COMMONWEALTH OF MASSACHUSETTS

**Division of Administrative Law Appeals**

**1 Congress Street, 11th Floor**

**Boston, MA 02114**

**www.mass.gov/dala**

**Board of Registration in Medicine**,

Petitioner

v. Docket No. RM-16-249

**Tyrone S. Cushing, M.D.**,

Respondent

**Appearance for Petitioner**:

Stephen C. Hoctor, Esq.

Board of Registration in Medicine

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**Appearances for Respondent**:

Brooks L. Glahn, Esq.

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**Administrative Magistrate**:

Kenneth Bresler

**SUMMARY OF RECOMMENDED DECISION**

**ON ORDER OF TEMPORARY SUSPENSION**

Temporary suspension is not recommended for the respondent physician,because he is not animmediate and serious threat to the public health, safety, or welfare. Nor may he be a serious threat to the public health, safety, or welfare.

**RECOMMENDED DECISION**

**ON ORDER OF TEMPORARY SUSPENSION**

The petitioner, Tyrone S. Cushing, M.D., appeals an Order of Temporary Suspension by the Board of Registration in Medicine (BRM). The Statement of Allegations against Dr. Cushing is not before me now, as both parties agree. (Tr. 6-8.)

I held a hearing on April 4, 2017, which was transcribed. The Board of Registration in Medicine (BRM) called as witnesses its investigator, Susan Dye, and Dr. Cushing. Dr. Cushing called one witness, Dr. Alan Wartenberg, as an expert.

I accepted into evidence two exhibits for BRM and eight for Dr. Cushing. Respondent’s Exhibit 1 is BRM’s Motion for Summary Suspension. It includes Exhibit A, the Affidavit of Susan Dye. Attached to Exhibit A are, in turn, seven exhibits, 1 through 7. (I refer to Exhibit A as “Attachment A” and the seven exhibits as tabs. I refer to, for example, “Resp. Ex. 1, Attach. A, Tab 5.”)

Respondent’s Exhibit 2 is the Opposition to the Motion for Summary Suspension, which includes seven exhibits, A through G.

Respondent’s Exhibit 3 is the Curriculum Vitae and affidavit of Dr. Elizabeth Sanford, who provided expert evidence. (BRM did not present expert evidence.)

The following documents are impounded: In Petitioner’s Exhibit 1, Attachment A’s Tabs 1, 5, and 7; and Petitioner’s Exhibit 2.

Both parties submitted post-hearing briefs. The usefulness of Dr. Cushing’s brief was limited by its citations to a 40-page document (Resp. Ex. 2, Tab F) without citing page numbers, and incorrect citations to attachments to Respondent’s Exhibit 2. My not being able to locate evidence in the record to support Dr. Cushing’s arguments made it hard to consider them.

**Findings of Fact**

Dr. Cushing

1. Dr. Cushing graduated Georgetown University medical school in 1971. (Tr. 111.)

2. Dr. Cushing has been a medical doctor for about 40 years. (Tr. 101.)

3. Dr. Cushing has practiced as a pediatrician and dermatologist. (Tr. 114-15.)

4. Since 1976, Dr. Cushing has been licensed to practice medicine in Massachusetts under certificate number 39666. (Pet. Ex. 1, Attach. A, p. 1.)

5. Dr. Cushing took the Massachusetts Medical Society’s course that is required for doctors to become licensed to issue medical marijuana certificates. (Tr. 117.) *See* 105 CMR 725.010(A).

6. Dr. Cushing began working at CannaMed, a medical marijuana practice, in 2013. (Tr. 77; Ex. 1, Attach. A, Tab 5, p. 1.)

7. In December 2014, Dr. Cushing became registered as a certifying physician under the medical marijuana program. (Ex. 1, Attach. A, p. 3.) (Certain regulations under the medical marijuana statute did not become effective until July 1, 2014. (Pet. Ex. 1, Attach. A, p. 2, Tab 3.) Hence, Dr. Cushing began working at CannaMed before becoming registered.)

Dr. Cushing at CannaMed

8. CannaMed is in Framingham. (Ex. 1, Attach. A, Tab 5, p. 1.)

9. Dr. Cushing worked from 9:00 a.m. to 4:00 or 5:00 p.m. At first, he worked two days a week. Later, he worked three days a week. (Tr. 78.)

10. Dr. Cushing saw 10 to 12 patients per day on a slow day. On other days, he saw the maximum of 30 patients. (Tr. 78.)

11. Doctor Cushing spent about 20 minutes with each new patient. He spent about seven to eight minutes with each returning patient. (Tr. 130-31.)

12. CannaMed paid Dr. Cushing $80 per hour. He was not compensated per patient. (Tr. 86.)

13. Patients came to CannaMed by word of mouth. Some patients were referred by doctors, such as at the Lahey Clinic and Massachusetts General Hospital, institutions whose doctors do not issue medical marijuana certificates. (Tr. 76-77.)

14. Patients paid $250 in cash when they walked into CannaMed. The owner reduced the fee to $150 for hardship cases. (Tr. 91.)

15. A person at CannaMed’s front desk screened would-be patients and turned some of them away as not eligible for medical marijuana under the medical marijuana law. (Tr. 85.)

16. Ninety percent of patients whom Dr. Cushing saw had only a letter from a referring doctor. Ten percent of patients brought in medical files. (Tr. 80-82.)

17. Dr. Cushing questioned patients to obtain their medical histories, reviewed the medical marijuana law with them, reviewed the risks and benefits of medical marijuana, and decided whether they qualified. He did not physically examine them. (Tr. 76, 79, 80-82.)

18. Dr. Cushing did not talk to most patient’s other doctors. (Tr. 96-97.)

19. Dr. Cushing decided against issuing a medical marijuana certificate to possibly 15% of the patients he saw. (Tr. 88-89.)

20. If Dr. Cushing decided that patients were not qualified for a medical marijuana certificate, they got their money back from CannaMed. (Tr. 76.)

Patient A’s medical history before CannaMed

21. Dr. Cushing had 25 pages of Patient A’s medical records. (Resp. Ex. 1, Attach A, Tab 5, pp. 17-40, Tab 6.) They are described below.

22. On April 22, 2010, Patient A conferred with Susanne Duszlak, a nurse practitioner. Patient A reported that she had hurt her back at work, and that Tylenol and heat had not helped. Ms. Duszlak prescribed her 10 mg. of Flexeril to take at bedtime and 800 mg. of ibuprofen every eight hours. She gave Patient A a note to limit her lifting at work: not to exceed 10 pounds for two weeks. (Resp. Ex. 1, Attach. A, Tab 5, p. 40.)

23. On May 1, 2011, Patient A conferred with Ms. Duszlak. Patient A reported continuing problems with back pain. She reported having been in the emergency room on the previous day; there, she was given diazepam/Valium, Percocet, and 800 mg. ibuprofen tablets. She reported that none of those medications seemed to help her pain. She had not been taking the diazepam and Percocet because it had made her too drowsy. Ms. Duszlak stated that she would schedule an MRI for Patient A and refer her to a spine specialist. (Resp. Ex. 1, Attach. A, Tab 5, p. 39.)

24. On May 25, 2011, Patient A conferred with Dr. Patrick J. Connolly. Patient A reported that on a scale of 1 to 10, her pain was 20. She reported having two children, a 4-year-old and a 5-month-old. Dr. Connolly reviewed an MRI that had been performed on May 11, 2011. It revealed “four bad disks”: an extruded disk at 4-5, a subarticular disk at 5-1, a central herniation at 3-4, and degenerative changes at 2-3. He wrote that “she is destined to have some problems with this back.” He recommended “an injection to settle down her symptoms so that she can carry on with her life.” (Resp. Ex. 1, Attach. A, Tab 5, pp. 37-38.)

25. On June 1, 2011, Patient A conferred with Ms. Duszlak about her back pain. Patient A reported the following: She had seen her orthopedist, who planned a cortisone injection. Her pain was at 6, 8, or 10, depending on the day. She had not started Gabapentin because she could not afford the prescription yet. She was not working. Ms. Duszlak stated that the MRI showed herniation at L4, L5, and L6. She observed that Patient A was able to sit and stand for only short periods, and was unable to get onto the examination table because of her pain. Ms. Duszlak assessed Patient A as having back pain with radiculopathy. She reported that the orthopedic specialists were awaiting the outcome of cortisone injections before deciding on surgery. (Resp. Ex. 1, Attach. A, Tab 5, p. 36.)

26. On June 2, 2011, Patient A conferred with Dr. Mark S. Kaplan. He wrote that her MRI revealed “multilevel findings of disc herniations” and “a right lateralization at the L4-L5 lever with right L5 nerve impingement.” He recommended an epidural injection, which was performed that day. He wrote, “If she does not improve, then right-sided L4-L5 and L5-S1 transforaminal epidurals would be an option….” (Resp. Ex. 1, Attach. A, Tab 5, p. 35.)

27. On June 17, 2011, Patient A conferred with Patricia MacCulloch, a nurse practitioner. Patient A reported that after the injection, her symptoms were worse. She reported having spasms in her right leg and that her gait remained antalgic. On a scale of 1 to 10, she reported her pain at 10. Ms. MacCulloch referred Patient A for an EMG, fitted her for a corset and cane, recommended that Patient A ice her lumbar four to six times a day, and prescribed one hydrocodone 7.5/500-mg. tablet every six hours. The prescription was for a 30-day supply with no refill. (Resp. Ex. 1, Attach. A, Tab 5, p. 33-34.)

28. On June 20, 2011, Patient A conferred with Dr. Connolly. He wrote in the clinic note:

The injections have not helped her and I think the likelihood of surgical intervention providing any benefit is relatively remote….She is going to have back pain and she is going to have to manage and function with this as best she can….So it is going to be management of medications by her family physician, Dr. Dey[,] and perhaps some additional suggestions for physical therapy by Dr. Williams.

(Resp. Ex. 1, Attach. A, Tab 5, p. 32.)

29. On August 29, 2011, Patient A conferred with Dr. Faren H. Williams. Patient A reported the following: She lived with her fiancé and two daughters, a four-year-old and an eight-month-old. She was a deli manager at a Price Chopper store. Under Assessment and Plan, Dr. Williams wrote:

Chronic pain with findings on physical exam, disproportionate to the patient’s history of pain complaints. The patient’s MRI scan reveals some degenerative changes[,] which are more nonspecific and do not correlate well with the patient’s clinical exam, which is essentially a normal neurological examination.

I do feel the patient’s primary problem is underlying depression and stressors, which are causing her to have more anxiety and…more pain. She acknowledges that this may be the case as she had more pain this morning after she had become visibly upset during this visit as we discussed some of these psychosocial problems.

I do not find any changes clinically, which will preclude this patient from continuing to be gainfully employed[,] including doing a job which is of moderate physical intensity. She may, however, need to work up to maintaining her strength in general[;] this should include [a] general conditioning program….Another option is to…look for [a] different kind of work, although she acknowledges that while she had a GED, there are few other work opportunities which pay as much per hour.

I do not feel that she has any surgical issues nor does Dr. Connolly. I feel that her lack of response to injections [reflects that] her pain issues are more complicated by the depression. The patient is agreeable to restarting on Prozac 20 mg. p.o. daily and if tolerated, I want her to increase that to 40 mg. p.o. daily. The patient needs to be reassured that she can work through this pain, and there are no physiological reasons for her not to push herself to do more and work through the pain. She may benefit from psychological counseling, which she has tried, but has not found a counselor with whom she can connect. She may need to look for a different counselor.

(Resp. Ex. 1, Attach. A, Tab 5, pp. 30-31.) The first two paragraphs were highlighted, presumably by Dr. Cushing at the time he conferred with Patient A. The third paragraph had some text highlighted or circled, also presumably by Dr. Cushing at the time he conferred with Patient A.

30. On August 29, 2011, Patient A met with Dr. Williams, who wrote in part in the Outpatient Consultation Report:

The patient herself apparently asked for narcotics and apparently these have been prescribed by others. She does not indicate that they have been efficacious in decreasing the pain. In fact, she states that the medical profession told her that she may need lifelong narcotics.

(Resp. Ex. 1, Attach. A, Tab 5, p. 29.) These sentences have been highlighted, apparently by Dr. Cushing.

31. On June 27, 2012, Patient A conferred with Ms. Duszlak as a follow-up to visiting the emergency room over the previous weekend. Ms. Duszlak wrote in part:

She states that she was at work and was carrying a large block of cheese that weighed approximately 50 pounds. She fell down on her back. She has a past history of back pain and sciatica for which she has had cortisone injections and been seen at the Spine Center. She states that I have had her on tramadol in the past for pain; however, that gives her headaches. Ibuprofen did not help. Flexeril and Valium…make[s] her too sedated. They did give her some Vicodin at the hospital and that seems to take the edge off. Her pain is an 8 to 10 on a scale of 1 to 10, since her fall….

Under “Assessment,” Ms. Duszlak wrote, “Back pain with radiculopathy.” Under “Plan,” she wrote that she would arrange for Patient A to see a Spine Center specialist again; referred her to the Pain Clinic for medication management; increased her Gabapentin to 400 mg. four times a day; and gave her Vicodin with instructions to take one tablet up to three times daily as needed.

(Resp. Ex. 1, Attach. A, Tab 5, p. 28.)

32. At some time, Patient A became addicted to opioids. (Ex. 1, Attach. A, p. 2.)[[1]](#footnote-1)

33. On March 5, 2013, Patient A conferred with Ms. Duszlak. Ms. Duszlak wrote that Patient A is four-and-one-half months pregnant; “[s]he declines any pain medication”; and “[s]he is in a drug rehab currently on Suboxone.”[[2]](#footnote-2) (Dr. Cushing later highlighted the sentence about Suboxone. (Tr. 144.)) Ms. Duszlak continued:

We will send her for physical therapy. I told her that I did not think [an] MRI would give us much information. Considering that she is not a good candidate for surgery and would not have injections at this point due to the pregnancy, it would serve us no good to image her.

(Resp. Ex. 1, Attach. A, Tab 5, p. 27.)

34. On May 20, 2013, Patient A conferred with Ms. Duszlak, who wrote:

…She is currently seven months pregnant….She is not taking any medication except Suboxone. She did have a problem in the past.[[3]](#footnote-3) She tells me she is definitely not drug seeking, does not want to take anything.

(Resp. Ex. 1, Attach. A, Tab 6.) Where Ms. Duszlak wrote, “This is a quite obvious pregnant young lady.” (Dr. Cushing later circled that language. (Tr. 100.)) She also wrote that Patient A “walks with a very guarded gait.” She noted “palpable spasm in the lumbar spine.” Ms. Duszlak called a chiropractor at UMass Memorial, who practices “gentle chiropractic and handled these… situations,” and who would see Patient A as soon as Patient A made an appointment. (Resp. Ex. 1, Attach. A, Tab 5, p. 26.)

35. Also on May 20, 2013, Ms. Duszlak physically examined Patient A, including taking her vital signs. (Resp. Ex. 1, Attach. A, Tab 5, p. 26.) It was nine days before Patient A went to CannaMed and conferred with Dr. Cushing.

Patient A at CannaMed

36. On May 29, 2013, Patient A came with medical records to CannaMed, where she signed the Patient Information form. (Resp. Ex. 1, Attach. A, Tab 5, p. 6.)

37. On the Patient Information form, Patient A reported that she had chronic back pain, sciatica, bulging disks, depression, and muscle spasms. (Resp. Ex. 1, Attach. A, Resp. Ex.5, p. 2.)

38. On the Patient Information form, Patient A reported that she was taking Gabapentin and Prozac. (Resp. Ex. 1, Attach. A, Tab 5, p. 3.)

39. On the Patient Information form, Patient A listed sciatica, back pain, and depression as the medical conditions for which she sought medical marijuana, and stated that she had had the symptoms since 2010. She stated that these conditions limited her ability to conduct major life activities. When asked whether she felt that if these medical conditions were not alleviated, it could cause serious harm to her safety or physical or mental health, she said yes. (Resp. Ex. 1, Attach. A, Tab 5, pp. 4-5.)

40. When asked to describe all treatments for her medical problems, Patient A wrote

Physical therapy – no help

Corti[s]one shots – made it worse

Cane – back brace

(Resp. Ex. 1, Attach. A, Tab 5, p. 5.)

41. On the Patient Information form, Patient A listed depression, restlessness, and headache; pain, weakness, or numbness in her back, hips, and legs; muscle cramps; and possible multiple sclerosis. (Resp. Ex. 1, Attach. A, Tab 5, p. 4.)

42. On the Patient Information form, Patient A wrote that she smoked marijuana daily to treat her medical conditions, she had learned in 2008 that cannabis eased her symptoms, and cannabis allowed her to experience less pain, eat regularly, and perform her job better. (Resp. Ex. 1, Attach. A, Tab 5, pp. 5-6.)

43. Dr. Cushing does not remember Patient A. (Tr. 93-94.)

44. Dr. Cushing thoroughly reviewed Patient A’s records. (Tr. 138.)

45. Dr. Cushing gave to Patient A, and she initialed, an Acknowledgement and Consent form, whose provisions included these:

\_\_ I acknowledge that using cannabis as medicine has been explained to me and that any questions that I have asked have been answered to my satisfaction.

\_\_ I have discussed and been informed of the potential of risks of using cannabis with medical practitioner.

\_\_ I know that I may ask now, or in the future, any questions I have about my treatment.

….

\_\_ I am aware that a Notice of Compliance has not been issued under the Food and Drug Regulations concerning the safety and effectiveness of marijuana as a drug. I understand the significance of this fact.

\_\_ I consent to using marijuana only for the treatment of the symptom stated in the medical declaration.

\_\_ I am aware that the benefits and risks associated with the use of marijuana are not fully understood and that the use of marijuana may involve risks that have not been identified; and I accept those risks.

\_\_ I am aware that medical cannabis has not been approved under Federal Regulations and I understand that medical marijuana has not been deemed legal under federal law.

\_\_ If the daily amount stated is more than five grams[,] I understand the potential risks associated with an elevated daily consumption of marijuana[,] including risks with respect to the effect on my cardiovascular and pulmonary systems and psycho motor performance, risks associated with the long-term use of marijuana, as well as potential drug dependency.

\_\_ I accept all the aforementioned risks….

\_\_ I attest that the information on this form is correct and any medical history presented to the doctor is also factual and complete.

(Resp. Ex. 1, Attach. A, Tab 5, p. 11.)

In addition to initialing each statement on the form, Patient A signed it at the end. (Resp. Ex. 1, Attach. A, Tab 5, p. 11.)[[4]](#footnote-4)

46. Dr. Cushing filled out an Assessment and Plan form, which he may have given to Patient A. He recommended medical marijuana to assist the treatment of back pain and chronic/severe pain. (Resp. Ex. 1, Attach. A, Tab 5, p. 12.) (While Patient A listed sciatica, back pain, and depression as the medical conditions or complaints for which she sought medical marijuana (Resp. Ex. 1, Attach. A, Tab 5, p. 4), Dr. Cushing did not approve it for depression. The Assessment and Plan form, which has a list of conditions to be checked off, does list depression.)

47. Dr. Cushing advised Patient A to follow up with him in a year. (Resp. Ex. 1, Attach. A, Tab 5, p. 12.)

48. Dr. Cushing gave a two-page document titled “Short term side effects of Cannabis” to Patient A, which she signed. (Resp. Ex. 1, Attach. A, Tab 5, pp. 13-14.)

49. “Short term side effects of Cannabis” has headings of Somatic Effects, Psychoactive Effects, and Neurological Effects. Under Neurological effects, the document states that

studies made in the USA have also shown that the children of those women who smoked Cannabis during pregnancy are also affected.

(Resp. Ex. 1, Attach. A, p. 13.)

50. The third-to-last sentence of “Short term side effects of Cannabis” states, “If an individual is aware about the ill-effects of Cannabis and similar drugs, he or she should always avoid it.” (Resp. Ex. 1, Attach. A, p. 14.)

51. In addition to “Short term side effects of Cannabis,” Dr. Cushing gave to Patient A, and she signed, a two-page document with two parts, “Long Term Effects Of Exposure to Cannabis” and “Minor Respiratory Complications, No Decrease in Pulmonary Function Associated With Long-Term Marijuana Smoking, Study Says.” (Resp. Ex. 1, Attach. A, Tab 5, pp. 15-16.)

52. Dr. Cushing did not talk to Patient A’s nurse practitioner, primary care physician, or obstetrician. (Tr. 99.)

53. Dr. Cushing did not conduct a physical examination. (Tr. 100.)

54. Dr. Cushing weighed various considerations, including these:

A. An injection and physical therapy had not eased Patient A’s pain. (Tr. 155.)

B. Patient A was not a candidate for surgery, so that she could not relieve her back pain through surgery. (Tr. 145.)

C. Because Patient A was on Suboxone and thus could not use opioids, she had limited options for pain treatment. (Tr. 145.)

D. Patient A’s being on Suboxone indicated that she was trying to rehabilitate herself. (Tr. 145.)

E. In addition to Suboxone, Patient A was on Prozac. Both carry risks for pregnant women. (Tr. 154.)

F. If Patient A could not relieve her pain with medical marijuana, there was a risk that she would return to opioids,[[5]](#footnote-5) which would have been worse for her fetus. (Tr. 154.)

G. Patient A was already using marijuana. She and her fetus were already experiencing whatever risks it had. (Tr. 155.)

H. Dr. Cushing decided it was better for Patient A to buy medical marijuana than illegal marijuana, which has pesticide residue. (Tr. 107.)

55. Dr. Cushing decided that the benefits of medical marijuana to Patient A were greater than the risks. (Tr. 153.)

56. On May 29, 2013, the same day as Dr. Cushing conferred with Patient A, he issued a medical marijuana certificate for her because of her back pain and chronic severe pain. The condition for which he issued it was chronic back pain. The certificate was valid for one year. (Resp. Ex. 1, Attach. A, Tab 5, pp. 7, 10.)

BRM’s investigation and procedure

57. On August 27, 2013, a staffer at the Department of Children and Families (DCF) filed a complaint against Dr. Cushing with BRM. The complaint reported that Dr. Cushing had approved Patient A’s use of medical marijuana to treat her back pain when she was pregnant and that she had used it for several months[[6]](#footnote-6) before her baby was born on August 21, 2013. The complaint also reported that Patient A “was also taking Subutex daily from which her son is currently withdrawing.” (Ex. 1, Attach. A, Tab 1.) Subutex is similar to Suboxone. (Tr. 40.)

58. BRM was unable to interview Patient A. (Resp. Ex. 1, Attach. A, p. 3, ¶ 8.)

59. When BRM believes that a doctor is a threat to the public safety, it generally investigates quickly. (Tr. 39.)

60. BRM did not act quickly on Dr. Cushing’s case. (Tr. 39.)

61. More than a year after receiving the complaint from DCF, BRM requested Patient A’s pharmacy records. (Tr. 45.)

62. For one-and-one-half years after interviewing Dr. Cushing, BRM did not act against him. (Tr. 49.)

63. On June 1, 2016, BRM moved for Dr. Cushing’s suspension because he poses “an immediate and serious threat to the public health, safety, or welfare,” 243 CMR 1.03(11)(a), or he “may be a serious threat to the public health, safety or welfare.” 243 CMR 1.03(11)(b).

64. The grounds for the motion, it stated, was Ms. Dye’s affidavit, “which includes documentary evidence,” and which “demonstrates that Dr. Cushing represents a serious threat to the public health, safety, or welfare.” (Resp. Ex. 1.)

65. Ms. Dye’s affidavit, in turn, seems to focus on three concerns: Dr. Cushing issued a medical marijuana certificate to Patient A while she was pregnant (Resp. Ex. 1, Attach. A, pp. 2-5); he prescribed Clonazepam to himself (Resp. Ex. 1, Attach. A, p. 3.); and he is the third highest issuer of medical marijuana certificates in Massachusetts, having issued 4,649 of them. (Resp. Ex. 1, Attach. A, p. 3.)

66. At the hearing, BRM confirmed that the crux of its case is that Dr. Cushing issued a medical marijuana certificate to Patient A. (Tr. 6.)

67. Ms. Dye’s affidavit mentioned Dr. Cushing’s conviction for medical financial fraud and perjury, his community service and the restitution he paid, and his discipline by BRM. (Resp. Ex. 1, Attach. A, pp. 1-2.) However, the case is closed, the affidavit apparently mentioned it as background, and BRM did not press it as a ground why he is an immediate and serious threat or may be a serious threat to the public health, safety, or welfare.

Dr. Wartenberg

68. Dr. Wartenberg graduated from the Medical College of Wisconsin in 1972. (Ex. 8.)

69. Dr. Wartenberg is a doctor in Massachusetts. He is certified in internal medicine by the American Board of Internal Medicine, and certified in addiction medicine by the American Board of Addiction Medicine. (Tr.167-68.)

70. Addiction medicine is a branch of medicine dealing with people’s chemical dependency, physical and psychological, on alcohol and other drugs of abuse, and psychiatric and medical problems and issues related to those drugs. (Tr. 168.)

71. For almost 15 years, Dr. Wartenberg was the medical director at the Faulkner Hospital’s addiction recovery program. (Tr. 170.)

72. Dr. Wartenberg has received multiple grants and academic and professional honors related to his work in addiction medicine. He has had many teaching roles and has made many presentations. His writing has appeared in many journals and other publications. He has written two book chapters on pain and addiction. (Resp. Ex. 8, Tr. 171.)

73. Dr. Wartenberg has dealt with patients who were in pain and who used marijuana. (Tr. 172.)

74. By practicing addiction medicine in Massachusetts and Rhode Island, including at Meadows Edge Recovery Center in Rhode Island, Dr. Wartenberg became familiar with the standard of care in 2013 for treating patients with pain, including pregnant women and patients recovering from opioid addiction. (Tr. 175-76.)

75. The pain-relieving effects of Suboxone are modest. Suboxone generally blocks the effect of opioids, so opioids were not an option for Patient A. (Tr. 190-91.)

76. Pregnancy can exacerbate a woman’s back pain. (Tr. 188.) Thus, Patient A’s pregnancy could have made her back pain worse.

77. Chronic pain is in and of itself a risk to a pregnant woman and her fetus. Women with chronic pain have higher rates of fetal loss, stillbirth, and pregnancy complications; their children have higher rates of problems later in life. (Tr. 196.) In addition, chronic pain is associated with depression and risk of suicide. (Tr. 197.)[[7]](#footnote-7)

78. Because some medications cause birth defects, pregnant women shouldn’t take them. That reduced Patient A’s options even further. (Tr. 192, 196.)

79. Almost everything that could have been done to treat Patient A’s pain had been done before she conferred with Dr. Cushing. (Tr. 186-87.)

80. Patient A had no reasonable options to treat her pain other than medical marijuana. (Tr. 216.)

81. Medical marijuana has various advantages over illegal marijuana. Medical marijuana is a pure product, free of pesticides, of known concentration, whereas illegal marijuana’s quality is doubtful. Buying illegal marijuana carries for a user the potential risks of violence during the transaction and contact with a seller who sells, in addition to marijuana, opioids and other drugs. (Tr. 202-04.) A patient may ingest medical marijuana in a safer way other than by smoking it. (Ex. 3, Tr. 64.)

82. According to the National Institutes of Health’s most recent meta-analysis, it is unsettled whether babies’ exposure to marijuana in the womb affects them after they’re born. The only consistent findings were that such babies had slightly lower birth weights, but not clinically significantly lower, and a small number of babies had the potential of delayed milestones. In almost all studies, babies who had been exposed to marijuana in the womb had caught up with non-exposed babies by two years old. Some studies show that babies who had been exposed to marijuana in the womb had behavioral issues, such as attention deficit and hyperactivity disorder and learning disabilities; other studies do not. (Tr. 192-93.)

83. Patient A had a qualifying condition under the medical marijuana statute, Dr. Cushing appropriately assessed her medical condition, and Dr. Cushing’s treatment of Patient A met the standard of care. (Tr. 177, 180-81, 190.)

84. Dr. Wartenberg testified (and I accept his testimony as factual findings) as follows:

The giving of a medical marijuana certificate is essentially a subspecialty function. It…does not involve the overall diagnosis of illness. If an internist or a family physician is seeing a patient who presents with symptoms and one is trying to find the cause of their symptoms…[taking] a full history and [making] a full examination is appropriate. But in a patient who is essentially coming with a question, does this patient have a debilitating condition…does the patient meet the criteria and does the condition meet the criteria of a debilitating illness as defined by the Massachusetts statute and regulations, a very complete clinical evaluation can be done in the absence of a complete history or a physical….

(Tr. 200-01.)

85. Not all doctors conduct physical examinations routinely. Psychiatrists are doctors who do not conduct physical examinations. “Ear, nose, and throat doctors may look at one ear as part of their evaluation.” (Tr. 201-02.)[[8]](#footnote-8)

86. Dr. Wartenberg also testified (and I accept his testimony as factual findings) as follows:

[T]his is a new field. Medical marijuana certification has only been around for a handful of years. The definition of a standard of care is what a reasonable and prudent physician of the same specialty in similar circumstances in that geographical area would do. I have spoken to many physicians who certify patients in medical marijuana, and being seen annually is what the majority of them do….All patients are told to come back if there are problems.

(Tr. 228.)

Dr. Sanford

87. Dr. Sanford graduated with an M.D. degree from the University of Texas Medical Branch in Galveston in 1982. (Resp. Ex. 3.)

88. Dr. Sanford is licensed to practice in Washington State. She is board-certified in obstetrics and gynecology. She is an obstetrical laborist at Tacoma General Hospital. (Resp. Ex. 3.)

89. She has been an expert witness in medical malpractice cases for plaintiffs and defendants since 2000. (Resp. Ex. 3, c.v., p. 1.) (I assume that Dr. Cushing paid her for her expert evidence.)

90. Dr. Sanford reviewed Respondent’s Exhibits 1 and 2, the Statement of Allegations and Dr. Cushing’s response to it (although the Statement of Allegations is not the subject of my decision), and the transcript of BRM’s suspension hearing on June 2, 2016. (Although I have read the transcript, I rely on the testimony at the April 4, 2017 hearing before me.) (Resp. Ex. 3, p. 2.)

91. Dr. Sanford opined, to a reasonable degree of certainty, that Dr. Cushing’s practice conformed with good and accepted standards of medical care and treatment and that his decision to certify Patient A for medical marijuana was fully appropriate under the circumstances. (Resp. Ex. 3, p. 2.)

92. Dr. Sanford opined in part (and I accept these opinions as factual findings):

7. While Dr. Cushing did not conduct a physical examination of Patient A, it was appropriate and reasonable for him to rely on the exams of more qualified specialists in the field of orthopedics and radiology. His role in this patient’s care was not to diagnose the patient’s longstanding back pain, but rather to determine whether Patient A’s condition met the criteria for a “debilitating medical condition” and evaluate the patient for a specific treatment modality. The information required to accomplish this evaluation was already noted in the MRI and orthopedic exams. A physical exam done in Dr. Cushing’s office was unnecessary, not indicated under the circumstances, and would not have added to the abundant information that Dr. Cushing already knew to be true from reviewing the patient’s medical record. In fact, a physical exam is not sufficient to diagnose a bulging disc. Therefore, an exam would not have provided Dr. Cushing with the information that he already had in hand from the records.

….

9. …[G]iven the history of her pain, and the documented bulging discs, there was no treatment modality that could have resolved the cause of her pain.

10. Additionally, there were several well established factors that made Patient A [a] poor candidate for any of the usual medications to alleviate her chronic pain. Specifically, she was taking Suboxone because she was recovering from opioid addiction. As a result, narcotic treatment was clearly contraindicated for her care. Additionally, the fetus would need to withdraw from narcotics after delivery. On the other hand, there is no medical evidence that fetuses must withdraw from marijuana. Furthermore, NSAID[[9]](#footnote-9) medications and aspirin are specifically contraindicated in pregnancy. As a result, Patient A had no available pharmaceutical options to address her pain. She had also failed cortisone injections and other non-invasive treatments. Accordingly, there were no treatment options available that the patient had not already attempted and found inadequate.

11. …Dr. Cushing noted this in his records, and he explicitly recommended that the patient not smoke the marijuana, but use other methods of consumption that avoided the risks of smoking….[[10]](#footnote-10)

12. Notably, a compound that is similar to the active ingredient in marijuana, Marinol, is used by physicians in the first trimester of pregnancy for nausea and vomiting. It is a Class C medication (meaning it may be used if, in the physician’s judgment, the benefits outweigh the potential risks). The first trimester of pregnancy is one of the most vulnerable times in the pregnancy for the development of defects in a fetus, and yet this medication is used at that sensitive time when it will benefit the mother and permit her to eat and provide nutrients to the fetus. This patient was well beyond this vulnerable first trimester when she was certified by Dr. Cushing, and she indicated that using marijuana allowed her to eat, sleep,[[11]](#footnote-11) and work, which in turn provided benefit to the fetus.

13. It is also noteworthy and significant that Patient A was already using cannabis, and had been using it to alleviate her pain for quite some time, including throughout her pregnancy. Therefore, the baby had already been exposed during the first trimester of gestation when birth defects were most likely to occur. It is also exceedingly unlikely that the patient would have discontinued using marijuana given her history of use and that she reported it was the only thing that alleviated her pain, allowing her to work and eat regularly. Accordingly, a certification for medical marijuana presented no added risk, but provided certain tangible and significant benefits. Giving the patient a certification for medical marijuana improved the quality of the cannabis that she would be able to obtain and allowed her to not need to smoke the drug. It also provided a legal means of obtaining the marijuana, as opposed to obtaining it through illicit means, which presents its own inherent and significant risks.

….

17. The number of certifications done by Dr. Cushing is wholly irrelevant, and is not an indication that his practice failed to confirm to good and appropriate care. As noted in his testimony, some of his patients take much less time and some take more….[T]here are cost pressures in every medical practice. Production is routinely and regularly evaluated in any medical practice, and is a fundamental component of any practice’s income. Dr. Cushing had...clearly reviewed the information he needed in this case to properly determine whether this patient qualified for the use of medical marijuana, and whether the potential risks were outweighed by the benefits for this patient. Judging his care because of the number of certifications that have been written without knowing the circumstances behind each of the patients represented in those certifications is an unsound extrapolation of data to prove a preconceived belief. Furthermore, the time Dr. Cushing spent on average with his patients is consistent with that of the vast majority of other treating physicians whose role in the patient’s care is more expansive than Dr. Cushing’s. Indeed, spending approximately 20 minutes on average with a patient under these circumstances is consistent with standard and appropriate practice, and not any indication of substandard care.

(Ex. 3.)

Clonazepam

93. Dr. Cushing has Parkinson’s Disease. (Tr. 118.)

94. Dr. Cushing used Clonazepam to help him sleep and control his seizures from Parkinson’s Disease. (Tr. 118.)

95. Dr. Cushing had a prescription from his doctor, but it ran out. (Tr. 118.)

96. On September 7, 2012, Dr. Cushing prescribed to himself 180 clonazepam 1-mg. tablets twice a day. (Resp. Ex. 1, Attach. A, p. 3, and Tab 4.)

97. Clonazepam is a Schedule IV drug. (Resp. Ex. 1, Attach. A, p. 3.)

98. Physicians are prohibited from self-prescribing drugs in Schedule IV and other schedules. (Resp. Ex. 1, Attach. A, p. 3; 243 CMR 2.07(19).) The reason is the potential that they will abuse the drugs. (Tr. 66.)

99. Dr. Cushing testified that he did not know Clonazepam was controlled, he should have checked it in the Physician’s Desk Reference or online, and he would not have written the prescription if he had known Clonazepam was a scheduled drug. (Tr. 119.)

100. Dr. Cushing admitted that prescribing Clonazepam for himself was an error. (Tr. 119.)

Dr. Cushing’s status as the third highest issuer of medical marijuana certificates

101. As of June 1, 2016, Dr. Cushing had issued 4,649 medical marijuana certificates. (Ex. 1, Attach. A, p. 5.)

102. As of May 20, 2016, Dr. Cushing was the third highest issuer of medical marijuana certificates in Massachusetts. (Ex. 1, Attach. A, p. 5.)

103. Marijuana, even medical marijuana, is illegal federally. Because large hospitals receive federal funds and are afraid of losing them, the hospitals are generally not involved with medical marijuana. (Tr. 130.)

**Discussion**

The medical marijuana statute and regulations under it

On November 6, 2012, the people of Massachusetts approved a ballot question that became the medical marijuana statute. St. 2012, c. 369. It has not been codified into the Massachusetts General Laws. The medical marijuana statute became effective on January 1, 2013. *Id.*

The medical marijuana statute defines “Written certification” as:

a document signed by a licensed physician, stating that in the physician’s professional opinion, the potential benefits of the medical use of marijuana would likely outweigh the health risks for the qualifying patient. Such certification shall be made only in the course of a bona fide physician-patient relationship and shall specify the qualifying patient’s debilitating medical condition(s).

St. 2012, c. 369, § 2(N). This decision calls written certifications “medical marijuana certificates.”

The statute in turn defines “Debilitating medical condition” as:

Cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome (AIDS), hepatitis C, amyotrophic lateral sclerosis (ALS), Crohn’s disease, Parkinson’s disease, multiple sclerosis and other conditions as determined in writing by a qualifying patient’s physician.

St. 2012, c. 369, § 1(C).

The statute defines “Qualifying patient” as “a person who has been diagnosed by a licensed physician as having a debilitating medical condition.” St. 2012, c. 369, § 1(K). This definition does not disqualify anyone categorically from receiving a medical marijuana certificate, including a pregnant woman. Nor does the rest of the statute.

The statute contains an immunity provision for doctors:

A physician, and other health care professionals under a physician’s supervision, shall not be penalized under Massachusetts law, in any manner, or denied any right or privilege, for:  
(a) Advising a qualifying patient about the risks and benefits of medical use of marijuana; or  
(b) Providing a qualifying patient with written certification, based upon a full assessment of the qualifying patient’s medical history and condition, that the medical use of marijuana may benefit a particular qualifying patient.

St. 2012, c. 369, § 3. *See also id.* § 1 (purpose and intent of the medical marijuana statute was that “there should be no punishment under state law for…physicians and health care professionals…”).

The statute does not specify how doctors should evaluate a patient and decide whether to issue a medical marijuana certificate. For example, the statute does not explicitly require a doctor to:

• establish a bona fide physician-patient relationship (that requirement is in the definition of “Written certification”);

• fully assess a patient’s medical history (that’s in the immunity provision);

• decide that the potential benefits of medical marijuana would likely outweigh the health risks, and so state in writing (that’s in the definition of “Written certification”);

• advise the patient of the risks and benefits (that’s in the immunity provision);

and

• specify in writing the patient’s debilitating medical condition(s) (that’s in the definition of “Written certification”).

The Department of Public Health (DPH) regulations under the medical marijuana statute also do not specify how doctors should evaluate a patient and decide whether to issue a medical marijuana certificate. One regulation indirectly and incompletely provides the procedure:

A certifying physician issuing a written certification *for his or her employees or co-workers* shall do so in accordance with 105 CMR 725.010, *including* conducting a clinical visit, completing and documenting a full assessment of the patient’s medical history and current medical condition, explaining the potential benefits and risks of marijuana use, and maintaining a role in the ongoing care and treatment of the patient.

105 CMR 725.010(M) (emphasis added).

Similarly, a *definition* indirectly and incompletely provides the *procedure* for how doctors should evaluate a patient and decide whether to issue a medical marijuana certificate:

*Bona Fide* Physician-patient Relationship means a relationship between a certifying physician, acting in the usual course of his or her professional practice, and a patient in which the physician has conducted a clinical visit, completed and documented a full assessment of the patient’s medical history and current medical condition, has explained the potential benefits and risks of marijuana use, and has a role in the ongoing care and treatment of the patient.

105 CMR 725.004. Another regulation, in turn, provides:

A certifying physician may issue a written certification only for a qualifying patient with whom the physician has a *bona fide* physician-patient relationship.

105 CMR 725.010(D).

The DPH regulation’s definition of “Debilitating Medical Condition” tracks the statute’s definition:

cancer, glaucoma, positive status for human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), hepatitis C, amyotrophic lateral sclerosis (ALS), Crohn’s disease, Parkinson’s disease, and multiple sclerosis (MS), when such diseases are debilitating, and other debilitating conditions as determined in writing by a qualifying patient’s certifying physician.

105 CMR 725.004. The regulation’s definition of “Debilitating” allows the definition of “Debilitating Medical Condition” to be expanded further:

causing weakness, *cachexia*, wasting syndrome, intractable pain, or nausea, or impairing strength or ability, and progressing to such an extent that one or more of a patient’s major life activities is substantially limited.

105 CMR 725.004. Thus, both the statute’s and regulation’s definitions allow doctors to go beyond a list of debilitating medical conditions, and grant doctors some discretion to determine what such a condition is.

The regulations define “Qualifying Patient” as:

a Massachusetts resident 18 years of age or older who has been diagnosed by a Massachusetts licensed certifying physician as having a debilitating medical condition, or a Massachusetts resident younger than 18 years old who has been diagnosed by two Massachusetts licensed certifying physicians, at least one of whom is a board-certified pediatrician or board-certified pediatric subspecialist, as having a debilitating medical condition that is also a life-limiting illness, subject to 105 CMR 725.010(J).

105 CMR 725.004. Thus, the regulation refines, but does not expand or contract the statute’s definition of qualifying patient. The regulations, like the statute, do not disqualify anyone categorically from receiving a medical marijuana certificate, including a pregnant woman.

The regulation’s definition of “Written certification” differs from the statute’s definition, but not significantly so:

a form submitted to the Department [of Public Health] by a Massachusetts licensed certifying physician, describing the qualifying patient’s pertinent symptoms, specifying the patient’s debilitating medical condition, and stating that in the physician’s professional opinion the potential benefits of the medical use of marijuana would likely outweigh the health risks for the patient.

105 CMR 725.004.

A regulation narrows the statute’s immunity provision. The regulation provides:

A certifying physician issuing a written certification shall comply with generally accepted standards of medical practice, including regulations of the Board of Registration in Medicine at 243 CMR 1.00 through 3.00.

105 CMR 725.010(B). The regulations at 243 CMR 1.00 through 3.00 govern discipline of medical doctors. Thus, as I said in another case, the statute’s immunity provision “does not confer blanket immunity from state action against a physician for any act related to the medical marijuana program.” Summary of Recommended Decision on Order of Temporary Suspension, *Board of Registration in Medicine v. John C. Nadolny, M.D.*, RM-16-238 (DALA 2016).

Dr. Cushing’s *bona fide* physician-patient relationship

BRM argues that Dr. Cushing did not establish a *bona fide* physician-patient relationship with any of his patients because he did not have enough time to do so. (BRM Br. 8-9.) In support of its argument, BRM posits three things: One, twenty minutes for first-time patients was not enough time for Dr. Cushing to conduct a clinical visit, complete and document a full assessment of the patient’s medical history and current medical condition, explain the potential benefits and risks of marijuana use, and have a role in the ongoing care and treatment of the patient.105 CMR 725.004.

Two, CannaMed terminated other doctors who did not see enough patients. It was pleased with Dr. Cushing’s speed in meeting with patients. Three, Dr. Cushing issued 4,649 medical marijuana certificates.

BRM’s argument has a few problems. The initial problem is that BRM makes this argument for the first time in its brief. It does not appear in the Motion for Summary Suspension or its Exhibit A, the Affidavit of Susan Dye. BRM did not identify this issue at the start of the hearing. (Tr. 6 (BRM confirmed that the crux of its case was Dr. Cushing’s certifying medical marijuana for Patient A).)

BRM’s argument that 20 minutes is not enough time to fulfill the requirements of 105 CMR 725.004 is *ipse dixit*. There is no support in the record for it. For example, BRM did not present an expert witness on this point. To the contrary, Dr. Wartenberg testified credibly that 20 minutes was sufficient. (Tr. 212, 245-46.) Dr. Sanford agreed. (Resp. Ex. 3 ¶ 17.)

That CannaMed considered him and Dr. Cushing considered himself to be expeditious does not mean that he did not spend enough time with patients. That CannaMed terminated other doctors may mean that they spent too much time with patients, but does not prove much about Dr. Cushing.

The number of medical certificates that Dr. Cushing issued does not prove that he did not spend enough time with patients. BRM did not present a mathematical argument; *e.g.*, Dr. Cushing worked so many hours, saw so many patients, issued so many certificates, and therefore spent so many minutes per average patient. If BRM had presented a mathematical argument, it would likely be along the lines of: Dr. Cushing spent only 20 minutes per patient. That argument would have been a variation of its *ipse dixit* argument that 20 minutes per patient was not enough to establish a *bona fide* physician-patient relationship under the medical marijuana statute.

Dr. Wartenberg

It was reasonable for Dr. Cushing to have certified Patient A for medical marijuana, but Dr. Wartenberg overstated the case for Dr. Cushing’s having done so. Dr. Wartenberg was not familiar with Patient A’s medical records,[[12]](#footnote-12) and I have the impression that he was “winging it” during his testimony. When asked if anything else was done to alleviate Patient A’s pain, he answered: “I have to review [her medical record]” – but then proceeded to answer without reviewing it. (Tr. 186-87.) When asked whether her records indicated that she had been offered surgery, Dr. Wartenberg responded:

I would have – at this point she was felt not to be a candidate. But she had had surgery that was unsuccessful, as I recall. But I’d have to review [her records] again.

(Tr. 187.) He did not review her records again. Exhibit 1, Attachment A, Tabs 5 and 6 do not indicate whether Patient A had surgery, successfully or otherwise.

When I asked Dr. Wartenberg if CannaMed’s disclosure handouts omitted any risks of medical marijuana, he answered, “There are no specific pieces of this regarding the pregnancy issue.” (Tr. 199.) However, the disclosure handouts do discuss pregnancy (Resp. Ex. 1, Attach. A, p. 13), as Dr. Cushing’s lawyer steered Dr. Wartenberg to acknowledge. (Tr. 199.)

Dr. Wartenberg testified, “Patient A self-escalated her use of opiates to the point where they cannot be safely continued….”[[13]](#footnote-13) He testified that Patient A “had physical therapy of various sorts[[14]](#footnote-14) and also chiropractic treatments.”[[15]](#footnote-15) (Tr. 187-88.) He also testified that Patient A’s pain “interfered with her life at many levels,[[16]](#footnote-16) including her work and home life, her ability to parent or care for her children….”[[17]](#footnote-17) (Tr. 190.) And he testified that she “had been using it [marijuana] without incident for a significant period of time.” (Tr. 207.)[[18]](#footnote-18)

Dr. Wartenberg testified about Patient A:

She received different kinds of injections, epidural injections,[[19]](#footnote-19) facet, nerve block injections.[[20]](#footnote-20)...She had extensive physical therapy.[[21]](#footnote-21) She was also seen by a pain psychologist.[[22]](#footnote-22) And a variety of techniques, relaxation techniques, meditative techniques,[[23]](#footnote-23) and other techniques[[24]](#footnote-24) were attempted.

(Tr. 185.)

She had had history earlier in life with it [marijuana], and then resumed it on another person’s recommendation that might reduce her back pain….[[25]](#footnote-25)

(Tr. 189-90).

Physical therapy of various sorts as well as invasive therapy such as nerve and facet blocks[[26]](#footnote-26) and epidural blocks had been tried with not only report of no relief, but patient report of exacerbation of the pain.[[27]](#footnote-27)

(Tr. 191.)

…Patient A had tried cannabis on her own and reported that it was so successful[[28]](#footnote-28) that she was able to continue working and parenting and taking care of her life needs[[29]](#footnote-29) while using it.

(Tr. 192.)

This does not mean that Dr. Wartenberg’s testimony was not useful. It was, and I accept much of his opinion in my factual finding. However, his testimony specific to Patient A deserves some skepticism. He didn’t have a clear memory of what her records said.

Compensating for the deficiencies in Dr. Wartenberg’s testimony were these factors: Dr. Sanford submitted an affidavit, Dr. Cushing testified, and BRM did not present expert evidence. (Ordinarily, I might disregard the testimony of a respondent as possibly self-serving but in this case, Dr. Cushing’s explanations for his decision-making were plausible – and not countered by expert evidence against him.)

Whether Dr. Cushing’s issuance of a medical marijuana certificate to a pregnant woman means that he is an immediate and serious threat or may be a serious threat to the public health, safety, or welfare

I cannot recommend a decision based on appearances, a snap judgment, or a reaction to one sentence, however alarming the sentence may seem to be, namely: Dr. Cushing issued a medical marijuana certificate to a pregnant woman.

Dr. Cushing’s issuance of a medical marijuana certificate to a pregnant woman does not mean that he is an immediate and serious threat or may be a serious threat to the public health, safety, or welfare.

The facts, which Dr. Cushing was aware of, are as follows: Patient A had severe back pain dating back to April 2010. (Resp. Ex. 1, Attach. A, Tab 5, p. 40.) In May 2011, Diazepam/Valium, Percocet, and 800 mg. ibuprofen tablets were not relieving her pain. (Resp. Ex. 1, Attach. A, Tab 5, p. 39.) Also in that month, Patient A was found to have four bad disks.

(Resp. Ex. 1, Attach. A, Tab 5, pp. 37-38.) In June 2011, Patient A reported that her pain, on a scale of 1 to 10, was at 6, 8, or 10, depending on the day. She received an epidural injection. (Resp. Ex. 1, Attach. A, Tab 5, pp. 35, 36.) However, later that month, Patient A reported that after the injection, her symptoms were worse. On a scale of 1 to 10, she reported her pain at 10. (Resp. Ex. 1, Attach. A, Tab 5, p. 33-34.) Also in June 2011, a doctor opined that the possibility that surgery would relieve her pain was “relatively remote” and that basically, she would have to learn to manage and live with her pain. (Resp. Ex. 1, Attach. A, Tab 5, p. 32.)

Further facts, which Dr. Cushing was aware of, are as follows: In June 2012, Patient A injured her back, leading her to go to the emergency room. (Resp. Ex. 1, Attach. A, Tab 5, p. 28.) At some time, Patient A became addicted to opioids. (Ex. 1, Attach. A, p. 2; Tr. 233.) By early March 2013, Patient A was four-and-one-half months pregnant, in a drug rehabilitation program, taking Suboxone, and declining any pain medication. (Resp. Ex. 1, Attach. A, Tab 5, p. 27.)

In May 2013, Patient A arrived at CannaMed, more advanced in her pregnancy. She reported in writing that her sciatica and back pain limited her ability to conduct major life activities, and that in her opinion, if these conditions were not alleviated, they would seriously harm her safety or physical or mental health. She also reported that physical therapy had not helped her, cortisone shots had worsened her pain, and that she had used a cane and back brace. (Resp. Ex. 1, Attach. A, Tab 5, pp. 4-5.) Dr. Cushing advised her of the risks of medical marijuana, including its possible effects on her fetus. (Resp. Ex. 1, Attach. A, Tab 5, p. 11, 13-16.)

Dr. Cushing weighed various considerations, including these: An injection and physical therapy had not eased Patient A’s pain. She was not a candidate for surgery, so that she could not relieve her back pain through surgery. Because she was on Suboxone, she could not use opioids and thus had limited options for pain treatment. Her being on Suboxone indicated that she was trying to rehabilitate herself. In addition to Suboxone, Patient A was on Prozac. Both carry risks for pregnant women. If she could not relieve her pain with medical marijuana, there was a risk that she would return to opioids, which would have been worse for her fetus. She was already using marijuana. She and her fetus were already experiencing whatever risks it had. (Tr. 145, 154, 155.)

Dr. Cushing decided it was better for Patient A to buy medical marijuana than illegal marijuana, which has pesticide residue. (Tr. 107.) He decided that the benefits of medical marijuana to Patient A were greater than the risks. (Tr. 153.)

Dr. Wartenberg provided further support for the reasonableness of Dr. Cushing’s decision. He pointed out that pregnancy can exacerbate a woman’s back pain. Thus, Patient A’s pregnancy could have made her back pain worse. Chronic pain is in and of itself a risk to a pregnant woman and her fetus. Women with chronic pain have higher rates of fetal loss, stillbirth, and pregnancy complications; their children have higher rates of problems later in life. Because some medications cause birth defects, pregnant women shouldn’t take them. That reduced Patient A’s options even further. Almost everything that could have been done to treat Patient A’s pain had been done before she conferred with Dr. Cushing. Patient A had no options to treat her pain other than medical marijuana. Medical marijuana has various advantages over illegal marijuana. Medical marijuana is a pure product of known concentration, whereas illegal marijuana’s quality is doubtful. Buying illegal marijuana carries for a user the potential risks of violence during the transaction and contact with a seller who sells, in addition to marijuana, opioids and other drugs. (Tr. 186-87, 188, 192, 196, 202-04, 216.)

Dr. Sanford also provided support for the reasonableness of Dr. Cushing’s decision. She wrote that “there was no treatment modality that could have resolved the cause of her pain” and “there were no treatment options available that the patient had not already attempted and found inadequate.” She wrote that Patient A could not take opioids to relieve her pain because she was on Suboxone and “the fetus would need to withdraw from narcotics after delivery.” And because “NSAID medications and aspirin are specifically contraindicated in pregnancy,” she “had no available pharmaceutical options to address her pain.” (Ex. 3.)

Dr. Sanford pointed out that Patient A was already smoking marijuana while pregnant. She wrote, “Accordingly, a certification for medical marijuana presented no added risk, but provided certain tangible and significant benefits.” The benefits were that the quality of medical marijuana would be higher than illegal marijuana, she could consume medical marijuana in a safer way other than by smoking it, and she could avoid the risks of buying illegal marijuana. (Ex. 3.) Under cross-examination, Ms. Dye, BRM’s investigator, agreed that medical marijuana had these benefits over illegal marijuana. (Tr. 64.)

Not only was it reasonable for Dr. Cushing to issue a medical marijuana certificate to this specific pregnant woman, it is unclear whether marijuana harms fetuses. According to the National Institutes of Health’s most recent meta-analysis, it is unsettled whether babies’ exposure to marijuana in the womb affects them after they’re born. The only consistent findings were that such babies had slightly lower birth weight, but not clinically significantly lower weight, and a small number of babies had the potential of delayed milestones. In almost all studies, babies who had been exposed to marijuana in the womb had caught up with non-exposed babies by two years old. Some studies show that babies who had been exposed to marijuana in the womb had behavioral issues, such as attention deficit and hyperactivity disorder and learning disabilities; other studies do not. (Tr. 192-93.)

Dr. Cushing described the medical and scientific studies about marijuana affecting fetuses as “variable.” (Tr. 106, 117, 156.) Dr. Sanford pointed out that

a compound that is similar to the active ingredient in marijuana, Marinol, is used by physicians in the first trimester of pregnancy for nausea and vomiting. It is a Class C medication (meaning it may be used if, in the physician’s judgment, the benefits outweigh the potential risks).

(Ex. 3.)

Nonetheless, at some point after issuing a medical marijuana certificate to Patient A, Dr. Cushing decided not to issue such certificates to pregnant women. (Tr. 108.) This further reduces any threat that he poses the public health, safety, or welfare. And the certificate that Dr. Cushing issued to Patient A expired on May 29, 2014, almost three years ago. Any threat that he posed to the public health, safety, or welfare, by issuing a medical marijuana certificate to a pregnant woman, ended more than three-and-one-half years ago on August 21, 2013, when Patient A gave birth. (Pet. Ex. 1, Attach A, p. 2.)

Dr. Cushing’s issuance of a medical marijuana certificate to a pregnant woman did not violate the medical marijuana statute or the regulations under it. Dr. Cushing’s issuance of a medical marijuana certificate to Patient A, whether or not she was pregnant, did not violate the statute or regulations. Dr. Cushing’s issuance of the certificate was reasonable under the circumstances and met the standard of care. Thus, on this ground, he does not pose an immediate and serious threat or a possible serious threat to the public health, safety, or welfare.

The fact that BRM did not act quickly against Dr. Cushing is only a slight indication that he does not pose an immediate and serious threat or a possible serious threat to the public health, safety, or welfare. I have negligible evidence about BRM’s resources or lack of them (Tr. 70 (Dye testified that an investigation usually takes a year, depending on BRM’s staffing, and how easily it can obtain records and experts)), or whether it had higher priorities and potentially more serious dangers to the public health than Dr. Cushing. Furthermore, if a hypothetical licensing agency were inefficient and delayed in acting against a hypothetical licensee, it would not necessarily mean that the licensee was not a threat to public safety. Thus, a delay in disciplinary action does not necessarily indicate lack of an immediate and serious threat to the public health, safety, or welfare.

Whether Dr. Cushing’s self-prescription of Clonazepam means that he is an immediate and serious threat or may be a serious threat to the public health, safety, or welfare

Dr. Cushing’s self-prescription of Clonazepam does not mean that he is an immediate and serious threat or may be a serious threat to the public health, safety, or welfare. He did it once, he did it in 2012, and he has called it an error (Tr. 66, 119, 158), making it less likely that he will do it again.

Dr. Cushing’s self-prescription of Clonazepam did not directly threaten the public health, safety, or welfare. His disregard of proper medical procedure and ignorance of the ban on self-prescription of scheduled medications means that his ignorance or disregard of other procedures could threaten the public safety, but that’s hypothetical. *At worst*, Dr. Cushing’s self-prescription put one person at risk, himself, and no one else. And the risk to himself was hypothetical.

Dr. Cushing’s self-prescription apparently violated 243 CMR 2.07(19)(“A licensee is prohibited from prescribing controlled substances in Schedules II, III, and IV for his own use.”). However, that is not directly the issue before me now. The issue is whether he is an immediate and serious threat or may be a serious threat to the public health, safety, or welfare.

BRM argues that Dr. Cushing’s self-prescription “likely compromised his professional objectivity and unduly influenced his medical judgment.” (BRM Br. 8 (paraphrasing BRM’s *Prescribing Practices Policy and Guidelines*).) BRM does not explain how Dr. Cushing’s self-prescription of a medication that Dr. Cushing’s doctor prescribed for him before and after Dr. Cushing’s one-time self-prescription compromised his professional objectivity and unduly influenced his medical judgment. I find that it did not do so.

Whether Dr. Cushing’s status as the third highest issue of medical marijuana certificates means that he is an immediate and serious threat or may be a serious threat to the public health, safety, or welfare

Dr. Cushing’s status as the third highest issue of medical marijuana certificates does not mean that he is an immediate and serious threat or may be a serious threat to the public health, safety, or welfare. I so conclude for three reasons.

One, someone has to be the third highest issuer of medical marijuana certificates. Someone has to be first, fifth, and so on. If BRM suspends Dr. Cushing from practicing medicine or this legal subspecialty, someone else will become the third highest issuer of certificates. That will not mean that the new third highest issuer is an immediate and serious threat or may be a serious threat to the public health, safety, or welfare.

Large medical institutions, or at least some of them, avoid involvement with medical marijuana, because they receive federal funds, and marijuana, even medical marijuana, is illegal under federal law. (Tr. 129-30.) That Dr. Cushing, working two to three days a week, became the third highest issuer of certificates indicates that this subspecialty is a niche practice, not that he was issuing certificates willy-nilly.

Two, Dr. Cushing’s third-place rank does not mean that he issued medical marijuana certificates in violation of the medical marijuana statute or the regulations under it. Until it filed its brief, BRM did not allege that he violated the statute or regulations by issuing certificates to patients other than Patient A. *See* Ex. 3 (Dr. Sanford’s affidavit (“Judging his care because of the number of certifications that have been written without knowing the circumstances behind each of the patients represented in those certifications is an unsound extrapolation of data to prove a preconceived belief.”)).

Three, if the medical marijuana statute’s immunity provision means anything – and statutory language should not be considered superfluous, *International Organization of Masters, Mates & Pilots, Atlantic and Gulf Maritime Region, AFL-CIO v. Woods Hole, Martha's Vineyard & Nantucket Steamship Authority*, 392 Mass. 811, 813 (1984) – it means that doctors generally cannot be disciplined for the simple act of issuing a medical marijuana certificate while complying with the statute and regulations under it. And if a doctor cannot be disciplined for the simple act of issuing one valid medical marijuana certificate, Dr. Cushing cannot be disciplined for issuing 4,648 certificates. (BRM did not question the validity and appropriateness of those 4,648 certificates until it filed its brief, alleging that Dr. Cushing did not establish physician-patient relationships with the certificate recipients.) Furthermore, if Dr. Cushing cannot be disciplined for issuing 4,648 medical marijuana certificates (the number he issued minus one for Patient A), he cannot be disciplined for being the third largest issuer. That is, if Dr. Cushing cannot be disciplined for the cardinal number related to certificates he issued (4,648 or 4,649), he cannot be disciplined for the ordinal number related to certificates (third in the state). This is especially so when he has little to no control over his ranking.

BRM’s argument regarding 105 CMR 725.010(J)

DPH’s medical marijuana regulations provide:

A qualifying patient who is younger than 18 years old and has been diagnosed by two Massachusetts licensed certifying physicians, at least one of whom is a board-certified pediatrician or a board-certified pediatric subspecialist, with a debilitating life-limiting illness, may receive a written certification, provided however that the physicians may certify a qualifying patient who is younger than 18 years old who has a debilitating medical condition that is not a life-limiting illness if those physicians determine that the benefits of the medical use of marijuana outweigh the risks. This must include a discussion of the potential negative impacts on neurological development with the parent or legal guardian of the qualifying patient, written consent of the parent or legal guardian, and documentation of the rationale in the medical record and the written certification.

105 CMR 725.010(J).

BRM argues for the first time in its brief that Dr. Cushing violated this regulation by issuing a medical marijuana certificate to Patient A. BRM so argues in two sentences:

The Respondent issued a written certification for the medical use of marijuana to Patient A while she was approximately seven months along in her pregnancy. This violated 105 CMR 725.010(J).

(BRM Br. 6.)

BRM does not explain how, in its opinion, Dr. Cushing violated 105 CMR 725.010(J). He issued a medical marijuana certificate to the fetus without establishing that it had a debilitating illness? He did not have a second doctor issue the certificate with him? He did not discuss “the potential negative impacts on neurological development” with Patient A? He did not get her written consent? He did not document “the rationale in the medical record and the written certification”?

BRM does not discuss, let alone acknowledge, the potential constitutional implications of considering a fetus to be a patient younger than 18 years old.

The regulation does not apply here. Patient A had the debilitating medical condition, not the fetus. Dr. Cushing issued a medical marijuana certificate to Patient A, not to her fetus.

I reject this argument because BRM has not given fair notice to Dr. Cushing that it would be invoking the argument; it has not developed the argument; it ignores the constitutional implications of the argument; and the regulation does not apply here.

BRM’s argument about Dr. Cushing’s judgment

BRM argues that Dr. Cushing is animmediate and serious threat to the public health, safety, or welfare because of his poor judgment, namely, in issuing a medical marijuana certificate to a pregnant woman (BRM Br. 7, 9), self-prescription of Clonazepam (BRM Br. 8), and absence of concern for “Patient A’s unborn child.” Dr. Cushing’s self-prescription of Clonazepam did not demonstrate optimal judgment, but as I have written, it does not make him a threat to the public health, safety, welfare. Dr. Cushing’s issuing a medical marijuana certificate to Patient A did not demonstrate poor judgment. BRM has not proved that Dr. Cushing had no concern for Patient A’s fetus, thereby demonstrating poor judgment.

**Conclusion and Order**

Because Dr. Cushing is not animmediate and serious threat to the public health, safety, or welfare, I recommend that the Board of Registration in Medicine not temporarily suspend him.

DIVISION OF ADMINISTRATIVE LAW APPEALS

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Kenneth Bresler

Administrative Magistrate

Dated: June 15, 2017

1. The only explicit (albeit second-hand) evidence that I can locate in the exhibits that Patient A had become addicted to opioids is in Ms. Dye’s affidavit. She wrote that she had interviewed a staff person at the Department of Children and Families, who reported: “Patient A was being treated with buprenorphine for opioid addiction at Primary Care Associates in Auburn.” (Resp. Ex. 1, Attach. A, p. 2.) Dr. Wartenberg testified that Patient A had a substance use disorder. (Tr. 233.) Dr. Cushing in his testimony, and Dr. Sanford in her affidavit, assumed Patient A’s opioid addiction and implied it without stating it. (*E.g.*, Tr. 145; Resp. Ex. 3, p. 3, ¶ 10.) The record does not state if her back pain led her to become addicted to prescription opioids. [↑](#footnote-ref-1)
2. Suboxone is used to treat opioid addiction. (*E.g.*, Tr. 190-91.) How long she had been in drug rehabilitation and on Suboxone is not in the record. [↑](#footnote-ref-2)
3. When she developed the drug problem is not in the record. [↑](#footnote-ref-3)
4. The Acknowledgment and Consent form has limited significance. Its significance is that Dr. Cushing properly advised Patient A of the risks, as the medical marijuana law and the standard of care require. A patient may acknowledge and accept the risks that a doctor exposes the patient to, and the doctor could still be animmediate and serious threat to the public health, safety, or welfare, and still be subject to discipline. Thus, Dr. Cushing’s advising Patient A of the risks of medical marijuana means that he cannot be disciplined for *failing* to so advise her. It does not mean that he cannot be disciplined. A patient, by acknowledging and accepting risks, cannot preempt action by the Board of Registration in Medicine or a recommended decision by the Division of Administrative Law Appeals. [↑](#footnote-ref-4)
5. This is assuming that Patient A stopped taking Suboxone, which generally blocks the effects of opioids. (Tr. 190-191.) [↑](#footnote-ref-5)
6. Patient A used medical marijuana while pregnant for two-and-three-quarters months. [↑](#footnote-ref-6)
7. The relevance of this last factual finding is decreased in this case, because Dr. Cushing issued the medical marijuana certificate due to Patient A’s pain, not depression. [↑](#footnote-ref-7)
8. BRM, after initially appearing to be proceeding against Dr. Cushing for not having physically examined Patient A, did not argue that issue in its post-hearing brief. I find that Dr. Cushing did not need to physically examine Patient A or other patients to whom he issued medical marijuana certificates, under the statute, the regulations, or the standard of care. I am persuaded by the expert testimony of Drs. Wartenberg and Sanford, and Dr. Cushing’s argument about comparable legislation in other states, some of which explicitly require medical-marijuana doctors to physically examine patients. Resp. Br. 21-23. [↑](#footnote-ref-8)
9. I assume that this stands for “Non-Steroidal Anti-Inflammatory Drug.” [↑](#footnote-ref-9)
10. I have unable to locate in the exhibits support for this assertion. Dr. Cushing testified that he advised patients to vaporize marijuana, rather than smoke it (Tr. 128), but he did not testify that he specifically so advised Patient A. [↑](#footnote-ref-10)
11. I have been unable to locate in the evidence support for this assertion about sleep. [↑](#footnote-ref-11)
12. Dr. Wartenberg’s testimony (Tr. 183, lines 7-12) indicates that he reviewed only Patient A’s records that were introduced at the hearing. [↑](#footnote-ref-12)
13. I saw no evidence in Exhibit 1, Attachment A, Tabs 5 and 6 of Patient A’s having escalated her use of opioids. Perhaps Patient A’s records implied self-escalation, but I as a layperson am unaware of it. [↑](#footnote-ref-13)
14. I saw no details in Exhibit 1, Attachment A, Tabs 5 and 6 of Patient A’s physical therapy, such as that she had received “various sorts.” [↑](#footnote-ref-14)
15. Patient A was referred for chiropractic (Resp. Ex. 1, Attach. A, Tab 5, p. 26), but I saw no evidence in Exhibit 1, Attachment A, Tabs 5 and 6 that she received it. [↑](#footnote-ref-15)
16. I saw no evidence in Exhibit 1, Attachment A, Tabs 5 and 6 of Patient A’s pain interfering with her life other than working. (*E.g.*, Resp. Ex. 1, Attach. A, Tab 5, p. 36 (“She has not been working…”).) [↑](#footnote-ref-16)
17. I saw no evidence in Exhibit 1, Attachment A, Tabs 5 and 6 of Patient A’s pain having interfered with her home life, including her ability to parent. [↑](#footnote-ref-17)
18. Patient A reported that she had learned in 2008 that cannabis eased her symptoms and allowed her to experience less pain, eat regularly, and perform her job better. (Resp. Ex. 1, Attach. A, Tab 5, pp. 5-6.) Presumably, she had been smoking marijuana since then. I saw no evidence in Exhibit 1, Attachment A, Tabs 5 and 6 of whether Patient A had been using marijuana *regularly* since 2008 and whether she had done so without incident. [↑](#footnote-ref-18)
19. I am aware of only one epidural injection. (Resp. Ex. 1, Attach. A, Tab 5, p. 35.) Although various medical records refer to “injections,” I am aware of only that one. [↑](#footnote-ref-19)
20. I saw no evidence in Exhibit 1, Attachment A, Tabs 5 and 6 of Patient A’s having received nerve or facet blocks. Perhaps Patient A’s records implied such treatment, but I as a layperson am unaware that she received such treatment. [↑](#footnote-ref-20)
21. I am unaware of evidence that would support Dr. Cushing’s characterization of Patient A’s physical therapy as “extensive.” [↑](#footnote-ref-21)
22. Dr. Cushing may be aware of the specialties of the various health care providers with whom Patient A conferred. However, I am unaware of evidence that Patient A conferred with a pain psychologist. I am aware that Dr. Williams wrote that Patient A “may benefit from psychological counseling, which she has tried, but has not found a counselor with whom she can connect.” (Resp. Ex. 1, Attach. A, Tab 5, pp. 30-31.) However, it is not evidence that Patient A conferred with a pain psychologist. [↑](#footnote-ref-22)
23. I saw no evidence in Exhibit 1, Attachment A, Tabs 5 and 6 of Patient A’s having engaged in or tried relaxation or meditative techniques. [↑](#footnote-ref-23)
24. I saw no evidence in Exhibit 1, Attachment A, Tabs 5 and 6 of Patient A’s having tried other techniques. [↑](#footnote-ref-24)
25. “[H]istory earlier in life” may be a reference to Respondent’s Exhibit 1, Attachment A, Tab 5, pp. 5-6 (Patient A began smoking marijuana in 2008). As for the assertion about the recommendation, I could not locate it in Exhibit 1, Attachment A, Tabs 5 and 6. [↑](#footnote-ref-25)
26. Again, I saw no evidence in Exhibit 1, Attachment A, Tabs 5 and 6 of Patient A’s having received nerve or facet blocks. [↑](#footnote-ref-26)
27. Patient A did report that after her epidural injection she felt worse. (Resp. Ex. 1, Attach. A, Tab 5, p. 5 (cortisone injections), 33-35.) However, to the extent that Dr. Wartenberg’s testimony implied that physical therapy exacerbated Patient A’s pain, she reported instead that it didn’t help her. (Resp. Ex. 1, Attach. A, Tab 5, p. 5, Tab 6.) [↑](#footnote-ref-27)
28. This was an overstatement. When asked on the Patient Information form whether marijuana relieved her symptoms, Patient A wrote simply: “less pain, I eat regularly if I use cannabis and perform my job better.” (Resp. Ex. 1, Attach. A, Tab 5, p. 5.) [↑](#footnote-ref-28)
29. I could not locate assertions about parenting and life needs, other than eating, in Exhibit 1, Attachment A, Tabs 5 and 6. [↑](#footnote-ref-29)