another cannabis letter was issued in case the parents decided it was necessary "should behavior exacerbate." (Ex. 22, p. 4 of 5.)

16. It should be noted that the original diagnosis was "probable combination of ADHD/BiPolar." (Ex. 22, p. 3 of 5.) Thus, a year after the first examination of T.T., the

diagnosis had changed from a probable diagnosis to a firmer one, albeit with a different take on attention deficit problems.

17. (A) Respondent saw the child on February 20, 2015. His chart entry states that the child is doing "fairly well." He was not going to a normal school, but not being home schooled, and there was not "pressure to put him on drugs from the outside." (Ex. 22, p. 4 of 5.) His blood pressure was noted as 95/65, with a pulse of 90. His lungs were clear. Mental status was described as "alert, oriented, calm, smiling. Able to participate in conversation normally." (*Id.*)

(B) As with the chart entry for September 13, 2013, the February 20, 2015 entry states a diagnosis of "ADD/BiPolar" and it records that another cannabis letter issued for the child in case the parents decided it was necessary "should behavior exacerbate." (*Ibid.*, p. 5 of 5.)

The Complaint to the Board

18. The San Bernardino County Sheriff's Department (Sheriff's) investigated the provision of cannabis to T.T., after learning of it from the school administration. The investigators contacted Respondent in September 2012. He spoke to investigators, and he wrote to them on September 27, 2012. A copy of the letter is found in exhibit 15, p. AGO-40.[5] The investigators generated a written report, which are 103 pages long.

19. On November 14, 2014, Jennifer Burkhart, from the Sheriff's office, emailed the report to Eric Ryan. She noted she had to break the report into four separate e-mails due to its length.

20. Eric Ryan was then an investigator who worked for the Health Quality Enforcement Section of the Department of Consumer Affairs' Division of Investigation. He was stationed in San Diego.

21. Mr. Ryan had, at some time prior to that, been an investigator with the Board. However, in June 2014, the Board's investigators were transferred to the Department of Consumer Affairs' Division of Investigation.

22. Thereafter, Mr. Ryan forwarded Burkhart's e-mail and the accompanying Sheriff's report to the Board's Complaint Unit. It was received there on November 25, 2014.

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[5] This page number refers to a stamped "Bates" number. However, a handwritten number is found on each page of the exhibit, which is different from the stamped number. It appears that the handwritten page numbers paginate the report itself. The stamped numbers paginate the entire exhibit.

23. Receipt of the Sheriff's report triggered an investigation by the Board, which led to this proceeding.

Respondent's Interview by Board Representatives

24. On August 7, 2017, Respondent was interviewed by Investigator Tracy Tu and Jill Klessig, M.D., a medical consultant. Respondent's attorney, Mr. Jaffe, accompanied Respondent.

25. During the interview, Respondent stated that the patient's father told him that the child's teacher had, essentially, kicked the child out of school and told the father he couldn't come back unless he was on some drug that would manage the child's behavior. Respondent apparently took the father's claim at face value. This is based on the fact that Dr. Klessig told him that the school told investigating sheriff's that the child was not a problem, which Respondent found "hard to believe."[6] (Ex. 24A, p. 10, lines 9-18.)

26. During his interview Respondent acknowledged that he did not contact the school about the child's behavior. He could not quantify in any way how often the child had tantrums, nor could he describe their duration or the nature of the tantrums; though at one point he said he knew that the tantrums occurred on a regular basis, even more than once per day. (Ex. 24A, p. 13, lines 23-25.) He stated that the parents were able to handle the tantrums in the home, but couldn't say what they were doing, "but they didn't feel the need to give him anything medication-wise." (*Id.*, p. 14, lines17-19.) When pressed later on the nature of the tantrums, Respondent stated he could not remember. (*Id.*, see p. 14, line 20 to p. 16, line 4.)

27. Early in the interview, Respondent stated that T.T. was the only child he had treated for temper tantrums.

28. At one point in the interview Respondent described the child as agitated and nervous, but later stated that "in the office, there wasn't anything that abnormal." (Ex. 24A, p. 21, lines 10-11.)

29. When Respondent was asked how he came to the diagnosis of Bipolar Disorder, he stated he did so based on the history that the father provided. He went on to say that the father and older brother had been diagnosed with Bipolar Disorder, and that the child had "up and down, uh, behaviors that were consistent with it." (Ex. 24A, p. 21, lines 19-20.) However, he could not describe the diagnostic criteria for the malady, except to state that family history is the number one criteria. (*Id.*, lines 23-25.) Respondent claimed he

[6] There is other evidence that Respondent relied on a claim by the parent that the school, or at least the teacher, was demanding action by the parent, and had claimed the child would be excluded. Respondent stated as much in his medical record. (Ex. 22, p. 3.) And, the child's father testified to the effect that the teacher told father he would have to take such steps with his son. (Factual Finding 10.)

reviewed the diagnostic criteria before diagnosing the child as bipolar, though he was vague about when he did so.

30. Respondent was asked what the child's sleep patterns were like, and he could not remember. When pressed about whether he would normally ask about sleep patterns, Respondent first stated that in a rare case such as this one, there is no normal, implying that there was no normal course to follow. But, he then said he would have asked about sleep patterns. (Ex. 24A, p. 23, lines 15-20.) However, no entry in the child's chart refers to sleep patterns. (See ex. 22.)

31. Respondent was asked why, if the situation with the child was so rare, he did not refer the child to a pediatric psychiatrist. He stated that father was not enthusiastic about psychiatrists, having had bad results for himself and the older brother. He stated he talked to the father about the issue, but that is not set out in the chart. He could not explain why he did not do a referral to at least obtain expertise in making the diagnosis, leaving the issue of the medical response for another day.

32. When asked what other diagnostic criteria he considered (besides ADHD and Bipolar Disorder) he said he didn't really consider anything else, and when asked what was the differential diagnosis for "behavior like this," he said at first that there wasn't one, but then said alternatives could be head trauma, and he could think of no other diagnoses that could account for the child's behavior. (Ex. 24A, p. 26, line 22 though p. 27, line 17.)

33. Respondent, when asked if the cannabis was being recommended to treat the ADHD or bipolar disorder, stated that he was just treating the symptoms. (Ex. 24A, p. 28, lines 1-3.)

34. Respondent stated that the risks to a child when given small amounts of medical marijuana were minimal, that "there's pretty much no risk." (Ex. 24A, p. 29, line 25.) He could cite no authority for that position, and when asked where the American Academy of Pediatricians stood on the issue of giving cannabis to a child, Respondent did not know. (*Id.*, p. 30, lines 23-25.)

Diagnostic Criteria for ADHD and Bipolar Disorder in 2012

35. (A) During the hearing, the ALJ gave notice that he would take notice of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, commonly known as the DSM-IV-TR. That tome is a standard reference for psychologists, psychiatrists, and other medical professionals. The DSM-IV-TR was superseded by the publication of the DSM-5 in March 2013. That latest iteration made a number of changes to diagnostic categories for a number of mental health conditions. Examples include changing Mental Retardation to Intellectual Disability, adopting the Autism Spectrum Disorder while doing away with the category previously known as Pervasive Developmental Disorders, and relevant to this case, changes in the diagnostic criteria for Bipolar Disorder.

(B) Because the DSM-IV-TR was the reference manual at the time that Respondent diagnosed the child, it will be referenced in this proposed decision, and referenced simply as the DSM. If there is need to refer to the newer version, it will be referenced as the DSM-5.

36. Regarding ADHD, the DSM states that:

> The essential feature of Attention Deficit/Hyperactivity Disorder is a persistent patter of inattention and/or hyperactivity-impulsivity that is more frequently displayed and more severe than is typically observed in individuals of comparable level of development (Criterion A). Some hyperactive-impulse or inattention symptoms that cause impairment must have been present before age 7 years, although many individuals are diagnosed after the symptoms have been present for a number of years, especially in the case of individual with the Predominantly Inattentive Type (Criterion B). Some impairment from the symptoms must be present in at least two settings (e.g., at home and at school or work) (Criterion C). There must be clear evidence of interference with developmentally appropriate social, academic, or occupational functioning (Criterion D). The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and is not better accounted for by another mental disorder, (e.g., a Mood Disorder, Anxiety Disorder, Dissociative Disorder, or Personality Disorder) (Criterion E).

(DSM, p. 85.)

37. (A) The diagnostic criteria are lengthy. Criterion A requires findings of six or more symptoms of inattention, and six or more symptoms of hyperactivity and impulsivity; the symptoms are taken from a list of nine possible symptoms for each category. Further, the symptoms must have "persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level." (DSM, p. 92.)

(B) The symptoms of inattention, from which at least six must be found, are as follows:

> (a) often fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities
> (b) often has difficulty sustaining attention in tasks or play activities
> (c) often does not seem to listen when spoken to directly
> (d) often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)
> (e) often has difficulty organizing tasks and activities
> (f) often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework)

(g) often loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)
(h) is often easily distracted by extraneous stimuli
(i) is often forgetful in daily activities

(DSM, p. 92. Punctuation as in original.)

(C) The list of symptoms pertaining to hyperactivity-impulsivity are as follows:

Hyperactivity

(a) often fidgets with hands or feet or squirms in seat
(b) often leaves seat in classroom or in other situations in which remaining seated is expected
(c) often runs about or climbs excessively in situations in which it is inappropriate (in adolescents or adults, may be limited to subjective feelings of restlessness)
(d) often has difficulty playing or engaging in leisure activities quietly
(e) is often "on the go" or often acts as if "driven by a motor"
(f) often talks excessively

Impulsivity

(g) often blurts out answers before question have been completed
(h) often has difficulty awaiting turn
(i) often interrupts or intrudes on others (e.g., butts into conversations or games)

(DSM, p. 92. Italics and punctuation as in original.)

(D) If Criterion A is met, the other four criterion (B through E), described in Factual Finding 36, must be met.

(E) There can be more than one pattern of behavior, where inattention may predominate over hyperactivity-impulsivity or vice-versa. In those cases, a subtype should be indicated, based on the predominant symptom pattern for the prior six months. The subtypes are "Combined Type," Predominantly Inattentive Type," and "Predominantly Hyperactive-Impulsive Type." (DSM, p. 87.)

38. The DSM states that ADHD is more common in the first-degree biological relatives of children with ADHD than in the general population. It goes on to say that "considerable evidence attest to the strong influence of genetic factors on levels of hyperactivity, impulsivity, and inattention as measured dimensionally. However, family, school, and peer influences are also crucial in determining the extent of impairments and comorbidity." (DSM, p. 90.)

39. (A) Regarding Bipolar Disorder, it must be noted that the DSM devoted 15 pages to Bipolar I Disorder, and Bipolar II Disorder. Further various behaviors or symptoms, such as a "mixed episode" which are components of the symptoms are defined at other parts of the DSM; their descriptions cover many pages. Some aspects of this mental illness as defined in the DSM will be summarized, in order to avoid a prolix discussion.

(B) At the outset of the chapter pertaining to Bipolar Disorder, it is stated that that there are six separate criteria sets for Bipolar I Disorder: Single Manic Episode, Most Recent Episode Hypomanic, Most Recent Episode Manic, Most Recent Episode Mixed, Most Recent Episode Depressed, and Most Recent Episode Unspecified. The first noted, Single Manic Episode, is used to describe someone who are having a first episode of mania. The other five categories are used to specify the nature of the current or most recent episode in individuals who have had recurrent mood episodes. (DSM, p. 382.)

(C) According to the DSM, the essential feature of Bipolar I disorder is a clinical course characterized by the occurrence of one or more Manic Episodes, or Mixed Episodes. (DSM, p. 382.) Manic Episodes are defined by a distinct period in which there is an abnormally and persistently elevated, expansive, or irritable mood. The period must last for at least a week. Other symptoms accompany the episode, including but not limited to inflated self-esteem, decreased need for sleep, and pressure of speech. (*Id.*, p. 357.) A Mixed Episode is characterized by a period of time, lasting at least one week, in which the criteria are met for both a Manic Episode and a Major Depressive Episode, nearly every day. This mood disturbance is severe enough that it causes marked impairment in occupational functioning or in usual social and personal relationships. (*Id.*, pp. 362, 365.)

(D) The average age of onset for Bipolar I Disorder is 20, for both men and women. (DSM, p. 386.)

40. Bipolar II Disorder has a clinical course that is characterized by the occurrence of one or more Major Depressive Episodes accompanied by at least one Hypomanic Episode. (DSM, p. 392.) As part of the diagnostic criteria, there could never be a Manic Episode or a Mixed Episode. (*Id.*, p. 397.)

T.T.'s Subsequent Diagnosis of Disruptive Mood Dysregulation Disorder

41. On December 31, 2016, T.T. was admitted to Del Amo Hospital in Torrance, California. His admission diagnosis was Disruptive Mood Dysregulation Disorder (DMDD). He was discharged on January 3, 2017. He was then in the fourth grade. (Ex. 32, p. 5.)

42. The chief complaint on admission is that the child had been acting out, violently, with younger siblings, intimidating them, punching them, and being defiant and exhibiting rage. He had tried to smother his four-year-old brother during a monitored visitation.

43. DMDD is a Depressive Disorder under the DSM-5. According to Dr. Raiss, a psychiatrist and one of the Board's experts, it came about because too many adolescents were being diagnosed as Bipolar. According to the DSM-5, "the core feature of [DMDD] is chronic, severe persistent irritability." (DSM-5, p. 156.) The DSM-5 confirms that the diagnosis was developed for inclusion in the DSM-5 because of issues with diagnosis of children as being Bipolar: "In fact, [DMDD] was added to the DSM-5 to address the considerable concern about the appropriate classification and treatment of children who present with chronic, persistent irritability relative to children who present with classic (i.e., episodic) bipolar disorder." (DSM-5, p. 157.)

44. Further explanation is provided. The authors of the DSM-5 noted there had been a sharp increase in diagnosis of children as having Bipolar Disorder, and that such appeared to have resulted from clinicians combining two clinical presentations into one category. "That is, both classic, episodic presentations of mania, and non-episodic presentations of irritability have been labeled as bipolar disorder in children." (DSM-5, p. 157.)

45. DMDD must have onset before age 10, and it should not be applied to children younger than six. "Age-related variations also differentiate classic bipolar disorder and [DMDD]. Rates of bipolar disorder generally are very low prior to adolescence [less than one percent], with a steady increase into early adulthood [one to two percent prevalence]." (DSM-5, p. 157.)

The Standard of Care for Diagnosing Bipolar Disorder or ADHD

46. (A) Diagnosis of mental health issues for a child require, at least, the physician to review the main complaint, the history of the present illness, history of prior treatment, family history, and the child's developmental history. The physician should conduct a mental status exam. Much of that information would have to come from an adult reporter, such as a parent or guardian.

(B) As to Bipolar Disorder, the physician should review the diagnostic criteria set out in the DSM, and search for symptoms of the type recognized by the DSM as indicators of that malady, such as mood, sleep patterns, disorganized thinking or flight of ideas.

(C) As to diagnosing ADHD, the physician should again be informed by the DSM, and should look for evidence of whether any of the nine symptoms of inattention, and of the nine indicators of hyperactivity/impulsivity exist, and note which ones. Furthermore, one should obtain feedback from teachers, because ADHD must exhibit itself in more than one environment.

47. Dr. Raiss testified credibly that rating scales are available to forward to a teacher to obtain feedback that would inform the diagnostic process.

48. The standard of care required Respondent to refer the subject child patient to a specialist in order to confirm whether the child suffered from Bipolar Disorder.

Respondent's Diagnosis of Bipolar Disorder and ADHD Did Not Meet the Standard of Care

49. (A) Respondent's diagnosis, whether "probable" or otherwise, did not comport with the standard of care. There is no evidence whatsoever that he consulted the DSM, virtually the Bible of mental health diagnosis. There is no indication that he sought information about T.T.'s moods, sleep patterns, any depression, or any of what Dr. Raiss referred to as pillars of the diagnosis. As noted by Complainant's other expert, Bridget Briggs, M.D., there was no indication of depression, a core symptom of Bipolar Disorder.

(B) Likewise, Respondent did not look to find any of the symptoms of inattention or hyperactivity or impulsivity, as required by the DSM. Nothing in his chart refers to any of the criteria.

50. Nothing in Respondent's chart notes for the September 2012 visit indicate that the child was then suffering from ADHD or Bipolar Disorder. Tantrums alone, and primarily exhibited in one environment (school), do not support either diagnosis. Indeed, his notes would not support a diagnosis of DMDD either. Being "agitated from the stress of the day in school, coming to the doctor" does not resonate with the diagnostic criteria. (Ex. 22, p. 3 of 5.) Being "agitated" and having "trouble sitting still" hint at ADHD, but could simply hint at a preschooler not happy to have driven many miles to a doctor's appointment.[7]

51. Respondent did not seek the opinion of a specialist to reach the correct diagnosis, and did not recommend such action to the father. As pointed out by Dr. Briggs, failure to seek a specialist in determining if there was ADHD was not so critical, but when it came to Bipolar Disorder, referral to a specialist should have been recommended. It is plain that Respondent, who holds himself out as a consultant, is not a specialist of the type that should be utilized to diagnose Bipolar Disorder in a five-year-old child. Even if the father did not want to pursue the traditional psychopharmacological response to ADHD or Bipolar Disorder, making an accurate diagnosis was crucial; it carries life-long significance.

52. It is clear from his interview with the Board that Respondent had not even a basic understanding of the diagnostic criteria for either ADHD or Bipolar Disorder, and he primarily relied on the family history. Family history is not itself a symptom of either condition, as shown by Factual Findings 35-40. Rather, family history is a factor for consideration in analyzing a patient's symptoms.

53. It is clear from his Board interview that Respondent looked to the family history and used that to make his diagnoses; no differential diagnosis was attempted. He

[7] The record indicates the family lived in Victorville, while Respondent's office was in Hollywood, a significant drive through Southern California traffic.

appeared ignorant of other possible explanations, medical or otherwise, for the tantrums at school. Given that it was early in the school year, the child's behavior might have been a function of separation anxiety of the type exhibited by young children when they begin school. But, Respondent clearly did not look to simpler explanations. Given that the average age of onset for Bipolar Disorder is 20 year of age, and because Bipolar Disorder occurs prior to adolescence in less than one percent of cases (Factual Finding 45) other explanations for the child's tantrums should have been considered.[8]

54. The subsequent diagnoses pronounced by Respondent in September 2013 and February 2015, of ADD/Bipolar Disorder, and the lack of symptoms shown by T.T. on those dates further discredit the original diagnosis. Each of those diagnoses was erroneous, made through violation of the standard of care. No explanation is given regarding the change of diagnosis from ADHD to ADD, or whether Respondent was just inexact in his notes. That the chart entry shows that the child was doing better, without any treatment, including the use of medicinal marijuana, undercuts the initial diagnosis, as well as those of September 2013 and February 2015. The chart notes from the later visits show there were less symptoms reported than were reported in 2012, and the seeming improvement is tied to not having the stress of school. Neither ADHD nor Bipolar Disorder are caused by stress in one environment; the deleterious effects of either condition are ongoing, though with Bipolar Disorder one should expect a series of days-long "episodes" of manic, hypomanic, or depressive behavior.

The Recommendation of Medicinal Marijuana for Treatment of T.T.

55. Complainant asserted that Respondent was grossly negligent when he recommended medical marijuana for T.T., a position supported by her experts. In the main, Dr. Raiss believes it is medical marijuana is not efficacious, not supported by evidentiary analysis. He opined that available literature indicates providing cannabis to a child could be harmful, and that Respondent should have used traditional medications that are prescribed for either ADHD or Bipolar Disorder, such as Ritalin, before recommending medical marijuana. In his report, Dr. Raiss cited studies associating adolescent marijuana use with later schizophrenia. Dr. Briggs, when testifying for Complainant, opined that cannabis simply should not be given to a child, let alone one this young. She was of the opinion that the standard of care required Respondent to use interventions approved and recommended by various boards that certify the training and skills of pediatricians and psychiatrists. She believed that the available literature supported her view that there was an undue risk to the child patient if marijuana was administered to the child due to the perceived ADHD or Bipolar Disorder.

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[8] Dr. Briggs testified that the diagnosis of Bipolar Disorder would be "incredibly uncommon" in a five-year-old child. (Reporter's Transcript, vol. II, p. 98, line 17.) That view is consistent with the statements made by William Murdoch, M.D., to Sheriff's investigators, that the youngest child to be reported to have Bipolar Disorder was a six-year-old on the east coast. (Ex. 15, p. AGO 12.)

56. Respondent's experts differed sharply with Dr. Raiss and Dr. Briggs. Dr. Herganrather, who has recommended medical marijuana in a variety of situations for many years, testified that he has recommended marijuana to children with great success. This includes children with genetic disorders, autism, seizure disorders, mood and behavioral disorders, and cancer. He asserted that the literature available has mostly been produced by the National Institute of Drug Abuse (NIDA), which he asserts is not engaged in research into beneficial use of cannabis, but into its abuse. The studies often looked at heavy users, who may also smoke and drink, confounding analysis of the effect of cannabis on young patients. Dr. Herganrather made a good case that much of the negative medical literature is not especially useful in this case, or in any other. Dr. Herganrather did acknowledged the lack of studies, which are difficult to conduct given federal proscription of marijuana use, that support use in patients, including children.

57. Dr. Scherger, who was Respondent's practice monitor when Respondent was on probation during the period between 2004 to 2009, testified that Respondent did not violate the standard of care by recommending marijuana to T.T. He noted the positive report by Father that ingesting the cannabis-laced cookie had a positive effect on the child's behavior.

58. (A) There was some discussion and disagreement about the importance and relevance of a 2012 report by Meier et. al. which was based on the Dunedin Longitudinal Study. That study was based on a sample that was in turn made up of all births at Dunedin's Queen Mary Hospital between April 1972 and March 1973, and which followed persons in the birth cohort for 38 years. Regarding cannabis use, it was reported by Meier that "'. . . persistent cannabis use was associated with neuropsychological decline broadly across domains of functioning,'" and it was further reported that "'. . . impairment was concentrated among adolescent-onset cannabis users, with more persistent use associated with greater decline.'" (Ex. 41, p. 1.) It should be noted that the issue of "persistent" use was important, as the report also stated that those in the Dunedin study who did not report regular use showed no decline in IQ or neuropsychological performance. (*Id.*, p. 2.)

(B) Respondent pointed to a publication which asserted that socio-economic status could have accounted for the results reported by Meier. The author, Ole Rogeberg, concluded that an alternative confounding model based on time-varying effects of socioeconomic effect on IQ indicated that Meier's likely over-estimated the effects of cannabis use in adolescents and young adults, and the effect could even be zero. While it was asserted that Rogeberg is an economist, and not a medical professional, his analysis was, essentially, focused on Meier's methodology and statistical analysis, and Rogeberg used other statistical methods to come to his conclusions. (See ex. 43.)

59. A study of nearly 70 studies of cannabis users was published by the American Medical Association in June 2018. It is titled "Association of Cannabis With Cognitive Functioning in Adolescents and Young Adults—A Systematic Review and Meta-Analysis" (Ex. 39.) In the section entitled "Conclusions and Relevance," the authors state:

> Associations between cannabis use and cognitive functioning in cross-sectional studies of adolescents and young adults are small and may be of questionable clinical importance for most individuals. Furthermore, abstinence of longer than 72 hours diminishes cognitive deficits associated with cannabis use. Although other outcomes (eg. psychosis) were not examined in the included studies, results indicate that previous studies of cannabis in youth may have overstated the magnitude and persistence of cognitive deficits associated with use. Reported deficits may reflect residual effects from acute use or withdrawal. Future studies should examine individual differences in susceptibility to cannabis-associated cognitive dysfunction.

(Ex. 39, p. 1.)

60. In a sense, the medical literature cannot be said to weigh heavily against use of medical marijuana to treat a child for ADHD or a mood disorder, even if the literature does not weigh heavily in favor of its use. In this case Father, rightly or wrongly, did not want to utilize the typical drugs, due to his own experience as a child, and with his older child. It should be noted that Dr. Raiss explained that a psychiatrist like himself would prescribe one of the drugs in the standard arsenal, and that the dosage would have to be titrated, to assess the effectiveness of the drug. If it did not work well, or had too many side-effects, another medication would be tried. This mirrors the process that Father went through as a child.

Plainly, the standard medical response has no sure fire success, and the side effects of the usual medications may be pernicious.[9]

61. The record shows that Father was knew of his choices in how to respond to T.T.'s condition. For Respondent to recommend a small amount of medical marijuana as first response alone does not violate the Board's written statement regarding the use of medical marijuana (ex. 20); they do not bar cannabis as a first-line response. There would have to be some feedback about the effectiveness of the cannabis (which Father initially provided), and whether more or less should be provided, which process mirrors the process that Dr. Raiss would use with pharmacological agents.

62. It has not been established, by clear and convincing evidence, that the recommendation of medical marijuana to T.T., with his father's consent, violated the standard of care. At bottom, the literature does not drive a finding that he did, and the split opinions of the experts, and Dr. Herganrather's positive experience with providing children with medical marijuana, make the matter less than clear.[10]

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[9] Dr. Klessig, during Respondent's interview by the Board, stated her personal (as opposed to the Board's) opinion that "kids are over-medicated with all that . . . other stuff, too." (Ex. 24A, p. 41, lines 8-10.)

[10] During cross examination, Dr. Raiss was asked if he agreed with the allegation, in the Accusation, to the effect that "there is evidence of adverse effects of marijuana on the age

The Medical Records Are Adequate

63. It was alleged, as Fourth Cause for Discipline, that Respondent was subject to discipline for failure to maintain adequate and accurate records. The allegation is based on the allegations set out in paragraphs 9 through 12 of the Accusation, a part of which are admitted by Respondent.

64. While the records do not support the diagnosis, they do set out a history, results of some physical examination, a diagnosis, and a plan to deal with the perceived problem.

65. Dr. Raiss in his report did not address Respondent's records. He did not provide testimony about the chart, from a record-keeping perspective. Neither did Dr. Briggs. On the other hand, Dr. Scherger, who had served as Respondent's practice monitor, opined that during that period he would have considered the records, as written, to be accurate.

66. The weight of the evidence does not support the allegation that Respondent failed to make and keep accurate and adequate medical records.

Respondent's Disciplinary History

67. On May 24, 2002, an ex parte Interim Order of Suspension (also known as an Interim Suspension Order or ISO) was issued against Respondent. That ISO was issued based on findings that Respondent had, in four cases, issued recommendations that people who were ostensibly his patients use medicinal marijuana. In fact, each of the four persons were undercover investigators. The evidence was that these four individuals did not have serious or substantial medical problem, that Respondent did not examine them, and Respondent had no reasonable basis for making any treatment recommendations.

68. On October 1, 2002, a noticed hearing on the petition for ISO occurred. It involved the same factual issues that were at issue in the ex parte ISO proceeding, that is, Respondent's issuance of recommendations for medical marijuana to four undercover operators. On October 9, 2002, the petition was granted, and Respondent's certificate was suspended pending the outcome of a disciplinary proceeding then pending against Respondent.

69. Prior to the time of the ex parte Petition for ISO, Complainant's predecessor had filed an Accusation against Respondent, seeking to discipline his certificate. That proceeding was initiated on July 13, 2001. That proceeding, *In the Matter of the Accusation*

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group . . . [of] a 4 year old just about to turn five." He testified that the statement is not accurate. He then discussed that the available literature had looked at adolescents, but had not looked at children either smoking or using marijuana. (Reporter's Transcript, vol. I, p. 125, line 23 to p.126, line 5.)

Against William s. Eidelman, M.D., case no. 06-2000-108619, OAH case no. 2000080183, alleged that Respondent, had provided medical marijuana recommendations without a good faith examination, without adequate follow-up, and failing to keep adequate records. Further, it was alleged that Respondent aided and abetted the unlicensed practice of medicine.

70. Subsequently, a First Amended and a Second Amended Accusation were filed against Respondent. The effect of the amendments, generally, was to add allegations pertaining to other patients, either actual or undercover investigators posing as patients.

71. (A) A hearing was held before H. Stuart Waxman, ALJ, on several days in February 2004, and on one day in April of that year. On May 21, 2004, ALJ Waxman issued his proposed decision, which was adopted by the Board and made effective on July 6, 2004.

(B) In a lengthy and detailed decision, ALJ Waxman found numerous departures from the standard of care. He concluded that cause was established to discipline Respondent's certificate for gross negligence, repeated negligent acts, incompetence, furnishing dangerous drugs without a good faith examination, dishonesty and false representations, aiding and abetting the unlicensed practice of medicine, failure to maintain adequate records, and for using a fictitious business name without approval. Judge Waxman rejected a number of Respondent's defenses, including that he had immunity based on the Compassionate Use Act.[11]

(C) Notwithstanding these serious violations, Respondent's certificate was placed on probation for five years, subject to a number of conditions, including that Respondent's practice be monitored, and that he attend a recordkeeping course.

72. On February 20, 2007, Complainant's predecessor filed an Accusation and Petition to Revoke Probation against Respondent, in case number D1-2000-108619, OAH number 200050035. A hearing in that matter took place in June 2009 before ALJ Samuel D. Reyes.

73. (A) ALJ Reyes found that in connection with one patient, Respondent had engaged in repeated negligent acts, and that he had failed to maintain adequate records. However, it was noted that at around the time of his examination and treatment of the patient, Respondent, with the help of his practice monitor, continued his then-ongoing efforts to improve his recordkeeping practices, which efforts had been underway since Respondent had

[11] In one instance, an undercover officer saw Respondent purporting to be a new patient. The officer did not claim a serious medical condition. Respondent asked if the "patient" was in pain, and the latter said after workouts. Respondent asked if the patient was depressed, and the latter said he was not. "Respondent then asked if [patient] would get depressed if he did not have marijuana, and [patient] answered affirmatively. Respondent then provided [patient] with a recommendation letter for medical marijuana." (Ex. 10, p. 18, Factual Finding 56.)

completed his record keeping class. Therefore, probation was not revoked; rather, Respondent's license was reproved.

(B) The Board adopted the proposed decision issued by ALJ Reyes on September 9, 2009, the adoption order being effective October 5 of that year.

74. On October 30, 2009, the Board ordered Respondent's certificate fully restored, effective October 6, 2009. Since that time, this matter is the only one brought against Respondent.

LEGAL CONCLUSIONS

General Principles Applied In This Case

1. (A) The standard (as opposed to the burden) of proof applicable to the Complainant in this proceeding was that of clear and convincing evidence, to a reasonable certainty. *(Eittinger v. Bd. of Med. Quality Assurance* (1982) 135 Cal.App.3d 853.) Complainant was obligated to adduce evidence that was clear, explicit, and unequivocal—so clear as to leave no substantial doubt and sufficiently strong as to command the unhesitating assent of every reasonable mind. (*In Re Marriage of Weaver* (1990) 224 Cal.App.3d 278.)

(B) On the other hand, where Respondent was burdened with proving some defense, such as the bar of the statute of limitations, he was required only to prove the factual basis of such by a preponderance of the evidence. (Evidence Code, sections 500 and 115.)

2. A professional is negligent if he or she fails to use that reasonable degree of skill, care, and knowledge ordinarily possessed and exercised by members of the profession under similar circumstances, at or about the time of the incidents in question. Just what that standard of care is for a given professional is a question of fact, and in most circumstances must be proven through expert witnesses. *(Flowers v. Torrance Memorial Hospital Medical Center* (1994) 8 Cal.4th 992, 997-998, 1001; *Alef v. Alta Bates Hospital* (1992) 5 Cal.App. 4th 208, 215; *see* 6 B. Witkin, *Summary of California Law* (9th Ed.), *Torts*, sections 749, 750, and 774.) However, in some cases the standard may be defined by a statute or regulation.

3. The Business and Professions Code[12] does not define what "gross negligence" means in proceedings of this type. However, the Court of Appeal addressed this matter in *Kearl v. Board of Medical Quality Assurance,* (1986) 189 Cal.App.3d 1040. There the Second District Court of Appeal stated:

[12] All statutory references shall be to the Business and Professions Code unless otherwise noted.

> Gross negligence is "'the want of even scant care or an extreme departure from the ordinary standard of conduct.'" (*Cooper v. Board of Medical Examiners* (1975) 49 Cal.App.3d 931, 941 [123 Cal.Rptr.[page 1053], quoting from *Van Meter v. Bent Construction Co.* (1956) 46 Cal.2d 588, 594 [297 Cal.Rptr. 644].) The use of the disjunctive in the definition indicates alternative elements of gross negligence—both need not be present before gross negligence will be found. (*Gore v. Board of Medical Quality Assurance* (1980) 110 Cal.App.3d 184, 196-197 [167 Cal.Rptr. 881].)[13]

(189 Cal.App.3d at 1052-53.)

4. The terms "negligent" and "incompetent" are not synonymous. (*Pollak v. Kinder* (1978) 85 Cal.App.3d 833, 838.) "[A] licensee may be competent or capable of performing a given duty but negligent in performing that duty." (*Ibid.*) While *Pollak* involved a single act of negligence by an insurance broker, as opposed to repeated negligent acts, and incompetence was not found, the Court made clear that incompetence may be found where a licensee demonstrates a "general lack of present ability to perform a given duty". (*Pollack, supra*, 85 Cal.App.3d at 837; *see also James v. Bd. of Dental Examiners* (1985) 172 Cal.App.3d 1096, at 1109: "Incompetence generally is defined as a lack of knowledge or ability in the discharging of professional obligations. Often, incompetency results from a correctable fault or defect.")

5. (A) Complainant has alleged general unprofessional conduct by Respondent. That term has been defined in *Shea v. Board of Medical Examiners* (1978) 81 Cal.App.3d 564. There the Medical Board initiated disciplinary proceedings against a physician for "unprofessional conduct" without specifying any particular subsection of the enabling statute. That statute, former section 2361, then stated that "unprofessional conduct includes, but is not limited to" various acts enumerated thereafter in the statute. (81 Cal.App.3d at 575.)

(B) The Court of Appeal held that while an overly broad connotation cannot be given to the term "unprofessional conduct," and that it must relate to conduct indicating an unfitness to practice, the meaning was not confined to those matters specifically set forth in the statute. Instead, "[un]professional conduct is that conduct which breaches the rules or ethical code of a profession, or conduct which is unbecoming a member in good standing of a profession." (81 Cal.App.3d at 575.)

6. (A) It is settled 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." (*Stevens v. Parke Davis & Co.* (1973) 9 Cal.3d 51, 67.) The trier of fact may also "reject part of the testimony of a witness, though not directly contradicted, and combine the accepted portions with bits of testimony or inferences from the testimony of other witnesses thus weaving a

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[13] The disjunctive definition set forth in *Gore* was also followed in *Yellen v. Bd. of Med. Quality Assurance* (1985) 174 Cal.App.3d 1040, 1058

cloth of truth out of selected material." (*Id.*, at 67-68, quoting from *Neverov v. Caldwell* (1958) 161 Cal.App.2d 762, 767.) Further, the fact finder may reject the testimony of a witness, even an expert, although not contradicted. (*Foreman & Clark Corp. v. Fallon* (1971) 3 Cal.3d 875, 890.) And, the testimony of "one credible witness may constitute substantial evidence", including a single expert witness. (*Kearl v. Board of Medical Quality Assurance, supra*, 189 Cal.App.3d at 1052.)

(B) The rejection of testimony does not create evidence contrary to that which is deemed untrustworthy. Disbelief does not create affirmative evidence to the contrary of that which is discarded. The fact that a trier of fact may disbelieve the testimony of a witness who testifies to the negative of an issue does not of itself furnish any evidence in support of the affirmative of that issue, and does not warrant a finding in the affirmative thereof unless there is other evidence in the case to support such affirmative. (*Hutchinson v. Contractors' State License Bd* (1956) 143 Cal.App.2d 628, 632-633, quoting *Marovich v. Central California Traction Co.* 191 Cal.295, 304.)

(C) As stated by the Court of Appeal in *Meiner v. Ford Motor Co.*, (1971) 17 Cal.App.3d 127, 140, "On the cold record a witness may be clear, concise, direct, unimpeached, uncontradicted -- but on a face to face evaluation, so exude insincerity as to render his credibility factor nil. Another witness may fumble, bumble, be unsure, uncertain, contradict himself, and on the basis of a written transcript be hardly worthy of belief. But one who sees, hears and observes him may be convinced of his honesty, his integrity, his reliability." In this case the undersigned has considered such factors in assessing the credibility of witnesses.

Legal Conclusions Dispositive of the Case

7. The legislature promulgated a statute of limitations that governs the Board's disciplinary actions; it is found at section 2230.5. Section 2230.5, subdivision (a), provides in pertinent part:

> Except as provided in subdivisions (b), (c), and (e), any accusation filed against a licensee pursuant to Section 11503 of the Government Code shall be filed within three years after the board, or a division thereof, discovers the act or omission alleged as the ground for the disciplinary action, or within seven years after the act or omission alleged as the ground for disciplinary action occurs, whichever occurs first.

8. (A) The Board adopted a regulation to be used in interpreting section 2230.5. That regulation is found at California Code of Regulations (CCR), title 16, section 1356.2.[14] CCR section 1356.2, subdivision (a) states in pertinent part:

[14] Further citations to the CCR shall be to title 16 thereof.

> For purposes of Section 2230.5 of the code, the word "discovers" means, with respect to each act or omission alleged as the ground for disciplinary action:
>
> (1) The date the board received a complaint or report describing the act or omission.

(B) Subdivision (b)(1) defines "complaint" as a "written complaint from the public or a written complaint generated by board staff that names a particular physician." Subdivision (b)(2) defines a "report" as "any written report required under the code to be filed with the board but does not include a notice filed under CCR sec. 364.1."

9. The receipt of the Sheriff's investigation report at the Department's Division of Investigation was not the receipt of that document by the Board. From the record it is clear that the Division of Investigation, although it provides investigation services for the Board, is a separate organization. The Division of Investigation in turn has a separate unit, the Health Quality Investigation Unit, which serves not only the Board, but several other agencies that license health care providers, such as the Board of Podiatric Medicine and the Board of Psychology. (§ 159.5, subd. (b)(1). See also, § 160.5,subd. (b).) The report was received at the Board's Complaint Unit on November 25, 2014, leaving the statute of limitations open until November 25, 2017. The filing of the Accusation herein was within the statute of limitations. (Factual Findings 5, 18-23.)

10. (A) Respondent asserts that he is immune from Board action pursuant to Health and Safety Code section 11362.5, subdivision (c), which states that "notwithstanding any other provision of law, no physician in this state shall be punished, or denied any right or privilege, for having recommended marijuana for medical purposes. He made the same claims to Judge Waxman and Judge Reyes, and failed in each case, as he must here.

(B) First of all, the Board adopted a precedential decision that pertains to this issue, after the first proceeding against Respondent, and before the second. (*In the Matter of the Accusation Against Tod H. Mikuriya,* M.D. (2007) Precedential Decision No. MBC-2007-02Q.) As noted by Judge Reyes, the Board concluded that the immunity is qualified, and that it does not exempt a physician from standards or regulations generally applicable to physicians, including those that govern the manner or process by which the physician's recommendation was reached. (Ex. 12, p. 17-18.)

(C) Judge Waxman had reached similar conclusion, pointing out that Respondent was not being disciplined because he recommended marijuana for medical purposes, but for a variety of other reasons relating to the methods he followed in arriving at the recommendation. (Ex. 10, p. 46.)

(D) The same reasoning applies here. Respondent made a diagnosis without adequate basis, and without adequate research and study. He is not immunized for making a diagnosis that was grossly negligent. The immunity defense fails.

11. Respondent's certificate is subject to discipline pursuant to section 2234, subdivision (b), for gross negligence in his care and treatment of T.T., by diagnosing him with ADHD and Bipolar Disorder, based on Legal Conclusions 1 through 3, and Factual Findings 1 through 54.

12. It was established that Respondent is subject to discipline for repeated negligent acts pursuant to section 2234, subdivision (c), in connection with his care and treatment of T.T., in that he made erroneous diagnoses of the child on three occasions, in September 2012 and 2013, and February 2015. This Conclusion is based on Legal Conclusions 1 and 2, and Factual Findings 1 through 54.

13. Respondent's certificate is subject to discipline for incompetence pursuant to section 2234, subdivision (d), for his care and treatment of T.T., based on Legal Conclusions 1, 2, and 4, and Factual Findings 1 through 54. He demonstrated ignorance of the diagnostic criteria for ADHD and Bipolar Disorder, and in how those disorders should be diagnosed, and he failed to recommend assessment of the child by a qualified specialist, among other things.

14. It was not established that Respondent's certificate should be disciplined pursuant to section 2266 for failing to maintain adequate and accurate records, based on Factual Findings 63 through 66.

15. Respondent's certificate is subject to discipline for general unprofessional conduct pursuant to section 2234, though his care and treatment of T.T., based on Legal Conclusions 1, 2, and 5, and Factual Findings 1 through 54.

16. Allegations or claims upon which findings or conclusions are not made are deemed unproven, or surplusage.

17. (A) Under the Board's Disciplinary Guidelines, Respondent is subject to an order ranging from revocation stayed, with probation, through revocation. This is Respondent's third disciplinary proceeding. Although he did not outright suggest a diagnosis that would justify a marijuana recommendation, as he did in his first proceeding (see Factual Finding 71), he all but made one up out of whole cloth, having no real knowledge of the diagnostic criteria, or proper diagnostic process, to determine if a child is suffering from either ADHD or Bipolar Disorder. His stated reliance on family history alone indicates incompetence.

(B) It was not established that the child was harmed by Respondent's actions, but Complainant need not establish that harm occurred. (*Kearl v. Board of Medical Quality Assurance* (1986) 189 Cal.App.3d 1040, 1053.) There was significant threat of harm in this case. Dr. Briggs pointed out that labelling a child with a significant mental condition can be harmful, and this resonates with the ALJ, who has held several hundred hearings or mediations for 10 of the state's 21 regional centers, and for schools in the special education

context.[15] Diagnostic labels can follow the child for life, and if those labels are incorrect, pernicious results may follow. In any event, proper diagnosis is the foundation of any subsequent medical action, and Respondent made little or no effort to acquaint himself with the then-prevailing diagnostic criteria.

(C) To be sure, not all of the claims have been proven against Respondent. It appears reasonable minds can, and did, differ over whether or not cannabis should be given in low amounts to a child who suffered from ADHD or Bipolar Disorder, as Respondent concluded. However, before such a step was taken, a proper diagnosis should have been made, and Respondent, through ignorance and neglect, failed to make a proper diagnosis.

(D) The purpose of hearings of this type is to protect the public, and not to punish an errant practitioner. (*Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 784-786; *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d 1471, 1476.) At the same time, public protection is the Board's highest priority. (§ 2229.) Respondent has had two opportunities to consider his practice methods and their shortcomings, and he has not learned from those cases. Public protection requires the revocation of Respondent's certificate.

ORDER

The Physician's and Surgeon's certificate issued to Respondent William S. Eidelman, M.D., number G 32011, is hereby revoked.

DATED: November 6, 2018

DocuSigned by:
Joseph D. Montoya
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JOSEPH D. MONTOYA
Administrative Law Judge
Office of Administrative Hearings

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[15] The regional centers provide services to the developmentally disabled pursuant to the Lanterman Developmental Disabilities Services Act (Lanterman Act), California Welfare and Institutions Code, section 4500, et seq. While ADHD is not an eligible condition for regional center services, whether a child has or does not have that condition is often an issue, and hence the ALJ had a passing familiarity with it. This is relevant because the ALJ may evaluate evidence based on his experience and training. (Govt. Code, § 11425.50, subd. (c).)

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FILED
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
SACRAMENTO November 22 2017
BY: R. Voong ANALYST

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

In the Matter of the Accusation Against: **William S. Eidelman, M.D.** **1654 N. Cahuenga Blvd.** **Los Angeles, California 90028** **Physician's and Surgeon's Certificate No. G 32011,** Respondent.	Case No. 800-2014-010147 **ACCUSATION**

Complainant alleges:

PARTIES

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

2. On or about July 1, 1976, the Medical Board issued Physician's and Surgeon's Certificate Number G 32011 to William S. Eidelman, M.D. (Respondent). The Physician's 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, 2019, unless renewed.

JURISDICTION

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

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

5. Section 2234 of the Code, states:

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

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

"(b) Gross negligence.

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

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

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

"(d) Incompetence.

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

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

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

proposed registration program described in Section 2052.5.

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

6. Section 2262 of the Code states:

AAltering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct.

AIn addition to any other disciplinary action, the Division of Medical Quality[1] or the California Board of Podiatric Medicine may impose a civil penalty of five hundred dollars ($500) for a violation of this section."

7. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

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

9. On or about September 13, 2012, Respondent[2] had an appointment with a four-year-old boy, A.A.[3] During the appointment, the boy and his father, L.T.S., were in the room. Respondent talked with each of them at various times for a total of approximately 20 minutes. Respondent had treated L.T.S. in the past and provided him recommendations for marijuana for medical purposes. The chief complaint for the child was that he had episodes of uncontrollable

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[1] References to the Division of Medical Quality is deemed by Business and Professions Code section 2002 to refer to the Board.

[2] Respondent indicates that he began practicing nutritional medicine around 1990 and his practice evolved to recommending marijuana for medical purposes around 1997. He has not had privileges at any hospitals or institutions. He is not a specialist in psychiatry, pediatrics or pediatric psychiatry.

[3] The child and his father are identified by random initials to protect their privacy. Respondent will be provided notice of their identities during discovery.

behavior and temper tantrums. Respondent primarily spoke with L.T.S. during the appointment. Respondent noted that the boy was normal appearing, agitated from the stress of the day in school, coming to the doctor, alert, oriented, appropriate, but agitated, and having trouble sitting still. No looseness of association was noted. He was not talkative and answered questions. L.T.S. and an older sibling of A.A. were diagnosed with attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD) and bipolar and were put on drugs for both. They found cannabis more effective.

10. Respondent did not observe the boy having a temper tantrum or uncontrollable behavior, but he did not attempt to contact the school or obtain further information from the school. He did not seek to obtain other medical records of the boy. He did not refer the boy to a pediatrician, psychiatrist or pediatric psychiatrist. Instead, after the twenty to thirty-minute interview with the child and his father, Respondent documented a diagnosis for the boy as a "probable combination of ADD/ADHD or bipolar." Respondent did not document how A.A. met any of the criteria for the attention deficit hyperactivity disorder or bipolar disorder.

11. Respondent documented the plan to "try cannabis in small amounts in cookies." He later indicated that he would let L.T.S. determine the dosage to be given to the boy. Respondent signed a letter that day stating that A.A. is under his medical care and that A.A. reports that cannabis relieves his medical symptoms. In the letter, Respondent indicates that he recommends/approves of his patient's use of cannabis pursuant to the Compassionate Use Act. He indicates he will continue to monitor A.A.'s condition and provide advice on his progress. It indicates that the recommendation letter is valid for one year. Respondent did not try or recommend any standard treatments for ADHD or bipolar disorder, either psychological or psychopharmacological.

12. Respondent's medical records are four pages long and reference the initial appointment described above, two telephone conversations and two in-person visits with a final date of February 20, 2015. Respondent subsequently indicated a lack of familiarity with any peer-reviewed scientific literature regarding the side effects of cannabis use in children and adolescents under the age of 18 years old.

13. Respondent committed gross negligence in his care and treatment of patient A.A. when he diagnosed A.A. with ADD/ADHD and bipolar disorder based on nothing more than a twenty to thirty-minute interview of the child and his father.

14. Respondent committed gross negligence in his care and treatment of patient A.A. when he recommended cannabis as a first-line treatment of ADD/ADHD and bipolar disorder despite evidence of adverse effects of marijuana on the age group.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

15. Respondent is subject to disciplinary action under section 2234, subdivision (c), in that he was negligent in his care and treatment of patient A.A. The circumstances are as follows:

16. Paragraphs 9 through 12 are incorporated here as if set forth in full.

17. Respondent committed negligence in his care and treatment of patient A.A. when he diagnosed A.A. with ADD/ADHD and bipolar disorder based on nothing more than a twenty to thirty-minute interview of the child and his father.

18. Respondent committed negligence in his care and treatment of patient A.A. when he recommended cannabis as a first-line treatment of ADD/ADHD and bipolar disorder despite evidence of adverse effects of marijuana on the age group.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

19. Respondent is subject to disciplinary action under section 2234, subdivision (d), in that he demonstrated incompetence in his care and treatment of patient A.A. and his discussion of same on a subsequent date. The circumstances are as follows:

20. Paragraphs 9 through 12 are incorporated here as if set forth in full.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

21. Respondent is subject to disciplinary action under section 2266 in that he failed to maintain adequate and accurate records pertaining to his care and treatment of patient A.A. The circumstances are as follows:

22. Paragraphs 9 through 12 are incorporated herein as if fully set forth.

FIFTH CAUSE FOR DISCIPLINE

(General Unprofessional Conduct)

23. Respondent is subject to disciplinary action under section 2234 in that he committed general unprofessional conduct in his care and treatment of patient A.A. The circumstances are as follows:

24. Paragraphs 8 through 22 are incorporated herein as if fully set forth.

DISCIPLINARY CONSIDERATIONS

25. To determine the degree of discipline, if any, to be imposed on Respondent, Complainant alleges that on or about May 24, 2002, an Ex Parte Interim Order of Suspension was issued in a matter entitled *In the Matter of the Petition for Interim Suspension Order Against William S. Eidelman, M.D.*, Case No. 06-2000–108619, due to the risk that Respondent's continued practice of medicine would endanger the public health, safety or welfare. The Order found that in four instances, Respondent had recommended treatment to patients without first obtaining an adequate history, conducting an adequate clinical exam or testing and without obtaining any reliable objective information regarding the patients' medical status. Further, his office lacked even basic medical assessment tools or equipment with which to assess a patient.

26. On or about October 9, 2002, an Interim Order of Suspension was issued in a matter entitled *In the Matter of the Petition for Interim Suspension Order Against William S. Eidelman, M.D.*, Case No. 06-2000–108619, due to the continuing risk that Respondent's practice of medicine would endanger the public health, safety or welfare. The Order made similar findings to the prior Ex Parte Interim Suspension Order issued earlier in the year.

27. On or about June 3, 2004, effective on July 6, 2004, in a prior disciplinary action entitled *In the Matter of the Accusation Against William S. Eidelman, M.D.*, before the Medical Board of California, following a hearing, good cause was found to discipline Respondent's license related to his issuance of recommendations for marijuana for medical purposes.[4] As a

[4] Specifically, he was found to have committed gross negligence and repeated negligent acts by disregarding his duty to diagnose and treat on the basis of a proper history, examination

result, Respondent's license was revoked, the revocation was stayed and Respondent was placed on five (5) years of probation on numerous terms and conditions including: (1) having a practice monitor or participating in a professional enhancement program that includes regular chart review, practice assessment, professional growth and education; (2) successfully completing a course in medical record keeping; and (3) successfully completing within six months from the effective date of the decision a clinical training or education program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California – San Diego School of Medicine. Respondent completed the probation effective October 6, 2009.

28. Following a hearing, effective on October 5, 2009, in a prior disciplinary action entitled *In the Matter of the Accusation and Petition to Revoke Probation Against William S. Eidelman, M.D.*, File No. D1-2000-108619, before the Medical Board of California, the Board found cause to exist to discipline Respondent's license for repeated acts of negligence and failure to maintain adequate and accurate medical records in care and treatment of a patient to whom he recommended marijuana in 2001 and 2005. The Board imposed discipline in the form of public reproval pursuant to Business and Professions Code sections 495 and 2227, subdivision (a)(4).

PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number 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 assistants and advanced practice nurses;

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and review of symptoms, sometimes failing to perform any physical exam at all, essentially placing decisions of diagnosis and treatment in his patients' hands. In several, histories obtained were limited to patients' explanation of why they sought recommendations marijuana for medical purposes. Also, Respondent failed to medically address patients' complaints that were not treatable with marijuana and he failed to establish and follow a plan for follow-up. Additionally, he was found to have made dishonest and false representations; to have aided and abetted the unlicensed practice of medicine, allowing an unlicensed individual to maintain and use a pad of his pre-signed prescription forms; and failing to maintain adequate and accurate records. Last, Respondent was found to be incompetent by 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.

3. Ordering William S. Eidelman, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

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

DATED: November 22, 2017

Christine L. Kelly for Kimberly Kirchmeyer

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

LA2017606142
62612634

PROOF OF SERVICE

STATE OF CALIFORNIA— COUNTY OF LOS ANGELES

I am employed in the County of Los Angeles, State of California. I am over the age of 18 and not a party to the within action; my business address is: Margolin and Lawrence Attorneys at Law, 8484 Wilshire Blvd., Ste 440, Beverly Hills, California 90211. My business telephone number is: (323) 653-9700; my business facsimile number is: (323) 653-9709.

On January 3, 2019, I served the foregoing document(s) described as:

EXHIBITS TO VERIFIED PETITION FOR WRIT OF ADMINISTRATIVE MANDAMUS (§1094.5) AND EX PARTE MOTION FOR ORDER TO STAY DECISION AND LICENSE REVOCATION ORDER

on the interested party(ies) in this action by sending service as follows:

By Personal Service:

Beneth A. Browne
Department of Justice
Beneth.browne@doj.ca.gov
300 S. Spring St.
Suite 1702
Los Angeles, CA 90013

By Mail Service:

Medical Board of California
Discipline Coordination Unit
2005 Evergreen Street
Suite 1200
Sacramento, CA 95815

By Personal Service:

Civic Center Courthouse
400 McAllister Street
Dept. 302
San Francisco, CA 94102

STATE - I declare under penalty of perjury, under the laws of the State of California, that the above is true and correct.

Executed January 3, 2019, at Beverly Hills, California.

Xochilt Gama

ATTORNEY OR PARTY WITHOUT ATTORNEY (Name, State Bar number, and address):
Tracy Green (SBN 137869) Green & Associates, Attorneys at Law
800 West 6th St, Ste. 450, Los Angeles, CA 90017
Allison B. Margolin (SBN 222370) J. Raza Lawrence (SBN 233771)
Margolin & Lawrence; 8484 Wilshire Blvd. Ste. 440 Beverly Hills, CA 90211
TELEPHONE NO.: (323) 653-9700 FAX NO.: (323) 6539709
ATTORNEY FOR (Name): William S. Eidelman

FOR COURT USE ONLY

FILED
San Francisco County Superior Court
JAN 25 2019
CLERK OF THE COURT
BY: Deputy Clerk

SUPERIOR COURT OF CALIFORNIA, COUNTY OF
STREET ADDRESS: 400 McAllister St.
MAILING ADDRESS:
CITY AND ZIP CODE: San Francisco, CA 94102
BRANCH NAME: San Francisco Superior Court

FAXED

CASE NAME:
William S. Eidelman v. Medical Board of California

CASE NUMBER: CPF-19-516480

JUDGE:
DEPT:

CIVIL CASE COVER SHEET

☒ **Unlimited** (Amount demanded exceeds $25,000) ☐ **Limited** (Amount demanded is $25,000 or less)

Complex Case Designation

☐ Counter ☐ Joinder

Filed with first appearance by defendant (Cal. Rules of Court, rule 3.402)

Items 1–6 below must be completed (see instructions on page 2).

1. Check **one** box below for the case type that best describes this case:

Auto Tort
- ☐ Auto (22)
- ☐ Uninsured motorist (46)

Other PI/PD/WD (Personal Injury/Property Damage/Wrongful Death) Tort
- ☐ Asbestos (04)
- ☐ Product liability (24)
- ☐ Medical malpractice (45)
- ☐ Other PI/PD/WD (23)

Non-PI/PD/WD (Other) Tort
- ☐ Business tort/unfair business practice (07)
- ☐ Civil rights (08)
- ☐ Defamation (13)
- ☐ Fraud (16)
- ☐ Intellectual property (19)
- ☐ Professional negligence (25)
- ☐ Other non-PI/PD/WD tort (35)

Employment
- ☐ Wrongful termination (36)
- ☐ Other employment (15)

Contract
- ☐ Breach of contract/warranty (06)
- ☐ Rule 3.740 collections (09)
- ☐ Other collections (09)
- ☐ Insurance coverage (18)
- ☐ Other contract (37)

Real Property
- ☐ Eminent domain/Inverse condemnation (14)
- ☐ Wrongful eviction (33)
- ☐ Other real property (26)

Unlawful Detainer
- ☐ Commercial (31)
- ☐ Residential (32)
- ☐ Drugs (38)

Judicial Review
- ☐ Asset forfeiture (05)
- ☐ Petition re: arbitration award (11)
- ☑ Writ of mandate (02)
- ☐ Other judicial review (39)

Provisionally Complex Civil Litigation (Cal. Rules of Court, rules 3.400–3.403)
- ☐ Antitrust/Trade regulation (03)
- ☐ Construction defect (10)
- ☐ Mass tort (40)
- ☐ Securities litigation (28)
- ☐ Environmental/Toxic tort (30)
- ☐ Insurance coverage claims arising from the above listed provisionally complex case types (41)

Enforcement of Judgment
- ☐ Enforcement of judgment (20)

Miscellaneous Civil Complaint
- ☐ RICO (27)
- ☐ Other complaint *(not specified above)* (42)

Miscellaneous Civil Petition
- ☐ Partnership and corporate governance (21)
- ☐ Other petition *(not specified above)* (43)

2. This case ☐ is ☑ is not complex under rule 3.400 of the California Rules of Court. If the case is complex, mark the factors requiring exceptional judicial management:
   a. ☐ Large number of separately represented parties
   b. ☐ Extensive motion practice raising difficult or novel issues that will be time-consuming to resolve
   c. ☐ Substantial amount of documentary evidence
   d. ☐ Large number of witnesses
   e. ☐ Coordination with related actions pending in one or more courts in other counties, states, or countries, or in a federal court
   f. ☐ Substantial postjudgment judicial supervision
3. Remedies sought *(check all that apply)*: a. ☐ monetary b. ☑ nonmonetary; declaratory or injunctive relief c. ☐ punitive
4. Number of causes of action *(specify)*:
5. This case ☐ is ☑ is not a class action suit.
6. If there are any known related cases, file and serve a notice of related case. *(You may use form CM-015.)*

Date:
Allison B. Margolin
(TYPE OR PRINT NAME)

(SIGNATURE OF PARTY OR ATTORNEY FOR PARTY)

NOTICE
- Plaintiff must file this cover sheet with the first paper filed in the action or proceeding (except small claims cases or cases filed under the Probate Code, Family Code, or Welfare and Institutions Code). (Cal. Rules of Court, rule 3.220.) Failure to file may result in sanctions.
- File this cover sheet in addition to any cover sheet required by local court rule.
- If this case is complex under rule 3.400 et seq. of the California Rules of Court, you must serve a copy of this cover sheet on **all** other parties to the action or proceeding.
- Unless this is a collections case under rule 3.740 or a complex case, this cover sheet will be used for statistical purposes only.

Form Adopted for Mandatory Use
Judicial Council of California
CM-010 [Rev. July 1, 2007]

CIVIL CASE COVER SHEET

Cal. Rules of Court, rules 2.30, 3.220, 3.400–3.403, 3.740;
Cal. Standards of Judicial Administration, std. 3.10
www.courtinfo.ca.gov

INSTRUCTIONS ON HOW TO COMPLETE THE COVER SHEET

To Plaintiffs and Others Filing First Papers. If you are filing a first paper (for example, a complaint) in a civil case, you **must** complete and file, along with your first paper, the *Civil Case Cover Sheet* contained on page 1. This information will be used to compile statistics about the types and numbers of cases filed. You must complete items 1 through 6 on the sheet. In item 1, you must check **one** box for the case type that best describes the case. If the case fits both a general and a more specific type of case listed in item 1, check the more specific one. If the case has multiple causes of action, check the box that best indicates the **primary** cause of action. To assist you in completing the sheet, examples of the cases that belong under each case type in item 1 are provided below. A cover sheet must be filed only with your initial paper. Failure to file a cover sheet with the first paper filed in a civil case may subject a party, its counsel, or both to sanctions under rules 2.30 and 3.220 of the California Rules of Court.

To Parties in Rule 3.740 Collections Cases. A "collections case" under rule 3.740 is defined as an action for recovery of money owed in a sum stated to be certain that is not more than $25,000, exclusive of interest and attorney's fees, arising from a transaction in which property, services, or money was acquired on credit. A collections case does not include an action seeking the following: (1) tort damages, (2) punitive damages, (3) recovery of real property, (4) recovery of personal property, or (5) a prejudgment writ of attachment. The identification of a case as a rule 3.740 collections case on this form means that it will be exempt from the general time-for-service requirements and case management rules, unless a defendant files a responsive pleading. A rule 3.740 collections case will be subject to the requirements for service and obtaining a judgment in rule 3.740.

To Parties in Complex Cases. In complex cases only, parties must also use the *Civil Case Cover Sheet* to designate whether the case is complex. If a plaintiff believes the case is complex under rule 3.400 of the California Rules of Court, this must be indicated by completing the appropriate boxes in items 1 and 2. If a plaintiff designates a case as complex, the cover sheet must be served with the complaint on all parties to the action. A defendant may file and serve no later than the time of its first appearance a joinder in the plaintiff's designation, a counter-designation that the case is not complex, or, if the plaintiff has made no designation, a designation that the case is complex.

CASE TYPES AND EXAMPLES

Auto Tort
- Auto (22)–Personal Injury/Property Damage/Wrongful Death
- Uninsured Motorist (46) *(if the case involves an uninsured motorist claim subject to arbitration, check this item instead of Auto)*

Other PI/PD/WD (Personal Injury/ Property Damage/Wrongful Death) Tort
- Asbestos (04)
  - Asbestos Property Damage
  - Asbestos Personal Injury/ Wrongful Death
- Product Liability *(not asbestos or toxic/environmental)* (24)
- Medical Malpractice (45)
  - Medical Malpractice–Physicians & Surgeons
  - Other Professional Health Care Malpractice
- Other PI/PD/WD (23)
  - Premises Liability (e.g., slip and fall)
  - Intentional Bodily Injury/PD/WD (e.g., assault, vandalism)
  - Intentional Infliction of Emotional Distress
  - Negligent Infliction of Emotional Distress
  - Other PI/PD/WD

Non-PI/PD/WD (Other) Tort
- Business Tort/Unfair Business Practice (07)
- Civil Rights (e.g., discrimination, false arrest) *(not civil harassment)* (08)
- Defamation (e.g., slander, libel) (13)
- Fraud (16)
- Intellectual Property (19)
- Professional Negligence (25)
  - Legal Malpractice
  - Other Professional Malpractice *(not medical or legal)*
- Other Non-PI/PD/WD Tort (35)

Employment
- Wrongful Termination (36)
- Other Employment (15)

Contract
- Breach of Contract/Warranty (06)
  - Breach of Rental/Lease Contract *(not unlawful detainer or wrongful eviction)*
  - Contract/Warranty Breach–Seller Plaintiff *(not fraud or negligence)*
  - Negligent Breach of Contract/ Warranty
  - Other Breach of Contract/Warranty
- Collections (e.g., money owed, open book accounts) (09)
  - Collection Case–Seller Plaintiff
  - Other Promissory Note/Collections Case
- Insurance Coverage *(not provisionally complex)* (18)
  - Auto Subrogation
  - Other Coverage
- Other Contract (37)
  - Contractual Fraud
  - Other Contract Dispute

Real Property
- Eminent Domain/Inverse Condemnation (14)
- Wrongful Eviction (33)
- Other Real Property (e.g., quiet title) (26)
  - Writ of Possession of Real Property
  - Mortgage Foreclosure
  - Quiet Title
  - Other Real Property *(not eminent domain, landlord/tenant, or foreclosure)*

Unlawful Detainer
- Commercial (31)
- Residential (32)
- Drugs (38) *(if the case involves illegal drugs, check this item; otherwise, report as Commercial or Residential)*

Judicial Review
- Asset Forfeiture (05)
- Petition Re: Arbitration Award (11)
- Writ of Mandate (02)
  - Writ–Administrative Mandamus
  - Writ–Mandamus on Limited Court Case Matter
  - Writ–Other Limited Court Case Review
- Other Judicial Review (39)
  - Review of Health Officer Order
  - Notice of Appeal–Labor Commissioner Appeals

Provisionally Complex Civil Litigation (Cal. Rules of Court Rules 3.400–3.403)
- Antitrust/Trade Regulation (03)
- Construction Defect (10)
- Claims Involving Mass Tort (40)
- Securities Litigation (28)
- Environmental/Toxic Tort (30)
- Insurance Coverage Claims *(arising from provisionally complex case type listed above)* (41)

Enforcement of Judgment
- Enforcement of Judgment (20)
  - Abstract of Judgment (Out of County)
  - Confession of Judgment *(non-domestic relations)*
  - Sister State Judgment
  - Administrative Agency Award *(not unpaid taxes)*
  - Petition/Certification of Entry of Judgment on Unpaid Taxes
  - Other Enforcement of Judgment Case

Miscellaneous Civil Complaint
- RICO (27)
- Other Complaint *(not specified above)* (42)
  - Declaratory Relief Only
  - Injunctive Relief Only *(non-harassment)*
  - Mechanics Lien
  - Other Commercial Complaint Case *(non-tort/non-complex)*
  - Other Civil Complaint *(non-tort/non-complex)*

Miscellaneous Civil Petition
- Partnership and Corporate Governance (21)
- Other Petition *(not specified above)* (43)
  - Civil Harassment
  - Workplace Violence
  - Elder/Dependent Adult Abuse
  - Election Contest
  - Petition for Name Change
  - Petition for Relief From Late Claim
  - Other Civil Petition

SUPERIOR COURT OF CALIFORNIA

COUNTY OF SAN FRANCISCO

Document Scanning Lead Sheet

Jan-03-2019 11:46 am

Case Number: CPF-19-516480

Filing Date: Jan-03-2019 11:36

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Image: 06630691

EX PARTE APPLICATION FOR ORDER

WILLIAMS S EIDELMAN MD VS. MEDICAL BOARD OF CALIFORNIA

001C06630691

Instructions:

Please place this sheet on top of the document to be scanned.

Tracy Green (SBN 137869)
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Attorney for Petitioner, WILLIAM S. EIDELMAN, M.D.

FILED
San Francisco County Superior Court
JAN 04 2019
CLERK OF THE COURT
BY: Deputy Clerk

SUPERIOR COURT OF CALIFORNIA,
CITY OF SAN FRANCISCO

FAXED

WILLIAM S. EIDELMAN, M.D., Petitioner, vs. MEDICAL BOARD OF CALIFORNIA, Respondent.	CASE NO: CPF-19-516480 ***EX PARTE* APPLICATION FOR STAY OF ADMINISTRATIVE ACTION PENDING COURT REVIEW OF PETITION; DECLARATIONS; EXHIBITS; [Proposed] ORDER** DATE: TIME: DEPT.:

TO THE COURT AND ALL PARTIES AND THEIR ATTORNEYS:

PLEASE TAKE NOTICE THAT on January 4, 2019 at 11:00 a.m. in Department 302 of the above-entitled Court, located at 400 McCallister Street, San Francisco, California, 94102, Petitioner will, and hereby does, apply *ex parte* for a stay of Respondent's decision dated December 6, 2018 to revoke Petitioner's medical license.

THERE IS URGENCY BECAUSE TODAY IS THE EFFECTIVE DATE OF PETITIONER'S LICENSE REVOCATION. A STAY IS NECESSARY TO PREVENT

THE IMMEDIATE LOSS OF PETITIONER'S ABILITY TO MAKE A LIVING AND TO PREVENT HARM TO THE PATIENT'S CURRENTLY UNDER PETITIONER'S CARE.

Petitioner is not a danger to the public, the very idea is the result of the Administrative Law Judge ignoring evidence in favor of Petitioner. As shown in the verified Petition filed herein, Petitioner's Administrative Record to be lodged for the hearing, the attached memorandum, the declarations of J. Raza Lawrence and William S. Eidelman, M.D., and any exhibits filed herewith, this court should stay the operation of Respondent's decision under Code Civ. Proc § 1094.5 subdv. (h) because: (1) the requested stay is not contrary to public interest and (2) Respondent is unlikely to prevail on the merits.

Petitioner's motion is based on the verified Petitioner for Writ of Administrative Mandamus, Petitioner's Administrative Record In Support of Writ Petition, this *ex parte* application, the supporting memorandum of points and authorities, the attached declarations and exhibits, the pleadings, filed and records in this action, and any such argument as may be received by this Court at the hearing on the motion.

Dated: January 3, 2019

By: _____
J. RAZA LAWRENCE
Margolin & Lawrence
Attorney for Petitioner
William S. Eidelman, M.D.

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MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

On November 14, 2018, Detective Burkhart with the San Bernardino Sheriff's Department, sent an e-mail to a Board investigator. The e-mail included documents pertaining to an investigation stemming from Petitioner's recommendation of medical cannabis to a five year old patient ("T.T."). T.T. had a favorable response to the medical cannabis and it was not T.T.'s parents who had contacted law enforcement, but rather administrative personnel at T.T.'s school after finding out from T.T.'s father that T.T. was being treated with medical cannabis.

The District Attorney refused to bring any charges against Petitioner following the Sheriff's department investigation. Furthermore, a Superior Court dismissed (with prejudice) all charges lodged against T.T.'s father by Child Protective Services ("CPS") related to the same incident. Despite having knowledge of these facts, Detective Burkhart sent the e-mail with details of the Sheriff's Department and Child Protective Services investigations to a Department of Consumer Affairs employee. Detective Burkhart's e-mail refereed to Petitioner as a suspect and insinuated he had been arrested by mention of a $50k bail. Petitioner was never arrested and Detective Burkhart failed to mention that the District Attorney had in fact refused to press charges.

Detective Burkhart's e-mail, despite having been improperly transmitted and received, led to a prejudicial and biased Board investigation of Petitioner. An accusation was lodged followed by a hearing and subsequent decision to revoke Petitioner's license, all in violation of Petitioner's first amendment and due process rights.

On January 3, 2018, William S. Eidelman, M.D. filed his Petition for Writ of Administrative Mandamus under Code Civ. Proc. §1094.5, directed to Respondent in order to redress the improper revocation of his license. Respondent violated Petitioner's due process rights because it did not have legal authority to open and investigation on Dr. Eidelman, Respondent's accusation is barred because it was filed outside the statute of limitations, Respondent's findings are not supported by the evidence and the decision to revoke Petitioner's license is excessive and a result of discriminatory bias. Petitioner seeks a stay of Respondent's decision and order revoking his medical license in order that both he and his patients avoid suffering irreparable adverse consequences of Respondent's improper administrative action.

II. LEGAL BACKGROUND

California's procedural and substantive standards for disciplinary proceedings against physicians begins with Code Civ. Proc.§ 1094.5 subdivisions (b) and (c), which require that (1) the Board has not proceeded without, or in excess of, jurisdiction; (2) there be no prejudicial abuses of discretion; (3) the proceeding be conducted "in the manner required by law"; (4) the decision be "supported by the findings"; and (5) the findings be "supported by the weight of the evidence."

Physicians facing license revocation have vested property rights in their license. *Suckow v. Alderson* (1920) 182 Cal. 247, 250; *Hewitt v. Board of Medical Examiners* (1906) 148 Cal. 590, 592; *Smith v. Board of Medical Quality Assurance* (1988) 202 Cal.App.3d 316, 326. Petitioner Eidelman is the person beneficially interested in the issuance of a peremptory writ of administrative mandate by virtue of the fact that his

license to practice medicine in the State of California has been subjected to discipline and revocation by the Board's decision. This court should stay the operation of Respondent's decision under Code Civ. Proc § 1094.5 subdv. (h) because: (1) the requested stay is not contrary to public interest and (2) Respondent is unlikely to prevail on the merits and (3) revocation of Dr. Eidelman's license is an excessive deprivation of his vested property rights.

III. STANDARD OF REVIEW

A. Independent Judgment, a Trial *De Novo*, Required Where Administrative Process Involves a Professional License.

In reviewing the administrative decision that involves a professional license the court applies the independent judgment rule. *Bixby v. Pierno*, (1971) 4 Cal. 3d 130, 143. The trial court reweighs the evidence in a limited trial *de novo* and examines the record for errors of law. *Id.* The reweighing of evidence requires that a preponderance of the evidence support the administrative decision. Code Civ. Proc. § 1094.5(c).

As to questions of law, the court applies its independent judgment. *Donaldson v. Department of Real Estate*, (2005) 134 Cal. App. 4th 948, 954. The issues in this case of whether the Board was permitted to conduct an investigation based upon an improperly lodged Sheriff's PAAC, as well as the statutory interpretation of BPC §2234, are questions of law: "A person aggrieved by an agency determination has a right to independent judicial review of questions of law, such as those dealing with the interpretation and application of statutes or judicial precedents." *Id*, citing Witkin Cal. Procedure (4th ed. 1997) Administrative Proceedings §111, p. 1156; *see also Medical*

Board v. Superior Court (Lee Roy Liskey, Real Party in Interest), (2003) 111 Cal. App. 4th 163, 171.

IV. BRIEF FACTUAL AND PROCEDURAL BACKGROUND.

Petitioner Dr. William S. Eidelman has been a licensed M.D. in the state of California for more than 43 years. He obtained his medical degree from St. Louis University Medical School in 1975 and has been practicing and consulting in the field of alternative medicine since 1980. Dr. Eidelman has spent much of his medical career as a pioneer amongst medical professionals, supporting and recommending the use of cannabis for medical purposes. In fact, Dr. Eidelman was and remains one of the first physicians to embrace medical cannabis following passage of the Compassionate Use Act in 1997. Dr. Eidelman has had much success with using cannabis to benefit the health of his patients, helping to alleviate a host of symptoms, including the negative behavioral symptoms experienced by T.T., the patient whose care was at issue during Respondent's investigation of Petitioner and subsequent license revocation. There has never been a patient complaint to the Respondent Medical Board ("Board") regarding the care provided by Dr. Eidelman.

The present matter stems from a Sheriff's submission, papers-that-were-accepted-as-a-complaint ("PAAC"), sent via e-mail, directly to an investigator with the Department of Consumer Affairs' Division of Investigation. There is no chain of custody, but the PAAC was officially stamped received by the Board's Complaint Unit which triggered the Board's investigation. This improper investigation is the basis for

the allegations in the Accusation against Dr. Eidelman regarding his alleged violations of Business and Professions Code section 2234.

The Sheriff's investigation began after school administrators contacted law enforcement and child protective services ("CPS") on learning of Dr. Eidelman's medical cannabis recommendation for T.T. Criminal charges were never brought against Dr. Eidelman as a result of the Sheriff's investigation. Similarly, the Superior Court dismissed (with prejudice) all CPS charges against T.T.'s father. Despite such exculpatory evidence being available at the time, Sheriff Burkhart proceeded with e-mailing the PAAC, papers that contained police records that allegedly show Dr. Eidelman as a "suspect" for furnishing drugs to a minor, with $50,000 bail. Since no charges were filed against Dr. Eidelman, these are false records. By including the false records, and records regarding police actions against LT, the father, that were dismissed with prejudice, these subversive actions set a discriminatory and prejudicial tone for the Board's unauthorized investigation and created bias that doctor had illegally furnished drugs to a minor.

Following the Board's investigation, an Accusation was filed against Dr. Eidelman, which proceeded to hearing and on December 6, 2018, Petitioner received Respondent's decision and order contending Petitioner guilty of unprofessional conduct on the ground that Petitioner was grossly negligent, repeatedly negligent, and incompetent in his care and treatment of T.T. Pursuant to its findings of fact, respondent ordered that Petitioner's Physician's and Surgeon's certificate (license) be revoked effective January 4, 2018. There are no available administrative remedies required to be

pursued prior to Petitioner's filing of this Petition for Writ of Mandate and *ex parte* request for Stay on January 3, 2018.

V. ARGUMENT

A. Applicable Law

Pursuant to Code Civ. Proc. § 1094.5 subd. (h), the Court may stay the operation of the administrative order or decision pending judgment, or until the filing of a notice of appeal from the judgment or until the expiration of the time for filing the notice, whichever occurs first. The stay shall not be imposed or continued unless the court is satisfied that the public interest will not suffer and that the Board is unlikely to prevail on the merits.

B. Respondent Is Unlikely To Prevail On The Merits

1. *The Board's Findings are Unsupported by the Evidence Because the Board Had No Authority to Open an Investigation and Lacked Jurisdiction.*

The Board had no authority to open an investigation and lacked jurisdiction because the Board did not receive any legally valid written complaint or mandatory report necessary to confer authority on the Board to open an investigation into Dr. Eidelman pursuant to its statutory authority under Business and Professions Code § 2220. The Board acted without and in excess of jurisdiction because the Board's mandated complaint submission and processing procedures pursuant to Business and Professions Code § 800(b)(1) were bypassed when it opened an investigation based on accusations submitted via e-mail which were by definition neither a report or complaint pursuant to California Code of Regulations, title 16, section 1356.2. Such statutory

procedures and processes are required to protect the due process and equal protection rights of those against whom complaints are lodged. The procedural irregularities presented by Detective Burkhart's failure to file a written complaint, and the Board's subsequent investigation based thereon, amount to a prejudicial abuse of discretion.

2. *The Board's Accusation Was Filed Beyond the Statute of Limitations.*

There is a conflict in the BPC regarding the applicable statute of limitations for filing an accusation pursuant to Section 11503 of the Government Code. BPC Section 10101 states the accusation "shall be filed no later than three years from the occurrence of the alleged ground for disciplinary action" while BPC Section 2230.5(a) states the accusation "shall be filed within three years after the board, or a division thereof, discovers the act or omission alleged as the ground for disciplinary action."

The Board did not file the accusation timely under either statute, and the rule of lenity requires that statutory ambiguities be resolved in Dr. Edelman's favor. The Court stated in *Ex parte Rosenheim* (1890) 83 Cal. 388 that a defendant is entitled to the benefit of every reasonable doubt, whether it arises out of a question of fact, or as to the true interpretation of words or the construction of language used in a statute. *Carter v. Welles Bowen Realty Inc.* (N.D. Ohio 20017), 493 F.Supp.2d 92 supports the conclusion that application of the rule of lenity in favor of Dr. Eidelman is appropriate by holding that "rules of interpretation bind all interpreters, administrative agencies included."

The provisions should be construed against the Board whose own wrongful actions exacerbated ambiguities related to determining whether the accusation was filed within the statute of limitations by accepting Detective Burkart's e-mail in lieu of a valid

legal complaint. There is ambiguity with regard to whether the accusation was timely filed because there is conflict regarding the date of the Board's receipt of said "complaint" which did not proceed via mandated avenues and procedures.

3. *The Investigation by the San Bernardino Sheriff's Department was Illegal, Resulting in the Board's Subsequent Unauthorized and Prejudicial Investigation.*

The court in *Conant v. Walters* (2002), 309 F.3d 629 ruled one cannot investigate on a marijuana recommendation only. The entire chain of events related to the investigation began because of Petitioner's medical cannabis recommendation. Following the Petitioner's actions, the patient was doing well and responding favorably. The Board's investigation was illegal and proceeded because of a series of discriminatory and biased actions, from initial involvement by the Sheriff through to the Administrative Law Judge's ("ALJ") proposed decision.

Detective Burkhart was aware that the District Attorney had already declined to bring charges against Dr. Eidelman when she proceeded to e-mail documentation that erroneously implicated Dr. Eidelman as a suspect with "bail set at $50,000." Such document is misleading in that it insinuates Dr. Eidelman was arrested and charged with some crime, which he was not. This was shown to all experts, further contaminating the investigation. Detective Wood-Burkhart's entire jumble of papers submitted and accepted as a "complaint" was biased, full of errors, and should not have been considered by the Board. Instead of rejecting the "complaint," the Board perpetuated the discrimination and bias against Petitioner by opening its own investigation solely based

on the marijuana recommendation. The Board's decision should be vacated for these reasons alone.

4. *Proposition 215 Provides Petitioner with Immunity.*

The clause in Proposition 215, "Notwithstanding any other provision of law . . ." provides Petitioner with immunity. Health and Safety Code section 11362.5(c). The Board claims the Proposition does not provide immunity from standard of care. Petitioner's closing addendum provided support for the fact that the phrase "Notwithstanding any other provision of law" protects every aspect of making a cannabis recommendation, including the standard of care. The ALJ rejected Petitioner's claim of immunity without addressing the merits of Petitioner's legal argument whatsoever. There has been no court interpretation or review of the statute serving as the basis for Petitioner's immunity claim. The Board's interpretation was made in error and this court's review and interpretation of Petitioner's immunity claim will not favor the Board's position.

5. *Petitioner Was Not Negligent in His Diagnosis and Medical Cannabis Recommendation*

The evidence does not support the ALJ's finding that Petitioner made the diagnosis based on family history alone. Instead, the evidence shows Petitioner's diagnosis was based on a history of the patient's **own** behaviors, within the context of and *in addition to* the family history, as learned by Petitioner during T.T.'s initial exam.

Additionally, there is nothing negligent or unusual about a doctor making an initial diagnosis following a 20-30 minute appointment. Expert testimony during the hearing

confirms this, and the Board's own expert agrees that it is hard to make a correct initial diagnosis in these cases. An initial diagnosis is based on a doctor's clinical judgment, then later either verified or rejected based on more information. Dr. Scherger testified that Petitioner had good clinical judgment, which was confirmed by the subsequent consistent DMDD diagnosis of T.T.

Petitioner's diagnosis in this case was correct and the subsequent consistent diagnosis of T.T. proves that. Even the Board's witnessed acknowledged that Petitioner had gotten it (the diagnosis) right. In addition, the evidence shows that the medical cannabis given to T.T. by his father, as approved of by Petitioner, was beneficial to T.T. and helped quell his negative behavioral symptoms. No harm was caused to this patient or any other.

6. *The Discipline Imposed Is Clearly Excessive*

The Board's erroneous and inaccurate finding that a single instance related to an alleged "misdiagnosis" that harmed no one is reason enough to revoke his license is an abuse of discretion.

The ALJ cites protection of the public as the reason for revocation of Petitioner's certificate. However, there is no evidence to support this contention. The alleged danger of harm, according to the ALJ, is that one can carry the wrong diagnosis for life. In the current case, in the medical record of the hospitalization, the earlier diagnosis was not mentioned. This record did contain the history of cannabis having a favorable effect. The evidence also shows that Dr. Eidelman is actually a specialist in correcting diagnostic errors by other doctors, as was the case when he corrected a wrongful Parkinson's

diagnosis as described in the record. Dr. Eidelman should not be robbed of his ability to make a living after 43 years of practice. His current and future patients should not be deprived of his experience and skills. The revocation is solely a function of the Board's bias and discrimination against Dr. Eidelman, a process that began solely with recommending medical cannabis to treat a child successfully.

C. ISSUANCE OF STAY NOT CONTRARY TO PUBLIC INTEREST

The public interest would not be hurt by a stay of the operation of Respondent's Decision and order pending the outcome of this proceeding in that Petitioner's continuing to practice medicine during the course of these proceedings would not represent a danger to his/her patients or to the public, as such practice has not harmed any patient in his 43 years of practice.

No patient has ever made a complaint against Dr. Eidelman and the ALJ's finding that Petitioner poses a risk to the public because he "didn't show his work" in reaching a single diagnosis, is preposterous. The ALJ posits that a wrongful diagnosis presents harm by "following" the patient forevermore. This is simply incorrect. It is well known within the medical field, that a doctor is required to make their own diagnosis of each and every patient, regardless of any previous diagnosis.

Taking away Petitioner's ability to practice medicine would cause irreparable harm to his current patients and the medical community because it prevents him from providing his valuable services the public, not only as a specialist in correcting diagnostic errors by other doctors. Dr. Eidelman is the discoverer and pioneer of a uniquely effective nicotine addiction treatment and program. Dr. Eidelman should not be robbed of his

ability to make a living and provide his valuable services after 43 years of practice.

VI. APPLICATION FOR STAY PROPERLY BEFORE THE COURT.

Ex parte applications are governed generally by California Rule of Court 3.1200 et seq. and must be in writing and include the following: (I) an application containing the case caption and stating the relief requested; (2) a declaration in support of the application; (3) a declaration, competent and based on personal knowledge, regarding the notice provided to other parties pursuant to California Rule of Court 3.1204; (4) a memorandum; and (5) a proposed order. Petitioner has filed the required *ex parte* application documents. Under California Rule of Court 3 .1202, the ex parte application must state the name, address, and telephone number of any attorney known by the applicant to be an attorney for any party. The names, addresses and telephone numbers are as follows:

Beneth A. Browne
Deputy Attorney General
Department of Justice
300 S. Spring St., Suite 1702
Los Angeles, CA 90013

Petitioner has complied with the *ex parte* rule and all parties were properly notified, as shown in the Declaration of J. Raza Lawrence. Respondent's counsel has not indicated whether they will appear on January 4, 2018 to oppose Petitioner's *ex parte* application for stay.

///

///

VII. CONCLUSION

Based on the foregoing, Petitioner respectfully requests that this Court stay the operation of Respondents' decision and order to revoke Petitioner's license pending court review of his petition.

Dated: January 3, 2019

By: _____
J. RAZA LAWRENCE
Margolin & Lawrence
Attorney for Petitioner
William S. Eidelman, M.D.

DECLARATION OF J. RAZA LAWRENCE

I, the undersigned, declare:

I am attorney admitted to practice in all courts in the State of California. I am responsible for representation of William S. Eidelman in this matter. I have personal and first-hand knowledge of the facts set forth in this Declaration, unless otherwise stated, and, if called as a witness, I could and would testify competently to those facts.

1. On filing Petitioner's Petition for Writ of Administrative Mandamus on January 3, 2019, I reserved an *ex parte* hearing date of January 4, 2019 in Department 302. I am seeking a stay *ex parte* because Petitioner will be irreparably harmed if a stay is not granted before his license revocation becomes effective January 4, 2019.

2. On Wednesday, January 2, 2019 at 7:46 p.m., I emailed Deputy Attorney General Beneth Browne, to inform her that Petitioner intends to appear *ex parte* on Friday, January 4, 2019 in Department 302 of the San Francisco Superior Court, 400 McAllister Street, San Francisco, California 94102, to stay the license revocation imposed by the Medical Board of California effective January 4, 2019.

3. Deputy Attorney Browne has not yet indicated whether she would appear to oppose the *ex parte* application.

I declare under penalty of perjury in the State of California and of the United States of America that the foregoing is true and correct. Signed on the date below in Los Angeles County.

Date: January 3, 2019

J. Raza Lawrence

DECLARATION OF WILLIAM S. EIDELMAN, M.D.

I, the undersigned, declare:

My name is William S. Eidelman and I am the Petitioner in this writ of administrative mandate matter. I have read the Motion for Stay and Writ Petition herein and am familiar with their contents. I have personal and first-hand knowledge of the facts set forth in this Declaration, unless otherwise stated, and if called as a witness, I could and would testify competently to those facts.

1. I am making this declaration in support of my request for a stay of the operation of the Medical Board of California's decision and order to revoke my medical license to that I can continue to practice medicine and treat my patients in California.

2. Without the stay, my professional livelihood and my ability to make a living will be on hold and I will lose time and opportunities that I could never be compensated for. I must be able to continue to practice medicine, not only for my sake but also for the sake of patients under my care, many of whom have been misdiagnosed by other doctors or seriously ill.

3. In my verified Writ Petition, I made representations related to my career and treatment of my patient T.T., as well as my contentions regarding the Board's investigation and decision that I do not want to repeat here, but a very important fact is that it was not my child patient's parents or any other patient who lodged any complaint against me regarding their care. No patient has ever made any complaint against me. I am attaching a copy of my representations and contentions from my verified Petition, pages 2, 3 and 6-10, and a copy of the factual background from the memorandum

supporting the Petition, pages 5 and 6, at **Exhibit A**, and incorporate those facts by this reference.

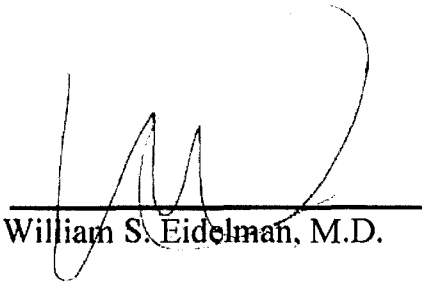
4. Both the Sheriff's Department and the Board carried out their investigations in a prejudicial manner, displaying bias and discriminating against me solely on the basis of having provided a medical cannabis recommendation to a child. Notwithstanding the Board's purported reason for revoking my license (that I did not "show my work" in reaching an accurate diagnosis), the investigation hinges 100% on the fact that I made a medical recommendation of cannabis. I should not be discriminated against just because cannabis has not yet been accepted by the wider medical community, and in particular for use by children.

4. I have already experienced irreparable harm to my livelihood and reputation as a result of the Board's lengthy and discriminatory investigation and proceedings. I have been forced to defend myself against the Board's actions which been a financial and emotional burden, not to mention a mar on my reputation. Now I am at risk of losing my ability to make a living and practice in the profession in which I've been successful for over 43 years.

5. If a stay is not issued, not only will I be harmed financially and reputation wise, but my patients who depend on me will be robbed of the benefit of my specialized expertise and care. Those who learn that my license has been revoked will certainly believe that such a serious punishment was substantiated by the weight of credible evidence, and their opinion of me, once lost, will be lost for good.

I declare under penalty of perjury in the State of California and of the United States of America that the foregoing is true and correct. Signed on the date below in Los Angeles County.

Date: January 3, 2019



William S. Eidelman, M.D.

Exhibit A To Declaration By William S. Eidelman

PETITION

By this petition, petitioner WILLIAM S. EIDELMAN, M.D., respectfully represents:

1. Petitioner is, and all time herein mentioned was, a resident of Los Angeles County, California.

2. Petitioner is now, and at all times was, the holder of a valid physician's and surgeon's certificate duly issued by the Medical Board of California July 1, 1976. Petitioner Eidelman practices functional medicine and specializes in recommending medical cannabis for the amelioration of symptoms stemming from various medical conditions.

3. Petitioner Eidelman has been a consultant in alternative medicine recommending marijuana for over 20 years, regularly seeing persons with a multitude of medical conditions, including approval of using medical cannabis for psychotherapeutic indications.

4. Respondent is the MEDICAL BOARD OF CALIFORNIA, and is an administrative agency of the State of California charged by law with the duty of implementing the provisions of Business and Professions Code Sections 2220 through 2319 and of investigating and hearing cases of possible unprofessional conduct by holders of the physician's an surgeon's certificate and imposing

discipline, including suspension or revocation of the certificate, on holders of the certificate who have been found guilty of unprofessional conduct.

5. Under Business and Professions Code Sections 2004 and 2220, respondent has discretion to determine on the facts whether or not cause exists for imposing discipline on a physician for unprofessional conduct, and particularly whether a licensee has been grossly negligent, repeatedly negligent, and incompetent.

6. Pursuant to Business and Professions Code Section 2230, Government Code Sections 11500 and 11529, and the decisional law of this state, respondent is required to hold a hearing and take evidence in its proceedings for the determination of those facts.

7. On July 11-13, 2018 at Los Angeles, California, a hearing was held to receive evidence on the issue of whether or not cause exists for disciplining petitioner for unprofessional conduct. Petitioner attended the hearing.

8. On December 6, 2018, Petitioner received respondent's decision and order contending Petitioner guilty of unprofessional conduct on the ground

C. <u>Petitioner's Contentions</u>

20. The ALJ found that Petitioner was negligent in his care and treatment by misdiagnosing patient with ADHD and Bipolar Disorder, repeatedly misdiagnosing patient, and demonstrated ignorance of the diagnostic criteria for

ADHD and Bipolar Disorder, and how the disorders should be diagnosed, and failed to recommend assessment of the patient by a qualified specialist. Respondent does not have the authority to revoke Petitioner's license based on any of these findings because such findings do not show that that Petitioner was grossly negligent, repeatedly negligent, incompetent or generally unprofessional.

21. The evidence received at the hearing does not support the finding for the following reasons: the evidence as to the circumstances surrounding the Board's investigation show that the Board had no authority to open an investigation, filed the accusation against Petitioner beyond the statute of limitations period, the Board wrongfully rejected petitioner's statutory immunities regarding standards of care for diagnoses applied to making medical cannabis recommendations and practicing alternative medicine.

22. Petitioner Eidelman contends that the action of respondent BOARD on December 6, 2018 rendering its Decision was without, and in excess of its jurisdiction, and was a prejudicial abuse of discretion in that:

a. The BOARD lacked jurisdiction because the BOARD did not receive any legally valid written complaint or mandatory report necessary to confer authority on the BOARD to open an investigation into Dr. Eidelman pursuant to its statutory authority under Business and Professions Code § 2220. The BOARD acted without and in excess of jurisdiction because the BOARD's mandated complaint

submission and processing procedures were bypassed when it opened an investigation based on accusations submitted via e-mail which were by definition neither a report or complaint pursuant to California Code of Regulations, title 16, section 1356.2.

b. Procedural irregularities related to the Board's acceptance of an informal "complaint" that bypassed the Board's standardized complaint process contaminated the Board's unwarranted investigation of and discriminatory enforcement action against Dr. Eidelman from the beginning. Such irregularities amount to a prejudicial abuse of discretion by the Board whose unlawful actions violated Dr. Eidelman's due process rights.

c. The initial investigation by the San Bernardino sheriff's office was illegal. The court in *Conant v. Walters* (2002), 309 F.3d 629 ruled one can not investigate on a marijuana recommendation only. The entire chain of events related to the investigation began because of Petitioner's medical cannabis recommendation. Following the Petitioner's actions, the patient was doing well and responding favorably. The Board's investigation was illegal and proceeded because of a series of discriminatory and biased actions, from initial involvement by the Sheriff through to the ALJ's proposed decision. Detective Wood-Burkhart's entire jumble of papers submitted and accepted as a "complaint" was biased, full of errors, and should not have been considered by the Board. Instead of rejecting the

"complaint," the Board perpetuated the discrimination and bias against Petitioner by opening its own investigation solely based on the marijuana recommendation.

While courts have often declined to apply the exclusionary rule in disciplinary proceedings, the application of the exclusionary rule was sanctioned in Elder v. Board of Medical Examiners (1966) 241 Cal.App.2d 246, 260. In Elder, a medical license revocation proceeding, the court held that "the exclusionary rule will apply to an administrative hearing where the proceeding contemplates the deprivation of a license which is recognized as a property right, as is the right to practice medicine." (Elder, 241 Cal.App.2d at 260.) In this case, exclusion of the complaint and evidence derived as a result thereof is proper to remedy the violation of Petitioner's First Amendment rights.

d. In *Conant*, the Ninth Circuit upheld the district court's order granting a permanent injunction to protect First Amendment rights which specifically enjoined the federal government from "either revoking a physician's license to prescribe controlled substances or conducting an investigation of a physician that might lead to such revocation, where the basis for the government's action is solely the physician's professional 'recommendation' of the use of medical marijuana." (*Id.* at 632.) The government flagrantly violated Petitioner's First Amendment rights by commencing an investigation of him based upon nothing more than the fact that he had engaged in lawful conduct by recommending the medical use of

marijuana to patients and the evidence obtained as a result of the illegal police conduct should have been suppressed, not only to protect Petitioner's rights, but also to deter this type of police misconduct, to protect society from the likely erosion of the physician-patient relationship stemming from the chilling effect on speech caused by such constitutional violations and to avoid breeding public distrust in the legal system.

e. The clause in Proposition 215, "Notwithstanding any other provision of law . . ." provides Petitioner with immunity. Health and Safety Code section 11362.5(c). The Board claims the Proposition does not provide immunity from standard of care. Petitioner's closing addendum provided support for the fact that the phrase "Notwithstanding any other provision of law" protects every aspect of making a cannabis recommendation, including the standard of care. The ALJ rejected Petitioner's claim of immunity without addressing the merits of Petitioner's legal argument whatsoever. There has been no court interpretation or review of the statute serving as the basis for Petitioner's immunity claim. The Board's interpretation was made in error and Petitioner now requests review and interpretation of the immunity claim by this court.

f. The BOARD's decision that Petitioner Eidelman's certificate is subject to discipline pursuant to Section 2234 for gross negligence is not supported by the weight of substantial evidence under the independent jurisdiction test. This trial

court must exercise its independent judgment upon the weight of the evidence produced . . . and any evidence which might have been improperly excluded. *Dare v. Bd. Of Medical Examiners* (1943) 21 Cal.2d 790, 799.

g. The ALJ's conclusion that Petitioner is a danger to the public because of an alleged wrongful diagnosis is not supported by the facts or expert witness testimony. The ALJ's contention I contrary to common sense, by concluding that a subsequent diagnosis *consistent* with Petitioner's initial diagnosis is immaterial as related to Petitioner's culpability. Even the Board's own expert, upon realizing the child received a subsequent consistent diagnosis remarked "looks like [Petitioner] got it right." In light of these facts, the ALJ's revocation of Petitioner's license was without merit and suggests prejudicial bias and an abuse of discretion. The ALJ's bias is further demonstrated by the fact that he erroneously stated on three occasions that Petitioner gave cannabis to the patient's father. Petitioner did not give cannabis to the patient or his father and nothing in the record states otherwise. These are erroneous statements of fact by ALJ are false and show his discriminatory bias based on the cannabis recommendation alone, as well as his fundamental misunderstanding of the facts.

h. Revoking Petitioner's medical license is clearly excessive, the result of the Board's arbitrary and capricious enforcement actions against Dr. Eidelman, and constitutes punishment of Dr. Eidelman that is too severe and not supported by the

Board's findings.

23. For the reasons stated in Paragraph 22 of this Petition it is unlikely that respondent will prevail ultimately on the merits in this proceeding, and the public interest would not be hurt by a stay of the operation of respondent's Decision and order pending the outcome of this proceeding in that Petitioner's continuing to practice medicine during the course of these proceedings would not represent a danger to his/her patients or to the public, as such practice has not harmed any patient in his 43 years of practice. Just the opposite, taking away petitioner's ability to practice medicine would cause irreparable harm to his current patients and the medical community.

II. STATEMENT OF FACTS

A. Factual Background

Dr. William S. Eidelman has been a licensed M.D. in the state of California for more than 43 years (Ex. E at 733.) He obtained his medical degree from St. Louis University Medical School in 1975 and has been practicing and consulting in the field of alternative medicine since 1980. *Id.* Dr. Eidelman has spent much of his medical career as a pioneer amongst medical professionals, supporting and recommending the use of cannabis for medical purposes. *Id.* In fact, Dr. Eidelman was and remains one of the first physicians to embrace medical cannabis following passage of the Compassionate Use Act in 1997. *Id.* Dr. Eidelman has had much success with using cannabis to benefit the health of his patients, helping to alleviate a host of symptoms, including the negative behavioral

symptoms experienced by T.T. (Ex. E at 732, 736.) There has never been a patient complaint to the Medical Board regarding the care provided by Dr. Eidelman. (Ex. E at 749-751.)

The present matter stems from a Sheriff's submission, papers-that-were-accepted-as-a-complaint ("PAAC"), sent via e-mail, directly to an investigator with the Department of Consumer Affairs' Division of Investigation. There is no chain of custody, but the PAAC was officially stamped received by the Board's Complaint Unit which triggered the Board's investigation. (Ex. E at 737.) This improper investigation is the basis for the allegations in the Accusation against Dr. Eidelman regarding his alleged violations of BPC §2234.

The Sheriff's investigation began after school administrators contacted law enforcement and child protective services ("CPS") on learning of Dr. Eidelman's medical cannabis recommendation for T.T. *Id.* Criminal charges were never brought against Dr. Eidelman as a result of the Sheriff's investigation. Similarly, the Superior Court dismissed (with prejudice) all CPS charges against T.T.'s father. Despite such exculpatory evidence being available at the time, Sheriff Burkhart proceeded with e-mailing the PAAC, papers that contained police records that allegedly show Dr. Eidelman as a "suspect" for furnishing drugs to a minor, with $50,000 bail. Since no charges were filed against Dr. Eidelman, these are false records. By including the false records, and records regarding police actions against LT, the father, that were dismissed with prejudice, these subversive actions set a discriminatory and prejudicial tone for the

Board's unauthorized investigation and created bias that doctor had illegally furnished drugs to a minor.

Following the Board's investigation, an Accusation was filed against Dr. Eidelman, which proceeding to hearing and the Board's finding that Dr. Eidelman was "grossly negligent" in his care and treatment of T.T. (Ex. E at 754.)

PROOF OF SERVICE

I am employed in the County of Los Angeles, California and am over the age of 18. I am not a party to the within action. My business address is:

MARGOLIN & LAWRENCE
8484 Wilshire Blvd. Suite 440
Beverly Hills, CA 90211
Telephone: (323) 653-9700
Facsimile: (323) 653-9709

On the date shown below, I served the foregoing document described as:

NOTICE OF EX PARTE APPLICATION AND EX PARTE APPLICATION FOR AN ORDER TEMPORARILY STAYING THE MEDICAL BOARD OF CALIFORNIA'S DECISION TO REVOKE PETITIONER'S MEDICAL LICENSE; MEMORANDUM OF POINTS AND AUTHORITIES; EX PARTE ORDER; DECLARATIONS OF J. RAZA LAWRENCE AND WILLIAM S. EIDELMAN, M.D.

On the following interested parties in this action:

By Electronic Service:

Beneth A. Browne
Department of Justice
Beneth.browne@doj.ca.gov
300 S. Spring St.
Suite 1702
Los Angeles, CA 90013

By Mail Service:

Medical Board of California
Discipline Coordination Unit
2005 Evergreen Street
Suite 1200
Sacramento, CA 95815

By Personal Service:

Civic Center Courthouse
400 McAllister Street
Dept. 302
San Francisco, CA 94102

I declare under penalty of perjury, under the laws of the State of California, that the above is true and correct.

Dated: January 3, 2019

By: _____
Xochilt Gama

SUPERIOR COURT OF CALIFORNIA
COUNTY OF SAN FRANCISCO

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Case Number: CPF-19-516480

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MEMORANDUM OF POINTS AND AUTHORITIES

WILLIAMS S EIDELMAN MD VS. MEDICAL BOARD OF CALIFORNIA

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Attorneys for Petitioner, WILLIAM S. EIDELMAN, M.D.

FILED
San Francisco County Superior Court
JAN 08 2019
CLERK OF THE COURT
BY: Deputy Clerk

SUPERIOR COURT OF CALIFORNIA,
CITY OF SAN FRANCISCO

WILLIAM S. EIDELMAN, M.D. Petitioner, vs. MEDICAL BOARD OF CALIFORNIA, Respondent.	CASE NO: MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF VERIFIED PETITION FOR WRIT OF ADMINISTRATIVE MANDAMUS (§1094.5) AND EX PARTE MOTION FOR ORDER TO STAY DECISION AND LICENSE REVOCATION ORDER

FAXED

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I. INTRODUCTION

Dr. William S. Eidelman, by way of the accompanying Petition for Writ, challenges the Medical Board's Decision of December 6, 2018, revoking his medical license. This case involves This case involves allegations that Dr. Eidelman is subject to revocation for violations of Business and Professions Code section 2234, including gross negligence, for consulting with his patient regarding the use of medical cannabis to help alleviate the child's ("T.T.") negative behavioral tendencies. The Medical Board ("Board") had no authority to investigate Dr. Eidelman in the first place. The Board's enforcement action against Dr. Eidelman is an illegal violation of his due process rights and the Board's decision and order to revoke Dr. Eidelman's license should be vacated.

II. STATEMENT OF FACTS

A. Factual Background

Dr. William S. Eidelman has been a licensed M.D. in the state of California for more than 43 years (Ex. E at 733.) He obtained his medical degree from St. Louis University Medical School in 1975 and has been practicing and consulting in the field of alternative medicine since 1980. *Id.* Dr. Eidelman has spent much of his medical career as a pioneer amongst medical professionals, supporting and recommending the use of cannabis for medical purposes. *Id.* In fact, Dr. Eidelman was and remains one of the first physicians to embrace medical cannabis following passage of the Compassionate Use Act in 1997. *Id.* Dr. Eidelman has had much success with using cannabis to benefit the health of his patients, helping to alleviate a host of symptoms, including the negative behavioral

symptoms experienced by T.T. (Ex. E at 732, 736.) There has never been a patient complaint to the Medical Board regarding the care provided by Dr. Eidelman. (Ex. E at 749-751.)

The present matter stems from a Sheriff's submission, papers-that-were-accepted-as-a-complaint ("PAAC"), sent via e-mail, directly to an investigator with the Department of Consumer Affairs' Division of Investigation. There is no chain of custody, but the PAAC was officially stamped received by the Board's Complaint Unit which triggered the Board's investigation. (Ex. E at 737.) This improper investigation is the basis for the allegations in the Accusation against Dr. Eidelman regarding his alleged violations of BPC §2234.

The Sheriff's investigation began after school administrators contacted law enforcement and child protective services ("CPS") on learning of Dr. Eidelman's medical cannabis recommendation for T.T. *Id.* Criminal charges were never brought against Dr. Eidelman as a result of the Sheriff's investigation. Similarly, the Superior Court dismissed (with prejudice) all CPS charges against T.T.'s father. Despite such exculpatory evidence being available at the time, Sheriff Burkhart proceeded with e-mailing the PAAC, papers that contained police records that allegedly show Dr. Eidelman as a "suspect" for furnishing drugs to a minor, with $50,000 bail. Since no charges were filed against Dr. Eidelman, these are false records. By including the false records, and records regarding police actions against LT, the father, that were dismissed with prejudice, these subversive actions set a discriminatory and prejudicial tone for the

Board's unauthorized investigation and created bias that doctor had illegally furnished drugs to a minor.

Following the Board's investigation, an Accusation was filed against Dr. Eidelman, which proceeding to hearing and the Board's finding that Dr. Eidelman was "grossly negligent" in his care and treatment of T.T. (Ex. E at 754.)

B. Procedural Background

The initial Accusation, based on an improperly lodged and inherently biased "complaint," was filed on November 22, 2017. (Ex. E at 756.) Dr. Eidelman defended himself against the allegations contained in the Accusation and a hearing was held on the matter before Administrative Law Judge Joseph D. Montoya ("ALJ") at the Office of Administrative Hearings in Los Angeles July 11-13, 2018. (Ex. E at 731.) Following that hearing, the ALJ issued the Proposed Decision on November 6, 2018, revoking Dr. Eidelman's medical license. (Ex. E at 755.) The Board adopted the Proposed Decision on December 6, 2018, delaying its effective date to January 4, 2019. By way of the accompanying Writ Petition, Dr. Eidelman challenges the Board's Decision and seeks a Stay against it and its dismissal.

III. LEGAL ANALYSIS

A. Basis for Relief And Standard of Review

Under Code of Civil Procedure § 1094.5 a court is authorized to evaluate the validity of an administrative decision and to enter a judgment setting aside such decision by issuing a writ of administrative mandate. In reviewing the administrative decision that involves a professional license the court applies the independent judgment rule. *Bixby v.*

Pierno, (1971) 4 Cal. 3d 130, 143. The trial court reweighs the evidence in a limited trial *de novo* and examines the record for errors of law. *Id.* The reweighing of evidence requires that a preponderance of the evidence support the administrative decision. Code Civ. Proc. § 1094.5(c).

As to questions of law, the court applies its independent judgment. *Donaldson v. Department of Real Estate*, (2005) 134 Cal. App. 4th 948, 954. The issues in this case of whether the Board was permitted to conduct an investigation based upon an improperly lodged Sheriff's PAAC, as well as the statutory interpretation of BPC §2234, are questions of law: "A person aggrieved by an agency determination has a right to independent judicial review of questions of law, such as those dealing with the interpretation and application of statutes or judicial precedents." *Id*, citing Witkin Cal. Procedure (4th ed. 1997) Administrative Proceedings §111, p. 1156; *see also Medical Board v. Superior Court (Lee Roy Liskey, Real Party in Interest)*, (2003) 111 Cal. App. 4th 163, 171.

B. <u>The Board Violated Petitioner's Due Process Rights Because It Did Not Have Legal Authority To Open An Investigation On Dr. Eidelman.</u>

1. The Board Was Not Permitted To Open An Investigation Based On Documents E-mailed By Detective Burkhart Because They Did Not Constitute A Legally Valid Complaint.

Under Business and Professions Code ("BPC") section 2220, the Board is granted power to investigate complaints from the public, from other licensees, from health care facilities, or from the Board that a physician may be guilty of unprofessional conduct. A

statute of limitations found at BPC § 2230.5(a) mandates that accusations by the Board "be filed within 3 years after the board . . . *discovers* the . . . ground for disciplinary action." (Emphasis added.) For purposes of Section 2230.5(a), the word "*discovers*" means the date the Board received a **complaint** or **report**. See California Code of Regulations (CCR), title 16, section 1356.2.

Section 1356.2 (b)(1) defines complaint as a "written complaint" from the public or a written complaint generated by Board staff. Detective Burkhart's e-mailed documents did not constitute a legally valid written complaint from the public and she is not Board staff. BPC Section 800(b)(1) mandates the Board to prescribe and promulgate forms on which members of the public file written complaints to the Board alleging any act of misconduct by the licensee. In accordance with this mandate, the Board provides a Consumer Complaint Form and reiterates that complaints must be filed in writing and that "written complaints may be submitted to the Board's Central Complaint Unit by mail, via fax, or online" (http://www.mbc.ca.gov/Consumers/Complaints/).

Because Detective Burkart's e-mail submission does not fall within the definition of a "written complaint" from the public, other licensee, health care facility, or from the Board, the Board did not have the power to investigate Dr. Eidelman pursuant to BPC §2220. The complaint submission and review process is dictated by statutes and regulations so that "all complaints filed with the Board are handled with equal consideration" (http://www.mbc.ca.gov/Publications/Brochures/complaint_info_english-web.pdf). Such statutory procedures and processes are required to protect the due process and equal protection rights of those against whom complaints are lodged. The procedural

irregularities presented by Detective Burkhart's failure to file a written complaint, and the Board's subsequent investigation based thereon, amount to a prejudicial abuse of discretion.

2. Neither Did Detective Burkhart's E-mail Submission Constitute an Actionable Report For Purposes Of Conferring Authority On The Board to Investigate.

Section 1356.2 (b)(2) defines "report" to mean any written report required under the code to be filed with the Board. Examples of such reports required to be filed with the Board are those pursuant to Section 802.1 (mandatory reporting of arrests and convictions) and Sections 803.5 and 803.6 (mandatory reporting by court clerks regarding convictions). Additionally, Section 2236 (b) mandates a district attorney or other prosecuting agency, as a mandatory reporter, to report pendency of an action against a licensee. Dr. Eidelman was never charged with any crime and the Sheriff's PAAC and accoutrement documentation provided by Detective Burkhart were not required under the Code to be filed with the Board and the detective was not a mandatory reporter.

3. The Procedural Irregularities That Resulted in the Board's Unauthorized Investigation of Dr. Eidelman Constitute a Prejudicial Violation of Dr. Eidelman's Due Process Rights.

Furthermore, Detective Burkhart was aware that the District Attorney had already declined to bring charges against Dr. Eidelman when she proceeded to e-mail documentation that erroneously implicated Dr. Eidelman as a suspect with "bail set at

$50,000." Such document is misleading in that it insinuates Dr. Eidelman was arrested and charged with some crime. When Petitioner objected to the complaint's validity and pointed out the procedural irregularities during his testimony, the ALJ stated "now I have to decide if you even belong here," indicating he was aware the Board's jurisdiction was deficient. Petitioner's efforts to attack the validity of the Board's decision to accept Detective Burkhart's documents in lieu of a formal complaint or mandatory report went unaddressed and Petitioner's lawyer neglected to heed Dr. Eidelman's repeated requests to issue subpoenas to obtain necessary testimony from relevant parties. Such inaction by Dr. Eidelman's own attorney amounts to ineffective assistance of counsel.

Because Dr. Burkhart's e-mail submission can neither be considered a complaint nor a report for purposes of conferring authority on the Board, the opening of an unwarranted investigation on Dr. Eidelman as a result of such procedural irregularities amount to a prejudicial abuse of discretion by the Board whose unlawful actions violated Dr. Eidelman's due process rights.

C. The Board's Accusation Is Barred Because It Was Filed Outside The Applicable Statute Of Limitations.

There is a conflict in the BPC regarding the applicable statute of limitations for filing an accusation pursuant to Section 11503 of the Government Code. BPC Section 10101 states the accusation "shall be filed no later than three years from the occurrence of the alleged ground for disciplinary action" while BPC Section 2230.5(a) states the accusation "shall be filed within three years after the board, or

a division thereof, discovers the act or omission alleged as the ground for disciplinary action."

The date of the "occurrence" is September 13, 2012. Pursuant to Section 10101, the accusation was required to be filed by September 13, 2015. The accusation against Dr. Edelman was filed November 22, 2017 and was therefore beyond the statute of limitations.

Similarly, Detective Burkhart's e-mail submission to the Board's investigator was made on November 14, 2014. Pursuant to Section 2230.5(a), the accusation was required to be filed by November 14, 2017. The November 22, 2017 accusation was therefore beyond the statute of limitations. The ALJ accepted the Board's argument that Detective Burkhart's e-mail was forwarded to and received by the Board's Complaint Unit on November 25, 2014, marking the date of discovery. (Ex. E at 753.)

This nearly two-week discrepancy with regard to when the Board should be considered to have discovered the alleged ground for disciplinary action is material with regard to whether the accusation was timely filed pursuant to Section 2230.5(a). Of course, had a legitimate complaint been filed in accordance with the Board's procedures, such discrepancy would have been avoided. Therefore, the Board's wrongful decision to accept Detective Burkart's e-mail in lieu of a valid legal complaint is exacerbated by the fact that it also creates ambiguity with regard

to whether the accusation was timely filed. This ambiguity must be resolved in Dr. Edelman's favor, as explained below.

The Board did not file the accusation timely under either statute, and the rule of lenity requires that statutory ambiguities be resolved in Dr. Edelman's favor. The Court stated in *Ex parte Rosenheim* (1890) 83 Cal. 388 that a defendant is entitled to the benefit of every reasonable doubt, whether it arises out of a question of fact, or as to the true interpretation of words or the construction of language used in a statute. *Carter v. Welles Bowen Realty Inc.* (N.D. Ohio 20017), 493 F.Supp.2d 92 supports the conclusion that application of the rule of lenity in favor of Dr. Edelman is appropriate by holding that "rules of interpretation bind all interpreters, administrative agencies included." Therefore, if this court concludes that the conflicting statutes create ambiguity, then the provisions should be construed against the Board whose own wrongful actions exacerbated ambiguities related to determining whether the accusation was filed within the statute of limitations.

D. <u>The Board's Decision that Petitioner Eidelman's Certificate is Subject to Revocation pursuant to §2234 Is Not Supported by the Weight of Evidence</u>.

1. Dr. Eidelman Was Not Negligent In His Diagnosis And Medical Cannabis Recommendation.

The ALJ asserts that Petitioner's diagnosis was made based on "family"

history alone. (Ex. E at 738.) This statement is both untrue, as well as taken out of context considering the ALJ transmutes "history" to "family history". (Ex. E at 738 and 744.) The evidence shows that Petitioner met with and personally observed T.T., speaking with both T.T. and his father, during an initial exam that lasted from 20-30 minutes. During that time, Petitioner learned of the child's own behavior history from the father, as affirmed by the child. It is true that family history is the number one risk factor for Petitioner's diagnosis of T.T. However, Petitioner's diagnosis was based on a history of the patient's **own** behaviors, within the context of and *in addition to* the family history. (Ex. E at 738-739.) Therefore, the evidence does not support the ALJ's finding that Petitioner made the diagnosis based on family history alone.

Additionally, there is nothing negligent or unusual about a doctor making an initial diagnosis following a 20-30 minute appointment. Expert testimony during the hearing confirms this, and the Board's own expert agrees that it is hard to make a correct initial diagnosis. An initial diagnosis is based on a doctor's clinical judgment, then later either verified or rejected based on more information. Dr. Scherger testified that Petitioner had good clinical judgment, which was confirmed by the subsequent consistent DMDD diagnosis of T.T.

Petitioner's diagnosis in this case was correct and the subsequent consistent diagnosis of T.T. proves that. Even the Board's witnessed acknowledged that

Petitioner had gotten it (the diagnosis) right. In addition, the evidence shows that the medical cannabis given to T.T. by his father, as approved of by Petitioner, was beneficial to T.T. and helped quell his negative behavioral symptoms. No harm was caused to this patient or any other.

Neither is there any risk of harm to the public. The ALJ's finding that Petitioner poses a risk to the public because he "didn't show his work" in reaching a single diagnosis, is preposterous. The ALJ posits that a wrongful diagnosis presents harm by "following" the patient forevermore. This is simply incorrect. It is well known within the medical field, that a doctor is required to make their own diagnosis of each and every patient, regardless of any previous diagnosis. In fact, T.T.'s hospital paperwork makes no mention of Petitioner's diagnosis, yet the hospital came to the same diagnosis.

The evidence does not support the ALJ's finding that Petitioner was negligent in making his initial diagnosis because it is not true that the diagnosis was made based on family history alone. The ALJ's mischaracterization of the diagnosis method and refusal to take into account the fact that T.T. was benefitted (and not harmed) by the recommendation shows bias and is an abuse of discretion.

2. Regardless, Dr. Eidelman Is Protected From Board Discipline Related To His Diagnosis And Medical Cannabis Recommendation, Which Was Medically Indicated To Alleviate Behavioral Symptoms Related To T.T's

Medical Condition.

BPC Section 2234.1 provides safe harbor immunity for Dr. Eidelman, as to any deviation from the standard of care, which is to be expected with experimental self-treatment options. Such experimental treatment options are routine recommendations for Dr. Eidelman who has over 20 years of experience in practicing alternative medicine.

Specifically, Section 2234.1(a) states that

> a physician and surgeon shall not be subject to discipline pursuant to subdivision (b), (c) or (d) of Section 2234 solely on the basis that the treatment or advice . . . rendered to a patient is alternative or complementary medicine . . .

Section 2234.1(b) defines "alternative or complimentary medicine," as:

> those health care methods of **diagnosis**, treatment, or healing that are not generally used but that provide a reasonable potential for therapeutic gain in a patient's medical condition that is not outweighed by the risk of the health care method.

(Emphasis added.) Finally, Section 2234.1(c) reads as follows:

> Since the National Institute of Medicine has reported that it can take up to 17 years for a new best practice to reach the average physician and surgeon, it is prudent to give attention to new developments not only in general medical care but in actual treatment of specific diseases, particularly those that are not yet broadly recognized in California.

When a doctor is confronted with a child's visit and is operating within the statutory confines of Section 2234.1, the holdings of *Parham v. J.R.* (1979), 442 US 584, 602-606 must be observed by Dr. Edelman and the Board. *Parham*

involves parents' rights to make medical decisions regarding their children's mental health. The lower court had ruled that Georgia's statutory scheme of allowing children to be subjected to treatment in the state's mental health facilities violated the Constitution because it did not adequately protect children's due process rights. The Supreme Court reversed, upholding the legal presumption that parents act in their child's best interest.

Dr. Eidelman has extensive knowledge regarding medical cannabis and of anecdotal reports circulating within the medical community. Dr. Eidelman has attended cannabis seminars to continue his education and remain abreast of new information coming out every day, some of which concerns the treatment of children. The Board's Guidelines state that the physician should base his or her determination on this type of information.

Dr. Eidelman's diagnosis of T.T. and his recommendations thereon comported with all statutory obligations owed to the Board and his patient. Dr. Eidelman's diagnosis was based on his observation of T.T. and discussions with T.T.'s father who was experienced in using medical cannabis for himself and another child for reasons related to behavior regulation. Dr. Eidelman lawfully presumed that T.T.'s father had T.T.'s best interest at heart and was intimately familiar with T.T.'s medical history and behaviors. Dr. Eidelman and T.T.'s father also discussed the father's disinterest in seeking mainstream psychiatric or

cognitive therapies, due to his own negative experience with their side effects and ineffectiveness.

Therefore, based on Dr. Eidelman's expertise in medical cannabis, there can be no circumstance involving a mental illness disorder of a child, who has been expelled from school, where a recommendation for the use of medical cannabis, which indeed alleviated the child's symptoms, in lieu of orthodox corporate medicine, is in any manner unlawful. In fact, California's Center for Medicinal Cannabis Research is currently doing clinical trials on treating children with autism and bipolar with medical cannabis. It seems that they, like Dr. Eidelman, perceive a potential benefit for the treatment of such children.

E. Revocation of Dr. Eidelman's License Is Excessive and Not Supported By The Board's Findings.

The Board's erroneous and inaccurate finding that a single instance related to an alleged "misdiagnosis" that harmed no one is reason enough to revoke his license is an abuse of discretion.

ALJ cites protection of the public as the reason for revocation of Petitioner's certificate. However, there is no evidence to support this contention. Instead, the evidence shows that the patient was helped and not harmed. The evidence also shows that Dr. Eidelman is actually a specialist in correcting diagnostic errors by other doctors, as was the case when he corrected a wrongful Parkinson's diagnosis

as described in the record. To take Dr. Eidelman's license away is not only an abuse of discretion, it also prevents him from providing his valuable services to the public. Dr. Eidelman should not be robbed of his ability to make a living after 43 years of practice. The revocation is solely a function of the Board's bias and discrimination against Dr. Eidelman for recommending medical cannabis to treat a child successfully.

IV. CONCLUSION

For the foregoing reasons, Dr. Eidelman requests that this Court issue a writ of administrative mandamus, stay the Board's Decision and grant other just and equitable relief.

Dated: January 3, 2018

By: _____

J. RAZA LAWRENCE
Margolin & Lawrence
Attorney for Petitioner
William S. Eidelman, M.D.

PROOF OF SERVICE

STATE OF CALIFORNIA— COUNTY OF LOS ANGELES

I am employed in the County of Los Angeles, State of California. I am over the age of 18 and not a party to the within action; my business address is: Margolin and Lawrence Attorneys at Law, 8484 Wilshire Blvd., Ste 440, Beverly Hills, California 90211. My business telephone number is: (323) 653-9700; my business facsimile number is: (323) 653-9709.

On January 3, 2019, I served the foregoing document(s) described as:

MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT OF VERIFIED PETITION FOR WRIT OF ADMINISTRATIVE MANDAMUS (§1094.5) AND EX PARTE MOTION FOR ORDER TO STAY DECISION AND LICENSE REVOCATION ORDER

on the interested party(ies) in this action by sending service as follows:

By Personal Service:

Beneth A. Browne
Department of Justice
Beneth.browne@doj.ca.gov
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Suite 1702
Los Angeles, CA 90013

By Mail Service:

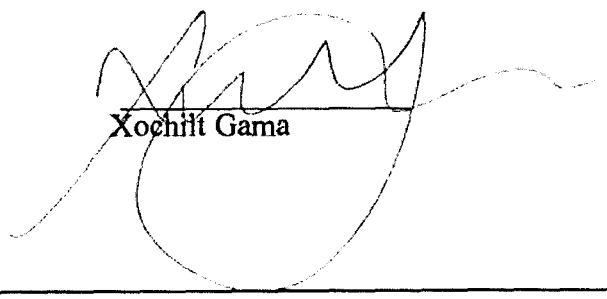
Medical Board of California
Discipline Coordination Unit
2005 Evergreen Street
Suite 1200
Sacramento, CA 95815

By Personal Service:

Civic Center Courthouse
400 McAllister Street
Dept. 302
San Francisco, CA 94102

STATE - I declare under penalty of perjury, under the laws of the State of California, that the above is true and correct.

Executed January 3, 2019, at Beverly Hills, California.



Xochilt Gama

SUPERIOR COURT OF CALIFORNIA

COUNTY OF SAN FRANCISCO

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OPPOSITION

WILLIAMS S EIDELMAN MD VS. MEDICAL BOARD OF CALIFORNIA

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FILED
San Francisco County Superior Court
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SUPERIOR COURT OF THE STATE OF CALIFORNIA
IN AND FOR THE CITY AND COUNTY OF SAN FRANCISCO

WILLIAM S. EIDELMAN, M.D., Petitioner, **v.** **MEDICAL BOARD OF CALIFORNIA,** Respondent.	Case No. CPF 19516480 **OPPOSITION TO APPLICATION FOR STAY** Date: January 4, 2019 Time: 11:00 a.m. Dept: 302

INTRODUCTION

Petitioner, William S. Eidelman, M.D., has filed a Writ of Administrative Mandate, and seeks a stay of discipline on his medical license by the Medical Board of California (Board). Petitioner claims great urgency in this matter, given the Board's disciplinary order goes into effect on January 4, 2019 at 5 p.m. However, this purported crisis is of Petitioner's own making: He was served with the Board's Decision on December 6, 2018, yet waited until the Decision's effective date to seek this stay. In any case, Petitioner's stay request falls far short of satisfying the two-pronged test set forth in Code of Civil Procedure section 1094.5, subdivision (h)(1): that `...the public interest will not suffer...' **and** (2) the `...agency is unlikely to prevail...on the

merits....'" (*Medical Board of California v. Superior Court (Elam)*(1991) 227 Cal.App.3d 1458, 1461; emphasis added.) If either one of those conditions is not established, it is an abuse of discretion for the Superior Court to grant a stay of the Board's decision. (*Elam, supra*, 227 Cal.App.3d at 1461.) In addition, Petitioner's application for a stay must overcome the strong presumption that the Board's actions were correct and regular. (*Fukuda v. City of Angels* (1999) 20 Cal.4th 805, 817; *Lemelle v. Superior Court* (1978) 77 Cal. App. 3d 148, 156.) Petitioner has failed to establish either prong of the *Elam* test and therefore the stay request should be denied.

ARGUMENT

1. The Petitioner is not likely to prevail.

Petitioner claims the Board will not prevail on the merits. His contentions are that the Board had no jurisdiction to commence an investigation based on a complaint from deputy sheriff; the disciplinary charges were barred by the applicable statute of limitations; he was immune from prosecution for his professional misconduct; he engaged in no acts of unprofessional conduct; and, the discipline imposed was excessive. Each of these contentions is without merit.

A. The Board Had Jurisdiction to Investigate and Prosecute Dr. Eidelman

Petitioner contends, without citing any authority, that the Board must receive some type of official complaint in order to have jurisdiction to investigate. This argument is frankly silly. The Board's authority to investigate is broad and unconstrained by the source of a complaint. The California Supreme Court has long held that the Board's authority to investigate is analogous to the power of a grand jury, and can be exercised "merely on suspicion that the law is being violated, or even just because it wants assurance that it is not." (*Brovelli v. Superior Court* (1961) 56 Cal.2d 524, 528; *Arnett v. Dal Cielo* (996) 14 Cal.4th 4.)

Petitioner also argues that the Sheriff's underlying investigation was illegal and as a consequence the Board's investigation was as well. The circumstances of the investigation of Petitioner by the San Bernardino Sheriff's department are not relevant to the complaint filed with the Board. Even assuming a complaint is biased or full of errors, it can be the basis of an

investigation where unprofessional conduct is alleged. The purpose of an investigation is to determine the facts and on that basis, to determine whether unprofessional conduct has occurred. Petitioner cites no authority limiting the Board's authority to investigate on the basis of a complaint. Further, to the extent that Petitioner would argue some theory of exclusion, the exclusionary rule does not apply in administrative cases. (*Emslie v. State Bar* (1974) 11 Cal.3d 210; *Department of Transportation v. State Personnel Board* (2009) 178 Cal.App.4th 568; *Borror v. Department of Investment* (1971) 15 Cal.App.3d 531.)

B. The Accusation Was Timely Filed

Petitioner asserts in a somewhat convoluted fashion that the Board's accusation was not timely filed. The Board convincingly addressed this issue in its decision, finding that the complaint was first received by the Board on November 25, 2014, making the accusation, filed on November 22, 2017, timely.[1] Petitioner does not address the findings and analysis of the Board that the receipt of the Sheriff's complaint by a different state entity (the Division of Investigation of the Department of Consumer Affairs) than the Board was not receipt by the Board. The Board's regulation requires the Board to receive the complaint; thus the Board has not authorized the Division of Investigation to be an agent for receipt of complaints within the meaning of Business and Professions Code section 2230.5 and California Code of Regulations, title 16, section 1356.2. Petitioner's assertion is thus without merit.

C. The Compassionate Use Act Does Not Confer Immunity for Unprofessional Conduct

Petitioner next claims that the Compassionate Use Act of 1996 (Proposition 215) exempts him from investigation and administrative discipline related to his recommendation of cannabis. He cites Health and Safety Code section 11362.5, subdivision (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 medial purposes."

However, contrary to Petitioner's contentions, Section 11362.5 was not enacted to provide a haven for incompetent and negligent physicians. As noted in the Board's decision,[2] the Board,

[1] At p. 22, para. 7, through p. 23, para. 8.
[2] At p. 23, para. 10.

in accordance with Government Code section 11425.60, adopted as a precedential decision, *In the Matter of the Accusation Against Tod H. Mikuriya, M.D.* (2007) Precedential Decision No. MBC-2007-02Q, which specifically rejected absolute immunity for physicians who recommend marijuana to patients: "... the immunity is qualified, and that it does not exempt a physician from standards or regulations generally applicable to physicians, including those that govern the manner or process by which the physician's recommendation was reached." Case law has consistently supported this interpretation of the law. Under the Compassionate Use Act, the physician is the designated "gatekeeper" who bears the legal responsibility make the determination whether the patient is seriously ill, and that marijuana use will be limited to medical purposes. (See *Conant v. Walters* (2002) 309 F.3d 629, 645.) While section 11362.5 provides that a physician may not be "punished, or denied any right or privilege" for recommending marijuana to a patient for medical purposes, both the law and public policy dictate that physicians who do recommend marijuana must conform their professional conduct to the standards of practice generally applicable to physicians. To hold otherwise would allow physicians to ignore the medical and health needs of "seriously ill Californians" and to simply issue a marijuana treatment recommendation without the exercise of sound medical judgment and with no oversight. No reasonable construction of the statute supports this interpretation. As Judge Kozinski observed in *Conant,*

> "[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."
>
> (*Conant v. Walters*, *id.* at p. 647.)[1/]

1. Note also, the United States Supreme Court noted the possibility that "unscrupulous" physicians might indiscriminately recommend or prescribe marijuana, and further noted the ability of state Medical Boards to sanction those physicians. (*Gonzales v. Raich* (2005) 545 U.S.1.)

D. The Board's Determinations Regarding Unprofessional Conduct Are Well Supported

Petitioner submits that he was not negligent in his care and treatment of the minor child. He asserts he based his diagnosis on the patient's behavior and the family history. Petitioner ignores the Board's finding, based on the credited testimony of experts with extensive experience addressing patients presenting as this one did, that there was no evidence whatsoever that Petitioner "consulted the DSM, virtually the Bible of mental health diagnosis."[3] There was no indication that Petitioner sought information about the child's moods, sleep patterns, any depression, or any of the pillars of pillars of the diagnosis as credibly defined by the Board's experts. Further, there was no indication of depression, a core symptom of Bipolar Disorder. Nor did Respondent seek to find any of the symptoms of inattention or hyperactivity or impulsivity, as required by the DSM. Based on the testimony of the Board's experts, the Board noted that nothing in Petition's chart refers to any of the criteria of the DSM or indicate that the child was then suffering from ADHD or Bipolar Disorder. The Board noted that tantrums alone, and primarily exhibited in one environment (school), do not support either diagnosis.[4] Petitioner does not address any of these finding in claiming he was not negligent. His claim thus lacks merit.

E. The Penalty Was Well Within the Board's Discretion

Petitioner argues that the penalty of revocation is clearly excessive. Again, it is highly unlikely that Petitioner will prevail in this argument. The penalty imposed by an administrative agency will not be disturbed in a mandamus proceeding unless a **manifest abuse of discretion** is demonstrated. (*Landau v. Medical Board* (1998) 81 Cal.App.4th 191, 218; *Fick v. Board of Medical Examiners* (1973) 31 Cal.App.3d 247, 252.) Petitioner has not made the required showing.

First, Petitioner ignores his own history of disciplinary action by the Board set forth in detail in the Board's decision.[5] The Board noted this is Petitioner's third disciplinary proceeding, and that prior efforts at rehabilitation had been unsuccessful in correcting Petitioner's practice deficiencies, and that he did not learn from the prior disciplinary actions. In this case, the Board

[3] At p. 14, para. 49.
[4] At p. 14, para. 50
[5] At p. 18, para. 67 to p. 20, para. 74.

found that the evidence established that Petitioner "all but made [a diagnosis] up out of whole cloth, having no real knowledge of the diagnostic' criteria, or proper diagnostic process, to determine if a child is suffering from either ADHD or Bipolar Disorder."[6] The Board also found a significant threat of harm from Petitioner's diagnosis, for which Petitioner made little or no effort to acquaint himself with the then-prevailing diagnostic criteria.[7] Citing Business and Professions Code section 2229 to the effect that public protection is the Board's highest priority, the Board stated, "Respondent has had two opportunities to consider his practice methods and their shortcomings, and he has not learned from those cases. Public protection requires the revocation of Respondent's certificate."[8]

Given the serious nature of Petitioner's transgressions in this case, and his failure to curb his unprofessional conduct despite two prior disciplinary actions, the Board was well within its ample discretion in revoking Petitioner's license.

2. Public Interest Will Suffer if a Stay is Granted.

Petitioner argues that the public will not be harmed if Petitioner is allowed to continue practicing, arguing that the patient here was not harmed. A showing of harm is not a prerequisite to discipline. (*Griffiths v. Superior Court* (2002) 96 Cal.App.4th 757, 772.) It is the risk of harm with which the standard of care is concerned. (*Donnelly v. Southern Pacific Co.* (1941) 18 Cal.2d 863, 871.) Petitioner in making this argument ignores the risk of harm to the patient he created by his conduct. Further, allowing Petitioner to practice medicine pending the outcome of his writ petition will put other patients risk of Petitioner's established willingness to ignore standard of care criteria for diagnosing patients. Denying the stay will ensure that no further patients are subjected to Petitioner's long history of risk-creating behavior. The "preventative functions of license discipline, whose main function is public protection. . . but whose purposes also include prevention of future harm"[9] should not be ignored. The stay should be denied.

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[6] At p. 24, para. 17A.
[7] At p. 24, para. 17B.
[8] At p. 25, para. 17D.
[9] *Griffiths v. Superior Court* (2002) 96 Cal.App.4th 757, 772.

CONCLUSION

It is apparent from even the preliminary analysis of the record in this case that the Board's Decision was made after thoughtful and careful evaluation of the evidence. The Decision was supported by the evidence. Petitioner is unlikely to ultimately prevail in this case. As Petitioner himself argues, the Board's discipline is not meant as punishment, but as a means to protect the public. The Decision seeks this protection by revoking Petitioner's license. The requested stay is against public interest because it will hurt the public interest by permitting Petitioner to persist in his unschooled practice, thereby putting patients at risk of harm. For these reasons, the stay requested by the Petitioner should be denied.

Dated: January 4, 2019

Respectfully Submitted,

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Medical Board of California

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DECLARATION OF SERVICE BY E-MAIL

Case Name: **In the Matter of the Accusation Against: WILLIAM S. EIDELMAN, M.D.**
No.: **2018030645**

I declare:

I am employed in the Office of the Attorney General, which is the office of a member of the California State Bar, at which member's direction this service is made. I am 18 years of age or older and not a party to this matter.

On January 4, 2019, I served the attached **OPPOSITION TO APPLICATION FOR STAY** by transmitting a true copy via electronic mail, addressed as follows:

Tracy Green
Attorney at Law
Green Associates
E-mail Address: tgreen@greenassoc.com

J. Raza Lawrence
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Margolin & Lawrence
E-mail Address:
raza@margolinlawrence.com

I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct and that this declaration was executed on January 4, 2019, at San Francisco, California.

David A. Limin
Declarant

Signature

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