Consumer Affairs

MEDICAL BOARD OF CALIFORNIA
EXECUTIVE OFFICE
1434 Howe Avenue, Suite 92
Sacramento, CA 95825-3236
(916) 263-2389 FAX (916) 263-2387
www.caldocinfo.ca.gov

May 24, 2004

To All California: Chiefs of Police
Sheriffs
District Attorneys

The Medical Board of California (MBC) is the state agency responsible for licensing and disciplining physicians and surgeons in the state of California. The mission of the MBC is to protect healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act.

Proposition 215 was passed by the voters of California on November 5, 1996. This initiative measure added Section 11362.5 to the Health and Safety Code and is also known as the "Compassionate Use Act of 1996." The purposes of the act were "to ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where the 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...and to ensure that patients and their primary caregivers who obtain and use marijuana for medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction."

On May 7, 2004 the Medical Board of California issued a statement titled "California Physicians & Medical Marijuana." The intent of this statement is to reassure physicians that if they use the same proper care in recommending medical marijuana as they would any other medication or treatment then they will not be subject to disciplinary action by the Medical Board. A copy of the May 7, 2004 statement is attached.

The issue of whether or not marijuana is a viable medical treatment is still unsettled. However, the law is clear: California physicians can recommend medical marijuana to their patients for medical purposes when clinically indicated.

This information is being furnished to clarify the position of the Medical Board relative to physicians who recommend medical marijuana.

Sincerely,

David T. Thornton
Interim Executive Director

Attachment

A Statement by the Medical Board of California, May 7, 2004

California Physicians & Medical Marijuana

On November 5, 1996, the people of California passed Proposition 215. Through this Initiative Measure, Section 11362.5 was added to the Health & Safety Code, and is also known as the Compassionate Use Act of 1996. The purposes of the Act include, in part:

> "(A) To ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where the 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 in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief; and
>
> (B) To ensure that patients and their primary caregivers who obtain and use marijuana for medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction."

Furthermore, Health & Safety Code section 11362.5(c) **provides strong protection for physicians who choose to participate in the implementation of the Act.** - "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."

The Medical Board of California developed this statement since medical marijuana is an emerging treatment modality. The Medical Board wants to assure physicians who choose to recommend medical marijuana to their patients, as part of their regular practice of medicine, that they WILL NOT be subject to investigation or disciplinary action by the MBC if they arrive at the decision to make this recommendation in accordance with accepted standards of medical responsibility. The mere receipt of a complaint that the physician is recommending medical marijuana will not generate an investigation absent additional information indicating that the physician is not adhering to accepted medical standards.

These accepted standards are the same as any reasonable and prudent physician would follow when recommending or approving any other medication, or prescription drug treatment and include the following:

1. History and good faith examination of the patient.
2. Development of a treatment plan with objectives.
3. Provision of informed consent including discussion of side effects.
4. Periodic review of the treatment's efficacy.

5. Consultation, as necessary.
6. Proper record keeping that supports the decision to recommend the use of medical marijuana.

In other words, if physicians use the same care in recommending medical marijuana to patients as they would recommending or approving any other medication, or prescription drug treatment they have nothing to fear from the Medical Board.

Here are some important points to consider when recommending medical marijuana:

1. Although it could trigger federal action, making a recommendation in writing to the patient will not trigger action by the Medical Board of California.

2. A patient need not have failed on all standard medications, in order for a physician to recommend or approve the use of medical marijuana.

3. The physician should determine that medical marijuana use is not masking an acute or treatable progressive condition, or that such use will lead to a worsening of the patient's condition.

4. The Act names certain medical conditions for which medical marijuana may be useful, although physicians are not limited in their recommendations to those specific conditions. In all cases, the physician should base his/her determination on the results of clinical trials, if available, medical literature and reports, or on experience of that physician or other physicians, or on credible patient reports. In all cases, the physician must determine that the risk/benefit ratio of medical marijuana is as good, or better, than other medications that could be used for that individual patient.

5. A physician who is not the primary treating physician may still recommend medical marijuana for a patient's symptoms. However, it is incumbent upon that physician to consult with the patient's primary treating physician or obtain the appropriate patient records to confirm the patient's underlying diagnosis and prior treatment history.

6. The initial examination for the condition for which medical marijuana is being recommended must be in-person.

7. Recommendations should be limited to the time necessary to appropriately monitor the patient. Periodic reviews should occur and be documented at least annually or more frequently as warranted.

8. If a physician recommends or approves the use of medical marijuana for a minor, the parents or legal guardians must be fully informed of the risks and benefits of such use and must consent to that use.

Physicians may wish to refer to CMA's ON-CALL Document #1315 titled "The Compassionate Use Act of 1996", updated annually for additional information and guidance. (http://www.cmanet.org/publicdoc.cfm/4)

Although the Compassionate Use Act allows the use of medical marijuana by a patient upon the recommendation or approval of a physician, California physicians should bear in mind that marijuana is listed in Schedule I of the federal Controlled Substances Act, which means that it has no accepted medical use under federal law. However, in Conant v. Walters (9th Cir.2002) F.3d 629 the United States Court of Appeals recognized that physicians have a constitutionally-protected right to discuss medical marijuana as a treatment option with their patients and make oral or written recommendation for medical marijuana. However, the court cautioned that physicians could exceed the scope of this constitutional protection if they conspire with, or aid and abet, their patients in obtaining medical marijuana.

Janet E. Joy, Stanley J. Watson, Jr., and John A. Benson, Jr., Editors. Marijuana and Medicine: Assessing the Science Base Division of Neuroscience and Behavioral Health, Institute of Medicine. National Academy Press, Washington, D.C. 1999. Internet address www.nap.edu

RECOMMENDATIONS

Recommendation 1: Research should continue into the physiological effects of synthetic and plant-derived cannabinoids and the natural function of cannabinoids found in the body. Because different cannabinoids appear to have different effects, cannabinoid research should include, but not be restricted to, effects attributable to THC alone.

Scientific data indicate the potential therapeutic value of cannabinoid drugs for pain relief, control of nausea and vomiting, and appetite stimulation. This value would be enhanced by a rapid onset of drug effect.

Recommendation 2: Clinical trials of cannabinoid drugs for symptom management should be conducted with the goal of developing rapid-onset, reliable, and safe delivery systems.

The psychological effects of cannabinoids are probably important determinants of their potential therapeutic value. They can influence symptoms indirectly which could create false impressions of the drug effect or be beneficial as a form of adjunctive therapy.

Recommendation 3: Psychological effects of cannabinoids such as anxiety reduction and sedation, which can influence perceived medical benefits, should be evaluated in clinical trials.

Numerous studies suggest that marijuana smoke is an important risk factor in the development of respiratory diseases, but the data that could conclusively establish or refute this suspected link have not been collected.

Recommendation 4: Studies to define the individual health risks of smoking marijuana should be conducted, particularly among populations in which marijuana use is prevalent.

Because marijuana is a crude THC delivery system that also delivers harmful substances, smoked marijuana should generally not be recommended for medical use. Nonetheless, marijuana is widely used by certain patient groups, which raises both safety and efficacy issues.

Recommendation 5: Clinical trials of marijuana use for medical purposes should be conducted under the following limited circumstances: trials should involve only short-term marijuana use (less than six months); be conducted in patients with conditions for which there is reasonable expectation of efficacy; be approved by institutional review boards; and collect data about efficacy.

If there is any future for marijuana as a medicine, it lies in its isolated components, the cannabinoids and their synthetic derivatives. Isolated cannabinoids will provide more reliable effects than crude plant mixtures. Therefore, the purpose of clinical trials of smoked marijuana would not be to develop marijuana as a licensed drug, but such trials could be a first step towards the development of rapid-onset, non-smoked cannabinoid delivery systems.

Recommendation 6: Short-term use of smoked marijuana (less than six months) for patients with debilitating symptoms (such as intractable pain or vomiting) must meet the following conditions:

* failure of all approved medications to provide relief has been documented;

* the symptoms can reasonably be expected to be relieved by rapid-onset cannabinoid drugs;

* such treatment is administered under medical supervision in a manner that allows for assessment of treatment effectiveness;

* and involves an oversight strategy comparable to an institutional review board process that could provide guidance within 24 hours of a submission by a physician to provide marijuana to a patient for a specified use.

IOM Home Page | NAP Home Page | Report Home Page
