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

In the Matter of the Accusation Against: **Eric Michael Jacobson, M.D.** **Behavioral Health Services** **576 Hartnell St., Ste. 300** **Monterey, CA 93940** **Physician's and Surgeon's Certificate No. G 36315,** Respondent.	Case No. 800-2014-009435 **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 April 24, 1978, the Medical Board issued Physician's and Surgeon's Certificate No. G 36315 to Eric Michael Jacobson, 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 April 30, 2018, 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 (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

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 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."

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FIRST CAUSE FOR DISCIPLINE
[Bus. & Prof. Code §2234(c)]
(Unprofessional Conduct/Repeated Negligent Acts)

7. Respondent Eric Michael Jacobson, M.D., is subject to disciplinary action under section 2234(c) of the Code in that he committed acts of repeated negligence in the care and treatment of patient D.S. The circumstances are as follows:

8. On or about October 22, 2014, the California Department of Public Health (CDPH) requested an investigation into the quality of psychiatric care and treatment Respondent provided to patient D.S. at Community Hospital of the Monterey Peninsula (CHOMP). The request stated that on or around August 15, 2014, the CDPH followed-up on complaints from patient D.S. where she alleged she was misdiagnosed and inappropriately placed on involuntary hold and received electroconvulsive therapy (ECT) without her consent. Patient D.S. also alleged that she suffered brain damage as a result of the treatment she received from Respondent at CHOMP.

TREATMENT PROVIDED TO PATIENT D.S. AT SHARP MESA VISTA HOSPITAL

9. On or about August 24, 2015, the Board received certified medical records of patient D.S. from CHOMP. On or about January 5, 2016, the Board received certified medical records of patient D.S. from Sharp Mesa Vista Hospital. An expert reviewer from the Board reviewed Respondent's treatment of patient D.S. and found that his actions constituted departures from the standard of care based upon the quality of psychiatric care and treatment he provided.

10. Patient D.S. was treated as an outpatient by psychiatrist E.R., MD in San Diego for bipolar disorder. She had been prescribed many psychotropic medications yet became increasingly depressed. As a result, she was referred by Dr. E.R. for outpatient ECT at Sharp Mesa Vista in San Diego. Patient D.S., up to one month prior to the commencement of this series of ECT, had been using cannabis on a daily basis. She had also used cocaine, ecstasy, LSD, alcohol and mushrooms. She was prescribed medication including Adderall (amphetamines) 60 mg daily and Xanax 2 mg daily in addition to lamotrigine, bupropion, zolpidem, and thioridazine. The initial series of ECT was administered voluntarily as an outpatient, but she was considered admitted to Sharp Mesa Vista Hospital for each episode of treatment, and discharged home the

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same day. She received 19 sessions of outpatient ECT at Sharp Mesa Vista Hospital from March 28 through June 15, 2012. These treatments were bilateral.

11. After 19 outpatient ECT treatments at Sharp, patient D.S. became more depressed and had short term memory difficulties. Patient D.S. considered discontinuing treatment, but instead requested voluntary inpatient admission to Sharp Mesa Vista Hospital. She remained inpatient from July 10 through July 21, 2012, and received 9 additional ECT treatments for a total of 28 ECT sessions. Drs. P.B., D.B. and R.F. administered ECT initially bilaterally. After patient D.S.'s 25th treatment, Dr. R.F. noted continued confusion on the part of the patient and changed any future treatments to unilateral. Nurse's notes indicated patient D.S. continued to use cannabis prior to her inpatient hospitalization and during outpatient ECT.

12. Patient D.S. was discharged on July 21, 2012, and moved near Monterey, California. She discussed with her psychiatrists and social services staff at Sharp Mesa Vista Hospital her intent to continue ECT treatment in Monterey. Respondent, a psychiatrist with the medical group at CHOMP, reviewed the earlier treatments and recommendations with Dr. E.R.

TREATMENT PROVIDED TO PATIENT D.S. AT CHOMP

13. On or about August 10, 2012, Patient D.S. was admitted voluntarily for outpatient ECT treatment at CHOMP. On that date, she received her first outpatient continuation ECT unilaterally from Dr. M.L. Dr. M.L. attempted to taper down the frequency of ECT, moving to continuation every week, then maintenance every other week, then monthly, but this did not work out. Dr. M.L., observing her increasing depression, decided to use the bilateral mode after ECT #6 at CHOMP (#34 for the year). Several ECT's were administered by Respondent in October during the vacation of Dr. M.L. At that time, because patient D.S. seemed profoundly more depressed, the ECT increased in frequency in October and was altered to bilateral. She received a total of 30 outpatient ECT sessions at CHOMP. Prior to the first ECT and every month thereafter, she was evaluated by Dr. M.L., and then 24 hours later by a "second opinion" psychiatrist who evaluated her capacity to give informed consent. The second opinion psychiatrist determined the patient's capacity by asking a series of questions to the patient and then observed the patient approve treatment by signing a consent form for ECT. In all those monthly sessions where she

signed the informed consent form, either her mother or father were present. Respondent and Dr. M.L. noted patient D.S. had some memory problems. Memory complaints had occurred when patient D.S. was receiving bilateral ECT at Sharp Mesa Vista Hospital prior to ECT treatment at CHOMP.

14. There was no formal assessment of cognitive complaints by either Respondent or Dr. M.L. They did not perform the Folstein Mini-Mental Status exam, draw a clock test or the Montreal Cognitive Assessment (MOCA) or similar instrument. Cognitive testing was non-uniform, perfunctory and incomplete. Respondent's failure to systematically, uniformly and thoroughly test for the validity of patient D.S.' reports of memory problems constitutes a departure from the standard of care.

15. Respondent did not document the implications of exceeding 30 ECT treatments. Patient D.S. received an unusually large number of treatments, a total of 58, in approximately nine months. Respondent's failure to refer patient D.S.'s ECT treatment to the ECT peer review committee for discussion is a departure from the standard of care. Further, Respondent omitted any discussion in the records of the extra-ordinary, prolonged course of ECT, and the usefulness of ECT as a mode of therapy. This is also a departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE
[Bus. & Prof. Code §2266]
(Unprofessional Conduct/Negligent Patient Record Keeping)

16. Respondent Eric Michael Jacobson, M.D., is subject to disciplinary action under section 2266 of the Code in that he failed to maintain adequate and accurate medical records in the care and treatment of patient D.S. The circumstances are as follows:

17. Paragraphs 7 through 15 above, are repeated here as if fully set forth.

18. Respondent's inadequate and inaccurate medical record keeping in his care and treatment of patient D.S., as described above, constitutes a violation of section 2266 of the Code and thereby provides cause for discipline to Respondent's license.

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 No. G 36315, issued to Respondent Eric Michael Jacobson, M.D.;

2. Revoking, suspending or denying approval of Respondent Eric Michael Jacobson, M.D.'s authority to supervise physician assistants and advanced practice nurses, pursuant to section 3527 of the Code;

3. Ordering Respondent Eric Michael Jacobson, 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: March 16, 2017

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

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