Medical Marijuana Program

165 Capitol Avenue, Room 145, Hartford, CT 06106-1630 • (860) 713-6066
E-mail: dcp.mmp@ct.gov • **Website:** www.ct.gov/dcp/mmp

Petition to Add a Medical Condition, Medical Treatment or Disease to the List of Debilitating Conditions

INSTRUCTIONS: Please complete each section of this Petition and attach all supportive documents. All attachments must include a title referencing the Section letter to which it responds. Any Petition that is not fully or properly completed will not be submitted to the Board of Physicians.

Please Note: Any individually identifiable health information contained in a Petition shall be confidential and shall not be subject to disclosure under the Freedom of Information Act, as defined in section 1-200, Connecticut General Statutes.

Section A: Petitioner's Information

Name (First, Middle, Last): [redacted]			
Home Address (including Apartment or Suite #): [redacted]			
City: [redacted]		State: [redacted]	Zip Code: [redacted]
Telephone Number: [redacted]	E-mail Address: [redacted]		

Section B: Medical Condition, Medical Treatment or Disease

Please specify the medical condition, medical treatment or disease that you are seeking to add to the list of debilitating medical conditions under the Act. Be as precise as possible in identifying the condition, treatment or disease.

Post-laminectomy syndrome with chronic radiculopathy
Also see Attached page

Section C: Background

Provide information evidencing the extent to which the condition, treatment or disease is generally accepted by the medical community and other experts as a valid, existing medical condition, medical treatment or disease.

- Attach a comprehensive definition from a recognized medical source.
- Attach additional pages as needed.

Http://nyp.org/health/failed-back.html | www.mdguidelines.com/post-laminectomy-syndrome

Http://bostonpaincare.com/post-laminectomy-syndrome.php
See Attached Pages

Section D: Negative Effects of Current Treatment

If you claim a treatment, that has been prescribed for your condition causes you to suffer (i.e. severe or chronic pain, spasticity, etc.), provide information regarding the extent to which such treatment is generally accepted by the medical community and other experts as a valid treatment for your debilitating condition.

- Attach additional pages as necessary.
- If not applicable, please indicate N/A.

N/A

Section E: Negative Effects of Condition or Treatment

Provide information regarding the extent to which the condition or the treatments thereof cause severe or chronic pain, severe nausea, spasticity or otherwise substantially limits one or more major life activities.

- Attach additional pages as necessary.

See attached pages

Section F: Conventional Therapies

Provide information regarding the availability of conventional medical therapies, other than those that cause suffering, to alleviate suffering caused by the condition or the treatment thereof.

- Attach additional pages as necessary.

Pain Management therapies (med's), spinal cord stimulator
see attached pages

Section G: General Evidence of Support for Medical Marijuana Treatment

Provide evidence, generally accepted among the medical community and other experts, that supports a finding that the use of marijuana alleviates suffering caused by the condition or the treatment thereof.

- Attach additional pages as necessary.

see attached pages

Section H: Scientific Evidence of Support for Medical Marijuana Treatment

Provide any information or studies regarding any beneficial or adverse effects from the use of marijuana in patients with the condition, treatment or disease that is the subject of the petition.

- Supporting evidence needs to be from professionally recognized sources such as peer reviewed articles or professional journals.
- Attach complete copies of any article or reference, not abstracts.

see attached pages

Section I: Professional Recommendations for Medical Marijuana Treatment

Attach letters in support of your petition from physicians or other licensed health care professionals knowledgeable about the condition, treatment or disease at issue.

see attached

Section J: Submission of Petition

In the event you are unable to answer or provide the required documentation to any of the Sections above (excluding Section D); provide a detailed explanation indicating what you believe is "good cause" for not doing so.

- Attach additional pages as necessary.

N/A

I hereby certify that the above information is correct and complete.

My signature below attests that the information provided in this petition is true and that the attached documents are authentic. I formally request that the commissioner present my petition and all supporting evidence to the Board of Physicians for consideration.

Signature:	Date Signed:
[redacted]	3/17/14

Section B

Connecticut Spine and Pain Center

accredited

October 1, 2008

Eric A. Polinsky, Esquire
Polinsky, Siegel & Polinsky, LLC
Attorneys at Law
890 W. Boulevard
Hartford, CT 06105-4139

RE: [redacted]

Dear Attorney Polinsky:

This letter is in follow-up to your letter dated September 25, 2008. [redacted] current prognosis is considered to be chronic and disabling in nature. He possesses a failed back syndrome diagnosis being status-post a lumbosacral fusion with a chronic radiculopathy component. His present restrictions are of a total disability status. A functional capacity evaluation may provide some additional insight to his functionality, however he is most likely going to fall into a total disability status or possibly a very restricted sedentary work capacity status. He is not a candidate for any additional surgical intervention or treatment. He is a candidate for the continuation of his present medication regimen as well as his continued usage of his spinal cord stimulator. These help slightly in the overall reduction of his pain and slightly with his functionality level. His medication usage would be needed chronically. Status-post a functional capacity evaluation, he would be considered to be at maximum medical improvement. At that point he will also possess a partial impairment disability rating for the lumbar region. [redacted] His rating will most likely be in the vicinity of that rating. His present lower back and lower extremity symptoms of pain and disability status are directly related to his workers' compensation injury of July 31, 1995. This is to a reasonable medical probability. He is likely to develop some progressive arthritis in the facet joints above his fusion level into the future due to the loss of segment motion from his prior fusion. [redacted] has not felt that he is a candidate for any additional future treatment and would not be considered a candidate for a re-evaluation of this.

Should you have any additional questions, please do not hesitate to contact me.

Sincerely,

[redacted]

Bristol Hospital • Brewster Road • P.O. Box 977 • Bristol, CT 06011-0977 • Telephone: (860) 585-3040 • Fax: (860) 585-3145

Section C: Background

See attached print outs for definition

Sources for medical definition of condition:

http://nyp.org/health/failed-back.html

http://www.bostonpaincare.com/post_laminectomy_syndrome.php

http://www.mdguidelines.com/post-laminectomy-syndrome/

Failed Back Syndrome

Failed back syndrome is a general term that refers to chronic severe pain experienced after unsuccessful surgery for back pain. Surgery for back pain is conducted when there is an identifiable source of pain-usually to decompress a pinched nerve root or to stabilize a painful joint. However, back pain can have a number of causes and accurate identification of a source of pain is complicated; often symptoms do not correlate well with x-rays or magnetic resonance imaging (MRI) scans. As a result, diagnosis and patient selection for surgery are essential.

Causes

Failed back syndrome can have any number of causes. For example, the original cause of the pain can recur or there may be complications during surgery. The nerve root causing the pain may be inadequately decompressed, joints or nerves may become irritated during the surgical procedure, or scar tissue may compress or bind nerve roots. In addition, nerve damage, either prior to surgery or during the procedure, will not heal and can contribute to ongoing pain. In some cases, nerves may regenerate to some extent, but even this can cause pain if the regeneration is abnormal. Inadequate or incomplete rehabilitation and physical therapy, especially in patients whose back muscles are deconditioned (out of shape), can cause chronic pain as well.

Spinal fusion surgery, a procedure used to stabilize joints in the spine, usually is very successful, but also carries the risk of failed back syndrome. For this procedure, hooks, rods, and screws are used to fix the spine, and then bone taken from another part of the body or from a bone bank is implanted to encourage bone to grow across the joints. Following surgery, there is a chance that the metal implants will fail, or the bones may fail to fuse for unknown reasons. Also, the fixing of one or more spinal joints may increase the strain on nearby joints. Any of these conditions may lead to ongoing pain.

Symptoms

The pain associated with failed back syndrome varies depending on the surgical procedure and the original condition. The pain, which ranges from a dull ache to sharp stabbing pain, may be localized to one region of the back or may extend to the legs.

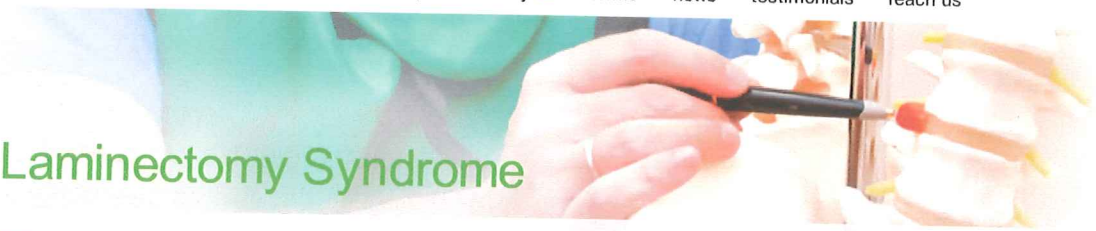
Diagnosis

The diagnosis of failed back syndrome is the same as the diagnosis of other forms of back pain. X-rays, MRI scans, and computed tomography (CT) scans are used to visualize the structures of the back to identify the source of the pain. Minimally invasive spine procedures, such as epidural injections of steroids or pain medication, also may be used to isolate the source of the pain and provide some pain relief to facilitate rehabilitation.

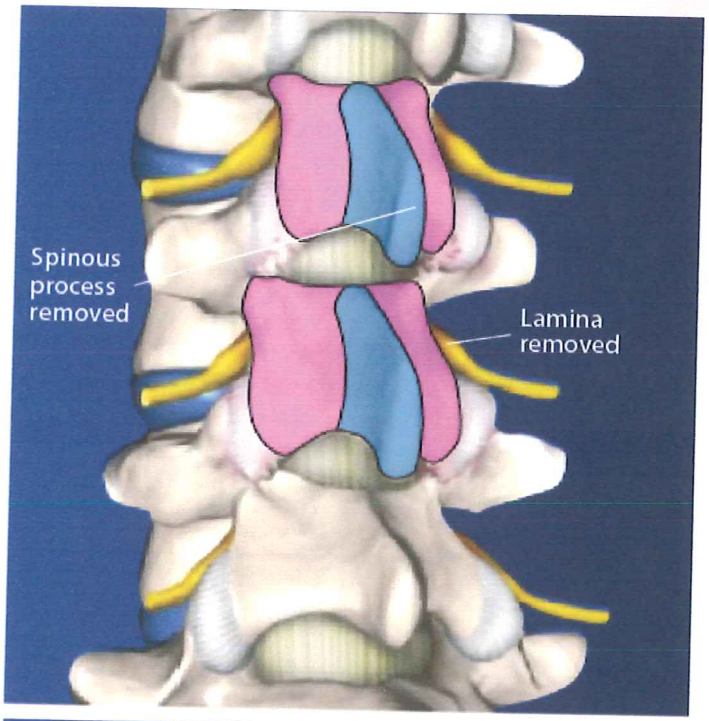
Treatment

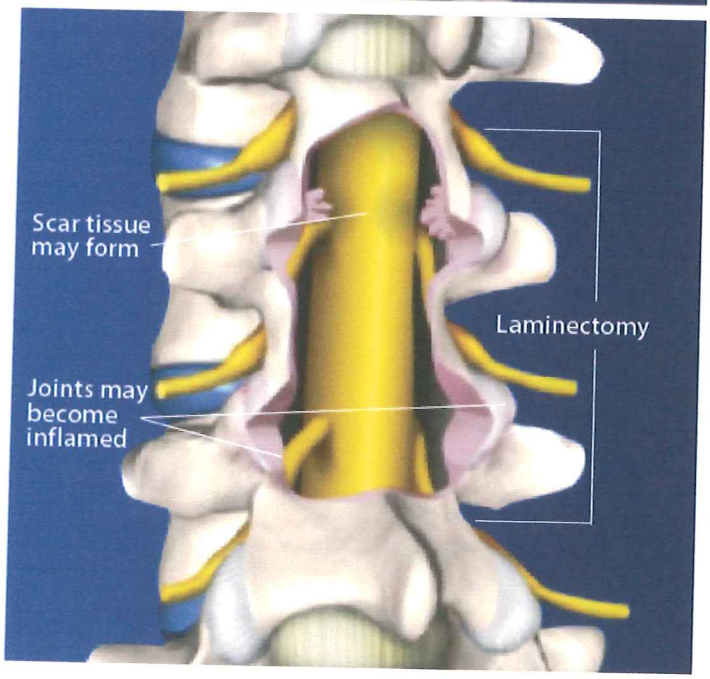
Treatment of chronic pain and failed back syndrome is difficult. It is important to obtain an accurate diagnosis before any surgery, especially surgery on the back. If a source of pain still can be identified after a first surgery, corrective surgery may be attempted again. Ongoing physical therapy is important and should be a part of any surgical treatment plan.

Other treatment options are available for chronic pain patients who have exhausted conservative treatment strategies and no longer are good candidates for surgery. Neurostimulation involves the implantation of a battery pack and stimulating electrodes. The electrodes stimulate the pain-causing nerves to block the pain signals going to the brain. Another treatment alternative is intrathecal drug delivery. For this procedure, a small pump and tube are implanted in the body to deliver small, regular doses of pain medication directly to the space surrounding the spinal cord. Like other surgical procedures, these implantation procedures carry the risk of infection and bleeding.



Post Laminectomy Syndrome





Overview

Post Laminectomy syndrome, also called failed back syndrome, is a continuous and chronic pain that can develop after certain types of back surgery.

Causes

A laminectomy is a surgical procedure where one or more lamina (a section of bone on the rear of the vertebra) are removed to relieve pressure on the spinal cord. Painful scar tissue can form at the surgery site or joints in the back may become irritated and inflamed.

Symptoms

Symptoms can include dull and achy pain in the back, pain that radiates into the hips, buttocks, and thighs, or sharp pain in the back and legs.

Treatment

Post laminectomy syndrome can be treated with medications, physical therapy, electrical nerve stimulation, spinal injections, or in severe cases, another surgery.

back to back pain treatments

Post-Laminectomy Syndrome

Medical Codes

ICD-9-CM:

722.8 - Post-laminectomy Syndrome
722.80 - Post-laminectomy Syndrome, Unspecified Region
722.81 - Post-laminectomy Syndrome, Cervical Region
722.82 - Post-laminectomy Syndrome, Thoracic Region
722.83 - Post-laminectomy Syndrome, Lumbar Region
737.12 - Kyphosis, postlaminectomy

Definition

Post-laminectomy syndrome refers to the persistence of pain and disability following laminectomy. Laminectomy is a type of back surgery performed to relieve nerve compression (radiculopathy) or nerve root injury in the spine caused by disc herniation or spinal canal narrowing (spinal stenosis) related to degenerative changes.

The spinal canal is formed by the posterior (back) portion of the vertebrae that surround the spinal cord and protect and confine the spinal nerves. A disc herniation or spinal stenosis may occur and cause pressure on the spinal cord and/or one or more spinal nerve roots. Removing a section of the bony arch, or lamina, which forms the posterior part of the spinal canal (laminectomy) allows for decompression of the nerves.

Post-laminectomy syndrome specifically refers to pain associated with symptoms not relieved following laminectomy. However, the term often is used more broadly to describe poor outcomes following any type of spinal surgery. The classic term laminectomy often is used to describe a partial laminotomy, which is removal of only a portion of the lamina to provide access to a disc herniation. The most frequent surgery preceding a diagnosis of post-laminectomy syndrome is lumbar discectomy. Spinal surgery may be performed in patients who do not improve with nonsurgical (conservative) treatment, even though surgical results are less predictable in the absence of correlation between specific clinical findings and imaging study results. In those cases, decompression may fail to provide relief, and the result is post-laminectomy syndrome.

The causes of poor results or failed back surgery syndrome, a term inclusive of post-laminectomy syndrome and persistent pain after other spinal procedures, including spinal fusion, include poor patient selection (i.e., operating when nerve compression did not exist), nerve root injury at the time of surgery, delayed surgery, infection in the disc space or epidural space, unrecognized lateral spinal stenosis or instability, arachnoiditis, and reherniation. Rarely, the first surgery will have been performed on the wrong side or at the wrong level (malpractice). Surgery may have been performed appropriately and the pathology corrected; however, psychosocial factors may contribute to chronic pain that develops after surgery.

Factors Influencing Duration

Duration depends on source of pain, underlying cause, and method of treatment. The type and amount of surgery and rehabilitation required have an effect on the duration of disability. Permanent disability may occur for individuals in certain job situations. Psychosocial factors have a significant impact on disability. Chronic opioid therapy may increase duration.

Related Terms

- Failed Back Surgery Syndrome
- Failed Back Syndrome

Differential Diagnoses

- Arachnoiditis
- Cauda equina syndrome
- Degenerative disc disease
- Fracture of the spine
- Infection (discitis, osteomyelitis, epidural abscess)
- Inflammatory disease
- Neurological disease
- Osteoarthritis
- Osteomyelitis
- Osteoporosis
- Pseudarthrosis (failure of a spinal fusion surgery to result in actual fusion)
- Psychosocial and environmental factors
- Recurrent disc herniation
- Rheumatoid arthritis
- Spinal instability
- Spinal stenosis
- Tumor

Specialists

- Clinical Psychologist
- Neurosurgeon
- Occupational Therapist
- Orthopedic (Orthopaedic) Surgeon
- Pain Medicine Physician / Pain Specialist
- Physiatrist
- Physical Therapist
- Psychiatrist
- Rheumatologist

Comorbid Conditions

- Arthritis
- Cancer
- Cardiopulmonary disease
- Depression and other mental disorders
- Diabetes
- General debility
- Obesity
- Osteoarthritis
- Psychosocial stressors
- Rheumatoid arthritis

Risk: The risk for poor surgical outcome is increased in cases of poor patient selection, a history of a previous unsuccessful surgery, and in an individual with a pre-existing documented history of clinical depression or other psychiatric disorder.

Incidence and Prevalence: About 450 cases of herniated disc per 100,000 require surgery in the US (Sleigh). Incidence of post-laminectomy syndrome correlates with data on the number of surgeries performed, of which an estimated 10% to 15% are considered unsuccessful (Wheeler).

Source: Medical Disability Advisor

Diagnosis

History: The medical history of individuals with post-laminectomy syndrome varies considerably; however, all the individuals will previously have had back surgery and are still experiencing low back pain and/or leg pain (sciatica). The individual may complain of a variety of symptoms including stiffness, local tenderness, generalized discomfort, and pain radiating to the leg, which may be indicative of nerve involvement.

Physical exam: The individual will be examined lying flat (supine), sitting, and standing. Palpation along the spine may reveal areas of localized tenderness from prior surgery. The physician will evaluate posture, gait, and range of motion and may observe asymmetry,

deformity, or spinal curvature. The exam will include a complete neurovascular and musculoskeletal exam to rule out all possible causes of symptoms other than post-laminectomy syndrome.

Tests: Flexion and extension x-rays of the spine may be obtained to determine the whether post-operative instability is present; it is a potential source of persistent pain. MRI with contrast and CT/myelography may both be performed to evaluate for persisting nerve compression, discitis or other disc disease, and to rule out infection or tumor. Lab studies include blood work to detect infection (e.g., white blood cell [WBC] count, erythrocyte sedimentation rate [ESR]). If an infection is suspected, a bone scan (nuclear imaging bone scan) and/or MRI may be ordered to examine bone and soft tissue in more detail. Nerve conduction and electromyography (EMG) studies may be performed to evaluate nerve root pain. Often, these studies fail to identify a specific source for the ongoing pain. Both psychological evaluation and a second surgical opinion should be obtained before spinal surgery is repeated.

Source: Medical Disability Advisor

Treatment

An anatomic cause for the "failed" surgery must be ruled out so that appropriate treatment can be provided. Conservative treatment usually is recommended initially, and may include additional rehabilitation efforts (e.g., physical therapy, exercise) and pain management using a combination of oral medications (e.g., analgesics, nonsteroidal anti-inflammatory drugs [NSAIDs], antidepressants, muscle relaxants, and anticonvulsants). Anesthetics or steroids may be injected in the form of trigger point injections, epidural steroid injections, and/or selective nerve root injections. Chronic opioid (narcotics) therapy may be prescribed for pain control. While these drugs may decrease pain, they do not predictably alter disability. Opioids usually are delivered orally. Implantation of a pain pump for chronic spinal pain is rarely indicated. Long-term (chronic) opioid therapy is common for treating non-malignant conditions, but controversy exists about long-term benefits vs. side effects, including affects on functional status (Soin).

Spinal cord stimulation is another pain management technique that employs an implantable, battery-powered unit that provides constant stimulation of the spinal cord. Relief of symptoms is reported in about 50% of patients (North).

Repeat surgical intervention (discectomy, vertebral fusion, and/or additional laminectomy) is only occasionally indicated, and then only when a clear-cut diagnosis has been established. Individuals with recurrent back pain without any identifiable physical cause may benefit from treatment by a pain specialist and

psychotherapy.

Source: Medical Disability Advisor

ACOEM

AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE

ACOEM's Practice Guidelines, the gold standard in effective medical treatment of occupational injuries and illnesses, are provided in this section to complement the disability duration guidelines.*

Low Back Disorders
Neck and Upper Back Disorders

** The relationship between the MDGuidelines (MDA) content and ACOEM's guidelines is approximate and does not always link identical diagnoses. The user should consult the diagnostic codes in both guidelines, as well as the clinical descriptions, before assuming an equivalence.*

Source: ACOEM Practice Guidelines

Prognosis

The outcome of post-laminectomy syndrome is extremely variable; it can range from complete relief to a lifetime of worsening pain. While an initial surgery, performed for appropriate reasons may yield good results, in patients who fail to improve, second or additional surgeries have less predictable results. The success rate declines with each additional surgery. Multiple surgeries on older individuals often have poorer outcomes. Unresolved psychosocial factors (e.g., marital or sexual problems, job dissatisfaction, pending litigation) and documented clinical depression or other psychiatric disorder may delay or prevent recovery.

Source: Medical Disability Advisor

Rehabilitation

The goal of rehabilitation in post-laminectomy syndrome is to maximize functional abilities of the individual. Because post laminectomy syndrome is a chronic condition, a comprehensive assessment at a tertiary or multi-disciplinary pain/rehabilitation clinic may be necessary. Consequent to the evaluation, individuals with post-laminectomy syndrome may best benefit from a comprehensive multidisciplinary rehabilitation intervention.

During the evaluation, surgically treatable structural causes may be sought, but they are rarely found. In some cases, additional surgical management is conducted, with mixed results.

Consistent with a multidisciplinary program, some individuals with the post laminectomy syndrome improve with the combination of intensive physical rehabilitation and cognitive and behavioral treatment for pain management. Some pain programs include peer group support, which may benefit the individual.

Spinal cord stimulation with an implantable, battery-powered unit that stimulates the spinal cord may be tried. Only about half of the individuals will respond to spinal cord stimulation, and, generally, with only a 50% or less decrease in pain (North).

Another option is to administer opioids (narcotics) for pain control, either orally or from an implanted pump which delivers the medication directly to the spine/spinal cord or nerves. This option may control pain but may also impact the functional status of the individual.

An ergonomic assessment may be beneficial prior to returning to work, and if necessary, a vocational counselor may be necessary to identify a suitable job. Additional information may provide greater insight into the implications for rehabilitation treatment (Epstein; Fischgrund). For additional guidelines for management of back pain see Low Back Pain.

FREQUENCY OF REHABILITATION VISITS	
Nonsurgical	
Specialist	Post-Laminectomy Syndrome
Physical Therapist	Daily for up to 6 weeks ‡
Occupational Therapist	Daily for up to 6 weeks ‡
Physical Therapist	Up to 15 visits within 6 weeks
Clinical Psychologist	Up to 12 visits within 6 weeks

‡ As part of multidisciplinary intervention (work condition).

The table above represents a range of the usual acceptable number of visits for uncomplicated cases. It provides a framework based on the duration of tissue healing time and standard clinical practice.

Source: Medical Disability Advisor

Complications

Post-laminectomy syndrome may be complicated by instability, infection, surgical trauma, or bleeding. Pseudarthrosis or failure of

fusion may occur following surgery designed to produce fusion (failed back surgery syndrome). Additional surgery may be necessary to address some of these conditions. Opioid dependence and altered functional status are possible results of chronic pharmacologic pain management.

Source: Medical Disability Advisor

Return to Work (Restrictions / Accommodations)

Individuals with this diagnosis rarely return to work, especially if their premorbid occupation required significant physical labor. If successfully treated by additional surgery, or multidisciplinary rehabilitation, they may return to sedentary, light or medium work.

An analysis of transferable skills and potential job retraining may be necessary in order to return the individual to work in any occupation. Company policy on medication usage should be reviewed to determine if pain medication use is compatible with job safety and function.

Source: Medical Disability Advisor

Failure to Recover

If an individual fails to recover within the expected maximum duration period, the reader may wish to consider the following questions to better understand the specifics of an individual's medical case.

Regarding diagnosis:

- Is the location of the pain the same as before surgery or is it in a different location?
- What were the results of the neurovascular and musculoskeletal exams?
- Have WBC count and ESR suggested the presence of infection?
- Have results of postoperative flexion extension bending x-rays, MRI, CT/myelography, EMG, and suggested a surgically treatable cause?
- Has individual had a complete psychiatric evaluation to rule out psychosocial factors?
- Has individual been referred to a clinical psychologist for a complete psychological evaluation including neuropsychological testing (Minnesota Multiphasic Personality Inventory) to identify contributing psychosocial factors?
- Has individual had a second surgical opinion?
- Has a functional assessment been performed to identify approximate activity tolerances?
- Have conditions such as tumor, arthritis, osteomyelitis, osteoporosis, muscle spasm and other conditions with similar symptoms been ruled out?
- Is impending litigation affecting the patient's presentation and rehabilitation?

Regarding treatment:

- Did the original surgery fail, or was there a 1-year or longer interval of little or no pain and normal function before the current pain began?
- Has the true cause of the failed surgery been determined?
- What has been the individual's response to conservative treatment (analgesics, NSAIDs, antidepressants, muscle relaxants, physical therapy, and exercise)?
- Did individual have additional surgery? Was it done in stages?
- Was electrical stimulation tried to stimulate bone healing in the case of a failed fusion?
- Is individual active in psychotherapy?
- Is evaluation at a multidisciplinary pain center indicated?
- Has individual consulted with a pain specialist?
- Has a pain pump been employed?
- Is individual receiving chronic opioid or other pharmacologic therapy?
- Has spinal cord stimulation been performed?

Regarding prognosis:

- How severe are the symptoms? Are they incapacitating? Can the individual perform the normal activities of daily life?
- Has individual undergone multiple back surgeries?
- Has individual's work area been evaluated and organized ergonomically?
- Is individual's employer able to accommodate the needed restrictions?
- Does individual have any comorbid conditions that could increase length of disability?
- Is individual receiving regular psychological counseling? Would such counseling be beneficial?

Source: Medical Disability Advisor

References

Cited

Sleigh, Bryan, and Ibrahim Nihum. "Lumbar Laminectomy." *eMedicine Consumer Health*. Eds. Joseph A. Salomone, Francisco Talavera, and Richard Harrigan. 5 Oct. 2005. Medscape. 13 Mar. 2009 <http://www.emedicinehealth.com/articles/6606-1.asp>.

Wheeler, Anthony H., James R. Stubbart, and Brandi Hicks. "Pathophysiology of Chronic Back Pain." *eMedicine*. Eds. Michael J. Schneck, et al. 9 Jul. 2007. Medscape. 13 Mar. 2009 <http://emedicine.medscape.com/article/1144130-overview>.

Soin, A. "Functional Outcomes in Patients with Chronic Nonmalignant Pain on Long-term Opiod Therapy." *Pain Practice* 8 5 (2008): 379-384.

Rehabilitation

Epstein, N. E. "Lumbar Laminectomy for the Resection of Synovial Cysts and Coexisting Lumbar Spinal Stenosis or Degenerative Spondylolisthesis: An Outcome Study." *Spine* 29 9 (2004): 1049-1055. *National Center for Biotechnology Information.* National Library of Medicine. 2 Dec. 2008 <PMID: 15105680>.

Fischgrund, J. S., et al. "1997 Volvo Award Winner in Clinical Studies. Degenerative Lumbar Spondylolisthesis with Spinal Stenosis: A Prospective, Randomized Study Comparing Decompressive Laminectomy and Arthrodesis with..." *Spine* 22 24 (1997): 2807-2812. *National Center for Biotechnology Information.* National Library of Medicine. 12 Feb. 2008 <PMID: 9431616>.

North, R. B., et al. "Spinal Cord Stimulation for Chronic, Intractable Pain: Superiority of 'Multi-Channel' Devices." *Pain* 44 2 (1991): 119-130. *National Center for Biotechnology Information.* National Library of Medicine. 2 Dec. 2008 <PMID: 2052378>.

Source: Medical Disability Advisor

Feedback

Send us comments, suggestions, corrections, or anything you would like us to hear. If you are not logged in, you must include your email address, in order for us to respond. We cannot, unfortunately, respond to every comment. If you are seeking medical advice, please contact your physician. Thank you!

Send this comment to:

○ Sales ○ Customer Support ○ Content Development

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This publication is designed to provide accurate and authoritative information in regard to the subject matter covered. It is published with the understanding that the author, editors, and publisher are not engaged in rendering medical, legal, accounting or other professional service. If medical, legal, or other expert assistance is required, the service of a competent professional should be sought. We are unable to respond to requests for advice. Any Sales inquiries should include an email address or other means of communication.

Section E: Negative Effects of Condition or Treatment

The condition that I have is a failed back syndrome which is a result of post lumbosacral fusion with a chronic radiculopathy component. This is also known as post-laminectomy syndrome. The negative effects of my condition limit me in many ways. I am unable to stand, sit or walk for long periods of time, causing me to have to lie down and rest for the majority of the day, every day. My sleep is very disruptive; I get 0-4 hours worth of sleep per day on a daily basis. This is caused because of the chronic back pain, muscle spasms, and nerve pain that I endure. My quality of life has significantly decreased over the past 18 years that I have had these conditions. Which in turn makes my home life quite restricted; I cannot do the things most people can do such as mowing my lawn, doing housework, having intimacy with my wife, and traveling. This condition also causes me to not be able to enjoy or do activities and hobbies that I used to do before my injury occurred such as hunting, fishing, and woodworking. This chronic back, muscle, and leg pain that is associated with these failed back surgeries and nerve damage that is a result of these back surgeries, limits me on vacations with my family, seeing as I cannot sit in cars, airplanes, buses, etc.. for very long before having to get up every 20-30 minutes in order to stretch and walk around for 5-10 minutes before being able to sit down for a few minutes and having to start that same process over and over until the driving or flying is finished. Extended traveling causes me to have excruciating pain to the extent of being in bed for 2-3 days when I arrive at my destination as well as when I return. This condition also puts a strain on my marriage with my wife. The severe back, muscle and leg pain, limits the intimacy I can have with my wife and it also limits the things that I can do with her. I cannot even go to the movie theater with her because as mentioned, I cannot sit for long periods of time and I consistently need to keep getting up to stretch which causes me to not even be able to enjoy doing things like this with my wife. My pain has also caused me to miss out on many activities that I could have done with my son while he grew up, and still limits the things that I can do with him now.

Section F: Conventional Therapies

Current treatment that I have for this condition is a pain management therapy which seems to only slightly mask the negative effects of my condition. I am currently taking multiple medications for my severe back pain, muscle spasms, leg pain, and the nausea that the pain medications give me. The medications that I take on a daily basis are as follows:

Amitriptyline - 150 mg tablet at night for nerve pain.

Prochloperazine - 10 mg tablet every 6 hours as needed for nausea.

Dilaudid - 4 mg tablet 1 every 4 hours max of 6 a day for pain.

Methadone - 10 mg tablet (20 mg morning, 10 mg lunch, 20 mg dinner, 10 mg bedtime)

Tizanidine- 4 mg tablet - 3 at bedtime for muscle pain and sleeping

Baclofen- 10 mg tablet - 1 in morning 1 at night for pain

Lyrica - 75 mg tablet – 2 in morning and 2 at night for pain.

Another conventional therapy that I have is a spinal cord stimulator implant. This was installed with 7 surgeries which 3 of which were to install the stimulator implant or replace it, and the other 4 were to reattach wires that moved locations and came off of the track of the stimulators. This as well helps with a slight reduction of my pain, but just as the pain medication it only masks a minor part of it.

Section G: General Evidence of Support for Medical Marijuana Treatment

Sources for general evidence (print outs attached in order of listing):

http://www.ucsf.edu/news/2011/12/11077/ucsf-study-finds-medical-marijuana-could-help-patients-reduce-pain-opiates

http://medicalmarijuana.procon.org/view.resource.php?resourceID=000881

UCSF Study Finds Medical Marijuana Could Help Patients Reduce Pain with Opiates

A UCSF study suggests patients with chronic pain may experience greater relief if their doctors add cannabinoids – the main ingredient in cannabis or medical marijuana – to an opiates-only treatment.

By Leland Kim on December 06, 2011

A UCSF study suggests patients with chronic pain may experience greater relief if their doctors add cannabinoids – the main ingredient in cannabis or medical marijuana – to an opiates-only treatment. The findings, from a small-scale study, also suggest that a combined therapy could result in reduced opiate dosages.

More than 76 million Americans suffer from chronic pain – more people than diabetes, heart disease and cancer combined, according to the National Centers for Health Statistics.

A vaporizer such as this one delivers the same amount of cannabis as if a patient smokes a marijuana cigarette.

"Pain is a big problem in America and chronic pain is a reason many people utilize the health care system," said the paper's lead author, Donald Abrams, MD, professor of clinical medicine at UCSF and chief of the Hematology-Oncology Division at San Francisco General Hospital and Trauma Center (SFGH). "And chronic pain is, unfortunately, one of the problems we're least capable of managing effectively."

In a paper published this month in *Clinical Pharmacology & Therapeutics*, researchers examined the interaction between

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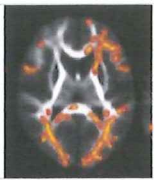

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cannabinoids and opiates in the first human study of its kind. They found the combination of the two components reduced pain more than using opiates alone, similar to results previously found in animal studies.

Major Components of Cannabis

- **Delta-9 Tetrahydrocannabinol (Delta-9 THC)** – It is the main psychoactive component of cannabis with mild to moderate painkilling effects. It also helps treat nausea associate with cancer chemotherapy and to stimulate appetite. It induces feelings of euphoria. Potential side effects include accelerated heartbeat, panic, confusion, anxiety and possible paranoia.
- **Cannabidiol (CBD)** – It is a major, non-psychoactive component of cannabis that helps shrink inflammation and reduce pain without inducing the euphoria effects of THC. It has been used to treat rheumatoid arthritis, inflammatory bowel diseases, psychotic disorders and epilepsy. Larger amounts of CBD can relax the mind and body without causing negative side effects associated with THC.
- **Cannabinol (CBN)** – It is a secondary psychoactive component of cannabis. It is not associated with painkilling effects of THC or CBD. CBN is formed as THC ages. Unlike the euphoria effects of THC, CBN can induce headaches and a sense of lethargy.
- **Tetrahydrocannabivarin (THCV)** – It is found primarily in strains of African and Asian cannabis. THCV heightens the intensity of THC effects and the speed in which the component is delivered, but also causes the sense of euphoria to end sooner.

Researchers studied chronic pain patients who were being treated with long-acting morphine or long-acting oxycodone. Their treatment was supplemented with controlled amounts of cannabinoids, inhaled through a vaporizer. The original focus was on whether the opiates' effectiveness increased, not on whether the cannabinoids helped reduce pain.

"The goal of the study really was to determine if inhalation of cannabis changed the level of the opiates in the bloodstream," Abrams said. "The way drugs interact, adding cannabis to the chronic dose of opiates could be expected either to increase the plasma level of the opiates or to decrease the plasma level of the opiates or to have no effect. And while we were doing that, we also asked the patients what happened to their pain."

Abrams and his colleagues studied 21 chronic pain patients in the inpatient Clinical and Transitional Science Institute's Clinical Research Center at SFGH: 10 on sustained-release morphine and 11 on oxycodone. After obtaining opiate levels from patients at the start of the study, researchers exposed them to vaporized cannabis for four consecutive days. On the fifth day, they looked again at the level of opiate in the bloodstream. Because the level of morphine was slightly lower in the patients, and the level of oxycodone was virtually unchanged, "one would expect they would have less relief of pain and what we found that was interesting was that instead of having less pain relief, patients had more pain relief," Abrams said. "So that was a little surprising."

The morphine group came in with a pain score of about 35, and on the fifth day, it decreased to 24 – a 33 percent reduction. The oxycodone group came in with an average pain score of about 44, and it reduced to 34 – a drop of 20 percent. Overall, patients showed a significant decrease in their pain.

"This preliminary study seems to imply that people may be able to get away perhaps taking lower doses of the opiates for longer periods of time if taken in conjunction with cannabis," Abrams said.

Opiates are very strong powerful pain medicines that can be highly addictive. They also can be deadly since opiates sometimes suppress the respiratory system.

As a cancer doctor, Abrams was motivated to find safe and effective treatments for chronic pain. Patients in the cannabis-opiates study experienced no major side effects such as nausea, vomiting or loss of appetite.

A scale is used to weigh cannabis before it is put in the vaporizer to ensure

"What we need to do now is look at pain as the primary endpoint of a larger trial," he said. "Particularly I would be interested in looking at the effect of different strains of cannabis."

For instance, Delta 9 THC is the main psychoactive component of cannabis but cannabis contains about 70 other similar compounds with different effects. One of those is cannabidiol, or

accurate dosage.

those is cannabidiol, or CBD. It appears to be very effective against pain and inflammation without creating the "high" created by THC.

"I think it would be interesting to do a larger study comparing high THC versus high CBD cannabis strains in association with opiates in patients with chronic pain and perhaps even having a placebo as a control," Abrams said. "That would be the next step."

Abrams is the lead author of the paper; co-authors are Paul Couey, BA, and Mary Ellen Kelly, MPH, of the UCSF Division of Hematology-Oncology at SFGH; Starley Shade, PhD, of the UCSF Center for AIDS Prevention Studies; and Neal Benowitz, MD, of the UCSF Division of Clinical Pharmacology and Experimental Therapeutics.

The study was supported by funds from the National Institutes on Drug Abuse (NIDA), a subsidiary of the National Institutes of Health (NIH).

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20 Legal Medical Marijuana States and DC

Laws, Fees, and Possession Limits

I. Summary Chart II. Details by State III. Sources

I. Summary Chart: 20 states and DC have enacted laws to legalize medical marijuana

State	Year Passed	How Passed (Yes Vote)	Fee	Possession Limit	Accepts other states' registry ID cards?
1. Alaska	1998	Ballot Measure 8 (58%)	$25/$20	1 oz usable; 6 plants (3 mature, 3 immature)	unknown[1]
2. Arizona	2010	Proposition 203 (50.13%)	$150/$75	2.5 oz usable; 0-12 plants[2]	Yes[3]
3. California	1996	Proposition 215 (56%)	$66/$33	8 oz usable; 6 mature or 12 immature plants[4]	No
4. Colorado	2000	Ballot Amendment 20 (54%)	$35	2 oz usable; 6 plants (3 mature, 3 immature)	No
5. Connecticut	2012	House Bill 5389 (96-51 House, 21-13 Senate)	TBD*	One-month supply (exact amount to be determined)	No
6. DC	2010	Amendment Act B18-622 (13-0 vote)	$100/$25	2 oz dried; limits on other forms to be determined	No
7. Delaware	2011	Senate Bill 17 (27-14 House, 17-4 Senate)	$125	6 oz usable	Yes[5]
8. Hawaii	2000	Senate Bill 862 (32-18 House; 13-12 Senate)	$25	3 oz usable; 7 plants (3 mature, 4 immature)	No
9. Illinois	2013	House Bill 1 (61-57	TBD*	2.5 ounces of usable cannabis during a period of 14 days	No
10. Maine	1999	Initiative 93 (61%)	$0	2.5 oz usable; 6 plants	Yes[6]
11. Massachusetts	2012	Ballot Question 3 (63%)	TBD[7]	Sixty day supply for personal medical use	unknown
12. Michigan	2008	Proposal 1 (63%)	$100/$25	2.5 oz usable; 12 plants	Yes
13. Montana	2004	Initiative 148 (62%)	$25/$10	1 oz usable; 4 plants (mature); 12 seedlings	No
14. Nevada	2000	Ballot Question 9 (65%)	$200[8]	1 oz usable; 7 plants (3 mature, 4 immature)	Yes[9]
15. New Hampshire	2013	House Bill 573 (284-66 House; 18-6 Senate)	TBD*	Two ounces of usable cannabis during a 10-day period	Yes
16. New Jersey	2010	Senate Bill 119 (48-14 House; 25-13 Senate)	$200/$20	2 oz usable	No
17. New Mexico	2007	Senate Bill 523 (36-31 House; 32-3 Senate)	$0	6 oz usable; 16 plants (4 mature, 12 immature)	No
18. Oregon	1998	Ballot Measure 67 (55%)	$200/$100[10]	24 oz usable; 24 plants (6 mature, 18 immature)	No
19. Rhode Island	2006	Senate Bill 0710 (52-10 House; 33-1 Senate)	$75/$10	2.5 oz usable; 12 plants	Yes
20. Vermont	2004	Senate Bill 76 (22-7) HB 645 (82-59)	$50	2 oz usable; 9 plants (2 mature, 7 immature)	No
21. Washington	1998	Initiative 692 (59%)	**	24 oz usable; 15 plants	No

Notes:

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a. **Residency Requirement** - 18 of the 20 states require proof of residency to be considered a qualifying patient for medical marijuana use. Only Oregon has announced that it will accept out-of-state applications. The Illinois law does not appear to have a residency requirement, but it is unknown whether the program rules will address this matter.

b. **Home Cultivation** - Karen O'Keefe, JD, Director of State Policies for Marijuana Policy Project (MPP), told ProCon.org in a August 5, 2013 email that "Some or all patients and/or their caregivers can cultivate in 15 of the 20 states. Home cultivation is not allowed in Connecticut, Delaware, Illinois, New Hampshire, New Jersey, or the District of Columbia and a special license is required in New Mexico. In Arizona, patients can only cultivate if they lived 25 miles or more from a dispensary when they applied for their card. In Massachusetts, patients can only cultivate if they have a hardship waiver. In Nevada, patients can cultivate if they live more than 25 miles from a dispensary, if they are not able to reasonably travel to a dispensary, or if no dispensaries in the patients' counties are able to supply the strains they need. In addition, Nevada patients who were growing by July 1, 2013 may continue grow until March 31, 2016."

c. **Patient Registration** - Karen O'Keefe stated the following in an Aug. 5, 2013 email to ProCon.org:

> "Affirmative defenses, which protect from conviction but not arrest, are or may be available in several states even if the patient doesn't have an ID card: Rhode Island, Michigan, Colorado, Nevada, Oregon, and, in some circumstances, Delaware. Hawaii also has a separate 'choice of evils' defense. Patient ID cards are voluntary in Maine and California, but in California they offer the strongest legal protection. In Delaware, the defense is only available between when a patient submits a valid application and receives their ID card.
>
> The states with no protection unless you're registered are: Alaska (except for that even non-medical use is protected in one's home due to the state constitutional right to privacy), Arizona, Connecticut, Montana, New Hampshire, Vermont, New Mexico, and New Jersey. Washington, D.C. also requires registration."

d. **Maryland** - Maryland passed two laws that, although favorable to medical marijuana, do not legalize its use. Senate Bill 502 (72 KB), the "Darrell Putman Bill" (Resolution #0756-2003) was approved in the state senate by a vote of 29-17, signed into law by Gov. Robert L. Ehrlich, Jr. on May 22, 2003, and took effect on Oct. 1, 2003. The law allows defendants being prosecuted for the use or possession of marijuana to introduce evidence of medical necessity and physician approval, to be considered by the court as a mitigating factor. If the court finds that the case involves medical necessity, the maximum penalty is a fine not exceeding $100. The law does not protect users of medical marijuana from arrest nor does it establish a registry program.

On May 10, 2011, Maryland Governor Martin O'Malley signed SB 308 (500 KB), into law. SB 308 removed criminal penalties for medical marijuana patients who meet the specified conditions, but patients are still subject to arrest. The bill provides an affirmative defense for defendants who have been diagnosed with a debilitating medical condition that is "severe and resistant to conventional medicine." The affirmative defense does not apply to defendants who used medical marijuana in public or who were in possession of more than one ounce of marijuana. The bill also created a Work Group to "develop a model program to facilitate patient access to marijuana for medical purposes."

Maryland passed two medical marijuana-related laws in 2013. HB 180 (150 KB), signed into law by Governor O'Malley on Apr. 9, 2013, provides an affirmative defense to a prosecution for caregivers of medical marijuana patients. HB 1101 (200 KB), signed into law by Governor O'Malley on May 2, 2013, allows for the investigational use of marijuana for medical purposes by "academic medical centers." The University of Maryland Medical System and Johns Hopkins University indicated they would not participate (230 KB).

e. Several states with legal medical marijuana received letters from their respective United States Attorney's offices (2 MB) explaining that marijuana is a Schedule I substance and that the federal government considers growing, distribution, or possession of marijuana to be a federal crime regardless of the state laws. An Aug. 29, 2013 (525 KB) Department of Justice memo clarified the government's prosecutorial priorities and stated that the federal government would rely on state and local law enforcement to "address marijuana activity through enforcement of their own narcotics laws."

f. Between Mar. 27, 1979 and July 23, 1991, five US states enacted laws that legalized medical marijuana with a physician's prescription, however, those laws are considered symbolic because federal law prohibits physicians from "prescribing" marijuana, a schedule I drug.

The five states were Virginia (25 KB) (Mar. 27, 1979), New Hampshire (Apr. 23, 1981), Connecticut (July 1, 1981), Wisconsin (Apr. 20, 1988), and Louisiana (July 23, 1991).

II. Details by State: 20 states and DC that have enacted laws to legalize medical marijuana

State and Relevant Medical Marijuana Laws	Contact and Program Details
1. Alaska Ballot Measure 8 (100 KB) -- Approved Nov. 3, 1998 by 58% of voters **Effective:** Mar. 4, 1999 Removed state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess written documentation from their physician advising that they "might benefit from the medical use of marijuana." **Approved Conditions:** Cachexia, cancer, chronic pain, epilepsy and other disorders characterized by seizures, glaucoma, HIV or AIDS, multiple sclerosis and other disorders characterized by muscle spasticity, and nausea. Other conditions are subject to approval by the Alaska Department of Health and Social Services. **Possession/Cultivation:** Patients (or their primary caregivers) may legally possess no more than one ounce of usable marijuana, and may cultivate no more than six	**Alaska Bureau of Vital Statistics** Marijuana Registry P.O. Box 110699 Juneau, AK 99811-0699 Phone: 907-465-5423 BVSSpecialServices@health.state.ak.us AK Marijuana Registry Online **Information provided by the state on sources for medical marijuana:** None found **Patient Registry Fee:** $25 new application/$20 renewal

more than one ounce of usable marijuana, and may cultivate no more than six marijuana plants, of which no more than three may be mature. The law establishes a confidential state-run patient registry that issues identification cards to qualifying patients.

Amended: Senate Bill 94
Effective: June 2, 1999
Mandates all patients seeking legal protection under this act to enroll in the state patient registry and possess a valid identification card. Patients not enrolled in the registry will no longer be able to argue the "affirmative defense of medical necessity" if they are arrested on marijuana charges.

Update: Alaska Statute Title 17 Chapter 37 (36 KB)

Creates a confidential statewide registry of medical marijuana patients and caregivers and establishes identification card.

Accepts other states' registry ID cards?
1: Unknown [Editor's Note: Four phone calls made Jan. 5-8, 2010 and an email sent on Jan. 6, 2010 by ProCon.org to the Alaska Marijuana Registry have not yet been returned and the information is not available on the state's website (as of Jan. 11, 2010).]

Registration:
Mandatory

2. Arizona

Ballot Proposition 203 (300 KB) "Arizona Medical Marijuana Act" -- Approved Nov. 2, 2010 by 50.13% of voters

Allows registered qualifying patients (who must have a physician's written certification that they have been diagnosed with a debilitating condition and that they would likely receive benefit from marijuana) to obtain marijuana from a registered nonprofit dispensary, and to possess and use medical marijuana to treat the condition.

Requires the Arizona Department of Health Services to establish a registration and renewal application system for patients and nonprofit dispensaries. Requires a web-based verification system for law enforcement and dispensaries to verify registry identification cards. Allows certification of a number of dispensaries not to exceed 10% of the number of pharmacies in the state (which would cap the number of dispensaries around 124).

Specifies that a registered patient's use of medical marijuana is to be considered equivalent to the use of any other medication under the direction of a physician and does not disqualify a patient from medical care, including organ transplants.

Specifies that employers may not discriminate against registered patients unless that employer would lose money or licensing under federal law. Employers also may not penalize registered patients solely for testing positive for marijuana in drug tests, although the law does not authorize patients to use, possess, or be impaired by marijuana on the employment premises or during the hours of employment.

Approved Conditions: Cancer, glaucoma, HIV/AIDS, Hepatitis C, ALS, Crohn's disease, Alzheimer's disease, cachexia or wasting syndrome, severe and chronic pain, severe nausea, seizures (including epilepsy), severe or persistent muscle spasms (including multiple sclerosis).

Possession/Cultivation: Qualified patients or their registered designated caregivers may obtain up to 2.5 ounces of marijuana in a 14-day period from a registered nonprofit medical marijuana dispensary. 2: If the patient lives more than 25 miles from the nearest dispensary, the patient or caregiver may cultivate up to 12 marijuana plants in an enclosed, locked facility.

Amended: Senate Bill 1443 (20 KB)
Effective: Signed by Governor Jan Brewer on May 7, 2013
"Specifies the prohibition to possess or use marijuana on a postsecondary educational institution campus does not apply to medical research projects involving marijuana that are conducted on the campus, as authorized by applicable federal approvals and on approval of the applicable university institutional review board."

[Editor's Note: On Apr. 11, 2012, the Arizona Department of Health Services (ADHS) announced the revised rules (1.1 MB) for regulating medical marijuana and set the application dates for May 14 through May 25.

On Nov. 15, 2012, the first dispensary was awarded "approval to operate." ADHS Director Will Humble stated on his blog that, "[W]e'll be declining new 'requests to cultivate' among new cardholders in most of the metro area... because self-grow (12 plants) is only allowed when the patient lives more than 25 miles from the nearest dispensary. The vast majority of the Valley is within 25 miles of this new dispensary."

On Dec. 6, 2012, the state's first dispensary, Arizona Organix, opened in Glendale.]

Arizona Department of Health Services (ADHS)
Medical Marijuana Program
150 North 18th Avenue
Phoenix, Arizona 85007
Phone: 602-542-1023

Prop 203 Information Hub

Information provided by the state on sources for medical marijuana:
"Qualifying patients can obtain medical marijuana from a dispensary, the qualifying patient's designated caregiver, another qualifying patient, or, if authorized to cultivate, from home cultivation. When a qualifying patient obtains or renews a registry identification card, the Department will provide a list of all operating dispensaries to the qualifying patient."
ADHS, "Qualifying Patients FAQs," (150 KB) Mar. 25, 2010

Patient Registry Fee:
$150 / $75 for Supplemental Nutrition Assistance Program participants

Accepts other states' registry ID cards?
3: Yes, but does not permit visiting patients to obtain marijuana from an Arizona dispensary

Registration:
Mandatory

3. California

Ballot Proposition 215 (45 KB) -- Approved Nov. 5, 1996 by 56% of voters
Effective: Nov. 6, 1996

Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess a "written or oral recommendation" from their physician that he or she "would benefit from medical marijuana." Patients diagnosed

California Department of Public Health
Office of County Health Services
Attention: Medical Marijuana Program Unit
MS 5203
P.O. Box 997377
Sacramento, CA 95899-7377

with any debilitating illness where the medical use of marijuana has been "deemed appropriate and has been recommended by a physician" are afforded legal protection under this act.

Approved Conditions: AIDS, anorexia, arthritis, cachexia, cancer, chronic pain, glaucoma, migraine, persistent muscle spasms, including spasms associated with multiple sclerosis, seizures, including seizures associated with epilepsy, severe nausea; Other chronic or persistent medical symptoms.

Amended: Senate Bill 420 (70 KB)
Effective: Jan. 1, 2004

Imposes statewide guidelines outlining how much medicinal marijuana patients may grow and possess.

Possession/Cultivation: Qualified patients and their primary caregivers may possess no more than eight ounces of dried marijuana and/or six mature (or 12 immature) marijuana plants. However, S.B. 420 allows patients to possess larger amounts of marijuana when recommended by a physician. The legislation also allows counties and municipalities to approve and/or maintain local ordinances permitting patients to possess larger quantities of medicinal pot than allowed under the new state guidelines.

S.B. 420 also grants implied legal protection to the state's medicinal marijuana dispensaries, stating, "Qualified patients, persons with valid identification cards, and the designated primary caregivers of qualified patients ... who associate within the state of California in order collectively or cooperatively to cultivate marijuana for medical purposes, shall not solely on the basis of that fact be subject to state criminal sanctions."

4: [Editor's Note: On Jan. 21, 2010, the California Supreme Court affirmed (S164830 (300 KB)) the May 22, 2008 Second District Court of Appeals ruling (50 KB) in the Kelly Case that the possession limits set by SB 420 violate the California constitution because the voter-approved Prop. 215 can only be amended by the voters.

ProCon.org contacted the California Medical Marijuana Program (MMP) on Dec. 6, 2010 to ask 1) how the ruling affected the implementation of the program, and 2) what instructions are given to patients regarding possession limits. A California Department of Public Health (CDPH) Office of Public Affairs representative wrote the following in a

Dec. 7, 2010 email to ProCon.org: "The role of MMP under Senate Bill 420 is to implement the State Medical Marijuana ID Card Program in all California counties. CDPH does not oversee the amounts that a patient may possess or grow. When asked what a patient can possess, patients are referred to www.courtinfo.ca.gov, case S164830 which is the Kelly case, changing the amounts a patient can possess from 8 oz, 6 mature plants or 12 immature plants to 'the amount needed for a patient's personal use.' MMP can only cite what the law says."

According to a Jan. 21, 2010 article titled "California Supreme Court Further Clarifies Medical Marijuana Laws," by Aaron Smith, California Policy Director at the Marijuana Policy Project, the impact of the ruling is that people growing more than 6 mature or 12 immature plants are still subject to arrest and prosecution, but they will be allowed to use a medical necessity defense in court.]

Attorney General's Guidelines:
On Aug. 25, 2008, California Attorney General Jerry Brown issued guidelines for law enforcement and medical marijuana patients to clarify the state's laws. Read more about the guidelines here.

Phone: 916-552-8600
Fax: 916-440-5591

mmpinfo@dhs.ca.gov

CA Medical Marijuana Program

Guidelines for the Security and Non-diversion of Marijuana Grown for Medical Use (55 KB)

Information provided by the state on sources for medical marijuana:
"Dispensaries, growing collectives, etc., are licensed through local city or county business ordinances and the regulatory authority lies with the State Attorney General's Office. Their number is 1-800-952-5225." (accessed Jan. 11, 2010)

Patient Registry Fee:
$66 non Medi-Cal / $33 Medi-Cal, plus additional county fees (varies by location)

Accepts other states' registry ID cards?
No

Registration:
Voluntary

4. Colorado

Ballot Amendment 20 – Approved Nov. 7, 2000 by 54% of voters
Effective: June 1, 2001

Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess written documentation from their physician affirming that he or she suffers from a debilitating condition and advising that they "might benefit from the medical use of marijuana." (Patients must possess this documentation prior to an arrest.)

Approved Conditions: Cancer, glaucoma, HIV/AIDS positive, cachexia; severe pain; severe nausea; seizures, including those that are characteristic of epilepsy; or persistent muscle spasms, including those that are characteristic of multiple sclerosis. Other conditions are subject to approval by the Colorado Board of Health.

Possession/Cultivation: A patient or a primary caregiver who has been issued a Medical Marijuana Registry identification card may possess no more than two ounces of a usable form of marijuana and not more than six marijuana plants, with three or fewer being mature, flowering plants that are producing a usable form of marijuana.

Patients who do not join the registry or possess greater amounts of marijuana than allowed by law may argue the "affirmative defense of medical necessity" if they are arrested on marijuana charges.

Medical Marijuana Registry
Colorado Department of Public Health and Environment
HSVR-ADM2-A1
4300 Cherry Creek Drive South
Denver, CO 80246-1530
Phone: 303-692-2184

medical.marijuana@state.co.us

CO Medical Marijuana Registry

Information provided by the state on sources for medical marijuana:
"The Colorado Medical Marijuana amendment, statutes and regulations are silent on the issue of dispensaries. While the Registry is aware that a number of such businesses have been established across the state, we do not have a formal relationship with them." (accessed Jan. 11, 2010)

Patient Registry Fee:
$35

Amended: House Bill 1284 (236 KB) and Senate Bill 109 (50 KB) **Effective:** June 7, 2010 Colorado Governor Bill Ritter signed the bills into law and stated the following in a June 7, 2010 press release: "House Bill 1284 provides a regulatory framework for dispensaries, including giving local communities the ability to ban or place sensible and much-needed controls on the operation, location and ownership of these establishments. Senate Bill 109 will help prevent fraud and abuse, ensuring that physicians who authorize medical marijuana for their patients actually perform a physical exam, do not have a DEA flag on their medical license and do not have a financial relationship with a dispensary."	**Accepts other states' registry ID cards?** No **Registration:** Mandatory
5. **Connecticut** HB 5389 (310 KB) -- Signed into law by Gov. Dannel P. Malloy (D) on May 31, 2012 **Approved:** By House 96-51, by Senate 21-13 **Effective:** Some sections from passage (May 4, 2012), other sections on Oct. 1, 2012 "A qualifying patient shall register with the Department of Consumer Protection... prior to engaging in the palliative use of marijuana. A qualifying patient who has a valid registration certificate... shall not be subject to arrest or prosecution, penalized in any manner,... or denied any right or privilege." Patients must be Connecticut residents at least 18 years of age. "Prison inmates, or others under the supervision of the Department of Corrections, would not qualify, regardless of their medical condition." **Approved Conditions:** "Cancer, glaucoma, positive status for human immunodeficiency virus or acquired immune deficiency syndrome [HIV/AIDS], Parkinson's disease, multiple sclerosis, damage to the nervous tissue of the spinal cord with objective neurological indication of intractable spasticity, epilepsy, cachexia, wasting syndrome, Crohn's disease, posttraumatic stress disorder, or... any medical condition, medical treatment or disease approved by the Department of Consumer Protection..." **Possession/Cultivation:** Qualifying patients may possess "an amount of usable marijuana reasonably necessary to ensure uninterrupted availability for a period of one month, as determined by the Department of Consumer Protection." The Connecticut Medical Marijuana Program website posted an update on Sep. 23, 2012 with instructions on how to register for the program starting on Oct. 1, 2012. "Patients who are currently receiving medical treatment for a debilitating medical conditions set out in the law may qualify for a temporary registration certificate beginning October 1, 2012. To qualify, a patient must also be at least 18 years of age and a Connecticut resident." Draft Regulations on Medical Marijuana (482 KB) were posted on Jan. 16, 2013.	**Medical Marijuana Program** Department of Consumer Protection (DCP) 165 Capitol Avenue Hartford, CT 06106 Phone: 860-713-6006 Toll-Free: 800-842-2649 dcp.mmp@ct.gov The DCP will "issue temporary patient registration certificates starting on October 1, 2012." CT Medical Marijuana Program **Information provided by the state on sources for medical marijuana:** "The Commissioner of Consumer Protection shall determine the number of dispensaries appropriate to meet the needs of qualifying patients in this state." **Patient Registry Fee:** *The Commissioner of Consumer Protection will establish a "reasonable fee." **Accepts other states' registry ID cards?** No **Registration:** Mandatory
6. **District of Columbia (DC)** Amendment Act B18-622 (80KB) "Legalization of Marijuana for Medical Treatment Amendment Act of 2010" – Approved 13-0 by the Council of the District of Columbia on May 4, 2010; signed by the Mayor on May 21, 2010| **Effective:** July 27, 2010 [After being signed by the Mayor, the law underwent a 30-day Congessional review period. Neither the Senate nor the House acted to stop the law, so it became effective when the review period ended.] **Approved Conditions:** HIV, AIDS, glaucoma, multiple sclerosis, cancer, other conditions that are chronic, long-lasting, debilitating, or that interfere with the basic functions of life, serious medical conditions for which the use of medical marijuana is beneficial, patients undergoing treatments such as chemotherapy and radiotherapy. **Possession/Cultivation:** The maximum amount of medical marijuana that any qualifying patient or caregiver may possess at any moment is two ounces of dried medical marijuana. The Mayor may increase the quantity of dried medical marijuana that may be possessed up to four ounces; and shall decide limits on medical marijuana of a form other than dried. On Apr. 14, 2011, Mayor Vincent C. Gray announced the adoption of an emergency amendment (450 KB) to title 22 of the District of Columbia Municipal Regulations (DCMR), which added a new subtitle C entitled "Medical Marijuana." The emergency amendment "will set forth the process and procedure" for patients, caregivers, physicians, and dispensaries, and "implement the provisions of the Act that must be addressed at the onset to enable the Department to administer the program." The final rulemaking (800 KB) was posted online on Jan. 3, 2012. On Feb. 14, 2012, the DC Department of Health's Health Regulation and Licensing Administration posted a revised timeline for the dispensary application process (180	**Medical Marijuana Program** Health Regulation and Licensing Administration 899 N. Capitol Street, NE 2nd Floor Washington, DC 20002 Phone: 202-442-5955 doh.mmp@dc.gov The law establishes a medical marijuana program to "regulate the manufacture, cultivation, distribution, dispensing, purchase, delivery, sale, possession, and administration of medical marijuana and the manufacture, possession, purchase, sale, and use of paraphernalia. The Program shall be administered by the Mayor." **Patient Registry** Fee: $100 initial or renewal fee /$25 for low income patients **Accepts other states' registry ID cards?** No **Registration:** Mandatory

KB), which listed June 8, 2012 as the date by which the Department intends to announce dispensary applicants available for registration.

The first dispensary, Capital City Care, was licensed in Apr. 2013.

7. Delaware

Senate Bill 17 (100 KB) – Signed into law by Gov. Jack Markell (D) on May 13, 2011
Approved: By House 27-14, by Senate 17-4
Effective: July 1, 2011

Under this law, a patient is only protected from arrest if his or her physician certifies, in writing, that the patient has a specified debilitating medical condition and that the patient would receive therapeutic benefit from medical marijuana. The patient must send a copy of the written certification to the state Department of Health and Social Services, and the Department will issue an ID card after verifying the information. As long as the patient is in compliance with the law, there will be no arrest.

The law does not allow patients or caregivers to grow marijuana at home, but it does allow for the state-regulated, non-profit distribution of medical marijuana by compassion centers.

Approved Conditions: Approved for treatment of debilitating medical conditions, defined as cancer, HIV/AIDS, decompensated cirrhosis, ALS, Alzheimer's disease, post-traumatic stress disorder; or a medical condition that produces wasting syndrome, severe debilitating pain that has not responded to other treatments for more than three months or for which other treatments produced serious side effects, severe nausea, seizures, or severe and persistent muscle spasms.

Possession/Cultivation: Patients 18 and older with certain debilitating conditions may possess up to six ounces of marijuana with a doctor's written recommendation. A registered compassion center may not dispense more than 3 ounces of marijuana to a registered qualifying patient in any fourteen-day period, and a patient may register with only one compassion center. Home cultivation is not allowed. Senate Bill 17 contains a provision that allows for an affirmative defense for individuals "in possession of no more than six ounces of usable marijuana."

On Feb. 12, 2012, Gov. Markell released the following statement (presented in its entirety), available on delaware.gov, in response to a letter from US District Attorney Charles Oberly (2 MB):

"I am very disappointed by the change in policy at the federal department of justice, as it requires us to stop implementation of the compassion centers. To do otherwise would put our state employees in legal jeopardy and I will not do that. Unfortunately,

this shift in the federal position will stand in the way of people in pain receiving help. Our law sought to provide that in a manner that was both highly regulated and safe."

On Aug. 15, 2013, Gov. Markell announced in a letter to Delaware lawmakers (175 KB) his intention to relaunch the state's medical marijuana program, despite his previous decision to stop implementation. Markell wrote that the Department of Health and Social Services "will proceed to issue a request for proposal for a pilot compassion center to open in Delaware next year."

Delaware Department of Health and Social Services
Division of Public Health
Phone: 302-744-4749
Fax: 302-739-3071

MedicalMarijuanaDPH@state.de.us

DE Medical Marijuana Program

Information provided by the state on sources for medical marijuana:
The Delaware Medical Marijuana Program website states (as of Aug. 5, 2013), "The creation of the state-licensed, privately owned compassion centers has been suspended by the state. Based on guidance from the US Attorney, the compassion centers concept conflicts with federal law. As a result there is no plan to open compassion centers at this time." On Aug. 15, 2013, Gov. Markell announced that he will seek approval to open one compassion center in 2014.

Patient Registry Fee:
$125 (a sliding scale fee is available based on income)

Accepts other states' registry ID cards?
5: Yes (a visiting qualifying patient is not subject to arrest if a visitor ID card is obtained)

Registration:
Mandatory

8. Hawaii

Senate Bill 862 (40 KB) – Signed into law by Gov. Ben Cayetano on June 14, 2000
Approved: By House 32-18, by Senate 13-12
Effective: Dec. 28, 2000

Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess a signed statement from their physician affirming that he or she suffers from a debilitating condition and that the "potential benefits of medical use of marijuana would likely outweigh the health risks." The law establishes a mandatory, confidential state-run patient registry that issues identification cards to qualifying patients.

Approved conditions: Cancer, glaucoma, positive status for HIV/AIDS; A chronic or debilitating disease or medical condition or its treatment that produces cachexia or wasting syndrome, severe pain, severe nausea, seizures, including those characteristic of epilepsy, or severe and persistent muscle spasms, including those characteristic of multiple sclerosis or Crohn's disease. Other conditions are subject to approval by the Hawaii Department of Health.

Possession/Cultivation: The amount of marijuana that may be possessed jointly between the qualifying patient and the primary caregiver is an "adequate supply," which shall not exceed three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant.

Amended: HB 668 (240 KB)
Effective: June 25, 2013

Establishes a medical marijuana registry special fund to pay for the program and

Department of Public Safety
Narcotics Enforcement Division
3375 Koapaka Street, Suite D-100
Honolulu, HI 96819
Phone: 808-837-8470
Fax: 808-837-8474

HI Medical Marijuana Application info

Information provided by the state on sources for medical marijuana:
"Hawaii law does not authorize any person or entity to sell or dispense marijuana... Hawaii law authorizes the medical use of marijuana, it does not authorize the distribution of marijuana (Dispensaries) other than the transfer from a qualifying patient's primary caregiver to the qualifying patient." (accessed Jan. 11, 2010)

Patient Registry Fee:
$25

Accepts other states' registry ID cards?
No

Registration:

transfers the medical marijuana program from the Department of Public Safety to the Department of Public Health by no later than Jan. 1, 2015. **Amended:** SB 642 (95 KB) **Effective:** Jan. 2, 2015 Redefines "adequate supply" as seven marijuana plants, whether immature or mature, and four ounces of usable marijuana at any given time; stipulates that physician recommendations will have to be made by the qualifying patient's primary care physician.	Mandatory
9. Illinois House Bill 1 (385 KB) **Approved:** Apr. 17, 2013 by House, 61-57 and May 17, 2013 by Senate, 35-21 Signed into law by Gov. Pat Quinn on Aug. 1, 2013 **Effective:** Jan. 1, 2014 The Compassionate Use of Medical Cannabis Pilot Program Act establishes a patient registry program, protects registered qualifying patients and registered designated caregivers from "arrest, prosecution, or denial of any right or privilege," and allows for the registration of cultivation centers and dispensing organizations. Once the act goes into effect, "a tax is imposed upon the privilege of cultivating medical cannabis at a rate of 7% of the sales price per ounce." **Approved Conditions:** Cancer, glaucoma, positive status for HIV, AIDS, hepatitis C, ALS, muscular dystrophy, Crohn's disease, agitation of Alzheimer's disease, multiple sclerosis, chronic pancreatitis, spinal cord injury or disease, traumatic brain injury, or "one or more injuries that significantly interferes with daily activities as documented by the patient's provider; and a severely debilitating or terminal medical condition or its treatment that has produced at least one of the following: elevated intraocular pressure, cachexia, chemotherapy induced anorexia, wasting syndrome, severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects, constant or severe nausea, moderate to severe vomiting, seizures, or severe, persistent muscle spasms." **Possession/Cultivation:** "Adequate supply" is defined as "2.5 ounces of usable cannabis during a period of 14 days and that is derived solely from an intrastate source." The law does not allow patients or caregivers to cultivate cannabis. Governor Pat Quinn's Aug. 1, 2013 signing statement (25 KB) explains key points of the law and notes that it is a four-year pilot program.	**Medical Marijuana Program** Illinois Department of Public Health http://www.idph.state.il.us/ **Information provided by the state on sources for medical marijuana:** Cultivation centers and dispensing organizations will be registered by the Department of Agriculture and Department of Financial and Professional Regulation, respectively. **Patient Registry Fee:** *To be determined during the rulemaking process* **Accepts other states' registry ID cards?** No **Registration:** Mandatory
10. Maine Ballot Question 2 – Approved Nov. 2, 1999 by 61% of voters **Effective:** Dec. 22, 1999 Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess an oral or written "professional opinion" from their physician that he or she "might benefit from the medical use of marijuana." The law does not establish a state-run patient registry. **Approved diagnosis:** epilepsy and other disorders characterized by seizures; glaucoma; multiple sclerosis and other disorders characterized by muscle spasticity; and nausea or vomiting as a result of AIDS or cancer chemotherapy. **Possession/Cultivation:** Patients (or their primary caregivers) may legally possess no more than one and one-quarter (1.25) ounces of usable marijuana, and may cultivate no more than six marijuana plants, of which no more than three may be mature. Those patients who possess greater amounts of marijuana than allowed by law are afforded a "simple defense" to a charge of marijuana possession. **Amended:** Senate Bill 611 **Effective:** Signed into law on Apr. 2, 2002 Increases the amount of useable marijuana a person may possess from one and one-quarter (1.25) ounces to two and one-half (2.5) ounces. **Amended:** Question 5 (135 KB) – Approved Nov. 3, 2009 by 59% of voters List of approved conditions changed to include cancer, glaucoma, HIV, acquired immune deficiency syndrome, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, Alzheimer's, nail-patella syndrome, chronic intractable pain, cachexia or wasting syndrome, severe nausea, seizures (epilepsy), severe and persistent muscle spasms, and multiple sclerosis. Instructs the Department of Health and Human Services (DHHS) to establish a registry identification program for patients and caregivers. Stipulates provisions for the operation of nonprofit dispensaries.	**Department of Health and Human Services** Division of Licensing and Regulatory Services John Thiele, Program Manager 11 State House Station Augusta, ME 04333 207-287-9300 Maine Medical Marijuana Program **Information provided by the state on sources for medical marijuana:** "The patient may either cultivate or designate a caregiver or dispensary to cultivate marijuana." ("Program Bulletin," Maine.gov, Sep. 28, 2011) **Patient Registry Fee:** $0 Caregivers pay $300/patient (limit of 5 patients; if not growing marijuana, there is no fee) **Accepts other states' registry ID cards?** Yes 6: "Law enforcement will accept appropriate authorization from a participating state, but that patient cannot purchase marijuana in Maine without registering here. That requires a Maine physician and a Maine driver license or other picture ID issued by the state of Maine. The letter from a physician in another state is only good for 30 days." (Aug. 19, 2010 email from Maine's Division of Licensing and Regulatory Services)

[Editor's Note: An Aug. 19, 2010 email to ProCon.org from Catherine M. Cobb, Director of Maine's Division of Licensing and Regulatory Services, stated:

"We have just set up our interface to do background checks on caregivers and those who are associated with dispensaries. They may not have a disqualifying drug offense."]

Amended: LD 1062 (25 KB)
Effective: Enacted without the governor's signature on June 26, 2013

Adds post-traumatic stress disorder (PTSD) to the list of approved conditions for medical marijuana use.

Registration:
Voluntary
"In addition to either a registry ID card or a physician certification form, all patients, including both non-registered and voluntarily registered patients, must also present their Maine driver license or other Maine-issued photo identification card to law enforcement, upon request." ("Program Bulletin," Maine.gov, Sep. 28, 2011)

11. Massachusetts

Ballot Question 3 – Approved Nov. 6, 2012 by 63% of voters
Effective: Jan. 1, 2013

"The citizens of Massachusetts intend that there should be no punishment under state law for qualifying patients, physicians and health care professionals, personal caregivers for patients, or medical marijuana treatment center agents for the medical use of marijuana...

In the first year after the effective date, the Department shall issue registrations for up to thirty-five non-profit medical marijuana treatment centers, provided that at least one treatment center shall be located in each county, and not more than five shall be located in any one county."

Approved diagnosis: "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."

Possession/Cultivation: Patients may possess "no more marijuana than is necessary for the patient's personal, medical use, not exceeding the amount necessary for a sixty-day supply...

Within 120 days of the effective date of this law, the department shall issue regulations defining the quantity of marijuana that could reasonably be presumed to be a sixty-day supply for qualifying patients, based on the best available evidence."

"The Department shall issue a cultivation registration to a qualifying patient whose access to a medical treatment center is limited by verified financial hardship, a physical incapacity to access reasonable transportation, or the lack of a treatment center within a reasonable distance of the patient's residence. The Department may deny a registration based on the provision of false information by the applicant. Such registration shall allow the patient or the patient's personal caregiver to cultivate a limited number of plants, sufficient to maintain a 60-day supply of marijuana, and shall require cultivation and storage only in an enclosed, locked facility.
The department shall issue regulations consistent with this section within 120 days of the effective date of this law. Until the department issues such final regulations, the written recommendation of a qualifying patient's physician shall constitute a limited cultivation registration."

Department of Public Health of the Commonwealth of Massachusetts
One Ashburton Place
11th Floor
Boston, MA 02108
617-573-1600

www.mass.gov/medicalmarijuana

Information provided by the state on sources for medical marijuana:
The state will issue registrations for up to 35 nonprofit medical marijuana treatment centers

Patient Registry Fee:
[7]:To be determined by DPH within 120 days of the effective date of Jan. 1, 2013.

Accepts other states' registry ID cards?
Unknown

Registration:
Mandatory
"Until the approval of final regulations, written certification by a physician shall constitute a registration card for a qualifying patient."

12. Michigan

Proposal 1 (60 KB) "Michigan Medical Marihuana Act" -- Approved by 63% of voters on Nov. 4, 2008
Approved: Nov. 4, 2008
Effective: Dec. 4, 2008

Approved Conditions: Approved for treatment of debilitating medical conditions, defined as cancer, glaucoma, HIV, AIDS, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, agitation of Alzheimer's disease, nail patella, cachexia or wasting syndrome, severe and chronic pain, severe nausea, seizures, epilepsy, muscle spasms, and multiple sclerosis.

Possession/Cultivation: Patients may possess up to two and one-half (2.5) ounces of usable marijuana and twelve marijuana plants kept in an enclosed, locked facility. The twelve plants may be kept by the patient only if he or she has not specified a primary caregiver to cultivate the marijuana for him or her.

Amended: HB 4856 (40 KB)
Effective: Dec. 31, 2012

Makes it illegal to "transport or possess" usable marijuana by car unless the

Michigan Medical Marihuana Program
Bureau of Health Professions,
Department of Licensing and Regulatory Affairs
P.O. Box 30083
Lansing, MI 48909
Phone: 517-373-0395

BHP-MMMPINFO@michigan.gov

MI Medical Marihuana Program

Information provided by the state on sources for medical marijuana:
"The MMMP is not a resource for the growing process and does not have information to give to patients." (accessed Jan. 7, 2013)

Patient Registry Fee:
$100 new or renewal application / $25 Medicaid patients

marijuana is "enclosed in a case that is carried in the trunk of the vehicle." Violation of the law is a misdemeanor "punishable by imprisonment for not more than 93 days or a fine of not more than $500.00, or both."

Amended: HB 4834 (40 KB)
Effective: Apr. 1, 2013

Requires proof of Michigan residency when applying for a registry ID card (driver license, official state ID, or valid voter registration) and makes cards valid for two years instead of one.

Amended: HB 4851 (40 KB)
Effective: Apr. 1, 2013

Requires a "bona fide physician-patient relationship," defined in part as one in which the physician "has created and maintained records of the patient's condition in accord with medically accepted standards" and "will provide follow-up care;" protects patient from arrest only with registry identification card and valid photo ID.

Amended: State of Michigan vs. McQueen (90 KB)
Decided: Feb. 8, 2013

The Michigan Supreme Court ruled 4-1 that dispensaries are illegal. As a result, medical marijuana patients in Michigan will have to grow their own marijuana or get it from a designated caregiver who is limited to five patients.

Accepts other states' registry ID cards?
Yes

Registration:
Mandatory

13. Montana

Initiative 148 (76 KB) -- Approved by 62% of voters on Nov. 2, 2004
Effective: Nov. 2, 2004

Approved Conditions: Cancer, glaucoma, or positive status for HIV/AIDS, or the treatment of these conditions; a chronic or debilitating disease or medical condition or its treatment that produces cachexia or wasting syndrome, severe or chronic pain, severe nausea, seizures, including seizures caused by epilepsy, or severe or persistent muscle spasms, including spasms caused by multiple sclerosis or Chrohn's disease; or any other medical condition or treatment for a medical condition adopted by the department by rule.

Possession/Cultivation: A qualifying patient and a qualifying patient's caregiver may each possess six marijuana plants and one ounce of usable marijuana. "Usable marijuana" means the dried leaves and flowers of marijuana and any mixture or preparation of marijuana.

Amended: SB 423 (100 KB) -- Passed on Apr. 28, 2011 and transmitted to the Governor on May 3, 2011
Effective: July 1, 2011

SB 423 changes the application process to require a Montana driver's license or state issued ID card. A second physician is required to confirm a chronic pain diagnosis.

"A provider or marijuana-infused products provider may assist a maximum of three registered cardholders..." and "may not accept anything of value, including monetary remuneration, for any services or products provided to a registered cardholder."

Approved Conditions: Cancer, glaucoma, or positive status for HIV/AIDS when the condition or disease results in symptoms that seriously and adversely affect the patient's health status; Cachexia or wasting syndrome; Severe, chronic pain that is persistent pain of severe intensity that significantly interferes with daily activities as documented by the patient's treating physician; Intractable nausea or vomiting; Epilepsy or intractable seizure disorder; Multiple sclerosis; Chron's Disease; Painful peripheral neuropathy; A central nervous system disorder resulting in chronic, painful spasticity or muscle spasms; Admittance into hospice care.

Possession/Cultivation: Amended to 12 seedlings (less than 12"), four mature flowering plants, and one ounce of usable marijuana.

On Nov. 6, 2012, Montana voters approved initiative referendum No. 124 by a vote of 56.5% to 43.5%, upholding SB 423.

Medical Marijuana Program
Montana Department of Health and Human Services
Licensure Bureau
2401 Colonial Drive, 2nd Floor
P.O. Box 202953
Helena, MT 59620-2953
Phone: 406-444-2676

jbuska@mt.gov

MT Medical Marijuana Program

Medical Marijuana Program FAQs (35 KB)

Information provided by the state on sources for medical marijuana:
"The Medical Marijuana Act... allows a patient or caregiver to grow up to six plants or possess up to one ounce of usable marijuana. The department cannot give advice or referrals on how to obtain a supply of marijuana... State law is silent on where grow sites can be located." (accessed Jan. 11, 2010)

Patient Registry Fee:
$25 new application/$10 renewal
(reduced from $50 as of Oct. 1, 2009)

Accepts other states' registry ID cards?
No (reciprocity ended when SB 423 took effect)

Registration:
Mandatory

14. Nevada

Ballot Question 9 -- Approved Nov. 7, 2000 by 65% of voters
Effective: Oct. 1, 2001

Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who have "written documentation" from their physician that marijuana may alleviate his or her condition.

Approved Conditions: AIDS; cancer; glaucoma; and any medical condition or treatment to a medical condition that produces cachexia, persistent muscle spasms or seizures, severe nausea or pain. Other conditions are subject to approval by the

Nevada State Health Division
4150 Technology Way, Suite 104
Carson City, Nevada
Phone: 775-687-7594
Fax: 775-684-4156

NV Medical Marijuana Program

Information provided by the state on sources for medical marijuana:
"The NMMP is not a resource for the growing process and does not have information to give to patients."

health division of the state Department of Human Resources. **Possession/Cultivation:** Patients (or their primary caregivers) may legally possess no more than one ounce of usable marijuana, three mature plants, and four immature plants. **Registry:** The law establishes a confidential state-run patient registry that issues identification cards to qualifying patients. Patients who do not join the registry or possess greater amounts of marijuana than allowed by law may argue the "affirmative defense of medical necessity" if they are arrested on marijuana charges. Legislators added a preamble to the legislation stating, "[T]he state of Nevada as a sovereign state has the duty to carry out the will of the people of this state and regulate the health, medical practices and well-being of those people in a manner that respects their personal decisions concerning the relief of suffering through the medical use of marijuana." A separate provision requires the Nevada School of Medicine to "aggressively" seek federal permission to establish a state-run medical marijuana distribution program. **Amended:** Assembly Bill 453 (25 KB) **Effective:** Oct. 1, 2001 Created a state registry for patients whose physicians recommend medical marijuana and tasked the Department of Motor Vehicles with issuing identification cards. No state money will be used for the program, which will be funded entirely by donations. **Amended:** Senate Bill 374 (280 KB) Signed into law by Gov. Brian Sandoval on June 12, 2013 "Provides for the registration of medical marijuana establishments authorized to cultivate or dispense marijuana or manufacture edible marijuana products or marijuana-infused products for sale to persons authorized to engage in the medical use of marijuana... From April 1, 2014, through March 31, 2016, a nonresident purchaser must sign an affidavit attesting to the fact that he or she is entitled to engage in the medical use of marijuana in his or her state or jurisdiction of residency. On and after April 1, 2016, the requirement for such an affidavit is replaced by computer cross-checking between the State of Nevada and other jurisdictions." Patients who were growing before July 1, 2013 are allowed to continue home cultivation until March 31, 2016.	**Patient Registry Fee:** $50 application fee, plus $150 for the card (new or renewal), plus $15-42 in additional related costs [8]: SB 374 requires the fee to be reduced at least by half before Apr. 1, 2014 **Accepts other states' registry ID cards?** [9]: Yes, starting Apr. 1, 2014 with an affidavit **Registration:** Mandatory
15. New Hampshire House Bill 573 (215 KB) **Approved:** May 23, 2013 by Senate, 18-6 and June 26, 2013 by House, 284-66 Signed into law by Gov. Maggie Hassan on July 23, 2013 **Effective:** Upon passage The bill authorizes the use of therapeutic cannabis in New Hampshire, establishes a registry identification card system, allows for the registration of up to four non-profit alternative treatment centers in the state, and establishes an affirmative defense for qualified patients and designated caregivers with valid registry ID cards. HB 573 also calls for the creation of a Therapeutic Use of Cannabis Advisory Council, which in five years will be required to "issue a formal opinion on whether the program should be continued or repealed." A valid ID card from another medical marijuana state will be recognized as allowing the visiting patient to possess cannabis for therapeutic purposes, but the "visiting qualifying patient shall not cultivate or purchase cannabis in New Hampshire or obtain cannabis from alternative treatment centers..." **Approved Conditions:** Cancer, glaucoma, positive status for HIV, AIDS, hepatitis C, ALS, muscular dystrophy, Crohn's disease, agitation of Alzheimer's disease, multiple sclerosis, chronic pancreatitis, spinal cord injury or disease, traumatic brain injury, or "one or more injuries that significantly interferes with daily activities as documented by the patient's provider; and a severely debilitating or terminal medical condition or its treatment that has produced at least one of the following: elevated intraocular pressure, cachexia, chemotherapy induced anorexia, wasting syndrome, severe pain that has not responded to previously prescribed medication or surgical measures or for which other treatment options produced serious side effects, constant or severe nausea, moderate to severe vomiting, seizures, or severe, persistent muscle spasms." **Possession/Cultivation:** "A qualifying patient shall not obtain more than 2 ounces of usable cannabis directly or through the qualifying patient's designated caregiver during a 10-day period." A patient may possess two ounces of usable cannabis and any amount of unusable cannabis.	**Medical Marijuana Program** New Hampshire Department of Health and Human Services http://www.dhhs.state.nh.us **Information provided by the state on sources for medical marijuana:** HB 537 requires DHHS to register two nonprofit alternative treatment centers within 18 months of the bill's effective date, provided that at least two applicants are qualified. There can be no more than four alternative treatment centers at one time. **Patient Registry Fee:** To be determined during the rulemaking process **Accepts other states' registry ID cards?** Yes **Registration:** Mandatory
16. New Jersey Senate Bill 119 (175 KB) **Approved:** Jan. 11, 2010 by House, 48-14; by Senate, 25-13	S119 was supposed to become effective six months after it was enacted on Jan. 18, 2010, but the legislature, DHHS, and New Jersey Governor Chris Christie did

Approved: Jan. 11, 2010 by House, 46-14, by Senate, 25-15
Signed into law by Gov. Jon Corzine on Jan. 18, 2010
Effective: Six months from enactment

Protects "patients who use marijuana to alleviate suffering from debilitating medical conditions, as well as their physicians, primary caregivers, and those who are authorized to produce marijuana for medical purposes" from "arrest, prosecution, property forfeiture, and criminal and other penalties."

Also provides for the creation of alternative treatment centers, "at least two each in the northern, central, and southern regions of the state. The first two centers issued a permit in each region shall be nonprofit entities, and centers subsequently issued permits may be nonprofit or for-profit entities."

Approved Conditions: Seizure disorder, including epilepsy, intractable skeletal muscular spasticity, glaucoma; severe or chronic pain, severe nausea or vomiting, cachexia, or wasting syndrome resulting from HIV/AIDS or cancer; amyotrophic lateral sclerosis (Lou Gehrig's Disease), multiple sclerosis, terminal cancer, muscular dystrophy, or inflammatory bowel disease, including Crohn's disease; terminal illness, if the physician has determined a prognosis of less than 12 months of life or any other medical condition or its treatment that is approved by the Department of Health and Senior Services.

Possession/Cultivation: Physicians determine how much marijuana a patient needs and give written instructions to be presented to an alternative treatment center. The maximum amount for a 30-day period is two ounces.

The New Jersey Department of Health and Senior Services released draft rules (385 KB) outlining the registration and application process on Oct. 6, 2010. A public hearing to discuss the proposed rules was held on Dec. 6, 2010 at at the New Jersey Department of Health and Senior Services, according to the *New Jersey Register.*

On Dec. 20, 2011, Senator Nicholas Scutari (D), lead sponsor of the medical marijuana bill, submitted Senate Concurrent Resolution (SCR) 140 (25 KB) declaring that the "Board of Medical Examiners proposed medicinal marijuana program rules are inconsistent with legislative intent." The New Jersey Senate Health, Human Services and Senior Citizens committee held a public hearing to discuss SCR 140 and a similar bill, SCR 130, on Jan. 20, 2010.

On Feb. 3, 2011, DHSS proposed new rules (200 KB) that streamlined the permit process for cultivating and dispensing, prohibited home delivery by alternative treatment centers, and required that "conditions originally named in the Act be resistant to conventional medical therapy in order to qualify as debilitating medical conditions."

On Aug. 9, 2012, the New Jersey Medical Marijuana Program opened the patient registration system on its website. Patients must have a physician's recommendation, a government-issued ID, and proof of New Jersey residency to register. The first dispensary is expected to be licensed to open in September.

On Oct. 16, 2012, the Department of Health issued the first dispensary permit (24 KB) to Greenleaf Compassion Center, allowing it to operate as an Alternative Treatment Center and dispense marijuana. The center opened on Dec. 6, 2012, becoming New Jersey's first dispensary.

Five other treatment centers are "in various stages of finalizing locations or background examinations of the principals of their organizations."

Amended: SB 2842 (40 KB)
Signed into law by Gov. Chris Christie on Sep. 10, 2013 following legislative adoption of his conditional veto (10 KB)

Allows edible forms of marijuana only for qualifying minors, who must receive approval from a pediatrician and a psychiatrist.

not agree on the details of how the program would be run.

The **Department of Health and Senior Services (DHSS)**, the state agency in charge of the program, issued its first dispensary permit on Oct. 16, 2012.

Medicinal Marijuana Program

Information provided by the state on sources for medical marijuana:
Patients are not allowed to grow their own marijuana. On Mar. 21, 2011, the New Jersey DHHS announced the locations of six nonprofit alternative treatment centers (ATCs) (100 KB) from which medical marijuana may be obtained.

Medical marijuana is not covered by Medicaid.

Patient Registry Fee:
$200 (valid for two years). Reduced fee of $20 for patients qualifying for state or federal assistance programs

Accepts other states' registry ID cards?
No ("[T]o be eligible for the New Jersey Medicinal Marijuana program you must... hold a valid patient identification card

issued by the New Jersey Medicinal Marijuana Program.")

Registration:
Mandatory

47. New Mexico

Senate Bill 523 (71 KB) "The Lynn and Erin Compassionate Use Act"
Approved: Mar. 13, 2007 by House, 36-31; by Senate, 32-3
Effective: July 1, 2007

Removes state-level criminal penalties on the use and possession of marijuana by patients "in a regulated system for alleviating symptoms caused by debilitating medical conditions and their medical treatments." The New Mexico Department of Health designated to administer the program and register patients, caregivers, and providers.

Approved Conditions: The 15 current qualifying conditions for medical cannabis are: severe chronic pain, painful peripheral neuropathy, intractable nausea/vomiting, severe anorexia/cachexia, hepatitis C infection, Crohn's disease, Post-Traumatic Stress Disorder, ALS (Lou Gehrig's disease), cancer, glaucoma, multiple sclerosis, damage to the nervous tissue of the spinal cord with intractable spasticity, epilepsy, HIV/AIDS

New Mexico Department of Health
1190 St. Francis Drive
P.O. Box 26110
Santa Fe, NM 87502-6110
Phone: 505-827-2321

medical.cannabis@state.nm.us

NM Medical Cannabis Program

Information provided by the state on sources for medical marijuana:
"Patients can apply for a license to produce their own medical cannabis... Once a patient is approved we provide them with information about how to contact the licensed producers to receive

to the nervous tissue of the spinal cord with intractable spasticity, epilepsy, HIV/AIDS, and hospice patients. **Possession/Cultivation:** Patients have the right to possess up to six ounces of usable cannabis, four mature plants and 12 seedlings. Usable cannabis is defined as dried leaves and flowers; it does not include seeds, stalks or roots. A primary caregiver may provide services to a maximum of four qualified patients under the Medical Cannabis Program.	medical cannabis." (accessed Jan. 11, 2010) **Patient Registry Fee:** $0 **Accepts other states' registry ID cards?** No **Registration:** Mandatory
18. Oregon Ballot Measure 67 (75 KB) – Approved by 55% of voters on Nov. 3, 1998 **Effective:** Dec. 3, 1998 Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess a signed recommendation from their physician stating that marijuana "may mitigate" his or her debilitating symptoms. **Approved Conditions:** Cancer, glaucoma, positive status for HIV/AIDS, or treatment for these conditions; A medical condition or treatment for a medical condition that produces cachexia, severe pain, severe nausea, seizures, including seizures caused by epilepsy, or persistent muscle spasms, including spasms caused by multiple sclerosis. Other conditions are subject to approval by the Health Division of the Oregon Department of Human Resources. **Possession/Cultivation:** A registry identification cardholder or the designated primary caregiver of the cardholder may possess up to six mature marijuana plants and 24 ounces of usable marijuana. A registry identification cardholder and the designated primary caregiver of the cardholder may possess a combined total of up to 18 marijuana seedlings. (per Oregon Revised Statutes ORS 475.300 – ORS 475.346) (52 KB) **Amended:** Senate Bill 1085 (52 KB) **Effective:** Jan. 1, 2006 State-qualified patients who possess cannabis in amounts exceeding the new state guidelines will no longer retain the ability to argue an "affirmative defense" of medical necessity at trial. Patients who fail to register with the state, but who possess medical cannabis in amounts compliant with state law, still retain the ability to raise an "affirmative defense" at trial. The law also redefines "mature plants" to include only those cannabis plants that are more than 12 inches in height and diameter, and establish a state-registry for those authorized to produce medical cannabis to qualified patients. **Amended:** House Bill 3052 **Effective:** July 21, 1999 Mandates that patients (or their caregivers) may only cultivate marijuana in one location, and requires that patients must be diagnosed by their physicians at least 12 months prior to an arrest in order to present an "affirmative defense." This bill also states that law enforcement officials who seize marijuana from a patient pending trial do not have to keep those plants alive. Last year the Oregon Board of Health approved agitation due to Alzheimer's disease to the list of debilitating conditions qualifying for legal protection. In August 2001, program administrators filed established temporary procedures further defining the relationship between physicians and patients. The new rule defines attending physician as "a physician who has established a physician/patient relationship with the patient;... is primarily responsible for the care and treatment of the patients;... has reviewed a patient's medical records at the patient's request, has conducted a thorough physical examination of the patient, has provided a treatment plan and/or follow-up care, and has documented these activities in a patient file." **Amended:** SB 281 (25 KB) Signed by Gov. John Kitzhaber on June 6, 2013 Adds post-traumatic stress disorder (PTSD) to the list of approved conditions for medical marijuana use. **Amended:** HB 3460 (50 KB) Signed by Gov. John Kitzhaber on Aug. 14, 2013 Creates a dispensary program by allowing the state licensing and regulation of medical marijuana facilities to transfer marijuana to registry identification cardholders or their designated primary caregivers. [Editor's Note: On Nov. 2, 2010, 55.79% of Oregon Voters rejected Measure 74 (100 KB), which would have allowed for the creation of state-regulated dispensaries.]	**Oregon Department of Human Services** Medical Marijuana Program PO Box 14450 Portland, OR 97293-0450 Phone: 971-673-1234 Fax: 971-673-1278 OR Medical Marijuana Program (OMMP) **Information provided by the state on sources for medical marijuana:** "The OMMP is not a resource for the growing process and does not have information to give to patients." (accessed Jan. 11, 2010) **Patient Registry Fee:** 10:$200 for new applications and renewals; $100 for application and annual renewal fee for persons receiving SNAP (food stamp) and for Oregon Health Plan cardholders; $20 for persons receiving SSI benefits An additional $50 grow site registration fee is charged if the patient is not his or her own grower. **Accepts other states' registry ID cards?** No **Registration:** Mandatory

19. Rhode Island

Senate Bill 0710 – Approved by state House and Senate, vetoed by the Governor. Veto was over-ridden by House and Senate.

Timeline:

1. June 24, 2005: passed the House 52 to 10
2. June 28, 2005: passed the State Senate 33 to 1
3. June 29, 2005: Gov. Carcieri vetoed the bill
4. June 30, 2005: Senate overrode the veto 28-6
5. Jan. 3, 2006: House overrode the veto 59-13 to pass the Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act (48 KB) (Public Laws 05-442 and 05-443)
6. June 21, 2007: Amended by Senate Bill 791 (30 KB) **Effective:** Jan. 3, 2006

Approved Conditions: Cancer, glaucoma, positive status for HIV/AIDS, Hepatitis C, or the treatment of these conditions; A chronic or debilitating disease or medical condition or its treatment that produces cachexia or wasting syndrome; severe, debilitating, chronic pain; severe nausea; seizures, including but not limited to, those characteristic of epilepsy; or severe and persistent muscle spasms, including but not limited to, those characteristic of multiple sclerosis or Crohn's disease; or agitation of Alzheimer's Disease; or any other medical condition or its treatment approved by the state Department of Health.

If you have a medical marijuana registry identification card from any other state, U.S. territory, or the District of Columbia you may use it in Rhode Island. It has the same force and effect as a card issued by the Rhode Island Department of Health.

Possession/Cultivation: Limits the amount of marijuana that can be possessed and grown to up to 12 marijuana plants or 2.5 ounces of cultivated marijuana. Primary caregivers may not possess an amount of marijuana in excess of 24 marijuana plants and five ounces of usable marijuana for qualifying patients to whom he or she is connected through the Department's registration process.

Amended: H5359 (70 KB) - The Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act (substituted for the original bill)

Timeline:

1. **May 20, 2009:** passed the House 63-5
2. **June 6, 2009:** passed the State Senate 31-2
3. **June 12, 2009:** Gov. Carcieri vetoed the bill (60 KB)
4. **June 16, 2009:** Senate overrode the veto 35-3
5. **June 16, 2009:** House overrode the veto 67-0

Effective June 16, 2009: Allows the creation of compassion centers, which may acquire, possess, cultivate, manufacture, deliver, transfer, transport, supply, or dispense marijuana, or related supplies and educational materials, to registered qualifying patients and their registered primary caregivers.

The first dispensary, the Thomas C. Slater Compassion Center, opened on Apr. 19, 2013.

Rhode Island Department of Health
Office of Health Professions Regulation,
Room 104
3 Capitol Hill
Providence, RI 02908-5097
Phone: 401-222-2828

RI Medical Marijuana Program (MMP)

Information provided by the state on sources for medical marijuana:
"The MMP is not a resource for marijuana and does not have information to give to patients related to the supply of marijuana." (accessed Jan. 11, 2010)

Patient Registry Fee:
$75/$10 for applicants on Medicaid or Supplemental Security Income (SSI)

Accepts other states' registry ID cards?
Yes, but only for the conditions approved in Rhode Island

Registration:
Mandatory

20. Vermont

Senate Bill 76 (45 KB) – Approved 22-7; House Bill 645 (41 KB) – Approved 82-59 **"Act Relating to Marijuana Use by Persons with Severe Illness"** (Sec. 1. 18 V.S.A. chapter 86 (41 KB) passed by the General Assembly) *Gov. James Douglas (R), allowed the act to pass into law unsigned on May 26, 2004*
Effective: July 1, 2004

Amended: Senate Bill 00007 (65 KB)
Effective: May 30, 2007

Approved Conditions: Cancer, AIDS, positive status for HIV, multiple sclerosis, or the treatment of these conditions if the disease or the treatment results in severe, persistent, and intractable symptoms; or a disease, medical condition, or its treatment that is chronic, debilitating and produces severe, persistent, and one or more of the following intractable symptoms: cachexia or wasting syndrome, severe pain or nausea or seizures.

Possession/Cultivation: No more than two mature marijuana plants, seven immature plants, and two ounces of usable marijuana may be collectively possessed between the registered patient and the patient's registered caregiver. A marijuana plant shall be considered mature when male or female flower buds are readily observed on the plant by unaided visual examination. Until this sexual differentiation has taken place, a marijuana plant will be considered immature.

Amended: Senate Bill 17 (100 KB) "An Act Relating To Registering Four Nonprofit Organizations To Dispense Marijuana For Symptom Relief"

Marijuana Registry
Department of Public Safety
103 South Main Street
Waterbury, Vermont 05671
Phone: 802-241-5115

VT Marijuana Registry Program

Information provided by the state on sources for medical marijuana:
"The Marijuana Registry is neither a source for marijuana nor can the Registry provide information to patients on how to obtain marijuana." (accessed Jan. 11, 2010)

Patient Registry Fee:
$50

Accepts other states' registry ID cards?
No

Registration:
Mandatory

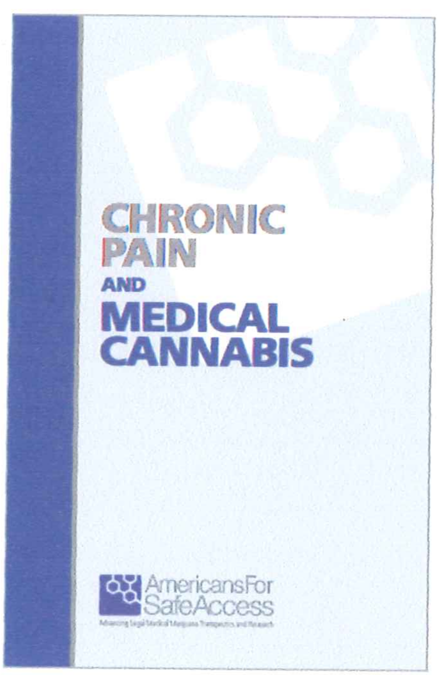
Signed by Gov. Peter Shumlin on June 2, 2011 The bill "establishes a framework for registering up to four nonprofit marijuana dispensaries in the state... A dispensary will be permitted to cultivate and possess at any one time up to 28 mature marijuana plants, 98 immature marijuana plants, and 28 ounces of usable marijuana." On Sep. 12, 2012, the State of Vermont Department of Public Safety announced conditional approval (65 KB) of two medical marijuana dispensaries. In June 2013, two dispensaries opened in Vermont.	
21. Washington Chapter 69.51A RCW (4KB) **Ballot Initiative I-692** – Approved by 59% of voters on Nov. 3, 1998 **Effective:** Nov. 3, 1998 Removes state-level criminal penalties on the use, possession and cultivation of marijuana by patients who possess "valid documentation" from their physician affirming that he or she suffers from a debilitating condition and that the "potential benefits of the medical use of marijuana would likely outweigh the health risks." **Approved Conditions:** Cachexia; cancer; HIV or AIDS; epilepsy; glaucoma; intractable pain (defined as pain unrelieved by standard treatment or medications); and multiple sclerosis. Other conditions are subject to approval by the Washington Board of Health. **Possession/Cultivation:** Patients (or their primary caregivers) may legally possess or cultivate no more than a 60-day supply of marijuana. The law does not establish a state-run patient registry. **Amended:** Senate Bill 6032 (29 KB) **Effective:** 2007 (rules being defined by Legislature with a July 1, 2008 due date) **Amended:** Final Rule (123 KB) based on Significant Analysis (370 KB) **Effective:** Nov. 2, 2008 **Approved Conditions:** Added Crohn's disease, Hepatitis C with debilitating nausea or intractable pain, diseases, including anorexia, which result in nausea, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms, or spasticity, when those conditions are unrelieved by standard treatments or medications. **Possession/Cultivation:** A qualifying patient and designated provider may possess a total of no more than twenty-four ounces of usable marijuana, and no more than fifteen plants. This quantity became the state's official "60-day supply" on Nov. 2, 2008. [Editor's Note: On Jan. 21, 2010, the Supreme Court of the State of Washington ruled that Ballot Initiative "I-692 did not legalize marijuana, but rather provided an authorized user with an affirmative defense if the user shows compliance with the requirements for medical marijuana possession." *State v. Fry* (125 KB) ProCon.org contacted the Washington Department of Health to ask whether it had received any instructions in light of this ruling. Kristi Weeks, Director of Policy and Legislation, stated the following in a Jan. 25, 2010 email response to ProCon.org: "The Department of Health has a limited role related to medical marijuana in the state of Washington. Specifically, we were directed by the Legislature to determine the amount of a 60 day supply and conduct a study of issues related to access to medical marijuana. Both of these tasks have been completed. We have maintained the medical marijuana webpage for the convenience of the public. The department has not received 'any instructions' in light of State v. Fry. That case does not change the law or affect the 60 day supply. Chapter 69.51A RCW, as confirmed in Fry, provides an affirmative defense to prosecution for possession of marijuana for qualifying patients and caregivers."] **Amended:** SB 5073 (375 KB) **Effective:** July 22, 2011 Gov. Christine Gregoire signed sections of the bill and partially vetoed others, as explained in the Apr. 29, 2011 veto notice. (50 KB) Gov. Gregoire struck down sections related to creating state-licensed medical marijuana dispensaries and a voluntary patient registry. [Editor's Note: On Nov. 6, 2012, Washington voters passed Initiative 502, which allows the state to "license and regulate marijuana production, distribution, and possession for persons over 21 and tax marijuana sales." The website for Washington's medical marijuana program states that the intiative "does not amend or repeal the medical marijuana laws (chapter 69.51A RCW) in any way. The laws relating to authorization of medical marijuana by healthcare providers are still valid and enforceable."]	**Department of Health** PO Box 47866 Olympia, WA 98504-7866 Phone: 360-236-4700 Fax: 360-236-4768 MedicalMarijuana@doh.wa.gov WA Medical Marijuana website **Information provided by the state on sources for medical marijuana:** "The law allows a qualifying patient or designated provider to grow medical marijuana. It is not legal to buy or sell it. The law does not allow dispensaries." (accessed Jan. 11, 2010) **Patient Registry Fee:** **No state registration program has been established **Accepts other states' registry ID cards?** No **Registration:** None

Section H:
Scientific evidence of support for Medical Marijuana Treatment

Chronic Pain

Chronic Pain & Medical Marijuana

A Note from Americans for Safe Access



(http://www.amazon.com/Chronic-Pain-Medical-Cannabis-ebook/dp/B00E8KC060/ref=sr_1_5?s=digital-text&ie=UTF8&qid=1380124547&sr=1-5)We are committed to ensuring safe, legal availability of marijuana for medical uses. This brochure is intended to help doctors, patients and policymakers better understand how marijuana - or "cannabis" as it is more properly called - may be used as a treatment for people with serious medical conditions. This booklet contains information about using cannabis as medicine. In it you'll find information on:

Why Cannabis is Legal to Recommend

Overview of the Scientific Research on Medical Cannabis

Research on Cannabis and Chronic Pain

Comparison of Medications: Efficacy and Side-Effects

Why Cannabis is Safe to Recommend

Testimonials of Patients and Doctors

History of Cannabis as Medicine

Scientific and Legal References

We recognize that information about using cannabis as medicine has been difficult to obtain. The federal prohibition on cannabis has meant that modern clinical research has been limited, to the detriment of medical science and the wellness of patients. But the documented history of the safe, medical use of cannabis dates to 2700 B.C. Cannabis was part of the American pharmacopoeia until 1942 and is currently available by prescription in the Netherlands and Canada.

Testimonials from both doctors and patients reveal valuable information on the use of cannabis therapies, and supporting statements from professional health organizations and leading medical journals support its legitimacy as a medicine. In the last few years, clinical trials in Great Britain, Canada, Spain, Israel, and elsewhere have shown great promise for new medical applications.

This brochure is intended to be a starting point for the consideration of applying cannabis therapies to specific conditions; it is not intended to replace the training and expertise of physicians with regard to medicine, or attorneys with regard to the law. But as patients, doctors and advocates who have worked intimately with these issues for many years, we have seen firsthand how helpful cannabis can be for a wide variety of indications. We know doctors want the freedom to practice medicine and patients the freedom to make decisions about their healthcare.

For more information about ASA and the work we do, please see our website at AmericansForSafeAccess.org or call 1-888-929-4367.

Is Cannabis Legal to Recommend?

In 2004, the United States Supreme Court upheld earlier federal court decisions that doctors have a fundamental Constitutional right to recommend cannabis to their patients.

The history. Within weeks of California voters legalizing medical cannabis in 1996, federal officials had threatened to revoke the prescribing privileges of any physicians who recommended cannabis to their patients for medical use.[1] In response, a group of doctors and patients led by AIDS specialist Dr. Marcus Conant filed suit against the government, contending that such a policy violates the First Amendment.[2] The federal courts agreed at first the district level,[3]then all the way through appeals to the Ninth Circuit and then the Supreme Court.

What doctors may and may not do. In Conant v. Walters,[4] the Ninth Circuit Court of Appeals held that the federal government could neither punish nor threaten a doctor merely for recommending the use of cannabis to a patient.[5] But it remains illegal for a doctor to "aid and abet" a patient in obtaining cannabis.[6] This means a physician may discuss the pros and cons of medical cannabis with any patient, and issue a written or oral recommendation to use cannabis without fear of legal reprisal.[7] This is true regardless of whether the physician anticipates that the patient will, in turn, use this recommendation to obtain cannabis.[8] What physicians may not do is actually prescribe or dispense cannabis to a patient[9] or tell patients how to use a written recommendation to procure it from a cannabis club or dispensary.[10] Doctors can tell patients they may be helped by cannabis. They can put that in writing. They just can't help patients obtain the cannabis itself.

Patients protected under state, not federal, law. In June 2005, the U.S. Supreme Court overturned the Raich v. Ashcroft Ninth Circuit Court of Appeals decision. In reversing the lower court's ruling, Gonzales v. Raich established that it is legal under federal law to prosecute patients who possess, grow, or consume medical cannabis in medical cannabis states. However, this Supreme Court decision does not overturn or supersede the laws in states with medical cannabis programs.

For assistance with determining how best to write a legal recommendation for cannabis, please contact ASA at 1-888-929-4367.

Scientific Research Supports Medical Cannabis

Between 1840 and 1900, European and American medical journals published more than 100 articles on the therapeutic use of the drug known then as Cannabis Indica (or Indian hemp) and now simply as cannabis. Today, new studies are being published in peer-reviewed journals that demonstrate cannabis has medical value in treating patients with serious illnesses such as AIDS, glaucoma, cancer, multiple sclerosis, epilepsy, and chronic pain.

The safety of the drug has been attested to by numerous studies and reports, including the LaGuardia Report of 1944, the Schafer Commission Report of 1972, a 1997 study conducted by the British House of Lords, the Institutes of Medicine report of 1999, research sponsored by Health Canada, and numerous studies conducted in the Netherlands, where cannabis has been quasi-legal since 1976 and is currently available from pharmacies by prescription.

Recent published research on CD4 immunity in AIDS patients found no compromise to the immune systems of patients undergoing cannabis therapy in clinical trials.[11-16]

The use of medical cannabis has been endorsed by numerous professional organizations, including the American Academy of Family Physicians, the American Public Health Association, and the American Nurses Association. Its use is supported by such leading medical publications as The New England Journal of Medicine and The Lancet.

Recent Research Advances

While research has until recently been sharply limited by federal prohibition, the last few years have seen rapid change. The International Cannabinoid Research Society was formally incorporated as a scientific research organization in 1991with 50 members; as of 2010, there are nearly 500 around the world. The International Association for Cannabis as Medicine (IACM), founded in March 2000, publishes a bi-weekly bulletin and holds international symposia to highlight emerging research in cannabis therapeutics. In 2001, the State of California established the Center for Medicinal Cannabis Research to coordinate an $8.7-million research effort at University of California campuses. As of 2010, the CMCR had completed six of 14 approved studies. Of those, five published double-blind, placebo-controlled studies studied pain relief; each showed cannabis to be effective.

In the United Kingdom, GW Pharmaceuticals has been conducting clinical trials with its cannabis-based medicine for the past decade. GW's Phase II and Phase III trials of cannabis-based medicine show positive results for the relief of neurological pain related to: multiple sclerosis (MS), spinal cord injury, peripheral nerve injury (including peripheral neuropathy secondary to diabetes mellitus or AIDS), central nervous

system damage, neuroinvasive cancer, dystonias, cerebral vascular accident, and spina bifida. They have also shown cannabinoids to be effective in clinical trials for the relief of pain and inflammation in rheumatoid arthritis and also pain relief in brachial plexus injury.

As of December 2010, the company has obtained regulatory approval in Spain, New Zealand, and the UK for Sativex® Oromucosal Spray, a controlled-dose whole-plant extract. Sativex® was approved in Canada for symptomatic relief of neuropathic pain in 2005, in 2007 for patients with advanced cancer whose pain is not fully alleviated by opiods, and in 2010 for spasticity related to multiple sclerosis. Sativex has been made available either for named patient prescription use or for clinical trials purposes in a total of 22 countries. In the US, GW was granted an import license for Sativex® by the DEA following meetings in 2005 with the FDA, DEA, the Office for National Drug Control Policy, and the National Institute for Drug Abuse. Sativex® is currently an investigational drug in FDA-approved clinical trials as an adjunctive analgesic treatment for patients with advanced cancer whose pain is not relieved by strong opioids.

Cannabis and Chronic Pain

Persistent and disabling pain can have numerous and sometimes multiple causes. Among them are cancer; AIDS; sickle cell anemia; multiple sclerosis; defects or injuries to the back, neck and spinal cord; arthritis and other rheumatic and degenerative hip, joint and connective tissue disorders; and severe burns. Pain is not a primary condition or injury, but rather a severe, frequently intolerable symptom that varies in frequency, duration, and severity according to the individual. The underlying condition determines the appropriate curative approach, but does not determine the proper symptom management. It is the character, severity, location and duration of the pain that determines the range of appropriate therapies.

Chronic pain is a public health issue that is widespread across the aging populations of industrialized nations. Epidemiological statistics are alarming: In Europe, it is estimated that one in four adults has a chronic pain condition.[17] In the US, it is estimated that at least 38 million adults suffer from chronic pain, and at least 12 million have used cannabis as a treatment.

For patients in pain, the goal is to function as fully as possible by reducing their pain as much as possible, while minimizing the often-debilitating side effects of the pain therapies. Failure to adequately treat severe and/or chronic pain can have tragic consequences. Not infrequently, people in unrelieved pain want to die. Despair can also cause patients to discontinue potentially life-saving procedures (e.g., chemotherapy or surgery), which themselves cause severe suffering. In such dire cases, anything that helps to alleviate the pain will prolong these patients' lives.

Cannabis can serve at least two important roles in safe, effective pain management. It can provide relief from the pain itself (either alone or in combination with other analgesics), and it can control the nausea associated with taking opioid drugs, as well as the nausea, vomiting and dizziness that often accompany severe, prolonged pain.

Opioid therapy is often an effective treatment for severe pain, but all opiates have the potential to induce nausea. The intensity and duration of this nausea can cause enormous discomfort and additional suffering and lead to malnourishment, anorexia, wasting, and a severe decline in a patient's health. Some patients find the nausea so intolerable that they are inclined to discontinue the primary pain treatment, rather than endure the nausea.

Inhaled cannabis provides almost immediate relief for this with significantly fewer adverse effects than orally ingested Marinol. Inhalation allows the active compounds in cannabis to be absorbed into the blood stream with greater speed and efficiency. It is for this reason that inhalation is an increasingly common, and often preferable, route of administration for many medications. Cannabis may also be more effective than Marinol because it contains many more cannabinoids than just the THC that is Marinol's active ingredient. The additional cannabinoids may well have additional and complementary antiemetic qualities. They have been conclusively shown to have better paincontrol properties when taken in combination than THC alone.

Research on cannabis and pain management

Cannabis has been used as an analgesic for thousands of years [18-20] and patients often report significant pain relief from cannabis, even in cases where conventional pain therapies have failed.[21-26].

After reviewing a series of trials in 1997, the U.S. Society for Neuroscience concluded that "substances similar to or derived from marijuana could benefit the more than 97 million Americans who experience some form of pain each year." [27] A 1999 study commissioned by the White House and conducted by the Institute of Medicine recognized the role that cannabis can play in treating chronic pain. [28] "After nausea and vomiting, chronic pain was the condition cited most often to the IOM study team as a medicinal use for marijuana." From 1975 to February 2011, there have been nearly 300 studies showing that cannabinoids and cannabis can help patients experiencing chronic pain.[29,30]

Some of the most encouraging clinical data on effects of cannabinoids on chronic pain are from studies of intractable cancer pain and hard-to-treat neuropathic pain.[31] The effectiveness of cannabis and cannabinoids in relieving neuropathic pain has been demonstrated in more than three dozen preclinical and clinical trials.[32] A trial of cannabis cigarettes to treat HIV-associated daily neuropathic pain in 50 patients showed an average reduction of pain by 30% over a treatment course of only 5 days.[33] In 2001, researchers reported that cannabis extract sprayed under the tongue (Sativex®) was effective in reducing pain in patients suffering intractable neuropathic pain.[34] A review of over 20 clinical trials on cannabis and cannabinoids found that whole plant cannabis and extracts are superior to oral THC for the treatment of pain. Health Canada approved Sativex® for prescription in the treatment of HIV-associated neuropathic pain in 2005 and cancer pain in 2007.

The activity of the more than 100 cannabinoids and other components on the plant may explain its superiority in reducing pain when comparing whole plant cannabis and extracts to THC alone. For instance, the cannabinoid cannabichromene (CBC), the third most common ingredient on the plant, exhibits anti-inflammatory and analgesic actions, although weaker than THC. [35] Similarly, beta-sitosterol, a non-cannabinoid ingredient found in cannabis, was able to decrease inflammation and edema in skin treatment.[36] And a unique flavanoid found only in cannabis, cannaflavin A, inhibits the inflammatory molecule PGE-2, thirty times more potently than aspirin.[37] Lastly beta-caryophyllene, a cannabinoid found in many plants besides cannabis, has strong anti-inflammatory properties but no noticeable side effects.[38] Beta-caryophyllen is the most commonly consumed FDA-approved cannabinoid in food.

The IOM report found that "basic biology indicates a role for cannabinoids in pain and control of movement, which is consistent with a possible therapeutic role in these areas. The evidence is relatively strong for the treatment of pain and intriguingly, although less well established, for movement disorder." According to the IOM Report and numerous independent research articles, a number of areas in the brain

that have an established role in sensing and processing pain respond to the analgesic effect of cannabis, adding that cannabinoids have been used successfully to treat cancer pain, which is often resistant to treatment with opiates. The effectiveness of cannabinoids in treating intractable cancer pain has been demonstrated in several subsequent clinical trials of a dosage-controlled sublingual spray. Several studies have found that cannabinoids have analgesic effects in animal models, sometimes equivalent to codeine.[39-43] Cannabinoids also seem to synergize with opioids, which often lose their effectiveness as patients build up tolerance. One study found morphine was 15 times more active in rats with the addition of a small dose of THC. Codeine was enhanced on the order of 900 fold.[44] In 1990, researchers conducted a double-blind study comparing the antispasmodic and analgesic effects of THC, oral Codeine, and a placebo on a single patient suffering from a spinal cord injury.[45] Their findings confirmed the analgesic effects of THC being "equivalent to codeine." A 1997 study made similar findings related to morphine.[46] A 1999 article reviewing the body of scientific animal research concerning the analgesic effects of marijuana concludes that "[t]here is now unequivocal evidence that cannabinoids are antinociceptive [capable of blocking the appreciation or transmission of pain] in animal models of acute pain."[47] The report further notes that multiple cannabinoids and noncannabinoid components can serve as anti-inflammatory agents, and so have potential in preventing and reducing pain caused by swelling (such as arthritis). In short, the research community recognizes the potential benefits of cannabis for certain patients, including:

- Chemotherapy patients, especially those being treated for mucositis, nausea, and anorexia.
- Postoperative pain patients (using cannabinoids as an opioid adjunct to reduce the nausea and vomiting).
- Patients with spinal cord injury, peripheral neuropathic pain, or central post-stroke pain.
- Patients with chronic pain and insomnia.
- AIDS patients with cachexia, AIDS neuropathy, or any significant pain.

Britain's House of Lords reached similar conclusions and called for making cannabis available by prescription.[48]

HOW CANNABIS COMPARES TO OTHER TREATMENTS

Chronic Pain Medications

According to the Institute of Medicine, "All of the currently available analgesic (pain-relieving) drugs have limited efficacy for some types of pain. Some are limited by dose-related side effects and some by the development of tolerance or dependence."

The opioid analgesics commonly used to combat pain include **codeine** (Dolacet, Hydrocet, Lorcet, Lortab); **morphine** (Avinza, Oramorph); **oxycodone** (Vicodin, Oxycontin, Roxicodone, Percocet, Roxicet); **propoxyphene** (Darvon, Darvocet) and **tramadol** (Ultram, Ultracet). These medicines can cause psychological and physical dependence, as well as constipation, dizziness, lightheadedness, mood changes, nausea, sedation, shortness of breath and vomiting. Taking high doses or mixing with alcohol can slow down breathing, a potentially fatal condition.

In addition, patients in pain are often prescribed muscle relaxants such as **Robaxin** and **Flexeril**; anti-anxiety agents such as **Valium**, **Sinequan**, **Vistaril**, **Ativan** and **Xanax**; hypnotics such as **Halcion**, **Restoril**, **Chloralhydrate**, **Dalmane** and **Doral** and anti-emetics such as **Zofran**, **Compazine**, **Phenergan**, **Tigan** and **Marinol**.

Robaxin's side effects include abnormal taste, amnesia, blurred vision, confusion, dizziness, drop in blood pressure and fainting, drowsiness, fever, flushing, headache, hives, indigestion, insomnia, itching, light-headedness, nasal congestion, nausea, pinkeye, poor coordination, rash, seizures, slowed heartbeat, uncontrolled eye movement, vertigo, vomiting and yellow eyes and skin.

Flexeril can cause abnormal heartbeats, aggressive behavior, agitation, anxiety, bloated feeling, blurred vision, confusion, constipation, convulsions, decreased appetite, depressed mood, diarrhea, difficulty falling or staying asleep, difficulty speaking, disorientation, double vision, excitement, fainting, fatigue, fluid retention, gas, hallucinations, headache, heartburn, hepatitis, hives, increased heart rate, indigestion, inflammation of the stomach, itching, lack of coordination, liver diseases, loss of sense of taste, low blood pressure, muscle twitching, nausea, nervousness, palpitations, paranoia, rash, ringing in the ears, severe allergic reaction, stomach and intestinal pain, sweating, swelling of the tongue or face, thirst, tingling in hands or feet, tremors, unpleasant taste in the mouth, urinating more or less than usual, vague feeling of bodily discomfort, vertigo, vomiting, weakness, and yellow eyes and skin.

The newer antiemetics, Anzamet, Kytril and Zofran, are serotonin antagonists, blocking the neurotransmitter that sends a vomiting signal to the brain. Rare side effects of these drugs include fever, fatigue, bone pain, muscle aches, constipation, loss of appetite, inflammation of the pancreas, changes in electrical activity of heart, vivid dreams, sleep problems, confusion, anxiety and facial swelling.

Reglan, a substituted benzamide, increases emptying of the stomach, thus decreasing the chance of developing nausea and vomiting due to food remaining in the stomach. When given at high doses, it blocks the messages to the part of the brain responsible for nausea and vomiting. Side effects include sleepiness, restlessness, diarrhea and dry mouth. Rarer side effects are rash, hives and decreased blood pressure.

Haldol and Inapsine are tranquilizers that block messages to the part of the brain responsible for nausea and vomiting. Possible side effects include decreased breathing rate, increased heart rate, decrease in blood pressure when changing position and, rarely, change in electrical activity of the heart.

Compazine and Torecan are phenothiazines, the first major anti-nausea drugs. Both have tranquilizing effects. Common side effects include dry mouth and constipation. Less common effects are blurred vision, restlessness, involuntary muscle movements, tremors, increased appetite, weight gain, increased heart rate and changes in electrical activity of heart. Rare side effects include jaundice, rash, hives and increased sensitivity to sunlight.

Benadryl, an antihistamine, is given along with Reglan, Haldol, Inapsine, Compazine and Torecan to counter side effects of restlessness, tongue protrusion and involuntary movements. Its side effects include sedation, drowsiness, dry mouth, dizziness, confusion, excitability and decreased blood pressure.

Benzodiazepine drugs Ativan and Xanax are prescribed to combat the anxiety associated with chronic pain. Ativan causes amnesia. Abruptly stopping the drug can cause anxiety, dizziness, nausea and vomiting, and tiredness. It can cause drowsiness, confusion, weakness and headache when first starting the drug. Nausea, vomiting, dry mouth, changes in heart rate and blood pressure and palpitations are possible side effects.

Cannabis: By comparison, the side effects associated with cannabis are typically mild and are classified as "low risk." Euphoric mood changes are among the most frequent side effects. Cannabinoids can exacerbate schizophrenic psychosis in predisposed persons. Cannabinoids impede cognitive and psychomotor performance, resulting in temporary impairment. Chronic use can lead to the development of tolerance. Tachycardia and hypotension are frequently documented as adverse events in the

cardiovascular system. A few cases of myocardial ischemia have been reported in young and previously healthy patients. Inhaling the smoke of cannabis cigarettes induces side effects on the respiratory system. Cannabinoids are contraindicated for patients with a history of cardiac ischemias. In summary, a low risk profile is evident from the literature available. Serious complications are very rare and are not usually reported during the use of cannabinoids for medical indications.

Is cannabis safe to recommend?

"The smoking of cannabis, even long term, is not harmful to health..." So began a 1995 editorial statement of Great Britain's leading medical journal, The Lancet. The long history of human use of cannabis also attests to its safety- nearly 5,000 years of documented use without a single death. In the same year as the Lancet editorial, Dr. Lester Grinspoon, a professor emeritus at Harvard Medical School who has published many influential books and articles on medical use of cannabis, had this to say in an article in the Journal of the American Medical Association (1995):

> "One of marihuana's greatest advantages as a medicine is its remarkable safety. It has little effect on major physiological functions. There is no known case of a lethal overdose; on the basis of animal models, the ratio of lethal to effective dose is estimated as 40,000 to 1. By comparison, the ratio is between 3 and 50 to 1 for secobarbital and between 4 and 10 to 1 for ethanol. Marihuana is also far less addictive and far less subject to abuse than many drugs now used as muscle relaxants, hypnotics, and analgesics. The chief legitimate concern is the effect of smoking on the lungs. Cannabis smoke carries even more tars and other particulate matter than tobacco smoke. But the amount smoked is much less, especially in medical use, and once marihuana is an openly recognized medicine, solutions may be found; ultimately a technology for the inhalation of cannabinoid vapors could be developed.[49]"

The technology Dr. Grinspoon imagined in 1995 now exists in the form of "vaporizers," (which are widely available through stores and by mail-order) and recent research attests to their efficacy and safety. [50] Additionally, pharmaceutical companies have developed sublingual sprays and tablet forms of the drug. Patients and doctors have found other ways to avoid the potential problems associated with smoking, though long-term studies of even the heaviest users in Jamaica, Turkey and the U.S. have not found increased incidence of lung disease or other respiratory problems.

A decade-long study of 65,000 Kaiser-Permanente patients comparing cancer rates among non-smokers, tobacco smokers, and cannabis smokers found that those who used only cannabis had a slightly lower risk of lung and other cancers as compared to non-smokers.[51] Similarly, a study comparing 1,200 patients with lung, head and neck cancers to a matched group with no cancer found that even those cannabis smokers who had consumed in excess of 20,000 joints had no increased risk of cancer.[52]

As Dr. Grinspoon notes, "the greatest danger in medical use of marihuana is its illegality which imposes much anxiety and expense on suffering people, forces them to bargain with illicit drug dealers, and exposes them to the threat of criminal prosecution." This was the conclusion reached by the House of Lords, which recommended rescheduling and decriminalization.

Cannabis or Marinol?

Those committed to the prohibition on cannabis frequently cite Marinol, a Schedule III drug, as the legal means to obtain the benefits of cannabis. However, Marinol, which is a synthetic form of THC, does not deliver the same therapeutic benefits as the natural herb, which contains at least 100 cannabinoids in addition to THC. Recent research conducted by GW Pharmaceuticals in Great Britain has shown that Marinol is simply not as effective for pain management as the whole plant; a balance of cannabinoids, specifically CBC and CBD with THC, is what helps patients most. In fact, Marinol is not labeled for pain, only appetite stimulation and nausea control. But studies have found that many severely nauseated patients experience difficulty in getting and keeping a pill down, a problem avoided with inhaled cannabis.

Clinical research on Marinol vs. cannabis has been limited by federal restrictions, but a 2001 review of clinical trials conducted in the 70's and 80's reports that ". . .the inhalation of THC appears to be more effective than the oral route."[53] Additionally, patients frequently have difficulty getting the right dose with Marinol, while inhaled cannabis allows for easier titration and avoids the negative side effects many report with Marinol. As the House of Lords observed, "Some users of both find cannabis itself more effective."

THE EXPERIENCE OF PATIENTS

Angel McClary Raich

I have been permanently disabled since September 1995. I am a mother of two teenage children. My children know more than anyone how medical cannabis brought their mommy back to them. The hardest part of being disabled is watching the suffering in your children's eyes as they watch you endure such suffering with no end in sight.

In late 1997, my doctor felt cannabis would be an effective medication to treat my many complicated and complex medical conditions. I was in a wheelchair from January 1996 to August 1999. Cannabis was responsible for getting me out of my wheelchair and restoring mobility on the whole right side of my body. For years I felt s if I was suffering in Hell. What I had to endure was unbelievable and indescribable torture.

I suffer greatly from severe chronic pain every single day. The prolonged pain and suffering from my medical conditions significantly interferes with my quality of life. My treatment is complicated by the fact that I am violently allergic and have severe multiple chemical sensitivities to almost all pharmaceutical medicines. This interferes with the treatment of all of my medical conditions, and it means my suffering cannot be controlled by synthetic medications. This makes it extremely difficult for doctors to effectively help me combat my diseases. Without cannabis my life would be a death sentence.[54]

Dorothy Gibbs

In 1911, at the age of one, I contracted the polio virus. The early onset of polio caused permanent damage in my legs, spine, and back, resulting in significant weakness and atrophy in my legs. As a result, I have never been able to walk without the assistance of crutches and braces or a wheelchair. Approximately 30 years ago, my condition began to deteriorate. I began to suffer from increasing levels of pain and weakness in my legs and back as well as severe osteoarthritis in my hands, arms, and joints. Over time, my deteriorating medical condition has been exacerbated by my pain, leaving me increasingly immobilized.

By May, 1996, my physician [Dr. Arnold Leff, M.D.] had tried various prescription medications to relieve my pain, including: Tylenol #3, Ultram, Daypro, Tegretol, Soma, Valium, steroid injections into the trigger point, Dilantin, Duragesic, Zofran and Comapazine for the nausea caused by the opioid pain relievers, and Doloboid and Lodine as nonsteroids. Nothing seemed to work, and the pain persisted. I was growing increasingly depressed by the inability of anything to relieve my pain. During this period it was clear to me, my caretaker and my physician that nothing was working to combat my pain. My caretaker, Pat, had heard of the success some people experience with the medicinal use of marijuana for pain management. Sometime during the end of 1997, she obtained a sample for me. Although I had never used marijuana in my previous eighty-seven years of life, I was willing to try anything that could alleviate even part of the pain.

The relief I experienced from medical marijuana was almost immediate. I was so pleased with the result that I wrote to Dr. Leff about my use of medical marijuana and we talked about the benefits of the medicine. Dr. Leff examined me and noted that medical marijuana helped me experience less chronic pain and nausea, leading him to recommended medical marijuana as part of my daily pain care regimen... I strongly feel that I should have the right to use anything that may relieve any or some of my pain, and my last days should not be spent suffering. . . . Ever since trying medical marijuana, my life has drastically improved. Although chronic pain, related to my post-polio syndrome will always be a part of my life, medical marijuana had helped me manage this pain by providing fast and effective relief for my muscle spasms, acute pains, and arthritis.

Since I began using medical marijuana, my pain is no longer persistent or debilitating. When I do suffer from pain, I am usually able to "get ahead of it" by using medical marijuana and make it manageable.[55]

James Daniel Baehr

In 1994, I was diagnosed with inoperable prostate cancer... the cancer had metastasized to my spine, hips, and ribcage. The neuropathic back pain was excruciating, emanating from my spine to my hips and ribcage. I also experienced an overall loss of strength that substantially limited my ability to work. Employment in the transportation industry involves a considerable amount of carrying, lifting, and other manual labor that requires flexibility and mobility. The performance of these requirements exacerbated the magnitude and amount of pain I experienced on a daily basis and depleted any energy that had not already been beaten down by the disease itself.

I began taking numerous medications to treat the cancer, the excruciating pain that it caused, and the depression I felt as a result of my prognosis and the profound restrictions on my life. My medications included a daily dosage of 7.5 mg of Lortab (a painkiller), .25 mg of Xanax (which combats depression and anxiety), 40 mg of Paxil (an anti-depressant), and 250 mg of Eulexin (which treats the cancer by reducing the testosterone emitted from adrenal glands), and monthly shots of 7.5 mg of Lupron Depot (a testosterone blocker/hormonal therapy). I suffered various side effects from these medications, including persistent exhaustion, general pain, a lack of mental focus, and overall body tenderness. In combination, these side effects were quite debilitating...

From September through December of 1995, I endured nine weeks of radiation. The treatment left me with continued back pain, intense nausea, loss of appetite, diverticulitis, sleep abnormalities, and digestive and intestinal complications. It also left me increasingly depressed. In late 1994 or 1995, a physician at the Radiology Department at Stanford University Hospital prescribed Marinol to alleviate my pain and nausea from the radiation. I tried the Marinol but did not respond well to it. Not only did Marinol make me feel drugged and not in control of my thoughts or body, but it failed to relieve my painful symptoms. In fact, Marinol just made me feel sicker, upsetting my stomach, disrupting my mental

acuity, and causing me to hallucinate. During this period, I was also taking 7.5 mg of Lortab, an opioid analgesic, several times a day and Ambien to help me sleep. These drugs alleviated the pain somewhat, but also made me disoriented, constipated, and caused me to lose my short-term memory and fine motor skills.

Perhaps sensing that my hope was receding as my misery was increasing, a nurse at Stanford Hospital suggested that medical marijuana could alleviate my nausea, restore my appetite, and even help me manage my pain - all potentially without the negative side effects I experienced with Marinol and other medications..

I decided to try a small amount of medical marijuana, and when I did I found that it provided significant relief from the side effects of the cancer medications and the radiation treatment. In addition, it helped reduce the pain I was experiencing from the cancer itself. This new combination of therapies, which included medical marijuana, turned my health around. Where before I had been doubled over with nausea, couldn't eat, or sleep, I was now not only able to handle my medications, but could sleep, eat and manage my pain. I found that a small amount of medical marijuana taken in the evening enabled me to sleep through the entire night so that I no longer needed to take Ambien.

Over time, the pain got progressively worse. In February 1997 I began to take morphine to help with the pain. The amount of morphine that I need to take to adequately control my pain leaves me utterly incapacitated, mentally and physically. Medical marijuana helps me manage my pain, while limiting my dependence on more powerful narcotics.

When I smoke medical marijuana, I can achieve the same degree of pain relief with a much smaller amount of morphine and with far fewer and less harsh side effects. The coupling of medical marijuana with my prescription analgesics has been one of the most significant and successful aspects of my medical treatment.[56]

THE EXPERIENCE OF DOCTORS

Harvey L. Rose, M.D.

Both my research and my many years as a clinician have convinced me that marijuana can serve at least two important roles in safe and effective pain management. Ample anecdotal evidence and clinical observations, as well as significant research findings, strongly indicate that marijuana, for whatever reason, is often effective in relieving pain. This is true across a range of patient populations, including the elderly, the terminally ill seeking comfort in their final days, young adults stricken with life-threatening conditions, and cancer patients unable to tolerate the devastating effects of potentially life-saving therapies. Marijuana is also widely recognized as an antiemetic that reduces the nausea and vomiting often induced by powerful opioid analgesics prescribed for chronic, severe pain, as well as the nausea, vomiting and dizziness which often accompany severe and/or prolonged pain. I have had the benefit of consultations on this subject over many years with a range of treatment providers, including physicians, oncologists, pharmacologists, family practitioners, hospice workers, and pain specialists.

Specifically, I have found that cannabis can have an important opioid-sparing effect for pain patients. That is to say, that patients who are prescribed high doses of opioid analgesics can significantly reduce their reliance on these medications and improve their daily functioning by incorporating cannabis into their pain care regimen.

Marijuana not only has important analgesic properties but it also is an effective and important adjuvant therapy for patients suffering acute and/or chronic pain. No experienced and respected physician will deny that for such patients opioid therapy is central to palliative care. By the same token, the same experienced physicians will readily acknowledge that opioids often induce nausea and vomiting. For a number of pain patients, standard prescription antiemetics (e.g., Compazine, Zofran and Reglan) simply do not substantially reduce their nausea. For many, those medications are substantially less effective, or produce more debilitating side effects, than marijuana.

Quite simply, marijuana can serve much the same function for pain patients undergoing opiate therapy that it does for cancer patients undergoing chemotherapy: it suppresses the nausea and vomiting associated with treatment, and reduces the pain associated with prolonged nausea and retching, thereby increasing the chances that the patient will remain compliant with the primary treatment. With both chemotherapy and long-term pain management, failure to obtain and continue proper palliative and adjutant care can have dire, even fatal, consequences.

Finally, it is important to note that in my clinical experience observing patients who ingest cannabis for relief from pain and nausea and/or to stimulate appetite, I have witnessed no adverse complications. By contrast, many of the first-line pharmaceuticals used to combat cancer, HIV/AIDS, and pain associated with these and other illnesses can induce a variety of iatrogenic effects, including, in some instances, death. While patients may face serious legal implications related to their use of medical marijuana, as a physician I have yet to encounter a medical downside to their cannabinoid therapy. . . .

[A]gainst the backdrop of a growing body of scientific research, the reports of myriad pain patients, and the burgeoning clinical experience of physicians like myself, it is my considered opinion that cannabis can constitute an acceptable and sometimes necessary medicine to alleviate the immediate suffering of certain patients.[57]

Dr. Rose has served as a medical officer in the Air Force, taught at UC Davis School of Medicine, and consulted with state legislative bodies.

Richard I. Gracer, M.D.

For a small number of patients, even aggressive opiate therapies are not sufficient. Unless alternative pain treatments are found for such patients, they will continue to suffer. For those individuals, their daily lives are often tortuous. As a physician, I am acutely aware of the disturbing connection between intractable pain, overwhelming despair, and suicide.

I can state confidently, as a physician with an extensive practice and specialized expertise in pain management, that marijuana can prove (and has proven) medically useful to at least some chronic pain patients. Accordingly, I believe that physicians should be able to recommend and/or prescribe marijuana to patients for whom it is medically appropriate. Absent that authority, my ability to treat my patients and provide relief from horrific pain is undermined, as is the trust essential to therapeutic relationship.

- Dr. Gracer is Director of Orthopedic Medicine for ChiroView. He is a Fellow of the American Academy of Family Physicians and a Diplomate of the American Academy of Pain Management.

Robert V. Brody, M.D.

As a physician responsible for the care and treatment of those who live in horrible pain, I believe that these patients need, above all else, the broadest possible range of therapeutic options and as full and accurate information as possible regarding those options as they relate to the individual patient. In recent years, I have noted that the public and the government have become increasingly aware of these needs,

and one hopes that measures have been taken to promote adequate pain care for the seriously ill and injured. Several states, including California, have adopted laws and/or guidelines for the prescribing of controlled substances, which seem to permit physicians to treat pain patients without fear of sanction or interference from state authorities.

Insofar as The Compassionate Use Act passed in 1996 expressly provides that chronic pain is a condition for which physicians are authorized to recommend marijuana without threat or fear of punishment, the Act appears to be an additional assurance for physicians like myself that we can rely upon a full range of treatment modalities to care for patients in pain. The IOM Report provides still further support for doctors insofar as it recognizes the potential medical benefits of marijuana... Marijuana has a place in any pain physician's armamentarium.[58]

- Dr. Brody is Chief of the Pain Consultation Clinic at San Francisco General Hospital. He is a peer reviewer for the Western Journal of Medicine, Journal of General Internal Medicine, Annals of Internal Medicine, and the Journal of Law, Medicine and Ethics.

THE HISTORY OF CANNABIS AS MEDICINE

The history of the medical use of cannabis dates back to 2700 B.C. in the pharmacopoeia of Shen Nung, one of the fathers of Chinese medicine. In the west, it has been recognized as a valued, therapeutic herb for centuries. In 1823, Queen Victoria's personal physician, Sir Russell Reynolds, not only prescribed it to her for menstrual cramps but wrote in the first issue of The Lancet, "When pure and administered carefully, [it is] one of the of the most valuable medicines we possess."[59]

The American Medical Association opposed the first federal law against cannabis with an article in its leading journal.[60] Their representative, Dr. William C. Woodward, testified to Congress that "The American Medical Association knows of no evidence that marihuana is a dangerous drug," and that any prohibition "loses sight of the fact that future investigation may show that there are substantial medical uses for Cannabis." Cannabis remained part of the American pharmacopoeia until 1942 and is currently available by prescription in the Netherlands and Canada.

Federal Policy is Contradictory

Federal policy on medical cannabis is filled with contradictions. Cannabis was widely prescribed until the turn of the century. Now cannabis is a Schedule I drug, classified as having no medicinal value and a high potential for abuse, yet its most psychoactive component, THC, is legally available as Marinol and is classified as Schedule III. But the U.S. federal government also grows and provides cannabis for a small number of patients today.

In 1976 the federal government created the Investigational New Drug (IND) compassionate access research program to allow patients to receive medical cannabis from the government. The application process was extremely complicated, and few physicians became involved. In the first twelve years the government accepted about a half dozen patients. The federal government approved the distribution of up to nine pounds of cannabis a year to these patients, all of whom report being substantially helped by it.

In 1989 the FDA was deluged with new applications from people with AIDS, and 34 patients were approved within a year. In June 1991, the Public Health Service announced that the program would be suspended because it undercut the administration's opposition to the use of illegal drugs. The program was discontinued in March 1992 and the remaining patients had to sue the federal government on the basis of "medical necessity" to retain access to their medicine. Today, a few surviving patients still receive medical cannabis from the federal government, grown under a doctor's supervision at the University of

Mississippi and paid for by federal tax dollars. Despite this successful medical program and centuries of documented safe use, cannabis is still classified in America as a Schedule I substance. Healthcare advocates have tried to resolve this contradiction through legal and administrative channels. In 1972, a petition was submitted to reschedule cannabis so that it could be prescribed to patients.

The DEA stalled hearings for 16 years, but in 1988 their chief administrative law judge, Francis L. Young, ruled that, "Marijuana, in its natural form, is one of the safest therapeutically active substances known... It would be unreasonable, arbitrary and capricious for the DEA to continue to stand between those sufferers and the benefits of this substance."

The DEA refused to implement this ruling based on a procedural technicality and continues to classify cannabis as a substance with no medical use.

Widespread public support; state laws passed

Public opinion is clearly in favor of ending the prohibition of medical cannabis and has been for some time. A CNN/Time poll in November 2002 found that 80% of Americans support medical cannabis. The AARP, the national association whose 35 million members are over the age of fifty, released a national poll in December 2004 showing that nearly two-thirds of older Americans support legal access to medical marijuana. Support in the West, where most states that allow legal access are located, was strongest, at 82%, but at least 2 out of 3 everywhere agreed that "adults should be allowed to legally use marijuana for medical purposes if a physician recommends it."

The refusal of the federal government to act on this support has meant that patients have had to turn to the states for action. Since 1996, 15 states have removed criminal penalties for their citizens who use cannabis on the advice of a physcian. Voters have passed medical cannabis ballot initiatives in 10 states plus the District of Columbia, while the legislatures in Hawaii, Maryland, New Jersey, New Mexico, Rhode Island, and Vermont and have enacted similar bills. Approximately one third of the U.S. population resides in a state that permits medical use, and medical cannabis legislation is introduced in more states every year.

Currently, laws that effectively remove state-level criminal penalties for growing and/or possessing medical cannabis are in place in Alaska, Arizona, California, Colorado, Hawaii, Maine, Montana, Nevada, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, Washington, and the District of Columbia. Maryland has reduced the criminal penalty for medical use to a maximum $100 fine. Thirty-six states have symbolic medical cannabis laws (laws that support medical cannabis but do not provide patients with legal protection under state law).

2005 U.S. Supreme Court ruling

In June 2005, the U.S. Supreme Court overturned a decision by a U.S. appeals court (Raich v. Ashcroft) that had exempted medical marijuana from federal prohibition. The 2005 decision, now called Gonzales v. Raich, ruled that federal officials may prosecute medical marijuana patients for possessing, consuming, and cultivating medical cannabis. But according to numerous legal opinions, that ruling does not affect individual states' medical marijuana programs, and only applies to prosecution in federal, not state, court.

Petitions for legal prescriptions pending

The federal Department of Health and Human Services (HHS) and the FDA are currently reviewing two legal petitions with broad implications for medical marijuana. The first, brought by ASA under the Data Quality Act, says HHS must correct its statements that there is no medical use for marijuana to reflect the many studies which have found it helpful for many conditions. Acknowledging legitimate medical use

would then force the agency to consider allowing the prescribing of marijuana as they do other drugs, based on its relative safety. A separate petition, of which ASA is a co-signer, asks the DEA for a full, formal re-evaluation of marijuana's medical benefits, based on hundreds of recent medical research studies and two thousand years of documented human use.

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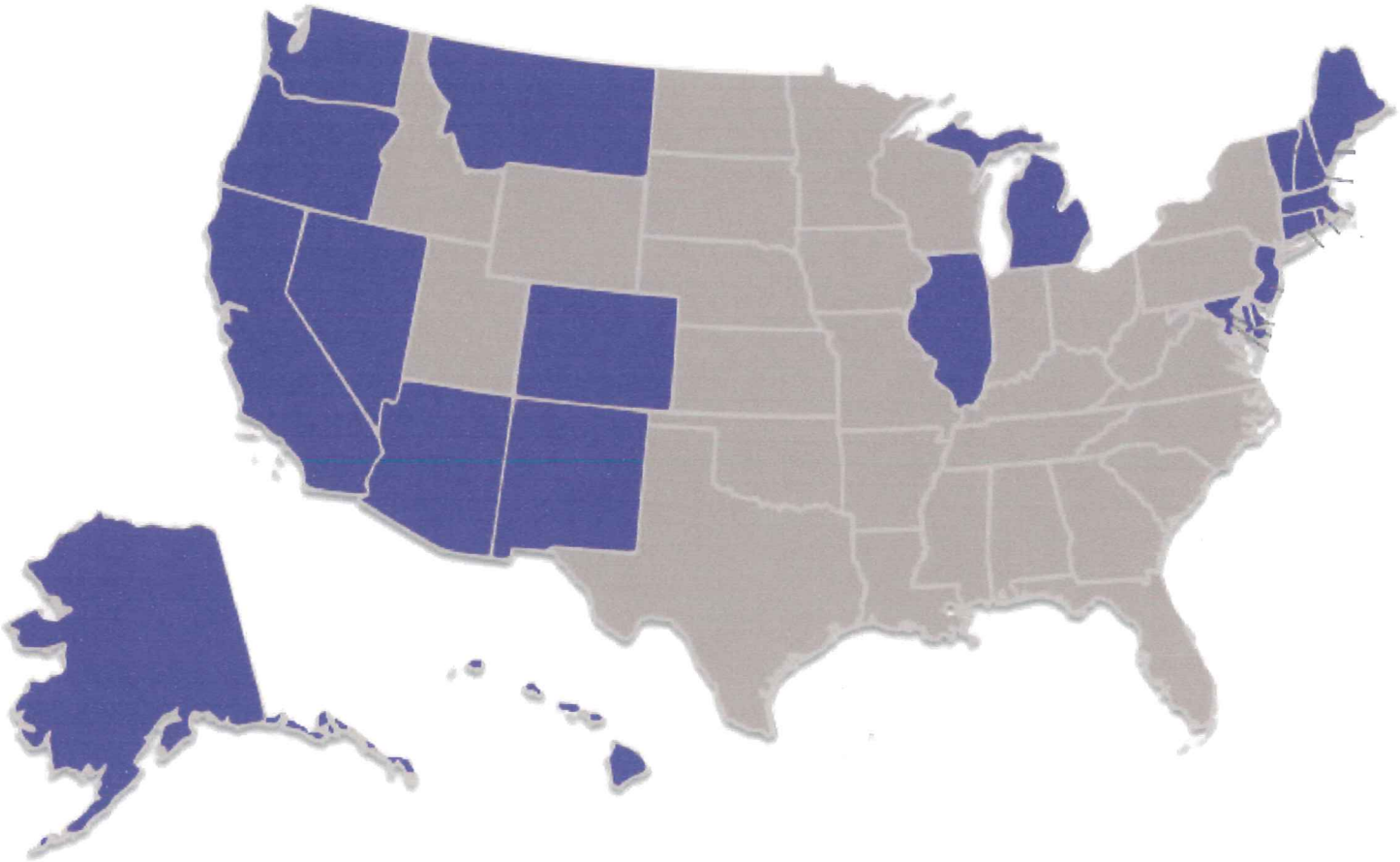

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UCSF Study Finds Medical Marijuana Could Help Patients Reduce Pain with Opiates

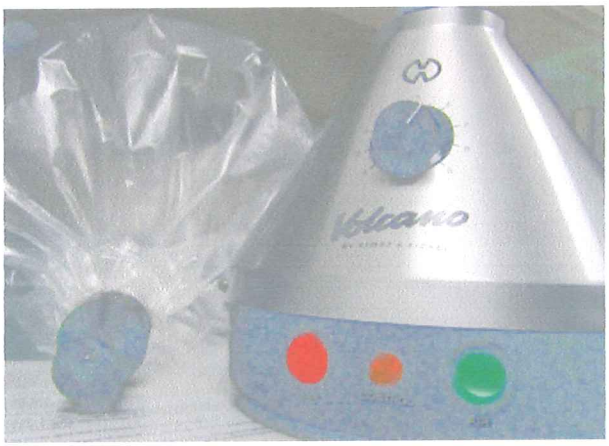
A UCSF study suggests patients with chronic pain may experience greater relief if their doctors add cannabinoids – the main ingredient in cannabis or medical marijuana – to an opiates-only treatment.

By Leland Kim on December 06, 2011

A UCSF study suggests patients with chronic pain may experience greater relief if their doctors add cannabinoids – the main ingredient in cannabis or medical marijuana – to an opiates-only treatment. The findings, from a small-scale study, also suggest that a combined therapy could result in reduced opiate dosages.

More than 76 million Americans suffer from chronic pain – more people than diabetes, heart disease and cancer combined, according to the National Centers for Health Statistics.

"Pain is a big problem in America and chronic pain is a reason many people utilize the health care system," said the paper's lead author, Donald Abrams, MD, professor of clinical medicine at UCSF and chief of the Hematology-Oncology Division at San Francisco General Hospital and Trauma Center (SFGH). "And chronic pain is, unfortunately, one of the problems we're least capable of managing effectively."



A vaporizer such as this one delivers the same amount of cannabis as if a patient smokes a marijuana cigarette.

In a paper published this month in *Clinical Pharmacology & Therapeutics*, researchers examined the interaction between

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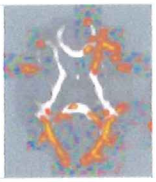

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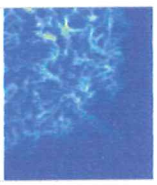

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cannabinoids and opiates in the first human study of its kind. They found the combination of the two components reduced pain more than using opiates alone, similar to results previously found in animal studies.

Major Components of Cannabis

- **Delta-9 Tetrahydrocannabinol (Delta-9 THC)** – It is the main psychoactive component of cannabis with mild to moderate painkilling effects. It also helps treat nausea associate with cancer chemotherapy and to stimulate appetite. It induces feelings of euphoria. Potential side effects include accelerated heartbeat, panic, confusion, anxiety and possible paranoia.
- **Cannabidiol (CBD)** – It is a major, non-psychoactive component of cannabis that helps shrink inflammation and reduce pain without inducing the euphoria effects of THC. It has been used to treat rheumatoid arthritis, inflammatory bowel diseases, psychotic disorders and epilepsy. Larger amounts of CBD can relax the mind and body without causing negative side effects associated with THC.
- **Cannabinol (CBN)** – It is a secondary psychoactive component of cannabis. It is not associated with painkilling effects of THC or CBD. CBN is formed as THC ages. Unlike the euphoria effects of THC, CBN can induce headaches and a sense of lethargy.
- **Tetrahydrocannabivarin (THCV)** – It is found primarily in strains of African and Asian cannabis. THCV heightens the intensity of THC effects and the speed in which the component is delivered, but also causes the sense of euphoria to end sooner.

Researchers studied chronic pain patients who were being treated with long-acting morphine or long-acting oxycodone. Their treatment was supplemented with controlled amounts of cannabinoids, inhaled through a vaporizer. The original focus was on whether the opiates' effectiveness increased, not on whether the cannabinoids helped reduce pain.

"The goal of the study really was to determine if inhalation of cannabis changed the level of the opiates in the bloodstream," Abrams said. "The way drugs interact, adding cannabis to the chronic dose of opiates could be expected either to increase the plasma level of the opiates or to decrease the plasma level of the opiates or to have no effect. And while we were doing that, we also asked the patients what happened to their pain."

Abrams and his colleagues studied 21 chronic pain patients in the inpatient Clinical and Transitional Science Institute's Clinical Research Center at SFGH: 10 on sustained-release morphine and 11 on oxycodone. After obtaining opiate levels from patients at the start of the study, researchers exposed them to vaporized cannabis for four consecutive days. On the fifth day, they looked again at the level of opiate in the bloodstream. Because the level of morphine was slightly lower in the patients, and the level of oxycodone was virtually unchanged, "one would expect they would have less relief of pain and what we found that was interesting was that instead of having less pain relief, patients had more pain relief," Abrams said. "So that was a little surprising."

The morphine group came in with a pain score of about 35, and on the fifth day, it decreased to 24 – a 33 percent reduction. The oxycodone group came in with an average pain score of about 44, and it reduced to 34 – a drop of 20 percent. Overall, patients showed a significant decrease in their pain.

"This preliminary study seems to imply that people may be able to get away perhaps taking lower doses of the opiates for longer periods of time if taken in conjunction with cannabis," Abrams said.

Opiates are very strong powerful pain medicines that can be highly addictive. They also can be deadly since opiates sometimes suppress the respiratory system.

As a cancer doctor, Abrams was motivated to find safe and effective treatments for chronic pain. Patients in the cannabis-opiates study experienced no major side effects such as nausea, vomiting or loss of appetite.

A scale is used to weigh cannabis before it is put in the vaporizer to ensure

"What we need to do now is look at pain as the primary endpoint of a larger trial," he said. "Particularly I would be interested in looking at the effect of different strains of cannabis."

For instance, Delta 9 THC is the main psychoactive component of cannabis but cannabis contains about 70 other similar compounds with different effects. One of those is cannabidiol, or

accurate dosage.

those is cannabidiol, or CBD. It appears to be very effective against pain and inflammation without creating the "high" created by THC.

"I think it would be interesting to do a larger study comparing high THC versus high CBD cannabis strains in association with opiates in patients with chronic pain and perhaps even having a placebo as a control," Abrams said. "That would be the next step."

Abrams is the lead author of the paper; co-authors are Paul Couey, BA, and Mary Ellen Kelly, MPH, of the UCSF Division of Hematology-Oncology at SFGH; Starley Shade, PhD, of the UCSF Center for AIDS Prevention Studies; and Neal Benowitz, MD, of the UCSF Division of Clinical Pharmacology and Experimental Therapeutics.

The study was supported by funds from the National Institutes on Drug Abuse (NIDA), a subsidiary of the National Institutes of Health (NIH).

UCSF is a leading university dedicated to promoting health worldwide through advanced biomedical research, graduate-level education in the life sciences and health professions, and excellence in patient care.

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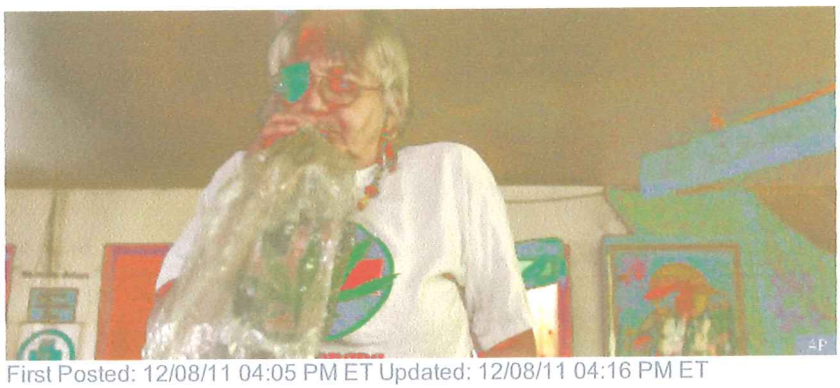
Marijuana, Narcotics Help Patients Reduce Chronic Pain, Study Finds



First Posted: 12/08/11 04:05 PM ET Updated: 12/08/11 04:16 PM ET

WASHINGTON -- A new study out of UC San Francisco has found that medical marijuana, combined with certain opiates, appears to be a safe and effective treatment for patients with chronic pain.

The study, published this month in *Clinical Pharmacology and Therapeutics*, found that patients who use cannabinoids inhaled through a vaporizer, combined with long-acting morphine or long-acting oxycodone, experienced a greater reduction of pain than those who used opiates alone.

The 21 chronic pain patients involved in the study were split into two groups. Those who combined four consecutive days of exposure to vaporized cannabis with morphine experienced a 33 percent reduction in pain, while those who combined it with oxycodone saw a drop in pain of 20 percent. The study is the first to examine the combined effect of these drugs on humans.

"Pain is a big problem in America and chronic pain is a reason many people utilize the health care system," said lead author Donald Abrams, a professor of clinical medicine at UCSF and chief of the Hematology-Oncology Division at San Francisco General Hospital and Trauma Center. "And chronic pain is, unfortunately, one of the problems we're least capable of managing effectively."

Abrams, a cancer doctor, has said that if the study can be corroborated by further research, marijuana could become a treatment for AIDS and cancer patients, augmenting with minimal side effects the benefits that narcotics provide to chronic pain patients.

Abrams said his study implies that patients may be able to get away with taking lower doses of opiates for longer periods of time if they take them in conjunction with vaporized cannabis

That's a laudable goal, since opiates, while a powerful pain medication, are also highly addictive and can prove deadly when they impair function of the respiratory system.

David Downs in the *East Bay Express* addressed the current problems of access that chronic pain patients face in getting medical marijuana, a problem that's only enhanced by the federal government's recent crackdown on pot dispensaries.

Fifteen years after Proposition 215 enshrined in the California Constitution a medical right to cannabis for the sick and dying, the sick and dying have the hardest time getting it. In fact, seniors and the sick had a difficult time getting access to medical marijuana even before the federal crackdown, back when many California patients had little trouble buying it, and the difficulty only increased as they progresssed from independent living to assisted living, nursing homes, hospitals, and in many instances, hospice.
"I think one of the greatest disappointments of the last sixteen years is that we have not been able to provide sufficient access for folks at the end of life," said Stephen DeAngelo, founder of Harborside Health Center in Oakland. "If you take a look at the things cannabis is most effective for, it reads like a laundry list of ailments afflicting seniors: stress, depression, anxiety, pain, insomnia. This is a tremendously underserved population."

The California Medical Association in October called for the legalization of medical cannabis "exclusively on medical and scientific grounds," arguing further research should be done on the drug to better determine its medicinal benefits.

Numerous studies have shown the benefits of using medical marijuana to treat chronic pain. The drug Sativex, a cannabinoid mouth spray, is already on the market in Europe and Canada.

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Jade P. (Coinyer101) 6
POLITICAL PUNDIT · 10,228 Fans · liberal-libertarian King of Doobiestan

Yet, the Obama administration says marijuana has no medical benefits.....,

REPLY FAVE SHARE MORE

frank_day 3
SUPER USER · 7,551 Fans · Obama cares about all of U.S.

I really don't understand the administrations stance against medical marijuana.

Very disappointing.

REPLY FAVE SHARE MORE

7 PEOPLE IN THE CONVERSATION Read Conversation →

empress_trudy 1
98 Fans

As a former two time cancer patient I can safely say that morphine is better than weed when it comes to extreme pain.

REPLY FAVE SHARE MORE

Franklin1776 7
1,969 Fans · Micro-bio rocks! So does Cell-bio!

As a person who has experienced the side effects of morphine I can safely say that weed is much MUCH better than morphine.

REPLY FAVE SHARE MORE

8 PEOPLE IN THE CONVERSATION Read Conversation →

zzlash 9
246 Fans · Age. Fac ut gaudeam

Until our corrupt political system is fixed, the needs of people in pain will always take a back seat to campaign contributions.
6 DEC 2011 4:55 PM

REPLY FAVE SHARE MORE

frank_day 3
SUPER USER · 7,551 Fans · Obama cares about all of U.S.

I'm afraid it is really just that simple.
8 DEC 2011 5:08 PM

REPLY FAVE SHARE MORE

Dave_Harrison 3
SUPER USER · 322 Fans · Fighting for the little guy!

I have been on Opiates for 6 years and recently did my own study regarding the use of Marijuana and opiates. I found I can use 50% less opiates with Marijuana than with out it. Nobody paid me millions to figure it out.
8 DEC 2011 4:50 PM

REPLY FAVE SHARE MORE

Bruce Morgen (editorjuno) 3
389 Fans · Musician, wordsmith, accidental mystic, etc.

I discovered the same thing during my late wife's struggle with cancer. Marijuana also does wonders for cancer patients' appetites and helps with the nausea that often comes with chemo and radiation.
8 DEC 2011 5:04 PM

REPLY FAVE SHARE MORE

3 PEOPLE IN THE CONVERSATION Read Conversation →

keemia 7
265 Fans

We don't need "medical research" for this info. Anyone who smokes pot knows it's a very effective pain killer.
8 DEC 2011 6:52 PM

REPLY FAVE SHARE MORE

Barbara Hawkins (champa10) 4
SUPER USER · 464 Fans · Lady With A Voice

Absolutely, so leave folk alone and find other, more pressing issues to deal with...like cleaning up corruption and and deal with jobs and economy.
8 DEC 2011 7:04 PM

REPLY FAVE SHARE MORE

Nic_in_daytona 8
136 Fans · CLINTON2016

Big pharma doesnt want you to know weed is an adequate substitute for most of the liver destroying dope they push on our society.
8 DEC 2011 5:43 PM

REPLY FAVE SHARE MORE

olitenup
1,310 Fans

Bingo.
8 DEC 2011 6:01 PM

REPLY FAVE SHARE MORE

6 PEOPLE IN THE CONVERSATION Read Conversation →

Casey F. (Danko)
SUPER USER · 248 Fans · Heathen.

8

Everyone should be able to grow their own poppies and cannabis.
8 DEC 2011 6:34 PM

REPLY FAVE SHARE MORE

Martin Beck (Martin_Beck)
SUPER USER · 50 Fans · was whelped in the back seat of a desolo sky view

2

thank you for saying that ! I could not agree more .
8 DEC 2011 6:46 PM

REPLY FAVE SHARE MORE

claygooding
SUPER USER · 59 Fans

4

It reduces the amount of opiates required to relieve pain,,it reduces alcohol consumption,,it grows everywhere,,mankind has used it as medicine for thousands of years,,,,hmmmm,,,could the drug czar or anyone that believes prohibition of cannabis is justified please clarify why cannabis is not a medicine?
8 DEC 2011 4:12 PM

REPLY FAVE SHARE MORE

Jon L. (LibertarianCentrist)
SUPER USER · 737 Fans · Gary Johnson 2016!

1

Because of those reasons mentioned plus all the money that Big Pharma can throw around!
8 DEC 2011 4:39 PM

REPLY FAVE SHARE MORE

4 PEOPLE IN THE CONVERSATION Read Conversation →

Jarhead_Vet
SUPER USER · 318 Fans · Eliot Spitzer for President!!!

5

Hate to rain on everyone's parade, and I know I may sound like a broken record, but special interests will never allow Marijuana to be legal. Heck, the AMA said something like this 2 years ago: **http://www.cbsnews.com/8301-503544_162-5614233-503544.html**

Look, Big Pharma would lose half their OTC pain and sleep aid market share almost overnight... And I can tell you that serious studies would be done in relation to depression and mental health and then you'll all the anti-depressant meds start to vanish. Why do you think Big Pharma has been the largest contributor to Drug Free America for the last 40 years?

And let's not forget law enforcement and judges, and all the people it takes to process the over 1 million arrested yearly for possession. Oh, and then you have to incarcerate enough of them to fill the jails to overflowing... But that's ok... because we need a good source of non-viloent slave labor to compete with China...

Just ask our glorious leader where he stands. 3 years ago he told us he'd back of of California dispensaries... But low and behold come

election time when he needs money from Big Pharma and the Prison Unions... Guess who's 'west coast' DEA division decides to ramp up arrests state wide? Please...

You want Marijuana to be leagal? Start here: **www.getmoneyout.com**

Because the special interests are killing this country...

8 DEC 2011 5:42 PM

REPLY FAVE SHARE MORE

Flying_Sparkz1 4
671 Fans

Special interests are indeed killing the country. However never say never. Our numbers are picking up. I think the first really progressive thing we can accomplish will be the legalization of pot. It has an appeal that goes across the political spectrum.

8 DEC 2011 3:48 PM

REPLY FAVE SHARE MORE

4 PEOPLE IN THE CONVERSATION Read Conversation →

Dawn Rodriguez (Dawn_Rodriguez) 7
SUPER USER · 3,158 Fans · When your work speaks for itself, don't interrupt

We need to stop making Grandma a criminal for using MJ for pain. Legalize it all ready. It should never have been illegal in the first place. Politicians care more about corporations than the people they're supposed to represent. When do we get to vote on these issues?

8 DEC 2011 7:31 PM

REPLY FAVE SHARE MORE

Christian R. (Renifer) 1
SUPER USER · 1,522 Fans · TeaPartiers = Neo-John-Birchers

"Legalize it all ready. It should never have been illegal in the first place."

You can thank Richard Nixon for making mj a schedule D narcotic, in the same league as cocaine or morphine, both of which are available by prescription.

9 DEC 2011 2:41 AM

REPLY FAVE SHARE MORE

3 PEOPLE IN THE CONVERSATION Read Conversation →

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Section I

Professional Recommedations for Medical Marijuana Treatment

Wallingford Internal Medicine / Hartford HealthCare Medical Group
67 Masonic Avenue, Suite 3100
Wallingford, CT 06492
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_Misc Note

Patient: [redacted]

DOB: [redacted]
Home: [redacted]
Work:

[redacted]

March 14, 2014

To Whom It May Concern:

This patient has a diagnosed chronic back condition called post-laminectomy syndrome. He has failed surgery, and suffers chronic pain in the low back and right leg. He continues to seek treatment from Pain Management, who also endorses him for medical marijuana. Patient's syndrome does qualify as a chronic pain condition and should be added to the list of debilitating conditions that qualify for medical marijuana.

Please contact me with any further questions.

Sincerely,

[redacted]

[redacted]

[redacted]