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

In the Matter of the Accusation
Against:

STEPHEN HERMAN, M.D.
9341 Hazel Circle
Villa Park, CA 92667

Physician and Surgeon License
No. A20234

and

VALENTINE BIRDS, M.D.
12626 Riverside Drive, Ste. 510
North Hollywood, CA 91607

Physician & Surgeon License
No. A28695

Respondents.

COMES NOW Complainant Kenneth Wagstaff, who as cause
for disciplinary action, alleges:

1. Complainant is the Executive Director of the
Medical Board of California (hereinafter the "Board") and makes
and files this accusation solely in his official capacity.

1.
LICENSE STATUS

2. On or about July 9, 1962, Physician and Surgeon Certificate No. A20234 was issued by the Board to Stephen Herman, M.D. (hereinafter "respondent Herman"), and at all times relevant herein, said Physician and Surgeon Certificate was in full force and effect.

3. On or about March 21, 1975, Physician and Surgeon Certificate No. A28695 was issued by the Board to Valentine Birds, M.D. (hereinafter "respondent Birds"). On June 14, 1978, respondent Birds was subject to discipline for unprofessional conduct pursuant to Business and Professions Code sections 490, 2141, and 2392 (aiding and abetting unlicensed persons to practice medicine). Respondent Birds' license was revoked with the revocation stayed. Respondent Birds was placed on five years probation on certain terms and conditions including actual suspension for sixty days. Probation terminated and respondent's license was fully restored to unrestricted status on December 28, 1980. Additionally, respondent Birds is a supervisor of a physician assistant, License No. SA16055.

STATUTES

4. This accusation is made in reference to the following sections of the California Business and Professions Code (hereinafter "Code"):  
   a. Code section 2220 provides, in pertinent part, that the Board may take action against all persons guilty of violating the Medical Practice Act.
   
   b. Code section 2227 provides that the Board may
revoke, suspend for a period not to exceed one year, or place on
probation, the license of any licensee who has been found guilty
under the Medical Practice Act.

c. Code section 2234 provides that unprofessional
conduct includes, but is not limited to, the following:

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

(b) Gross negligence.

(c) Repeated negligent acts.

(d) Incompetence.

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

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

FACTS

DEVELOPMENT OF "VIROXAN"

5. "Viroxan", also referred to as LP-1, LP-4,
Geraniol, Linolool, and Linolool Ozonide, was first "synthesized" 
from plant sources by respondent Herman and Herman's son in 1988.

6. At all times relevant herein, respondent Herman and
others "manufactured" quantities of "Viroxan" in a "primitive"
laboratory located in the kitchen of respondent Herman's
7. "Viroxan" has never received approval by the United States Food and Drug Administration (USFDA), or the Food and Drug Branch of the California Department of Health Services, or any other regulatory agency as being safe and efficacious for use against HIV infections (AIDS) in human beings.

8. On or about, and before September 1, 1989, respondent Herman and respondent Birds were aware that "Viroxan" was not proven safe for use in human beings or efficacious against AIDS infection HIV, infection or any bacterial, fungal, or viral infections. Nonetheless, prior to receiving even basic animal toxicity data, respondents Herman and Birds began injecting human beings with "Viroxan".

9. Respondent Herman and respondent Birds failed to heed the warnings of Dr. Herman's scientific consultant Dr. R. concerning the fact rubber stoppers on the vials containing "Viroxan", manufactured and bottled in respondent Herman's kitchen, were not airtight; they leaked and were therefore subject to contamination. Furthermore, Dr. R. informed respondent Herman that "Viroxan" had a toxic effect on animals at doses greater than 1.9mm (107mg/kg). In fact doses greater than 1.9mm killed all test mice and rats; and, rabbits experienced adverse reactions at the "Viroxan" injection site.

UNDERCOVER OPERATIONS

INVESTIGATOR COLBY S.

10. On or about December 27, 1989, Colby S., a Senior Special Investigator for the Medical Board of California called
respondent Birds and told respondent Birds he had just been
tested HIV positive and was interested in receiving treatment.
Respondent Birds told Colby S. he used typhoid therapy.
Respondent Birds then referred Colby S. to respondent Herman to
discuss treatment. Respondent Birds gave Colby S. respondent
Herman's telephone number and represented to Colby S. that
respondent Herman had good results treating AIDS patients with
"Viroxan".

11. On or about January 8, 1990, Colby S. contacted
respondent Herman via telephone and explained to respondent
Herman that Colby S. was interested in hearing about respondent
Herman's treatment for AIDS. Respondent Herman told Colby S. to
come to respondent Herman's home the next day at 11:00 a.m.

12. On or about January 9, 1990, Colby S. and
approximately five other individuals attended a two-hour
presentation conducted by respondent Herman at respondent
Herman's home. During the presentation respondent Herman
informed the group that other AIDS treatments were ineffective,
but his treatment with "Viroxan" has long-term effects in
arresting the disease. Respondent Herman claimed treatment with
"Viroxan" produced no side-effects and that "Viroxan" had been
tested and found non-toxic and effective against a wide spectrum
of diseases. Respondent Herman recommended to the group that any
patient receiving "Viroxan" be referred to respondent Birds so
respondent Birds could arrange surgery for placement of Hickman
catheters.

13. Respondent Herman told attendees that treatment
with "Viroxan" requires daily injections, and a thirty-day supply costs three hundred dollars. Respondent Herman also told the group it would be unnecessary for them to return to see respondent Herman except to pick up more "Viroxan" because patients could self-inject the "Viroxan".

14. On or about January 11, 1990, pursuant to arrangements made at the previous day's seminar, Colby S. purchased ten vials of "Viroxan" from respondent Herman for three hundred dollars. As soon as the sale occurred respondent Herman was arrested by the authorities.

15. As a result of the conduct described in Paragraphs 5-14 above, respondent Herman and respondent Birds are subject to disciplinary action pursuant to Code section 2234, subdivision (e) because of their acts of dishonesty and/or corruption in willfully and unlawfully representing "Viroxan" as being effective in treating HIV positive patients, AIDS patients, and patients with diseases, disorders, or conditions of the immune system with the intent to defraud or mislead the individuals to whom the representations were made.

16. As a result of the conduct described in Paragraphs 5-14 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in making available for self-administration a foreign substance not shown to be safe for use in human beings or efficacious against HIV infection.

17. As a result of the conduct described in Paragraphs 5-14 above, respondent Herman is subject to disciplinary action
pursuant to Code section 2234, subdivision (b) because of his gross negligence in making available to patients, a substance ("Viroxan"), which is not manufactured according to good pharmaceutical manufacturing practices, and which may be contaminated with micro organisms.

18. As a result of the conduct described in paragraphs 5-14 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (d) because of his incompetence in making available for patients' self-administration, a foreign substance not shown to be safe for use by human beings or efficacious against HIV infection.

19. To the extent it is determined respondent Birds aided and abetted respondent Herman in the above-described conduct, respondent Birds is also subject to discipline pursuant to section 2234, subdivisions (b), (d), and (e) because of his gross negligence, incompetence, dishonesty or corruption.

INVESTIGATOR JEFFREY Y.

20. On or about January 10, 1990, Jeffrey Y., a Food and Drug Investigator called respondent Herman's home and arranged to attend a "Viroxan" presentation set to occur at 11:00 a.m. on January 11, 1990.

21. On or about January 11, 1990, Investigator Jeffrey Y. attended a presentation on "Viroxan" conducted by respondent Herman at respondent Herman's home. During the presentation, respondent Herman represented "Viroxan" to be a "break through" "clearly demonstrated" to be effective in treating the entire spectrum of T-cell mediated diseases. Respondent Herman further
represented that "Viroxan" was proven non-toxic, and was effective in treating chronic, long-term arthritis and cancers such as Hodgkin's Disease and leukemia.

22. As a result of the conduct described in Paragraphs 5-9 and 20-21 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (e) because of his dishonest and/or corrupt representation that "Viroxan" was safe and effective for treatment of T-cell mediated diseases, chronic, long-term arthritis and cancers.

PATIENT TREATMENT WITH "VIROXAN"

PATIENT MARK S.

23. On or about December 1, 1988, Mark S., an HIV infected individual, became a patient of respondent Birds. On that day, respondent Birds gave Mark S. a "typhoid skin test".

24. On or about December 5, 1988, respondent Birds began Mark S. on a "therapeutic protocol using typhoid vaccine."

25. On or about, and between approximately December 5, 1988 and March 21, 1989, Mark S. kept approximately thirteen separate appointments with respondent Birds during which Mark S. received varying amounts of typhoid vaccine for treatment of his HIV infection.

26. On or about August 17, 1989, Mark S. had a CD4-T-cell measurement of 132 cells/Cumm. It was recommended by the Staff at Philip Mandelker AIDS Prevention Clinic of the Gay and Lesbian Services Center in Hollywood that Mark S. consider treatment with Zidovudine (formerly known as AZT) and receive primary prophylaxis against the development of Pneumocystic
Pneumonia.

27. On or about September 5, 1989, Mark S. gave a copy of his latest CD4-T-cell count to respondent Birds. Respondent Birds administered more typhoid vaccine and made no recommendation concerning use of Zidovudine or primary prophylaxis against development of Pneumocystic Pneumonia.

28. On or about October 13, 1989, pursuant to respondent Birds recommendation, Mark S. contacted and visited respondent Herman at respondent Herman's home in Orange County. Respondent Herman noted that Mark S. had a CD4-T-cell count of 132 cells/cu.mm. and "thrush moderate Lymphadenopathy, SLGI upset, fatigue, herpes recurrent and hair loss." Accordingly, respondent Herman began Mark S. on "Viroxan" via intravenous injection.

29. On or about October 16, 1989, to facilitate injection of the "Viroxan" supplied by respondent Herman, respondent Birds recommended Mark S. have a Hickman catheter surgically implanted.

30. On or about October 17, 1989, Mark S. was admitted to the Medical Center of North Hollywood where a Hickman catheter was placed pursuant to respondent Birds' order. Respondent Birds indicated the need for placement of a Hickman catheter was due to his professional diagnosis of "lymphoma".

31. On or about October 18, 19, 20, 23, and 31, 1989, Mark S. visited respondent Birds. On each of the five visits, respondent Birds supplied Mark S. with quantities of "Viroxan" IV.
32. On or about October 26, 1989, Mark S. again saw respondent Herman and was given "4,000 mg IV" of the substance "Viroxan."

33. On or before October 31, 1989, Mark S. was experiencing severe breathing problems and was acutely ill. Respondent Birds noted Mark S. had nausea and vomiting for three days. Nonetheless, respondent Birds failed to perform a physical examination nor did he draw any blood from Mark S. for laboratory analysis. Rather, respondent Birds infused "Viroxan" via Mark S.'s Hickman catheter and dispensed additional amounts of "Viroxan" to Mark S. so Mark S. could self-infuse the "Viroxan" at home.

34. On or about November 5, 1989, (a Sunday) Mark S. visited respondent Birds at respondent Birds' office. Mark S. complained of "total body numbness and pain." Without performing a physical examination, respondent Birds gave Mark S. some Cipro (an antibiotic used to treat urinary tract infection), and recommended Mark S. continue with "Viroxan."

35. On or about November 8, 1989, Mark S. was found lying immobile in his bath tub at approximately 2:30 a.m. Mark S. had been in the bath tub for several days. The paramedics were called. After the paramedics arrived, respondent Birds was contacted to get approval for transporting Mark S. to the hospital. Respondent Birds did not give his approval for transportation to the hospital.

36. On or about November 8, 1989, at approximately 4:30 a.m., respondent Birds was again called and informed that
Mark S.'s condition was worsening. Again, respondent Birds failed to recommend hospitalization. Instead, respondent Birds indicated Mark S. would be fine and just to keep an eye on him.

37. On or about November 8, 1989, at approximately 7:00 a.m., respondent Birds was called for the third time and informed that Mark S. needed immediate medical attention. Respondent Birds promised to call for an ambulance. However, two hours later, respondent Birds arrived at Mark S.'s apartment and informed those present that he had just called for an ambulance. It was not until approximately 9:00 a.m. that morning that the paramedics arrived to transport Mark S. to Queen of Angels Hollywood Presbyterian Medical Center. Mark S. was admitted to that hospital at approximately 10:10 a.m. with signs of septicemia, meningitis, dehydration, pneumonitis, and rhabdomyolysis due to prolonged immobilization. Mark S.'s CD4+ T-cell count demonstrated Mark S.'s immunodeficiency.

38. Despite treatment, Mark S.'s condition continued to deteriorate. A chest X-ray taken on or about November 11, 1989, revealed bilateral pulmonary infiltrates.

39. On or about November 12, 1989, Mark S. suffered a respiratory arrest and was intubated. Cardiac arrest quickly followed and Mark S. died at 6:13 a.m. on November 12, 1989.

40. An autopsy on Mark S. revealed the presence of an extensive bilateral staphylococcal cavitating pneumonia together with a bilateral *pneumocystis carinii* pneumonia. Staphylococcal infection was also noted in other organs of Mark S.'s body, including but not limited to acute staphylococcal inflammation of

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the diaphragm and bilateral extensive necrotizing staphylococcal nephritis. Cerebrospinal fluid cultures also yielded staphylococcus aureus.

41. Respondents Herman and Birds are subject to disciplinary action pursuant to section 2234, subdivisions (b), (d), (e) based on their gross negligence, incompetence, and dishonesty or corruption in recommending and referring Mark S. to a surgeon for insertion of a Hickman catheter without adequate medical indication, especially when respondents knew, or should have known that Mark S. was severely immunocompromised.

42. As a result of the conduct described in Paragraphs 23-40 above, respondent Birds is subject to disciplinary action pursuant to Code section 2234, subdivision (d) because of his incompetency in using typhoid vaccine without proper medical indication.

43. As a result of the conduct described in Paragraphs 5-9 and 23-40 above, respondents Herman and Birds are subject to disciplinary action pursuant to section 2234, subdivisions (b), (d) and (e) because of numerous incidents of gross negligence, incompetence, and dishonesty or corruption in administering, and/or making available for patients' self-administration a foreign, nonsterile substance ("Viroxan"), not proven safe for use in human beings or efficacious against HIV infection.

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44. As a result of the conduct described in Paragraph 5-9 and 23-40 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of their numerous acts of gross negligence in administering and/or making available to patients, a substance ("Viroxan"), which is not manufactured according to good pharmaceutical manufacturing practices, and which may be contaminated with micro organisms.

45. As a result of the conduct described in Paragraphs 23-40 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of their gross negligence in treating an AIDS patient by self-administered intravenous infusion, their failure to instruct the patient on proper sterile injection technique, and their failure to monitor a patient's home use of a foreign substance by parenteral delivery.

46. As a result of the conduct described in Paragraphs 5-9 and 23-40 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of their gross negligence in failing to obtain investigational approval, as required by law, from regulatory agencies prior to administering the substance "Viroxan" to human beings.

47. As a result of the conduct described in Paragraphs 26-27 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivisions (b) and (d) because of their gross negligence and incompetence in
failing to timely recognize the presenting symptoms of
Pneumocystis carinii pneumonia (PCP), and failing to initiate
chemoprevention against PCP.

48. As a result of the conduct described in Paragraphs
23-40 above, respondents Herman and Birds are subject to
disciplinary action pursuant to Code section 2234, subdivisions
(b) and (d) because of their gross negligence and incompetence in
failing to perform a physical examination, take an adequate
medical history, or formulate a treatment plan based on a
diagnosis of Mark S.'s ailment(s).

49. As a result of the conduct described in Paragraphs
23-40 above, respondents Herman and Birds are subject to
disciplinary action pursuant to Code section 2234, subdivision
(c) because of their repeated negligent acts in failing to keep
adequate medical records of their treatment of Mark S., their
failure to make professional assessment of Mark S.'s medical
condition, their failure to instruct Mark S. on proper sterile
injection techniques, their failure to monitor his use of a
foreign substance, their failure to present Mark S. with options
other than the substance "Viroxan" for treatment of HIV
infection, their failure to monitor Mark S.'s medical condition,
and their failure to refer Mark S. to a recognized medical
specialist.

50. As a result of the conduct described in Paragraph
33-37 above, respondent Birds is subject to disciplinary action
pursuant to Code section 2234, subdivision (b) because of his
gross negligence in failing to immediately hospitalize Mark S.
PATIENT ROBERT H.

51. On or about August 3, 1989, Robert H., an HIV infected individual became a patient of respondent Birds.

52. On or before August 15, 1989, Robert H. complained to respondent Birds of chills, fever, and sweats.


54. On or about October 3, 1989, Robert H. again complained to respondent Birds about night sweats and chills. Respondent Birds attributed Robert H.'s problem to the typhoid vaccine and failed to consider other diagnostic explanations for the development of night sweats and chills in Robert H., an HIV positive patient.

55. On or about October 16, 1989, test results indicated Robert H. was at risk of developing pneumocystis carinii pneumonia (PCP). Rather than recommending medication to treat or prevent PCP, respondent Birds instead recommended "Aloe Vera Juice."

56. At no time after Robert H.'s initial examination, on or about August 7, 1989, was Robert H. given a physical examination. In fact, during office visits which occurred after August 7, 1989, respondent Birds did not even record Robert H.'s temperature.

57. Pursuant to respondent Birds recommendation, on or about October 17, 1989, Robert H. was seen by respondent Herman.
Respondent Herman took a very brief medical history noting Robert H. was "HIV positive", but respondent Herman did not perform a physical examination, formulate a treatment plan, nor recommend measures to prevent PCP, despite the fact Robert H. had a low CD4+ T-cell count.

58. Respondent Herman began treating Robert H. with "Viroxan" on or about October 17, 1989.

59. Respondent Herman and respondent Birds arranged for Robert H. to have a Hickman catheter surgically placed on or about October 24, 1989.

60. On or about October 24, 1989, Robert H. had a double-lumen Hickman catheter implanted. Respondent Birds indicated the reason for placement of the Hickman catheter was "for chemotherapy for his lymphoma."

61. While Robert H. was undergoing continuous treatment by respondents Herman and Birds with "Viroxan", he visited respondent Birds on or about October 30, 1989, because Robert H. was suffering flu-like symptoms which respondent Birds believed may have been associated with the "Viroxan". Respondent Birds also believed Robert H.'s cough, fever, night sweats, chills and breathing problems might be due to a lower respiratory tract infection-PCP, the most common illness in HIV infected individuals with low CD4+ T-cell levels.

62. On or about November 6, 1989, Robert H. had a chest X-ray taken at San Pedro Peninsula Hospital. The X-ray revealed "evidence of bilateral interstitial disease greater on the left than the right. This likely represents an infectious
Robert H. was too ill to go see respondent Birds, so, based on telephone communication, respondent Birds prescribed inadequate doses of Bactrim to treat Robert H.'s PCP, even though respondent Birds was aware Robert H. was allergic to sulpha. Respondent Birds ordered Robert H. to take the Bactrim at home through his Hickman catheter.

63. Robert H.'s condition continued to deteriorate. Accordingly, on or about November 8, 1989, via telephone, respondent Birds ordered Robert H. receive supplemental oxygen by nasal cannula at home. Respondent Birds did not physically examine Robert H., rather he prescribed over the telephone.

64. On or about November 10, 1989, Robert H. became acutely short of breath and turned blue due to lack of oxygen. Paramedics were called and Robert H. was admitted to San Pedro Peninsula Hospital where he was diagnosed with adult respiratory distress syndrome secondary to PCP. On admission, Robert H.'s condition was grave and his survival "improbable."

65. On or about November 16, 1989, Robert H. died due to cardiopulmonary arrest.

66. As a result of the conduct described in Paragraphs 5-9 and 51-65 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivisions (b) and (d) because of their gross negligence and incompetence in failing to perform a physical examination, take an adequate medical history, or formulate a treatment plan based on a diagnosis of Robert H.'s ailment(s).
67. As a result of the conduct described in Paragraphs 5-9 and 51-65 above, respondents Herman and Birds are subject to disciplinary action pursuant to section 2234, subdivisions (b), (d) and (e) because of numerous incidents of gross negligence, incompetence, and dishonesty or corruption in administering, and/or making available for patients' self-administration a foreign, nonsterile substance ("Viroxan"), not proven safe for use in human beings or efficacious against HIV infection.

68. As a result of the conduct described in Paragraphs 5-9 and 51-65 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of their gross negligence in failing to obtain approval, as required by law, from regulatory agencies prior to administration of the substance "Viroxan" to human beings.

69. As a result of the conduct described in Paragraphs 5-9 and 51-65 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of their acts of gross negligence in administering, or making available to patients for self-administration a substance which is not manufactured according to good pharmaceutical manufacturing practices, and which may be contaminated with microorganisms.

70. As a result of the conduct described in Paragraphs 51-65 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivisions (b) and (d) because of their gross negligence and incompetence in failing to timely recognize the presenting symptoms of
Pneumocystis carinii pneumonia (PCP), and failing to initiate chemoprevention against PCP.

71. As a result of the conduct described in Paragraphs 51-65 above, respondent Birds is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because he was grossly negligent in that: He prescribed inadequate doses of Bactrim; He prescribed Bactrim over the telephone to a sulfa allergic patient; He failed to monitor his patient's use of the Bactrim; and, He failed to hospitalize his patient.

72. As a result of the conduct described in Paragraphs 51-65 above, respondent Birds is subject to disciplinary action pursuant to Code section 2234, subdivision (e) because of his dishonest or corrupt act in using a diagnosis of lymphoma to justify admission of Robert H. to the hospital for placement of a Hickman catheter.

73. Respondents Herman and Birds are subject to disciplinary action pursuant to section 2234, subdivisions (b) and (d) based on their gross negligence and incompetence in recommending and referring Robert H. to a surgeon for insertion of a Hickman catheter without adequate medical indication, especially when respondents knew, or should have known that Robert H. was severely immunocompromised. Respondents failed to properly advise Robert H. of the potential lethal complications of such a procedure and the extremely low likelihood of any benefit.

74. As a result of the conduct described in Paragraphs 51-65 above, respondent Birds is subject to disciplinary action.
pursuant to Code section 2234, subdivision (d) because of his incompetency in using typhoid vaccine without proper medical indication.

75. As a result of the conduct described in Paragraphs 5-9 and 51-65 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of their gross negligence in treating an AIDS patient by self-administered intravenous infusion, their failure to instruct the patient on proper sterile injection technique, and their failure to monitor the patient's home use of a foreign substance by parenteral delivery.

76. As a result of the conduct described in Paragraphs 5-9 and 51-65 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivision (c) because of their repeated negligent acts in the treatment of Robert H. in that they: failed to keep adequate medical records; they failed to properly diagnose Robert H.'s medical condition; and, failed to initiate proper chemoprevention against Pneumocystis carinii Pneumonia (PCP).

PATIENT RONALD M.

77. On or about December 18, 1989, Ronald M. was diagnosed as having AIDS related complex (ARC.)

78. On or about May 15, 1989, Ronald M. was diagnosed as having encephalitis due to HIV ("AIDS dementia").

79. On or about August 14, 1989, Ronald M. became one of respondent Birds' patients.
80. On or about August 17, 1989, without reviewing Ronald M.'s medical records, respondent Birds began Ronald M. on a "therapeutic protocol using typhoid vaccine." These "treatments" continued until approximately November 1, 1989.

81. On or about August 25, 1989, respondent Birds began administering Oncovin (Vincristine) intravenously to Ronald M.

82. Billing slips from respondent Birds' office indicate Ronald M. saw respondent Birds on November 1, 1989, November 8, 1989, and December 5, 1989, however, there are no medical/chart records after October 30, 1989.

83. On or about November 3, 1989, Ronald M. had a "Landmark" catheter inserted in his left arm to facilitate respondent Herman's treatment of Ronald M. with "Viroxan".

84. On or about November 6, 1989, Ronald M. visited respondent Herman at respondent Herman's Orange County home. Respondent Herman noted that Ronald M. was HIV+; 34y/0; T415; severe debilitation and KS; diarrhea; severe neurological damage." No further history was noted, nor was a physical examination done. Nonetheless, respondent Herman prescribed two thousand milligrams of "Viroxan" IV and noted the dosage would increase to four thousand milligrams after a Hickman catheter was placed in Ronald M.

85. On or about November 7, 1989, Ronald M. again visited respondent Herman and was administered three thousand milligrams "Viroxan" IV.
66. On or about November 8, 1989, respondent Birds admitted Ronald M. to the Medical Center of North Hollywood for insertion of a Hickman catheter so Ronald M. could "start a chemotherapy program that requires daily IV medication...". A double-lumen Hickman catheter was placed in Ronald M. and the "Landmark" catheter removed.

67. On or about November 22, 1989, Ronald M. developed a cough and began experiencing difficulty swallowing.

68. On or about December 5, 1989, Ronald M. saw respondent Birds at respondent Birds' office, as indicated by a billing slip, however, respondent Birds failed to make any physician notations concerning the visit.

69. On or about December 6, 1989, Ronald M. was taken to Kaiser Anaheim Emergency room because of high fever, chills and mental confusion. Ronald M. was admitted to the hospital and treated with antibiotics for bacteria infection resulting from the Hickman catheter site and/or contamination due to self-injections with "Viroxan".

70. On or about December 15, 1989, Ronald M. suffered cardiopulmonary arrest.


72. As a result of the conduct described in Paragraphs 77-91 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivisions (b) and (d) because of their gross negligence and incompetence in failing to perform a physical examination, take an adequate
medical history, or formulate a treatment plan based on a proper diagnosis of Ronald M.'s ailment(s).

93. As a result of the conduct described in Paragraphs 5-9 and 77-91 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivisions (b), (d) and (e) because of numerous incidents of gross negligence, incompetence, and dishonesty or corruption in administering, and/or making available for patients' self-administration a foreign, nonsterile substance ("Viroxan"), not proven safe for use in human beings or efficacious against HIV infection.

94. As a result of the conduct described in Paragraphs 5-9 and 77-91 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in failing to obtain investigational approval, as required by law, from regulatory agencies prior to administering the substance "Viroxan" to human beings.

95. As a result of the conduct described in Paragraphs 5-9 and 77-91 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in administering, or making available to patients for self-administration a substance which is not manufactured according to good pharmaceutical manufacturing practices, and which may be contaminated with micro organisms.

96. As a result of the conduct described in Paragraphs 5-9 and 77-91 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in treating a patient with "AIDS dementia"
by self-administered intravenous infusion, his failure to
instruct the patient on proper sterile injection technique, and
his failure to monitor the patient's home use of a foreign
substance by parenteral delivery.

97. As a result of the conduct described in Paragraphs
77-91 above, respondent Birds is subject to disciplinary action
pursuant to Code section 2234, subdivision (d) because of his
incompetency in using typhoid vaccine without proper medical
indication.

98. As a result of the conduct described in Paragraphs
77-91 above, respondent Birds is subject to disciplinary action
pursuant to Code section 2234, subdivisions (b), (d), and (e)
because of his gross negligence, incompetence, and dishonesty or
corruption in ordering a Hickman catheter inserted in Ronald M.
chest without proper medical indication for the Hickman catheter
when respondent Birds knew, or should have known that Ronald M.
was severely immunocompromised; and, by failing to properly
advise Ronald M. of the potential lethal complications of such a
procedure and the extremely low likelihood of any benefit.

99. As a result of the conduct described in Paragraphs
77-91 above, respondents Herman and Birds are subject to
disciplinary action pursuant to Code section 2234, subdivision
(c) because of their repeated negligent acts in failing to keep
adequate medical records of their treatment of Ronald M., their
failure to make a proper professional assessment of Ronald M.'s
medical condition, their failure to instruct Ronald M. on proper
sterile injection techniques, their failure to monitor his use of
a foreign substance, their failure to present Ronald M. with options other than the substance "Viroxan" for treatment of HIV infection, their failure to properly monitor Ronald M.'s medical condition, and their failure to refer Ronald M. to a recognized medical specialist.

PATIENT MICHAEL K.

100. Michael K., an HIV infected individual, became a patient of respondent Herman on or about September 12, 1989. On or about that date, when Michael K. visited respondent Herman, respondent Herman failed to perform any type physical examination. Nonetheless, respondent Herman started Michael K. on "Viroxan" via intramuscular injection in Michael K.'s Gluteus Maximus muscle.

101. Michael K. self-injected "Viroxan" daily until he developed a black "eschar" at the injection site and began experiencing extreme pain. Consequently, sometime between September 12, 1989 and October 24, 1989, pursuant to respondent Birds order, Michael K. had a Hickman catheter implanted in his chest so he could inject "Viroxan" intravenously on a daily basis. Even after installation of the Hickman catheter Michael K. continued experiencing pain in his right gluteal area.

102. On or about November 13, 1989, Michael K. began undergoing a series of excisions of his right buttock.

103. On or about December 7, 1989, Michael K. was admitted to Eisenhower Memorial Hospital for extensive debridement of a deep muscle abscess in his right buttock. (Pathology of the debrided tissue demonstrated necrotic material...
of the right buttock. There was necrosis extending deep into the
subcutaneous tissue and skeletal muscle.) Michael K. remained in
Eisenhower Memorial Hospital for fifteen days and was treated for
toxic shock syndrome secondary to the gluteal wound.

104. On or about January 15, 1990, Michael K. was
again admitted to Eisenhower for recurrent toxic shock.

105. On or about January 26, 1990, Michael K. was
again admitted to Eisenhower Memorial Hospital after being found
in a stuporous state due to injection of an overdose of
methadone, elavil, and an anxiolytic agent. Chest X-rays of
Michael K. revealed bilateral interstitial infiltrates, and
Michael K. was treated for PCP until his death on February 4,
1990.

106. An autopsy revealed Michael K. had "bilateral
staphylococcal pneumonia" and "massive ulceration of the right
buttock." It was determined that the gluteal abscess resulted
from contamination due to regular intramuscular injection of
"Viroxan" supplied by respondent Herman.

107. As a result of the conduct described in
Paragraphs 5-9 and 100-106 above, respondent Herman is subject to
disciplinary action pursuant to Code section 2234, subdivisions
(b) and (d) because of numerous incidents of gross negligence,
incompetence, and dishonesty or corruption in administering,
and/or making available for patients' self-administration a
foreign, nonsterile substance ("Viroxan"), not proven safe for
use in human beings or efficacious against HIV infection.
108. As a result of the conduct described in Paragraphs 5-9 and 100-106 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in administering and/or making available to patients, a substance ("Viroxan"), which is not manufactured according to good pharmaceutical manufacturing practices, and which may be contaminated with micro organisms.

109. As a result of the conduct described in Paragraphs 100-106 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in treating an AIDS patient by self-administered intravenous infusion, his failure to instruct the patient on proper sterile injection technique, and his failure to monitor a patient's home use of a foreign substance by parenteral delivery.

110. As a result of the conduct described in Paragraphs 5-9 and 100-106 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in failing to obtain investigational approval, as required by law, from regulatory agencies prior to administering the substance "Viroxan" to human beings.

111. As a result of the conduct described in Paragraphs 100-106 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivisions (b) and (d) because of his gross negligence and incompetence in failing to timely recognize the presenting symptoms of
Pneumocystis carinii pneumonia (PCP), and failing to initiate chemoprevention against PCP.

112. As a result of the conduct described in Paragraphs 100-106 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivisions (b) and (d) because of his gross negligence and incompetence in failing to perform a physical examination, take an adequate medical history, or formulate a treatment plan based on a diagnosis of Michael K.'s ailment(s).

113. As a result of the conduct described in Paragraphs 100-106 above, respondent Birds is subject to disciplinary action pursuant to Code section 2234, subdivisions (b), (d), and (e) because of his gross negligence, incompetence, and dishonest or corrupt act of recommending and referring Michael K. to a surgeon for the purpose of having a central indwelling Hickman catheter inserted through his chest even though respondent Birds knew or should have known Michael K. was severely immunocompromised. Respondent Birds also failed to properly advised Michael K. of the potential lethal complication of such a procedure and the extremely low likelihood of any benefit.

114. As a result of the conduct described in Paragraphs 100-106 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (c) because of his repeated negligent acts in failing to keep adequate medical records of his treatment of Michael K., his failure to make professional assessment of Michael K.'s medical
condition, his failure to instruct Michael K. on proper sterile
injection techniques, his failure to monitor Michael K.'s use of
a foreign substance, his failure to present Michael K. with
options other than the substance "Viroxan" for treatment of HIV
infection, his failure to monitor Michael K.'s medical condition,
and his failure to refer Michael K. to a recognized medical
specialist.

PATIENT CHRI S A.

115. On or about September or October 1989, Chris A.,
an HIV infected individual, became one of respondent Herman's
patients. Respondent Herman supplied Chris A. with "Viroxan"
after representing to Chris A. that "Viroxan" would ameliorate
HIV infection. Respondent Herman administered, and/or instructed
Chris A. to self-inject "Viroxan" into his buttocks.

116. Chris A. self-injected "Viroxan" intramuscularly
into his right buttock until respondent Birds directed placement
of a Hickman catheter. The Hickman catheter was placed in Chris
A.'s chest on or about October 10, 1989.

117. Eventually Chris A. began experiencing pain and
swelling in his right buttock. Chris A. contacted respondent
Herman by telephone and respondent Herman, without physically
examining Chris A., prescribed an antibiotic, Reflex.

118. On or about December 10, 1989, due to pain and
swelling in his right buttock, Chris A. went to the emergency
room at Eisenhower Memorial Hospital in Rancho Mirage. Chris A.
had a gluteal abscess (similar to that experienced by Michael K.)
and was given an intravenous dose of an antibiotic.
119. On or about December 11, or 12, 1989, Chris A. was admitted to Eisenhower Memorial Hospital because of deterioration in his condition. Chris A. was diagnosed as having an abscess of his right buttock with muscle necrosis (mummification) secondary to intramuscular injection. Chris A.'s condition required debridement of a 16 x 18 cm area of his right buttock.

120. Although respondent Herman made "Viroxan" available to Chris A. and prescribed an antibiotic over the telephone, respondent Herman kept no medical records concerning Chris A.

121. As a result of the conduct described in Paragraphs 115-120 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivisions (b) and (d) because of his gross negligence and incompetence in failing to perform a physical examination, take an adequate medical history, or formulate a treatment plan based on a diagnosis of Chris A.'s ailment(s).

122. As a result of the conduct described in Paragraphs 5-9 and 115-120 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivisions (b) and (d) because of numerous incidents of gross negligence, incompetence, and dishonesty or corruption in administering, and/or making available for patients' self-administration a foreign, nonsterile substance ("Viroxan"), not proven safe for use in human beings or efficacious against HIV infection.
123. As a result of the conduct described in Paragraphs 5-9 and 115-120 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in failing to obtain investigational approval, as required by law, from regulatory agencies prior to administering the substance "Viroxan" to human beings.

124. As a result of the conduct described in Paragraphs 5-9 and 115-120 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in administering and/or making available to patients, a substance ("Viroxan"), which is not manufactured according to good pharmaceutical manufacturing practices, and which may be contaminated with microorganisms.

125. As a result of the conduct described in Paragraphs 115-120 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in treating an AIDS patient by self-administered intravenous infusion, his failure to instruct the patient on proper sterile injection technique, and his failure to monitor a patient's home use of a foreign substance by parenteral delivery.

126. As a result of the conduct described in Paragraph 117 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in prescribing an antibiotic over the telephone without physically examining the patient.
127. As a result of the conduct described in Paragraphs 115-120 above, respondent Birds is subject to disciplinary action pursuant to Code section 2234, subdivisions (b), (d) and (e) because of his gross negligence, incompetence, and fraud in recommending and referring Chris A. to a surgeon for the purpose of having a central in-dwelling Hickman catheter inserted through his chest even though respondent Birds knew or should have known that Chris A. was severely immunocompromised. Furthermore, respondent Birds failed to properly advise Chris A. of the potential lethal complications of such a procedure and the extremely low likelihood of any benefit.

128. As a result of the conduct described in Paragraphs 100-106 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (c) because of his repeated negligent acts in failing to keep adequate medical records of his treatment of Chris A., his failure to make professional assessment of Chris A.'s medical condition, his failure to instruct Chris A. on proper sterile injection techniques, his failure to monitor Chris A.'s use of a foreign substance, his failure to present Chris A. with options other than the substance "Viroxan" for treatment of HIV infection, his failure to monitor Chris A.'s medical condition, and his failure to refer Chris A. to a recognized medical specialist.

PATIENT DAVID P.

129. On or about June 1, 1989, David P. was admitted to LAC-USC Medical Center, Psychiatric Ward because of suicidal
tendencies. After discharge from the Psychiatric Unit, a Chiropractor David P. saw recommended David P. see respondent Birds.

130. On or about June 21, 1989, David P. became one of respondent Birds' patients. During the June 21, 1989 office visit, respondent Birds took a brief medical history but did not physically examine David P. Furthermore, respondent Birds did not include a psychiatric history and therefore failed to discover David P.'s past psychiatric problems.

131. On or about June 21, June 27, and July 18, 1989, respondent Birds ordered laboratory tests to be performed on blood samples obtained from David P. The tests included a CD4-T-cell count, p-24 antigen assay. No HIV antibody test was ordered. The tests disclosed mild normochromic, normocytic anemia. However, respondent Birds failed to initiate any type diagnostic "work-up." The laboratory tests also revealed an elevated base line measurement of herpes (I and II) IgG serum antibody titters. Respondent Birds concluded David P. had "herpes-long term--under stress--brain changes."

132. On or about July 25, 1989, respondent Birds started David P. on a "Therapeutic protocol using typhoid vaccine".

133. On or about November 6, 1989, respondent Birds recommended David P. visit respondent Herman for help with the herpes infection.
On or about November 13, 1989, David P. returned to respondent Birds for a medical history and physical examination in preparation for insertion of a Hickman catheter. On or about November 14, 1989, pursuant to respondent Birds' order, David P. had a Hickman catheter placed. Respondent Birds' admission history and physical examination of David P. stated he had "lymphatic enlargement in axillary, cervical and inguinal area, most likely of a viral nature but of a lymphocytic type problem."

On or about November 15, 1989, David P. visited respondent Birds and respondent Birds gave David P. his first treatment with "Viroxan" which had been prescribed and provided by respondent Herman. Respondent Birds showed David P. how to self-administer the "Viroxan" via an IV drip.

Sometime during early December 1989, David P. moved back home to San Antonio, Texas. While in Texas, David P. talked with both respondent Birds and respondent Herman via telephone and the respondents sent David P. "Viroxan" through the mail. David P. continued to self-inject "Viroxan" through the Hickman catheter until approximately January 17, 1989, when, pursuant to the advise of another physician, David P. discontinued using "Viroxan".

As a result of the conduct described in Paragraphs 5-9 and 129-136 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivisions (b), and (d) because of numerous incidents of gross negligence, incompetence, and dishonesty or corruption in
administering, and/or making available for patients' self-
administration a foreign, nonsterile substance ("Viroxan"), not
proven safe for use in human beings or efficacious against HIV
infection.

138. As a result of the conduct described in
Paragraphs 5-9 and 129-136 above, respondent Herman is subject to
disciplinary action pursuant to Code section 2234, subdivision
(b) because of his gross negligence in failing to obtain
investigational approval, as required by law, from regulatory
gencies prior to administering the substance "Viroxan" to human
beings.

139. As a result of the conduct described in
Paragraphs 5-9 and 129-136 above, respondent Birds is subject to
disciplinary action pursuant to Code section 2234, subdivision
(b) because of his gross negligence in failing to ascertain
whether or not investigational approval existed from regulatory
gencies prior to administration of the substance "Viroxan" to
human beings.

140. As a result of the conduct described in Paragraph
5-9 and 129-136 above, respondents Herman and Birds are subject
to disciplinary action pursuant to Code section 2234, subdivision
(b) for their gross negligence in administering and/or making
available to patients, a substance ("Viroxan"), which is not
manufactured according to good pharmaceutical manufacturing
practices, and which may be contaminated with micro organisms.

141. Respondents Herman and Birds are subject to
disciplinary action pursuant to section 2234, subdivisions (b),
(d), (e) based on their gross negligence, incompetence, and
dishonesty or corruption in recommending and referring David P.
to a surgeon for insertion of a Hickman catheter without adequate
medical indication, especially when respondents knew, or should
have known that David P. was severely immunocompromised.
Respondents failed to properly advise David P. of the potential
lethal complications of such a procedure and the extremely low
likelihood of any benefit.

142. As a result of the conduct described in
Paragraphs 129-136 above, respondents Herman and Birds are
subject to disciplinary action pursuant to Code section 2234,
subdivision (b) because of their gross negligence in treating an
AIDS patient by self-administered intravenous infusion, their
failure to instruct the patient on proper sterile injection
technique, and their failure to monitor a patient’s home use of a
foreign substance by parenteral delivery.

143. As a result of the conduct described in
Paragraphs 129-136 above, respondent Birds is subject to
disciplinary action pursuant to Code section 2234, subdivisions
(b) and (d) because of his gross negligence and incompetence in
failing to perform a physical examination, take an adequate
medical history, or formulate a treatment plan based on a
diagnosis of David P.’s ailment(s).

144. As a result of the conduct described in
Paragraphs 5-9 and 129-136 above, respondent Birds is subject to
disciplinary action pursuant to Code section 2234, subdivision
(d) because of his incompetency in using typhoid vaccine without
proper medical indication.

145. As a result of the conduct described in Paragraphs 129-136 above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivision (c) because of their repeated negligent acts in failing to keep adequate medical records of their treatment of David P., their failure to make professional assessment of David P.'s medical condition, their failure to instruct David P. on proper sterile injection techniques, their failure to monitor his use of a foreign substance, their failure to present David P. with options other than the substance "Viroxan" for treatment of HIV infection, their failure to monitor David P.'s medical condition, and their failure to refer David P. to a recognized medical specialist.

PATIENT STANLEY H.

146. Stanley H., an HIV infected individual began "Viroxan" treatment with respondent Herman on or about June 21, 1989.

147. Stanley H. injected "Viroxan" by peripheral vein in various doses. Eventually, Stanley H. began having "trouble with his veins" due to the "Viroxan" injections. Accordingly, respondent Herman referred Stanley H. to respondent Birds for placement of a Hickman catheter.

148. On or about December 12, 1989, Stanley H. was admitted to the Medical Center of North Hollywood by respondent Birds for insertion of a Hickman catheter. According to Respondent Birds, the catheter was necessary "to allow for IV
therapy for the infection and the evidence of lymphocytic
elevation. Possible viral lymphoma type reaction to be
considered as the cause." No explanation was given by respondent
Birds concerning the nature of the "developing lymphocytic
elevation or the developed viral lymphoma." There was also no
explanation of the type therapy contemplated which required
insertion of a Hickman catheter.

149. Stanley H. received a Hickman catheter on or
about December 12, 1989, and was discharged from the hospital
that same day. Stanley H. began using the Hickman catheter for
self-administration of "Viroxan" obtained from respondent Herman.

150. On or about January 15, 1990, Stanley H. was
admitted to Fountain Valley Regional Hospital and Medical Center
for possible blood poisoning (Septicemia) caused either by the
Hickman catheter site or contaminated "Viroxan". On admission,
Stanley H. reported a two-week history of fever, shaking, chills,
headaches, and increased respirations.

151. Although Stanley H. received medical treatment
from respondent Herman, respondent Herman kept no medical records
concerning his evaluation or treatment of Stanley H.

152. As a result of the conduct described in
Paragraphs 146-151 above, respondent Herman is subject to
disciplinary action pursuant to Code section 2234, subdivisions
(b) and (d) because of his gross negligence and incompetence in
failing to perform a physical examination, take an adequate
medical history, or formulate a treatment plan based on a
diagnosis of Stanley H.'s ailment(s).
153. As a result of the conduct described in Paragraphs 5-9 and 146-151 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivisions (b), (d), and (e) because of numerous incidents of gross negligence, incompetence, and dishonesty or corruption in administering, and/or making available for patients' self-administration a foreign, nonsterile substance ("Viroxan"), not proven safe for use in human beings or efficacious against HIV infection.

154. As a result of the conduct described in Paragraphs 5-9 and 146-151 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in failing to obtain investigational approval, as required by law, from regulatory agencies prior to administering the substance "Viroxan" to human beings.

155. As a result of the conduct described in Paragraphs 5-9 and 146-151 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in administering and/or making available to patients, a substance ("Viroxan"), which is not manufactured according to good pharmaceutical manufacturing practices, and which may be contaminated with microorganisms.

156. As a result of the conduct described in Paragraph 5-9 and 146-151 above, respondent Herman is subject to disciplinary action pursuant to Code section 2234, subdivision (b) because of his gross negligence in treating an AIDS patient
by self-administered intravenous infusion, his failure to
instruct the patient on proper sterile injection technique, and
his failure to monitor a patient's home use of a foreign
substance by parenteral delivery.

157. As a result of the conduct described in
Paragraphs 146-151 above, respondents Herman and Birds are
subject to disciplinary action pursuant to Code section 2234,
subdivisions (b), (d), (e) based on their gross negligence,
incompetency, and dishonesty or corruption in recommending and
referring Stanley H. to a surgeon for insertion of a Hickman
catheter without adequate medical indication, especially when
respondents knew, or should have known that Stanley H. was
severely immunocompromised. Respondents failed to properly
advise Stanley H. of the potential lethal complications of such a
procedure and the extremely low likelihood of any benefit.

158. As a result of the conduct described in Paragraph
5-9 and 146-151 above, respondents Herman and Birds are subject
to disciplinary action pursuant to Code section 2234,
subdivisions (b) and (d) because of their gross negligence and
incompetence in failing to perform a physical examination, take
an adequate medical history, or formulate a treatment plan based
on a diagnosis of Stanley H.'s ailment(s).

159. As a result of the conduct described in
Paragraphs 146-151 above, respondents Herman and Birds are
subject to disciplinary action pursuant to Code section 2234,
subdivision (c) because of their repeated negligent acts in
failing to keep adequate medical records of their treatment of

40.
Stanley H., their failure to make professional assessment of Stanley H.'s medical condition, their failure to instruct Stanley H. on proper sterile injection techniques, their failure to monitor his use of a foreign substance, their failure to present Stanley H. with options other than the substance "Viroxan" for treatment of HIV infection, their failure to monitor Stanley H.'s medical condition, and their failure to refer Stanley H. to a recognized medical specialist.

160. As a result of respondent Herman's and respondent Birds' custom and habit or modus operandi evidenced by their pattern and conduct in treating patients, and aiding and abetting each other in treating patients, as described in Paragraphs 5-14, 20-21, 23-40, 51-65, 77-91, 100-106, 115-120, 129-136, and 146-151, above, respondents Herman and Birds are subject to disciplinary action pursuant to Code section 2234, subdivisions (b), (c), (d), (e), for their gross negligence, repeated negligent acts, incompetence, and dishonesty and corruption in treating patients with "Viroxan" and ordering Hickman catheters to be placed in the patients without proper medical indication notwithstanding the fact respondents knew, or should have known the patients were at extremely high risk of infection because they were immunocompromised. Respondents' conduct was exacerbated further by their continued neglect of patients as evidenced by their lack of proper medical records, and failure to monitor patients home use (self-injection) and progress while using "Viroxan", a substance toxic to laboratory animals and unproven as effective in treating AIDS, HIV positive patients.
arthritis, cancer, or any other ailment.

WHEREFORE, Complainant requests the Board hold a
hearing on the matters alleged herein; and, following said
hearing, the Board issue a decision:

1. Revoking or suspending respondent Herman's and
   respondent Birds' physician and surgeon licenses;

2. Revoking or suspending respondent Birds' license to
   supervise physician assistants; and,

3. Taking such other and further action the Board
dems appropriate to protect the public health, safety
and welfare.

DATED: May 17, 1991

Kenneth Wagstaff
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant