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9 **BEFORE THE**  
10 **DIVISION OF MEDICAL QUALITY**  
11 **MEDICAL BOARD OF CALIFORNIA**  
12 **DEPARTMENT OF CONSUMER AFFAIRS**  
13 **STATE OF CALIFORNIA**

14 In the Matter of the Accusation Against:

Case No. 12-1999-98783

15 TOD H. MIKURIYA, M.D.  
16 1168 Sterling Avenue  
17 Berkeley, CA 94708

**SECOND AMENDED ACCUSATION**

18 Physician's and Surgeon's Certificate No.  
19 G-9124

Respondent.

20 Complainant alleges:

PARTIES

21 1. Ron Joseph (Complainant) brings this First Amended Accusation  
22 ("Accusation") solely in his official capacity as the Executive Director of the Medical Board of  
23 California, Department of Consumer Affairs.

24 2. On or about October 16, 1963, the Medical Board of California issued  
25 Physician's and Surgeon's Certificate Number G-9124 to Tod H. Mikuriya, M.D. (Respondent).  
26 The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the  
27 charges brought herein and will expire on September 30, 2003, unless renewed.

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2 JURISDICTION

3 3. This Accusation is brought before the Division of Medical Quality,  
4 Medical Board of California (Division), under the authority of the following sections of the  
5 Business and Professions Code (Code).

6 4. Section 2003 of the Code states: "The board shall consist of the following  
7 two divisions: a Division of Medical Quality, and a Division of Licensing."

8 5. Section 2004 of the Code states:  
9 "The Division of Medical Quality shall have the responsibility for the following:

10 "(a) The enforcement of the disciplinary and criminal provisions of the Medical  
11 Practice Act.

12 "(b) The administration and hearing of disciplinary actions.

13 "(c) Carrying out disciplinary actions appropriate to findings made by a medical  
14 quality review committee, the division, or an administrative law judge.

15 "(d) Suspending, revoking, or otherwise limiting certificates after the conclusion  
16 of disciplinary actions.

17 "(e) Reviewing the quality of medical practice carried out by physician and  
18 surgeon certificate holders under the jurisdiction of the board."

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

23 7. Section 2234 of the Code provides, in pertinent part, that the Division of  
24 Medical Quality shall take action against any licensee who is charged with unprofessional  
25 conduct. Unprofessional conduct includes, but is not limited to, the following:

26 (a) Violating or attempting to violate, directly or indirectly, or assisting in or  
27 abetting the violation of, or conspiring to violate, any provision of this chapter [Chapter  
28 5, the Medical Practice Act].

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(b) Gross negligence.

(c) Repeated negligent acts . . .

(d) Incompetence.

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

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

8. Section 2242 of the Code states, in pertinent part:

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

9. Section 2266 of the Code provides:

“The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.”

10. Section 125.3 of the Code provides, in part, that 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.

11. Welfare and Institutions Code section 14123.12 states, in pertinent part, as follows:

“(a) Upon receipt of written notice from the Medical Board of California, that a licensee’s license has been placed on probation as a result of a disciplinary action, the department may n to reimburse any Medi-Cal claim for the type of surgical service or invasive procedure that gave rise to the probation, that was performed by the license on or after the effective date of the probation and until the termination of all probationary terms and conditions or until the probationary period has ended, whichever occurs first. This section shall apply except in any case in which the relevant licensing board determines that compelling circumstances warrant the continued reimbursement during the probationary period of any Medi-Cal claim...In such a case, the department shall continue to reimburse the licensee for all procedures, except for those invasive or surgical procedures for which the licensee was placed on probation.”

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2 FIRST CAUSE FOR DISCIPLINARY ACTION

3 (Patient R.A.)

4 (Unprofessional Conduct/Gross Negligence/Negligence/Incompetence)

5 12. Respondent is subject to disciplinary action under sections 2234, and/or  
6 2234(b), and/or 2234(c), and/or 2234(d) of the Code in that respondent committed  
7 unprofessional conduct, and/or was grossly and/or simply negligent, and/or incompetent in the  
8 care and treatment of Patient R.A.<sup>1</sup> The circumstances are as follows:

9 A. On or about March 5, 1997, Patient R.A., a 34 year old male, self-referred  
10 to respondent for medical advice regarding treatment of R.A.'s condition with  
11 marijuana, a Schedule I controlled substance. Respondent's records do not reflect  
12 the nature of the patient's health problems at that time, nor do the records reflect  
13 what advice was given to the patient by respondent. No psychiatric history,  
14 medical history, physical examination or mental status examination is recorded.  
15 A note by respondent indicates that two pages of the original record were given  
16 away by respondent. Respondent was interviewed and stated that he did conduct  
17 an examination, which he described as "observing the patient closely" and  
18 "talking with him."

19 B. On or about November 6, 1998, Patient R.A. responded to a "Follow Up  
20 Visit Questionnaire", wherein he reported that marijuana had been used by him  
21 for treatment of "Gastritis/Anxiety Disorder." No psychiatric history, medical  
22 history, physical examination or mental status examination is recorded by  
23 respondent. The only remarks recorded by respondent are "irritation from low  
24 potency" and "recounts stressors of arrest + case + involvement + insomnia. Disc  
25 effects on life." Inquiry as to the status of the patient's two complaints was made  
26 in the form of a check-the-appropriate-box response ("stable", "improved" or

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27 1. Patients' names are abbreviated to protect privacy. Full information will be provided to  
28 the respondent upon timely request for discovery.

1 "worse") by the patient re "illness status." A "physician's statement, dated  
2 November 18, 1998, states that Patient R.A. is under respondent's care and  
3 supervision for the treatment of gastritis and anxiety disorder, for which  
4 respondent recommends and approves the use of marijuana. The physician's  
5 statement indicates that it is an update from one dated March 5, 1997.

6 C. According to respondent's records, dated August 5, 1999, Patient R.A.  
7 provided a further follow-up questionnaire in which he reported treating  
8 complaints of anxiety disorder, gastritis and irritable bowel syndrome with  
9 marijuana, 15-38 grams per week. Respondent's only comments are noted as  
10 "vaporize" and "oral", presumably referring to a recommended method of  
11 marijuana utilization.

12 D. Respondent's records, dated April 28, 2000, indicate that R.A. complained  
13 of increased anxiety and insomnia. There is no documented medical response by  
14 Dr. Mikuriya to the patient's increased symptoms.

15 E. On January 4, 2001, Patient R.A. submitted a follow up questionnaire  
16 which indicated that he continued to suffer from anxiety and gastritis. No  
17 psychiatric history, medical history, physical examination or mental status  
18 examination is recorded by respondent. The patient's reported marijuana use was  
19 stated to be 60 grams or more per week -- about double what he had previously  
20 described -- and the patient stated that only price and availability prevented him  
21 from consuming four times that amount. Respondent issued a "physician's  
22 statement" which indicated that Patient R.A. was under respondent's medical care  
23 and supervision for treatment of a serious medical condition, which is noted as  
24 Anxiety Disorder, for which respondent recommended and approved the use of  
25 marijuana.

26 F. On March 12, 2001, Patient R.A. consulted respondent by telephone. He  
27 reported a 20 lb. weight loss and an increase in his anxiety, bowel complaints and  
28 insomnia. He also reported lumbosacral back pain. There is neither documented

1 medical response nor recommendation that the patient seek medical evaluation of  
2 his increased symptoms.

3 13. Respondent's conduct, as described above, constitutes unprofessional  
4 conduct and represents extreme and/or simple departures from the standard of care, and/or acts  
5 of incompetence in that respondent committed errors and omissions in the care and treatment of  
6 Patient R.A., including but not limited to the followings:

- 7 A. Respondent failed to evaluate R.A.'s complaints of anxiety and insomnia  
8 by means of a standard psychiatric history, medical history, physical  
9 examination and mental status examination;
- 10 B. Respondent failed to evaluate R.A.'s gastrointestinal complaints and failed  
11 to rule out serious and perhaps life threatening illness while  
12 recommending palliative treatment;
- 13 C. Respondent failed to follow up on R.A.'s complaints and used an  
14 inadequate check box questionnaire which lumped R.A.'s multiple  
15 complaints together as a single illness;
- 16 D. Respondent falsely and unethically represented that R.A. was under his  
17 care and supervision for treatment of serious medical conditions, when in  
18 fact respondent provided neither care nor treatment, but only approved the  
19 patient's use of marijuana as a palliative.

20 SECOND CAUSE FOR DISCIPLINARY ACTION

21 (Patient S.A.)

22 (Unprofessional Conduct/Gross Negligence/Negligence/Incompetence)

23 14. Respondent is subject to disciplinary action under sections 2234, and/or  
24 2234(b) and/or 2234(c), and/or 2234(d) of the Code in that respondent committed unprofessional  
25 conduct, and/or was grossly and/or simply negligent and/or incompetent in the care and  
26 treatment of Patient S.A. The circumstances are as follows:

- 27 A. On or about May 20, 1996, Patient S.A., a 20 year old male, presented to  
28 respondent for a recommendation/approval for marijuana. The patient gave a

1 history of nausea, vomiting, motion sickness and anorexia. Medical records  
2 indicate that the patient had previously been worked up by physicians for a  
3 suspected ulcer. The patient also had a history significant for an arrest for  
4 possession and cultivation of marijuana 18 months earlier. In respondent's  
5 records there is no documentation that respondent elicited a history of other  
6 medical conditions, took vital signs or performed a physical/mental status  
7 examination. Respondent prescribed Marinol, a pharmaceutical containing the  
8 active ingredient in marijuana, for the patient's symptoms. Respondent did not  
9 otherwise formulate a treatment plan or propose follow up for the patient's  
10 continuing gastrointestinal problems.

11 B. On November 10, 1997, respondent charted a note indicating that the  
12 patient reported that Marinol provided less relief than crude marijuana. Based  
13 upon the patient's statement that the patient was "doing well with symptom  
14 control", respondent issued a "physician's statement" stating that Patient S.A. was  
15 under respondent's medical care and supervision for the serious medical  
16 condition of gastritis and that respondent recommended marijuana for his  
17 condition.

18 C. On May 12, 1998, Patient S.A. requested a renewal of his Marinol  
19 prescription. The communication is stated to be a "televisit" and the patient's  
20 gastritis is described by a box checked "stable." A note at the bottom of the form  
21 states that a certificate, presumably for continued marijuana use, was mailed to  
22 the patient.

23 D. On October 16, 1999, the patient again requested a "renewal of cannabis  
24 recommendation." As with the prior 1998 communication, the communication  
25 was not face-to-face, but was conducted via fax transmittal of a "Cannabis Patient  
26 Follow Up Visit Questionnaire." The form contains the patient's assessment that  
27 his gastritis was "stable" and his nausea was "better." The patient checked the  
28 box indicating that he found the treatment "very effective" and answered "no" to

1 the question whether he had experienced "adverse effects."

2 15. Respondent's conduct, as described above, constitutes unprofessional  
3 conduct and represents extreme and/or simple departures from the standard of care, and/or acts  
4 of incompetence in that respondent committed errors and omissions in the care and treatment of  
5 Patient S.A., including but not limited to the following:

- 6 A. Respondent failed to evaluate the patient's gastrointestinal complaints by  
7 appropriate physical examination and prescribed Marinol, a Schedule III  
8 controlled substance, without ruling out progression of the previously  
9 suspected duodenal ulcer;
- 10 B. Respondent failed to re-evaluate the patient's gastrointestinal complaints  
11 on subsequent visits or to refer the patient to a physician for re-evaluation;
- 12 C. Respondent renewed the patient's medications in 1998 and 1999 without  
13 an interval history of the patient's condition and with the last examination  
14 not having been performed since on or before November 10, 1997;
- 15 D. Respondent charged the patient for medication renewal without  
16 conducting an examination.

17 THIRD CAUSE FOR DISCIPLINARY ACTION

18 (Patient J.B.)

19 (Unprofessional Conduct/Gross Negligence/Negligence/Incompetence)

20 16. Respondent is subject to disciplinary action under sections 2234, and/or  
21 2234(b) and/or 2234(c), and/or 2234(d) of the Code in that respondent committed unprofessional  
22 conduct, and/or was grossly and/or simply negligent and/or incompetent in the care and treatment  
23 of Patient J.B.. The circumstances are as follows:

- 24 A. On August 9, 1997, Patient J.B., a 40 year old female, presented with a ten  
25 year history of chronic depression, anxiety, and acute stress secondary to a recent  
26 arrest for possession and cultivation of marijuana. Respondent's records include a  
27 one page document entitled "Mental Status" on which he recorded a diagnostic  
28 impression included of Dysthymic Disorder on Axis I and Acute Post Traumatic

1 Stress Disorder on Axis III.

2 B. Respondent was interviewed regarding J.B. and, although it is not charted,  
3 indicated that Patient J.B. had a history of alcoholism, was paranoid and abusive and  
4 was "categorically opposed to any chemicals." Respondent also recalled that the  
5 patient had additional, unrecorded, symptoms, including nausea, vomiting and  
6 diarrhea.

7 C. On August 9, 1997, respondent issued a "physician's statement" in which he  
8 stated that Patient J.B. was under his medical care and supervision for the treatment  
9 of medical conditions designated as Post Traumatic Stress Disorder and Dysthymic  
10 Disorder.

11 17. Respondent's conduct, as described above, constitutes unprofessional conduct  
12 and represents extreme and/or simple departures from the standard of care, and/or acts of  
13 incompetence in that respondent committed errors and omissions in the care and treatment of Patient  
14 J.B., including but not limited to the following::

- 15 A. Respondent conducted an inadequate evaluation of Patient J.B.'s symptoms  
16 of depression, anxiety and panic attacks;
- 17 B. Respondent arrived at diagnoses of post traumatic stress disorder and  
18 dysthymic disorder without conducting a documented clinical evaluation;
- 19 C. Respondent failed to offer Patient J.B. standard psychiatric treatment for her  
20 condition;
- 21 D. Respondent failed to provide follow up care for Patient J.B.'s complaints.

22 FOURTH CAUSE FOR DISCIPLINARY ACTION

23 (Patient J.M.B.)

24 (Unprofessional Conduct/Gross Negligence/Negligence/Incompetence)

25 18. Respondent is subject to disciplinary action under sections 2234, and/or  
26 2234(b) and/or 2234(c), and/or 2234(d) of the Code in that respondent committed unprofessional  
27 conduct, and/or was grossly and/or simply negligent and/or incompetent in the care and  
28 treatment of Patient J.M.B.. The circumstances are as follows:

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2 A. On or about December 30, 1998, Patient J.M.B., a 26 year old male,  
3 presented with a history of multiple cervical and thoracic spinal fractures alleged  
4 to have been sustained in prior accidents. The patient reported that he was taking  
5 multiple, prescribed, controlled substances for his back condition. He also  
6 reported that he had been arrested and was facing prosecution for possession and  
7 cultivation of marijuana. Patient J.M.B. requested a recommendation for the use  
8 of marijuana. Respondent's records contain no vital signs, physical examination  
9 or other medical evaluation of the patient's spinal complaints. On the same day,  
10 respondent issued a "physician's certificate" which states that Patient J.M.B. is  
11 under respondent's medical care and supervision for the treatment of  
12 intervertebral disk disease.

13 B. On June 22, 1999, respondent issued a "physician's statement" to Patient  
14 J.M.B., reiterating that J.M.B. was under respondent's medical care and  
15 supervision for the treatment of intervertebral disk disease. There is no record  
16 that respondent re-evaluated J.M.B. on this date, nor is there any evidence that  
17 respondent obtained an interval history from the patient. Respondent's records  
18 indicate that J.M.B. was incarcerated in September, 1999, and that it was reported  
19 to respondent that J.M.B. was "bragging to other prisoners get letter from"  
20 respondent. At his interview, respondent recalled that J.M.B. desired a marijuana  
21 recommendation that would allow its use while incarcerated.

22 19. Respondent's conduct, as described above, constitutes unprofessional  
23 conduct and represents extreme and/or simple departures from the standard of care, and/or acts  
24 of incompetence in that respondent committed errors and omissions in the care and treatment of  
25 Patient J.M.B., including but not limited to the following:

- 26 A. Respondent failed to evaluate J.M.B. for intervertebral disk disease and  
27 arrived at a diagnosis without performing appropriate medical work up;
- 28 B. Respondent renewed the patient's recommendation without interval

1 history or re-evaluation;

2 C. Respondent's statement that J.M.B. was under his medical care and  
3 supervision for intervertebral disk disease was false and unethical.

4 FIFTH CAUSE FOR DISCIPLINARY ACTION

5 (Patient R.B.)

6 (Unprofessional Conduct/Gross Negligence/Negligence/Incompetence)

7 20. Respondent is subject to disciplinary action under sections 2234, and/or  
8 2234(b) and/or 2234(c), and/or 2234(d) of the Code in that respondent committed unprofessional  
9 conduct, and/or was grossly and/or simply negligent and/or incompetent in the care and  
10 treatment of Patient R.B.. The circumstances are as follows:

11 A. On May 21, 1999, Patient R.B., a 27 year old male, presented to  
12 respondent with complaints of nausea and dizziness. Respondent made diagnoses  
13 of nausea and alcohol-related gastritis. There is no record of a history, physical  
14 examination or other appropriate methods by which to arrive at a medical  
15 diagnosis. No vital signs are recorded and no laboratory tests are ordered to  
16 investigate the patient's potentially serious symptoms. The patient was not seen  
17 again by respondent. On January 27, 2000, Patient R.B. advised that he had been  
18 arrested and charged with possession and cultivation and requested that  
19 respondent "furnish a letter confirming my use of Marijuana to control my  
20 symptom [sic] of Psychogenic Nausea and Gastritis Dyspepsia."

21 21. Respondent's conduct, as described above, constitutes unprofessional  
22 conduct and represents extreme and/or simple departures from the standard of care, and/or acts  
23 of incompetence in that respondent committed errors and omissions in the care and treatment of  
24 Patient R.B., including but not limited to the following:

25 A. Respondent diagnosed the patient with nausea and gastritis without taking  
26 a history, performing a physical evaluation, recording vital signs or  
27 ordering laboratory tests.

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SIXTH CAUSE FOR DISCIPLINARY ACTION

(Patient D.B.)

(Unprofessional Conduct/Gross Negligence/Negligence/Incompetence)

22. Respondent is subject to disciplinary action under sections 2234, and/or 2234(b) and/or 2234(c), and/or 2234(d) of the Code in that respondent committed unprofessional conduct, and/or was grossly and/or simply negligent and/or incompetent in the care and treatment of Patient D.B. The circumstances are as follows:

A. On June 26, 1998, Patient D.B., a 20 year old male, presented with a history of cerebral palsy since birth and post-traumatic arthritis "after a car wreck." No physical examination is recorded, no vital signs are noted. A release signed by the patient for the records of an Oregon physician was provided, but the records were not obtained. On June 27, 1998, respondent provided D.B. with a "physician's statement" which states that D.B. is under respondent's medical care and supervision for the treatment of cerebral palsy and post-traumatic arthritis.

B. On October 9, 1998, D.B. advised by telephone that he had been arrested for trespassing and that officers had confiscated 4-5 grams of marijuana. D.B. requested that respondent verify his status as a medical marijuana user and respondent did so for a charge of \$100.00. D.B. was not re-examined at that time, but respondent relayed to law enforcement that D.B. suffered increased insomnia after his arrest.

C. On January 21, 2000, Patient D.B. submitted a follow up questionnaire. The reason for the contact was stated to be that the patient had "funds to contact" respondent. No physical examination is recorded. Respondent's comments on the questionnaire state only that the efficacy of treatment is "good" and that the patient is "now on probation but growing." The patient sent respondent a money order for \$120.00 on January 29, 2000, and on February 14, 2000, respondent provided a "physician's statement" that states that Patient D.B. "is under my medical care and

1 supervision for treatment of the serious medical conditions: Cerebral Palsy,  
2 Traumatic Arthritis.”

3 23. Respondent's conduct, as described above, constitutes unprofessional conduct  
4 and represents extreme and/or simple departures from the standard of care, and/or acts of  
5 incompetence in that respondent committed errors and omissions in the care and treatment of Patient  
6 D.B., including but not limited to the following:

- 7 A. Respondent recommended treatment to the patient without conducting a  
8 physical examination;
- 9 B. Respondent obtained a release from the patient for his medical records, but  
10 failed to obtain and/or document review of the records;
- 11 C. Respondent failed to provide follow up or referral for the patient's  
12 complaints;
- 13 D. Respondent charged for renewal of the patient's recommendation albeit no  
14 examination was performed;
- 15 E. Respondent's statement that D.B. was under his medical care and supervision  
16 for cerebral palsy and traumatic arthritis was false and unethical.

17 SEVENTH CAUSE FOR DISCIPLINARY ACTION

18 (Patient K.J.B.)

19 (Unprofessional Conduct/Gross Negligence/Negligence/Incompetence)

20 24. Respondent is subject to disciplinary action under sections 2234, and/or  
21 2234(b) and/or 2234(c), and/or 2234(d) of the Code in that respondent committed unprofessional  
22 conduct, and/or was grossly and/or simply negligent and/or incompetent in the care and  
23 treatment of Patient K.J.B. The circumstances are as follows:

- 24 A. On August 24, 1998, Patient K.J.B., a 42 year old male, presented with  
25 complaints of muscle spasm which he attributed to a 1992 motor vehicle accident  
26 and resulting lumbosacral sprain. The patient reported that he was being  
27 prescribed Valium and Ultram, but was not taking the Ultram. There is no record  
28 of a physical examination of the patient by respondent, nor is there a proposed

1 treatment plan or plan for follow up noted on the 4 page "registration form."

2 Respondent issued a "physician's statement", dated August 24, 1998, in which  
3 respondent stated that K.J.B. "is under my medical care and supervision for the  
4 treatment of medical condition(s): Lumbosacral Disease."

5 B. On September 20, 1999, Patient K.J.B. completed a "follow up visit  
6 questionnaire" to which he appended a one page document entitled "Beck's  
7 Inventory for Depression." That 21 page inventory is used by medical  
8 practitioners to assess the severity of a patient's depression. Patient K.J.B.'s  
9 inventory contained endorsements of multiple statements indicating a significant  
10 level of depression. The patient also submitted a January 21, 1999 form on which  
11 another physician certified that drug/alcohol treatment was medically necessary  
12 for K.J.B. and a form that K.J.B. had completed on which he indicated that he had  
13 suffered from depression, insomnia, weigh loss, cannabis addiction and back pain.  
14 There is no recorded assessment by respondent of the patient's multiple  
15 complaints. No plan for treatment or follow up for the patient's depression and  
16 back pain is set forth, except for a check mark in the box indicating follow up in  
17 "6-12 months."

18 C. On or about June 17, 2001, Patient K.J.B. submitted a follow up  
19 questionnaire in which he stated that he continued to suffer from recurrent  
20 depression and lumbosacral pain. Patient K.J.B. indicated that his marijuana use  
21 was 28-56 grams per week and, although this represented a marked increase in  
22 usage since the initial report of 3.5 grams per week in 1998, there is no inquiry  
23 noted in respondent's records. Respondent recommended regular massage and  
24 noted the efficacy of treatment as "very good."

25 25. Respondent's conduct, as described above, constitutes unprofessional  
26 conduct and represents extreme and/or simple departures from the standard of care, and/or acts  
27 of incompetence in that respondent committed errors and omissions in the care and treatment of  
28 Patient K.J.B., including but not limited to the following:

- 1 A. Respondent failed to conduct a physical examination of Patient K.J.B.  
2 before recommending treatment;
- 3 B. Respondent failed to conduct an evaluation of the patient's depression;
- 4 C. Respondent failed to re-evaluate the patient in light of the patient's  
5 continuing depression or to consider alternative treatments for the  
6 patient's recurrent depression;
- 7 D. Respondent's statement that K.J.B. was under respondent's medical care  
8 and treatment for lumbosacral disease was false and unethical.

9 EIGHTH CAUSE FOR DISCIPLINARY ACTION

10 ( Patient J.C. )

11 (Unprofessional Conduct/Gross Negligence/Negligence/Incompetence)

12 26 Respondent is subject to disciplinary action under sections 2234, and/or  
13 2234(b) and/or 2234(c), and/or 2234(d) of the Code in that respondent committed unprofessional  
14 conduct, and/or was grossly and/or simply negligent and/or incompetent in the care and treatment  
15 of Patient J.C.. The circumstances are as follows:

16 A. On December 11, 1998, Patient J.C., an 18 year old female, presented with  
17 complaints of anorexia. J.C. stated that she was in court-ordered drug diversion, was  
18 six months pregnant (Expected Due Date: 3/31/99) and used marijuana to keep food  
19 down. Donnatal and over-the-counter medications were reported by her to be  
20 ineffective.

21 B. Respondent failed to note the patient's height, weight or vital signs. No  
22 history relevant to the patient's anorexia is set forth. No history or mental status  
23 examination relevant to a diagnosis of prolonged traumatic stress disorder is taken.  
24 Although the patient reported that she was pregnant, respondent failed to inquire  
25 whether she had a treating Ob/Gyn and/or to consult with that physician before  
26 recommending treatment. There is no record of discussion of the relative risks and  
27 benefits of marijuana use and, although he had prescribed Marinol to other patients,  
28 he did not consider this potentially less risky alternative to smoked marijuana for J.C.

1 C. Respondent issued a "physician's statement" in which he stated that the  
2 patient was under his care and treatment for anorexia and prolonged traumatic stress  
3 disorder.

4 D. A note dated January 1, 1999, states that the patient's symptoms of nausea  
5 are well controlled and that she is undergoing prenatal testing.

6 27. Respondent's conduct, as described above, constitutes unprofessional conduct  
7 and represents extreme and/or simple departures from the standard of care, and/or acts of  
8 incompetence in that respondent committed errors and omissions in the care and treatment of Patient  
9 J.C., including but not limited to the following:

- 10 A. Respondent failed to adequately evaluate Patient J.C.'s reported anorexia;  
11 B. Respondent failed to work up Patient J.C. prior to arriving at a diagnosis of  
12 prolonged traumatic stress disorder;  
13 C. Respondent failed to contact the patient's treating Ob/Gyn;  
14 D. Respondent failed to consider alternatives to smoked marijuana for this  
15 pregnant patient, including Marinol;

16 NINTH CAUSE FOR DISCIPLINARY ACTION

17 (Patient S.F.)

18 (Unprofessional Conduct/Gross Negligence/Negligence/Incompetence)

19 28 Respondent is subject to disciplinary action under sections 2234, and/or  
20 2234(b) and/or 2234(c), and/or 2234(d) of the Code in that respondent committed unprofessional  
21 conduct, and/or was grossly and/or simply negligent and/or incompetent in the care and treatment  
22 of Patient S.F. The circumstances are as follows:

23 A. On March 18, 1999, Patient S.F., a 16 year old female, presented with  
24 multiple complaints: Migraine headaches, status post head injury, depression, painful  
25 premenstrual cramps, status post TAB. The patient gave a history of having been hit  
26 with a stick, as a result of the battery she stated that she suffered from recurring  
27 headaches. She also reported that she had a history which included stress and  
28 "flipping out." Respondent made a note that the pain was left sided and that there

1 was visual blurring. There is no recorded history regarding the headaches, no  
2 physical examination, no mental status examination and no charted vital signs.

3 B. On March 18, 1999, respondent issued a "physician's statement" that  
4 indicated that Patient S.F. "is under my medical care and supervision for the  
5 treatment of medical condition(s): Migraine headache, premenstrual syndrome."

6 29. Respondent's conduct, as described above, constitutes unprofessional conduct  
7 and represents extreme and/or simple departures from the standard of care, and/or acts of  
8 incompetence in that respondent committed errors and omissions in the care and treatment of Patient  
9 S.F., including but not limited to the following:

- 10 A. Respondent failed to adequately work up the etiology and nature of S.F.'s  
11 headaches;
- 12 B. Respondent failed to address the patient's stress and depression and failed  
13 to make a counseling or psychotherapy referral;
- 14 C. Respondent failed to evaluate the patient's complaints of painful  
15 premenstrual cramps and failed to make an ob/gyn referral for S.F.;
- 16 D. Respondent failed to evaluate S.F.'s head injury;
- 17 E. Respondent's statement that S.F. was under his medical care and supervision  
18 for treatment of migraine headaches and premenstrual syndrome was false  
19 and unethical.

20 TENTH CAUSE FOR DISCIPLINARY ACTION

21 (Patient D.H.)

22 (Unprofessional Conduct/Gross Negligence/Negligence/Incompetence)

23 30. Respondent is subject to disciplinary action under sections 2234, and/or  
24 2234(b) and/or 2234(c), and/or 2234(d) of the Code in that respondent committed unprofessional  
25 conduct, and/or was grossly and/or simply negligent and/or incompetent in the care and treatment  
26 of Patient D.H. The circumstances are as follows:

- 27 A. On April 30, 1999, Patient D.H., a 36 year old female, presented with  
28 complaints of very painful headaches, as well as neck and shoulder pain. The latter

1 complaint was said to increase with stress. The patient reported that she had been  
2 prescribed Anaprox and Lodine, which are anti-inflammatory medications, and  
3 Norflex, which is an analgesic, for her musculoskeletal complaints. The  
4 prescriptions had "expired" and Patient D.H.'s physician did not renew them. D.H.  
5 was also treating with a chiropractor. D.H.'s self-reported history, as set forth on the  
6 page questionnaire, did not reference complaints of pruritus (itching) or anxiety.

7 B. Respondent's records contain no record of physical examination, vital signs,  
8 mental status examination or other work up of the patient's complaints. Respondent  
9 recommended that the patient receive massages and issued a "physician's statement"  
10 in which he represented that D.H. was under his medical care and supervision for the  
11 treatment of tension headaches, pruritus and anxiety.

12 31. Respondent's conduct, as described above, constitutes unprofessional conduct  
13 and represents extreme and/or simple departures from the standard of care, and/or acts of  
14 incompetence in that respondent committed errors and omissions in the care and treatment of Patient  
15 D.H., including but not limited to the following:

- 16 A. Respondent failed to evaluate Patient D.H.'s complaints of headaches and,  
17 aside from recommending the patient's use of marijuana, failed to develop  
18 a treatment plan for her;
- 19 B. Respondent failed to document and evaluate Patient D.H.'s complaints of  
20 pruritus and, aside from recommending the patient's use of marijuana, failed  
21 to develop a treatment plan for her;
- 22 C. Respondent failed to document and evaluate Patient D.H.'s complaints of  
23 anxiety and, aside from recommending the patient's use of marijuana, failed  
24 to develop a treatment plan for her;
- 25 D. Respondent's statement that D.H. was under his medical care and supervision  
26 for treatment of headaches, pruritus and anxiety was false and unethical.

27 ELEVENTH CAUSE FOR DISCIPLINARY ACTION

28 (Patient J.K.)

1 (Unprofessional Conduct/Gross Negligence/Negligence/Incompetence)

2 32. Respondent is subject to disciplinary action under sections 2234, and/or  
3 2234(b) and/or 2234(c), and/or 2234(d) of the Code in that respondent committed unprofessional  
4 conduct, and/or was grossly and/or simply negligent and/or incompetent in the care and treatment  
5 of Patient J.K. The circumstances are as follows:

6 A. On or about July 23, 1999, Patient J.K., a 37 year old male, presented with  
7 complaints of "dysthemic [sic] disorder" and "steel pin in leg." Patient J.K. reported  
8 that he had previously been prescribed Trazadone and Zyrtec for his condition. His  
9 6 page questionnaire, which is dated June 27, 1999, states that J.K. had been disabled  
10 since 1986. The patient's questionnaire also indicates that he was on parole after  
11 conviction of a felony, i.e., possession of marijuana for sale.

12 B. Respondent's records contain no record of psychiatric history, physical  
13 examination, vital signs, mental status examination or other work up of the patient's  
14 complaints. Respondent noted that a decrease in sleep and appetite were related to  
15 J.K.'s depression, but there is no indication of the length or severity of these  
16 symptoms. Neither J.K.'s height nor weight are noted. Respondent recommended  
17 that the patient discontinue his alcohol consumption, the extent of which is not  
18 specified, and issued a "physician's statement" in which he represented that Patient  
19 D.H. was under his medical care and supervision for "Post Traumatic Stress Disorder  
20 and Traumatic Arthritis."

21 33. Respondent's conduct, as described above, constitutes unprofessional conduct  
22 and represents extreme and/or simple departures from the standard of care, and/or acts of  
23 incompetence in that respondent committed errors and omissions in the care and treatment of Patient  
24 J.K., including but not limited to the following:

25 A. Respondent failed to evaluate Patient J.K.'s reported depression by obtaining  
26 a psychiatric history and mental status examination;

27 B. Respondent diagnosed Patient J.K. with post traumatic stress disorder  
28 without specifying any of the symptoms or criteria requisite to that diagnosis;

1 C. Respondent failed to evaluate Patient J.K. for traumatic arthritis by  
2 appropriate history and examination;

3 D. Respondent's statement that J.K. was under his medical care and supervision  
4 for treatment of post traumatic stress disorder and traumatic arthritis was  
5 false and unethical.

6 TWELFTH CAUSE FOR DISCIPLINARY ACTION

7 (Patient D.K.)

8 (Unprofessional Conduct/Gross Negligence/Negligence/Incompetence)

9 34. Respondent is subject to disciplinary action under sections 2234, and/or  
10 2234(b) and/or 2234(c), and/or 2234(d) of the Code in that respondent committed unprofessional  
11 conduct, and/or was grossly and/or simply negligent and/or incompetent in the care and  
12 treatment of Patient D.K. The circumstances are as follows:

13 A. On June 27, 1998, Patient D.K., a 53 year old female, presented to  
14 respondent with a reported history of a stroke secondary to birth control pills at  
15 age 21 and tobacco dependence. Patient D.K.'s family history included the fact  
16 that her mother had died of a cerebral hemorrhage in her early 60's. D.K. stated  
17 that she was abstinent from tobacco for one year prior, but a smoking history is  
18 not set forth in respondent's records. There is no record of physical examination,  
19 mental status examination or other work up for either brain trauma or nicotine  
20 dependence. Although Patient D.K. gave respondent a release for her medical  
21 records from a neurosurgeon in San Mateo County, the records were not obtained  
22 and reviewed.

23 B. On June 27, 1998, respondent issued a "physician's statement" in which  
24 he  
25 represented that Patient D.K. was under his medical care and supervision for brain  
26 trauma and nicotine dependence.

27 C. On July 24, 1999, Patient D.K. completed a 2 page patient questionnaire.  
28 In response to a check-the-box inquiry regarding "illness status" the patient

1 checked the box indicating that she was "improved." It cannot be determined  
2 from the response whether one or both conditions had improved. No physical or  
3 mental status examination is recorded. Respondent's only comments on the  
4 patient's status are a checked box indicating "good" efficacy of treatment and a  
5 remark that the patient discontinued tobacco use June 1, 1999.

6 D. On July 28, 2000, Patient D.K. completed a 2 page questionnaire and sent  
7 it to respondent via facsimile. Respondent's only comments on the patient's  
8 status are a checked box indicating "good" efficacy of treatment and a remark that  
9 the patient discontinued nicotine use June 1, 1999 and had been abstinent one  
10 year.

11 E. On August 10, 2000, respondent issued a "physician's statement" in which  
12 he represented that Patient D.K. was under his medical care and supervision for  
13 brain trauma and nicotine dependence. A note on the document indicates that it  
14 was "sent 8/16/00."

15 35. Respondent's conduct, as described above, constitutes unprofessional  
16 conduct and represents extreme and/or simple departures from the standard of care, and/or acts  
17 of incompetence in that respondent committed errors and omissions in the care and treatment of  
18 Patient D.K., including but not limited to the following::

- 19 A. Respondent failed to evaluate Patient D.K.'s brain injury, failed to  
20 establish a diagnosis of the patient's condition and failed to develop an  
21 appropriate treatment plan;
- 22 B. Respondent failed to evaluate the patient's nicotine dependency;
- 23 C. Respondent failed to document a tobacco smoking history for Patient  
24 D.K.;
- 25 D. Respondent failed to conduct appropriate follow up evaluation for Patient  
26 D.K.'s condition;
- 27 E. Respondent charged Patient D.K. for medication renewal albeit the patient  
28 was not re-examined by him.

1 F. Respondent's statement that D.K. was under his medical care and  
2 supervision for brain trauma and nicotine dependence was false and  
3 unethical.

4 THIRTEENTH CAUSE FOR DISCIPLINARY ACTION

5 (Patient E.K.)

6 (Unprofessional Conduct/Gross Negligence/Negligence/Incompetence)

7 36. Respondent is subject to disciplinary action under sections 2234, and/or  
8 2234(b) and/or 2234(c), and/or 2234(d) of the Code in that respondent committed unprofessional  
9 conduct, and/or was grossly and/or simply negligent and/or incompetent in the care and treatment  
10 of Patient E.K. The circumstances are as follows:

11 A. On February 17, 1997, Patient E.K., a 49 year old male, presented with  
12 complaints of insomnia and back pain. The patient reported that his back pain was  
13 secondary to scoliosis and that he had been rated 4F as unfit for the military for that  
14 reason. Patient E.K. gave a history of hypertension since 1956 (age 6) and a "bad  
15 back" since 1966 (age 18). Patient E.K. dated his marijuana usage to 1965 (age 17),  
16 when he discovered that it relieved back pain. Respondent did perform a mental  
17 status examination, after which he made an Axis I diagnosis of adjustment reaction  
18 with depressed mood and an Axis III diagnosis of scoliosis, recurrent pain and  
19 muscle spasm. No physical examination is documented and no vital signs are  
20 recorded. Patient E.K. advised that he had served two years in a federal prison on  
21 marijuana charges and was on probation. A condition of E.K.'s probation was  
22 urinalysis and marijuana was causing positive urinalysis results. Respondent  
23 prescribed Marinol, 10 g., #30.

24 B. On March 17, 1999, Patient E.K. filled out a 1 page follow up questionnaire  
25 in which he stated that he wished to replace Marinol -- which was described as  
26 having "worked" -- with crude marijuana. The patient described the conditions for  
27 which he used marijuana as "sleep, hypertension, blood pressure, blood sugar,  
28 eating." It is noted on the form that a \$120.00 fee was "received" after the date of

1 the follow up questionnaire. E.K. reported using 25 grams of marijuana per week,  
2 with a frequency of eight times per day. Respondent noted that the patient was  
3 sleeping better, his moods were better and he had 50 days of probation left.

4 C. On March 13, 2000, a 1 page follow up questionnaire was completed by  
5 Patient E.K. The patient stated that his last visit (March 17, 1999) had not been a  
6 face-to-face meeting. E.K.'s complaints were extreme anxiety, insomnia (stated to  
7 be controlled with unspecified medications), blood sugar and pressure fluctuations.  
8 E.K. indicated that he used marijuana seven times per day and that his use was now  
9 up to 42 grams per week. The patient stated that he was then facing charges of  
10 marijuana cultivation in Nevada County.

11 D. On March 23, 2000, respondent issued a "physician's statement" in which he  
12 represented that E.K. "is under my medical care and supervision for anxiety disorder,  
13 insomnia, essential hypertension."

14 E. On March 8, 2001, Patient E.K. completed a follow up questionnaire in  
15 which he lists his symptoms as anxiety and insomnia. The patient stated that his last  
16 follow up (March 2000) was conducted by telephone. E.K. reported using marijuana  
17 seven or eight times per day and that his use was now 84 grams per week. There is  
18 no charted inquiry into the trebling of the patient's marijuana use. No physical  
19 examination, mental status examination or interval history is recorded. Respondent  
20 recorded that the patient had been convicted of felony marijuana possession in  
21 Nevada County. Efficacy of treatment was stated to be "good."

22 F. On March 14, 2001, respondent issued a "physician's statement" in which he  
23 represented that E.K. "is under my medical care and supervision" for treatment of  
24 anxiety disorder and insomnia.

25 37. Respondent's conduct, as described above, constitutes unprofessional conduct  
26 and represents extreme and/or simple departures from the standard of care, and/or acts of  
27 incompetence in that respondent committed errors and omissions in the care and treatment of Patient  
28 E.K., including but not limited to the following::

- 1 A. Respondent failed to evaluate Patient E.K.'s hypertension;
- 2 B. Respondent failed to evaluate Patient E.K.'s complaints of anxiety and
- 3 insomnia;
- 4 C. Respondent failed to evaluate Patient E.K.'s complaints of fluctuating blood
- 5 sugar;
- 6 D. Respondent's statement that E.K. was under his medical care and supervision
- 7 for treatment of anxiety disorder, insomnia and essential hypertension was
- 8 false and unethical;
- 9 E. Respondent dropped his diagnosis of essential hypertension without
- 10 documenting normalization of the patient's blood pressure.
- 11 F. Respondent charged for medication renewal albeit the patient was not re-
- 12 examined by him.

13 FOURTEENTH CAUSE FOR DISCIPLINARY ACTION

14 (Patient F.K.)

15 (Unprofessional Conduct/Gross Negligence/Negligence/Incompetence)

16 38. Respondent is subject to disciplinary action under sections 2234, and/or

17 2234(b) and/or 2234(c), and/or 2234(d) of the Code in that respondent committed unprofessional

18 conduct, and/or was grossly and/or simply negligent and/or incompetent in the care and treatment

19 of Patient F.K. The circumstances are as follows:

20 A. On or about June 30, 1997 Patient F.K. first consulted respondent.

21 Respondent's record that day includes a four page "registration form", a one page

22 typed summary of F.K.'s demographic information and cannabis use pattern and a

23 "physician's statement." Respondent's diagnosis for F.K. was thoracic or

24 lumbosacral neuritis or radiculitis, unspecified and alcohol dependence syndrome,

25 unspecified. Respondent's history of the alcohol problem stated only "3 glasses of

26 wine/wk, work." Respondent conducted no mental status examination, no adequate

27 medical, psychiatric or substance history, no physical examination to evaluate the

28 lumbosacral problem and no treatment plan except "D/C ETOH[alcohol] NSAIDS

1 vaporize 360°F F/U 6 mo-1 yr.” On June 30, 1997 respondent issued F.K. a  
2 “physician’s statement” that stated in part “This certifies that F.K. ...is under my  
3 medical care and supervision for the treatment of medical conditions(s):  
4 Alcoholism, Lumbosacral Radiculitis ICD9-CM 309.0 [Brief depressive reaction]  
5 (sic) 724.4 [thoracic or lumbosacral neuritis or radiculitis, unspecified].”

6 B. Respondent’s records contain a “Physician’s Statement”, which is dated  
7 March 5, 1998, but not any documented evaluation or other chart notes. The  
8 diagnoses are the same as for June 30, 1997. Respondent’s chart reflects another  
9 “physician’s statement” on November 24, 1998, similar to those issued previously.  
10 There are no notes documenting any evaluation substantiating the November 24,  
11 1998 physician’s statement.

12 C. Respondent’s chart contains a May 23, 2000 one page “Cannabis Patient  
13 Follow Up Questionnaire” apparently filled out by Patient F.K. The patient indicates  
14 that his previous consultation of November 24, 1998, was not a face-to-face meeting.  
15 The only notation made by respondent for the May 23 “follow up” are the words  
16 “well controlled” in reference to the alcoholism. A subsequent note, dated  
17 September 28, 2000, indicates that respondent received \$120.00 for this medication  
18 renewal. Respondent’s next contact with F.K. appears to be another “Cannabis  
19 Patient Follow Up Visit Questionnaire” dated July 25, 2001, wherein the only  
20 notations by respondent include ICD-9 codes, a check mark in the box indicating  
21 follow-up in 6-12 months and “VRIPTECH.COM” under the heading “progress  
22 notes.” At the bottom of the form are the words “return form and requested fee to  
23 the address on reverse side.” A “Physician’s Statement” of July 25, 2001 is almost  
24 identical to those issued to F.K. previously, with the same diagnoses stated. Past  
25 medical records dated 1996 and 1997 from a chiropractor and documents from the  
26 Social Security Administration documenting F.K.’s lumbosacral problem are part of  
27 the record.

28 39. Respondent’s conduct, as described above, constitutes unprofessional conduct and

1 represents extreme and/or simple departures from the standard of care, and/or acts of incompetence  
2 in that respondent committed errors and omissions in the care and treatment of Patient F.K.,  
3 including but not limited to the following:

- 4 A. Respondent failed to adequately evaluate or to substantiate F.K.'s reported  
5 substance abuse problem prior to issuing a diagnosis of alcoholism.
- 6 B. Respondent failed to formulate a treatment plan for F.K.'s alcoholism.
- 7 C. Respondent failed to conduct an adequate mental status or physical  
8 examination of Patient F.K.
- 9 D. Respondent charged for medication renewal albeit he did not conduct an  
10 examination of the patient.

11 FIFTEENTH CAUSE FOR DISCIPLINARY ACTION

12 (Patient R.H.)

13 (Unprofessional Conduct/Gross Negligence/Negligence/Incompetence)

14 40. Respondent is subject to disciplinary action under sections 2234, and/or  
15 2234(b) and/or 2234(c), and/or 2234(d) of the Code in that respondent committed unprofessional  
16 conduct, and/or was grossly and/or simply negligent and/or incompetent in the care and treatment  
17 of Patient R.H. The circumstances are as follows:

18 A. On March 26, 1998, Patient R.H., a 50 year old male, presented to respondent  
19 with a history of alcoholism and alcohol-related cerebellar ataxia, peripheral  
20 neuropathies and spastic dysphonia. R.H. provided respondent with documents  
21 relating to a 1990 neurologic evaluation and a work readiness assessment, which  
22 records indicated that R.H.'s alcoholism rendered him disabled as of 1988.  
23 Respondent prepared a "psychiatric report and examination" and a "mental status"  
24 examination, after which he diagnosed R.H. with alcoholism, recovering, on Axis I  
25 and cerebellar ataxia and insomnia on Axis III. There is no documentation of a  
26 physical examination at that time. Respondent determined that Patient R.H. would  
27 benefit from the use of marijuana and issued a recommendation that Patient R.H. use  
28 cannabis for the treatment of "alcoholic encephalopathy, recovering alcoholic,

1 insomnia, post traumatic arthritis.”

2 B. Patient R.H. was charged with violation of the terms of his court probation  
3 and on July 22, 1998, respondent provided a letter to “reconfirm the recommendation  
4 and approval for the use of cannabis for the treatment of chronic alcoholism with  
5 encephalopathy, persisten [sic] insomnia, and posttraumatic arthritis.”

6 C. On September 18, 1998, Patient R.H. responded to a second questionnaire,  
7 reiterating his complaints of brain damage, insomnia and arthritis. There is no  
8 documentation of a physical examination. On the same day, respondent testified in  
9 Tuolumne County Superior Court in R.H.’s criminal matter. At that time, respondent  
10 admitted that he had performed no physical examination of R.H., other than  
11 observing his gait, which he said indicated cerebellar atrophy, and listening to his  
12 voice, which he said indicated vocal cord paralysis.

13 D. On April 16, 2001, Patient R.H. submitted a follow up questionnaire to  
14 respondent in which he indicated that his complaints of cerebellar ataxia, post  
15 traumatic arthritis and insomnia were continuing. Patient R.H. also indicated that he  
16 consumed 8-10 cups of coffee per day. This questionnaire was presented either by  
17 fax or by mail, as indicated by R.H.’s April 17 letter to respondent: “Thanks for the  
18 understanding. There’s no way I can drive 240 miles round trip and pay the  
19 \$120.00.” Respondent did not comment on the patient’s reported caffeine use and  
20 there is no documentation of an attempt to evaluate the behavioral causes of R.H.’s  
21 chronic insomnia. As on prior occasions, there is no indication of respondent’s  
22 rationale in recommending use of a psychoactive drug for Patient R.H.’s post  
23 traumatic arthritis. On May 3, 2001, respondent issued a “physician’s statement”  
24 in which he stated that R.H. “Is under my medical care and supervision for treatment  
25 of the serious medical condition(s): Insomnia, Traumatic Arthritis, Brain Injury.”

26 41. Respondent’s conduct, as described above, constitutes unprofessional conduct  
27 and represents extreme and/or simple departures from the standard of care, and/or acts of  
28 incompetence in that respondent committed errors and omissions in the care and treatment of Patient

1 R.H. including but not limited to the following::

- 2 A. Respondent failed to evaluate Patient R.H.'s complaints of insomnia or to  
3 employ standard behavioral treatment for its underlying causes;
- 4 B. Respondent failed to evaluate Patient R.H.'s arthritis or to document a  
5 medical rationale for recommendation of treatment with a psychoactive drug;
- 6 C. Respondent's statement that R.H. was under his medical care and supervision  
7 for treatment of post traumatic arthritis and chronic insomnia were false and  
8 unethical.

9 SIXTEENTH CAUSE FOR DISCIPLINARY ACTION

10 (Patient W.H.)

11 (Unprofessional Conduct/Gross Negligence/Negligence/Incompetence)

12 42. Respondent is subject to disciplinary action under sections 2234, and/or  
13 2234(b) and/or 2234(c), and/or 2234(d) of the Code in that respondent committed unprofessional  
14 conduct, and/or was grossly and/or simply negligent and/or incompetent in the care and treatment  
15 of Patient W.H. The circumstances are as follows:

16 A. At some time prior to November 1, 1998, a conservator for W.H., a 58 year  
17 old man with Multiple Sclerosis, contacted respondent and asked respondent to visit  
18 W.H. for the purpose of obtaining recommendations for the use of marijuana for  
19 medical purposes. W.H. was quadriplegic and experienced muscle spasms as a result  
20 of his M.S. W.H. was bedridden and relied upon the care of his conservator and  
21 other caretakers. W.H. was capable of speech and was mentally coherent. W.H. was  
22 taking Baclofen and Ativan, but was not under the regular care of a physician.

23 B. On or about November 1, 1998, respondent went to W.H.'s home where he  
24 met with W.H.'s conservator. Respondent saw W.H. for a total of approximately  
25 5 minutes. Respondent's physical examination of W.H. was described by respondent  
26 as "I looked at him and there he was lying in bed...He looked relatively  
27 comfortable...He appeared to be clean and appeared to be well-cared for, but again,  
28 I didn't lift the covers." Similarly, respondent performed no mental status

1 examination of W.H. and obtained virtually no medical or psychiatric history from  
2 or about W.H. Respondent made no attempt to speak with W.H., and had no  
3 discussion with W.H. regarding the possible risks or benefits of marijuana use.  
4 Respondent's complete medical record for W.H. consists of an "eligibility  
5 questionnaire", only partially completed by respondent, and several pages of medical  
6 records from other practitioners provided to respondent by the conservator.  
7 Respondent provided the conservator with a recommendation for W.H. to use  
8 marijuana for medical purposes<sup>2</sup>. In that recommendation, respondent represented  
9 that W.H. was under his medical care and supervision for the treatment of Multiple  
10 Sclerosis, and that respondent had discussed the medical risks and benefits of  
11 cannabis use with W.H. Respondent made no arrangements to see W.H. in the  
12 future, nor did he provide a treatment plan. In fact, W.H. had no desire to use  
13 marijuana for any purpose, had never used marijuana, and was unaware that  
14 respondent had recommended marijuana for his use.

15 43. Respondent's conduct, as described above, constitutes unprofessional conduct  
16 and represents extreme and/or simple departures from the standard of care, and/or acts of  
17 incompetence in that respondent committed errors and omissions in the care and treatment of Patient  
18 W.H. including but not limited to the following::

- 19 A. Respondent failed to adequately evaluate W.H.'s mental status;  
20 B. Respondent failed to adequately evaluate W.H.'s purported complaints of  
21 pain and/or muscle spasms.  
22 C. Respondent failed to evaluate the efficacy of W.H.'s current medication  
23 regimen.  
24 D. Respondent failed to discuss the risks associated with marijuana and failed  
25 to address alternate treatments available to W.H.

26  
27 2. The conservator was removed from his position after it was discovered that he was  
28 stealing money from W.H. Moreover, on the same visit, respondent also issued a  
recommendation for the conservator's use of marijuana.

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

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

7 SEVENTEENTH CAUSE FOR DISCIPLINARY ACTION

8 (Undercover officer)

9 (Unprofessional Conduct/Gross Negligence/Incompetence/Dishonest or Corrupt Acts)

10 46. Respondent is subject to disciplinary action under sections 2234, and/or  
11 2234(b) and/or 2234(c), and/or section 2234(d), and/or 2234(e) of the Code in that respondent  
12 committed unprofessional conduct, and/or was grossly negligent, and/or simply negligent, and/or  
13 incompetent, and/or committed acts of dishonesty or corruption, in his interactions with and care  
14 and treatment of an undercover narcotics officer. The circumstances are as follows:

15 A. In or about January 2003, an undercover officer associated with the  
16 Sonoma County Narcotic Task Force received information suggesting  
17 that he could obtain a recommendation for medical marijuana from a physician by  
18 simply appearing at an office with \$200 cash and a California driver's license or  
19 identification card. The officer made a telephone call to a telephone number he  
20 obtained, and scheduled an appointment to see an unknown physician on January  
21 31, 2003.

22 B. On January 31, 2003, the officer went to 353 30<sup>th</sup> Street in Oakland for  
23 his scheduled appointment. Signage on the office and the recording on the  
24 telephone number identified the address as "Medical Referral Services 215."  
25 The officer observed a number of people in the outer office, and they appeared to  
26 be registering for appointments. By 10 a.m. there were approximately 30 people  
27 waiting to see the doctor. An individual who identified himself as "Ben"  
28 announced that only 15 people could see the doctor on that date, but that the

1 remaining people could pay a \$50 deposit and would be placed on a "medical  
2 priority" list for the following week. The undercover officer paid a \$50 deposit  
3 and obtained a "medical priority" appointment for February 7, 2003.

4 C. On February 7, 2003, the officer returned to 353 30<sup>th</sup> Street, Oakland.  
5 He was advised by a female handling the sign-in sheet that he would be seen by  
6 the doctor, that he needed to pay an additional \$150 cash, and to fill out some  
7 paperwork. She then provided the officer with a questionnaire form and a blank  
8 "Physician's Statement" form bearing respondent's name and license number.  
9 The officer was instructed to complete the questionnaire, except for the section  
10 regarding his current medical condition. He was advised that "Ben" would help  
11 everyone with that section. The officer was also instructed that the doctor would  
12 complete the top portion of the "Physician's Statement" form.

13 D. The officer completed his questionnaire form, which was then reviewed  
14 by "Ben". The officer had indicated that the reason for his visit was that he was  
15 unable to sleep due to stress, and that his shoulder hurt. He stated that his stress  
16 was due to a pending criminal case involving 54 grams of marijuana, and that he  
17 needed a medical recommendation so that the District Attorney would dismiss the  
18 criminal charges. "Ben" stated that stress and sleep would be difficult to use as a  
19 primary reason for using marijuana, but would be good "secondary" reasons.  
20 "Ben" then asked the officer about his shoulder problem, and the officer  
21 responded that his shoulder hurt sometimes. He stated that he could move the  
22 shoulder, and pointed generally to an area he said hurt. "Ben" then stated that he  
23 knew exactly what the officer was talking about, that the officer had dislocated  
24 his shoulder at one time and it still hurt. He told the officer to write down that  
25 the dislocated shoulder caused anxiety and inability to sleep, and that a friend had  
26 suggested marijuana. "Ben" told the officer that he would get "all legal today."

27 E. The officer proceeded to an inner room, where respondent introduced  
28 himself. Respondent reviewed the questionnaire, and asked several questions

1 about his family health history. In response to respondent's question about his  
2 current medical condition, the officer stated that he was stressed about his  
3 pending criminal case. The officer told respondent he had injured his shoulder  
4 4-5 years ago, that he had not seen any doctor about the shoulder, that he did not  
5 have a regular doctor, and that he had not worked in several years. Respondent  
6 suggested that the officer should consider physical therapy. The officer spent  
7 approximately 10 minutes in respondent's office. Respondent conducted  
8 absolutely no physical examination of the officer, and made no arrangements or  
9 suggestion regarding follow-up visits or a treatment plan. He did not discuss the  
10 benefits and risks of marijuana with the officer. Respondent simply took a  
11 photograph of the officer, checked his driver's license and signed a physician's  
12 statement recommending the use of marijuana.

13 F. When the officer returned to the waiting room, "Ben" told him he was  
14 "all legal". He advised everyone in the waiting room to go to the Oakland  
15 Cannabis Buyers' Cooperative to get a card, and that they could grow marijuana  
16 for sale to the various marijuana "Clubs". "Ben" also announced that there was a  
17 "special treat" for everyone, after which the officer was sent to another room  
18 where he was given a small plastic container containing approximately 1.2  
19 grams of marijuana by an unidentified female who stated that she was a  
20 representative of the Oakland Community Health & Wellness Collective, and that  
21 he could purchase his marijuana from that organization.

22 .47. Respondent's conduct, as described above, constitutes unprofessional  
23 conduct and represents extreme and/or simple departures from the standard of care, and/or acts  
24 of incompetence, and/or dishonest or corrupt acts, in that respondent committed errors or  
25 omissions in the care and treatment and interaction with the undercover officer, including but not  
26 limited to the following:

27 A. Respondent recommended treatment to the officer without conducting a  
28 physical examination;

- 1 B. Respondent failed to make any effort to determine whether the officer  
2 was in fact suffering from any physical ailment or condition.  
3 C. Respondent failed to provide follow-up or referral for the officer's  
4 complaints;  
5 D. Respondent's statement that the officer was under his medical care and  
6 supervision for treatment of a serious medical condition diagnosed after  
7 review of available records and in person medical examination was false  
8 and unethical.  
9 E. Respondent's conduct in permitting his office staff to fabricate medical  
10 information, to "coach" patients regarding their current medical condition,  
11 and to dispense marijuana, was unethical, and constitutes acts of  
12 dishonesty or corruption.

13 EIGHTEENTH CAUSE FOR DISCIPLINARY ACTION

14 (Inadequate/Inaccurate Medical Records)

15 48. The allegations of the First through Seventeenth Causes for Disciplinary  
16 Action are incorporated herein by reference.

17 49. Respondent is subject to disciplinary action under section 2263 of the Code  
18 in that respondent's medical records for each and every patient alleged above routinely lacked  
19 adequate documentation of physical examination, clinical findings, vital signs, mental status  
20 examination, laboratory tests, follow-up and treatment plans, and other matters relevant and  
21 necessary to an evaluation and diagnosis of the patient's condition, or to support the  
22 recommendation or prescription of any medication.

23 NINETEENTH CAUSE FOR DISCIPLINARY ACTION

24 (Prescribing Without Prior Good Faith Examination)

25 50. The allegations of the First through Seventeenth Causes for Disciplinary  
26 Action are incorporated herein by reference.

27 49. Respondent is subject to disciplinary action under section 2242 of the Code  
28 in that in each case, respondent prescribed, dispensed or furnished marijuana, a controlled  
substance, without conducting a prior good faith examination and/or without medical indication.

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PRAYER

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

1. Revoking or suspending Physician's and Surgeon's Certificate Number G-9124, issued to Tod H. Mikuriya, M.D.;
2. Revoking, suspending or denying approval of Tod H. Mikuriya, M.D.'s authority to supervise physician's assistants;
3. Ordering Tod H. Mikuriya, M.D. to pay the Division of Medical Quality the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring;
4. Taking such other and further action as deemed necessary and proper.

DATED: \_\_\_\_\_

\_\_\_\_\_  
RON JOSEPH  
Executive Director  
Medical Board of California  
Department of Consumer Affairs  
State of California  
Complainant