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

In the Matter of the Accusation Against:

MICHAEL EDWARD PLATT, M.D.
73-345 Highway 111, Suite 203
Palm Desert, CA 92260
Physician's and Surgeon's Certificate No.
G23729

Respondent.

Complainant alleges:

PARTIES

1. Barbara Johnston (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California.

2. On or about November 24, 1972, the Medical Board of California issued Physician's and Surgeon's Certificate Number G23729 to Michael Edward Platt, 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 November 30, 2009, unless renewed.
JURISDICTION

3. This Accusation is brought before the Medical Board of California, under the authority of the following sections of the Business and Professions Code ("Code"):  

4. Section 2220 of the Code states:  

"Except as otherwise provided by law, the Division of Medical Quality may take action against all persons guilty of violating this chapter [Chapter 5, the Medical Practice Act]. The division shall enforce and administer this article as to physician and surgeon certificate holders, and the division shall have all the powers granted in this chapter..."

5. 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 have such other action taken in relation to discipline as the Division deems proper.

6. Section 2234 of the Code states:  

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

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical Practice Act].

(b) Gross negligence.

(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"

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1. California Business and Professions Code section 2002, as amended effective January 1, 2008, provides in part that the term "board" as used in the State Medical Practice Act (Business and Professions Code, section 2000, et seq.) means the "Medical Board of California," and that references to the "Division of Medical Quality" and "Division of Licensing" in the Act or any other provision of law shall be deemed to refer to the Board.
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.”

7. Section 2242 of the Code states:

“(a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication, constitutes unprofessional conduct.

“(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

“(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient’s physician and surgeon or podiatrist, as the case may be, and if the drugs were
prescribed, dispensed, or furnished only as necessary to maintain
the patient until the return of his or her practitioner, but in any case
no longer than 72 hours.

"(2) The licensee transmitted the order for the drugs to a
registered nurse or to a licensed vocational nurse in an inpatient
facility, . . . ."

"(3) The licensee was a designated practitioner serving in
the absence of the patient’s physician and surgeon or podiatrist, as
the case may be, and was in possession of or had utilized the
patient’s records and ordered the renewal of a medically indicated
prescription for an amount not exceeding the original prescription
in strength or amount or for more than one refill.

"(4) The licensee was acting in accordance with Section
120582 of the Health and Safety Code."

8. 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)

9. Respondent is subject to disciplinary action pursuant to Section 2234,
subdivision (b) of the Code, in that Respondent was grossly negligent in his care, treatment and
management of C.B. The circumstances are as follows:

A. On or about February 22, 2006, C.B., a 42 year old female, sought
treatment from Respondent for urinary incontinence, weight loss and headaches.
She was referred by a friend and had seen one of Respondent’s infomercials on
television regarding his ability to cure incontinence.

C. C.B.’s primary complaint was incontinence. She told Respondent that she had three children, aged 12, 15 and 18, and that on occasion she would “piddle” in her pants after sneezing or coughing. Respondent told C.B. he could control incontinence in about six days with a 100 per cent success rate.

D. In response to Respondent’s questions, C.B. told him that she was not generally tired in the afternoon, her sex drive was okay, but that a little extra help was always nice. She reported she had been on birth control pills for seventeen (17) years, that her periods were consistent, and she had very little cramping. Respondent told C.B. that birth control pills caused six different types of cancer and advised her to stop taking her birth control pills. He did not discuss or recommend alternative methods of birth control or suggest she contact her OB/GYN before instructing her to stop taking her birth control pills.

E. Respondent did not conduct a review of systems or perform a physical examination of C.B., nor perform a pelvic examination.

F. Respondent’s chart notes on the visit were sparse and failed to include a diagnosis or treatment plan.

G. Respondent did not obtain C.B.’s release nor take any steps to obtain C.B.’s medical records from any prior treating physicians, nor to consult with any of them.

H. Respondent’s lab technician drew C.B.’s blood for the purpose of running a hormone panel. Though Respondent did not yet have the results, he prescribed testosterone and progesterone for C.B. Respondent prescribed and told C.B. to take testosterone cream vaginally daily in the morning and to apply the 1/4
teaspoon progesterone cream to her forearm twice a day, morning and evening.

He told C.B. to consider him her primary physician.

1. C.B. filled the prescriptions and began using the drugs as
prescribed, though she only did the morning applications (and did not apply
progesterone cream in the evening).

J. On or about April 28, 2006, C.B. had blood work taken at a local
laboratory. Her testosterone level was extremely elevated, at 1988.2

K. By early May and approximately two months after starting the
treatment, C.B. began to get concerned. She was taking her birth control pills and
the drug creams prescribed by Respondent, but was still incontinent and had now
missed her period. She was alarmed about the prospect of possibly being
pregnant at age 42. On or about May 5, 2006, C.B. contacted Respondent and
conveyed these concerns. In response, Respondent told her to stop taking the
progesterone and testosterone, and to wait for her period. When C.B. asked if the
testosterone or progesterone could have caused her birth control pills to be
ineffective, or whether she should start the active portion of her birth control pills
on May 7, Respondent became angry and rude. Respondent said he had not seen
this problem before. Though he did not appear to have an answer for the cause of
C.B. ’s stopped periods, Respondent again told C.B. to stop taking birth control
pills, and advised her to get her tubes tied or use an IUD.

L. On or about May 16, 2006, C.B. had a scheduled conference call
with Respondent. C.B. wanted to discuss her continued incontinence, reduced sex
drive and her concerns that her period had still not resumed, even though a recent
test concluded she was not pregnant. Respondent wanted to know if she was
taking the testosterone as prescribed and doing the kegel exercises. C.B. stated
that she was. Respondent told her the incontinence problem should have been

2. The normal range is from 20 to 76.
resolved in six days to one month after starting his treatment. For the first time,
Respondent recommended C.B. see a urologist.

M. During this same phone call, C.B. complained that her libido had
not increased despite her taking the testosterone as prescribed by Respondent.
Respondent told her she should be fantasizing about “the mailman.” When she
explained she was not, Respondent appeared to become angry and told her she
must not be happy with her partner, that libido is all in one’s head, and that it had
not increased because she was obsessive compulsive and wanted everything to be
perfect.

10. Respondent committed acts of gross negligence in his care, treatment and
management of patient C.B. by reason of, but not limited to, the following:

A. Respondent failed to perform a pelvic examination and failed to
perform an adequate physical examination of C.B. prior to diagnosing and treating
her urinary incontinence.

B. Respondent failed to request permission to consult with the
patient’s current or prior treating physicians, did not consult with any, and failed
to request or obtain C.B.’s medical records from her prior or current treating
physicians.

C. Respondent prescribed testosterone and progesterone to C.B.
before having the results of her hormone panel.

D. Respondent advised C.B. to stop taking birth control pills without
making provision for alternative contraceptive methods.

E. Respondent failed to follow the standard of care by prescribing
testosterone to treat the patient’s urinary incontinence.

Patient “N.M.”

11. Respondent is subject to disciplinary action pursuant to Section 2234,
subdivision (b) of the Code, in that Respondent was grossly negligent in his care, treatment and
management of patient “N.M.” The circumstances are as follows:
A. "N.M." is the undercover name used by a female investigator employed by the Enforcement Program of the Medical Board of California.

B. N.M. was first seen by Respondent on April 23, 2007, for a complaint of urinary incontinence. N.M. filled out an intake questionnaire listing her age as 43 and giving a history of heart problems, palpitations and urinary incontinence. After speaking with a nutritional counselor in Respondent’s office and having a medical assistant take her blood pressure and weight, N.M. had a consultation with Respondent.

C. The consultation occurred in Respondent’s office, with Respondent seated behind a desk. Respondent took a brief medical history. N.M. told Respondent her primary complaint was her incontinence. She stated that for the past six months, she “leaked” when she coughed or laughed, and that she wanted an alternative treatment for her urinary incontinence that would not involve surgery. N.M. told Respondent she was taking Lo/Ovral 28, a birth control pill, and that he was the first doctor she was seeing for the incontinence.

D. N.M. brought laboratory test results dated April 4, 2007, which showed her tested values were within the normal range.

E. Respondent did not conduct a review of systems or perform a pelvic examination or any physical examination of N.M.

F. Respondent did not request N.M.’s release and did not take any steps to obtain her medical records from any current or prior treating physicians.

G. Respondent told N.M. that if she followed his treatment of testosterone and kegel exercises, her urinary incontinence would be gone in three to six days. He asked about her libido, and told her that by taking the testosterone he would prescribe, she would be “looking” at “the mailman.”

H. Respondent told N.M. she had a thyroid problem and that he was going to treat her thyroid.
1. When Respondent asked N.M. if she gets tired when she travels in the car, she relayed that she always falls asleep when she is a passenger on a car trip. When Respondent asked if she had a short temper, she stated she could get irritable. Respondent told N.M. she had ADHD.

J. Respondent’s progress notes of April 23, 2007 charted that her concerns were “incontinence” and “estrogen dominance”. He noted she was on birth control pills and had dry skin. Respondent’s chart notes on the visit were sparse, failed to include a diagnosis or treatment plan, and were inadequate. He did not make a referral for her complaints of palpitations or heart problems.

12. Respondent committed acts of gross negligence in his care, treatment and management of N.M., by reason of, but not limited to, the following:

A. Respondent failed to perform a pelvic examination and failed to perform an adequate physical examination of N.M. prior to diagnosing her incontinence and telling her how he would treat it.

B. Respondent failed to request or obtain N.M.’s medical records from her current or prior treating physicians.

C. Respondent never discussed with N.M. her complaints of palpitations or heart problems, never evaluated them, and made no referral to any other medical specialist to address those problems.

D. Respondent told N.M. he would treat her urinary incontinence with testosterone, even though the use of testosterone to treat urinary incontinence is not within the standard of care.

E. Despite Respondent’s failure to examine N.M.’s neck and thyroid and her normal blood test results, Respondent believed N.M. suffered from a thyroid disorder and told her he would provide medication to treat her.

F. Respondent failed to conduct a physical examination of N.M.’s thyroid and her neck to check the size of her thyroid, if she had any tenderness, and the presence or absence of nodules.
Patient - E.K.

13. Respondent is subject to disciplinary action pursuant to Section 2234, subdivision (b) of the Code, in that Respondent was grossly negligent in his care, treatment and management of patient E.K.. The circumstances are as follows:

A. Respondent treated E.K. over a period of two years. Respondent first treated E.K. on or about July 28, 2003, when she was 71 years old and presented with a complaint of urinary incontinence. E.K. gave a history of having cardiac arrhythmias, dizziness, palpitations, shortness of breath and headaches. Respondent did not conduct a physical examination or pelvic examination of E.K.

B. Respondent did not request or obtain medical records from E.K.’s prior or current treating physicians, nor did he consult with any of them during the time he treated E.K..

C. On or about July 27, 2003, before laboratory tests results were available, Respondent prescribed several hormones for E.K., including thyroid supplements (T3 and T4 thyroid replacement), progesterone, testosterone, and DHEA.

D. Laboratory tests were taken on or about July 28, 2003. When respondent learned the results were within normal range, he did not instruct E.K. to stop taking the thyroid prescriptions.

E. E.K.’s laboratory reports from blood drawn on July 28, 2003, showed a total cholesterol reading of 310 with LDL of 188.3 A repeat total cholesterol was 258 with a LDL of 139. Respondent did not treat or refer E.K. for treatment of her high cholesterol readings.

F. On August 5, 2003, Respondent charted that E.K. was told to stay on ½ dose of thyroid supplements for the time being. There was no other entry in the chart note.

3. Normal reference range for total cholesterol is under 200; for LDL it is under 130.
G. On September 16, 2003, E.K. reported she was still having hot
flashes. Respondent increased her T4 thyroid supplement to 0.125. On
September 14, 2004, E.K. had an episode of shortness of breath and chest pain.
Respondent entered a notation in E.K.’s records that he suspected her discomfort
was secondary to degenerative arthritis of the spine. He took no action to evaluate
or address the symptoms she reported.

H. On March 18, 2005, E.K. complained to Respondent that she was
losing her hair and her heart rate had increased. Respondent told E.K to decrease
T3 to once each day and decrease the T4 to ½ tablet. He charted that he suspected
she was hyperthyroid and that he would see her in the next 1-2 weeks, check her
rate and “maybe do thyroid tests.”

I. Respondent’s chart entries for E.K.’s visits are sparse and
inadequate.

14. Respondent committed acts of gross negligence in his care, treatment and
management of patient, E.K. by reason of, but not limited to, the following:

A. Respondent did not perform any physical examination of E.K.
during any of her visits or evaluations from on or about July 28, 2003 to July 12,
2005.

B. Respondent prescribed thyroid replacement therapy (T3 and T4) to
E.K., without medical indication or an appropriate physical examination.

C. Thyroid supplements can precipitate ischemic heart disease in
cardiac patients. Despite its contraindication for a patient with a cardiac history
and normal laboratory values. Respondent not only prescribed thyroid
supplementation to E.K., but continued to do so even though E.K. experienced
heart palpitations and chest pain.

D. Respondent failed to stop the thyroid supplements when he
suspected E.K. was hyperthyroid.
E. Respondent treated E.K.'s urinary incontinence without performing an appropriate physical examination of E.K., including a pelvic examination.

F. Respondent prescribed testosterone for the treatment of E.K.'s urinary incontinence even though the use of testosterone to treat urinary incontinence is not within the standard of care.

G. Respondent failed to treat E.K.'s extremely high cholesterol and LDL levels reported in her laboratory reports and failed to refer her to another physician for treatment of these levels.

H. Respondent failed to have E.K. sign a release to obtain her prior treating physician's medical records, failed to obtain medical records from her prior or current treating physicians, and failed to consult with them.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

Patient C.B.

15. Respondent is subject to disciplinary action pursuant to section 2234, subdivision (c), in that, Respondent committed repeated acts of negligence in his care, treatment and management of patient C.B., as described above in paragraphs 9 and 10, and their subsections, which are incorporated by reference herein.

Patient N.M.

16. Respondent is subject to disciplinary action pursuant to section 2234, subdivision (c), in that, Respondent committed repeated acts of negligence in his care, treatment and management of N.M., as described above in paragraphs 11 and 12, and their subsections, which are incorporated by reference herein.

Patient E. K.

17. Respondent is subject to disciplinary action pursuant to section 2234, subdivision (c), in that, Respondent committed repeated acts of negligence in his care, treatment and management of patient E.K., as described in above in paragraphs 13 and 14, and their subsections, which are incorporated by reference herein.
THIRD CAUSE FOR DISCIPLINE

(Incompetence)

Patient C.B.

18. Respondent is subject to disciplinary action pursuant to Section 2234, subdivision (d) of the Code, in that respondent was incompetent in his care, treatment, and management of C.B., as described above in paragraphs 9 and 10, and their subsections, which are incorporated by reference herein.

Patient N.M.

19. Respondent is subject to disciplinary action pursuant to Section 2234, subdivision (d) of the Code, in that respondent was incompetent in his care and treatment of patient N.M., as described above in paragraphs 11 and 12, and their subsections, which are incorporated by reference herein.

Patient E.K.

20. Respondent is subject to disciplinary action pursuant to Section 2234, subdivision (d) of the Code, in that Respondent was incompetent in his care and treatment of patient E.K., as described above in paragraphs 13 and 14, and their subsections, which are incorporated by reference herein.

Physician Interview and Submissions

21. On August 22, 2007, Respondent was interviewed as part of the investigation giving rise to the allegations set forth in this Accusation. During the interview, Respondent asserted the following:

A. He does not conduct a physical examination of his patients and does not believe they are “needed.” He believes he gets sufficient information from his patients by talking to them.

B. Respondent stated that he is not bound by the peer reviewed medical literature because he learns from his patients and relies on his own opinions.

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C. Respondent does not use normal ranges for laboratory test values to determine hormonal deficiencies and does not feel bound by the accepted normal ranges in determining hormonal deficiencies of cortisone, testosterone and for the thyroid.

D. Respondent referred the Board to a book he authored, *The Miracle of Bio-identical Hormones*, concerning his approach regarding the diagnosis and treatment of certain conditions and diseases.


23. Respondent is subject to disciplinary action under section 2234, subdivision (d), in that Respondent’s statements and representations demonstrate incompetence, by reason of but not limited to the following:

A. Respondent purposely fails to use normal recognized and accepted values in evaluating laboratory studies done on his patients and purposely fails to use the normal values to guide his diagnosis and treatment of his patients.

B. Respondent does not believe the standard of care requires that he perform a physical examination of a patient as part of his medical evaluation before making a diagnosis or giving treatment to the patient.

C. Because he believes he can obtain the information he needs without conducting a physical examination of a patient, Respondent does not perform an appropriate physical examination of his patients before evaluating, diagnosing, or commencing treatment of his patients.
FOURTH CAUSE OF ACTION

(Furnishing Dangerous Drugs Without an Examination)

Patient C.B.

24. Respondent is subject to disciplinary action pursuant to Section 2242 of the Code, in that Respondent prescribed C.B. dangerous drugs, as defined by Section 4022, without an appropriate prior examination or medical indication, as described above in paragraph 9 and its subsections, incorporated by reference herein.

Patient N.M.

25. Respondent is subject to disciplinary action pursuant to Section 2242 of the Code, in that Respondent prescribed N.M. dangerous drugs, as defined by Section 4022, without an appropriate prior examination or medical indication, as described above in paragraph 14 and its subsections, incorporated by reference herein.

Patient E.K.

26. Respondent is subject to disciplinary action pursuant to Section 2242 of the Code, in that Respondent prescribed patient E.K. dangerous drugs, as defined by Section 4022, without an appropriate prior examination or medical indication, as described above in paragraph 14 and its subsections, incorporated by reference herein.

FIFTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Records)

27. Respondent is subject to disciplinary action for failing to maintain adequate and accurate records in violation of Business and Professions Code section 2266, as follows:

A. Respondent failed to maintain adequate and accurate medical records for patient C.B., as set forth above in paragraph 9, and its subsections.

B. Respondent failed to maintain adequate and accurate medical records for N.M., as set forth above in paragraph 11, and its subsections.

C. Respondent failed to maintain adequate and accurate medical records for patient E.K., as set forth above in paragraph 13, and its subsections.
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 G23729, issued to Michael Edward Platt, M.D.

2. Revoking, suspending or denying Michael E. Platt, M.D., the authority to supervise physician assistants, pursuant to section 3527 of the Code;

2. Ordering Michael E. Platt, M.D., to pay the costs of probation monitoring, should he be placed on probation; and,

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

DATED: May 2, 2008

Barbara Johnston
Executive Director
Medical Board of California
State of California
Complainant