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

In the Matter of the Accusation Against:	)	
	)	OAH No. N2002110020
	)	
TOD H. MIKURIYA, M.D.	)	MBC Case No. 12-1999-98783
	)	
Physician's and Surgeon's	)	PRECEDENTIAL DECISION
Certificate No. G 9124	)	No. MBC-2007-02-Q
	)	
Respondent.	)	
	)	

DESIGNATION AS A PRECEDENTIAL DECISION

Pursuant to Government Code section 11425.60 and Title 16 CCR 1364.40, the Division of Medical Quality, Medical Board of California, hereby designates as precedential Decision No. MBC-2007-02-Q the decision in the Matter of the Accusation Against Tod H. Mikuriya, M.D.

This precedential designation shall be effective July 27, 2007.

Cesar A. Aristeiguieta, M.D., F.AC.E.P.,
President
Division of Medical Quality
Medical Board of California

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In the Matter of the Accusation Against: TOD H. MIKURIYA, M.D. 1168 Sterling Avenue Berkeley, California 94708 Physician's and Surgeon's Certificate No. G-9124 Respondent.	Case No. 12-1999-98783 OAH No. N2002110020

AMENDED DECISION AFTER REMAND FROM SUPERIOR COURT

This matter was heard before Administrative Law Judge Jonathan Lew, State of California, Office of Administrative Hearings on September 3, 4, 5, 8, 9 and 24, 2003, in Oakland, California.

Complainant Ron Joseph was represented by Deputy Attorneys General Lawrence A. Mercer and Jane Zack Simon.

Respondent Tod H. Mikuriya, M.D. was present and represented by John L. Fleer, Esq., Susan J. Lea, Esq. and William M Simpich, Esq.

Submission of the matter was deferred pending receipt of closing argument. Complainant's Closing Argument and Reply Brief were received on November 7 and 20, 2003, and marked respectively as Exhibits 26 and 27 for identification. Respondent's Closing Brief and Reply Brief were received on November 7 and 21, 2003, and marked respectively as Exhibits AA and BB for identification. The case was submitted for decision on November 21, 2003[1]

[1] On December 26, 2003, respondent also submitted an Amicus Curiae Brief filed by the California Medical Association in a matter before the California Court of Appeal that respondent believes directly concerns the facts in this case. Respondent requests that judicial notice be taken of that brief. Complainant filed an Objection to Request for Judicial Notice on December 26, 2003, and such objection is sustained.

On January 30, 2004, the administrative law judge submitted his proposed decision to the Medical Board of California. The board adopted that decision on March 18, 2004, to become effective on April 19, 2004.

Thereafter, respondent filed a Petition for Writ of Mandate in Sacramento County Superior Court, Case No. 04CS00477. On November 2, 2006, the court issued its Order in the matter, granting the peremptory writ of administrative mandamus solely to the extent that the board based its decision on a finding of unprofessional conduct based on a violation of section 2242 and denying the Petition on all other grounds.

The Superior Court of the State of California, pursuant to its Judgment and Order dated November 2, 2006, commanded this board to reconsider its Decision in light of the court's finding.

Having reconsidered its Decision pursuant to the court's direction in the Judgment and Order, the board now makes a modified decision in compliance with the Judgment and Order dated November 2, 2006. A copy of the Judgment and Order is attached as Exhibit "A" and incorporated herein by reference.

FACTUAL FINDINGS

1. Ron Joseph (complainant) is the Executive Director of the Medical Board of California (Board), Department of Consumer Affairs. He brought the Accusation, First and Second Amended Accusations solely in his official capacity.

2. On October 16, 1963, the Board issued Physician's and Surgeon's Certificate Number G-9124 to Tod Hiro Mikuriya, M.D. (respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times pertinent to this case.

3. On July 25, 2003, a Second Amended Accusation was filed against respondent alleging unprofessional conduct, gross negligence, negligence and incompetence arising out of his care and treatment of sixteen patients. In each case he recommended marijuana for medical purposes. Complainant alleges that respondent's medical records for these patients were inadequate in that they routinely lacked adequate documentation of physical examination, clinical findings, vital signs, mental status examination, laboratory tests, follow-up and treatment plans. Complainant contends such matters are relevant and necessary to an evaluation and diagnosis of each patient's condition, or to support the recommendation or prescription of any medication. Complainant further alleges that respondent prescribed, dispensed or furnished marijuana, a controlled substance, without conducting a prior good-faith examination and/or without medical indication. Finally, complainant contends that respondent committed unprofessional conduct and/or was grossly negligent, negligent, incompetent or committed acts of dishonesty or corruption in his interactions with and care and treatment of an undercover narcotics officer.

Respondent's Background

4. Respondent has been a licensed California physician for 40 years. He is recognized as an expert on the use of marijuana for medical purposes and he has conducted research and has numerous publications on the topic of medical marijuana. He founded California Cannabis Research Medical Group to facilitate shared cannabis research. Respondent has been actively involved in the efforts to legalize marijuana for medical purposes.

Respondent attended Temple University School of Medicine before completing psychiatric residencies at Oregon State Hospital in Salem, Oregon, and Mendocino State Hospital in Talmage, California. He has served as Director, Drug Addiction Treatment Center, New Jersey NeuroPsychiatric Institute, Princeton, New Jersey (1966-67); Consulting Research Psychiatrist, National Institute of Mental Health Center for Narcotics and Drug Abuse Studies (1967); Consulting Psychiatrist, Alameda County Alcoholism Clinic, Oakland (1968-69); Consulting Psychiatrist, Alameda County Health Department Drug Abuse Project (1969); Attending Staff Psychiatrist, Gladman Hospital, Oakland (1969-92); Consultant, National Commission on Marihuana and Drug Abuse (1972); Chair, Department of Psychiatry, Eden Hospital, Castro Valley (1993-94); and Psychiatric Consultant, Fairmont Hospital, San Leandro (1991-95).

He is currently an attending psychiatrist at Eden Medical Center, Castro Valley; Vencor Hospital, San Leandro; San Leandro Hospital, San Leandro; and St. Anthony's, Park View Convalescent, Clinton Village. He describes his private practice in Berkeley as all about medicinal cannabis consultations and this includes activities in his role as Medical Coordinator of California Cannabis Centers (Oakland Cannabis Buyers Cooperative, Hayward Hempery, CHAMP, San Francisco and the Humboldt Cannabis Center, Arcata).

Respondent is a member of professional organizations including the California Medical Association, Alameda-Contra Costa Medical Association (Chemical Addictions Committee), American Psychiatric Association, Northern California Psychiatric Society, East Bay Psychiatric Association, American Society of Addiction Medicine and the California Society of Addiction Medicine (CSAM). He has been on CSAM's Medical Marijuana Task Force since April 1997.

The Compassionate Use Act

5. On November 5, 1996, the voters of California passed Proposition 215, the Compassionate Use Act of 1996, also known as the Medical Marijuana Initiative. (Health & Saf. Code, § 11362.5.) The Compassionate Use Act provides that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana. The Act makes specific provision for the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief. One of the Act's purposes

is to ensure that seriously ill Californians have the right to obtain and use marijuana for "medical purposes" and "where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana." (*Ibid.*)

The Act also expressly affirms public policy against conduct that endangers others or the diversion of marijuana for non-medical purposes. It is left for the physician, as gatekeeper, to ensure that marijuana is used for "medical purposes" to benefit the seriously ill[2]. Under these circumstances it is presumed that physicians who recommend marijuana under the Act will follow accepted medical practice standards and make good faith recommendations based on honest medical judgments. (*Conant* v. *McCaffrey* (2000 WL 1281174.) The parties agree that good faith recommendations based on honest medical judgments must be made in every case. Where they differ, and rather markedly so, is on what constitute accepted medical practice standards to be followed in making such a recommendation.

Standard of Practice Issues

6. Complainant sees no need to articulate a new standard of practice to assist physicians in recommending marijuana, believing that the standard of practice in the area of medical marijuana is not new at all, but the same as pertains to recommending any treatment or prescribing any other medication – namely history, physical examination and appropriate treatment plan. Where marijuana is being recommended for a psychiatric condition, complainant believes the examination would entail a mental status examination to establish a psychiatric diagnosis, and might either not include a physical examination or might only include a limited physical examination appropriate to the clinical situation. Complainant relies heavily upon a policy statement issued by the Board to all California physicians in its January 1997 Action Report. This statement came on the heels of Proposition 215 and recognized that there was at that time "a great deal of confusion concerning the role of physicians under this law." The policy statement specifies:

> While the status of marijuana as a Schedule I drug means that no objective standard exists for evaluating the medical rationale for its use, there are certain standards that always apply to a physician's practice that may be applied. In this area, the Board would expect that any physician who recommends the use of marijuana by a patient should have arrived at that decision in accordance with accepted standards of medical responsibility; i.e., history and physical examination of the patient; development of a treatment plan with objectives; provision of informed consent, including discussion of side effects; periodic

[2] In *Conant* v. *Walters* (2002) 309 F.3d 629, Justice Kozinski described the key role of physicians anticipated under the Act: "The state law in question does not legalize use of marijuana by anyone who believes he has a medical need for it. Rather, state law is closely calibrated to exempt from regulation only patients who have consulted a physician. And the physician may only recommend marijuana when he has made an individualized and bona fide determination that the patient is within the small group that may benefit from its use."

review of the treatment's efficacy and, of critical importance especially during this time of uncertainty, proper record keeping that supports the decision to recommend the use of marijuana.

In spring of 1997, CSAM issued a position statement regarding the recommendation of marijuana, in which it stated that marijuana is a mood-altering drug capable of producing dependency, urging the Board to formally adopt the standards set forth in the January 1997 Action Report, and further suggesting that the Board's statement be expanded to include a requirement for notation of a diagnosis or differential diagnosis.

7. Respondent notes that there are only a handful of physicians, less than twenty, who consult on medical cannabis issues as a primary part of their practice and among whom there is no uniform agreement and few guidelines on practice standards. Physicians consulting in this way are not "treating physicians" and patients who are seen are primarily self-referred and come with a single question in mind – "Do I qualify for a medical cannabis recommendation?" These patients typically are already using cannabis for their medical condition and claim a benefit from so doing. In seeking a physician's recommendation their main consideration is avoiding involvement with the criminal justice system. Most physicians are very reluctant to become involved in making such recommendations. They are afraid to say anything to patients about medical cannabis for fear that they will become targets of law enforcement themselves. The Compassionate Use Act does provide that no physician shall be punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes. (Health and Saf. Code, § 11362.5, subd. (c).) However, as even the Board recognized early on, this language offers no protection from federal prosecution, including threat of criminal prosecution of physicians, revocation of DEA registration and exclusion from participation in the Medicare and Medicaid program for having made such recommendations.[3]

Given this history and climate respondent believes this case has been motivated politically, directed both by federal government officials and California State officials opposed to Proposition 215, and conducted from the outset in bad faith. Yet, in considering this case, every effort has been made to remain squarely focused on determining what practice standards govern medical cannabis recommendations. That is the primary issue and therefore evidence proffered on the history, motivation and other matters underlying or relating to the investigation and prosecution of this case, though considered, have been largely disregarded.[4]

8. Respondent urges as the standard of practice a more focused medical cannabis consultation model consisting of a good faith examination designed to gain needed information, no more and no less. The needed information would be limited to that sought in

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[3] January 17, 1997 Memorandum to Board Members from Ron Joseph regarding Proposition 215, Use of Marijuana for Medicinal Purposes.

[4] Respondent submitted an Offer of Proof on remaining Exhibits P – W. These exhibits have been received into evidence as marked. Objections to relevancy go largely to the weight attached, and in most cases this was very marginal

answering the simple question whether a patient is eligible for inclusion under the Compassionate Use Act. Respondent believes a physician would primarily be concerned with determining if there is medical evidence supporting eligibility. There would also be a future obligation to monitor patients using medical marijuana. Respondent proposes as minimum practice standards that physicians conduct an initial face to face interview, obtain identifying information, make a diagnosis and arrange for follow-up examinations that allow for incorporation of fax, e-mail or telephone exchanges of patient information. Respondent notes that while there have been uniform guidelines recommended and submitted to the California Medical Association (CMA), practice guidelines have yet to be adopted by the CMA or by the Board. Respondent views the protocols followed in making a Proposition 215 recommendation as quite different from those followed by a physician in making a prescription. He also believes that any treatment plan should address only the medical use of cannabis and not the patient's entire medical profile/condition. Respondent believes that the relevant practice standard should not require him to fully evaluate or treat every symptom present or suspected at the time the patient is evaluated.

This generally summarizes what the parties believe to be the correct practice models in making medical cannabis recommendations. In determining which governs, the appropriateness of the two models is best evaluated by considering the medical expert opinions offered in this case. The opinions relate directly to respondent's management of the sixteen patients referenced in the Second Amended Accusation and, accordingly, patient summaries and respondent's actions with respect to each patient are briefly outlined below.

A discussion of appropriate practice standards and whether or not respondent complied with them is incorporated within these discussions of each patient.

Patient R.A.

9. Patient R.A. was seen by respondent on March 5, 1997. Medical records include a Registration Form completed by Patient R.A., but two of the five pages from that form are missing. No other documentation reflects respondent's initial evaluation of this patient. There are no records reflecting the patient's medical complaints/health problems, medical/psychiatric history, physical/mental status examination or what advice was given by respondent. A Physician's Statement dated March 5, 1997, was issued indicating that Patient R.A. was under respondent's "medical care and supervision for the treatment of medical condition(s): Anxiety Disorder Gastritis." It also indicated that respondent had discussed the medical risks and benefits of cannabis use as a treatment and that he condoned the use of cannabis.

Patient R.A. completed a "Cannabis Patient Follow Up Visit Questionnaire" dated November 6, 1998. It indicated that marijuana had been used by him for treatment of gastritis/anxiety disorder. No psychiatric history, medical history, physical/mental status examination is recorded. Respondent noted "irritation from low potency" and "recounts stressors of arrest & case & involvement & insomnia" and that he discussed the effects on the patient's life. A Physician's Statement dated November 18, 1998, confirmed that Patient

R.A. was under respondent's "medical care and supervision" for "Gastritis Anxiety Disorder." Respondent also noted that Patient R.A. "Must return by 12-2-98 for follow up."

Patient R.A. completed a follow up questionnaire dated August 5, 1999, which reported treating complaints of anxiety disorder, gastritis and irritable bowel syndrome with marijuana, 15 to 38 grams/week. An "Illness status" category on the questionnaire was checked as "Stable". There were follow up visits on April 28, 2000, and on January 4, 2001. A progress note for April 28, 2000, noted increased anxiety and insomnia. The January 4, 2001 follow up questionnaire listed gastritis and anxiety as symptoms/conditions treated with cannabis and Patient R.A.'s illness status was marked as "Stable". Respondent noted that Patient R.A. planned on relocating to Holland secondary to his fear of continuing prosecution. R.A. did leave the country and respondent maintained contact with him. On March 12, 2001, respondent consulted with Patient R.A. by telephone. He reported increased anxiety, bowel symptoms/constipation, lumbosacral back pain and a 20 pound weight loss.

10. Complainant contends that respondent committed errors and omissions in the care and treatment of Patient R.A. by: 1) failing to evaluate his anxiety and insomnia complaints by means of a standard psychiatric history, medical history, physical examination and mental status examination; 2) failing to evaluate gastrointestinal complaints to rule out serious and perhaps life threatening illness while recommending palliative treatment; 3) failing to follow up on complaints and using a questionnaire that inappropriately lumped multiple complaints into a single illness category; 4) falsely and unethically representing that Patient R.A. was under his care and supervision for treatment of serious medical conditions; maintaining medical records that lacked adequate documentation of physical/mental status examination, clinical findings, vital signs, laboratory tests, follow-up and treatment plans necessary to an evaluation and diagnosis of the patient's condition, or to support the recommendation/prescription of any medication; and 6) furnishing marijuana without conducting a prior good faith examination and/or without medical indication.

11. Laura Duskin, M.D. testified as an expert witness on behalf of complainant. She is a psychiatrist with Kaiser Permanente, Adult Psychiatry Department, and a senior physician specialist, psychiatry with the San Francisco Department of Public Health, Community Clinics. Dr. Duskin is an Assistant Clinical Professor, UCSF School of Medicine. Her responsibilities there include teaching interviewing skills and diagnosis/treatment of psychiatric conditions to interns and residents at the medical school. Dr. Duskin is a Diplomate, American Board of Psychiatry and Neurology in Psychiatry (unlimited) and Geriatric Psychiatry. She has practiced psychiatry since 1983.

Dr. Duskin is familiar with the standard of practice for psychiatrists in both treating and consulting capacities. In terms of the initial patient evaluation she opines that the standard of practice is essentially the same, regardless of whether the physician is acting as a treating physician or as a consultant. She believes the standard of practice for recommending marijuana is identical to that governing any medication – mainly that the physician does an evaluation of the patient's complaints, formulates a differential diagnosis, discusses treatment options with the patient including the risks and benefits of medications, and

develops a treatment plan with provision for future monitoring. There is always an initial evaluation, some more comprehensive than others depending upon the status of the patient. When marijuana is being recommended for a psychiatric condition, the examination would include a mental status examination. This is basically an assessment of the patient's behavior, speech, reported mood, coherency, short term memory, impaired insight or judgment, thoughts of suicide or harming others, obsessive thoughts, etc. In some cases formal testing is required.

Where a psychiatrist is called upon to treat a condition that is non-psychiatric in nature the standard of practice is the same as that followed by any other physician, namely history, physical examination, differential diagnosis, appropriate treatment plan and plans for follow-up and responsibility for management of the problem unless it can be referred to the patient's primary care physician. Dr. Duskin emphasizes that this is really very basic, something all physicians learn as part of their medical school education. She makes specific reference to the Board's 1997 Action Report and to CSAM's policy statement (Finding 6) noting that they both merely confirm existing and accepted medical standards for treatment or prescribing of any medication.

Dr. Duskin notes that the standard of practice when treating patients in follow-up is to reevaluate the problem(s), the efficacy or problems with treatment, and to appropriately address any new concerns. If more than one condition is the focus of treatment, each condition is evaluated independently even if the same drug is being used to treat all of the conditions. Where referral for further evaluation and follow-up is warranted, a psychiatrist is responsible for making this referral and documenting this in the medical record. The standard of practice for medical records is for the psychiatrist to keep all records pertaining to the treatment of the patient, including prescriptions or certificates, and where copies of any portions of the medical records are provided to others, the psychiatrist retains the originals and sends copies only.

12. Dr. Duskin believes that respondent's treatment of Patient R.A. represented an extreme departure from the standard of practice in numerous areas of concern. The patient records contain no adequate initial evaluation note, no psychiatric or medical history, no mental status examination and no differential diagnosis. She notes that such lack of documentation for a patient for whom a psychoactive drug was being recommended was an extreme departure from the standard of care.

Dr. Duskin is critical of respondent's failure to document the history and make an appropriate follow-up plan for the patient's potentially serious gastrointestinal complaints. She is particularly concerned that "gastrointestinal cancer or other disease manifest with symptoms as described by this patient, and without appropriate medical evaluation the cannabis, if symptomatically effective, might only mask the problem until the disease progressed to a life threatening degree." There is no indication from the records that Patient R.A. was receiving ongoing treatment from another physician, important information that should be ascertained. If a physician is offering pain management or palliative treatment the physician is also responsible for making sure that the underlying problem is being addressed,

or that the patient is refusing to have that problem addressed. If such occurred in this case it was not documented and there is no indication that respondent discussed Patient R.A.'s medical or psychiatric treatment with any other health care provider.

Respondent used a patient questionnaire that allowed for illness status to be described in single word categories such as "stable", "improved" or "worse" and that grouped multiple conditions into a single evaluation category. Thus, on August 5, 1999, in reference to anxiety disorder, gastritis and irritable bowel syndrome that were being treated with cannabis, the reevaluation of the conditions consisted of the single word "stable". Dr. Duskin notes that when a symptom or condition is the focus of treatment, a one word description of the clinical situation is grossly inadequate, and that no competent clinician would lump multiple conditions into an illness category and evaluate them together as one.

In follow-up evaluations it was noted that the patient had increased anxiety and insomnia on April 28, 2000, and on March 12, 2001. No evaluation of these symptoms was documented and no treatment plan other than to recommend cannabis was made. Dr. Duskin allows that cannabis may have been efficacious for these problems but given the ongoing nature of the problems "further evaluation and consideration of supplemental treatment with other medications, other treatment modalities or a complete change in treatment for these conditions was clearly in order." Dr. Duskin is also critical of the length of time between follow-up contacts and the lack of an interval history of the progress of the patient's conditions between contacts.

Dr. Duskin has additional concerns that respondent provided a certification indicating that the patient was under his "care and supervision," something she characterizes as false and misleading. She notes, for example, that the patient's gastritis was not being followed in any way in a manner that would be expected if he was under respondent's care and supervision for that condition.

13. Respondent did not view himself as R.A.'s primary care physician and avers that he only rendered a diagnosis sufficient for the purpose of determining that R.A. had a serious and chronic condition that was helped by marijuana. He contends that R.A. was under his care and treatment because he had seen him frequently and stayed in telephone contact and followed his condition even after he left the country. He believes that he conducted a bona fide examination in determining that R.A.'s condition was both serious, chronic and helped by cannabis. He attributes R.A.'s symptoms (psycho-physiologic gastrointestinal dysfunction) to R.A.'s anxiety related to law enforcement. He disagrees that he failed to evaluate R.A.'s gastrointestinal complaints to rule out more serious disease, dismissing the notion that marijuana was palliative treatment at all.

14. Philip Andrew Denney, M.D. testified as an expert witness on behalf of respondent. He attended the University of Southern California School of Medicine and has been in medical practice since 1976. Recent professional activities include positions as the Facility Medical Director of Meridian Occupational medicine Group, Sacramento (1996-97); Facility Medical Director of Healthsouth Medical Clinic, Rocklin (1997-99); Medical

Director, Marshall Center for Occupational Health (1999-2000); and Occupational and Legal Medicine (2000 – present). From 1999 his medical legal practice has included medical cannabis recommendations. Dr. Denney's membership in professional societies includes the American College of Occupational and Environmental Medicine and the California Cannabis Research Medical Group. He remains informed about medical cannabis from the small universe of practitioners in this field who exchange information informally or through organized conferences. He describes one of respondent's publications as an authoritative and seminal work that introduces western physicians to appropriate citations in medical literature in this field. Although he believes thousands of doctors give cannabis recommendations, Dr. Denney notes that fewer than twenty consult on medical cannabis issues as a primary part of their practice. He falls within this category.

Dr. Denney views respondent's role as that of a consultant, and not as that of a treating physician. Because cannabis cannot be prescribed he notes that the physician is not involved in treatment at all, rather the patient is engaged in self treatment of a medical condition. The physician's role is that of recommending the cannabis for a medical condition. The physician is not saying that this is the sole treatment, it may be only one small part. Dr. Denney believes that the good faith examination required in these cases is only that which is necessary to gain the information needed. He considers the Board's 1997 Action Report to be advisory in nature and not the standard of practice.

With regard to Patient R.A., Dr. Denney opines that cannabis has salutary effects on gastritis but would not mask a more serious condition. He describes its effects as very mild compared to other prescription drugs, opiates for example. He has no criticism of respondent's medical records or lack thereof. Dr. Denney notes that it is not uncommon to have cursory, largely unintelligible and useless information contained in medical records. In making a sincere medical judgment he believes physicians rely more on actual observations and face to face contact with patients, and not upon medical records or other written documents provided by the patient.

15. Dr. Denney acknowledges obtaining a patient's history and performing physical examinations in his own practice, including medical cannabis consultations. He explains that he does so primarily for administrative and legal reasons yet he has consistently taken this examination approach for patients over his entire career in an effort to practice "excellent medicine." During medical cannabis evaluations he investigates complaints raised by the patient and if warranted he advises patients to seek follow-up care. He documents such discussions in his medical records. Dr. Denney opines that respondent is a superb physician whose medical cannabis practices were both appropriate and within the standard of care. Yet Dr. Denney's own practices are very different from respondent's and his practices are entirely consistent with the Board's 1997 Action Report policy statement. In conducting his medical cannabis evaluation Dr. Denney obtains a medication history and reviews the reason for using cannabis. He discusses medical cannabis and any problems with its use with the patient, reviews any available records and tries to determine whether the patient is being truthful. He conducts a "head to toe" physical examination and evaluates the presenting complaint for each patient. Dr. Denney notes that if a patient raises a complaint of

importance he would "certainly" advise the patient to seek follow-up care with a physician. He acknowledges that it is important to keep medical records documenting the medical evaluation, and that such records might be important to subsequent treating physicians.

Essentially, the good faith examination Dr. Denney performs to support a recommendation for medical marijuana is no different than what he follows in any other medical evaluation.[5] It is also consistent with the standards articulated by Dr. Duskin.

16. The above matters having been considered, it does appear that the standard of practice for conducting a medical cannabis evaluation is identical to that followed by physicians in recommending any other treatment or medication. The standard applies regardless of whether the physician is acting as a treating or as a consulting physician. The medical cannabis evaluation is certainly focused on the patient's complaints, but it does not disregard accepted standards of medical responsibility. These standards include history and physical examination of the patient; development of a treatment plan with objectives; provision of informed consent; periodic review of the treatment's efficacy and proper record keeping. When a cannabis recommendation is being made for a psychiatric condition the examination would additionally entail a mental status examination to establish a psychiatric diagnosis and severity of the condition. In such cases a physical examination might not be included, or might only include a limited physical examination appropriate to the clinical situation. In sum, the standard of practice for a physician recommending marijuana to a patient is the same as pertains to recommending any other treatment or medication.

Respondent contends that consulting physicians would be unreasonably burdened with conducting a complete work up on each conceivable diagnosis or symptom presented or suspected and that he would have to maintain extensive notes on every item of communication between physician and patient. He is also concerned that he would be responsible for referring patients out for additional medical care if not provided personally and that patients would be required to return for further evaluations and extensive testing to independently verify medical diagnoses or symptoms.

A physician must obviously exercise some discretion in making clinical judgments and it would be unreasonable to require a comprehensive physical/mental examination in every case. Complainant's major criticism of respondent is that he failed to perform any work up on each patient's chief presenting complaint and that he failed to conduct even the most cursory of physical or mental status examinations. Dr. Denney's practice is instructive because, like respondent, he also performs numerous medical cannabis evaluations. Yet he incorporates traditional elements of a medical evaluation and the examination that he

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[5] Dr. Denney acknowledged in prior testimony that he makes a determination of whether a patient should be given a prescription or some kind of treatment as follows: "I take a medical history. I examine the patient. I do a physical examination. I base my opinion on those things, on records if they're available, on my opinion as to the patient's truthfulness, etc." When asked what is a recommendation for cannabis he answered: "A recommendation is an opinion based upon history and physical exam and experience that says that the patient has a condition which in the physician's opinion will benefit from cannabis use." (*People* v. *Urziceneau*, Sacramento Superior Court No. 00F06296.)

undertakes is the same that he performs on all his patients. The model is not as rigid or as burdensome as respondent suggests. Dr. Duskin allows for flexibility, noting for example that no physical examination or only a limited physical examination may be appropriate in cases where medical marijuana is recommended for a psychiatric condition. When warranted, it hardly seems burdensome at all to refer a patient out for additional evaluation or care if one is not the treating physician and a serious condition is suspected or confirmed. Failure to do so is an extreme departure from the standard of care.

17. It was established that respondent committed errors and omissions in his care of Patient R.A. in the following respects:

a. Respondent failed to evaluate R.A.'s gastrointestinal complaints, anxiety, and insomnia by means of a standard medical history, physical examination and mental status examination. Medical records for R.A. lacked adequate documentation of physical examination, clinical findings, vital signs, mental status examination, test results and treatment plan. Such failures constituted an extreme departure from the standard of care.

b. Respondent failed to evaluate or refer R.A. out for evaluation of gastrointestinal complaints to rule out serious and perhaps life threatening illness and such constituted an extreme departure from the standard of care.

c. Respondent failed to follow-up on R.A.'s complaints and used an inadequate check box questionnaire that lumped multiple complaints together into a single illness category. It was designed to be completed by the patient. The lumping of multiple complaints into a single illness category is a matter of poor questionnaire design, a departure from the standard of care.

d. Respondent falsely represented that R.A. was under his care and supervision for treatment of a serious medical condition. The choice of language on respondent's Physician Statement was intended to assist the patient in certifying eligibility under Proposition 215, no more. It was boilerplate and the form was designed by respondent at a time when there was little guidance on appropriate language to be used. Under these circumstances it reflected a departure from the standard of care.

Patient S.A.

18. Patient S.A., a 20 year old male, was seen by respondent on May 20, 1996. He reported a history of nausea, vomiting, motion sickness and anorexia. Medical records indicated that he had previously been worked up by physicians with an upper GI exam showing "probable small duodenal ulcer." Respondent's medical records for S.A. contain no

documentation that he elicited a history of other medical conditions, that he took vital signs or that he performed a physical/mental status examination. No treatment plan was formulated and there was no plan for follow-up of the patient's continuing gastrointestinal problems. Respondent did prescribe Marinol, a pharmaceutical containing the active ingredient in marijuana, for the patient's symptoms.

On November 10, 1997, respondent noted that the Marinol provided less relief than crude marijuana and based upon the patient's statement that he was "doing well with symptom control" respondent issued a Physician Statement indicating that S.A. was under his medical care and supervision for the serious medical condition of gastritis and that respondent recommended marijuana for this condition.

On May 12, 1998, S.A. requested a renewal of his Marinol prescription. The communication was characterized as a "televisit" and the patient's gastritis was described by a box checked "stable." A note on the form indicates that the certificate was mailed to the patient.

On October 16, 1999, the patient again requested a "renewal of cannabis recommendation." The communication was not in person, but was conducted via fax transmittal of a "Cannabis Patient Follow Up Visit Questionnaire." The form contains the patient's assessment that his gastritis was "stable" and his nausea was "better." S.A. also checked the box indicating that he found the treatment to be "very effective" and answered "no" to the question whether he experienced adverse effects. He issued the cannabis recommendation after he received the follow-up questionnaire and requested fee.

19. Dr. Duskin notes that S.A. was first seen by respondent approximately three years after he was diagnosed with a possible duodenal ulcer and that it was incumbent upon him to obtain an interim history to determine whether disease progression or some other gastrointestinal problem could account for current symptoms. Vital signs, frequency of vomiting, loss of blood and weight loss would all have been basic parts of a medical evaluation in this case. No vital signs or patient weight were recorded by respondent. On the basis of the patient's verbal reports, respondent justified a diagnosis of "gastritis, rule out peptic ulcer." Respondent prescribed Marinol without documenting informed consent and there is no indication that he referred S.A. back to his gastroenterologist or primary care provider for further evaluation. During his initial visit respondent noted that S.A.'s chemistry panel was within normal limits.

Two of the three follow-up visits were not face to face meetings. The standard of practice for follow-up visits is for the physician to reevaluate the clinical complaint(s) and any new problems. This entails an interval history of the symptoms or condition. A one word statement ("Stable") checked on a form by the patient is not sufficient information upon which to make a clinical decision to continue Marinol. A medication renewal to treat gastritis, nausea and motion sickness would necessitate a clinical evaluation of the patient or documentation that an appropriate clinical evaluation was done by another practitioner prior to renewing the medication. A doctor might renew a prescription for a brief period without

seeing a patient if the patient had been seen recently, but in this case respondent issued a cannabis recommendation on October 29, 1999, more than seventeen months after his previous evaluation. It appears that respondent issued the cannabis recommendation only after he received the follow-up questionnaire and requested fee. Dr. Duskin opines that "to charge for what amounts to a medication renewal without reevaluating the patient is unethical and grossly inappropriate. Likewise, this action would constitute an extreme departure from the standard of practice from a clinical standpoint."

Respondent signed a statement indicating that S.A. was under his "medical care and supervision" for the treatment of gastritis. If this were the case respondent would have been coordinating the ongoing evaluation and treatment of this condition with the patient's gastroenterologist or other medical practitioner and this was not the case.

20. Respondent notes that he evaluated S.A. only for a medical marijuana recommendation and that for purposes of follow-up, telephone contact and questionnaire were sufficient. He did not see himself as the primary care physician, noting that S.A. was self treating with cannabis before he saw respondent. Respondent believes that he performed a bona fide examination on the initial as well as on follow-up evaluations. He acknowledges that he did nothing to rule out peptic ulcer or to work up the gastritis. His focus was on determining eligibility under the Compassionate Use Act. When asked if he would be concerned if S.A. did not have a physician he answered in the negative, noting that it was not his responsibility and that it was beyond the scope of a consultative exam.

21. It was established that respondent committed errors and omission in the care and treatment of Patient S.A. in the following respects:

a. Respondent failed to evaluate S.A.'s gastrointestinal complaints by means of a standard medical history, physical examination. Medical records for S.A. lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan. He prescribed Marinol without ruling out progression of the previously suspected duodenal ulcer. Such failures constituted extreme departures from the standard of care.

b. Respondent failed to re-evaluate or refer S.A. out for evaluation of gastrointestinal complaints to rule out serious illness and such constituted an extreme departure from the standard of care.

c. Respondent renewed S.A.'s recommendation in 1998 and 1999 without an interval history of the patient's condition and with the last examination not having been performed since November 1997.

d. Respondent charged S.A. for medication renewal without conducting an examination, an extreme departure from the standard of practice.

Patient J.B.

22. Patient J.B., a 40 year old female, was seen by respondent only once, on August 9, 1997. She presented with a ten year history of chronic depression and anxiety.

He diagnosed her with dysthymic disorder and Post Traumatic Stress Disorder (PTSD).

Dr. Duskin opines that respondent's treatment represented an extreme departure from the standard of practice when he failed to evaluate her symptoms of anxiety, depression and panic attacks. Respondent did not obtain the requisite history of the onset and duration of the patient's complaints, nor did he determine whether the patient had ever been hospitalized or ever been suicidal. He conducted a mental status examination that Dr. Duskin believes was deficient because it provided information only about the patient's current state and nothing about her history. Further, he did not offer her standard treatment for these diagnosed conditions when many effective treatments are available for both PTSD and dysthymia. The medical records contain no documentation that he offered standard treatment for these conditions or that if he did that the patient refused. Dr. Duskin also opines that he inappropriately instructed her to follow-up with him as needed instead of establishing a follow-up plan given the severity of her psychiatric conditions. Dr. Duskin has no quarrel with the cannabis recommendation, only with respondent's failure to do more. She emphasizes that a treatment plan in this case would need a number of elements – life circumstances needed to be addressed, and consideration given to behavioral interventions and perhaps adjunctive medications. Respondent issued a statement indicating that J.B. was under his "medical care and supervision" for dysthymic disorder and PTSD and this simply was not the case.

Respondent views his role in this case as that of providing J.B. with medicinal justification and protection from law enforcement. His understanding is that a clinical evaluation is a visit where a clinical decision is made and he believes he conducted a bona fide examination in this case. He avers that he spent over an hour with this patient. He does not know if J.B. had another physician and notes that she was opposed to taking pharmaceuticals making treatment options and interventions limited. He did not refer her to therapy or to another physician. Respondent believes the scope of the consultative evaluation was to issue her a certificate even though he felt that she needed much more.

23. It was established that respondent committed errors and omissions in the care and treatment of J.B. in the following respects:

a. Respondent conducted an inadequate evaluation of her symptoms of depression, anxiety and panic attacks.

b. Respondent arrived at a diagnosis of PTSD and dysthymic disorder without conducting a documented clinical evaluation.

c. Respondent failed to offer or refer J.B. out for standard psychiatric treatment for her conditions.

d. Respondent failed to provide follow up care for J.B.'s complaints.

Respondent's overall treatment of J.B. as above described represented an extreme departure from the standard of care.

Patient J.M.B.

24. On December 30, 1998, Patient J.M.B., a 26 year old male, consulted respondent for complaints of chronic pain that he attributed to spinal injuries sustained in prior automobile accidents. Respondent's records contain no vital signs physical examination or other medical evaluation of the patient's spinal complaints. Respondent issued a physician's certificate stating that J.M.B. was under his medical care and supervision for the treatment of intervertebral disc disease. A physician evaluating a patient with chronic orthopedic complaints is required to perform a physical examination, to obtain a history of the patient's condition, to assess any decrease in range of motion and limitations in daily activities. Respondent did none of these things.

On June 22, 1999, respondent issued a physician's statement to J.M.B. reiterating that he remained under respondent's care and supervision for the treatment of intervertebral disc disease. There is no record that respondent re-evaluated J.M.B. on this date, nor is there any evidence that respondent obtained an interval history.

Respondent believes he performed a bona fide examination for purposes of recommending medical cannabis. When asked whether a physical examination might have assisted in verifying complaint he explains that in most cases he takes what a patient says to be true and accurate.

25. It was established that respondent committed errors and omissions in the care and treatment of J.M.B. in the following respects:

a. Respondent failed to evaluate J.M.B. for intervertebral disc disease and arrived at a diagnosis without performing appropriate medical work up. Such failure constituted an extreme departure from the standard of care.

b. Respondent renewed the patient's recommendation without interval history or re-evaluation, an extreme departure from the standard of care.

c. Respondent's statement that J.M.B. was under his medical care and supervision for intervertebral disc disease was false, a departure from the standard of care.

Patient R.B.

26. Respondent saw R.B., a 27 year old male, on May 21, 1999. R.B. presented with complaints of nausea and dizziness and respondent made diagnoses of nausea and alcohol-related gastritis. In doing so he recorded no vital signs and ordered no laboratory tests. Medical records do not document any history, physical examination or other appropriate methods by which respondent arrived at a diagnosis. Dr. Duskin opines that respondent's treatment of R.B. "represented an extreme departure from the standard of practice when he made two diagnoses without obtaining an adequate medical history e.g. review of the onset, course of illness, alleviating and exacerbating factors in enough detail to make an accurate diagnoses."

R.B. did bring medical and other records, 40 pages worth, with him to his examination with respondent along with his medications. He had a primary care physician with Kaiser and had undergone extensive medical work-up and treatment prior to being seen by respondent. R.B. indicated that he was told that Kaiser would not permit its doctors to sign Proposition 215 recommendations and that was why he sought out respondent.

Respondent notes that he reviewed the records that R.B. brought with him and that he examined him. This included a family and past medical history, present illness, treatment plan and a review of cannabis use pattern. Respondent believes vital signs and laboratory tests were irrelevant in that they have nothing to do with the specific question of whether medical cannabis is appropriate. He acknowledges that he does not take vital signs, including blood pressure, for any of his patients. He notes that he conducted a bona fide examination of R.B.

27. It was established that respondent diagnosed R.B. with nausea and gastritis without performing a physical evaluation, recording vital signs or ordering laboratory tests.

Medical records for R.B. lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan. Such failures constituted extreme departures from the standard of care. It was not established that respondent failed to take an adequate history given the information that R.B. provided to him via patient records and clinical interview.

Patient D.B.

28. Respondent saw D.B. on June 26, 1998, with complaints of cerebral palsy and post-traumatic arthritis. No physical examination and no vital signs were recorded. On June 27, 1998, respondent issued a recommendation for the patient's medical cannabis use and indicating that D.B. was under his medical care and supervision for the treatment of cerebral palsy and post-traumatic arthritis. There were no treatment goals and no baseline data upon which progress could be measured. By the time of a follow-up evaluation on January 21, 2000, there were still no records of any kind, nor any type of appropriate referral for medical reevaluation of the physical condition of concern. D.B. was charged $100 for "confirming

status" without any apparent examination. Dr. Duskin notes that even though cannabis was reportedly beneficial to the patient "other adjunctive treatments would need to be explored including possible medication, physical therapy, occupational therapy for assistive or corrective devices, etc." Just addressing the cannabis portion of treatment did not amount to "medical care and supervision."

It was established that respondent committed errors and omissions in the care and treatment of D.B. in the following respects:

a. Respondent recommended treatment to D.B. without conducting a physical examination. Medical records for D.B. lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent failed to provide follow up or referral for the patient's complaints.

c. Respondent charged for renewal of the patient's recommendation even though no examination was performed.

d. Respondent's statement that D.B. was under his medical care and supervision for cerebral palsy and traumatic arthritis was false.

Respondent's overall treatment of D.B. as above described represented an extreme departure from the standard of care.

Patient K.J.B.

29. Respondent first saw K.J.B., a 42 year old male with complaints of muscle spasm and lumbosacral pain, on August 24, 1998. There is no record of a physical examination of the patient, nor is there a proposed treatment plan or plan for follow-up. Respondent issued a physician statement indicating that K.J.B. was under his medical care and supervision for the treatment of Lumbosacral Disease. On September 20, 1999, K.J.B. again contacted respondent and on that occasion he provided respondent with a Beck Inventory, a self-administered questionnaire that is used to measure the degree of a patient's depression. K.J.B. endorsed a number of items and multiple statements indicating a significant level of depression. K.J.B. also completed a form indicating that he suffered from depression, insomnia, weight loss, cannabis addiction and back pain. There is no recorded assessment by respondent of the patient's multiple complaints and there was no plan for treatment or follow-up for the patient's depression and back pain except for a box indicating follow-up in 6 – 12 months.

The standard of practice for treating musculoskeletal pain and muscle spasm is to take an adequate history, do a pertinent physical examination, obtain old records when available, make or confirm the diagnosis, and develop a treatment plan presenting all reasonable

treatment options and making referrals as appropriate. The same standard applies to treating depression except that the examination would consist of a mental status examination and pertinent parts of the physical examination. In this case there was not an adequate evaluation of either the psychiatric or the musculoskeletal complaints.

K.J.B. believed that respondent was his treating psychiatrist and was the "best" in the field and it is therefore troubling that respondent indicates that he did not perform a formal mental status examination and that K.J.B. was mistaken if he believed that he was his psychiatrist. Dr. Duskin notes that though cannabis may have helped in the patient's depression, there are many effective treatments for depression including both antidepressants and psychotherapy, treatments that respondent failed to provide or refer out for. Respondent avers that he did not suggest therapy or standard treatment for K.J.B. because he believed K.J.B. was not the sort of person who would be accepting of therapy.

30. It was established that respondent committed errors and omissions in the care and treatment of K.J.B. in the following respects:

a. Respondent failed to conduct a physical examination of K.J.B. before recommending treatment. Medical records for K.J.B. lacked adequate documentation of physical/mental status examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent failed to conduct an evaluation of the patient's depression.

c. Respondent failed to reevaluate the patient in light of the patient's continuing depression or to consider alternative treatments for the patient's recurrent depression.

d. Respondent's statement that K.J.B. was under his medical care and supervision for lumbosacral disease was false.

Respondent's overall treatment of K.J.B. as above described represented an extreme departure from the standard of care.

Patient J.C.

31. Respondent saw J.C., an 18 year old female, on December 11, 1998. She complained of anorexia and stated that she was 6 months pregnant and had used marijuana to keep food down. Donnatal and over-the-counter medications were apparently ineffective. Dr. Duskin opines that such complaints in pregnant patients are potentially serious for the patient and for the fetus. The standard of care requires that a physician evaluate, first, the type of anorexia that is being addressed and include a description of the patient, her weight, vital signs and a detailed history. Respondent failed to record the patient's height, weight or vital signs and no history relevant to the patient's anorexia is documented, nor is a history documented with regard to his diagnosis of prolonged traumatic stress disorder. There is no

record of discussion of the relative risks and benefits of marijuana use. Dr. Duskin believes the failures above described were simple departures from the standard of care, but given the multiple simple departures represented an extreme departure.

J.C. and her mother both testified. As soon as J.C. began using cannabis she began to gain weight and her pregnancy was a healthy one. She provided a substantial number of patient records to respondent that he reviewed at the time of his evaluation. Respondent is criticized for his failure to contact J.C.'s treating obstetrician, but he explains that J.C.'s mother told him that the obstetrician approved of her daughter receiving cannabis but was afraid to provide a written recommendation. Under the circumstances respondent believed it unnecessary to contact this physician. Respondent also recommended cannabis instead of Marinol because he believed that J.C.'s stomach would be too sensitive and that through vaporization technique J.C. would be able to inhale therapeutic resins without other contaminants.

32. It was established that respondent committed errors and omissions in the care and treatment of J.C. in the following respects:

a. The medical records for J.C. lacked adequate documentation of physical/mental status examination, clinical findings, vital signs, test results and treatment plan.

b. He failed to work up J.C. prior to arriving at a diagnosis of prolonged traumatic stress disorder.

Respondent's overall treatment of J.C. as above described represented an extreme departure from the standard of care. However, it was not established that he failed to adequately evaluate J.C.'s reported anorexia given the amount of information about her condition that was made available to him. Similarly, it was not established that he failed to consider alternatives to smoked marijuana for J.C. His decision not to prescribe Marinol was based on his reasonable clinical judgment that her stomach would not be able to tolerate this medication. Respondent also provides a reasonable explanation for his decision not to contact J.C.'s treating physician.

Patient S.F.

33. Patient S.F. was 16 when she saw respondent on March 18, 1999, complaining of migraine headaches, depression and painful menstrual cramps that had worsened following a therapeutic abortion. She had no treating physician and had received no medical work up for any of these conditions. Her reported history included stress and "flipping out" during periods of extreme anger. Respondent recorded no history regarding the headaches. No physical or mental status examination and no vital signs are documented in the records. Respondent issued a physician's statement indicating that S.F. was under his medical care and supervision for the treatment of migraine headache and premenstrual syndrome.

Dr. Duskin agrees that marijuana might be helpful for these complaints but notes that respondent took only a partial history from S.F. regarding her headaches and did not adequately assess their triggering factors, duration and progression. Regarding the complaints of persistent and severe menstrual cramping, the standard of care would require an evaluating physician to obtain a history, including cycle, where in the cycle the symptoms are occurring, whether the menses are heavy or light, as well as what has helped or aggravated the condition. Infertility issues should be considered for a patient this young with a history of therapeutic abortion and referral for gynecological examination was indicated.

S.F. reported past medical history of depression, stress and head injuries and there is no indication that respondent undertook an evaluation of these conditions. The standard of practice upon hearing that a patient has had a head injury is to do a full history and neurological examination, or arrange for same.

34. Respondent relied upon information provided to him by S.F. and her father. He believes that he did an adequate work up regarding the etiology of the headaches and he determined that the head injury had occurred some time in the distant past and that she had recovered with diminishing sequela. He made a specific recommendation for psychological evaluation to S.F. and to her father. There were significant behavior problems at issue in their home.

35. It was established that respondent committed errors and omissions in the care and treatment of S.F. in the following respects:

a. Respondent failed to adequately work up the etiology and nature of S.F.'s headaches. The medical records for S.F. lacked adequate documentation of physical/mental status examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent failed to evaluate the patient's complaints of painful menstrual cramps and failed refer her to an obstetrician/gynecologist for further evaluation.

c. Respondent's statement that S.F was under his medical care and supervision for treatment of migraine headaches and premenstrual syndrome was false.

Respondent's overall treatment of S.F. as above described represented an extreme departure from the standard of care. However, it was not established that respondent failed to address her stress and depression or that he failed to make a counseling or psychotherapy referral. He did so. He also made a clinical determination that her head injury was not recent and that she had recovered with no ill effects.

Patient D.H.

36. Respondent saw D.H., a 36 year old female, on April 30, 1999. She complained of very painful headaches as well as neck and shoulder pain associated with stress. Respondent issued a recommendation for the patient to use marijuana for tension headaches, pruritus and anxiety disorder. Medical records for D.H. contain no record of physical examination, vital signs, mental status examination or other work up of her complaints. The records consist largely of a questionnaire completed by the patient. There is no written evaluation by respondent.

Dr. Duskin opines that respondent failed to conduct an adequate history and physical examination to make or confirm the diagnoses presented by D.H. This was particularly important for headache complaints given the different causes and the need for a physician to develop a treatment plan specific to the cause of headache symptoms.[6] D.H. brought with her to her appointment medical reports and evidence of her condition. She told him that she had benefited from the use of cannabis in that her headaches were less intense and the itching was not as bad. She had a primary physician and had also been to a chiropractor and respondent advised her to also follow what her other doctors had recommended.

37. It was established that respondent committed errors and omissions in the care and treatment of D.H. in the following respects:

a. Respondent failed to adequately work up the etiology and nature of D.H.'s headache complaints and, aside from recommending marijuana, did not develop a treatment plan for her. The medical records for D.H. lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent failed to document and evaluate D.H.'s complaints of pruritus and, aside from recommending marijuana, did not develop a treatment plan for her.

c. Respondent failed to document and evaluate D.H.'s complaints of anxiety and, aside from recommending marijuana, did not develop a treatment plan for her.

d. Respondent's statement that D.H. was under his medical care and supervision for treatment of headaches, pruritus and anxiety was false.

Respondent's overall treatment of D.H. as above described represented an extreme departure from the standard of care.

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[6] Causes may include benign conditions as tension headache, uncorrected vision problems, teeth clenching and migraine, to much more serious conditions such as carbon monoxide poisoning, subdural hematoma or even brain tumor.

Patient J.K.

38. Respondent issued a physician's statement dated July 23, 1999, indicating that J.K., a 37 year old year old male, was under his care and supervision for posttraumatic stress disorder and traumatic arthritis. J.K. completed a questionnaire dated June 27, 1999, describing his present illness as dysthymic disorder and steel pin in right leg. Respondent's records contain no record of psychiatric history, physical examination, vital signs, mental status examination or other work up of the patient's complaints. The standard of practice for a psychiatrist evaluating a patient with a history of dysthymia is to complete a psychiatric history and to perform a mental status examination to determine the degree of depression. In diagnosing PTSD the standard of practice is to determine whether the diagnosis is justified in light of symptoms and history. Dr. Duskin opines that respondent's treatment represented an extreme departure from the standard of practice when he diagnosed PTSD without specifying any of the symptoms/criteria necessary for this diagnosis.

Respondent avers that he learned sufficient medical history from this patient to indicate that he suffered from these conditions but acknowledges that documentation supporting PTSD was not present. With regard to traumatic arthritis, he believes that the fact of an indwelling pin indicates serious trauma with consequent arthritis.

39. It was established that respondent committed errors and omissions in the care and treatment of J.K. in the following respects:

a. Respondent failed to evaluate J.K.'s reported depression by obtaining a psychiatric history and mental status examination. The medical records for J.K. lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent diagnosed J.K. with PTSD without specifying the symptoms or criteria requisite to that diagnosis.

c. Respondent failed to evaluate J.K. for traumatic arthritis by appropriate history and examination.

d. Respondent's statement that J.K. was under his medical care and supervision for treatment of PTSD and traumatic arthritis was false.

Respondent's overall treatment of J.K. as above described represented an extreme departure from the standard of care.

Patient D.K.

40. D.K., a 54 year old female, was seen by respondent on June 27, 1998, with a history of stroke and tobacco dependence. Respondent issued a physician's statement representing that D.K. was under his medical care and supervision for brain trauma and nicotine dependence. Other than that which was apparent through observation, respondent did not conduct an evaluation of her brain trauma nor did he evaluate her tobacco smoking addiction. Dr. Duskin opines that the standard of practice when treating symptoms associated with prior brain injury is to specifically identify the symptoms, onset, intensity, exacerbating and relieving factors, and effectiveness of past treatments. Though cannabis might be very effective for symptoms of brain trauma, other psychotropic medications may be equally or more effective and the patient needs to be made aware of therapeutic options. Dr. Duskin recognizes the value of cannabis being of assistance in a harm reduction treatment of nicotine dependence but notes that the standard of practice requires obtaining a smoking history (pack years, recent history including attempts to quit, etc.) and discussing treatment options.

Respondent notes that D.K. was specifically seeking recommendation for use of medical cannabis that she had found useful for symptoms of organic brain damage she suffered at age 21. He observed her peculiar speech patterns, that she was emotionally labile, depressed and had difficulty controlling her reactions. Cannabis helped her become less agitated and less disorganized. He felt that he was able to adequately evaluate her brain injury and determine that it was a serious chronic condition that would be helped by cannabis. His response to criticism of his practice regarding evaluation, diagnosis and treatment plans is that these were matters beyond his role as a medical cannabis consultant and that he had all the information that he needed to determine whether D.K. had a condition that would benefit from the use of marijuana. Respondent believed that she would also benefit from neuropsychological testing and possible eligibility for public rehabilitation programs. He issued a written recommendation for such testing.

D.K. returned to see respondent on July 24, 1999, and July 28, 2000, and records consist largely of a questionnaire completed by the patient indicating status by checked categories on the form that lumped multiple serious conditions together.

41. It was established that respondent committed errors and omissions in the care and treatment of D.K. in the following respects:

a. Respondent failed to evaluate D.K.'s brain injury, failed to establish a diagnosis of the patient's condition and failed to develop a treatment plan. The medical records for D.K. lacked adequate documentation of physical/mental status examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent failed to evaluate D.K.'s nicotine dependency and to document her tobacco smoking history.

c. Respondent failed to conduct an appropriate follow-up evaluation for D.K.'s condition and charged for renewal without reexamining her.

d. Respondent's statement that D.K. was under his medical care and supervision for treatment of brain trauma and nicotine dependence was false.

Respondent's overall treatment of D.K. as above described represented an extreme departure from the standard of care.

Patient E.K.

42. Respondent saw E.K., a 49 year old male with complaints of insomnia and back pain, on February 17, 1997. He reported that he had a back pain since age 18 secondary to scoliosis and that he had been using marijuana to relieve pain symptoms. He also reported a history of hypertension. No physical examination is documented and no vital signs were recorded. Respondent prescribed Marinol.

On March 17, 1999, E.K. completed a follow-up questionnaire indicating a desire to replace Marinol with crude marijuana. He sought marijuana for conditions of "sleep, hypertension, blood pressure, blood sugar, eating." Respondent charged E.K. $120 and sent him a recommendation for the use of marijuana for anxiety disorder and persistent insomnia. E.K. contacted respondent in March 2000 and March 2001, and received recommendation renewals, all without examination. The recommendations indicated that E.K. was under his care and supervision for anxiety disorder, insomnia and essential hypertension, except that the 2001 statement omitted the reference to hypertension. No explanation is documented for this change.

Dr. Duskin notes that the standard of practice for a psychiatrist evaluating a patient with these conditions is to evaluate each condition and develop a treatment plan specific to each. She opines that his treatment of E.K. constituted an extreme departure from the standard of practice because he failed to evaluate the patient insomnia and anxiety in even a basic way – type, severity, duration, accompanying symptoms, exacerbating and alleviating factors. He also failed to evaluate the blood sugar and blood pressure complaints, not even taking a blood pressure reading or ordering or referring him for appropriate laboratory tests that are routine in the evaluation of a hypertensive patient.

Respondent explains that E.K. sought no more than a cannabis recommendation from him, that he conducted a sufficient examination, that he determined that the conditions were both serious and chronic and by E.K.'s account relieved by cannabis. He notes that E.K. is a Christian Scientist and his personal/religious beliefs precluded him from consultation with most physicians. Respondent did not believe he was being consulted for hypertension or high blood sugar and notes that they were conditions that were mentioned in passing. Yet, respondent listed hypertension as a condition for which E.K. was under his care and supervision and that cannabis was recommended for same.

43. It was established that respondent committed errors and omissions in the care and treatment of E.K. in the following respects:

a. Respondent failed to evaluate E.K.'s hypertension, fluctuating blood sugar and complaints of anxiety and insomnia. The medical records for E.K. lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent's statement that E.K. was under his medical care and supervision for treatment of anxiety disorder, insomnia and essential hypertension was false.

c. Respondent dropped his diagnosis of essential hypertension without documenting normalization of the patient's blood pressure.

d. Respondent charged for renewal of recommendation without re-examining the patient.

Respondent's overall treatment of E.K. as above described represented an extreme departure from the standard of care.

Patient F.K.

44. Respondent saw F.K., on June 30, 1997, for complaints of alcohol dependency and lumbosacral radiculitis. His diagnosis for F.K. was thoracic or lumbosacral neuritis or radiculitis, unspecified and alcohol dependence syndrome, unspecified. He documented no mental status examination, no adequate medical, psychiatric or substance history, no physical examination to evaluate the lumbosacral problem and no treatment plan other than to discontinue alcohol. Respondent issued a physician's statement indicating that F.K. was under his care and treatment for lumbosacral thoracic radiculitis and alcoholism. Dr. Duskin opines that the standard of practice when diagnosing substance abuse or dependence is to document the substance abuse history, psychiatric history, perform a mental status examination and perform relevant physical examination and laboratory tests. A treatment plan addressing the problem should be stated in the medical record. She notes that respondent's evaluation seemed to consist only of references to three glasses of wine per week and this was inadequate. A mental status exam is needed to assess whether there is a primary or secondary psychiatric problem associated with the substance abuse. Simply informing a patient that he should "stop drinking" is not sufficient treatment.

Patient F.K. brought with him Veterans Administration (V.A.) medical records to his initial interview and they were reviewed by respondent. He had begun self-medicating with marijuana well before this meeting. It eased his back pain. V.A. physicians told him they could not recommend medical marijuana but also told him that respondent was an expert. F.K. prefers not to use opiates. In the past he drank a six pack and a couple of glasses of wine daily after work. He drinks a single glass per day with dinner if he is using marijuana.

Respondent believes he adequately evaluated F.K.'s drinking problem and that he engaged in thorough telephonic interviews for all follow-up evaluations. Telephone contacts were on March 5, 1998, November 24, 1998, and July 25, 2001. They typically lasted up to fifteen minutes after which a medical cannabis recommendation would be issued. Respondent charged F.K. $120 for this service.

45. It was established that respondent committed errors and omissions in the care and treatment of F.K. in the following respects:

a. Respondent failed to substantiate F.K.'s reported substance abuse problem prior to issuing a diagnosis of alcoholism and failed to formulate a treatment plan. The medical records for F.K. lacked adequate documentation of physical examination, mental status examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent charged for recommendation renewal without conducting an examination of the patient.

Respondent's overall treatment of F.K. as above described represented an extreme departure from the standard of care.

Patient R.H.

46. Respondent saw R.H., a 50 year old male with a history of alcoholism and alcohol-related cerebellar ataxia on March 26, 1998. He issued a recommendation for marijuana for the treatment of "Alcoholic encephalopathy & Recovering alcoholic Insomnia & Posttraumatic arthritis." A follow-up questionnaire dated April 16, 2001 indicated "No Change" on these three diagnoses. Though the patient specified that he drinks up to ten cups of coffee daily, there was no comment in the record regarding its relevance to the insomnia complaint. The standard of practice for a psychiatrist diagnosing and evaluating insomnia is to obtain a full history including onset, type, exacerbating and ameliorating factors, medications taken, drugs, caffeine history, etc. The treatment plan should be directed at the primary cause of the insomnia, and may include both a pharmacologic and behavioral component. Respondent issued a physician's statement on May 3, 2001, indicating that R.H. was under his medical care and supervision for treatment of the serious medical conditions insomnia, traumatic arthritis and brain injury and that he recommended and approved his use of cannabis for these conditions. The medical record contains no documentation of traumatic arthritis.

47. It was established that respondent committed errors and omissions in the care and treatment of R.H. in the following respects:

a. Respondent failed to evaluate R.H.'s complaints of insomnia or to consider standard treatments for its underlying cause. He also failed to

evaluate and document R.H.'s arthritis. The medical records for R.H. lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent's statement that R.H. was under his medical care and supervision for post traumatic arthritis and chronic insomnia were false.

Respondent's overall treatment of R.H. as above described represented an extreme departure from the standard of care.

Patient W.H.

48. Respondent saw W.H., a 58 year old male with advanced multiple sclerosis, on November 1, 1998. W.H. was bedridden and under the care of a conservator who had requested respondent's services. Respondent met with the conservator and then saw W.H. for approximately 5 minutes. He obtained virtually no medical or psychiatric history from or about W.H. Medical records consist of an eligibility questionnaire partially completed by respondent, and several pages of medical records from other practitioners given to respondent by the conservator. He performed no physical and no mental status examination. He did not discuss the risks and benefits of cannabis with W.H. and documented no diagnosis or treatment plan. Respondent noted: "I looked at him and there he was lying in bed...He looked relatively comfortable...he appeared to be clean and appeared to be well-cared for, but again, I didn't lift the covers." Respondent issued a recommendation stating that W.H. was under his medical care and supervision for treatment of multiple sclerosis, and that he had discussed the medical risks and benefits of cannabis use with W.H.

Respondent avers that he briefly evaluated W.H. and observed ashtrays full of the ends of smoked joints near the bed. He opines that his condition was very serious, chronic and that he attained some relief from cannabis for muscle spasticity and depression. He avers that he got W.H. to articulate whether he knew about medical marijuana and was able to use it. Respondent believes discussion of the risks with W.H. was irrelevant because he had been using it for years. The conservator indicated to respondent that W.H. was deriving benefit from its use.

Dr. Duskin opines that though W.H. had severe difficulties with speech, and likely fatigued easily, this did not preclude a mental status examination, an evaluation of the painful muscle groups (rigidity, range of motion, etc.) and a focused evaluation of the pain intensity, duration, alleviating and exacerbating factors, efficacy of the current medication regimen, etc. If changing the dosing of existing medications (Baclofen and Ativan) had been tried in the past and was not efficacious, respondent did not document this fact and he was not in a position to recommend discontinuation or taper of either drug on a trial basis if either one or both were not helpful.

The standard of practice when a psychiatrist provides a focused consultation is to determine if follow-up is necessary, and if so to see the patient in follow-up at an appropriate

interval, depending upon the diagnosis and severity of the problem. Respondent failed to schedule a follow-up appointment at an appropriate interval. For pain management of a bedridden patient, planned follow-up in 6 – 12 months is inappropriate.

49. It was established that respondent committed errors and omissions in the care and treatment of W.H. in the following respects:

a. Respondent failed to adequately evaluate W.H.'s mental status.

b. Respondent failed to adequately evaluate W.H.'s complaints of pain and or muscle spasm. The medical records for W.H. lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan.

c. Respondent failed to evaluate the efficacy of W.H.'s current medication regimen.

d. Respondent failed to discuss the risks associated with marijuana and alternative treatments available to W.H.

e. Respondent failed to schedule a follow-up appointment for W.H. at an appropriate interval.

f. Respondent's statement that W.H. was under his medical care and supervision for treatment of Multiple Sclerosis, and that respondent had discussed the medical risks and benefits of cannabis use with W.H. was false.

Respondent's overall treatment of W.H. as above described represented an extreme departure from the standard of care.

Undercover Officer

50. In early 2003, Detective Steve Gossett, lead investigator for the Sonoma County Narcotics Task Force, was involved in a marijuana investigation of a couple implicated in illegal cultivation. He was provided the telephone number of an Oakland clinic where they had intended to obtain a medical marijuana recommendation. Detective Gossett made a telephone call to the clinic and made an appointment for himself using the undercover name Scott Burris. He went to the clinic, but because there were so many people waiting to be seen he paid $50 for a medical priority appointment for the following week. He returned to the clinic on February 7, 2003, signed in for an appointment, paid an additional $150 and was given a blank questionnaire to complete. He was asked by the receptionist to fill out all questions except for his current condition, and was told that "Ben" would be helping everyone with this particular section.

Detective Gossett disregarded instructions and filled in "sleep, stress, shoulder" for his current medical condition. A Ben Morgan came to assist him with the form and told him that stress was not the best medical condition. When Detective Gossett told him that his shoulder hurt, Ben asked him to move his shoulder up and down and then suggested that Detective Gossett state on the form that he had a dislocated shoulder.

Detective Gossett was escorted into a separate room where respondent was sitting behind a desk. Respondent reviewed the paperwork and asked him questions about his parents' health, his current medical problems and his stress over a pending criminal case. Detective Gossett made up a story about being arrested for possession of 54 grams of marijuana. He also told respondent that he did not have a regular doctor and that he was an unemployed construction worker. Respondent did not conduct any type of physical examination. He did not ask which shoulder had been injured.

Respondent observed that Detective Gossett's complexion was coarse and somewhat puffy, suggesting to him that he had a drinking problem, although he stopped short of diagnosing alcoholism. Respondent did advise him not to drink so much alcohol and suggested physical therapy. He issued a medical cannabis recommendation that indicated that Scott Burris (Detective Gossett) was under his medical care and supervision for treatment of serious medical conditions. The entire session lasted 10 to 15 minutes. Following the visit with respondent, Detective Gossett returned to the waiting area and was told to go to the Oakland Cannabis Club to obtain an identification card and that he and others were now "all legal" and could grow marijuana for sale to the different clubs. Ben Morgan advised the group to stick around for a "special treat" and Detective Gossett was given a bag of marijuana by an unknown female.

51. Respondent contends that Detective Gossett's law enforcement bias from past participation on a DEA task force, his prior statements that respondent was a "quack", his failure to wear a wire and his inconsistent statements all combine to make him a highly biased witness whose testimony should be discredited. Respondent notes that his overwhelming observation of Detective Gossett was that of a person with a serious drinking problem whose chronic shoulder pain had benefited from his alleged cannabis use and that respondent acted sincerely after performing a good faith medical examination. He acknowledges that he did not perform a physical examination. Respondent felt that marijuana would help ease his anxiety and his abuse of alcohol could be avoided. Respondent's challenge of Detective Gossett's credibility is somewhat moot because he does not dispute what occurred during the course of the medical interview itself. Their accounts differ only in terms of the length of the evaluation, respondent recalling that it was 20 minutes.

Respondent avers that he had no role in setting up the protocols and procedures followed at the Oakland Clinic. He was not the medical director and he had no authority to hire or supervise staff. He did not own or lease the property. He characterizes his position as that of an independent contractor there for the specific purpose of performing clinical evaluations. He was paid cash, $150 per patient seen. The medical records were his and they went home with him. Respondent had no role or knowledge of Ben Morgan's role in helping

patients prepare questionnaires and he was unaware that cannabis samples were being given away on the premises. Ben Morgan had asked respondent to participate in a number of different clinics. Respondent does not know if Ben Morgan had any health or medical license and he does not know if any other physicians worked out of the clinic. Respondent made no inquiries into whether the owners of the clinic were non-physicians and he is apparently unaware of laws governing physician practice under non-physicians. He avers that he did not view the clinic as carrying out full medical functions because it was a consultative venue as opposed to a medical clinic per se.

52. It was established that respondent committed errors or omissions in the care and treatment and interaction with an undercover officer in the following respects:

a. Respondent recommended treatment to the officer without conducting a physical examination. He undertook minimal effort to determine whether the officer was in fact suffering from any physical ailment or condition. The medical records for Detective Gossett lacked adequate documentation of physical examination, clinical findings, vital signs, test results and treatment plan.

b. Respondent failed to provide follow-up or referral for the stated complaints.

c. Respondent's statement that the patient was under his medical care and supervision for treatment of a serious condition diagnosed after review of available records and in person medical examination was false.

Respondent's overall treatment of Detective Gossett as above described represented an extreme departure from the standard of care.

By virtue of his position as the physician practicing at the clinic, respondent assumed shared responsibility for the actions of the clinic facilitator/receptionist (Ben Morgan) in exaggerating information regarding patient medical conditions and for dispensation of marijuana on the premises. However, it was not established that respondent was aware of any of these practices. Whether respondent's license should be subject to disciplinary action for the acts of Ben Morgan is reserved for discussion in the Legal Conclusions section.

Cost Recovery

53. The Board has incurred the following costs in connection with the investigation and prosecution of this case:

Medical Board of California Investigative Services

Year	Hours[7]	Hourly Rate	Charges
1999	4	103.07	$ 412.28
2000	234	109.93	25,723.62
2001	52	110.84	5,763.68
2002	78	110.84	8,645.52

An additional 61 hours @ $100 were spent by medical experts for reviewing and evaluating case-related materials, report writing, hearing preparation and examinations. Board investigative costs total $46,645.16.

Attorney General Costs

The costs of prosecution by the Department of Justice for Deputy Attorneys General Jane Zack Simon and Lawrence A. Mercer total $23,608, and $30,884, respectively. The declarations of both have been reviewed and the time and charges are found to be in reasonable performance of tasks necessary for the prosecution of this case.[8] Investigative and prosecution costs total $101,137.

LEGAL CONCLUSIONS

Immunity

1. Respondent contends that the Compassionate Use Act of 1996 confers absolute immunity upon a licensed physician who recommends medical marijuana. He relies upon Health and Safety Code section 11362.5, subdivision (c), which provides:

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[7] Approximately 27 hours were spent conducting interviews, 53 hours for record review, 53 hours for travel, 173 hours on report writing and 62 hours on telephone, subpoena service, court, meetings with the Attorney General and Medical Consultant

[8] Though a breakout of hours for each task was not provided, cost certifications detailed tasks including 1) conducting an initial case evaluation, 2) obtaining, reading and reviewing the investigative material and requesting further investigation, as needed; 3) drafting pleadings, subpoenas, correspondence, memoranda, and other case-related documents; 4) researching relevant points of law and fact; 5) locating and interviewing witnesses and potential witnesses; 6) consulting and/or meeting with colleague deputies, supervisory staff, experts, client staff, and investigators; 7) communicating and corresponding with respondent's counsel; 8) providing and requesting discovery; 9) preparing for and attending trial setting, status, prehearing and settlement conferences, as required, and 10) preparing for hearing.

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

Respondent believes that his medical marijuana recommendations should be protected by the "absolute immunity" afforded under section 11362.5. He asserts that California law enforcement officials from various jurisdictions began bringing complaints against him to the Board based almost entirely on their own failed prosecutions of various medical marijuana patients and that no patient has initiated or joined a complaint against respondent. He suggests that this action is politically motivated by law enforcement officials who are now working in tandem with the Board to circumvent Proposition 215, along with other protections afforded him and his patients under the First Amendment and patient confidentiality laws.

Complainant characterizes this case as having "virtually nothing to do with medical marijuana" and notes that Board medical expert Dr. Duskin was not even critical of the recommendation, or use, of marijuana medicinally. Rather, complainant's criticism is leveled at respondent's alleged failure in virtually every case to examine the patient, to obtain a history, to perform an appropriate work up of the patient's symptoms and findings, or to follow up with or monitor the patients.

2. Respondent contends that by its use of the term "notwithstanding any other provision of law," a legal term of art, the Compassionate Use Act confers absolute immunity of doctors for their actions related to recommending or approving medical marijuana. He notes that conduct necessary to perform the immunized act falls within the scope of the grant of immunity and is thus not subject to Board discipline. Specifically, he argues that a doctor must always take some action attendant upon approving or recommending medical marijuana and that recognizing immunity for the approval or recommendation, but not the *approving* or *recommending*, is logically impossible, and legally unsupportable. Complainant would instead draw a clear distinction between the physician's recommendation, and the process by which that recommendation was reached.

Generally, decisions about when, where or how to carry out the immunized act is conduct that comes within the privilege because the methods of doing the immunized act are typically matters so intimately linked to the immunized act itself "that they are within the scope of the privilege." (*Katsaris* v. *Cook* (1986) 180 Cal.App.3d 256, 266-267; *Scozzafava* v. *Lieb* (1987) 190 Cal.App.3d 1575.) Both *Katsaris* and *Scozzafava* considered a statute that immunized the killing of dogs trespassing on the property of livestock owners. In *Scozzafava*, a chicken farmer's employee wounded a dog that was attacking the farmer's chickens. The dog returned to its owner, who then brought the dog to a veterinarian. The dog later bit a veterinary assistant as she was attempting to pick it up. The veterinary assistant brought a negligence action against the chicken farmer, who raised the immunity statute as a defense. In construing the immunity rather broadly to bar the claim the Court of Appeal held:

> The context of *Katsaris* makes it clear that the test of acts or conduct "necessary to the killing" is not rigidly limited to such obvious incidents as loading and aiming, but is instead generously construed so as to reach categories of specific decisions pertaining to more general areas such as employment practices, business policies, and most manner of matters concerning firearms. These are precisely the issues for which plaintiff seeks to impose liability on defendant. Just as we did in *Katsaris*, we hold that these acts and omissions constitute decisions necessary to the exercise of the privilege to kill.

(*Scozzafava* v. *Lieb*, *supra*, 190 Cal.App.3d at 1581.)

Respondent contends that every single fact relied upon by the Board refers to the methods by which he went about recommending or approving the use of marijuana, and nothing more. He believes that the Board has no jurisdiction or authority to discipline, or even investigate him for the methods by which he recommended medical marijuana because such matters are shielded by absolute immunity.

3. Immunity statutes, like privileges, are either absolute or conditional. Absolutely privileged conduct does not permit any remedy by way of a civil action, regardless of whether or not the privileged conduct was undertaken in bad faith or with malice. (*Saroyan v. Burkett* (1962) 57 Cal.2d 706, 708) A qualified or conditional privilege protects the actor only if he or she acts for the purpose of advancing or protecting the interest which the privilege seeks to protect. "Thus, under a qualified privilege an actor may be liable for conduct which he undertakes with an improper motive. Likewise a qualified privilege may be lost if the actor engages in conduct outside the scope of the privilege, thus 'abusing' it." (*Katsaris* v. *Cook*, *supra*, 180 Cal.App.3d at 265.) To determine the scope of privilege the analytical model adopted by courts in defamation cases has been applied to immunity statutes, incorporating a two step analysis. (*Id.* at p. 266.) First, what is the policy rationale which underlies the privilege? Second, does that policy justify applying the privilege to this particular conduct? (*Ibid.*; *Bradley* v. *Hartford Acc. & Indem. Co.* (1973) 30 Cal.App.3d 818, 824.)

In this case the immunity afforded physicians under Health and Safety Code section 11362.5 does appear to be conditional. The language of the Compassionate Use Act is instructive in this regard. Subdivision (b)(2) provides that "Nothing in this section shall be construed to supersede legislation prohibiting persons from engaging in conduct that endangers others, nor to condone the diversion of marijuana for nonmedical purposes." One of the Act's purposes is to ensure that seriously ill Californians have the right to obtain and use marijuana for "medical purposes" and "where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana." Yet, the Act also expressly affirms public policy against conduct that endangers others or the diversion of marijuana for nonmedical purposes. It is left for the physician, as gatekeeper, to ensure that marijuana is used for "medical purposes" to benefit the seriously ill. Under these circumstances it is presumed that

physicians who recommend marijuana under the Act will follow accepted medical practice standards and make good faith recommendations based on honest medical judgments. (*Conant* v. *McCaffrey* (2000 WL 1281174) Complainant correctly notes that to hold otherwise and to extend absolute immunity to physicians would allow them to simply issue marijuana recommendations without the exercise of sound medical judgment and with no oversight.

4. The primary function of the Board is protection of the public. (Bus. & Prof. Code, § 2229, subd. (a).) The various provisions of the Medical Practice Act dealing with physician misconduct are designed to promote public safety by ensuring that the standards of practice for physicians are maintained and enforced. The language of the Compassionate Use Act does not conflict with these goals. Thus, the immunity afforded physicians who recommend marijuana to patients for medical purposes provides that they may not be punished, or denied any right or privilege, for having made that recommendation. However, it does not exempt them from standards or regulations generally applicable to physicians, including those that govern the manner or process by which the physician's recommendation was reached.[9] Judge Kozinski reached the same conclusion in contemplating the role of the physician in determining legal and illegal marijuana use under the Compassionate Use Act:

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

(*Conant* v. *Walters* (2002) 309 F.3d 629, 647.)

Application of Business and Professions Code Section 2242

5. Respondent contends that he did not "prescribe" marijuana and for that reason he cannot be held accountable for his failure to conduct a prior good faith examination nor for his failure to determine that a medical indication existed for treatment recommended by him. Business and Professions Code section 2242 provides that it is unprofessional conduct for a physician to prescribe, dispense or furnish drugs without a good faith prior examination and medical indication therefore. Respondent did not "prescribe" marijuana because one cannot prescribe a Schedule I controlled substance. (Health & Saf. Code, § 11054, subd. (d)(13).)

[9] That respondent also has a First Amendment right to recommend medical marijuana to his patients is undisputed. (*Conant* v. *Walters* (2002) 309 F.3d 629.) The Board has not imposed any content-based restrictions on his speech and he is able to communicate freely, candidly and meaningfully with his patients and to offer sincere medical judgments about the pros and cons of medical marijuana. For these reasons respondent's First Amendment challenge to the Board's action is overruled.

The administrative law judge found that the standard for prescribing cannot be distinguished from the standard of practice which proscribes recommending any other treatment without examination or medical work-up and the standard of practice is no different for "recommending" or "approving" marijuana than it is for prescribing any other medication.

However, in its Judgment and Order in this matter dated November 2, 2006, the Superior Court found, as a matter of law, that "a recommendation for marijuana is not a 'prescription' and as such, respondent was not subject to discipline pursuant to Business and Professions code section 2242". The board, therefore has excluded Business and Professions code section 2242 from consideration on remand.

Standard of Practice

6. The standard of practice for conducting a medical cannabis evaluation is as set forth in Finding 16. It is identical to that followed by physicians in recommending any other treatment or medication and it applies regardless of whether the physician is acting as a treating or as a consulting physician. Although focused on the patient's complaints, the evaluation does not disregard accepted standards of medical responsibility. These standards include history and physical examination of the patient; development of a treatment plan with objectives; provision of informed consent; and periodic review of the treatment's efficacy. When a cannabis recommendation is being made for a psychiatric condition the examination would additionally entail a mental status examination. In such cases a physical examination might not be included, or might only include a limited physical examination appropriate to the clinical situation. In sum, the standard of practice for a physician recommending marijuana to a patient is the same as that for recommending any other treatment or medication.

The standard of practice requires that the evaluation be supported by adequate documentation. That documentation must reflect the physician's initial history and physical/mental status exam, evaluation of each condition in question and a diagnosis and/or differential diagnosis. A physician must document pertinent physical and/or psychiatric findings, referrals, a treatment plan and follow-up. Business and Professions Code section 2266 provides that "[t]he failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

Disciplinary Grounds

7. Under Business and Professions Code section 2234 the Division of Medical Quality shall take action against any licensee who is charged with unprofessional conduct. Unprofessional conduct includes gross negligence, repeated acts of negligence, incompetence and the commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions or duties of a physician and surgeon. (Bus. & Prof. Code, § 2234, subds. (b) – (e).)

8. Cause for disciplinary action exists under Business and Professions Code section 2234, subdivision (b), by reason of the matters set forth in Findings 17, 21, 23, 25, 27, 28, 30, 32, 35, 37, 39, 41, 43, 45, 47, 49 and 52. Respondent's errors and omissions in connection with his care and treatment of sixteen patients and the undercover officer constituted gross negligence.

9. Cause for disciplinary action exists under Business and Professions Code section 2234, subdivision (c), by reason of the matters set forth in Findings 17, 21, 23, 25, 27, 28, 30, 32, 35, 37, 39, 41, 43, 45, 47, 49 and 52. Respondent's errors and omissions in connection with his care and treatment of sixteen patients and the undercover officer constituted repeated negligent acts.

10. No cause for disciplinary action exists under Business and Professions Code section 2234, subdivision (d), by reason of the matters set forth in Finding 54. The above described errors and omissions do not reflect respondent's incompetence, but rather choices consistent with his belief that a different standard was applicable to the evaluation of patients for purposes of medical cannabis recommendations. Incompetence generally is defined as a lack of knowledge or ability in the discharging of professional obligations and it often results from a correctable fault or defect. (*James* v. *Board of Dental Examiners* (1985) 172 Cal.App.3d 1096, 1109.) There are no apparent deficits in his education, knowledge, training, or skills as a physician. He is clearly capable of observing standard medical evaluation protocols for history, physical and mental status examination, development of a treatment plan, informed consent and follow up or referral. He has also demonstrated that he can maintain proper records when he chooses to do so.

11. No cause for disciplinary action exists under Business and Professions Code section 2234, subdivision (e), by reason of the matters set forth in Finding 52. It was not established that respondent had any awareness of the activities of Ben Morgan, an element necessary to a finding that he committed an act involving "dishonesty or corruption" under this particular subdivision. Generally, a licensee is responsible for the acts of agents, whether independent contractors or employees, acting in the course of the licensee's business. This is true even when the licensee does not have actual knowledge of the agent's activities. Thus, a licensee was charged with submitting false statements in MediCal billings that were done through an office manager without his review, and a pharmacist may be disciplined by the pharmacy board for the unlawful acts of his employee for illegally filling prescriptions. (*Heisenberg* v. *Myers* (1983) 148 Cal.App.3d 814, 824; *Arenstein* v. *State Board of Pharmacy* (1968) 265 Cal.App.2d 179, 192.) But even where respondent is ultimately responsible for the actions of agents, it does not also follow that he engaged in unprofessional conduct. Unprofessional conduct under section 2234, subdivision (e) contemplates more than vicarious liability for the actions of an agent and a licensee should not be found to have engaged in unprofessional conduct unless directly implicated for committing acts involving "dishonesty or corruption." A violation of this subdivision (e) should be based upon findings of respondent's own acts of dishonesty or corruption, or on

such acts by those working for him of which he had personal knowledge and which he actually ratified.[10] That is not the case here.

12. The Superior Court has found that cause for disciplinary action does not exist under Business and Professions Code section 2242.

13. Cause for disciplinary action exists under Business and Professions Code section 2266, by reason of the matters set forth in Findings 17, 21, 23, 25, 27, 28, 30, 32, 35, 37, 39, 41, 43, 45, 47, 49 and 52. Respondent failed to maintain adequate and accurate records relating to the provision of services to his patients.

14. Cost Recovery. Under Business and Professions Code section 125.3 the Board may request the administrative law judge to direct any licentiate found to have committed a violation or violations of the licensing act to pay the Board a sum not to exceed the reasonable costs of the investigation and enforcement of the case. Requested costs total $101,137. (See Finding 53.)

The Board must not assess the full costs of investigation and prosecution when to do so will unfairly penalize a licensee who has committed some misconduct, but who has used the hearing process to obtain dismissal of other charges or a reduction in the severity of the discipline imposed. The Board must consider the licensee's "subjective good faith belief in the merits of his or her position" and whether the licensee has raised a "colorable challenge" to the proposed discipline. (*Zuckerman* v. *Board of Chiropractic Examiners* (2002) 29 Cal.4th 32, 45.) Such factors have been considered in this matter.

This is a case of first impression. The scope of physician immunity under Health and Safety Code section 11362.5 and other legal issues had not been considered previously and required greater time and preparation on the part of complainant. Respondent should not bear the full burden of such costs. The Board acknowledged in its own policy statement on Proposition 215 that there was "a great deal of confusion concerning the role of physicians under this law" and following passage of the Compassionate Use Act there was uncertainty over what protocols physicians should follow in making medical cannabis recommendations. Some uncertainty persisted, notwithstanding the Board's January 1997 policy statement. There was credible testimony that among the handful of physicians who consult regularly on medical cannabis issues there was no uniform agreement on practice standards. Respondent had a good faith belief in the merits of his position and he raised a colorable challenge, factually and legally, to accusation allegations. He successfully defended allegations against him based upon incompetence, dishonesty or corruption. An adjustment of approximately 25 percent would fairly and equitably accounts for these several factors. Accordingly, reasonable investigation and prosecution costs are adjusted to $75,000.

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[10] See also *James* v. *Board of Dental Examiners*, *supra*, 172 Cal.App.3d at 1110, where the Court of Appeal noted: "An important factor in our review is that any attack to revoke the personal license to practice dentistry of Dr. James of course must be based upon findings of his own acts of misfeasance, or on such acts by those working with him of which he had personal knowledge and which he actually ratified."

However, effective January 1, 2006, Business and Professions code section 125.3 was changed to prohibit the board from requesting or obtaining from a physician and surgeon the costs of investigation and prosecution of a disciplinary proceeding. Therefore, the board waives cost recovery in this matter.

15. Other Considerations. The protection of the public is the Board's highest priority. Yet, in determining appropriate disciplinary action and in exercising disciplinary authority the Board shall, whenever possible, "take action that is calculated to aid in the rehabilitation of the licensee." (Bus. & Prof. Code, § 2229.) This includes ordering restrictions as are indicated by the evidence. Respondent's competence was really not at issue in this case. He understands what the traditional medical examination model entails. He has applied it when patients have been evaluated for reasons outside his focused medical cannabis consultation model and indeed, when Dr. Duskin was asked to review nine of respondent's inpatient case files, she found all to be within the standard of care. In a few cases she determined his care to be excellent. He is clearly capable of observing standard medical evaluation protocols for history, physical and mental status examination, development of a treatment plan, informed consent and follow up or referral. He has also demonstrated that he can maintain proper records in such cases. Dishonesty or corruption allegations against respondent were not sustained.

Respondent strongly believed that Proposition 215 contemplated something very different than the traditional medical examination model. Such beliefs were based upon his active involvement in efforts to legalize marijuana for medical purposes and his own good faith interpretation of Proposition 215. This, combined with his practice experience as a medical cannabis consultant, resulted in rather rigid yet consistent adherence to the more focused medical cannabis consultation model. He did so even after he was on notice of the accusation allegations. The question now is whether he is willing and able to set aside these very strong views regarding the type of examination he feels is necessary to support a medical cannabis recommendation and comply with traditional medical examination standards. Complainant characterizes respondent as "obviously intransigent" and is concerned that this will impede not only his ability to successfully complete probation, but the Board's ability to adequately supervise and monitor his activities. Respondent should only be placed on probation if there is a reasonable likelihood that he will conform his practice to acceptable standards, and if he can reasonably be expected to abide by necessary practice restrictions and oversight. Respondent has certainly been a forceful advocate for his approach throughout the investigation, prosecution and hearing of this case. He has raised colorable factual and legal defenses to accusation allegations and several first impression issues were considered in this case. Importantly, he has indicated that he would be willing to conform his practices if required and it is not unreasonable to expect that he will do so.[11] He should be given that opportunity.

[11] Respondent's failure to conform his behaviors after he was on notice that the Board took issue with his evaluation process and his lack of medical documentation is troubling, but it is countered somewhat by his sincere belief that he was breaking new ground in setting standards under Proposition 215 for recommending and approving medical cannabis. He has also persisted in his belief that this case has been driven from the start by federal and state government officials opposed to Proposition 215.

It would therefore not be contrary to the public interest to place respondent on probation at this time. One of the conditions should include appointment of a practice monitor and the development of a monitoring plan. Respondent has suggested that if his practice were monitored or supervised by a physician who was not a medical cannabis consultant he would "reject" it.[12] This is a case where compliance can best be ensured through a physician monitor/supervisor approved by the Board. This physician monitor may be a medical cannabis consultant, but this is certainly not a necessary requirement. The Board normally allows licensees, in lieu of having a practice monitor, to participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education (PACE) Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. While respondent may opt to participate in program such as PACE, it remains critical that an approved practice monitor be in place to monitor his practice. Participation in PACE should not be done in lieu of having a practice monitor.

16. Reconsideration After Remand. Consistent with the Superior Court's Judgment and Order, the board has reconsidered its decision in this matter. It finds that the original Order is appropriate for the violations that remain.

Respondent has been found, by clear and convincing evidence, to have been grossly negligent and also to have committed repeated negligent acts in his care and treatment of 16 patients and 1 undercover officer. Those two types of violations, standing alone, would warrant the Order initially adopted. That Order is consistent with the board's Disciplinary Guidelines, which call for a minimum of stayed revocation and 5 years probation on terms and conditions. The board finds no reason to deviate from the Order initially imposed, given the nature and extent of respondent's misconduct and the sheer number of patients. However, for the reasons indicated in Legal Conclusion No. 14, the board has stricken cost recovery from the order.

ORDER

Physician's and Surgeon's Certificate No. G-9124 issued to respondent Tod H. Mikuriya, M.D. is revoked pursuant to Legal Conclusions 8, 9, 12 and 13, separately and for

[12] Respondent's own expert, also a medical cannabis consultant, documents all medical cannabis evaluations and conducts a good faith examination that is identical to any other medical evaluation he performs. He does so consistent with his philosophy of practicing excellent medicine in all cases. If a medical cannabis consultant such as Dr. Denney performs the same medical evaluation for all patients, then it should really make no difference whether a physician assigned to monitor respondent's practice is also a medical cannabis consultant.

all of them. However, revocation is stayed and respondent is placed on probation for five (5) years upon the following terms and conditions:

The Panel recognizes that respondent has been on probation during the course of judicial review and accordingly, time already served on probation shall be credited toward completion of the probationary period.

1. Monitoring of Practice. Within 30 calendar days of the effective date of this Decision, respondent shall submit to the Division or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Division, including but not limited to any form of bartering, shall be in respondent's field of practice, and must agree to serve as respondent's monitor. Respondent shall pay all monitoring costs.

The Division or its designee shall provide the approved monitor with copies of the Decision and Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the decision and Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

The monitor shall submit a quarterly written report to the Division or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standards of practice of medicine or billing, or both, and whether respondent is practicing medicine safely, billing appropriately or both.

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

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Division or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 days of the resignation or unavailability of the monitor, respondent shall be suspended from the practice of medicine until a replacement monitor is approved and prepared to assume immediate monitoring responsibility. Respondent shall cease the practice of medicine within 3 calendar days after being so notified by the Division or designee.

Failure to maintain all records, or to make all appropriate records available for immediate inspection and copying on the premises, or to comply with this condition as outlined above is a violation of probation.

2. Notification. Prior to engaging in the practice of medicine respondent shall provide a true copy of the Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Division or its designee within 15 calendar days. This condition shall apply to any change in hospitals, other facilities or insurance carrier.

3. Supervision of Physician Assistants. During probation, respondent is prohibited from supervising physician assistants.

4. Obey All Laws. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

5. Quarterly Declarations. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

6. Probation Unit Compliance. Respondent shall comply with the Division's probation unit. Respondent shall, at all times, keep the Division informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the Division or its designee. Under no circumstances shall a post office box serve as an address of record,

except as allowed by Business and Professions Code section 2021(b). Respondent shall not engage in the practice of medicine in respondent's place of residence. Respondent shall maintain a current and renewed California physician's and surgeon's license.

Respondent shall immediately inform the Division or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

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

8. Residing or Practicing Out-of-State. In the event respondent should leave the State of California to reside or to practice respondent shall notify the Division or its designee in writing 30 calendar days prior to the dates of departure and return. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program outside the State of California which has been approved by the Division or its designee shall be considered as time spent in the practice of medicine within the State. A Board-ordered suspension of practice shall not be considered as a period of non-practice. Periods of temporary or permanent residence or practice outside California will not apply to the reduction of the probationary term. Periods of temporary or permanent residence or practice outside California will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; Probation Unit Compliance; and Cost Recovery.

Respondent's license shall be automatically cancelled if respondent's periods of temporary or permanent residence or practice outside California totals two years. However, respondent's license shall not be cancelled as long as respondent is residing and practicing medicine in another state of the United States and is on active probation with the medical licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

9. Failure to Practice Medicine - California Resident. In the event respondent resides in the State of California and for any reason respondent stops practicing medicine in California, respondent shall notify the Division or its designee in writing within 30 calendar days prior to the dates of non-practice

and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding thirty calendar days in which respondent is not engaging in any activities defined in sections 2051 and 2052 of the Business and Professions Code.

All time spent in an intensive training program which has been approved by the Division or its designee shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a Board-ordered suspension or in compliance with any other condition of probation, shall not be considered a period of non-practice.

Respondent's license shall be automatically cancelled if respondent resides in California and for a total of two years, fails to engage in California in any of the activities described in Business and Professions Code sections 2051 and 2052.

10. Violation of Probation. Failure to fully comply with any term or condition of probation is a violation of probation. If respondent violates probation in any respect, the Division, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

11. License Surrender. Following the effective date of this Decision, if respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntary surrender of respondent's license. The Division reserves the right to evaluate respondent's request and to exercise its discretion whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall within 15 calendar days deliver respondent's wallet and wall certificate to the Division or its designee and respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action.

If respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

12. Probation Monitoring Costs. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Division, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Division or its designee no later than January 31 of each calendar year. Failure to pay costs within 30 calendar days of the due date is a violation of probation.

13. Completion of Probation. Respondent shall comply with all financial obligations (e.g., cost recovery, restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon completion successful of probation, respondent's certificate shall be fully restored.

This decision shall become effective at 5:00 pm on March 12, 2007

IT IS SO ORDERED this 9th day of February, 2007.

BARBARA YAROSLAVSKY
Chairperson , Panel B
Division of Medical Quality
Medical Board of California

EXHIBIT A

ORIGINAL

COPY

BILL LOCKYER, Attorney General
of the State of California
JANE ZACK SIMON, State Bar No. 116564
LAWRENCE MERCER, State Bar No. 111898
Deputy Attorney General
California Department of Justice
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5544 (Simon)
(415) 703-5539 (Mercer)
Facsimile: (415) 703-5480

Attorneys for Respondent Medical Board of California

FILED
ENDORSED
NOV - 2 2006
By FRANK TEMMERMAN
Deputy Clerk

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF SACRAMENTO

TOD H. MIKURIYA, M.D.,

Petitioner,

v.

MEDICAL BOARD OF CALIFORNIA

Respondent.

Case No. 04CS00477

JUDGMENT AND ORDER RE: PETITION FOR WRIT OF ADMINISTRATIVE MANDATE

KEYD
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The hearing on the Petition for Writ of Administrative Mandate (the "Petition") in the above-entitled matter was heard in Department 20 on February 10, 2006, before the Honorable Jack Sapunor, Judge Presiding. Petitioner Tod Mikuriya, M.D., appeared in court, and was represented by Scott Candell, Attorney at Law; Medical Board of California, appeared by its counsel, Bill Lockyer, Attorney General of the State of California, by Lawrence A. Mercer and Jane Zack Simon, Deputy Attorneys General. The record of the administrative proceeding was received in evidence and reviewed by the Court. The Court read all the pleadings on file in the action, and the matter was orally argued and submitted.

Exercising its independent judgment, the Court therefore ORDERS, ADJUDGES AND DECREES that:

1. The Court finds that as a matter of law, a recommendation for marijuana is not a "prescription" and as such, respondent was not subject to discipline pursuant to Business and Professions Code section 2242. The petition for writ of mandate is granted solely to the extent that the Board based its Decision on a finding of unprofessional conduct based on a violation of section 2242. Accordingly, a peremptory writ of mandamus shall issue from this Court, remanding this matter to respondent for reconsideration of its Decision in light of this finding.

2. On all other grounds, the Petition is DENIED.

DATED: November 7, 2006

JACK SAPUNOR
Judge of the Superior Court