

The Oregon Medical Marijuana Guide

**A Resource for Patients
& Health Care Providers**



Edward Glick, RN

*Foreword by Mary Lynn Mathre, RN, MSN, CARN
Edited by Erik Ackerson, MFA*

The Oregon Medical Marijuana Guide (OMMG)

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Dedication

The Oregon Medical Marijuana Guide is dedicated to all Oregon patients, and their care givers, who struggle against the ravages of disease and government, to preserve their lives.

Copies of this book are available for electronic downloading on Contigo-Conmigo's website <www.or-coast.net/contigo>.

The price for the book is \$5 for patients, and \$10 for health care providers, mailed to:

OMM-Guide, P.O. Box 50 Corvallis, OR, 97339

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* **Cannabis**

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Legal Disclaimer

The Oregon Medical Marijuana Guide is, among other things, an instruction manual on how to use the Oregon Medical Marijuana Act (OMMA). The *Guide's* purpose is also to educate and inform patients and health care providers about the specific diseases for which Cannabis has proven to be a useful treatment. *This book is not a replacement for a medical consultation.* Anyone who uses medical Cannabis should contact his or her health care provider.

Neither OMMA, nor this *Guide*, can confer total legal protection for patients who use Cannabis. It remains illegal to use and possess Cannabis under federal law. The OMMA is, rather, an *exclusion* from Oregon criminal and civil laws banning Cannabis cultivation, possession and use. Cannabis-using patients in Oregon should understand that they are violating federal law and may be arrested, prosecuted, and jailed for their use of the drug *even if they are registered in Oregon's Medical Marijuana Program*. Thus, the author and publisher can assume no responsibility for legal problems arising from the use of this book. It is offered, instead, as an informational and educational resource designed to assist suffering Oregonians in making informed use of the OMMA.

Oregon law, specifically the OMMA, represents the present legal situation concerning medical Cannabis use *in Oregon*. The Controlled Substances Act (CSA) is the legal justification claimed by the federal government for banning all use of Cannabis. Federal authorities, most notably recently retired “Drug Czar” General Barry McCaffery, have steadfastly pursued a policy which refuses to recognize state laws which contravene the CSA. This lack of leadership has relegated the federal government to an increasingly irrelevant position as state after state (now nine) declares open defiance of the Controlled Substance Act. Nevertheless, patients in all fifty states remain in grave danger of prosecution.

This book, as an exercise in the right of expression protected by the First Amendment of the United States Constitution, does not intend to break any laws, rather it seeks to inform its readers so that they may remain in compliance, where possible, with the laws of the land. And, in keeping with fundamental human rights, this book assumes that anyone, anywhere, who uses Cannabis to control disease symptoms, does so to preserve their comfort, health or life. This fact, we would advocate, justifies the “medical necessity” defense, a judicial doctrine that excuses otherwise illegal actions if they were taken to support some greater good. It would seem that the mitigation of debilitating symptoms falls clearly into the protection of this doctrine since there is virtually no harm to society caused by a patient’s therapeutic use of Cannabis. Thus, all patients should consider the use of this doctrine as a defense if they are arrested or prosecuted for Cannabis “crimes.”

Federal prosecutors have not, as of 2001, targeted registrants in the Medical Marijuana Program. If and when they do, the Oregon Health Division will be obliged by law to defend the OMMA and all registered patients. Thus, registration in the Oregon Health Division’s Medical Marijuana Program remains the safest option for most Oregon Cannabis-using patients today.

Edward Glick, RN

Foreword

Healthcare professionals are not educated about the therapeutic use of Cannabis in their formal training due to the wrongful placement of marijuana in Schedule One of the Controlled Substances Act, which makes it a forbidden drug. In the United States, Cannabis remains an illegal substance, yet innumerable patients have found relief in their suffering through the illicit use of this herbal remedy. For the sake of the patients, it is imperative that healthcare professionals not only learn about the dosage and administration of Cannabis, but also help patients in their fight to obtain legal access to this natural medicine.

In the decades since the Marihuana Tax Act of 1937, research regarding the therapeutic properties of Cannabis has been stagnant, due to the numerous roadblocks and lack of funding for such research. However, in the past few decades, major discoveries and advances in the pharmacology of Cannabis have taken place on the international level and thanks in great part to the Internet, this information is available to all who choose to learn. Cannabis receptors have been found in the human body, first in key areas of the brain, then in the immune system, spinal chord and just recently, in the lungs. An endogenous cannabinoid, Anandamide, has been “discovered”. This means that our bodies actually make our own version of a cannabinoid molecule. While these new developments will serve to teach us how the cannabinoids act in the human body, it has been known for centuries throughout the world that Cannabis is a safe and effective medicine for a variety of ailments.

Although the federal government stubbornly continues its prohibition of marijuana, more and more citizens are learning about its efficacy and in turn, supporting efforts to help patients gain legal access to marijuana, especially through voter initiatives which have passed in eight states and Washington DC. This seems like great progress, but the federal prohibition remains as a dark cloud impeding access. Despite the state laws allowing patients to use marijuana as medicine, patients can still suffer legal penalties under federal law, physicians fear potential negative consequences if they recommend this prohibited medication, and there is no guaranteed access to quality-controlled marijuana. These obstacles make it difficult for patients and their primary care providers to have an open discussion about the medical use of marijuana.

Under the new state laws, Cannabis is to be considered as a final medical option from an assortment of symptom-management therapies. However, when considering its wide margin of safety and potential benefit, it should be one of the first therapeutic options chosen for a wide variety of symptoms. I encourage/challenge all healthcare providers to take additional steps in efforts to fight for an end to marijuana prohibition. Until legal penalties cease, patients will continue to be victimized and traumatized.

As healthcare providers, we are obligated to understand the potential risks and benefits of all medicines we administer, so that we can advise patients in their safe use and monitor outcomes. Herbal Cannabis is no different. Once aware of its long history of efficacy we are also obligated to advocate for legal access to marijuana on behalf of all patients who could benefit from its use. One way you can help is to encourage your professional/specialty organization to issue a formal position paper or resolution calling upon the federal government to allow the medical use of marijuana.

Patients Out of Time is a non-profit organization that is dedicated to educating the public and health care professionals about the therapeutic use of Cannabis. One of our tactics has been to compile a list of organizations that support patient access to medical marijuana. We recognize that the intimidation of the federal government scares many well-intentioned and well-informed healthcare professionals from taking a stand. However, these same healthcare professionals gain confidence and courage to explore this issue when their professional specialty organization passes a resolution or position paper supporting patient access to medical marijuana.

This list of endorsing organizations currently includes American Public Health Association, Physicians for AIDS Care, ten state nurses associations and the National Association of Medical Students. While the list continues to grow in number, there remain a large number of organizations that maintain silence. In their silence they accept the current practice of arresting patients who are simply trying to ease their suffering. As healthcare professionals we must not close our eyes, minds and hearts to this injustice. This is an ancient medicine and modern science is only confirming what healers throughout the world have known. Cannabis has been tested for centuries. It does not work for everyone, but it has demonstrated its medicinal value and safety more reliably than most of our modern remedies.

As a registered nurse who helped fight for patient access to medical marijuana in the state of Oregon, Ed Glick is keenly aware of the confusion, fear, misinformation and/or lack of information about the use of Cannabis by patients in Oregon. This book has been written to provide guidelines for patients, caregivers, and healthcare professionals about the medical use of Cannabis in general and the laws regarding such use under the Oregon Medical Marijuana Act. Ed's goal is to prevent any further harm to patients in their struggle to find relief from their suffering through the use of marijuana. In order to make this information readily available and affordable, he has decided to put it on the Internet.

While physicians focus on diagnosing and treating various maladies, nurses focus on symptom management and comfort—helping patients *feel better*. Nurses spend more time with patients and understand the pain and suffering of their illnesses. When a cancer patient stops vomiting and wants to eat after smoking marijuana, this is a good thing. When a spinal cord injury patient has little or no spasticity with the use of marijuana, this is a good thing. When a glaucoma patient's intraocular pressure is reduced to safe limits with the use of marijuana thereby saving the patient's sight, this is a good thing. When a chronic pain patient is able to decrease the use of a strong narcotic and increase his/her activity with the use of marijuana, this is a good thing. When nurses don't have to worry about serious side effects and/or death with an incorrect dose of Cannabis because of its wide margin of safety, this is a good thing. Cannabis as a therapeutic agent is gentle and effective. The prohibition of this plant is cruel and unjust.

It seems fitting that an RN would write this guide. Nurses are aware of the potential risks associated with medications and our role has been to administer medications, monitor their effects, and to teach patients how to use their medicines safely and appropriately to minimize the risks. The focus of this guide is to help the patients, their caregivers, and healthcare professionals from suffering the legal risks attached to this medicine. Access to therapeutic Cannabis shouldn't have to be this difficult, but until the medical marijuana prohibition ends, Oregon patients will need to follow these guidelines to ensure their safety from the law.

This book is a must read for all physicians, nurses, and other healthcare providers who care for Cannabis-using patients in the state of Oregon. Chapters 3 and 4 are highly recommended for healthcare professionals throughout the country as they provide the essential information about the indications for use, risks and benefits. Chapter 5 presents basic information on Cannabis cultivation and is especially helpful to patients and/or their caregivers who will need to grow a continuous supply of the herb. This book can also serve as a guide for other states that are considering medical marijuana, because it clearly addresses the numerous issues that arise in trying to get around the federal prohibition and its consequences.

Mary Lynn Mathre, RN, MSN, CARN

Acknowledgments

To whatever degree the Oregon Medical Marijuana Guide educates and protects patients, nurses and doctors, it is due to the cumulative efforts of many people over many years including those who contributed valuable insight and wisdom to this book.

These people include Dr. Richard Bayer for invaluable strategic, historical and medical guidance. Thanks also to Attorney Lee Berger for legal refinement and suggestions to accurately describe complicated legal arrangements in the Oregon Medical Marijuana Act, and to his tireless efforts to protect patients from cruel laws. Thanks, also to professor Wendell Glick, my father, for giving me a little bit of literary genetics and a lot of feedback, and for proof reading the manuscript.

Thanks to my editor, and friend, Erik Ackerson, who worked tirelessly through handwritten pages and notes, to distill the valuable information. The Guide simply would not exist but for his continuing effort.

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Thank you to Dr. Tod Mikuriya, a pioneer in medical Cannabis research and advocacy. "Doctor Tod" has amassed an enormous research body over decades, and has been an eloquent and steadfast voice for drug-war sanity. I am honored to present a small amount of his work in this book. As well, thank you to Mary Lynn Mathre RN for contributing not only the Forward to this book, but for proofreading it as well. She, and her husband Al Byrne, have worked for many years supporting patients and "pounding on the door" of a reluctant medical establishment.

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Finally, thank-you to all Oregon Cannabis-using patients whose perseverance and courage is a constant inspiration. This book is mostly, for you.

Edward Glick, RN

Preface

The need for the Oregon Medical Marijuana Guide grows out of one basic circumstance: the listing, in the federal Controlled Substances Act, of Cannabis as a Schedule One (banned) substance. More than any other single political or legal fact, this placement prevents virtually all medical use of Cannabis in the United States.

It does not belong there.

The historical record of use backed up by recent science shows that Cannabis is a valuable, safe, and effective treatment for a great number of conditions. Political, not medical considerations have determined the course of this issue. But change is in the wind.

As of the year 2000 nine states have passed recent legal protections for patients who use Cannabis. In Alaska, Hawaii, Washington, Oregon, California, Arizona, Colorado, Nevada and Maine, patients have some measure of protection to use Cannabis.

The Controlled Substances Act requires that a drug must be highly addictive, medically useless, and dangerous to be listed in Schedule One. It is ironic that tobacco more closely fits Schedule One criteria, yet is legal and available. Chapter three of the guide refutes the “dangerousness” justification for Cannabis’ Schedule One designation. Chapter four refutes the “lack of demonstrated medical utility” justification for inclusion. This information would long ago have resulted in Cannabis’ rescheduling, if not for the politicization of the issue.

The current scheduling of Cannabis within the Controlled Substances Act is an insurmountable obstacle for any patients who live outside the “ring of states” that have sanctioned its use.

Medical research combined with the pressure of public opinion will soon force the rescheduling of Cannabis.



“Marijuana, in its natural state, is one of the safest therapeutically active substances known to man....[It] has a currently accepted medical use in treatment in the United States for nausea and vomiting resulting from chemotherapy.”

DEA administrative law judge Francis Young writing in 1988 that marijuana should be classified as a Schedule II drug. The DEA, however, rejected this opinion.

Schedules of Controlled Substances

“It’s a very frightening thing for a physician to be faced with...On the one hand, you have the obligation to inform your patients of your knowledge of medical issues that bear on his or her case. And on the other hand, there is the potential criminal liability that could completely wipe out your career. Even if you win, going through a criminal action would be a nightmare.”

Stephen N. Sherr, a San Francisco attorney, speaking of doctors who know of marijuana’s potential as a medicine yet who are faced with the fact that it is not a medicine that they can legally prescribe because of the federal government’s unjustified position.

The *Comprehensive Drug Abuse Prevention and Control Act of 1970* was signed by President Richard M. Nixon on October 27, 1970, and became effective on May 1, 1971. Commonly known as the *Controlled Substances Act of 1970*, this law specifically states that all drugs controlled by the Act are under the jurisdiction of federal law. Under this law, five Schedules were created to categorize drugs according to their potential for abuse.

Schedule I: These drugs are not safe, have no accepted medical use in the United States, and have a high potential for abuse. These drugs cannot be prescribed and are available only for research after special application to federal agencies. Examples: marijuana, natural THC, heroin, LSD, peyote, psilocybin.

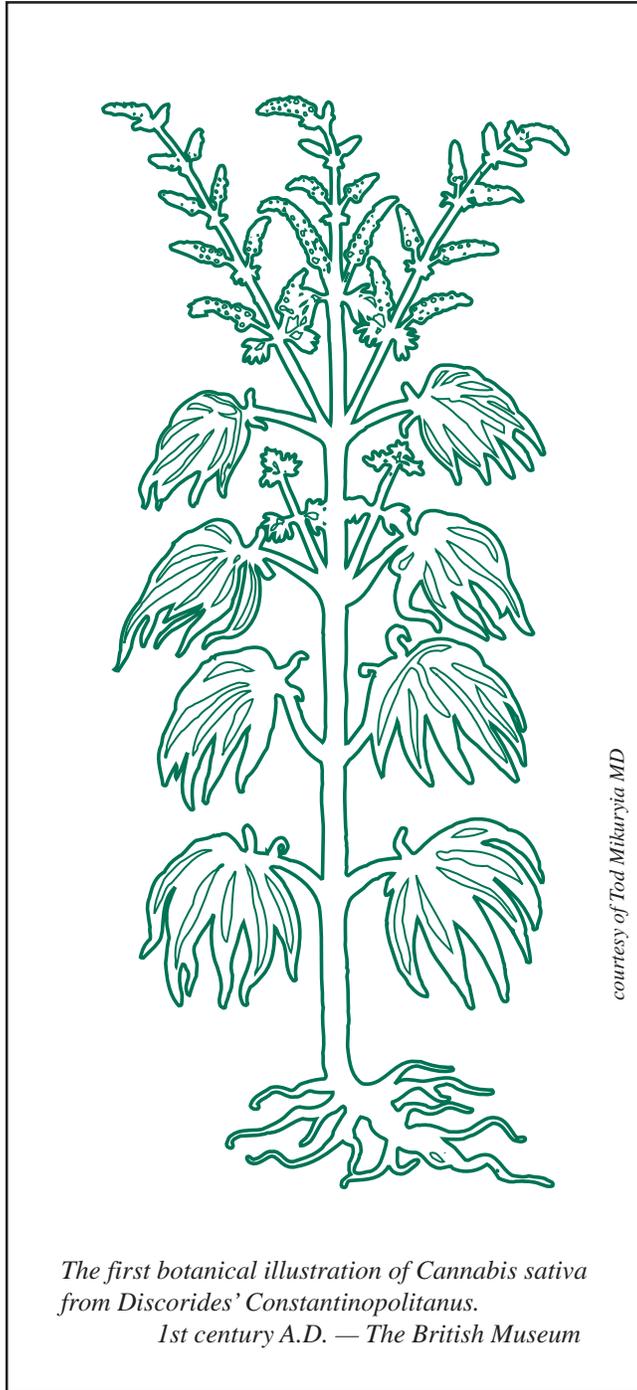
Schedule II: These drugs have a currently accepted medicinal use and have a high potential for abuse and dependence. A written prescription is required by a physician who is registered with the Drug Enforcement Administration (DEA). Telephoned prescriptions refills are not allowed. Examples: opium derivatives (e.g., morphine, codeine), meperidine (Demerol), methadone, Fentanyl, cocaine, amphetamines (Dexedrine) and short-acting barbiturates (e.g., Nembutal, Seconal).

Schedule III: Medicinal drugs with potential for abuse and dependence liability less than Schedule II, but greater than Schedule IV. A telephoned prescription is permitted to be converted to written form by the dispensing pharmacist. Prescriptions must be renewed every six months and refills are limited to five. Examples: paregoric, some appetite suppressants (e.g., Didrex, Tenuate), some hypnotics (e.g., glutethimide, methyprylon) and dronabinol (Marinol) a synthetic THC.

Schedule IV: Medicinal drugs with less potential for abuse and dependence liability than Schedule III drugs. Prescription requirements are similar to Schedule III drugs. Examples: pentazocin (Talwin), propoxyphene (Darvon), benzodiazepines (e.g., Librium, Valium), meprobamate.

Schedule V: Medicinal drugs with the lowest potential for abuse and dependence liability. Drugs requiring a prescription are handled the same way as any nonscheduled prescription drug. The buyer may be required to sign a log of purchase. Examples: codeine and hydrocodone in combination with other active, non-narcotic drugs usually in cough suppressants and antidiarrheal agents.

Chart thanks to *Patients Out of Time*



Chapter 1: Understanding and Using the Oregon Medical Marijuana Act



This chapter describes the basic features of the Oregon Medical Marijuana Act (OMMA) including how to apply to the Oregon Health Division's Medical Marijuana Program. It also describes registry program management and renewal procedures as well as issues concerning the designated primary caregiver. Various concerns relating to growing and obtaining marijuana (Cannabis) for medical use are also considered.

What is the Oregon Medical Marijuana Act?

The Oregon Medical Marijuana Act creates an *exemption from Oregon State criminal law* for certain people to cultivate, use, possess and transport dried herbal Cannabis and live plants. The main (but not only) legal safeguard for Cannabis-using patients is registration in the Medical Marijuana Program managed by the Oregon Health Division. (For descriptions of the “*affirmative defense*” and “*choice of evils*” defense see Chapter 2.)

How do I apply?

In order for a patient to qualify for the registry program s/he must meet certain conditions:

First, the patient must suffer from a “*debilitating medical condition*” as defined in Section 3 of the Act. Debilitating medical condition means:

Cancer, glaucoma, positive status for human immunodeficiency virus or acquired immune deficiency syndrome, or treatment for these conditions...

A medical condition or treatment for a medical condition that produces, for a specific patient, one or more of the following: cachexia; severe pain; severe nausea; seizures, including but not limited to spasms caused by multiple sclerosis; or (a)ny other medical condition or treatment for a medical condition adopted by the division by rule or approved by the division pursuant to a petition submitted pursuant to Section 14 of this Act.

(ORS475.302) ¹

Second, the patient must be under the care of a physician, (MD or DO) licensed to practice medicine in Oregon.



The Oregon Medical Marijuana Act creates an *exemption from Oregon State criminal law* for certain people to cultivate, use, possess and transport dried herbal Cannabis and live plants.



...the patient must suffer from a “*debilitating medical condition*”...



The physician is the “*gatekeeper*” who must be willing to provide written documentation that marijuana may help alleviate the symptoms of the particular disease condition.



...the patient must submit the physician's written documentation ...brief application information, and an application fee of \$150 to the Oregon Health Division.



Patients who are unable or unwilling to grow their own Cannabis may, under OMMA, enlist the assistance of a *designated primary caregiver*.



The Oregon Medical Marijuana Act only covers patients and designated primary caregivers who are Oregon residents. *There is no interstate reciprocity* even though the entire West Coast of the U.S. now has similar laws on the books.

The physician is the “gatekeeper” who must be willing to provide written documentation that marijuana may help alleviate the symptoms of the particular disease condition. This written documentation is a “*medical opinion*” not a “*prescription*” for Cannabis. The patient may also use forms issued by the Oregon Health Division.

(See Appendix A for copies of the Medical Marijuana Program application forms.)

Third, the patient must submit the physician's written documentation (any paper or chart note with the required information may be used for this purpose), brief application information, and an application fee of \$150 to the Oregon Health Division. This program fee was established as part of the Oregon Health Division's rule-making hearings. Ballot Measure 67 required that the costs of operating the registry card system would be placed upon the patients who use it. Thus patients who use the program pay all fees. (This is an unfortunate burden for sick people, especially those who have may well have been bankrupted by the medical establishment. But it has a “silver lining”. The fee structure also isolates and protects the medical marijuana program from legislative cuts, which could have occurred in an attempt to destroy the Act.)²

Designated primary caregivers

Patients who are unable or unwilling to grow their own Cannabis may, under the OMMA, enlist the assistance of a *designated primary caregiver* (DPC). If a designated primary caregiver is used, the patient must also submit that person's name, address, date of birth, and copy of photo identification with the application materials. A designated primary caregiver may be added on (or removed) at any time during the year, at either party's discretion. Whenever a designated primary caregiver arrangement is agreed upon or terminated, the Oregon Health Division's Medical Marijuana Program staff should be notified in writing. Patients should expect to have this transaction confirmed by program staff. (There are instances where failure to notify the Division of a change in cardholder status has resulted in searches and inconvenience for registrants.) Also, any time a designated caregiver (or patient) changes their address, the Oregon Health Division should be notified. If the address growing Cannabis does not match the address on file with the Medical Marijuana Program the police will conduct further investigation.

The Oregon Medical Marijuana Act only covers patients and designated primary caregivers who are Oregon residents. *There is no interstate reciprocity* even though the entire West Coast of the U.S. now has similar laws on the books. The OMMA is not available to patients who are residents of another state. However, an Oregon patient may engage a caregiver who lives outside of Oregon if s/he wishes.

The designated primary caregiver should be made aware that the OMMA *would not* cover him/her in another State, although they would still receive a card from the Oregon Health Division certifying that they are cultivating for a patient in Oregon. As an example, if the patient lives in Portland Oregon, s/he could engage a caregiver living in Vancouver, Washington. The caregiver would receive a card from the Oregon Health Division but would not be protected from *Washington State* laws that ban cultivation and possession of Cannabis. If this person was in compliance with Washington law allowing the possession of a “60 day supply” s/he may be safe; however, this is far from certain since neither state’s medical marijuana law expressly includes anyone from the other state. To date, no court cases have addressed this interstate “reciprocity” issue. Thus the safest action would be for all parties to be registered *as patients* in each of their respective programs.

Applying to the registry program

In order to be properly registered in the medical marijuana program the patient must send all the required information to the State Health Division or drop it off at their county health department.³

The county health department is required to forward the application to the Oregon Health Division within “*five days of receipt*”. Any patient who drops off their application at the county health department should obtain a receipt showing the date exchanged and the document name. This is important because the applicant (patient) is covered by the legal protections of the registry card program *from the time the application is mailed to the Oregon Health Division or dropped off at the county health department*. The receipt is proof that the patient has applied to the registry card program. Patients are required to show this receipt (and hopefully a copy of the entire application) to police officers who request documentation. These legal protections cease if the application is rejected; however, incomplete applications are maintained as “pending” for some time, allowing the patient to safely complete the application procedure. Patients who have submitted an application, but have not yet received a card, must abide by all provisions of the law—possession and cultivation limits. Designated primary caregivers who have not received a card from the Oregon Health Division should consider themselves as *not* registered or legally protected. Unlike the patient, the caregiver *is not* legally registered at the time the application is submitted, only when the application has been approved. This could take weeks or months.

Once the Oregon Health Division receives the application it is date-stamped and reviewed for completeness. The program staff then contacts the physician, usually by telephone, to verify the accuracy of the information. The physician is asked to affirm that the applicant is presently under his/her care for a debilitating condition that qualifies. The physician is also asked to verify that they have provided the written documentation and that they agree that “*marijuana might help*”.



In order to be properly registered in the medical marijuana program the patient must send all the required information to the Oregon State Health Division or drop it off at their county health department.



Patients who have submitted an application, but have not yet received a card, must abide by all provisions of the law—possession and cultivation limits.



The physician is asked to affirm that the applicant is presently under his/her care for a debilitating condition that qualifies.



The Oregon Health Division has no authority to “second-guess” the physician’s written documentation or judgement.

Sometimes physicians are squeamish or unsure about exactly what documentation is allowed or how to document it. The program staff frequently must provide information to physicians concerning their role and what the law allows the patient to do. However, the OHD has no authority to “second-guess” the physician’s written documentation or judgement.

If any application information is found to be fraudulently submitted then the application is rejected and is subject to criminal investigation by the Oregon State Police or the Oregon Health Division. A rejected applicant may not submit another application for a period of six (6) months.

The “Marijuana license” cards

Once the application has been verified as accurate and complete it is approved. When the \$150 fee has been received the Oregon Health Division issues and mails a *numbered certificate* and a *laminated wallet card* to the patient, and any caregiver. These documents contain application information for any and all registrants. The laminated wallet card has two sides. The Oregon Seal is on the front, along with the name and address of the patient or caregiver (whichever person the card is issued to). The Oregon Health Division’s telephone number and the date of issue and expiration also appear, as does the card number, printed in red.

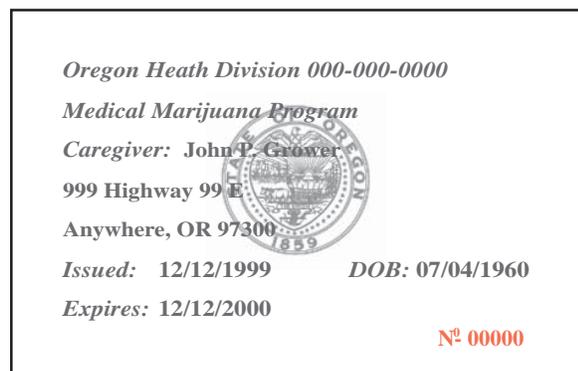
The back of the patient’s card has the corresponding information for the designated primary caregiver (if there is one). The name, address and date of birth of the caregiver is printed underneath the words “Oregon Health Division Medical Marijuana Program.” Once again, it is critical that the address of the caregiver match the location of the Cannabis “grow” since the caregiver is, by definition, cultivating Cannabis. If the caregiver’s address does not match with the grow location, police may telephone the Division for verification.



...it is critical that the address of the caregiver match the location of the Cannabis “grow” since the caregiver is, by definition, cultivating Cannabis.



Extra copies of the documents should be made and stored. In the event that a patient is contacted by law enforcement, s/he should show either document as proof of registration.



The Medical Marijuana Program Caregiver Card

An 8X9 inch, card-stock identification card is also sent to the patient and caregiver. This sheet contains “Record No.” and “Audit No.” in addition to all the information listed above. The record number is the database reference number. The audit number is the number given by the cashier to record the payment. Finally, the card-stock registration sheet also shows the Oregon Health Division letterhead.

These two documents are to be kept secure and available at all times for police inspection. Extra copies of the documents should be made and stored. In the event that a patient is contacted by law enforcement, s/he should show either document as proof of registration. The police should then contact the Oregon Health Division before conducting any further search or investigation, unless they have reason to believe that a crime is being committed. (Chapter 2 describes law-enforcement issues including “knock-and-talk” procedures.) Registered patients should remember that the law allows them to possess, use and grow Cannabis. Therefore, a police officer cannot use the presence of Cannabis or plants to justify a search.

The registry identification card is valid for one year from the date issued, and must be renewed annually to remain active. Renewal occurs when the patient completes and submits a renewal form and encloses the annual fee. (\$150 in 2000.) Renewing a registry card only requires the physician to confirm that the patient is still suffering from a debilitating condition. Information on the application should be updated at this time. If the information contained on the original application is still correct a new card is issued.

Possession limits and “legal” behaviors

Registration in the Medical Marijuana Program allows patients to grow up to seven Cannabis plants. It allows the caregiver to grow seven plants *if* the patient is not growing. There is some ambiguity regarding Cannabis grown at more than one location but in general as long as the number of plants between one patient/caregiver group does not exceed seven, the parties are protected. The law allows growers to flower up to 3 plants at a time and possess up to one ounce of dried (i.e. usable) Cannabis for each flowering plant. Patients may exceed the seven-plant limit if they obtain written documentation from the physician affirming that the greater amount is medically necessary. The Oregon Attorney General’s Guidelines also state that the law allows *more than seven plants* and recommends that the patient’s physician would need to agree that the greater allowance is legitimate. Unfortunately the OMMA does not clearly spell out a medical method for patients to establish greater need. Proving in court the greater need presupposes that the patient may have to get arrested and contest the charge.

If the patient (or caregiver) has three flowering plants then s/he is allowed three ounces of dried Cannabis. The law does not allow patients to flower more than three (3) plants at a time. Thus, if the grower has two flowering plants, s/he is allowed to possess two ounces of usable Cannabis. These limits do not appear to be a problem for police unless the total number of plants exceeds seven (7). If a caregiver is growing Cannabis for the patient at another location than the patient’s residence, the patient can only legally possess one (1) ounce of dried Cannabis. (See chapter 7 for a discussion of the convoluted legislative maneuverings that clouded the question of possession limits.)



Renewal occurs when the patient completes and submits a renewal form and encloses the annual fee.



Registration in the Medical Marijuana Program allows patients to grow up to seven Cannabis plants. It allows the caregiver to grow seven plants *if* the patient is not growing.



The Oregon Medical Marijuana Act allows patients or caregivers to transport up to one (1) ounce of dried Cannabis.



Under provisions of the Oregon Medical Marijuana Act Cannabis and plants may not be sold.



...since cultivation places the financial burden on the caregiver it *might* be interpreted that a patient may pay for the expenses incurred by the caregiver to grow Cannabis.



The Oregon Medical Marijuana Act prohibits use of Cannabis in “public,” which includes highways, even if the patient is not driving.



Black-market Cannabis may also be contaminated with dirt, debris, bugs, seeds, other plants, or microorganisms. It may also be adulterated with harmful chemical residues like pesticides.

The Oregon Medical Marijuana Act allows patients or caregivers to transport up to one (1) ounce of dried Cannabis. Patients and caregivers may also transfer up to this amount of Cannabis (or up to seven live plants) to another registrant. Live plants are not “usable marijuana” and therefore they may weigh over an ounce. Since three of the seven plants must be flowering, patients may be at risk if they transport seven plants. To be safe, most patients only transport four plants at a time. Caution should be used to ensure that all parties involved in this transaction are registered with the program. If a registered patient gives Cannabis or plants to a non-registered person, s/he is breaking Oregon law. If the registered patient receives plants from someone who is not registered with the medical marijuana program, the unregistered person is breaking Oregon law. The patient is not. Even so, the patient is associating with someone who is committing a crime and wily prosecutors could manipulate the law by charging the patient with a “conspiracy” to commit a crime. For this reason, registered patients should deal with other registered patients or caregivers in any medicine or plant transactions.

Under provisions of the Oregon Medical Marijuana Act, Cannabis and plants may not be sold. Selling herbal Cannabis is a violation of the Medical Marijuana Program and may result in prosecution. However, since cultivation places the financial burden on the caregiver it *might* be interpreted that a patient may pay for the expenses incurred by the caregiver to grow Cannabis. (These expenses can be substantial and include electricity, fertilizer, soil, water, lights, fans, Carbon Dioxide [CO₂] generators, and timers.) Reimbursement for expenses may actually be allowed under the OMMA, but the issue has not been the subject of litigation as of 2001. There is a strong argument to be made that paying for electricity and equipment *is not* selling Cannabis but *assisting* in its cultivation. Until the issue gets litigated, patients and caregivers should understand that exchanging money for Cannabis attracts police attention. Not keeping records and using cash is easy. Carefully documenting electricity bills and other expenses takes a little work and time, but it shows exactly what the true costs of production are. The patient and caregiver should agree on what accounting method to use. In any case, patients and caregivers should carry their registry I. D. card with them any time they transport Cannabis or plants. (Medical Cannabis labels are provided in Appendix J to officially stamp the transported Cannabis as “medicine.”)

The Oregon Medical Marijuana Act prohibits use of Cannabis in “public,” which includes highways, even if the patient is not driving. Caregivers must also understand that the law does not permit them to use Cannabis unless they are also “patients.” The penalty in Oregon for simple possession of under an ounce of Cannabis is equivalent to a traffic citation and carries a *maximum* fine of \$1000.

Safely obtaining a supply of Cannabis

Although federal law bans possession and use of Cannabis its cultivation and sale is a multi-billion dollar business in the United States—another example in the long list of Drug War failures. In this difficult context sick people all over America struggle to meet their medical needs as they face the dual obstacles of dealing with the dynamics of illegal supply and federal prohibition.

Searching for and procuring illegal Cannabis forces many patients (and their families) into illegal drug markets. This is undesirable for several reasons: First, the quality of “black-market” Cannabis varies tremendously. Supplies are *economically* rather than *medically* driven. And, as with corporate dominance of American pharmaceutical and monetary systems, black-market systems have no particular regard for disease or suffering. Potency may vary significantly, from the nearly zero cannabinoid levels of Midwestern hemp, to the common low-to-medium quality Mexican Cannabis that gets bricked for shipping with little quality control. (It is worth noting that in areas of the country with large Cannabis industries, like Oregon, the quality of Cannabis is often superior. The demand for, and availability of high-potency Cannabis, unfortunately, also escalates the price.) Since there is no quality assurance, or cannabinoid assay, the patient has no idea of what s/he is paying outrageous prices to obtain. Black-market Cannabis may also be contaminated with dirt, debris, bugs, seeds, other plants, or microorganisms. It may also be adulterated with harmful chemical residues like pesticides. Imported Cannabis is often poorly cured, if at all. It continues drying after packaging and this can result in decomposition and bacterial infection.

Second, patients are searching for medicine among profiteers. Medical Cannabis patients are sometimes victimized. They are forced to pay extreme prices in much the same way as they now do for pharmaceuticals. The “market” price for medium-quality Cannabis ranges from \$40- \$100 for an eighth of an ounce. An ounce of high-potency Cannabis like “B.C. Bud” may cost \$400, higher than the price of gold! The price of Cannabis is a direct reflection of the supply and demand dynamics of illegal drug networks. The actual price to grow an ounce of high-potency “sinsemilla” ranges from \$10 to \$15 using metal halide lights. (Much less outdoors.)

Recreational users dominate the illegal Cannabis market. They have money and can afford to pay incredible prices. Patients can't. This undercuts the ability of patients to find and buy their medicine.⁵

Third, patients who associate with illegal drug networks are far more likely to be arrested and prosecuted because of this association.

For these reasons, patients are advised to avoid black-market Cannabis if possible. If an adequate safe supply is available from “the guy down the street” a patient will have to decide if the risks justify the benefits. Patients should deal with growers who they know and trust if at all possible.



The price of Cannabis is a direct reflection of the supply and demand dynamics of illegal drug networks. The actual price to grow an ounce of high-potency “sinsemilla” ranges from \$10 to \$15 using metal halide lights.



In order to minimize or eliminate black-market safety issues, the Oregon Medical Marijuana Act was written to include provision for cultivation and possession of plants.



The organization perhaps most responsible for assisting Oregon's patients is Voter Power which supports patients by providing information and assistance.



Ordering seeds by mail is another option that some patients are using. Cannabis seeds are widely available in many countries, especially in Europe.



Possession of viable Cannabis seeds is a federal crime in the United States. Patients who are apprehended attempting to smuggle seeds back into the United States face extreme legal consequences including forfeiture of assets and jail.



The belligerent attitude of the “feds” towards medical Cannabis will likely not cease until the laws surrounding Cannabis are changed in many individual states.

In order to minimize or eliminate black-market safety issues, the Oregon Medical Marijuana Act was written to include provision for cultivation and possession of plants. At this time, the only “legal” method for patients to obtain and possess Cannabis is to do it themselves under an umbrella of safety provided by the Oregon Health Division. The Oregon Medical Marijuana Act “allows” the transfer of plants between registered patients, aiding patients to provide their own supply. In Oregon, patient-to-patient supply networks are slowly establishing a network of safe communications allowing patients to grow their own supply. The overriding illegality of the herb, however, makes this process extremely difficult, and sometimes dangerous, since there are always people who are willing to exploit the law, as well as vulnerable patients, for profit.

With the continual threat of federal intervention hanging over the OMMA, patient-centered advocacy organizations that provide seeds and clones to registered patients have “sprouted” up. The organization perhaps most responsible for assisting Oregon’s patients is Voter Power which supports patients by providing information, assistance, and leadership. Other organizations like Medi-juana, and the Stormy Ray Foundation also work to support patients. (The “Oregon Resources” section provides contact information for most of the organizations in Oregon that assist patients.)

As statewide advocacy organizations develop, so too will patient networks. Many registrants know other registrants. They often provide clones or Cannabis to each other. This is smart, since networks of patients growing the same variety create “insurance” against any one patient’s crop loss. This arrangement also allows larger numbers of patients to compare the same strain.

Mail order seeds

Ordering seeds by mail is another option that some patients are using. Cannabis seeds are widely available in many countries, especially in Europe. Dozens of seed companies, selling hundreds of different strains advertise on the Internet and in publications like *High Times* magazine. On this continent, British Columbia, Canada has evolved a large commercial domestic Cannabis industry. Many Americans travel to Vancouver, B.C. to buy seeds, then smuggle or mail them back to the United States.

Again patients are in grave danger, not because of predatory drug gangs, but because of predatory police enforcement. What is perhaps worse is that police have the law on their side. Possession of viable Cannabis seeds is a federal crime in the United States. Patients who are apprehended attempting to smuggle seeds back into the United States face extreme legal consequences including forfeiture of assets and jail. As a result of the booming Cannabis industry in Canada, customs agents in Washington State are on heightened alert for anyone smuggling seeds or medicine. Patients should carefully evaluate the potential

risks of smuggling seeds into the United States. It is also a federal crime to use the U.S. Postal Service to send seeds through the mail although many people do so.

Where do we go from here?

Since Oregon's Legislators are generally fearful and insecure around the issue of medical Cannabis, it is unlikely that major legislative change will happen any time soon. In 2000, a group of medical Cannabis advocates met to discuss shortcomings and formulate a legislative bill. This working-group clarified language and suggested improvements to the OMMA. In any case, the OMMA in the year 2001 is equivalent to a patient in the intensive care unit on a respirator. Just keeping this program "alive" is progress. Probably the greatest single threat to the OMMA's security is federal interference. The belligerent attitude of the "feds" towards medical Cannabis will likely not cease until the laws surrounding Cannabis are changed in many states. Still, the Oregon State Health Division's Medical Marijuana Program remains the safest option because it removes patients from Oregon State criminal laws. Prior to 1999, these laws accounted for the majority of patient prosecutions.

Until the federal laws are changed, the safest way for Oregon patients to gain access to quality Cannabis strains for cultivation purposes is to network among themselves. In Oregon, patient and advocacy organizations serve as that basic structure. In the future when prohibitions against Cannabis are erased, these issues will not be a concern.

But for now, patients can ensure a safe, consistent supply of Cannabis, and stay out of legal trouble, by growing it themselves, never selling Cannabis and only exchanging plants, medicine and seeds with other registrants.



...for now, patients can ensure a safe, consistent supply of Cannabis, and stay out of legal trouble, by growing it themselves, never selling Cannabis and only exchanging plants and seeds with other registrants.

Footnotes

¹ The Oregon Health Division added “Agitation due to Alzheimer’s disease” to the list of approved conditions in June 2000. (See chapter 7 for a description of the Debilitating Medical Conditions Advisory Panel.)

² Originally the fee was set at \$50 based upon guesses about how large or costly the program would be. Due to the statutory requirement that patient fees must fund the program, the Oregon Health Division decided upon a \$150 annual fee with the provision that the fee could be adjusted as the program evolved. This should eventually lead to a reduction in the fee as the program establishes a stable base.

³ Applications should be mailed registered mail to: Oregon Department of Human Services, Oregon Health Division, 800 NE Oregon Street, Suite 640. PO Box 14450, Portland Oregon 97293-0450. Attention: Medical Marijuana Program. A pre-addressed envelope is enclosed in the application packet. The Health Division sends a confirmation letter after receiving the application.

⁴ The OMMA has no provision for monitored cultivation in larger facilities like the Cannabis resource centers in California. Federal prohibition, which makes large grow operations vulnerable to interference from various agencies of the federal government, has contributed to implementation difficulties in California.

Chapter 2: Legal Protections of the Oregon Medical Marijuana Act



A truce in Oregon's war against sick people

The passage of Ballot Measure 67—Oregon Medical Marijuana Act (OMMA)—in November of 1998 was a watershed event for Oregon's Cannabis-using patients. Before the OMMA, patients in Oregon were routinely prosecuted for any Cannabis possession and cultivation. If a district attorney could stack on other charges—conspiracy, possession near a school—he would routinely do so. The climate was ugly. Diane Densmore, a Portland patient and Director of the Alternative Health Center, was arrested and convicted in 1997 for operating a dispensary serving patients. Diane received this treatment from an enforcement system which simply rolled over people in need while echoing the War on Drugs party line. Other sad dramas of a criminal “justice” system gone mad were all too common. (These stories still abound in many states.) Patients had no defense, and judges routinely disallowed any “desperation defenses.” If patients were “lucky,” they had their medicine taken by police and were shackled to their homes with electronic monitoring bracelets. The less fortunate fell victim to the legal extortion of district attorneys who would fine the patient thousands of dollars in exchange for dropping charges.

Mercifully, this situation changed when Oregon voters passed the OMMA, finally reining in state-supported abuse of sick and dying Oregonians. Indeed, the passage of the OMMA into Oregon law completely changed the relationship between police and Cannabis-using patients. Its passage sent a clear signal to Oregon's law enforcement officers to stand clear of patients. And, by and large, they have. This is not to say that police supported the OMMA. Many didn't. A few high-profile law-enforcement officials, most notably Multnomah County Sheriff Dan Noelle and Molalla Police Chief Rob Elkins, campaigned actively against the initiative. They claimed that its passage would undermine the ability of law enforcement to prosecute any Cannabis-related crime. Instead, they offered voters Ballot Measure 57, which had been passed by the legislature and signed into law by Governor John Kitzhaber, a physician. (It was *referred* back to voters as a *referendum*, by collecting enough signatures to send it to the voters.)

Ballot Measure 57, otherwise known as “recrim” would have *increased* Cannabis penalties against sick and well people alike. Ballot Measure 57 went up in flames at the ballot box and the OMMA was



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... the passage of Oregon Medical Marijuana Act ... completely changed the relationship between police and Cannabis-using patients.



the [Oregon] Attorney General assembled law-enforcement groups to formulate guidelines for police...



Unresolved issues center around situations police may encounter which do not fall into clear categories.



The [Attorney General's] Guidelines question the legal right of patients to each possess up to seven plants.



...*anyone* who is registered in the State Health Division's Medical Marijuana Program, may transport plants and usable Cannabis to any other registrant as long as quantity limits are not exceeded.

born, all in the same election. Chapter 7 recounts some of the highlights of the campaign.

Understanding the Attorney General's guidelines

Once the Oregon Medical Marijuana Act was passed, Hardy Myers, the state's Attorney General, assembled law-enforcement groups to formulate general guidelines for police. The effort yielded modest results. While the work-group did clearly recommend that officers investigate the circumstances of the situation before acting, they deferred to local authorities on most of the complicated issues. This lack of leadership had the potential to create the same vacuum of a lack of consistency that has plagued implementation of California Prop. 215.¹

The Attorney General's OMMA Guidelines state the obvious: patients registered through the Oregon Health Division are legally protected from prosecution for using Cannabis. Police should therefore investigate only to see if the situation in question falls outside the boundaries of the law. The Guidelines are quite clear and specific on this point. Unresolved issues center around a variety of situations police may encounter which do not fall into clear categories.

First, the Attorney General's Guidelines question the legality of transporting Cannabis on the interpretation that *any* possession of plants or Cannabis on public highways constitutes "public use" which is forbidden by the OMMA. But the Attorney General's claim that *any* transporting of Cannabis constitutes "public use" is a circular argument which only serves to cloud rather than clear interpretation of the OMMA. This interpretation also leaves open the possibility that local law-enforcement may prosecute patients for transporting Cannabis or plants. (There is no indication that this has yet occurred in Oregon.)

This should not be an issue. The OMMA intended that registrants would be permitted to transport Cannabis *and* plants on Oregon's highways. (In fact, the OMMA intended to allow *any* designated primary caregiver to transport plants and usable Cannabis to *any* registered patient. Also, any registered patient may transport Cannabis and plants to any other registered patient. A patient may also transport plants and Cannabis to any registered caregiver. Thus, *anyone* who is registered in the State Health Division's Medical Marijuana Program, may transport plants and usable Cannabis to any other registrant as long as quantity limits are not exceeded.)

Second, the Attorney General's Guidelines draw a hard line in interpreting complex situations involving more than one registered patient living at the same address.

The Guidelines question the legal right of patients to each possess up to seven plants. "Statutory Disqualification's" 7 (b) i states:

Section 7 of the Act does not expressly state whether a different limit applies when several registrants are present at a single location where marijuana is being produced. The Act can be interpreted to limit the total amount of marijuana grown on

that location to seven plants. This interpretation is premised on the assumption that each registrant at the location simultaneously possesses the same marijuana.

Alternately, the Act may be interpreted to permit seven growing plants for each registrant who is present at the growing site. In consultation with the appropriate prosecuting attorney, law enforcement agencies should adopt policies for officers to follow when multiple registrants are encountered at the same location.

This wording appears to ignore the implied allowances written into the OMMA—seven plants for each patient. The *absence* of wording to describe this scenario is construed by the Attorney General to mean that it may not be legal. Again, the intent of the OMMA was clear: any patient registered with the Oregon Health Division has the legal right to grow and possess seven plants. If two patients live at the same address they have the right to collectively possess up to 14 plants. By deferring to local law-enforcement agencies the interpretation of this question, patients in different parts of Oregon will be treated differently. (This local interpretation of state law is one reason why California has had monumental difficulty in implementing Prop. 215.)

In similar fashion the Guidelines muddle the issue of a designated primary caregiver who cares for multiple patients and who grows seven plants for *each* patient.

Section 7 of the Act does not expressly state whether a different limit applies when one person is the primary caregiver for multiple patients. Under one interpretation, a primary caregiver may not exceed the seven-plant limit on property under his or her control, regardless of the number of patients under his or her care. Accordingly, if the primary caregiver for three patients is growing three mature plants and four immature plants for one patient on property that is under the control of the primary caregiver, the marijuana for the other two patients must be grown on property that is under the control of the patients themselves. (II B (7) b ii.)

The Guidelines attempt to resolve this problem by suggesting that legislative intent is to allow a caregiver to grow Cannabis for more than one patient if several conditions are met. These include:

- (a) The multiple sites consist of an address under the control of the primary caregiver and other addresses under the control of the patients, but not more than one address for any of these persons;
- (b) Any address where marijuana is grown is registered with the Health Division;
- (c) The presumptive limit regarding the quantity of plants and usable marijuana is not exceeded at any of these addresses; and



...the intent of the OMMA was clear: any patient registered with the Oregon Health Division has the legal right to grow and possess seven plants. If two patients live at the same address they have the right to collectively possess up to 14 plants.



By deferring to local law enforcement agencies the interpretation of this question, patients in different parts of Oregon will be treated differently.



...caregivers who intend to cultivate multiples of seven plants for more than one patient should first check with local law-enforcement agencies.



...the Attorney General’s Guidelines suggest that police officers should conduct detailed interviews of patients in an effort to establish the legitimacy for their claim of medical use.



This interview...would thus occur without patients being informed of their *right to refuse* to answer questions (the Miranda warning).

(d) The person is not otherwise disqualified from the exception.

Although this language does not answer the question of whether the caregiver can grow more than seven plants, it does draw boundaries around it. Thus, caregivers who intend to cultivate multiples of seven plants for more than one patient should first check with local law-enforcement agencies. Some localities, like Benton County, promote a more flexible interpretation. ²

Third, the Attorney General’s Guidelines suggest that police officers should conduct detailed interviews of patients in an effort to establish the legitimacy for their claim of medical use. These interviews are to include questions relating to medical diagnoses as well as other personal medical information. The Guidelines make no suggestion that the police officer should obtain a release of medical information. This interview (investigation) would thus occur without patients being informed of their *right to refuse* to answer questions (the Miranda warning). Additionally, “*knock-and-talk*” searches involve intimidating interviews in an attempt to coerce persons to voluntarily relinquish their privacy rights. The omission of clarifying language serves to increase legal burdens on sick people who have little rhetorical skill in a meeting with well-trained police officers.

There are also situations that are not adequately addressed by the Guidelines such as the legal right patients have to grow more than seven plants. Oregon Revised Statutes 475.319(c) allows patients to use the affirmative defense for a charge of possession or production of Cannabis if the patients:

Possess or produces marijuana only in the amount allowed in ORS 475.306 (1), or in excess of those amounts if the person proves by a preponderance of the evidence that the greater amount is medically necessary as determined by the person’s attending physician...to mitigate the symptoms or effects of the person’s debilitating condition. (ORS475.319(c))

The only reference in the Guidelines is under Section III (B): “Seeking Evidence Regarding the Amount of Marijuana Grown or Possessed.” It states:

If the amount of marijuana manufactured or possessed exceeds the presumptive limits established by the Act...the person cannot establish the affirmative defense unless the person proves by a preponderance that “the greater amount is medically necessary as determined by the person’s attending physician to mitigate the symptoms or effects of the person’s debilitating medical condition.

This statement does tell officers that patients may possess greater amounts in certain circumstances. But it neglects to describe a process for officers to follow when they contact a patient with more than seven plants, other than that they may destroy the “extra” plants or arrest the

patient. (Many patients find that seven plants are inadequate to produce a reliable supply of medicine. OMMA requires that they prove this greater medical need by a “preponderance” of evidence, that is to say, more than half.) Most officers are told to harvest plants above seven in number. Few patients seem to know that they could contest this limit with their physician’s support, namely that more plants are indeed medically justified.

The Guidelines define “usable” marijuana as dried leaves and flowers, but make no mention of a patient or caregiver’s legal protection when transporting or possessing uncured or fresh flowers. Since fresh flowers are around 75 % water by weight, patients and caregivers *may transport up to three (3) ounces of fresh flowers*, if not more. Registrants may transport and possess an amount of Cannabis which, *when dried down*, would equal up to one ounce. Registrants may also transport up to seven live Cannabis plants, but must ensure that the plants are “not exposed to public view” (must be covered) during transport.

In relatively simple situations the Guidelines clearly state the obvious. But in less-clear circumstances, they defer to local interpretation. Fortunately, some local law-enforcement agencies have assumed a flexible approach that acknowledges the social mandate of the OMMA, as well as law-enforcement priorities. The first Oregon locality to draft policies was Benton County. During the first half of 2000, Corvallis Police Chief Pam Roskowski and District Attorney Scott Heiser began a process of clarifying the circumstances that fell outside of the Guidelines. The policy was drafted in coordination with all county law-enforcement agencies. It demonstrated an important priority in quickly distinguishing medical Cannabis patients from others by suggesting that officers evaluate the patient’s circumstances.

While acknowledging that obvious violations of the law—selling Cannabis—would be prosecuted, the Benton County Guidelines improve upon the Attorney General’s Guidelines in one key way: It explicitly allows multiple registrants in a house to *each* grow up to seven plants. Although the number of situations this will occur is probably small, it acknowledges a more tolerant attitude on the part of Benton County law-enforcement. When officers encounter a “grow” with more than seven plants, they are expected to use reasonable judgement as to what the law allows. The Benton County policy recommends that:

In cases where the grow does not substantially (emphasis added) exceed the 7 plants authorized (3 mature and 4 immature), the officer should simply harvest all plants in excess of the seven plants authorized, but should NOT seize the growing equipment. (1.3.2 (2))

This policy recommendation makes no mention of arresting the patient, only harvesting the excess plants. It also makes no mention of the possibility that the patient may be entitled to grow more than 7 plants. Although the policy is relatively new, Benton County law



Few patients seem to know that they could contest this [seven plant] limit with their physician’s support, namely that more plants are indeed medically justified.



Registrants may also transport up to seven live Cannabis plants, but must ensure that the plants are “not exposed to public view”... during transport.



Benton County law-enforcement officials have clarified important issues of police scrutiny regarding medical Cannabis patients.



There are three specific defenses written into the OMMA for use by Cannabis-using patients. These legal strategies are each distinct.



Patients and caregivers should clearly understand that OMMA **DOES NOT** provide any legal protection against federal laws that prohibit use and cultivation of Cannabis.



The exception from criminal laws regarding Cannabis...offers... patients a defense from prosecution and is the essence of OMMA...



The exception permits the use, possession, cultivation and transport of Cannabis and plants to persons who are registered in Oregon's Medical Marijuana Program.

enforcement officials have clarified important issues of police scrutiny regarding medical Cannabis patients. This protects patients and prioritizes police resources into more important areas. As of 2000, no other Oregon locality had assumed responsibility to adapt the Attorney General's Guidelines for local use.

The three defenses

There are three specific defenses written into the OMMA for use by Cannabis-using patients. These legal strategies are each distinct. Patients and caregivers should study them and prepare for the day when they may be needed—before the officer knocks at the door. The three defenses are:

1. An “*exception*” from Oregon criminal laws forbidding Cannabis; (the registry card program),
2. An “*affirmative defense*” to a charge of unlawful possession; and
3. A “*choice of evils*” defense.

Patients and caregivers should clearly understand that OMMA **DOES NOT** provide any legal protection against federal laws that prohibit use and cultivation of Cannabis. Patients in many states are arrested and prosecuted under federal statutes. Federal prosecutors in Oregon have expressed no interest in locating and prosecuting patients who grow small amounts of Cannabis, but this posture could change at any time. Patients and caregivers should clearly understand this risk before deciding to participate in the Medical Marijuana Program.

The “exception”

The exception from criminal laws regarding Cannabis is a legalistic way of saying that those patients who participate in the “registry card program” are not subject to the regular laws regarding Cannabis in Oregon. It offers these patients a defense from prosecution and is the foundation for the Oregon Health Division's Medical Marijuana Program. The exception permits the use, possession, cultivation and transport of Cannabis and plants to persons who are registered in Oregon's Medical Marijuana Program. (Chapter 1 details the application procedure patients should follow to enter this program.) Registration is the preferable choice for most patients. Once registered patients are issued documentation by the Division, which certifies that they are permitted to use Cannabis. Police prefer this program because it quickly establishes the patient's protected status and it is backed by an official state agency, the Oregon Health Division.

Patients who are registered with the Medical Marijuana Program also have the legal protection of assigning caregiver responsibilities to another person, who is also registered with the Division. This “designated primary caregiver” may cultivate and transport Cannabis for the patient's benefit.

Patients and caregivers enrolled in the Medical Marijuana Program should also clearly understand what they are *NOT* permitted to do. Neither party can sell Cannabis or divert it to others for non-medical use. A caregiver cannot use Cannabis unless registered as a patient as well. Quantity limits are also written into the law. A patient or caregiver may grow a total of seven (7) plants. ³

Up to three flowering plants are permitted at one time. The person cultivating the plants is allowed to possess up to one ounce of usable (dried and cured) Cannabis for each flowering plant, not to exceed 3 ounces. If the garden has two flowering plants the grower is allowed two ounces. The patient who is not cultivating is allowed to possess up to one ounce of usable Cannabis.

If patients are engaged in activity that is prohibited, like using Cannabis in a car or in public, they are breaking the law and may be prosecuted or lose their registry card. Patients and caregivers should also keep multiple copies of important papers in a safe place in case of contact with law-enforcement. They should carry the plastic laminated wallet card any time Cannabis or plants are transported. Patients should also be aware that a pending application to the program carries the same legal protection as a registry identification card. Once the application is post-marked the applicant is covered, until (and if) the application is rejected. Keeping copies of the application papers, including the physician recommendation, close at hand can save problems. Also, the pending application does not protect the designated primary caregiver, only the patient.

Police contacts

In order for police to know when patients are legally protected, OMMA contains an allowance for police to verify the status of anyone claiming to be a patient. This is accomplished usually by telephoning the Oregon Health Division to verify a patient's status. A patient, contacted by law-enforcement, may be asked if they are registered in the medical marijuana program. If the answer is "yes" the patient should be prepared to show the officer either the laminated wallet card, a copy of an application with proof of mailing, or the license form. Any of these documents will establish that the patient is covered by the exception. The police officer will inspect and copy the information on the document and verify it with the Health Division by telephone during business hours. If the Medical Marijuana Program manager verifies the patient's status to the police, no further action or contact should be taken. If the patient is not currently in the program, police may investigate further or initiate criminal proceedings. For this reason it is important to send any application *return receipt requested* from the post office. This ensures that the patient is notified that the Health Division has received the application. The return receipt postcard may also demonstrate to any officer that the application is pending. Keep the postcard with the copy of the application. If the officer observes



A caregiver cannot use Cannabis unless registered as a patient as well.



Patients should also be aware that a pending application to the program carries the same legal protection as a registry identification card.



A patient, contacted by law-enforcement, may be asked if they are registered in the medical marijuana program.



If the officer observes Cannabis plants or dried Cannabis they will want verification of patient status. Once this proof has been shown the patient is under no obligation to cooperate further with the police.



Knock-and-talk searches are conducted at locations where the police DO NOT have sufficient reason to obtain a search warrant. Otherwise, police may only search a property if they request and receive permission from the occupant.



Essentially, the affirmative defense allows patients to escape conviction if they meet *all* the registry card provisions, but don't have a registry card.

Cannabis plants or dried Cannabis they will want verification of patient status. Once this proof has been shown the patient is under no obligation to cooperate further with the police.

Knock-and-talk searches

Sometimes, police will want to conduct a “knock-and-talk” search of the premises. Knock-and-talk searches are conducted at locations where the police DO NOT have sufficient reason to obtain a search warrant.⁴

Otherwise, police may only search a property if they request and receive permission from the occupant. This process is intimidating and frightening for patients. It is meant to be. Police officers have extensive training in obtaining permission through coercive and intrusive questioning techniques. Patients must decide whether or not to allow the officer to search. Patients should clearly understand that *the presence of Cannabis plants, paraphernalia, or dried Cannabis is not sufficient grounds for a search if the patient is legally registered and not exceeding any limits. This includes any plants, up to seven in number, which are in plain sight of the officer.* The patient may, and many do, consent to a search in order to establish their legal compliance, but this is not necessary. All the patient needs to do is show the officer the registry card or copy of the pending application. The officer cannot require a search. A police officer who obtains consent to search and discovers some other unrelated criminal activity in the location (such as 25 Cannabis plants) may take legal action. But even in cases where the patient is growing more than seven plants, police should tread lightly. Many patients in Oregon would need to grow 15 to 30 plants to supply their needs, and they have a legal defense to do so.

In the event that a patient is verbally intimidated by a law officer in an encounter, the patient should terminate the conversation or call “911” and request help from the emergency dispatcher. There are few reports of police intimidation of Oregon patients since OMMA became law.

Understanding and using the affirmative defense

The *exception* from criminal laws provides a safety net over Cannabis-using patients and caregivers who grow Cannabis for these patients. Some patients refuse to participate in the Medical Marijuana Program for various reasons. These include fear and distrust of government, philosophical objections to intrusive drug laws or inability to pay the fee (\$150 in 2000.) The “*affirmative defense*” was written to include these people. Essentially, the affirmative defense has two parts. The first allows patients to escape criminal conviction if they meet all of the Medical Marijuana Program provisions, but are not registered. This defense still requires that a physician has previously diagnosed the patient as having a medical condition that qualifies under OMMA and has also advised the patient that “marijuana may help”.

The second, as stated by House Bill 3052, allows patients to grow more than seven plants if they have their physician’s written support.

These affirmative defense provisions were expanded to state:

... [I]t is an affirmative defense to a criminal charge of possession or production of marijuana, or any other criminal offense in which possession or production of marijuana is an element, that the person charged with the offense is a person who:

(a) Has been diagnosed with a debilitating medical condition within 12 months prior to arrest and has been advised by his or her attending physician [that] the medical use of marijuana may mitigate the symptoms or effects of that debilitating medical condition;

(b) Is engaged in the medical use of marijuana; and

(c) Possesses or produces marijuana only in the amounts allowed in Section 7 (1) chapter 4, Oregon Laws 1999, or in excess of those amounts if the person proves by a preponderance of the evidence that the greater amount is medically necessary as determined by the person’s attending physician to mitigate the symptoms or effects of the person’s debilitating medical condition.

(ORS 475.319)

Nineteen ninety-nine legislative changes carried the legal requirements for asserting the affirmative defense one step further by stating:

Any defendant proposing to use the affirmative defense provided for by this section in a criminal action shall, not less than 5 days before the trial of the cause, file and serve upon the district attorney a written notice of the intention to offer such a defense that specifically states the reasons why the defendant is entitled to assert and the factual basis for such affirmative defense. If the defendant fails to file and serve such notice, the defendant shall not be permitted to assert the affirmative defense at the trial of cause unless the court for good cause orders otherwise.

(ORS 475.319 (4))

In plain English, the rules governing the affirmative defense are as follows:

1. The person must be diagnosed within the past year with a “debilitating medical condition,” and be under the care of an Oregon physician;
2. The patient must be advised by the physician that using Cannabis may help. (The patient does not have to have this recommendation in writing but the physician will probably have to state this in court. If the patient cannot get the physician to provide this recommendation, or if the patient has no physician then the patient may have to resort to the “choice of evils” defense.) For this reason it is critical that



...(the affirmative defense) still requires that a physician has previously diagnosed the patient as having a medical condition that qualifies under OMMA and has also advised the patient that marijuana may help.



The affirmative defense provisions of OMMA were changed in HB 3052—the rewrite of OMMA by the 1999 Oregon Legislature.



The patient or patient's attorney must submit papers to the district attorney...stating that the patient intends to use the affirmative defense.



As its name implies [the choice of evils defense] is a "desperation defense for use when other defenses are not available."

patients discuss their use of Cannabis with the physician before legal troubles arise and request that documentation be made in the medical chart describing this use;

3. The patient must be using Cannabis.
4. The patient must be in compliance with the legal possession limits. (There is a provision for possession of greater amounts but the physician will have to verify that the greater amount is justified. Physicians will likely be nervous about the entire proceeding. If an additional complication, like more than seven plants, is added to the situation, physicians will probably be less supportive.)
5. The patient may grow more than seven (7) plants if he/she has written physician support that the larger number is medically necessary, on file with the Health Division.
6. The patient, or patient's attorney *must* submit papers to the district attorney, not less than 5 days before trial, stating that the patient intends to use the affirmative defense. The patient must also write out the reasons why they are using it and the "factual basis" for it. The factual basis could be met by referring to research, which demonstrates Cannabis' value at treating the condition. The reasons for use could be contained in detailed descriptions of how the patient is helped by using Cannabis. (An Affirmative Defense Notification Form is included in Appendix D)
7. The patient should not be already registered in the Medical Marijuana Program run by the Oregon Health Division.

Simple or not, these legalisms give many non-registered patients the tools to avoid conviction by understanding and using the affirmative defense. Unfortunately, this does assume that the patient will have to hire an attorney and possibly go to court. Preparing for and appearing in court is stressful and expensive. This defense also requires the participation of the physician to affirm that Cannabis is helping the patient. Since so many physicians are squeamish about providing documentation into the registry card program, it is hard to believe they would go to court and testify in the patient's behalf. This fact may disqualify many patients from being able to use the affirmative defense.

The choice of evils defense

The third and final defense is the "choice of evils". As its name implies, it is a desperation defense for use when other defenses are not available. The Oregon Attorney General Guidelines clearly define the choice of evils defense as:

A 'defense of choice of evils,' by which the person asserts that marijuana possession, delivery or manufacture is 'necessary as an emergency measure to avoid an imminent public or private

injury' and '[t]he threatened injury is of such gravity that, according to ordinary standards of intelligence and morality, the desirability and urgency of avoiding the injury clearly outweigh the desirability of the injury sought to be prevented' by the marijuana laws. The state would be required to disprove the defense beyond a reasonable doubt, but the defense is available only to persons who have taken a substantial step to comply with the Act.

(Section 6(3) of the Act; 1999 Or Laws, ch 825, 4; ORS 161.055(1); 161.190; 161.200)

The choice of evils defense does not require that the person suffer from a debilitating medical condition. But the patient is still required to prove that Cannabis use is an emergency measure that protects life and health. The important issue is that the patient must demonstrate that they have taken a *substantial step* to comply with the Act. This substantial step could be documentation, which demonstrates medical use or an application to the Medical Marijuana Program that has been rejected.

Ultimately, the three legal defenses can protect most Oregon patients. Hiring an attorney who understands them is very important. It is an unpleasant fact that Cannabis-using patients will require legal help and protection until the laws governing *non-medical* use are eliminated, since patients will continually get snarled in legal interpretations that vary from one Oregon county to another. Knowing these defenses allows the patient to make a conscious decision as to how best to proceed by understanding the strengths and limitations of each. This ultimately allows patients to interact with law-enforcement agencies from a position of knowledge and strength.

Patient rights and responsibilities

As increasing numbers of Cannabis-using patients find relief from their suffering and as medical research adds its blessing, the acceptance of legitimate medical use will also expand. (See Chapter 4 for a discussion of medical uses of Cannabis.) But for these uses to be legal for patients in Oregon the OMMA will have to evolve and legally embrace these expanded medical uses. Meanwhile, to be safe, Cannabis-using patients should become familiar with both their legal rights and their responsibilities under the current law.

These rights and responsibilities generally revolve around patients' legal protections and behaviors. Legal protections include understanding the defenses and which one is best fits the patient's situation. Legal protections also include adherence to the legal limits of OMMA and, if venturing into more nebulous areas of OMMA, such as increasing the number of plants grown, doing so based upon informed judgement. Behaviors, on the other hand, are relevant because patients have wide latitude of personal responsibility to grow, preserve and safely use their medicine. The ability of patients to refrain from diversion of Cannabis



...the patient is still required to prove that cannabis use is an emergency measure that protects life..



...Cannabis-using patients should become familiar with...their legal rights and responsibilities.



These rights and responsibilities...revolve around...legal protections and behaviors.



Patients have the right to grow the amount of Cannabis that meets their medical needs.



Patients have the right to organize.



Police officers around Oregon...know the basics: Leave the patient alone if he has under seven plants and a card...



...the guiding principle of police contacts... should be “as little as possible and as short as possible.”

into the recreational market (selling) will also determine how the OMMA “experiment” goes. Selling medical Cannabis on the recreational market jeopardizes the security of OMMA by reinforcing the preconceptions of those legislators who would pounce on the issue as justification to destroy the OMMA. These behaviors and legal protections give the Oregon Medical Marijuana Act life. Adherence to them will keep patients on the safe side of the law, and also preserve it for others.

Patients have rights too. OMMA grants the freedom to patients to possess their medicine, be it in plant form or in consumable form, and to control the use of the drug. Patients have the right to medicate any time they need to in the privacy of a home, without fear of contact with police. Patients also may transport Cannabis and plants to others. (Under OMMA Cannabis is proliferating in many small gardens all over Oregon, by and for patients.) Patients have the right to grow the amount of Cannabis that meets their medical needs. Patients may grow more than the seven plants explicitly allowed by OMMA but must be prepared to back this up with written documentation from the physician affirming that increased amount. If the physician verifies the need for more than seven plants, the patient will probably be protected by OMMA.

Lastly, patients have the right to organize. Patients should consider searching out other patients in their area and forming collectives. This is valuable as a source of medicine when one person runs out, or a place to exchange plants and clones. Meeting together also allows patients to try many different varieties and locate the strain that works for them. Protected by law patients have the right to organize these types of support activities. The right to meet is perhaps the most important right. This allows knowledge to proliferate. Patients are taking care of themselves, and each other.

Police rights and responsibilities

Some parts of OMMA are confusing, and complicated. Police officers around Oregon have had little training in it, but they know the basics: Leave the patient alone if he has under seven plants and a card from the Oregon Health Division. Beyond that, things get murky fast, due in part to the complexity of the legal defenses written into OMMA. The Attorney General’s Guidelines to law enforcement helped somewhat, but they pushed the hard choices to the local jurisdictions. Fortunately for patients (and taxpayers) most law enforcement agencies are taking a low-key approach by simply de-emphasizing the priority of Cannabis in general, not just Cannabis-using patients. The profoundly destructive realities of heroin, methamphetamine, and violence keep intruding on the attention of police departments.

Police departments also have rights and responsibilities. These occupy some of the same issues as Cannabis-using patients but with some differences. The major difference is that the police wield a high

level of authority to intrude on the patient's time and life. Cannabis-using patients in Oregon fear, and distrust police. They remember the devastating results of dealing with police, the intimidating knock-and-talks, and the narcotics task-force raids. This psychic scarring is still fresh. The justified fear of police will, hopefully, fade as police interactions with patients are positive and do not harm the patient. Thus, the guiding principle of police contacts with Cannabis-using patients should be "*as little as possible and as short as possible.*" Police do have the right to ask questions of patients and conduct interviews and investigations. But that right is limited. They do not have the right to go to a patient's house unannounced and talk the patient into allowing a search. If the patient is not engaging in "disqualifying behavior" and shows proper documentation, any interview should be short.

Police organizations also have a responsibility to squarely deal with this complicated law by developing guidelines that protect patients in all circumstances. Increasing numbers of patients will use Cannabis, and many of them will have little or no documentation.

Today, patients must jump through legal hoops to prove their medical need. Nevertheless, prosecuting a cancer patient because he didn't have the registry card harkens back to the "old days" when patients were traumatized by police and prosecutors. If an officer contacts a person lacking a registry I.D. card, who claims a medical need, the officer should, at most, ask the patient for evidence to show their medical status. This could be pharmaceutical bottles, or medical documentation. The officer should simply recommend that the patient contact the Oregon Health Division and apply to the Medical Marijuana Program. The only time an officer should conduct further investigation is when there is a substantial discrepancy between the patient's actions and the law. For instance, police will be very concerned if they find evidence of sales. Since OMMA does not allow sales of Cannabis under any circumstances this would be considered a serious violation. However, if the officer finds the patient in possession of ten or fifteen plants, s/he should consider ignoring this situation, especially if the patient says seven plants is not enough. Although possession of seven plants is the basic limit of the law, police should understand that this is an inadequate number for many patients. OMMA does allow patients to cultivate more than seven plants, if they can show a medical need through their doctor. Officers in that situation should suggest that the patient get a letter from their physician supporting the greater amount. Although the law gives officers the right to harvest the plants above seven, this is a potentially traumatic and intrusive action to take upon a patient who is not engaged in egregious violations of the law. The bottom line for officers is that they should always tread lightly.

Lingering fear of police will be reduced when police agencies all across Oregon simply stop dealing with patients, unless there is a compelling reason. And when there is a reason, contacts should be considerate and short. This will save needless trauma to patients and



Police do have the right to... conduct interviews and investigations. But that right is limited.



The only time an officer should conduct further investigation is when there is a substantial discrepancy between the patient's actions and the law.



Police [are] public servants entrusted with the safety and protection of, not just ill people, but all citizens.

allow police to focus on more important public safety issues. It will also begin to rebuild society’s trust in police, as the public servants entrusted with the safety and protection of, not just ill people, but all citizens.

Footnotes

¹ Prop. 215 has been variously interpreted from one locality to another since its passage in November 1996. While large metropolitan areas like San Francisco and Oakland have developed policies which favorably support licensing and oversight of Cannabis cooperatives, other rural localities continue to arrest and prosecute patients in direct defiance of California law. The previous Attorney General, Dan Lundgren, worked tirelessly to undercut and destroy Prop. 215. His successor, Bill Lockyear came to power on a pledge to fully implement the law. His efforts were unraveled by democratic Governor Gray Davis’ refusal to support statewide implementation efforts. Thus, California spins out of control because key political leaders lack the integrity to carry out the will of the people.

² The confusing language surrounding multiple patients or caregivers was compounded by the 1999 Oregon Legislature in an attempt to limit grow operations exceeding seven plants. Language was inserted which forbids the manufacture or production of marijuana “*at a place other than one address for property under the control of the patient and one address for property under the control of the primary caregiver...*” (HB 3052 Section 5 (e)). But Section 5 (f) prohibits the production of marijuana at more than one address. An attempt to add language which would forbid any caregiver from registering for more than one patient was withdrawn.

³ The Oregon Medical Marijuana Act allows cultivation of Cannabis in amounts in excess of seven plants, but the patient might have to prove the medical necessity of this increased quantity in the courts. The 1999 legislative revision added a clause to the affirmative defense stating that a patient who has their physician’s agreement that seven plants are not adequate can thereby prove that the greater amount is medically necessary. Thus it is possible that the patient could petition the Medical Marijuana Program for increased cultivation limits by obtaining written support from their doctor prior to action by law-enforcement that would bring the issue to the courts. A few patients have done so.

⁴ If the police have sufficient evidence that a law is being broken a judge will issue a warrant to search. If police announce that they have a warrant to search, they are legally entitled to enter and search the premises without the consent of the occupant. Of course, they must produce the warrant and show it to the occupant.

Chapter 3: Cannabis and Marinol Compared



In the year 2001, there are still many people who doubt or dismiss reports of Cannabis' medical utility and safety. Nevertheless, one quick glance at Dr. Tod Mikuriya's International Classification of Diseases, (ICD) table shows the vast number of medical conditions that have been treated with Cannabis. Some investigators and researchers

argue that including these conditions is not based on randomized and controlled clinical trials, but "self-reports" that are scientifically suspect.

The use of Cannabis as medicine has rarely been based on detailed clinical investigation of unique medical indications. It is, rather, a response by large numbers of people who gain significant symptomatic relief for a variety of sensory complaints by using Cannabis in many different forms. Suffering people, tired of using pharmaceuticals and medical treatments that not only bankrupt them but cause intolerable side effects, use Cannabis to assert a greater measure of control over their own lives.

The lack of investigation is largely the result of deliberate U.S. governmental policy that subtly controls what, if any, research is carried out. In this context, it is reasonable that the vast historical record carries more evidentiary weight than the meager (but increasing) clinical research body. It is also remarkable that millions of Americans continue to place themselves and their families at great personal risk to obtain and use Cannabis to treat their symptoms. They often do this against the advice of physicians who can not, or will not advise their patients to "do what they need to do". In this climate the risks to patients and family members attempting to secure Cannabis for medical use include arrest, prosecution and conviction by a legal system so blinded by law-and-order hyperbole that it will not see the destruction it causes to the lives of sick people. This continues all over America, even in states that have medical Cannabis legislation.

Patient reports of efficacy comprise the largest knowledge-base for physicians and nurses to use in evaluating Cannabis as a medical treatment. Patient experiences guide the treatment planning and provide the foundation for the "feedback loop" of reevaluation which medical professionals (should) continuously use. As nurses and doctors know, the patient is the expert about her/his particular symptoms and disease. Patients know when, how, where, and often why they suffer. No physician or nurse can appreciate this extraordinary level of knowledge based upon experience, unless they experience the condition.



The use of Cannabis as medicine has rarely been based on detailed clinical investigation of unique medical indications.



Suffering people...use Cannabis to assert a greater measure of control over their own lives.



The clinical research base into the medical indications of Cannabis is steadily expanding.

Dr. Tod Mikuriya's International Classification of Diseases (ICD) Table

Ailments Grouped by Body Systems Affected Benefited by Use of Cannabis

1) Neurological

291.0 Delirium tremens
295.xx schizophrenia
300.5 Neurasthenia
307.0 Stuttering
307.23 Tourette's syndrome
307.42 Persistent insomnia
307.81 Tension headache
310.8 Nonpsychotic organic brain syndrome
340.0 Multiple Sclerosis
343.9 Cerebral palsy
345.x Epilepsies
345.1 Grand Mal seizures
345.41 Limbic rage syndrome
345.5 Jacksonian epilepsy
346.x Migraines
350.1 Tic Dolorous
357.x Neuropathy
379.5 Nystagmus, Congenital
780.52 Insomnia
780.7 Tremor/involuntary movements
782.0 Myofascial pain syndrome

2) Musculoskeletal

138.0 Post polio syndrome
335.2 Amyotrophic lateral sclerosis
340.0 Multiple sclerosis
344.0x Quadraplegia
344.1x Paraplegia
354.0 Carpal tunnel syndrome
714.0 Arthritis, rheumatoid
715.0 Arthritis, degenerative
716.1 Arthritis, post traumatic
716.9 Arthropathy, degenerative
717.7 Patellar chondromalacia
718.5 Ankylosis
722.x Intervertebral disk disease
724.x Lumbosacral back disease
728.85 Muscle spasm
738.4 spondylolisthesis
754.21 Scoliosis

3) Immunological

042 AIDS related illness
070.52 Viral B hepatitis, chronic
070.54 Viral C hepatitis, chronic
199.0 Cancer
710.0 Lupus
710.1 Scleroderma
710.5 Eosinophilia-Myalgia Syndrome
729.11 Fibromyalgia
780.7 Chronic fatigue syndrome
571.4 Hepatitis (non-viral)
571.5 Pancreatitis
600.0 Prostatitis

4) Gastrointestinal

306.4 Psychogenic pylorospasm
346.x Migraine
535.0 Acute gastritis
535.5 Gastritis
535.6 Peptic ulcer/Dyspepsia
536.9 Colitis, ulcerative
537.81 Pylorospasm, reflex
555.2 Regional enteritis
555.9 Crohn's disease
558.9 Colitis
564.1 Irritable bowel syndrome (spastic colon)
786.8 Hiccough
787.01 Vomiting
787.02 Nausea
787.91 Diarrhea
799.4 Cachexia
994.6 Motion sickness

5) Dermatological

287.0 Henoch-Schoelei Purpura
698.9 Pruritis (generalized itching)
710.1 Scleroderma

6) Cardiopulmonary

401.1 Hypertension
427.0 Paroxysmal atrial tachycardia
429.4 Post cardiectomy syndrome
461.9 Acute sinusitis
473.9 Chronic sinusitis
493.9 Asthma (unspecified)
518.89 Cystic Fibrosis
786.2 Cough

7) Psychological

290.0 Senile dementia
295.x Schizophrenia
295.7 Schizoaffective disorder
296.0 Mania
296.3 Major depression, recurrent
296.6 Bipolar disorder
3000.00 Anxiety disorder
300.1 Panic disorder
300.3 Obsessive compulsive disorder
303.0 Alcoholism
304.0 Opiate dependence
304.1 Sedative dependence
304.2 Cocaine dependence
304.4 Amphetamine dependence
305.0 Tobacco dependence
309.81 Post traumatic stress disorder
310.91 Intermittent explosive display
316.0 Psychogenic PAT
345.41 Limbic rage syndrome

8) Endocrine

242.0 Graves disease
245.x Thyroiditis
250.6 Diabetic gastroparesis
277.3 Amyloidosis
300.4 Dysthymic disorder
332.0 Parkinson's disease
333.4 Huntington's disease
345.41 Limbic rage syndrome
571.5 Pancreatitis
600.0 Prostatitis

9) Chemo/Radiation therapy

199.0 Cancer
V66.2 Chemotherapy
E929.9 Radiation therapy
296.3 Major depression, recurrent
300.00 Anxiety disorder
300.01 Panic disorder
304.0 Opiate dependence
304.1 Sedative dependence
346.x Migraine
535.0 Acute gastritis
535.5 Gastritis
535.6 Peptic ulcer/ Dyspepsia
537.81 Pylorospasm
781.0 Anorexia
787.01 Vomiting
787.02 Nausea
787.91 Diarrhea
799.4 Cachexia

10) Ophthalmological

362.5 Macular degeneration
365.23 Glaucoma
368.0 Dyslexic Amblyopia
368.55 Color blindness
372.9 Conjunctivitis
377.21 Drusen of optic nerve

11) Gynecological

617.9 Endometriosis
625.4 Premenstrual syndrome

Courtesy of Dr. Tod Mikuriya

Health care professionals, on the other hand, possess voluminous and detailed knowledge concerning the established patterns of *many* disease conditions and their treatments. This level of expertise about the clinical nature of disease provides physicians with the tools to cure, stop, or minimize the undesirable effects of disease. A collaborative approach will usually result in the greatest benefit for patients and doctors, with each person respecting the expertise of the other.

In order for patients, nurses or doctors to understand why any particular drug or treatment works, they need to know about the disease. Cannabis is no exception. The more common medical indications for Cannabis are: *pain (of many types), nausea, anorexia, elevated intraocular pressure, spasms, cramps and seizures, insomnia, anxiety, cancer and AIDS or HIV symptoms*. There are over 100 other symptomatic diseases in which Cannabis has provided clear symptomatic relief. These include *opiate or benzodiazepine withdrawal, lupus, scoliosis, amyotrophic lateral sclerosis (ALS), brain trauma, schizoaffective disorder, bipolar disorder, post traumatic stress disorder (PTSD), tobacco dependence, hypertension and menopausal symptoms*. The list is long.

Cannabis helps people feel better

One underlying denominator, which underscores Cannabis' vast utility, is its antianxiety effect. Most people who suffer from disease suffer also from the accumulation of the *experience of suffering*. Coping strategies and finances deteriorate over time. This ongoing mental and emotional "weight" contributes to hopelessness and depression and, in turn, increases the severity of the disease process. Cannabis has the quality, similar to benzodiazepines like Xanax and Ativan, to compartmentalize the emotional strain of disease away from immediate perception. This shunting of the awareness of symptoms seems to allow patients to relax and even understand deeper meanings in the disease. Unlike benzodiazepines, Cannabis does not often lead to serious drug-dependence issues. Many patients report using Cannabis to counter the withdrawal effects of long-term benzodiazepine use.

This antianxiety effect originates in part from the human ability to regulate emotional and physical functions by the use of *intention* or desire. The brain and body are biochemically integrated. Humans use the brain, focused through emotions and thoughts, to alter many different regulatory systems of the body. The adrenal gland responds to emotionally distressing situations by releasing neurotransmitters, like adrenaline (epinephrine), to heighten "survival" functions. For example, in the "fight-or-flight" response, the brain tells the body that there is potential for serious injury or death. The heart rate increases, the brain becomes more alert and blood gets shunted to the heart from the extremities. Cannabis helps to tone down "fight-or-flight" responses that may result from the disease or the stress of trying to cope.

For *most* people, Cannabis allows calming thoughts and feelings to influence the perception of pain or nausea. Some individuals experience *paradoxical* reactions to Cannabis. A paradoxical reaction occurs when



...the patient is the expert about their particular symptoms and disease.



Health care professionals, on the other hand, possess voluminous and detailed knowledge concerning the established patterns of many disease conditions and their treatments.



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...pain accounts for probably the greatest single indication for Cannabis.



Marinol is the trade name given the artificially synthesized delta-9-tetrahydrocannabinol (THC), molecule.



Marinol is not marijuana.



The dosage of Marinol varies depending on set, setting, and medical condition.

the drug has the exact opposite effect than expected, such as when someone taking Ativan becomes *more* anxious rather than less.

With the exception of glaucoma, Cannabis seems to be a treatment mostly for *symptomatic relief* from many neurological functions including pain. It is not usually *curative*. Since pain accompanies most disease processes at some time during their course, pain accounts for probably the greatest single indication for Cannabis. Pain also increases anxiety. Now we are beginning to clearly understand why.

Still, many medical professionals and patients do not understand these clinical applications, or don't understand the differences between Cannabis and Marinol-the "government-approved" THC molecule.

Marinol and Cannabis: What's the difference?

Marinol (dronabinol)

Marinol is the trade name given the artificially synthesized delta-9-tetrahydrocannabinol (THC) molecule. (In Europe, THC is marketed under the name Nabilone.) Marinol is marketed by Roxane Laboratories under a licensing agreement with Unimed Pharmaceuticals. Marinol is not marijuana. It is single molecule THC that does not contain any of the other cannabinoids found in herbal Cannabis. Marinol is manufactured in a sesame seed oil base and, like herbal Cannabis, is insoluble in water. ¹

The lipid soluble nature of Cannabis and Marinol allow it to pass through the blood-brain barrier. (The blood-brain barrier is a cellular membrane that protects the brain and central nervous system from infection by filtering out certain chemical compounds.) This accounts for some of the *cognitive* effects of Cannabis and THC. Marinol also contains extra chemicals *like gelatin, glycerin, methylparaben, propylparaben, yellow, red and blue dye, and titanium dioxide*. (Vegetarians should be aware that gelatin is an animal product.) Any patient who has an allergy towards any of these substances should avoid taking Marinol.

Dosage and metabolism

The dosage of Marinol varies depending on set, setting, and medical condition. Generally a *psychoactive* dose is 0.05mg/kg. This translates into around 3.5 mg for a 70-kg (144-lb.) person. Patients should differentiate a *psychoactive* dose from a *therapeutic* dose. They are often not the same. Marinol is taken only by the oral route, unlike smoked Cannabis. Marinol is metabolized by the liver much the same way as Cannabis brownies are. Ninety percent (90%) of the Marinol dose is absorbed in the GI tract because of its high lipid solubility. Also, blood circulating through the intestines goes directly to the liver via the Portal veins carrying with it the large dose of THC absorbed through the stomach and intestines. Only about 10-20% of the dose reaches *systemic circulation* because the liver rapidly metabolizes the dose, converting it into other chemical compounds. ²

Marinol comes in three dosage forms: 2.5, 5 and 10 mg. It is approved by the Food and Drug Administration (FDA) for appetite stimulation in AIDS wasting syndrome, and nausea and vomiting in cancer chemotherapy, for patients who have not responded to more conventional treatments.

For *anti-emetic* use the usual dosage is 5 mg., three or four times per day, increasing the dosage carefully until the therapeutic benefit is obtained without serious side effects. This may be achieved by dividing doses in the morning and evening. Doses can also be given before or after meals. The important consideration is to achieve a stable blood level of the drug. Ten and fifteen milligram (mg.) doses are more psychoactive and do not increase the benefit.

For *appetite stimulation* Marinol is given in lower doses, usually around 5 milligrams per day. The dosage should be slowly titrated up to the effective dosage short of significant side effects. For naive users this process may take repeated trials of different doses at different times. Altering the dosage up or down should be done in consultation with the patient's medication prescriber. Patients should consider increasing the *frequency* of smaller doses before increasing the total dosage.

Side effects

Side effects with Marinol vary widely among different people. One person's experience will be different than another's. Psychoactive effects may be desirable or undesirable. Roxane Laboratories lists euphoria (feeling "high") as an "adverse reaction," but this is often not the case. One of the significant psychiatric uses of Cannabis, if not Marinol, is as an anti-anxiety agent. However, other potentially serious side effects and adverse reactions may occur. The most common effects are: heart palpitations, tachycardia (rapid sustained heart rate), postural hypotension (low blood pressure caused by standing up), conjunctivitis (eye irritation), abdominal pain, nausea, vomiting, diarrhea, anxiety, confusion, depersonalization, paranoid reactions (possibly worse among people suffering from schizophrenia), and somnolence (lethargy). Less-common effects include tinnitus (ringing in the ears), depression, nightmares, visual disturbances, sweating and chills.

If disturbing experiences occur, patients should evaluate the benefits derived from the use of the drug versus the disagreeable effects. This risk-benefit ratio is the same for all drugs; Marinol and Cannabis are no exception. If the problems associated with the use of *any* drug exceed the benefits derived, patients should consider stopping therapy. Again, this is a decision that should be made with the knowledge of the prescriber.

The therapeutic benefits and side effects of dronabinol are *reversible*, that is, the effects fade away after the Marinol is stopped. Since Marinol and Cannabis are fat-soluble this process takes time as the drug slowly moves out of the tissues. Missed doses are not a problem. Taking the next dose early, then following the previous schedule will minimize drops in the blood level of the drug.



Marinol is metabolized by the liver much the same way as Cannabis brownies are.



...only 10-20% of the dose reaches systemic circulation because the liver rapidly metabolizes the dose, converting it into other chemical compounds.



Marinol...is approved by the FDA for appetite stimulation in AIDS wasting syndrome, and nausea and vomiting in cancer chemotherapy, for patients who have not responded to more conventional treatments.



Roxane Laboratories lists euphoria (feeling fine) as an "adverse reaction," but this is often not the case.



...the most common effects [of Marinol] are: heart palpitations, tachycardia, postural hypotension, conjunctivitis, abdominal pain, nausea, vomiting, diarrhea, anxiety, confusion, depersonalization, paranoid reactions, and somnolence.



If disturbing experiences occur, patients should evaluate the benefits derived from the use of the drug versus the disagreeable effects.



As with Cannabis, there are few truly life-threatening reactions with Marinol. The most likely severe reaction is dysphoria or increased apprehension and fear without cause.



...combinations [of drugs] can be additive as one drug potentiates or increases the effects of another.

As with Cannabis, there are few truly life-threatening reactions with Marinol. The most likely severe reaction is *dysphoria* or increased apprehension and fear without cause. (*Euphoria* is the more common effect, a feeling of expansion and inner peace.) Persons suffering from severe liver or cardiac disease should use Marinol carefully. As is the case with Cannabis, the dosage-related mortality is extremely low. Simply put, there are no dosage-related deaths from using Marinol (or Cannabis) in medical literature.

Cannabis dependence syndrome is a psychiatric disease classification. Long-term heavy use of Cannabis can lead to a lack of ability to control use despite adverse consequences. Cannabis dependence syndrome is treated by abstinence.

Drug/drug interactions

Drug interactions can be either *metabolic* or *pharmacological*. Drugs interact because they share the same metabolic (chemical breakdown) pathways, or directly interact with each other chemically. The chemical interaction of drugs can create totally different compounds in the body and can be dangerous. Also, these chemical combinations can be *additive* as one drug potentiates or increases the effects of another. Marinol is no exception. It has several notable drug/drug interactions, though none life-threatening. Since Cannabis is chemically similar to Marinol it is reasonable to consider the following drug interactions in connection with Cannabis. Any person taking other pharmaceuticals along with Marinol or Cannabis should research interactions and consult with the prescriber.

Phenothiazines are a class of major tranquilizers including Compazine (prochlorperazine) and Thorazine (chlorpromazine). Use of phenothiazines in combination with Marinol may cause *synergistic* effects. (Synergistic actions are those where the effects of different drugs taken together result in greater action than either drug alone.)

Sympathomimetic agents are drugs that stimulate the sympathetic nervous system resulting in increased blood pressure and heightened excitement. Examples of sympathomimetic drugs include amphetamines, cocaine, and epinephrine. Use of Marinol or Cannabis with these drugs may result in cardiotoxicity, increasing hypertension (blood pressure), and tachycardia (rapid heart rate).

Anticholinergic agents are those that block or interfere with parasympathetic nerve impulses. Parasympathetic nerve fibers carry impulses that constrict the pupil, contract smooth muscle of gastrointestinal tract and slow heart rate, among other functions. Examples of anticholinergic medications include atropine, scopolamine and antihistamines. Marinol or Cannabis use with these drugs may cause additive effects, including rapid heart rate and drowsiness.

Tricyclic antidepressant agents are a chemical class of antidepressants that increase the amount of neurotransmitters in the brain by blocking the “reuptake” of the neurotransmitter at the synapse. Common

examples of tricyclic antidepressants include Elavil (amitriptyline), Anafranil (clomipramine), Sinequan (doxepin) and Pamelor (nortriptyline.) Use of Marinol or Cannabis with these drugs may lead to additive effects, hypertension or drowsiness.

Benzodiazapines, barbiturates and opioids are drugs that depress or decrease central nervous system function resulting in somnolence, lethargy, drowsiness, constipation and slow heart rate among other effects. Examples include Ativan (lorazepam) Xanax (alprazolam), alcohol, Serax (oxazepam), Valium (diazepam), heroin, morphine and methadone. Marinol or Cannabis use with these drugs may result in additive effects including drowsiness, dizziness or hypotension (low blood pressure.) These drugs may also metabolize more slowly because of competition for the same metabolic pathways.

Theophylline is a drug used to relieve bronchial spasms in diseases like emphysema and asthma by relaxing “smooth muscle” in the airway and interfering with enzyme production. Cannabis or Marinol used concurrently with theophylline may increase the metabolism of the theophylline yielding unpredictable results.

Marinol overdose and treatment

The lethal dose of Marinol is 30 milligrams per kilogram (mg./kg.) This translates into 2100 mg. in a 70 kg. (144 lb.) person. This is an exceedingly high dose and reflects the relatively non-lethal nature of Marinol. Cannabis has an unobtainable lethal dosage because it does not overwhelm vital functions. Anyone attempting to overdose on Cannabis would probably fall asleep first.

Treatment of a life-threatening Marinol overdose consists of gastric lavage, intravenous fluid administration, vasopressors to stabilize blood pressure and perhaps intravenous Valium. If the person is responsive, treatment includes close monitoring of blood pressure and heart rate, reassurance, a quiet peaceful environment and hydration.

Herbal Cannabis

Herbal Cannabis is *not* Marinol. Unlike Marinol, Cannabis is an herb that contains many chemicals in addition to THC. Cannabis is made up of more than 60 *cannabinoids*, chemicals of similar composition to THC but with subtle differences. Additionally, Cannabis is packed with other compounds because it is a plant and not a sterile product of human manipulation, like Marinol. These additional chemicals include: alcohols, ketones, simple and fatty acids, steroids, vitamins, pigments, hydrocarbons and enzymes, among others. In fact, Cannabis is literally packed with over 300 chemical compounds.³ But the major chemical compounds of interest to patients (and recreational smokers) are the afore-mentioned cannabinoids. The major cannabinoids—ones in greatest quantity—are: Tetrahydrocannabinol (THC), Cannabidiol (CBD), and Cannabinol (CBN). Although there are a number of other cannabinoids, these three are thought to exert most of the *physiologic* effects that patients experience. The *metabolism*



Phenothiazines...a class of major tranquilizers ...in combination with Marinol may cause synergistic effects.



Use of Marinol or Cannabis with [sympathomimetic agents] may result in cardiotoxicity, increasing hypertension and tachycardia...



Marinol or Cannabis use with [anticholinergic agents] may cause additive effects including rapid heart rate and drowsiness.



Marinol or Cannabis use with [Benzodiazapines, barbiturates and opioids] may result in additive affects including drowsiness, dizziness or hypotension. These drugs may also metabolize more slowly because of competition for the same metabolic pathways.



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Treatment of a life-threatening Marinol overdose would consist of gastric lavage, intravenous fluid administration, vasopressors to stabilize blood pressure and perhaps intravenous Valium.



Herbal Cannabis is not Marinol. Unlike Marinol, Cannabis is an herb that contains many chemicals in addition to THC.

of cannabinoids affects their chemical nature also, because they are broken down by the liver into other compounds. This is why the effects of smoking or eating the same variety of herbal Cannabis will result in a different effect. (Chapter 8 discusses the different effects of smoking or eating Cannabis.)

Delta-9-Tetrahydrocannabinol (THC)

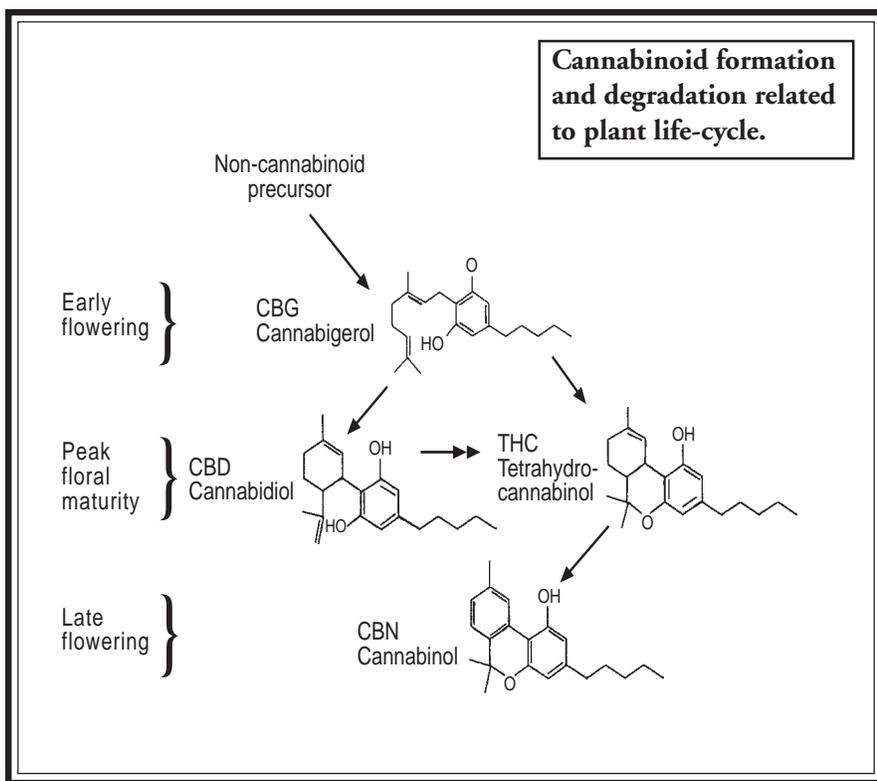
THC is the cannabinoid responsible for most of the effects of herbal Cannabis. Marinol is also pure THC. United States government Cannabis contains two to four percent THC. High-quality Cannabis contains ten percent and greater. (The world's record is 30%.) All the leaf surfaces produce THC but flowering tops are the highest source of THC on the plant. THC is indicated mostly for pain, spasticity, appetite stimulation and anti-nausea effects. Pure THC has a tendency to produce anxiety or even psychotic reactions in some vulnerable people. Other cannabinoids probably moderate or lessen the anxiety-producing qualities of pure THC. Tropical strains seem to have higher levels of THC than temperate strains. When THC is eaten in food, the drug passes through the liver (a process called "first-pass hepatic circulation"). Liver metabolism of THC creates a compound called "11-hydroxy-THC." This compound is more psychoactive than THC alone. For this reason, THC effects are *route-dependent*. Eating brownies or smoking the same strain will result in different effects.

Cannabidiol (CBD)

CBD is present in much smaller amounts than THC. It is called a *precursor* in the formation of THC—one of its chemical building blocks. Much less research has been done on CBD. CBD is present in higher amounts in northern climate plants like *C. ruderalis*, however CBD has no psychoactive effects. It does appear to have antipsychotic and possibly antispasmodic properties, and seems to moderate the effects of THC. It probably does this by interfering with, and decreasing THC metabolism in the liver. This can lead to higher sustained blood levels of THC. (This is one reason patients prefer Cannabis to Marinol.) CBD has also been shown to have an antidystonic effect. Dystonia is, among other causes, a side effect of *neuroleptic* (antipsychotic) drugs, and is defined as painful rhythmic muscular contractions of the face, neck, and body. CBD seems to increase cerebral (brain) blood flow and this may contribute to its reputed anti-psychotic effect. It also has *antioxidant* effects. Overall, there is a lack of research evidence describing exactly what CBD does. Most of the reports are from patients who find that CBD *attenuates* or moderates effects of THC.

Cannabinol (CBN)

Cannabinol is the third most common cannabinoid. Cannabinol is another link in the conversion of cannabinoids. CBN is formed from the *degradation*, or breakdown of THC. Like CBD, it is found in minute amounts in Cannabis preparations, but seems to have pharmacological and metabolic effects. CBN in laboratory animals lowered



The metabolism of cannabinoids affects their chemical nature ...because they are broken down by the liver into other compounds.

Delta-9-Tetrahydrocannabinol (THC) is the cannabinoid responsible for most of the effects of herbal Cannabis.

Cannabinoid biosynthesis is the process that cannabinoids undergo as they chemically develop and degrade. CBG is an “early” cannabinoid molecule in the flowering process. As the plant matures, CBG is converted into CBD and then into THC. Delta-9-Tetrahydrocannabinol is the cannabinoid most responsible for pharmacological effects, and is present in highest concentration with peak floral maturity. Over time, as THC is exposed to oxygen, it degrades into CBN.

body temperature and increased duration of sleep. CBN is formed as THC degrades. Cultivation experts report that after flowers have fully matured they begin the process of *oxidation* as they begin to degrade into CBN. Older flowers appear to have a sedative effect and this may be due to the higher percentages of CBN, especially if they are damaged, exposed to light or heat. There is little research demonstrating specific effects.

The complexities of Cannabis: Making informed choices

Herbal Cannabis is a drug “cocktail” with many different constituents. Smoking or eating the same variety will result in different effects. Smoking Cannabis will also form many chemical substances, some of them harmful. For these reasons, patients should understand the complexities. Patients who expect to use Cannabis on a long-term basis have decisions to make about the amount, variety, frequency of dosing, procurement, metabolic interactions with other drugs, and work involved in procuring, growing, and storing the drug. Patients need to understand the basis of their disease and how Cannabis may help. Additionally, patients need to understand a whole host of legal and regulatory issues in their community. This is a daunting task.

Cannabidiol (CBD) ...has no psychoactive effects. It does appear to have anti-psychotic and possibly anti-spasmodic properties...

Cannabinol (CBN)... another link in the conversion of cannabinoids... seems to have pharmacological and metabolic effects.



...patients need to understand a whole host of legal and regulatory issues in their community. ...patients...are left to themselves to answer these questions... these barriers and obstructions will remain until Cannabis treatment is incorporated into the medical system instead of the legal system.



The field of cannabinoid research is wide open and quickly expanding. This is occurring as an outgrowth of understanding the biochemical actions of cannabinoids for several different conditions.



Today, the United Kingdom is perhaps the leader in researching cannabinoid therapeutics.

Unfortunately, patients can expect little help from physicians, nurses or governmental agencies who are either ignorant of it, or still entrenched in the War on Drugs. Thus, they are left to themselves to answer these questions, or rely on support from small, overworked networks. Fundamentally, these barriers and obstructions will remain until Cannabis treatment is incorporated into the medical system instead of the legal system. Until that day comes, patients who use Cannabis should expect to study the issues involved in order to understand how to safely use Cannabis and avail themselves of any laws or protections (like the Oregon Medical Marijuana Act), that exist.

Cannabinoid research today and tomorrow

The field of cannabinoid research is wide open and quickly expanding. This is occurring as an outgrowth of understanding the biochemical actions of cannabinoids for several different conditions. Basic science has now charted the actions of cannabinoids on spastic disorders and analgesia. In the near future researchers will uncover the basic biochemical utilization of cannabinoids in glaucoma and immune function. This deeper understanding of cannabinoid physiology is profoundly altering the knowledge base and giving tremendous impetus to the design of new cannabinoid-based dosage forms. The future will show multiple delivery systems like transdermal patches, creams, and pills. Ironically, this explosion of knowledge is leading medical science *back in time* as new dosage forms remake the tinctures, lotions, pills and extracts that were widely manufactured and prescribed by physicians more than 50 years ago.

Today, the United Kingdom is perhaps the leader in researching cannabinoid therapeutics. GW Pharmaceuticals is conducting large clinical trials that meet FDA prescription drug-development protocols. By developing non-smoked cannabinoid-based medicines, GW Pharmaceuticals is rapidly expanding the therapeutic application of Cannabis. According to GW Pharmaceuticals:

The key consideration when developing plant-based medicines is control of starting material so as to satisfy the “quality” criteria laid down by the medical regulatory authorities. All of GW’s Cannabis plant material comes from clones grown under computer-controlled conditions in a specialist cultivation facility in the UK.

(GW Pharmaceutical written notes, First National Clinical Conference on Cannabis Therapeutics, April 6-8, 2000, Iowa City, Iowa, USA)

By controlling both genetics and environmental conditions it is possible to maintain high bud-to-bud and plant-to-plant consistency in terms of cannabinoid ratios and non-cannabinoid constituents. Such consistency is required for the development of pharmaceutical products. Additionally, GW is collaborating with other researchers and universities to conduct pre-clinical and clinical trials of their standard-

ized preparations. These steps will likely result in eventual approval of cannabinoid-based medicines by the U.S. Food and Drug Administration (FDA).

In the U.S., Larry Brooke and Cal C. Herrmann of General Hydroponics have completed the extensive patent application process, and received United States Patent # 6,113,940 for a “Cannabinoid patch and method of transdermal delivery” (Cannabis skin patch).

So, finally, the “cannabinoid is out of the bag.” Governmental interference and obstruction is giving way to an inevitable process of rediscovery. Cannabis clearly does not belong as a Schedule One substance of the *Controlled Substances Act*. It is doubtful that listing Cannabis is justified at all. Cannabinoids have been around for a long time as medicine and are here to stay. New dosage forms and new preparations will appear within the next decade. These welcome advances may lessen, but they will not preclude “old-fashioned” smoking as the preferred delivery route for many patients. Twenty-first century medicine will incorporate the best of 19th century medicine, but will not eliminate it.

Marinol and Cannabis: Whats the difference? Notes

Marijuana and Medicine- Assessing the Science Base, National Academy of Sciences, Institute of Medicine, 1998, pp.22-26, 33-37, 44-49, 109

Marijuana Grower’s Guide, Revised Color edition, M. Frank, Red Eye press, 1997, pp. 310-313.

Marinol Drug Information Package Insert, Roxane Laboratories, 1999.

Cannabinoid research today and tomorrow Notes:

From illegal plant to prescription medicine, D. Hadorn, **First Clinical Conference on Cannabis Therapeutics**, Iowa City, Iowa, 2000, written materials.

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Footnotes

¹ Simply put, solubility is a measure of a chemical's ability to disperse and disintegrate in water. Fat or *lipid*-soluble chemicals do not readily dissolve in water. This property affects the way the chemical disperses throughout the body. Since cannabinoids are sticky and poorly soluble in water, they accumulate in tissues and require much longer time to be chemically broken down by the body. An entire drug-testing industry exploits this fact.

² This process is called "first-pass hepatic circulation." The liver is an extremely vascular organ. It filters 1500 ml/min of the body's entire blood volume, mostly coming from the portal veins. It performs many complicated functions including; breaking down and metabolizing chemical compounds. This is also why taking a Marinol capsule is much different than smoking a joint.

³ Cannabis a virtual factory for chemical compounds *and* nutritional ones. Cannabis contains many important nutritional supplements including GLA (gamma-linolenic acid) an essential fatty acid, high levels of protein and carbohydrates, and vitamins.

Chapter 4: Common Medical Conditions Treated with Cannabis



Recent breakthroughs in cannabinoid analgesic research

In October 1997 Ian Meng presented research to the 27th annual meeting of the Society for Neuroscience in New Orleans. His team, working from the Department of Neurology at UCSF, presented breakthrough research that detailed the neurochemical effects of cannabinoids as they interfere with pain impulses in mammals. In order to understand the importance of this research it is necessary to understand the basic biochemical process of nerve impulse transmission.

Nerve-impulse transmission simplified

All nerve impulses, whether sensory (incoming) or motor (outgoing) are transmitted via either the peripheral or the central nervous system (PNS/CNS). The central nervous system is composed of bundles of nerve fibers that make up the spinal chord and part of the brain. Peripheral nerves are those outside of the brain and spinal chord, in the arms, legs and organs. Nerve impulses are chemically and electrically carried along nerve fibers to and from the brain and spinal chord. Individual nerve cells are called neurons. There is a space between each nerve cell, called a synapse. The synapse separates the end of one neuron from the beginning of the next. Nerve impulses move rapidly across the synapse in response to chemical neurotransmitters. Neurotransmitters are released by one neuron cell, move across the synapse and fit into specific sites—called receptor sites—on the next neuron. Receptor sites come in many different shapes, allowing many different chemical signals to activate the cell in different ways. Receptors will generally only accept a “chemical cousin” of similar shape. These pain receptors are activated by chemicals called agonists, which carry the same imprint.

How analgesics work

Most analgesics including morphine (an opiate), work by interfering with and modifying neuron receptor signals. They do this by chemically binding with the opiate receptors that are responsible for pain transmission. Morphine is also chemically similar to internally-produced, or endogenous, chemicals known as endorphins.¹

Morphine is considered the most potent analgesic in common use today and is often used for severe pain. Unfortunately it has significant “side effects” on specific vital areas in the central nervous system which



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There is a space between each nerve cell, called a synapse. The synapse separates the end of one neuron from the beginning of the next.



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...analgesics including morphine (an opiate), work by interfering with [that is]...chemically binding with the opiate receptors that are responsible for pain transmission.



In 1988, cannabinoid research took a quantum leap. That year, researchers first conclusively demonstrated the presence of human receptors to cannabinoids.



In 1992 Doctor Raphael Mechoulam...first described the presence in humans of an endogenous (internally-produced) cannabinoid.



The discovery of the second cannabinoid receptor in humans, called “CB-2,” ... described an even more important biological role of the cannabinoid receptor system ...widespread in the immune system and throughout the body.

are also receptor mediated. Morphine can slow or stop breathing, cause drowsiness or dizziness and effect many bodily functions that are regulated by the brain. In spite of morphine’s potentially lethal side-effects it is considered a mainstay in pain management because of its high therapeutic value. Morphine, placed in Schedule Two of the federal Controlled Substances Act, is available for controlled medical use.



Topical Cannabis preparation label, date unknown.

Image thanks to Farmacy

The cannabinoid receptor is “discovered”

In 1988, cannabinoid research took a quantum leap. That year, researchers first conclusively demonstrated the presence of human receptors to cannabinoids. (Many other receptor systems had been located, like opiate receptors.) The first cannabinoid receptor located was named “CB-1,” and was found only in the brain. CB-1 receptors were also found to be extremely abundant, indicating great importance. Brain areas of highest concentration include basal ganglia cells, cerebellum, hippocampus and cerebral cortex. These brain locations are also responsible for controlling body movement, coordination, learning and memory- all systems affected by Cannabis the drug.

In 1992 Doctor Raphael Mechoulam, working at Hebrew University in Israel, first described the presence in humans of an endogenous (internally-produced) cannabinoid. His research confirmed that humans possess a unique receptor-mediated system based upon chemicals similar to the cannabinoids found in Cannabis. He named the endogenous chemical *Anandamide* after the Sanskrit word “Ananda” which means bliss. It was found in the brain areas that control pain.

The discovery of the second cannabinoid receptor in humans, called “CB-2,” was announced in 1993. This remarkable discovery described an even more important biological role of the cannabinoid receptor system because, unlike centrally acting receptor systems located only in the brain, CB-2 receptors were found to be widespread in the immune system and throughout the body. This discovery opened up research possibilities aimed at describing the precise biochemical

details of the pain-soothing affects that are experienced and appreciated by many patients.

These discoveries led scientists to conclude that humans possess great numbers of cannabinoid receptors distributed throughout the body, which are activated by a chemical we produce ourselves, called anandamide. In other words, humans possess a unique cannabinoid-based analgesia system.

Before Doctor Meng's research, the specific process of nerve impulse transmission for this new cannabinoid receptor system was unknown. He elaborated upon the work of other teams in Europe and the U.S. by showing for the first time precisely *how* cannabinoids in marijuana bind to the CB-1 and CB-2 receptors and inhibit pain signals. He did this by administering a *synthetic cannabinoid* molecule known as WIN-55212 to laboratory rats and measuring the specific changes. (Synthetic cannabinoids are more effective for research purposes because of their standardized potency and purity).

After intravenous injection, Meng recorded the activity of specific *neurons* (nerve cells) in this cannabinoid receptor system and determined that cannabinoids reduce the pain signal transmission *from* the site of injury and up through the spinal chord. Cannabinoids do this by binding to pain receptors. He also determined that the *cannabinoid receptor system* works independently from *opioid receptor system*, by injecting *antagonists*² to both opioids and cannabinoids to see if the analgesic effect of one was diminished by the other.

In the experiments Nalaxone, the opioid antagonist, and SR-141716-A, the cannabinoid antagonist, were administered to rats previously treated with the respective agonist (morphine or WIN-55212). In all cases the opioid antagonist *failed* to counteract the effects of the cannabinoid, and the cannabinoid antagonist *failed* to counteract the effects of the opioid. The cannabinoid receptor "lock" would not accept the opioid "key". This demonstrated that the cannabinoid and opioid receptor systems are not the same. The researchers noted that this research not only proved that cannabinoids in marijuana have analgesic properties, but that cannabinoids could be the basis for an entirely new class of analgesic compounds.

Kenneth Hargreaves and his research team from the University of Minnesota took the same underlying cannabinoid research in a new direction. Their studies of cannabinoids showed that local (at the site of injury) administration of anandamide (the naturally occurring cannabinoid) produced pain relief without causing CNS effects. In other words, the cannabinoid worked locally-at the site of injury-and not in the brain as does morphine. In addition to relieving pain, anandamide decreased *hyperalgesia*, the increased sensitivity to pain occurring with tissue injury and inflammation. Other research teams confirmed these analgesic properties and presented their findings at the Society for Neuroscience conference.

The Society for Neuroscience presenters all described dramatic analgesic properties of cannabinoids. This research described, for the



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first time, the biochemical and neurological basis for the vast historical record of Cannabis use as an analgesic.



The debilitating disease processes of cancer and AIDS deplete the body's stores of protein by metabolizing muscle tissue to fuel critical functions. *Anorexia* and *cachexia* are the two complications that begin a downward nutritional spiral. ...Patients...often die because they are too weak or sick to eat.

Cannabis Indica, Squibb

Ground (30) for Pecolation tin, lb. \$2.50; 1/2 lb. \$1.29;
1/4 lb. 67c.

Cannabis Indica; Indian Cannabis or Indian Hemp. The dried flowering tops of female plant of *Cannabis sativa* (Fam. *Moraceae*), grown in the East Indies, gathered while the fruit is yet undeveloped and while it is carrying the whole of its natural resin. We use select tops only, no stems. This hemp produces galeonical preparations of a most satisfactory degree of activity. Narcotic, Sedative, Anodyne. Average Dose: 1 gr. (0.065 Gm.). (See also Extract; Fluidextract; Tincture.)

¶ The prices of Squibb Products are in all instances as low as quality and quantity of ingredients and expense of manufacture allow. They include containers, packing and boxing. When ordering or prescribing please specify SQUIBB'S.

Image thanks to Pharmacy

Advertisement for ground Indian Cannabis flowering tops, in pre-1938 Squibb catalog of pharmaceutical products.

Cannabis for cachexia/anorexia associated with AIDS wasting syndrome and cancer

Wasting syndrome is a debilitating or lethal complication, occurring in two-thirds of cancer patients and nearly 90% of AIDS patients. It is defined as greater than 10% loss of body weight. The debilitating disease processes of cancer and AIDS deplete the body's stores of protein by metabolizing muscle tissue to fuel critical functions. *Anorexia* and *cachexia* are the two complications that begin a downward nutritional spiral. Anorexia is the loss of appetite or desire to eat. Cachexia is a general term, which describes a wasting or malnourished process resulting from illness. Both anorexia and cachexia are probably caused by increased metabolism created by cancerous tumors or the AIDS virus combined with decreased absorption of nutrients. This depletion can quickly spiral out of control leading to nausea, vomiting, poor appetite, diarrhea and subsequent weakness which further blocks the body's ability to combat the disease. As patients are weakened, resistance to infection creates further stress. Opportunistic infections like *Pneumocystis carinii pneumonia*, *Giardia lamblia* and *cytomegalovirus* quickly develop. Patients suffering from these infections often die because they are too weak or sick to eat.

Anticancer treatments (like *chemotherapy*) involve repeated, large, powerful doses of drugs strong enough to interfere with and kill cellular processes of the tumor (hopefully without killing the patient). Protease inhibitor therapies are anti-viral drugs, which interfere with the Human Immunodeficiency virus replication (HIV). Unfortunately chemotherapy and protease inhibitor therapy is often non-specific, and normal healthy cells are affected as well, especially in the gastrointestinal tract. Nausea and vomiting are commonly associated with several common chemotherapeutic agents like Cisplatinum, Methotrexate, or 5-FU. Nausea and vomiting quickly sap energy and sometimes patients

terminate treatment rather than endure incapacitating side effects. Physicians, nurses and researchers continually search for remedies that will control nausea and vomiting.

Conventional medical management of anorexia/cachexia is aimed at restoring digestion and appetite, and increasing muscle mass. Treatments include *Total Parental Nutrition* (TPN), and medications. TPN is the direct intravenous infusion of solutions containing all necessary vitamins, minerals, carbohydrates, proteins and fats. Although it is often effective at reversing cachexia it has several drawbacks. These include diarrhea, expense (at least \$500 per day) and an intensive level of medical supervision. It also is administered via peripheral or central intravenous lines, which increase a patient's susceptibility to infections. Lastly, introducing and maintaining IV lines is painful and limits activity. TPN is usually considered as a short-term approach for use in critical situations.

Recent pharmacological advances have proven more effective than TPN. At this time two oral medications are approved by the FDA for use as appetite stimulants: *megestrol acetate* (Megace), and *dronabinol* (Marinol). Megace is supplied in 20 and 40 mg tablets and is commonly used as a treatment for breast or endometrial cancer. Its side effects include abnormal uterine bleeding, carpal tunnel syndrome, thrombophlebitis (blood clots) and alopecia (hair loss). Dronabinol is a synthetic tetra-hydro-cannabinol (THC) molecule in capsule form. It has been shown in clinical research to significantly increase appetite and body weight at a dosage level of 2.5-mg TID (three times per day), without euphoric effects associated with larger doses. Cannabis contains THC as its main pharmacological component, along with about 60 other lesser-known cannabinoids.

For short-term use during courses of cancer chemotherapy, inhaled Cannabis is a preferable treatment, partly because of its route. Using the lungs bypasses the gastrointestinal tract. Since the stomach and intestines are extremely sensitive from the chemotherapy, this is a huge advantage. Inhaled Cannabis is quickly absorbed in 1-10 minutes giving relief from either *anticipatory nausea* (before treatments) or actual nausea. Dronabinol is unsuited for severe nausea because of its slow onset and its oral route. The inhaled route is superior also because of ease of dosage titration (the ability to fine-tune the dose with experience) and rapid onset. Although the lungs are clearly harmed by inhaling any smoke, this situation still should be evaluated on a risk/benefit continuum. Also, vaporizers may offer an alternative to smoking.

The large amount of literature, both anecdotal and clinical, on the beneficial effects of Cannabis justifies its inclusion in the pharmacopoeia. Cachexia and wasting syndrome are severe, often fatal complications of disease process with few medical alternatives. Cannabis is a superior treatment for these conditions. Simply put, the minimal harm associated with short or medium-term use of Cannabis does not compare to the agonizing and rapid death brought on by cachexia or anorexia.



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Doctor Abrams described significant clinical improvement in health—measured weight gain—without increasing the viral load of the Human Immunodeficiency Virus (HIV) among participants who smoked Cannabis.



Increasing viral load is an indication that the virus that causes AIDS is replicating.



Protease inhibitors ... [interfere] with the reproduction of the HIV and keeps the level of the virus low enough to not allow opportunistic infections to develop.



The study evaluated the effect of Cannabis smoking, Marinol (dronabinol) and a placebo.

New research: Cannabis-smoking best treatment of all tried

In the first study to be approved by the labyrinthine U.S. Federal cannabinoid research bureaucracy in years, smoked Cannabis was found to be the most effective treatment of those treatments compared for HIV/AIDS, without causing negative drug-drug interactions.

Doctor Donald Abrams and his research team from the University of California at San Francisco compared the effects of Cannabis (smoked), Marinol (dronabinol) and a placebo on a population of HIV positive patients. He announced his preliminary results at the XIII International AIDS Conference in Durban, South Africa in July of 2000. There was little media coverage of this remarkable presentation. In his comments, Doctor Abrams described significant clinical improvement in health—measured weight gain—without increasing the viral load of the Human Immunodeficiency Virus (HIV) among participants who smoked Cannabis.

The “viral load”

One basic interpretation of HIV status is the measurement of a person’s “viral load”. The viral load is measured as a blood test that registers HIV RNA. ³

A result of fewer than 50 copies per milliliter (copies/ml.) of blood is considered “undetectable” or not significant enough to cause disease. Increasing viral load is an indication that the virus that causes AIDS is replicating.

Many HIV patients endure complicated and difficult regimes of drugs called *antiretrovirals*. *Protease inhibitors* are one type of antiretroviral drug. This class of drugs ideally interferes with the reproduction of the HIV and keeps the level of the virus low enough to not allow opportunistic infections to develop. Unfortunately, protease inhibitors have all kinds of serious side effects. Many patients report serious nausea, headache, anorexia, diarrhea and liver function abnormalities.

The UCSF research team used repeated measurement of viral load over the length of the study to determine the effect different cannabinoid-based therapies. The study evaluated the effect of Cannabis smoking, Marinol (dronabinol) and a placebo.

The study

The research protocol consisted of 67 initial subjects. (Sixty-two completed the study.) All the subjects were undergoing antiretroviral therapy with either of two common protease inhibitors, *indinivir* (30 subjects), or *nelfinavir* (37 subjects). Baseline measurements of viral load were taken twice on all subjects. At the beginning of the study over half the participants, thirty-seven, had viral loads less than 50 copies/ml. Ten persons had HIV RNA levels of 50-499 copies/ml., thirteen had levels of 500-9999 copies/ml., and seven persons had levels over 10,000 copies/ml.

All 67 participants were randomly divided into three groups. The first group consisting of 21 patients used smoked U.S. Government-grown Cannabis with a THC percentage of around 4%. (Four percent THC is considered medium quality). The second group of 25 patients was treated with Marinol (dronabinol). The third group of 21 received an oral placebo. ⁴

Blood measurements of viral load were taken eight times over the twenty-one day study. In the beginning weeks, viral load was measured every three to four days. Measurements were increased in frequency as the weeks progressed so that by the third week, viral load was measured every other day. The dosage of each drug was as follows: Cannabis smoking patients smoked one cigarette three times a day before meals. The dronabinol and placebo groups each received a 2.5-milligram capsule, or placebo, also three times per day before meals.

During the length of the study, five subjects left for various reasons. One subject left the smoked Cannabis section because of what were called “neuropsychiatric” symptoms. Two left the dronabinol section, one for “neuropsychiatric” effects and one for headache and nausea. Other minor side effects occurred including rapid heart rate.

The results

After the three-week study concluded, a statistical analysis was conducted comparing the baseline measurements of weight and HIV RNA, with those obtained at various intervals. This analysis showed that the 36 participants with undetectable viral loads (under 50 copies/ml) at the beginning of the study remained in the same category. This held true for the dronabinol, Cannabis and placebo users. The 26 participants who had measurable viral loads at the beginning of the study showed declines over time. The dronabinol/Cannabis groups showed greater declines in viral load than did the placebo group although this was statistically insignificant according to the researchers. What was of major importance was the conclusion that smoking Cannabis did not appear to interfere with the efficacy of protease inhibitor therapy or cause the HIV to increase. In other words, smoking Cannabis did not seem to lead to immunological compromise in this key indicator of HIV status. A more complex immunological analysis had not been done at the time of the Durban AIDS Conference. Future analysis may support or refute the conclusion that Cannabis does not interfere with more complicated immunological functions.

But there was another surprising and significant result of this study, something that HIV/AIDS patients have long since known: Cannabis stimulates appetite. This correlation was established because of the measurements of weight taken before and during the study that demonstrated significant weight gain among both the dronabinol and smoked Cannabis groups. Since Marinol is presently clinically indicated for appetite stimulation in HIV and cancer, this was not surprising. Of more importance was the comparison of weight gain between the Cannabis and Dronabinol groups. The Cannabis-smoking group



Blood measurements of viral load were taken eight times over the twenty-one day study.



The dronabinol/Cannabis groups showed greater declines in viral load than did the placebo group ...smoking Cannabis did not appear to interfere with the efficacy of protease inhibitor therapy or cause the HIV to increase.



Clearly, the Cannabis-smoking group demonstrated the greatest improvement in health as measured by weight gain.

gained an average of 3.5 kilograms (7.7 lbs.), more than any other group. The placebo group gained 1.3 kilograms (2.8 lbs.) and the dronabinol group gained 3.1 kilograms (6.8 lbs.). Clearly, the Cannabis-smoking group demonstrated the greatest improvement in health as measured by weight gain.

None of these results can conclusively establish that Cannabis is without serious adverse interactions in some people. Thus, the results will not settle this question and other researchers will look for more subtle interactions between Cannabis and HIV/AIDS. There could well be some other unknown factor that would make Cannabis use *not* desirable for people suffering from HIV. More extensive measurement of these results will shed some deeper understanding on how cannabinoids interact with protease inhibitors and immune function. But the study clearly demonstrated, in these circumstances at least, that smoked Cannabis was the most beneficial treatment of all studied- even using relatively poor quality government Cannabis. Whether these results, paid for by federal tax dollars, will lead to meaningful federal movement on the medical Cannabis issue is much more doubtful.



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Tablets Zinc Phosphide, Cannabis and Nux, Squibb			
(Nerve Tonic No. 5)			
	Per 1000	Per 500	Per 100
Chocolate-coated	\$1.80	95c.	23c.
Zinc Phosphide	1/8 gr.	} The action of these tablets is that of a Nerve Tonic and Stimulant. They are used mainly to control nervous irritability. Dose: 1 tablet with water after meals.	
Ext. Nux Vomica	1/8 gr.		
Ext. Cannabis Ind.	1/8 gr.		
Tablets Zinc Phosphide and Cannabis Compound, Squibb			
(Neuralgic, Dr. Kenyon)			
	Per 1000	Per 500	Per 100
Plain	\$2.00	\$1.05	25c.
Chocolate-coated	\$2.10	\$1.10	26c.
Zinc Phosphide	1/16 gr.	} These tablets are employed in pains caused by derangement of nerve functions. In neuralgias, sciatica, and spasmodic pains generally; they lessen nerve irritability and excitement, and, by improving the nutrition of the nerves, tend to prevent a recurrence of the neuralgic attacks. Dose: 1 tablet every two hours for three doses, then every three or four hours until relieved.	
Strychnine Sulph.	1/60 gr.		
Ext. Cannabis Indica	1/8 gr.		
Sodium Arsenite	1/20 gr.		
Aconitine	1/400 gr.		

Image thanks to Pharmacy

Cannabis pharmaceutical tablets for neurological pain, pre-1938

Cannabis for spasticity and neurological disorders: Now we know “why”

One of the oldest and most dramatic indications for Cannabis is as a treatment to decrease spasticity associated with neurological disorders like *multiple sclerosis* (MS). Until recently, basic science had not

uncovered the precise biochemical mechanism underlying its efficacy. Thanks to research conducted in Britain, the scientific basis for Cannabis' use as an antispasmodic is now clear. Published in the March 2nd 2000 issue of the journal *Nature* is the article: "*Cannabinoids Control Spasticity and Tremor in Multiple Sclerosis Model.*" Scientific scrutiny is finally unlocking the secrets about *how* and *why* cannabinoids work.

Physiology of multiple sclerosis

Multiple sclerosis is a disease that progressively destroys the body's nervous system. It has several different clinical pictures that roughly translate into the speed and severity of the neurological collapse. Symptoms can intermittently wax and wane or quickly progress to severe incapacitation and death. The underlying cause of MS is not clear. Most medical researchers think that it is somehow caused as an immunological defect that may be brought on by a viral or bacterial illness. The viral illness triggers a process of deterioration in the protective coverings of the *Central Nervous System*. The CNS composes the brain and spinal chord. Simply put, it regulates the complex management of nerve impulses that control everything from thought processes to hormone release to bodily functions and reflexes. Multiple sclerosis is understood as a process of *demyelination* of the nerve coverings. The myelin sheath is a lipid (fat) covering that surrounds and protects the nerves in the spinal chord and brain. Nerve signals, or impulses, pass through the nerve cell at high speeds, carrying *sensory* or *motor* signals. These allow humans to feel pain (sensory) or physically act (motor). The myelin sheath probably enhances the signaling in somewhat the way that plastic coating protects electrical wires.

As MS progresses, the myelin sheath deteriorates in places over time. Plaques develop and alter nerve conduction pathways. This leads to abnormalities in many organ systems that depend upon nerve cells to signal environmental changes and carry chemical messages throughout the body. The *Autonomic Nervous System* (ANS) is severely affected by multiple sclerosis. The ANS controls many involuntary body functions like heart rate, sweating, and glands. ⁵ This is why MS can affect so many varied bodily systems.

Symptoms of MS are varied but include movement and coordination problems, visual or speech alterations, bladder and bowel control, emotional changes and spasms, cramps or tremors. These symptoms vary widely from patient to patient. They may be severe and incapacitating or mild and barely noticeable.

Common treatments for multiple sclerosis

The treatment for MS varies with the symptoms and severity of the disease. At this time there are no medical procedures to eliminate the disease. Mainly, treatment is supportive, relying on medications and physical therapy to help control the body functions. The pharmaceuticals in common use include dantrolene (Dantrum) and baclofen



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Multiple sclerosis is understood as a process of *demyelination* of the nerve coverings.



...treatment [for MS] is supportive, relying on medications and physical therapy to help control the body functions.



Physical therapy strengthens muscles, increases rang-of-motion, stimulates heart and lung function and decreases contractures and skin breakdown.



Several U.K. research teams...coordinated investigations into the anti-spasmodic properties of cannabinoids.

(Lioresal) to relax muscles, benzodiazapines like diazepam (Valium), sedatives and tranquilizers. Common side effects of these drugs range from minimal to incapacitating. Dantrolene can cause drooling, sweating, and pleural effusions, hepatitis and tachycardia. Xanax can cause nausea, constipation, drowsiness, benzodiazepine dependence headache and dry mouth. As with many pharmaceutical regimens, the dosage of the drug is increased as the severity of the disease increases. Thus, patients who suffer from the severest functional and sensory effects of MS also suffer from the worst effects of pharmaceuticals.

The other basic line of treatment for MS involves exercise and physical therapy. Lack of mobility increases many problems and can lead to skin breakdown, gastrointestinal problems, contractures and muscle wasting. Physical therapy strengthens muscles, increases rang-of-motion, stimulates heart and lung function and decreases contractures and skin breakdown. Exercise should be carefully monitored to not injure weak muscles. Some patients report that magnets also decrease spasticity, although this has not been scientifically established.

Herbal Cannabis decreases spasticity

Until recently, little or no research had evaluated the biochemical foundation for reports that Cannabis decreased spasticity. This is not surprising since research into medical uses of cannabinoids has been held hostage to United States governmental opposition. Research—undertaken mostly in the U.K.—has uncovered the physiological action of cannabinoids in controlling spasticity and, as the authors state: “...provides a rationale for patients’ indications of the therapeutic potential of Cannabis in the control of the symptoms of multiple sclerosis.”

Several U.K. research teams including The Multiple Sclerosis Society of Great Britain and Northern Ireland and the University College of London, coordinated investigations into the anti-spasmodic properties of cannabinoids. They used an “artificial” research model of MS called *chronic relapsing experimental allergic encephalomyelitis* or CREAE for short. Mice were given drugs to induce the CREAE, then used as research subjects to test the effectiveness of the different cannabinoid compounds. Researchers injected a total of four different cannabinoids (WIN 55212, Delta-9-THC, methanandamide, JWH-133) and measured the effect on the CREAE.

They pointed out that “cannabinoid (CB) receptor agonism using WIN 55212, Delta-9-THC, methanandamide, JWH-133 quantitatively ameliorated both tremor and spasticity in diseased mice.” Additionally, they injected cannabinoid *antagonists* (deactivators), into the mice and found that as the drugs bind with cannabinoid receptors, the spasms returned. Antagonists, by occupying receptor sites, make them unavailable for cannabinoid activators. This research demonstrated that mice, and by extension humans, possess an endogenous cannabinoid receptor system that helps regulate coordination, spasms and tremors.

104 Canadian Hemp, see Apocynum, N. F.

Cannabis, U. S. P., Cannabis sativa(alcohol 80%).. (No. 598).. 6 00
 (American Cannabis)

Tested physiologically. Every package stamped with the date of manufacture. Physiologic standardization was introduced by Parke, Davis & Co. Average dose, 1½ mins. (0.1 cc). Narcotic, analgesic, sedative. This fluid extract is prepared from Cannabis sativa grown in America. Extensive pharmacological and clinical tests have shown that its medicinal action cannot be distinguished from that of the fluid made from imported East Indian cannabis. Introduced to the medical profession by us.

Image thanks to Farmacy

Cannabis pharmaceutical-grade elixer label, 1929-1930 catalog

Cannabis and glaucoma

Glaucoma is defined as an abnormal elevation in intraocular pressure (IOP) within the eye. It is caused by inadequate control of the fluid that lubricates and nourishes the eye—called *aqueous humor*. Aqueous humor is produced by an eye structure called the ciliary process. The aqueous humor passes through the eye and nourishes the tissues inside the eye. If there is a blockage of the valves that control the flow of aqueous humor out of the eye, pressure builds up. If there is excessive production of aqueous humor then pressure can also increase. Either condition causes degenerative changes including damage and destruction of the optic nerve. The eventual outcome is blindness for many patients. Normal IOP is 10-20 millimeters of Mercury (mm Hg.). IOP above 20 mm Hg. indicates glaucoma. Elevated IOP alone does not diagnose glaucoma. Damage to the optic nerve *caused* by the high pressure defines clinical glaucoma.

Glaucoma and diabetes are variously listed as the leading causes of blindness in the United States. At least 80,000 Americans are blind from glaucoma and three million Americans are afflicted with it. A higher percentage of African Americans suffer from glaucoma and blindness than do Caucasians.

The goal of medical management of glaucoma is to preserve the sight. Treatments for glaucoma include drugs and surgical intervention. Topical (applied directly to the eye) treatments include drugs containing beta-blockers like timolol maleate (Timoptic), miotic drugs which constrict the pupil to increase aqueous humor outflow like Pilocarpine, and carbonic anhydrase inhibitors like Diamox. Epinephrine may also be used. Side effects to these medications are varied in frequency and severity but include impaired night vision, blurred vision, fatigue, decreased appetite, weight loss, heart palpitations. As the degenerative process continues, topical agents are increased in dosage resulting in more significant side effects. Fifty percent of patients cannot tolerate the side effects of these medications, narrowing their available options. Surgical interventions carry significant risk of worsening the condition.

Cannabinoids have been shown in repeated research studies to reduce IOP to normal levels thereby slowing or arresting the disease. Pharmacological action on the formation and flow of aqueous humor is poorly understood. Tests using THC (tetra-hydrocannabinol) alone



This research demonstrated that mice, and by extension humans, possess an endogenous cannabinoid receptor system that helps regulate coordination, spasms and tremors.



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The goal of medical management of glaucoma is to preserve the sight. Treatments ...include drugs and surgical intervention.



Cannabinoids have been shown in repeated research studies to reduce [intraocular pressure] to normal levels thereby slowing or arresting the disease.

have not shown significant benefits. Several different cannabinoids within Cannabis seem to act in conjunction with one another.

Cannabis has some 60 different cannabinoid molecules. Many glaucoma sufferers report that inhaled Cannabis quickly reduces symptoms of elevated IOP. Some patients who use Cannabis report slowing or stopping of their loss of sight for long periods of time.

Cannabis therapy for glaucoma should be evaluated on the risk/benefit continuum. Research on long-term pulmonary effects of smoked Cannabis shows that cellular changes similar to tobacco occur with chronic use. The duration of action of Cannabis in lowering intraocular pressure is four to six hours. Thus, for long-term control of symptoms, patients need to dose four to six times per day. In general medical terms, this is not a desirable option. However, when compared to the incapacity of blindness or the increasingly dangerous medical options, Cannabis falls within an acceptable range. The patient and physician should be the ones to decide if the benefits outweigh the risks, by evaluating the patient's ability to maintain this therapy long-term.

In 1980, researchers in Jamaica formulated a topical eye drop made from *Cannabis sativa*. They named this compound *Canasol*. It has been used widely in Jamaica. Canasol is manufactured as a sterile solution and is dispensed in five milliliter (ml.) bottles for instillation into the eye. The IOP-lowering effects are similar to pilocarpine in degree. Canasol appears to work synergistically with pilocarpine, without the serious side effects. There have been no adverse effects noted as of 1998. There are no FDA clinical trials ongoing or planned to evaluate Canasol. As of 2001, this medicine is not available to patients in the United States.

Footnotes

¹ Endorphins are manufactured in the brain and are activated when a person is injured. As our natural pain-killing system, they are responsible when soldiers with grievous wounds feel no pain.

² Antagonists are chemical compounds that rapidly block and chemically counteract the effects of other substances by receptor-binding. People who overdose on heroin, (an opioid), are given Nalaxone, an antagonist, which quickly reverses the effects of heroin by competing for receptor sites occupied by the heroin.

³ Ribonucleic Acid (RNA) is a genetic structure that controls protein synthesis within all living cells. Since HIV is a virus, it contains RNA. Thus, measuring the RNA present in the AIDS virus gives a marker as to the extent of the virus.

⁴ A “placebo” is a “fake drug” that acts as a baseline control to evaluate the effect of no specific treatment. By using the placebo as a standard of comparison researchers are able to determine if the drug in question, in this case Cannabis, has any real effect. Patients and sometimes researchers do not know if the drug being evaluated is “real” or is a placebo. If neither the patient nor the researcher knows which it is then the test is called “double blind.” (There was no placebo Cannabis smoking group to establish a baseline for the Cannabis smokers in the study.)

⁵ The *Autonomic Nervous System* acts to slow or stimulate these systems in response to environmental situations in order to maintain *homeostasis* or physiologic equilibrium. In hot weather we perspire which releases heat from the body, reestablishing internal comfort.

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Chapter 5: Basic Issues of Cannabis Cultivation



The Cannabis plant: botanical description

Cannabis is an annual, herbaceous, dioecious, (sexually differentiated) woody plant. It grows outdoors in temperate climates worldwide on all continents except Antarctica. Cannabis is grown intentionally indoors in many countries in clandestine operations.

Cannabis can be subdivided into 3 main species: *C. sativa*, *C. indica*, and *C. ruderalis*. Each species carries unique genetic, botanical and biochemical traits. Breeding programs in the United States, Canada, Holland and Switzerland have resulted in hundreds of unique *cultivars*, plants selected for specific characteristics like floral appearance, THC content, disease resistance, size or vitality. These *strains* are grown in seed-breeding facilities in Holland, Canada and Switzerland by crossing different varieties to bring out some desirable trait. The genetic makeup of the parent plant determines the potency and other individual traits. Optimal growing conditions allow the *potential* of the genetics to develop.

Sativas are large plants grown in South and Central America. *Sativas* can often reach 8 feet tall outside with branching habit that resembles a Christmas tree. Large stature is not desirable for indoor cultivation therefore breeders have crossed *sativas* with smaller sized *indicas*. *Indica* plants are common in India and Afghanistan. *Ruderalis*, the third, and less common species, originated from northern Europe. It is notable for early flowering characteristics and thin-leafed appearance.

The unique chemical constituents of Cannabis are termed “Cannabinoids.” Cannabis contains some 60 cannabinoids that modify and contribute in complex ways to the medicinal or therapeutic properties.¹

The highest-concentration cannabinoid present in Cannabis is termed Delta-9-tetrahydrocannabinol, or “THC.” Other cannabinoids (than THC) are present in smaller amounts. (Chapter 3 describes the common cannabinoids and their basic chemical functions.)

Cannabinoids are present in the leaves and flowers of the plant to varying degrees. The highest concentration is found in the unfertilized flowers (called “*sinsemilla*”) which have been harvested, dried and cured at peak cannabinoid production. *Sinsemilla* is quality Cannabis because the process of forcing flowers causes layer after layer of resinous *buds* to form. These are harvested when morphological changes indicate *peak floral maturity and highest cannabinoid content*. Left unharvested, the flowers begin physical and chemical decomposition as the plant enters



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Sativas are large plants grown in South and Central America ...and can often reach 8 feet tall...



Indica plants are common in India and Afghanistan. *Ruderalis*, the third, and less common species, originated from northern Europe.



Cannabinoids are present in the leaves and flowers...The highest concentration is found in the unfertilized flowers (called “*sinsemilla*”) ...



THC concentration represents the fraction (or percentage) of THC in relation to all the cannabinoids present.



Outdoor growers ...should...select Cannabis strains, which will flower in their shorter growing season.



The Oregon Medical Marijuana Act was written to allow the cultivation of Cannabis specifically to remove patients from the underground drug markets.



Cultivation of one's own medicine flies in the face of the established medical model in the United States.

“*senescence*,” its decline towards death. Senescence is sometimes interrupted by growers who “force” the harvested plant to grow new leaves, a process called “*regeneration*”.

THC concentration represents the fraction (or percentage) of THC in relation to all the cannabinoids present. Ten percent (10%) THC concentration means that ten percent of all the cannabinoids present are THC. (Ninety percent are other cannabinoids.) THC concentration can range from 0.02% (hemp) to 15-30% for some Dutch and Canadian hybrids. The U.S. government grows 2-4% THC Cannabis at a research farm in Mississippi. This Cannabis is of poor to medium quality, and is considered harsh and difficult to smoke by the few patients still enrolled in the *Investigational New Drug Program*.²

Plant varieties

Outdoor growers in Oregon should, if possible, select Cannabis strains which will flower in their shorter growing season. Since Cannabis has acclimated to climates from equatorial to Northern and southern, its flowering pattern will follow these genetic tendencies. Thus, an equatorial variety that is accustomed to long slow flowering may not ripen in time if grown outdoors in Oregon. Patients planning to cultivate outdoors should consider surfing the Internet under “Cannabis seeds” and contact other patient networks for information and support about what variety to grow.

Basic cultivation issues

Oregonians registered in the Medical Marijuana Program have few choices when it comes to obtaining an adequate supply of medicine. They must buy Cannabis or seeds in the black market, rely on other patients, caregivers or grow it themselves. The Oregon Medical Marijuana Act was written to allow the cultivation of Cannabis specifically to remove patients from the underground drug markets. Patients and caregivers registered in the Oregon Health Division’s Medical Marijuana Program can legally exchange plants, seeds, clones and medicine among themselves. (Chapter 1 discusses issues surrounding procurement and exchange of seeds and clones as well as application procedures.)

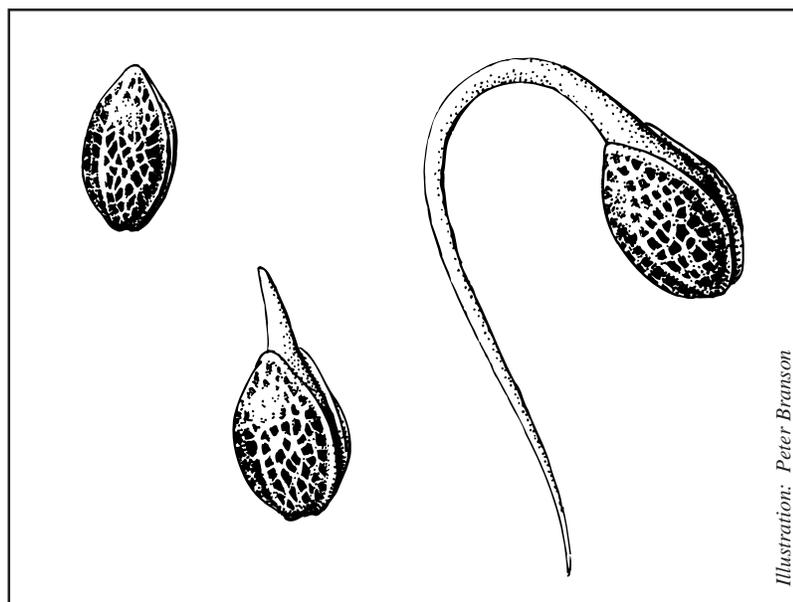
Cultivation of Cannabis is both simple and complex. Growing a consistent supply of medical-grade Cannabis requires patience, trial and error, and careful observation. Outdoor and indoor cultivation also require different (though similar) skills. Throwing a seed into dirt will likely result in a plant, but the quality of medical-grade Cannabis will not be adequate unless the grower has some basic knowledge of horticulture. This knowledge must be coordinated with the flowering limits written into the OMMA.

Cultivation of one’s own medicine flies in the face of the established medical model in the United States. Patients must not only bring energy and commitment to the process of safely growing an adequate supply of Cannabis, but they must often do so with disapproval or

obstruction of the doctor. These considerations must be evaluated along with the physical limitations of the patient and the space available. Patients should carefully consider all these issues before committing to cultivation. Lastly, anyone serious about growing their own Cannabis should buy a copy of *Marijuana Growers Guide*, by Mel Frank, or another guidebook. (The “resources” section lists several excellent books.)

Seed germination

Germinating seeds is easy. Start by soaking the seeds for 12 hours in either clean water or dilute “Start up” fertilizer. The seed will expand and begin to sprout quickly if it is viable. If the seeds are old or unhealthy they will sprout poorly if at all. After soaking, plant the seed in potting soil or seed starting mix, which is purchased at the gardening center. Place the seed pointed end up about 1/8-inch deep. Keep it moist, not soaked, by covering the container with plastic wrap. Keep the container warm and don’t dig or move the seed to check it. In 3-6 days most healthy seeds will sprout by sending out a single root. Be careful at this time not to disturb the delicate root, which is going through rapid growth. Fertilize the sprouted seedling with dilute start up fertilizer after the first two round leaves (cotyledons) have emerged. This should be about a week after sprouting. Once serrated leaves have opened and photosynthesis is occurring, place the container under lights. Gradually lengthen the light intensity over a week until the plant is established and growing “true” leaves.



Healthy seeds should sprout in a week. Resist the urge to dig up the seed to check it.

Germinating seeds is easy.

If the seeds are old or unhealthy they will sprout poorly if at all.

Fertilize the sprouted seedling with dilute start up fertilizer after the first two round leaves (cotyledons) have emerged.

All plants need nutrients, carbon dioxide, water and light to grow...The basic nutrients are *Nitrogen (N)* *Phosphorus (P)* and *Potassium (K)*.



Use commercial fertilizers with care. They are very concentrated and “overdosing” can kill the plant.



Carbon dioxide is a fundamental requirement for plant growth driven by the energy of sunlight (or artificial light) through the process of photosynthesis.



Cannabis plants typically grow indoors to the height of 2-4 feet before flowering.

Plant requirements

All plants need nutrients, carbon dioxide, water and light to grow. (Plants also need small amounts of micronutrients like Magnesium and Zinc.) The basic nutrients are *Nitrogen (N)*, *Phosphorus (P)* and *Potassium (K)*. All fertilizer bottles have an “NPK” rating that represents relative amounts of each. Nitrogen promotes leaf growth. Fertilizers high in “N” are suitable for the initial growing, or vegetative, stage. Flowering or bloom fertilizer formulations have larger percentages of Phosphorus and Potassium as these two nutrients are needed at that stage of growth. There are many fertilizers on the market. Most growers should choose something organic like fish emulsion, bat guano or kelp.

People suffering from immune suppression should consider using a commercial fertilizer like “Peters 20-20-20”. Use commercial fertilizers with care. They are very concentrated and “overdosing” can kill the plant. Organic fertilizers are less concentrated and “easily digestible” by plants. For the planting medium use a general purpose sterilized planting mix.

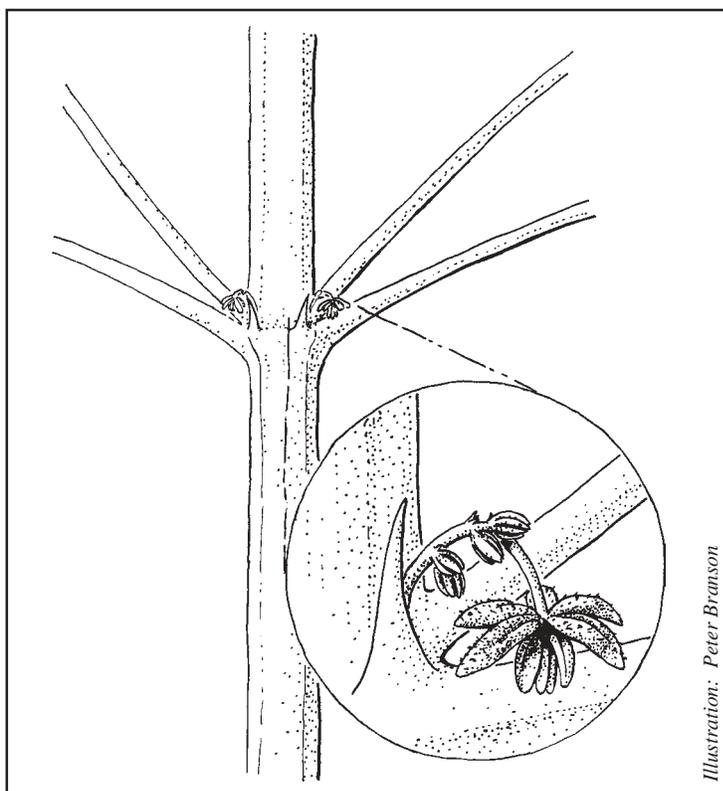
Carbon dioxide (CO₂), present in small quantities in the air, is the colorless gas which mammals exhale as a by-products of respiration. Carbon dioxide is a fundamental requirement for plant growth driven by the energy of sunlight (or artificial light) through the process of photosynthesis. (This process produces the oxygen (O₂) which animals breathe, completing this symbiotic relationship.) Increased CO₂ can spur accelerated plant growth. Some growers add supplemental CO₂ to their plants but this is not recommended for beginners because of the complexity and expense. Most plants will grow fine with available air. (Use fans to help bring in fresh air.)

Water is the third essential. Keep plants watered but not soaked. A moisture meter is a simple and inexpensive device to measure soil moisture. Most plants can be planted in 1 or 2 gallon containers and irrigated every 2nd or 3rd day. (There should be holes in the bottom of all containers to allow for drainage.) Large sativas should be planted in larger containers, like 5-gallon buckets. They should also be flushed with large amounts of water to leach out salts and sprayed with lots of water to wash bugs and debris off the leaves about every 2 weeks. The hotter the space the more water the plant will need. Fans should be used to vent excess heat which can be monitored with an inexpensive thermometer placed on the wall. Venting also helps control excess humidity which can lead to mold.

Indoors or out, Cannabis plants require high levels of light for healthy growth. Outdoor growers rely on the sun, which is both inexpensive and powerful. (They also avoid the cost of ventilation.) Indoors, the light timing cycle should be set to 18 hours on and 6 hours off for vegetative growth, the first phase of the plant’s growth. An Intermatic brand timer makes this safe and easy. Cannabis plants typically grow indoors to the height of 2-4 feet before flowering. As discussed above there is much variation in size due to the many

varieties. Each variety has different genetic characteristics that result in unique features. Sativas are generally not adaptable for indoor growing. Many varieties combine qualities from different sources. No single plant will be as useful as those from these carefully bred combinations. The inexperienced grower will need to experiment by procuring seeds or clones and growing them out. New growers should be patient and observe the plant's development to learn what a healthy plant looks like. When receiving new clones ask the provider about the variety and individual needs. Attention to the plant, aided by study of cultivation references, will help in understanding how to care for the plant through all the stages of its life.

Since the number of flowering plants allowed under the OMMA is three, growers may consider growing the plants larger if the space is available.



Male Cannabis plants should be removed from the garden as soon as the plant is identified as male. This will prevent pollination of the female plants.

Flowering

Genetics and environment determine the flowering of Cannabis. Generally Cannabis will attain floral maturity after about 50-70 days. Most hybrid varieties have specific flowering profiles such as number of days to floral maturity and physical appearance. Fertilize the plants on day 1 and day 25 with flowering fertilizer in concentrations recommended by the manufacturer for tomatoes. Keep notes about the process, especially if you are unfamiliar with the variety. You need to be



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Cannabis, like many other plants, begins to form flowers in response to decreases of light...



Normally, floral characteristics will begin to appear in about a week. At this time males should be removed.

able in the future to understand what conditions yielded what results. Notes provide that information.

Cannabis, like many other plants, begins to form flowers in response to decreases of light, which indicate the end of the season. Thus, when flowers are desired the light cycle must be changed. Generally, the light cycle is changed to 12:12 (12 hours of light followed by 12 hours of darkness.) If the grow chamber is light tight or in a dark room the 12 hour cycle can be at any time of day. The critical concern is that the 12 hours of darkness must be *uninterrupted*. Any light (except green) that hits the plants during the 12 hours of darkness will “confuse” the flowering process. Normally, floral characteristics will begin to appear in about a week. At this time males should be removed. Male flowers have segmented “umbrella” flowers with small clusters of pods hanging from them. It is important to be able to differentiate males from females because unfertilized female flowers have the greatest cannabinoid concentration and are the most desirable. Take cuttings from the best female plants to make new plants.

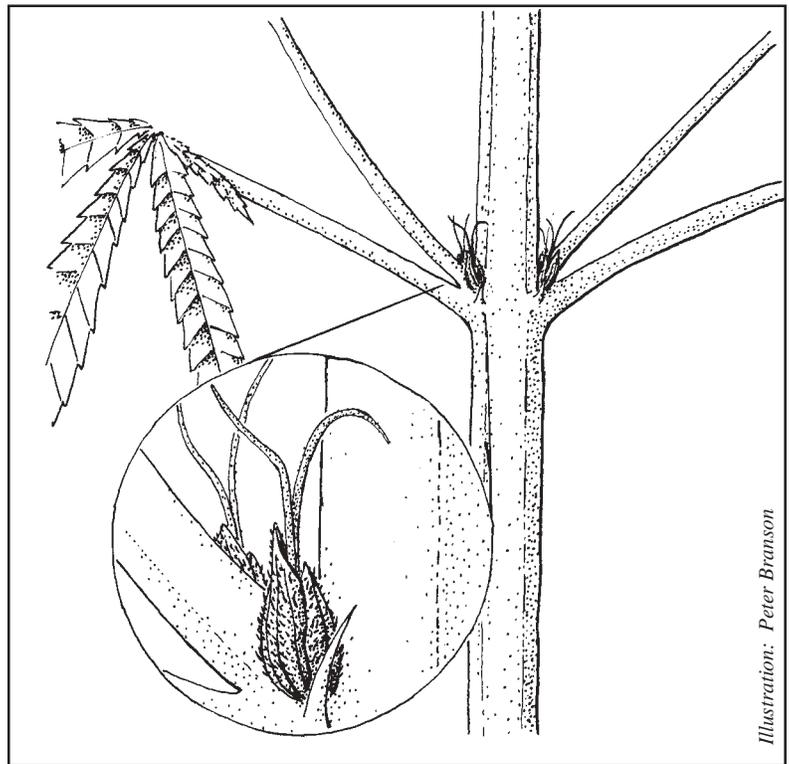


Illustration: Peter Branson

Female plants are easily identifiable about two weeks after the flowering cycle has begun.



Flowers can be cut off the plant individually or the entire plant can be uprooted.

The end-point of floral maturity is quite precise and the reader is encouraged to consult a reference for detailed instructions. Generally, when the female flowers (pistils) have mostly turned brown and there are clear crystals, which look like sugar, all over the flowers they are ready to harvest. These crystals are called “trichomes.”

They are highly resinous cellular sacs that concentrate cannabinoids. If left too long flowers will begin to rot and mold, therefore it is important to know when to harvest. The THC level of the flowers increases to the point of floral maturity then begins to decline as THC is oxidized and converted to Cannabidiol (CBD). Successive harvests of the same variety allow the grower to “finely-tune” the flowering process for best results as familiarity with the plant grows.

Harvesting, drying and curing

Flowers can be cut off the plant individually or the entire plant can be uprooted. For indoor growers the plant can be regenerated.³

Cut flower clusters off the plant and carefully trim off leaves. Handle the flowers carefully so the trichomes—resin sacks—aren’t dislodged.

Hang the harvested flowers upside down on a line or string in a dark cool space with lots of air circulation. Observe the clusters for mold or rotting, since they are tightly packed with little air inside. Care must be taken to keep good air circulation. Dry for four days or until the stems snap and break when bent. Then the flowers should be put into a plastic sack or glass jar for another month to *cure*. Curing allows a chemical reaction to take place that makes the plant much less harsh to smoke and increases potency. Remove any flowers that appear soggy and continue to dry. After a month the flowers should be dry, whole, fresh smelling and without any mold or contaminants. Look closely at the individual flowers with a magnifying glass. If any mold or rot is seen destroy the flower cluster.

Preserving the dried flowers is easy. They can be frozen in airtight zip-lock plastic bags. Or they can be canned. To do this wash, mason jars and lids in soapy water, dry and microwave the jars **ONLY** until hot to touch. Pack the dried flower clusters into the jars lightly and microwave jars and flowers for one minute. Carefully screw on lids tightly. Label jar with date and variety. As the jar cools the lid will vacuum seal. Keep unused buds in a dark place to prevent oxidation.

OMMA harvest limits

Oregon patients and caregivers should clearly understand the limits that are allowed while harvesting. The OMMA stipulates that the grower may grow up to 7 (seven) plants and flower 3 (three). They may possess one ounce of dried (usable) Cannabis for each flowering plant. If there are two flowering plants the caregiver or patient (whoever is growing the plants) may possess up to two ounces of “usable” marijuana. The grower may not possess in excess of three ounces of usable Cannabis. Hopefully, these ridiculously low possession limits will be increased soon.

Dried Cannabis is much lighter than freshly harvested flowers. Therefore, growers may harvest 3 to 4 ounces of fresh flowers knowing that the dry weight of the flowers will be under an ounce. Growers should have and use a scale to measure the harvest weight to ensure legal compliance.



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The basic requirements for an indoor growroom are: space, light, air circulation and heat.

Indoor growroom basics

The typical growroom has several basic features that must be adapted to the particular location. Careful planning of the growing area will prevent many problems. The basic requirements for an indoor growroom are: space, light, air circulation and heat.

Space

Many growers use a closet or enclosed space. It should be around 16 square feet- that is, a 4 foot by 4-foot space. A 16 square foot space is adequate for three moderate-sized flowering plants (the legal flowering limit under OMMA.) Since the law allows for seven plants total, the size of the plants should be matched to the space available. (Although flowering seven plants is a violation of the OMMA, police usually aren't concerned unless the *total number* of plants exceed seven.) The space should be painted bright white or hung with *Mylar*- a reflective foil that reflects light onto the plants. Mylar can also be hung as drapes in a larger room to create the space and hold light.

The light source

The light source should be a *High Intensity Discharge* (HID) light. They are available in two lighting systems: *Metal Halide* (MH) and *High Pressure Sodium* (HPS). The difference between the two is the spectrum or *wavelength* of emitted light. HPS lights emit warmer, reddish light that is thought to enhance flowering. MH lights emit cooler or bluer light that supports vegetative (leaf) growth. Many people use both, either together, or MH and then HPS matching the different phases of growth. First time growers should probably purchase an HPS light. These are available in many sizes (wattage ratings) but a 400-watt is adequate for most small spaces. The light is probably the most expensive purchase of a growroom. Lights range from \$100 to \$250 and can be purchased from hydroponic/indoor gardening stores in Portland and nationwide. *Fluorescent tube lights* can be used instead of HID's but aren't recommended because they are too weak and inefficient and will actually cost more to use in the long run.

Lights should be plugged into a timer to regulate on and off light cycles. Timers are inexpensive and easily available at most lighting or hardware stores. The timer should be capable of safely handling the wattage of the light and any other appliances it is controlling. Read the rating of the light and match it with the rating of the timer.

The basic problem with HID lights indoors is the heat they produce. The "*ballast*" is a heavy (10-15 lb.) metal case, which contains the electronic components which run the light. The ballast is connected to the reflector hood and bulb by a heavy gauge cord and should, if possible, be placed outside the growroom to minimize heat production.

Air circulation

In any case, growers must ventilate the space with enough fans to maintain the temperature below 80° F. For a 16 square foot room at least two fans are recommended: one to blow cool air into the room at



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floor level and a second at ceiling level to blow hot air out of the room. Fans are critically important because plants need moderate temperatures and air circulation to grow. Box type fans are inexpensive and available at most department stores. Oscillating fans keep air circulating around the plants and strengthen the stems.

Electricity

All these grow room devices, of course, take electricity. If you have outlets nearby then installing them is easy, just plug them in *after making sure that you are not overloading the electrical circuit*. Otherwise, it is imperative to hire an electrician to install lamps and fans along with “ground fault interrupters” to prevent shocks. The key is to safely have the light, fans and timers running 18 hours a day without the temperature getting above 80°F.

Warning: Correct and safe electrical wiring is extremely important. The total load of all the components of the growroom must not be greater than the capacity of the wiring. Overloading electrical circuits can result in fires. Licensed electricians should be consulted by anyone who is not experienced in electrical wiring.

Outdoor cultivation basics

If Cannabis is being grown outside there are several other issues that must be considered. An outdoor garden has the advantage of size, a free light source (the sun), great air circulation, and no need for electrical hookups. Outdoor issues include location, security, weather conditions, and possession limits set by OMMA .

Sunshine and water

Probably the most basic benefit to outdoor growers is free, powerful sunlight. Sunlight is uniformly intense. This means that the sun’s rays penetrate deeply into the plant increasing photosynthesis and growth. Depending on the variety grown, outdoor Cannabis plants grow much larger and produce more than those grown indoors. Because of this accelerated growing process, outdoor plants require more water and fertilizer. It is practically impossible to give plants too much sun as long as the temperature is not excessive and enough water is provided. In hot weather, Cannabis plants should be watered more frequently, especially if they are large (over five feet.)

Soil and fertilizer

Since outdoor Cannabis grows large, so do its roots. Careful growers pay attention to this by preparing a large fertile area for the plant to grow. If the location is out in the woods, holes must be dug and filled with rich high-nitrogen soil. In an established garden this is easier since other herbs and vegetables are also growing. In either case, Cannabis likes drained, rich soil. Amend any soil with bat guano, fish



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Outdoor plants do not need the repeated flushing with water that is required with indoor plants since salts and chemical residues do not accumulate.



Growers with maturing plants outside should watch weather reports and be alert for rain or frost.



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These limits are relatively simple to follow for indoor gardens since the plants are smaller and flowered according to the wishes of the grower.

fertilizer or tomato food. There are countless soil and fertilizer options. Repeated growing will show what works. Growers should also keep weeds away from the plant to decrease competition. Outdoor plants do not need the repeated flushing with water that is required with indoor plants since salts and chemical residues do not accumulate.

Weather

Outdoor plants are much more susceptible to climate changes. In Oregon, cloudy, cold and rainy weather systems blow in off the Pacific Ocean beginning in October, or earlier. This can be a problem for any slow-flowering varieties. Colombian and other Southern latitude strains will grow large because they are accustomed to long growing seasons. Worse yet, sustained rain in warm months creates perfect conditions for rot. Entire plants can mold in a few days. Growers with maturing plants outside should watch weather reports and be alert for rain or frost. If these conditions are imminent, plants should be covered with plastic trash bags. Make sure to remove the bags when conditions improve, or every day, to promote air circulation.

Outdoor harvest issues

Outdoor gardens also present challenges related to harvest and possession limits written into the OMMA. The Initiative was written to accommodate political realities, thus the allowable harvest and possession limits were kept unrealistically small. (The OMMA allows possession of one (1) ounce of dried Cannabis. The person who is acting as a designated primary caregiver is allowed one (1) ounce of dried Cannabis *for each flowering plant, not to exceed three (3) ounces.* (Chapter One details the application and possession issues.) These limits are relatively simple to follow for indoor gardens since the plants are smaller and flowered according to the wishes of the grower. Outdoor growers give up this control. Thus, seven plants planted outdoors in the Spring may result at least in several pounds of flowers which need to be harvested and cured at peak floral maturity to produce medical-grade Cannabis. Since the OMMA differentiates between flowered and unflowered plant limits, this scenario is illegal. Additionally, the possession limits are so small that the grower must harvest only enough fresh Cannabis to remain under the possession limit. Since the grower who is flowering three plants can possess up to three ounces of *dried* Cannabis, they should be safe if they harvest ten ounces of *fresh* flowers at a time. This will dry down to a “legal” amount. The problem occurs because the harvested flowers take weeks to dry and cure. Meanwhile the remaining flowers continue to mature past peak floral maturity.

It is a practical reality that most Oregon patients harvest and dry the entire crop at one time. Although this is a sensible approach it is still illegal. However, using a *cyclic harvest*, in which ten ounces at a time is taken off the plants, dried and given to the patient network or another patient, is an alternative means of harvesting. By sharing excess amounts, the patient can stay safe and help others. Another possible

answer is for the grower to grow different strains with different flowering times. In this scenario, the mature plants are harvested one by one.

Another problem with these scenarios is the three-plant designation. If the patient harvests one of the three plants then his possession limit is reduced since he no longer has three flowering plants! This bizarre situation results from the framers of the OMMA who put political considerations above practical ones.

Patients should be aware that they may be permitted to grow more than seven plants and possess larger quantities of usable Cannabis if they gain the support of their physician. House Bill 3052, the Oregon legislative rewrite of the OMMA, included this provision. (Chapter Two includes information on how patients may legally increase the limits.)

Security issues

Since the passage of the OMMA, legal Cannabis gardens have sprouted in Oregon. For patients, this has been a great benefit. Patients all over Oregon planted Cannabis in sunny, open locations in back yards and garden plots. Unfortunately, as medical gardens proliferated, so too did the theft of medicine. Oregon patients in 2000 suffered through a blizzard of rip-offs, theft of plants and medicine, and in at least one case, home-invasion armed robbery. Practically every outdoor grower in Oregon was faced with questions of how to protect plants, that sometimes had \$2000 worth of medicine on them, from thieves who cruised through back yards looking for and stealing Cannabis.

This abhorrent situation is an outgrowth of the illegal drug market. Profiteers and thieves see profit in patients' gardens. The fact that patients are suffering for lack of medicine counts for nothing in a world of underground capitalism. Why should it? The American medical system has perfected *profiteering* from disease. (Pharmaceutical stockholders in the United States make billions of dollars in stock profits while Americans can't afford to buy the drugs that keep them alive.) This profit-centered approach fits equally well in the world of illegal drug markets. In any case, patients are the losers. Thus, patients who grow Cannabis outdoors must factor in security issues if they wish to harvest the plants.

Location, protection and secrecy

Outdoor gardens should be located to make maximum use of natural or vegetative features for visual protection without, hopefully, sacrificing sun exposure. This is a difficult but not impossible balance. For those living in rural areas, planting a hedge of sunflowers around the plants will block the view. Interspersing Cannabis plants with tomato plants will also de-emphasize the distinctive appearance. If the garden is in a city or town, growers should use barriers like fences, trees or shrubs to mask the Cannabis. By planting other plants around the Cannabis, and maintaining south-facing exposure, plants have protection. Cannabis should not be planted within view of roadways. This is



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Patients in Oregon have one big advantage over those in most other states: the protection of law.



Since police are protectors of society, patients should have nothing to fear by calling police and asking for increased patrols through a neighborhood. If there has been plant theft...



...patients should carefully plan the issues involved in growing Cannabis at their location. They should also maintain secrecy.

an invitation for theft or accidental mowing since roadway mowers clear vegetation along many of Oregon's roads in the summer. East facing hillsides are excellent locations since they have sun exposure. But care must be taken to protect plants from deer and other animals.

Outdoor growers must also consider protecting the plants. There are several ways they can do this. Putting cages around plants can keep animals and people away. This can range from simple chicken-wire cones to chain link fences. Although esthetically ugly, cyclone fencing can be easily installed. Growers should consider adding motion sensors or cameras to the garden. These are inexpensive and can be purchased at Radio Shack.

Police protection and patrols

Patients in Oregon have one big advantage over those in most other states: the protection of law. This legal support may be the most valuable security any Cannabis-growing patient can achieve. Since Cannabis is now a legal medicine (for those registered with the Oregon Health Division), patients should consider calling police to protect their crop. This may seem difficult for patients who have lived in secrecy for years. However, most police in Oregon have no interest in dealing with legal patients. Since police are protectors of society, patients should have nothing to fear by calling police and asking for increased patrols through a neighborhood. If there has been plant theft in a neighborhood, this would be advisable.

Another method for protecting plants could be a "neighborhood patrol." This would be accomplished in coordination with police, by a Cannabis co-op, whose members take turns going from garden to garden during the weeks preceding harvest. This could work if there are several gardens in a small area, and the group members maintain high levels of trust in each other.

It is an unpleasant reality that the illegal recreational market sets the value of Cannabis. Patients lose in this situation. An ounce of medicine costing \$400 rivals the "organized crime" pharmaceutical market. Patients are faced with hard choices about how to grow and protect their medicine, whether indoors or out. These issues will remain until Cannabis is completely legalized and medicalized—the physician writes the prescription and the patient picks up the medicine at the pharmacy. When the pressure of the "recreational" market has disappeared so too will obscene prices and patient thefts.

Until this time arrives, patients should carefully plan the issues involved in growing Cannabis at their location. They should also maintain secrecy. Talking about the garden invites scrutiny. Patients who maintain secrecy are more likely to harvest their crop.

Many patients find the complexities involved in cultivation an insurmountable obstacle. Patients must have commitment, energy, money and time to cultivate an adequate supply. As time passes and unresolved issues become more apparent improvements to the OMMA will hopefully include larger controlled-growing facilities with security,

increased harvest possession limits and increased patient networking. In the mean time, patients will do what they always have: make do as best they can.

Footnotes

¹ GW Pharmaceuticals is licensed by the United Kingdom Home Office to conduct a research program to develop prescription Cannabis-based medicines. Detailed bioassays of specific varieties quantify different cannabinoids and their relationships. This knowledge will eventually allow GW to formulate Cannabis-based medicines that help specific conditions. Patients will benefit from these medicines as well as the expanded information about the varying effects of different varieties.

² The Investigational New Drug Program (IND) was begun by the federal government in 1976, to facilitate access to *non FDA-approved drugs* on an emergency basis. Federal permits to possess and use Cannabis were obtained by a handful of patients after protracted legal battles. Patients enrolled in the IND received a tin of around 300 U.S. Government grown Cannabis cigarettes each month. This equaled about eight ounces per month. The IND program was closed in 1992 as the numbers of applicants (mostly those suffering from HIV) exploded, leaving only a handful of those few already approved included.

³ Regeneration recycles the plant through another vegetative and flowering phase. This can be done by leaving five or six nodes on an intact plant after harvesting and returning the plant to a 24-hour light cycle. After a week and some high nitrogen fertilizer the plant will usually begin sprouting new leaves.

Chapter 6: Cannabis-using Patients and the Medical System



Working with the doctor

The Oregon Medical Marijuana Act (OMMA) has created a unique role-reversal for Oregon's patients and doctors. Physician knowledge has traditionally guided patient/doctor relationships. The physician, as the authority on medical matters, diagnoses diseases and prescribes pharmaceuticals and treatments. The OMMA

changed all that.

Cannabis-using patients are now in the position of advocating for their Cannabis use to a physician who, in many instances, knows less about it than the patient, or is opposed to it. This role-reversal has been difficult for patients and doctors for different reasons.

Many patients have become accustomed to simply carrying out their doctor's orders without questioning the justification or educating themselves on the disease and medical options. This complacency comes at a price, since the patient who doesn't actively participate will not be in a position to know and understand why the doctor suggests a particular treatment.

The ideal physician/patient relationship is one of collaboration. In this relationship the physician listens to and accepts the patient's reports and tailors a medical regimen to those needs. Relying on the physician's educated judgement, the informed and involved patient can then follow medical regimens in a more intelligent manner. The OMMA strengthens this collaborative relationship by its reliance on communication.

Doctors may be reluctant to participate

Participation in the Medical Marijuana Program has strengthened the doctor/patient relationship for those willing to participate. Many patients, however, find their physician unapproachable or in opposition to a request for a medical Cannabis recommendation. Since Oregon's marijuana registry program is voluntary, physicians are *not required to participate*. Doctors may refuse to participate for a number of reasons. Some physicians have strong philosophical objections to Cannabis use and will not provide the documentation that allows the patient direct entry into the medical marijuana registry. Some physicians even refuse to make a chart note acknowledging the patient's assertion of therapeutic efficacy. Another commonly stated objection is the lack of medication control and monitoring of the drug.

The physician may say that Cannabis is not indicated as a treatment for the particular condition, an assertion that may be accurate.



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Since Oregon's marijuana registry program is voluntary, physicians are *not required to participate*. Doctors may refuse to participate for a number of reasons.



A doctor who believes that the patient is physically or emotionally unprepared to safely navigate the many issues involved is unlikely to consent to participation in the Medical Marijuana Program.



Physicians also...refuse to participate because of the fear of federal investigation of their practice...[but] Oregon physicians should be reassured by the complete lack of federal intervention into physician practice.



Writing a detailed “story” that describes the specific symptoms followed by a point-by-point evaluation of how Cannabis helps each symptom will give the physician (and patient) a clear understanding of its medical usefulness.

(There are two legitimate medical contraindications to Cannabis: *liver failure* and serious *respiratory disease*. Cannabis may also interfere with metabolism of other drugs like Theophylline. Physicians should know these issues.)

A doctor who believes that the patient is physically or emotionally unprepared to safely navigate the many issues involved is unlikely to consent to participation in the Medical Marijuana Program. In this case, the burden is on the patient to “prove” to the doctor’s satisfaction that s/he is capable of responsibly and safely using Cannabis.

Physicians also commonly refuse to participate because of the fear of federal investigation of their practice. Since a doctor’s livelihood is dependent upon Drug Enforcement Administration (DEA) prescription privileges, doctors might fear that they could be forced from practice for helping a single patient obtain the registry card. While not a legitimate concern, it is understandable given the “big stick” approach followed by federal drug enforcement. Oregon physicians should be reassured by the complete lack of federal intervention into physician practice. Indeed as of 2001 there were over 500 physicians enrolled for 1500 patients, with no record of physicians being harassed or intimidated by DEA agents.² (The insignificant possession limits written into the OMMA also minimize the importance to federal law-enforcement agencies which usually emphasize investigating large commercial Cannabis operations.)

Patients will hopefully appreciate that all of these concerns are valid to some degree. The patient should be willing to patiently work through the objections with the doctor. If the overall relationship is considerate and of value, patients would do well to consider the physician’s point of view. If the relationship is based on an attitude of superiority by the physician, the patient may have to pursue other options.

Documenting use of Cannabis and keeping records

In the future, Cannabis-based inhalers, transdermal patches and elixirs (if not herbal Cannabis for smoking) will be easily available by prescription. Unfortunately, today, patients must too often convince the physician that they use Cannabis medically and not recreationally. One way to do this is by documenting Cannabis use.

Patients should clearly communicate to the physician their need for and use of Cannabis, (verbally and then in writing). Physicians want and need to know specifics: Does the target symptom decrease consistently with regular use? What is the dosage and how frequently is it used? Are there any negative effects the patient has noticed? Are there collateral benefits like decreased anxiety or better sleep? Ultimately, the patient should be willing to *keep records* and communicate their experience. Writing a detailed “story” that describes the specific symptoms followed by a point-by-point evaluation of how Cannabis helps each symptom will give the physician (and patient) a clear under-

standing of its medical usefulness. This written record should be given to the physician with instructions to place it in the chart as a permanent part of the medical record. This will demonstrate clearly to the physician that Cannabis is helping the patient, and can act as a legal protection to establish legitimate medical use in a court hearing. If the patient is not registered in the Medical Marijuana Program, physician documentation of medical use, or a letter from the patient to the doctor in the medical record will establish that the patient has communicated this use to the doctor. This may establish legitimate medical need and allow the patient access to the other two legal defenses: the *affirmative defense* and the *choice-of-evils defense*. If the medical record does not contain *any* reference to medical Cannabis use then the patient carries the entire burden of proving it.

This is why patients should insist that the doctor make chart documentation, even if it is to oppose the patient's request to use Cannabis. (An intentional omission of medical discussions and documentation jeopardizes the patient's legal position vis-a-vis medical Cannabis use [and violates the physician's legal requirement to document important medical information]). If the chart does contain a physician statement opposing the patient's Cannabis use (or the doctor refuses to write any chart note at all) the patient should write a statement detailing the benefits obtained by its use. The patient should make at least two copies of this paper. One copy should be sent to the physician's office along with a cover letter asking that the paper be included as a permanent part of the patient's medical record. The other copy should be added to the patient's files for use as a legal support of an attempt to take a "substantial step" to accommodate the law.

(Patients should request and receive copies of their entire medical record including progress notes, orders, lab results, history and physical and diagnostic tests. Physicians are sometimes reticent about providing this information; however, patients have the legal right to access copies of their medical record if they complete a release of information form. By reading the progress notes, the patient will discover exactly what the doctor says about his/her medical use of Cannabis.)

Collecting medical research

Patients should also be prepared to collect medical research about their particular condition. (Physicians in the 19th century knew about and prescribed Cannabis widely. This ongoing process of education ended in the 1930's when Cannabis was criminalized. As a result physicians today know little about it. Doctors, like the rest of America, have been brainwashed by half a century of government propaganda demonizing Cannabis.)

Collecting research about a medical condition can be time-consuming, but it will give the physician valuable information. If the research demonstrates value at controlling the patient's symptoms then the physician will (hopefully) be more receptive. (See Chapter 4 for



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Patients should also be prepared to collect medical research about their particular condition... If the research demonstrates value at controlling the patient's symptoms then the physician will (hopefully) be more receptive.



It is essential that patients communicate their knowledge and commitment to the doctor to elicit support—using Cannabis is not a passive process.



A physician who disregards the patient’s practical judgement or lectures about the perils of drug abuse is unlikely to be swayed.



Physician refusal to document these discussions [about the patient’s experience with Cannabis] in the patient’s progress notes is unconscionable.

articles describing some important research findings.) The bottom line is that *patients are the educators*.

The uncooperative doctor: “No” means “not yet”

Patients faced with an uncooperative physician must decide how to proceed. It is essential that patients communicate their knowledge and commitment to the doctor—using Cannabis is not a passive process. It involves issues of procurement, communication, safety, monitoring, feedback with the physician and legal considerations.

Patients need to understand indications and contraindications, side effects and preexisting health conditions that may influence Cannabis’ utility. Possible contaminants also are a factor to consider for those who use Cannabis.

The process of cultivating Cannabis involves a whole host of issues that are different from any other medical regimen the doctor or patient has faced. (See Appendix F for a “Cannabis Drug Information Sheet”.)

Additionally, the patient is required to follow through with the application procedure, a process that takes time and energy. The patient must have a high degree of commitment to follow these different issues and communicate with the doctor. If a patient is not willing or able to maintain in-depth monitoring of Cannabis use as it relates to the medical condition (and doesn’t have a designated primary caregiver to do so), s/he probably should not use it.

Many physicians will eventually provide the written documentation if the patient perseveres in this education process. Patients should not take “no” for an answer, but continue broaching the subject with every office visit.

If the physician completely refuses to discuss medical Cannabis with the patient, or if s/he dismisses the issue without serious consideration, the patient should evaluate the relationship as a whole and decide whether or not to continue with that physician. Here again, patients must convincingly assert their experience with Cannabis and be willing to keep the discussion going. A physician who disregards the patient’s practical judgment or lectures about the perils of drug abuse is unlikely to be swayed. (Since physician knowledge and support are key to entry into the registry card system, a patient who lacks it may be unable to legally utilize the other defenses written into the OMMA. These legal defenses are discussed in Chapter 2.) Physician refusal to document these discussions in the patient’s progress notes is unconscionable.

Patients should be willing to discuss and try alternatives to Cannabis prior to obtaining a registry card. Many physicians are willing to accept a trial of dronabinol (Marinol) before supporting Cannabis use.⁴ (See Chapter 3 for a discussion of Marinol and Cannabis.)

Well-informed patients will be in a position to understand physician recommendations as well as justify their own medical Cannabis use. If an established treatment like Marinol adequately treats the symptom then the patient’s medical need has been met. If it fails then

the case is bolstered to move on to other treatments. (The OMMA was written to promote Cannabis use for those who have exhausted their medical options. According to the law, therefore, it should not be the *first* alternative tried, but the *last*. This wording belies the point that Cannabis is probably a safer medical treatment than many pharmaceuticals. The language was inserted by the framers of the OMMA to accommodate *political* realities not as a statement of relative safety.)

Patients may want to submit an incomplete application to the Oregon Health Division knowing that it will eventually be rejected, lacking a doctor's documentation. *The OMMA expressly protects applicants who have submitted an application to the Division, from the post-marked date.* This application carries the same legal protection as a registry card *until the application is rejected.* Since the processing time for applications can range from weeks to months, this will "buy" the patient some time. The application also serves to establish an attempt at compliance for the patient and may help document medical use. Again, the critical element is a documentary trail that the patient must create, first with the physician, then with the Oregon Health Division. The more supporting documentation the patient can produce, the greater the legal protection. Patients should always have this documentation at hand in case they are contacted by police. (They must also be in compliance with all provisions of the Act regarding behavior.)

If the patient chooses to use Cannabis without the physician's support, s/he should carefully read the Oregon Attorney General's Guidelines (Appendix C) and plan a defense before the officer knocks at the door.

Finally, the patient can search for another physician. There are a few physicians in Oregon who will openly write medical documentation for patients whom they don't follow on an ongoing basis. Patients should contact networks of other patients and find the names of physicians who cooperate. Patients should normally not go to an unknown doctor and simply ask for the documentation. Virtually all physicians require an ongoing serious relationship. The search for a physician should be in the context of the entire medical relationship, not as a "drug-seeking" patient.

Working with a physician can be a struggle, or it can be gratifying. The physical, emotional and financial burdens of disease create great stress and hardship for patients *and* doctors. This is an inherently stressful arrangement for everyone involved. Patience, collaboration, mutual consideration and respect allow the relationship to progress to patients' benefit. The physician is an expert in human physiology and disease. The patient is an expert in symptoms and suffering. This is why patients must be willing to work with and educate the physician. And the physician must be willing to listen and sometimes acquiesce to the patient's expert judgement. Patient efforts are breaking new ground for those who will be benefited in the future.



The OMMA was written to promote Cannabis use for those who have exhausted their medical options... therefore, it should not be the *first* alternative tried, but the *last*...[this] language was inserted ...to accommodate *political* realities not as a statement of relative safety [of Cannabis].



Patients should be persistent, not rude. Some physicians acquiesce to the patient's request for medical Cannabis documentation after repeated office visits.



Patients may want to submit an incomplete application to the Oregon Health Division, knowing that it will eventually be rejected, lacking a doctor's documentation. This application carries the same legal protection as a registry card *until the application is rejected*...this will "buy" the patient some time.



There are a few physicians in Oregon who will openly write medical documentation for patients who they don't follow on an ongoing basis...The search for a physician should be in the context of the entire medical relationship, not as a "drug-seeking" patient.



Future changes in the OMMA should include broadening the range of medical professionals who can provide documentation...This will take some of the burden off physicians and decrease the difficulty that too many patients face...



As of 2001...neither the Oregon Board of Nursing nor the Oregon Nurses Association have yet made recommendations or nursing practice guidelines...

Future changes in the OMMA should include broadening the range of medical professionals who can legally provide documentation to include nurse practitioners, chiropractors or naturopaths. This will take some of the burden off physicians and decrease the difficulty that too many patients face in obtaining support from the "gatekeeper".

Guidelines for nurses and patients

After the passage of OMMA in November 1998, the Oregon Medical Association (OMA), representing physicians, issued guidelines describing how physicians may respond to patients who are requesting their help in applying to the Oregon Medical Marijuana Act.⁵ (See Appendix E.) The OMA guidelines, however, do not address nursing issues, which are arising as medical Cannabis users integrate into health-care settings.

Unfortunately, nursing organizations in Oregon didn't follow suit. As of 2001, more than two years after the passage of the Oregon Medical Marijuana Act, neither the Oregon Board of Nursing nor the Oregon Nurses Association have yet made recommendations or nursing practice guidelines, although both organizations have studied the issue.

Physicians (or nurse practitioners) usually prescribe a drug and conduct an initial PARQ (Procedure, Alternatives, Risks, Questions) conference to educate the patient on the drug's safe use. Nurses are responsible for the safe administration of a medication, monitoring and documenting its effect, and communicating this information to the physician. Nurses have more opportunities for detailed monitoring and patient teaching due to their frequent and lengthy contact. This raises several nursing issues, among them: legal boundaries between registered and unregistered patients, confidentiality, in-hospital and out-of-hospital issues, and nurses as patients. These nursing issues also directly relate to how any Cannabis-using patient will be able to function in a hospital or assisted living facility. Nurses who interact with Cannabis-using patients face situations that relate to the nature of the nurse/patient relationship and a nurse's practice requirements. Without policy guidelines for the nursing care of Cannabis-using patients, nurses and patients must "take care of themselves."

Acute care settings (hospitals)

The distinction between *registered* (legal use) and *unregistered* (illegal use) is important in situations surrounding hospitalized patients. If a hospitalized patient expresses the desire or intent to use Cannabis, the nurse caring for that patient should first determine if the patient is registered with the Medical Marijuana Program. If so, then the nurse may, as part of her continual teaching responsibility, provide medication information about Cannabis. Documentation of the patient's medical use of Cannabis would be included the nurse's notes. Nurses might also describe the patient's reasons for using Cannabis and any other specifics the patient can report including side effects.

A copy of the registry card should be attached to the chart if the patient has it in his or her possession. The registry card *SHOULD NOT* be confiscated or withheld from the patient.

If the patient *is not* registered with the Oregon Health Division but says that s/he uses Cannabis for a medical reason the nurse needs to recommend that the patient speak with the physician about registering, and document that conversation in the nurse's notes. If an unregistered patient brings Cannabis into the hospital the drug should be handled according to hospital policy. This usually means confiscation, documenting its presence and notifying the nursing supervisor.

Registered or not, a patient needing to smoke Cannabis should be informed of the smoking policy of the hospital. (For years, nurses have been quietly supporting patients by encouraging them to “step outside” to smoke.) At this time hospital policies in the United States prohibit smoking of Cannabis on hospital grounds.⁶ Hospitalized patients may be encouraged to take the drug by a different route, such as eating or drinking, without violating state laws or smoking prohibitions. However, this still would be a violation of hospital policies prohibiting the use of *Schedule One* drugs. Ultimately, hospital policies prohibiting use of Cannabis will have to be revised in order to meet patient needs and conform to Oregon law. Standardized Cannabis preparations like tinctures, inhalers and transdermal patches will one day reduce the need for patients to smoke the drug and will allow more comfortable integration of Cannabis use in hospitals.

A registered patient may legally possess up to one ounce of Cannabis. Legal Cannabis should not be confiscated or turned over to law-enforcement officials. If legal Cannabis cannot be taken home by the patient's designated primary caregiver it should be labeled with the patient's name and date, and sent to the pharmacy for secure storage. (Only designated primary caregivers or other registered patients can legally possess Cannabis. Therefore, the nurse must not give the Cannabis to anyone who is not registered. It would be preferable for the pharmacy to store it and return it upon discharge.) Most nurses will treat “illegal” Cannabis as dictated by hospital policy. This usually means turning the Cannabis over to law-enforcement. (Nurses should be aware that a non-registered patient still has access to the affirmative defense. Thus, even if the patient is not registered with the medical marijuana program, the patient may still be “legal”.) If the (unregistered) patient suffers from a debilitating medical condition covered under the act, compassion would dictate the return of the Cannabis to the patient upon discharge with a recommendation that the patient register in the Medical Marijuana Program.

Nurses in contact with Cannabis-using patients should be aware that any *information about a patient's Cannabis use is strictly confidential and privileged* since it is medical information protected under Oregon law.



Nurses have more opportunities for detailed monitoring and patient teaching due to their frequent and lengthy contact.



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Long-term care facilities present different issues...In general, patients will need to restrict Cannabis use to private rooms or designated smoking areas...



Nurses who are drug tested and found to possess THC metabolites...are subject to harsh legal and employment consequences...the Oregon Board of Nursing does not recognize any legal reason for a nurse to test positive for THC.

Long-term care settings (nursing homes, skilled nursing facilities and group homes)

Long-term care facilities present different issues. Since patients convalesce for long periods it is necessary to provide situations where they may be allowed to smoke. In general, patients will need to restrict Cannabis use to private rooms or designated smoking areas where others are not in contact with second-hand smoke. Nurses in frequent and close contact with patients smoking Cannabis should shield themselves from second-hand smoke. One way to do this is by agreeing on a time for nursing cares which does not conflict with the patient's need to medicate. Open windows, if possible.

(One of the problems long-term, home and hospice nurses face with second-hand smoke is the possibility that they will develop detectable levels of cannabinoid metabolites in their urine. Environmental exposure is unlikely to result in psychoactive effects. Drug tests for cannabinoids, however, do not measure intoxication, only the presence of Delta-nine-tetrahydrocannabinol [THC] metabolites, which may remain detectable for days or weeks after exposure. Nurses who are drug tested and found to possess THC metabolites [generally 50 ng/dl] are subject to harsh legal and employment consequences.) Unfortunately, *the Oregon Board of Nursing does not recognize any legal reason for a nurse to test positive for THC.* Nurses who find themselves in frequent and close contact with Cannabis-smoking patients should document this fact in their notes and make copies for their records. They should also be aware that these notes are confidential medical information.

Many long-term care facilities in Oregon are forming policies to assist their Cannabis-using patients. Nurses working in these locations are advised to consult the policy. They should also monitor and educate patients, just as they would with any other drug. Additionally, the institutional policy may require the nurse to dispense the Cannabis to the patient, or assist the patient with its use. Nurses in long-term care facilities should consider themselves within the law, especially if the institutional policy requires their assistance.

Home health settings

Some nurses care for Cannabis-using patients in a home setting where evidence of Cannabis use is visible. The distinction between registered and unregistered usage can create problems for the nurse and patient. A non-registered patient is breaking Oregon law by using Cannabis. A nurse who assists him/her with Cannabis use is "aiding and abetting" the commission of a crime.⁷

Additionally, an unregistered patient who (illegally) uses Cannabis while under the care of a home health nurse presents difficulties regarding record-keeping and confidentiality. *Documenting illegal behavior places the nurse in the position of collecting evidence*, which could be used in a court to convict the patient of illegal drug activity. Failing to document significant medical issues constitutes a willful charting

omission on the nurse's part. Thus, the distinction between registered and unregistered use puts the nurse at considerable risk and may prevent adequate care of all Cannabis-using patients, especially those who use it illegally. This problem would best be addressed by the State Board of Nursing. Until that happens, the safest course of action for the nurse is to advise the unregistered patient to consult his/her physician about registering with the Oregon Health Division, and document the conversation.

A nurse may choose to document the patient's use of Cannabis with the understanding that *chart documentation may allow the patient to claim the affirmative defense* if charged with a Cannabis-related crime. (The affirmative defense allows unregistered patients to escape conviction if they have taken *substantial steps* to comply with the law. Nursing documentation of appropriate medical use *may* be a "substantial step.") The nurse must understand that she/he might be called to testify in court to verify the chart documentation. *The nurse may also choose to not document any Cannabis-related behavior; however, this is a violation of the scope of practice rules.* The nurse should consult institutional policies addressing confidentiality and record keeping.

Registered patients are somewhat better protected. The nurse may conduct follow-up teaching about Cannabis' effects, just as would be done with any drug. Since the patient is in compliance with Oregon law, the presence of paraphernalia and Cannabis at the patient's residence does not jeopardize the nurse's ability to provide care and document that care.

A nurse may refuse to care for a Cannabis-using patient for reasons of "conscience." In that circumstance, the nurse may follow institutional policies regarding withdrawing from the care of a patient. Refusing to care for a patient who is engaged in legal medical behavior may put the nurse in a position of having to justify that decision, especially if the patient's behavior poses no health or safety risk to the nurse.

Nurses as patients

A nurse suffering from a debilitating medical condition, like any other citizen, may apply for a registry identification card from the Oregon Health Division, which, if issued, permits the use of Cannabis. The use of therapeutic Cannabis poses issues that will need to be addressed by the Board of Nursing and the nurse's employer. The nurse who uses medical Cannabis will test positive for cannabinoid metabolites and will have to challenge the institutional policy that, at this time, does not differentiate legal from illegal Cannabis use. The nurse should obtain and read policies of the institution regarding the use of illegal substances and mind-altering pharmaceuticals. Generally, hospital policies forbid a nurse from working when behaviorally or cognitively impaired by the use of any substance. Thus, the nurse who has used Cannabis within the past six to eight hours should consider not working unless tolerance to the psychoactive effects has developed.



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By placing Cannabis within the policy guidelines of psychoactive drugs, the nurse and institution can agree on what constitutes safe practice.



The OMMA forbids licensing boards (like the Board of Nursing) from disciplining a nurse for their own medical use of Cannabis (or for assisting a registered patient to use Cannabis)...

By placing Cannabis within the policy guidelines of psychoactive drugs, the nurse and institution can agree on what constitutes safe practice.

The OMMA forbids licensing boards (like the Board of Nursing) from disciplining a nurse for his/her own medical use of Cannabis (or for assisting a registered patient to use Cannabis):

Limits on professional licensing board's authority to sanction licensee for medical use of marijuana. No professional licensing board may impose a civil penalty or take other disciplinary action against a licensee based on the licensee's medical use of marijuana in accordance with the provisions of ORS 475.300 to 475.346 or actions taken by the licensee that are necessary to carry out the licensee's role as a designated primary caregiver to a person who possesses a lawful registry identification card issued pursuant to ORS 475.309.

The license to practice nursing is issued by the Oregon State Board of Nursing, a state agency. Any nurse who is registered as a patient or designated primary caregiver is thus protected. Unfortunately, this language only protects the nurse from disciplinary actions initiated by the Oregon Board of Nursing, not the nurse's employer. *Possession of an OHD registry identification card will not protect the nurse from employment disciplinary actions including employment termination and forced drug treatment.* A nurse in this situation should consult a lawyer. None-the-less, any nurse who suffers from a debilitating medical condition and uses Cannabis should apply for a registry card and also consult an attorney. Eventually, institutional policies will catch up to state law.

Since Marinol, the prescription form of the THC molecule, has been down-scheduled to *Schedule Three* in the Controlled Substances Act, it is more widely available. The use of prescribed Marinol will result in a THC positive reading on any urine drug test, and will also be considered a violation of hospital policies as they are presently written.

Until institutional policies regarding Cannabis use differentiate legal from illegal use (and the Oregon Board of Nursing issues guidelines which clarify the scope of practice), nurses should be advised that they are at risk for employment and/or legal sanctions for any and all actions related to contact with patients who use Cannabis as a medicine, whether those patients are registered or not. Nurses should be aware that institutional policies have not kept up with Oregon State law. Thus, acting either as a nurse who educates the patient, as a designated primary caregiver, or as a registered patient, nurses should understand that many important issues have yet to be resolved. Until the Board of Nursing adapts the *Standards and Scope of Practice for the Licensed Practical Nurse and Registered Nurse* to reflect legal Cannabis use, nurses who interact in any way with Cannabis-using patients put themselves and their patients at risk.

This situation will not be fully resolved until legal penalties for Cannabis use are finally abolished.

Footnotes

¹ With the complete legal and social isolation of Cannabis, physicians today are unsure of how to proceed with patient requests. Many physicians are also understandably reluctant to recommend a drug which lacks FDA approval. Heavy-handed political pressure originating from federal authorities (most notably the Office of National Drug Control Policy) also intimidates physicians who depend on federal licensure through the Drug Enforcement Administration to prescribe drugs listed in Schedules 2 through 5 of the Controlled Substances Act. Without this prescriptive authority a physician is unable to effectively practice medicine.

² In response to the 1996 passage of Proposition 215 in California, federal authorities threatened to investigate and revoke DEA licenses of doctors who participated. Some physicians were actually investigated and intimidated, prompting physician groups to file and obtain in federal court an injunction forbidding interference in a physician's right to discuss valid medical treatments with their patients. Since then, the DEA has avoided investigations against doctors who participate in state medical marijuana programs.

³ Physicians in the 19th century were educated about Cannabis' therapeutic value through their extensive experience and research of it. This is mostly due to the efforts of one man, W. O. O'Shaunassey, a physician practicing in Calcutta, India. Dr. O'Shaunassey carefully documented his patients' use of Cannabis for many conditions and published his findings in medical journals in England. As word of clinical usefulness grew, standardized Cannabis preparations were manufactured and sold as elixirs in the U.K. and U.S. Common uses were for pain, spastic disorders, insomnia, anxiety, dysmenorrhea, alcoholism, and opiate addiction. The passage of the Marihuana Tax Act in 1937 began the process of increasing restriction, which culminated in Cannabis' placement in *Schedule One* of the Controlled Substances Act in 1971. Research and physician education ceased.

⁴ Marinol (trade name for dronabinol) is composed of the synthetic THC molecule, which is encapsulated in a sesame seed oil base. Marinol was moved from *Schedule Two* to *Three* in the Controlled Substances Act in 1999, thereby making it more widely prescribable by physicians. It is indicated for anorexia and weight loss in patients with AIDS and nausea and vomiting in patients undergoing cancer chemotherapy.

⁵ The guidelines are also available from the Oregon Medical Association by calling 503/226-1555.

⁶ In Holland, hospitals allow smoking Cannabis in certain situations. In the United States, sympathetic nurses quietly encourage the patient to step outside the hospital and smoke in a private location. There is an argument to be made that in a private room, a patient may be allowed to smoke Cannabis with safety allowances, although the non-smoking trend in the United States makes this possibility remote in the near future.



Any nurse who is registered as a patient or designated primary caregiver is...[partially]protected.



Possession of an OHD registry identification card will not protect the nurse from employment disciplinary actions including employment termination and forced drug treatment.



Until the Board of Nursing adapts the *Standards and Scope of Practice for the Licensed Practical Nurse and Registered Nurse* to reflect legal Cannabis use, nurses who interact in any way with Cannabis-using patients put themselves and their patients at risk.

⁷ *The [Oregon] Standards and Scope of Practice for the Licensed Practical Nurse and Registered Nurse* defines behavior which “fails to conform to the legal standard and accepted standards of the nursing profession.”

Among the provisions is:

Aiding, abetting, or assisting an individual to violate or circumvent any law, rule or regulation intended to guide the conduct of nurses... (851-45-015) (2) (I).

Providing medical instruction on the use of Cannabis could be considered as assisting any Cannabis-using patient to violate federal law. Acting as a designated primary caregiver certainly does but again only as regards federal but not state law in Oregon. (See note 2 above.)

Chapter 7: Legislative History of Medical Cannabis in Oregon



Part One: Pre-OMMA

House Bill 2267

The Oregon Medical Marijuana Act in some ways represents an end-point of focused attention and efforts by a considerable number of Oregonians over many years. It is also a beginning for Oregon patients.

The first legislative attempt in 1979 at creating a “medical marijuana bill” was, remarkably, passed and signed into law. House Bill (HB) 2267 called for a coordinated effort between the Oregon State Police and the Oregon Health Division (OHD) to channel confiscated Cannabis through the OHD to patients suffering from two specific conditions: cancer chemotherapy and glaucoma. This legislation was cosponsored by six Oregon Senators and nine Representatives. It also provided for the testing of confiscated Cannabis by the OHD for purity and safety. HB 2267 allowed physicians to “lawfully obtain, prescribe, and dispense marijuana...” to their patients. Essentially this meant that doctors would have to stock and supply Cannabis to their patients from their office. HB 2267 was never implemented because of the placement of Cannabis in Schedule One of the federal Controlled Substance Act. However, encouraged by the intent of the Oregon legislature in creating HB 2267 the OHD initiated a research study, approved by the DEA, to conduct an experimental program that would supply Cannabis cigarettes and THC capsules to patients. Although these Cannabis products were eventually received by several hospitals around Oregon, the research was never carried out.

Legislative memory is short: less than a year after enactment, the OHD had undercut HB 2267 by claiming that they couldn’t adequately test for purity. The Division’s half-hearted effort to establish a therapeutic research program put a kind face upon this situation. Although this 1979 law quickly faded into legal obscurity, a small group of statewide activists continued to advocate for passage of such legislation.

The 1980’s ushered in Ronald Reagan as President, and Ronald Reagan ushered in a renewed War-on-Drugs. State legislatures nationwide came under increasing federal pressure to not appear “soft on drugs” and Nancy Reagan promoted her “just say no” campaign. The prospects for medical Cannabis legislation appeared bleak as the federal position hardened. Nationwide, the issue was off the political radar screen save for the rescheduling petition submitted by the National



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Organization for the Reform of Marijuana Laws (NORML). (During the eighties, NORML was widely derided for “riding the coattails of sick people” to advance their drug-legalization agenda. In fact, NORML was the only nationwide voice for medical Cannabis at a time when national media spouted drug-war rhetoric with little regard to accuracy or balance.) The Rescheduling Petition slowly worked its way through legal obstructions at the Department of Health and Human Services (HHS), finally to land at the Drug Enforcement Administration (DEA). In 1987, after long and detailed hearings in the matter, DEA Administrative Law Judge Francis Young issued a landmark ruling ordering Cannabis to be rescheduled from Schedule One to Schedule Two of the Controlled Substances Act. He called the laws forbidding medical Cannabis use “arbitrary and capricious.” Judge Young’s ruling was quickly overturned by DEA Administrator John Lawn who had no intention of backpeddling in the War-on-Drugs. In part, this flagrant abuse of judicial power set the stage for statewide initiatives as drug-reform activists realized that the federal government would not give redress to the issue. Creative minds on the West Coast began to formulate a strategy to bypass federal legislative “constipation.” In 1995, Jon Gettman submitted a new rescheduling petition. This procedure is ongoing in 2001. This petition may eventually succeed where the previous one failed, because the scientific understanding of cannabinoid biochemistry has dramatically advanced.

In Oregon, after a decade of inertia, 1990’s brought new activity in support of medical Cannabis. Three more legislative attempts were made to remove ill Oregonians from criminal prosecution for using Cannabis.

Senate Bill 865

In 1993 Laird Funk, a veteran activist of Oregon drug-reform, nearly single-handedly carried Senate Bill 865. Others assisted him in this process, including Sandee Burbank. Together, this small group effectively pushed the issue of medical marijuana onto the front of the ’93 legislatures’ plate. SB 865 was an important linkage between perennial initiative campaigns during the time when Democrat President Bill Clinton was revving up the prosecution of marijuana users nation-wide, beyond the scale even of George Bush (the first).

Senate Bill 865 introduced some of the OMMA’s key provisions, including the development of a registry card program- in this case operated by the Oregon Board of Pharmacy. The bill also proposed allowing patients to grow up to six (6) Cannabis plants and had no possession limit. The physician was responsible to prescribe the dosage. The proposed legislation addressed the issue of qualifying medical conditions by requiring the physician to submit extensive medical documentation to the State Board of Pharmacy; but it did not specifically list approved conditions, as does the OMMA. It said, simply, that “any patient who uses or wishes to use marijuana in the therapeutic treatment of a medical condition shall register with the board...”



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Senate Bill 865 introduced some of the OMMA’s key provisions, including the development of a registry card program- in this case operated by the Oregon Board of Pharmacy.

(The OMMA would eventually adopt the *disease* and *symptom* approach.) The beauty of this language was to put the decision-making authority into the hands of the patient and physician in deciding whether the patient should be covered. The OMMA, in contrast, mandated the Oregon Health Division to only allow specific diseases and symptoms and to conduct a debilitating medical conditions advisory panel to evaluate the inclusion of other conditions.

Senate Bill 865 called for the establishment of a five-year review board whose members would be appointed by the Governor. Its purpose was to determine “the appropriate classification, if any, of marijuana in the schedule of controlled substances.” This review board would also, within one year, “present to the board recommendations for procedures to protect from prosecution individuals... and to provide for lawful supply channels.”

These features came to represent the basic underpinnings of what would become the OMMA. The importance of the issue was illustrated through the sponsorship of SB 865 by an ailing state Senator named Frank Roberts. As a man suffering from cancer who was married to the Oregon Governor at that time, Sen. Roberts brought attention to the bill.

Senator Bill Bradbury, who would go on to become Oregon Secretary of State, assigned the bill to be heard in two different committees: The Health and Bioethics Committee, and the Judiciary Committee.

One prominent member of both of these committees was an aspiring Oregon State Senator named Gordon Smith, who was subsequently elected to the United States Senate after he toned down his religious conservative philosophy. Senator Smith opposed SB 865 and ultimately killed it.

Sandee Burbank was active during the hearings. She coordinated patient testimony, including that of Elvy Musikka, and Bob Randall, two of the handful of patients nationwide granted access to marijuana from the U.S. Government farm in Mississippi. Other prominent speakers included Drs. Tod Mikuriya and John Morgan (who testified via videotape).

In spite of Senator Smith’s opposition, SB 865 was passed out of the Health and Bioethics Committee and into the Judiciary committee. However, the legislature was coming to an end with the customary crush of last-minute legislation. The Judiciary hearing was interrupted numerous times by legislators who left the hearing in order to cast votes. This disruption eliminated any chance of serious testimony. Senator Smith moved to table the bill, his motion was passed, and SB 865 died a sudden bureaucratic death. Sadly, Senator Roberts, who had courageously pushed this legislation, died before seeing protections for patients become law in Oregon. Thus began another initiative cycle which would evolve into HB 2970, the 1995 legislative bill.



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The Governor's signature initiated a mad scramble by Oregon's drug-reform organizations to refer the law back to Oregon voters as a referendum.



The 1995 Oregon Legislature considered HB 2970 sponsored by Rep Repine. HB 2970, which died in committee, exempted Oregonians suffering from illnesses (not specified) who were under the care of a physician, from criminal sanctions for their use of Cannabis.



HB 2900 died for lack of legislative attention. The chairman of the House Judiciary Committee, Rep. Minnis (who was also a police officer) refused to schedule the bill for a hearing.

House Bill 2970

The 1995 Oregon Legislature considered HB 2970 sponsored by Rep. Repine. HB 2970, which died in committee, exempted Oregonians suffering from illnesses (not specified) who were under the care of a physician, from criminal sanctions for their use of Cannabis. This bill required the Oregon State Board of Pharmacy to maintain a registry database and issue “numbered certificates” to patients enrolled in the program. Unlike its predecessor, it did not allow police-confiscated Cannabis to be redirected. HB 2970 also did not describe quantity limits which could be possessed, specifying only that: “...the quantity of marijuana to be used and the method and frequency of use...” had to be included on the application.

In important ways, HB 2970 was the predecessor of the Oregon Medical Marijuana Act. It continued the refinement of language begun by SB 865, in simplified form. HB 2970 required patients to assume the expenses associated with running the registry program, as did BM 67. The registry card system, described in HB 2970, ultimately came to pass in the OMMA to be managed by the OHD, not the Board of Pharmacy. Both bills also required the applicant to submit an application to the state agency including a statement signed by a physician attesting to the patient's need for the drug.¹

One interesting difference between the two Acts was HB 2970's mandated 5 year review of the registry program which was to have convened an “advisory board” to evaluate: “*What medical conditions appear to be amenable to therapeutic use of marijuana...*”

Although HB 2970 died in a legislative committee in September of 1995, events in California were occurring which would quickly change the balance of power and engulf the states of Oregon, Washington, Alaska, Nevada and Arizona in rapid legislative change. The initiative and referendum process in these states would do what legislators and governors could not.

“The California Compassionate Use Act” of 1996

California's Proposition 215 in 1996 was the legislative equivalent of an explosion in the midst of the drug-war. Under-funded and written off by government and media, last minute contributions from wealthy supporters financed a signature gathering blitz which succeeded in collecting enough signatures to place it on the ballot. Then, in November of 1996, to the amazement of supporters and chagrin of detractors, Prop 215 was approved by a few percentage points. It was written by patients for patients, and did not conform to the detailed legalistic culture of California politics. It was vaguely written and to the point. It said, among other things:

Section 11357, relating to the possession of marijuana, and Section 11358, relating to the cultivation of marijuana, shall not apply to a patient, or to a patient's primary caregiver, who possesses or cultivates marijuana for the personal medical purposes of the patient upon written or oral recommendation or approval of a physician. (Section 1 (d) CCUA)

The drug-war establishment was dumbstruck, but quickly found its voice, in the form of prominent federal officials. Within days after Californians approved this sweeping revision to California law, federal officials reacted. In a Washington DC press conference retired General and Drug-Czar Barry McCaffery, Health and Human Services Secretary Donna Shalala, and Attorney General Janet Reno issued tough-talking threats to prosecute any California physician who complied with the law. This stance quickly angered physician groups nationwide and resulted in a lawsuit in federal court against the “gag-order.”

Notwithstanding the tough talk, the watershed event had occurred. Federal interventions were weak and ineffective. Now California was doing what the federal government couldn't. The ramifications quickly spread to surrounding states like Oregon, which had also failed to legislatively protect patients.

Oregon's 1997 legislature: Dueling bills

The Republican-led 1997 Oregon legislature reacted to the medical Cannabis uprising in the south by considering two contradictory bills, which continued for years to be tied together like two presidential candidates fighting endless ballot counts. Legislators wrote, argued for, and subsequently passed HB 3251 over the objections of a number of activists and patients. HB 3251 became quickly known as “Recrim.” Governor John Kitzhaber signed it into law, 15 minutes before the automatic veto would send it back to the legislature to override. Governor Kitzhaber expressed reservations about signing it in his comments.

Among other provisions, HB 3251 ratcheted up the penalties for simple possession to a class B Misdemeanor instead of being a simple citation with a fine of between \$500 and \$1000. (Governor Tom McCall, a Republican, signed a bill decriminalizing simple Cannabis possession into law in 1973, making Oregon the first state to do so.) Ironically, Recrim's most pernicious effect was invisible. By upgrading simple Cannabis possession into the category of a Misdemeanor crime, police could conduct warrantless searches. The Governor's signature initiated a mad scramble by Oregon's drug-reform organizations to refer the law back to Oregon voters as a referendum.²

The signature gathering had to be completed within 60 days, and it was. Thus, HB 3251 became Ballot Measure 57 and was scheduled to appear on the November 1998 statewide ballot.

House Bill 2900

Also during the 1997 legislature one lone Oregon Legislator, Rep. George Eighmey, introduced HB 2900. HB 2900 evolved and expanded the previous medical Cannabis legislation that had died in the 1995 legislature. It revived the certification process, this time using the State Board of Pharmacy as the agency to establish and maintain the central registry. The program would issue certificates to persons



California's Proposition 215 in 1996 was the legislative equivalent of an explosion in the midst of the drug-war ...It was written by patients for patients...



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who had a statement from their physician stating that the patient was suffering from:

...serious physical illness or disease and that the use of marijuana would improve the person's health or relieve physical pain and suffering.” (HB 2900 Section 2 (e))

Rep. Eighmey's bill was in some ways more restrictive than the OMMA but it continued a refinement process. Among other provisions, distribution of Cannabis to any other person was forbidden. It also required the Oregon State Police to inspect all grow operations. This was the first legislative attempt to permit cultivation, basing the allowable quantity of Cannabis and plants a patient could possess upon “the attending physician's dosage and use recommendations.”

HB 2900 died for lack of legislative attention. The chairman of the House Judiciary Committee, Rep. Minnis (who was also a police officer) refused to schedule the bill for a hearing. (This was the same Legislative committee which had enthusiastically approved Recrim.) Rep. Eighmey's last-ditch attempt to attach his modest medical Cannabis bill to Recrim failed, and with it went any chance at legislative redress of the issue. Seeing no chance that a conservative Republican legislature would pass a law protecting sick people, Oregon activists were forced to use the initiative process.

Medical Cannabis legislation in Oregon “hopscoched” back and forth from the initiative process to the legislature. Initiatives were resorted to after failures of the legislature to act. Each successive attempt built upon previous language. In many ways, the OMMA represented the culmination of this process. OMMA far surpasses any previous initiative or bill in its protection of patients.

Part Two: Ballot Measure 67

In 1997, after the demise of Rep. Eighmey's modest bill, Americans For Medical Rights (AMR), a political lobbying organization based in Santa Monica, California, began contacting Oregon activists in an attempt to write an initiative for the Oregon ballot. AMR had successfully waged California's groundbreaking medical marijuana initiative under the name “Californians for Medical Rights”. In Oregon, The Sugarman Group was chosen to coordinate the campaign strategy.

The drafting of the OMMA involved three attorneys, two physicians, two nurses, AMR strategists, patients and long-time Oregon activists. Meticulous writing, debating and reviewing yielded an initiative that expanded the protections to patients in several key ways. First, the OMMA expressly allowed cultivation of a specific number of plants—seven—and included provisions for patients to increase the number beyond seven if the greater need was “medically necessary.” The OMMA also instituted a registry card system operated, this time, by the Oregon Health Division, as had its 1979 and 1993 predecessors. As another refinement, the OMMA specifically listed *symptoms* and *conditions* that would be allowed, intentionally omitting inclusion of



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any psychiatric illness or symptoms. The decision to include symptoms on the list was a deliberate attempt to cast the net of allowance as wide as possible without exceeding the political reality of the time. In another significant expansion of past attempts, the language required the Health Division to create rules to govern the process of evaluating new conditions for the inclusion of new diseases or symptoms in the list of debilitating medical conditions.³

But it was the language addressing legal defenses that expanded the OMMA far beyond the scope of any of its legislative predecessors. This key provision was also hotly opposed by law-enforcement groups statewide. (Legal defenses available to patients are covered in detail in Chapter 2.) The legal protections written into the OMMA consisted of three successive defenses. The first layer was *possession of the registry card*. The second layer was the “*affirmative*” defense for those patients not registered and the third layer was the “*choice of evils*” defense. Police groups and prosecutors in characteristic oversimplification expressed the opinion that this language would essentially block all Cannabis prosecution except large-scale commercial grow operations.

The OMMA also permitted “*designated primary caregivers*,” who would be registered and protected, to grow Cannabis away from the patient’s residence and transport Cannabis and plants to the patient. It also prohibited any state licensing board from disciplining a licensee for his or her compliance with the law. This language protected doctors, nurses, and anyone who received a license from the state.

All in all, the initiative language drafted by the working group was a detailed and complete text, which far surpassed any previous legislative attempt. It substantially removed the burden of proof from patients, and placed it on prosecutors and police.

In the months leading up to the passage of Ballot Measure 67 (the ballot title assigned to the OMMA), furious signature gathering took place in Oregon, coordinated by “Progressive Campaigns.” Boxes of hastily tabulated petition pages were submitted to the Secretary of State’s office in Salem within the last few minutes before the deadline for signature gathering expired. Subsequent mathematical sampling of signatures for accuracy concluded that enough valid signatures were included to qualify the initiative on the November ballot, by 2220 signatures. Thus, OMMA was certified by the Oregon Secretary of State’s office to appear on the 1998 ballot as Ballot Measure (BM) 67. And the campaign commenced.

Yes on 67, No on 57

Both BM 67 and BM 57 were ushered through the campaign by Oregonians who were funded by George Soros, John Sperling, and Peter Lewis, wealthy patrons of the drug-reform movement.⁴ Oregonians for Medical Rights (OMR) faced off against Oregonians Against Dangerous Drugs (OADD), their law-enforcement counterpart.

OMR had a strategic problem. Ballot Measure 67, standing alone, appeared to have solid support among voters. But the “ugly sister”



The drafting of the OMMA involved three attorneys, two physicians, two nurses, AMR strategists, patients and a handful of long-time Oregon activists.



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Oregonians for Medical Rights...faced off against Oregonians Against Dangerous Drugs...



...voters were being asked by OMR, and the drug-reform movement to vote 'No' on BM 57 (Recrim), and "yes" on BM 67 (OMMA).



...Voter Power coordinated a voter registration campaign at fairs and music festivals all over Oregon that added more than 10,000 Oregonians to the voter roles.



Ballot Measure 67 had, as its two Chief Petitioners, physician Richard Bayer and patient Stormy Ray. Bayer and Ray formed a powerful and articulate voice in favor of the OMMA.

Recrim was appearing on the same ballot, as BM 57. Since BM 57 (Recrim) had been passed by the legislature and signed by Governor Kitzhaber, it was law in Oregon, albeit on hold until after the election. The referendum, which went to the voters asked them to decide whether or not they wished the law to take effect. A “yes” vote would result in immediate activation of the law; a “no” vote would nullify it completely. Ballot Measure 67, on the other hand was asking voters to approve or reject the OMMA. A “yes” vote for BM 67 would make the ballot measure Oregon Law, a “no” vote would reject it. Thus, voters were being asked by OMR, and the drug-reform movement to vote ‘No’ on BM 57 (recrim), and “Yes” on BM 67 (OMMA).

While the Sugarman Group and OMR coordinated the campaign, another organization, Voter Power, filled in the activist gap. Headed by John Sajo, an articulate advocate of drug reform in Oregon, Voter Power designed and implemented the “Yes on 67, No on 57” campaign. Additionally, Voter Power coordinated a voter registration campaign at fairs and music festivals all over Oregon that added more than 10,000 Oregonians to the voter roles. Voter Power was instrumental in educating and motivating young, progressive, voting age Oregonians to show up at the polls. Coordinated literature mailings and television advertisements produced by OMR combined with “get out the vote” messages by Voter Power resulted in a powerful and ultimately successful campaign.

Ballot Measure 67 had, as its two Chief Petitioners, physician Richard Bayer and patient Stormy Ray. Bayer and Ray formed a powerful and articulate voice in favor of the OMMA. Doctor Bayer publicly debated, discussed and wrote in favor of BM 67 continuously from November 1997, through out the election. He forcefully debated the merits of the initiative by emphasizing the specific limitations written in to the measure to prevent abuse. He also articulated a message that doctors, not police should be the ones deciding the value of medical Cannabis. Ms. Ray traveled throughout Oregon publicly speaking and interviewing with news organizations. She gave a dignified and gentle “face” to the issue as a patient who suffered with cramps, spasms and pain from Multiple Sclerosis. She eloquently gave a voice to the many suffering Oregonians who used Cannabis illegally. When asked if she smoked marijuana, Ms. Ray responded: “I do what anyone in my position would do.”

Law-enforcement opposition: It’s a “Trojan Horse!”

Opposition to BM 67 formed mainly around law-enforcement groups. Arguments against BM 67 centered around several areas. First, police spokesmen negated the validity of marijuana as a medical treatment. According to OADD, Ballot Measure 67 was a “Trojan horse” for drug legalization in the form of compassion for the sick. They argued that BM 67 was actually a cynical ploy by drug-legalizers to manipulate patients into believing that Cannabis was a useful medicine. Law-enforcement representatives reasoned that passage of BM 67:

... would create loopholes large enough to drive a triple-trailer through that would have the effect of effectively barring any criminal prosecution of anyone with the slightest amount of initiative... (Oregon District Attorneys Association testimony before the Oregon Criminal Justice Commission, September 23, 1998.)

Beyond that, police organizations strenuously objected to the provision of the ballot measure, which required police to maintain and care for any confiscated Cannabis plants until the case had been resolved. They argued that this provision would force police departments all over Oregon to set up and maintain large grow rooms of marijuana.⁵

Police spokesmen often complained about the overly broad definition of debilitating medical conditions, which included disease conditions as well as symptoms. This would force the Oregon Health Division:

... to issue a marijuana use permit to anyone who claims to suffer from any number of ailments, such as an eating disorder, tooth-ache, or chronic back pain.

(Multnomah County District Attorney, *Legal Analysis of the Impact of M-67 on the Prosecution of Marijuana Possession, Delivery and Cultivation Cases*, Written testimony before the Oregon Criminal Justice Commission, September 23, 1998.)

Oregonians Against Dangerous Drugs tried valiantly to present the medical marijuana issue as confusing, a dangerous precedent, and a threat to youth. Seriously underfunded, OADD could barely afford a media campaign. A handful of police spokesmen doggedly traveled the state arguing the issue in front of mostly hostile crowds. Without significant funding from drug-war proponents, OADD limped along to defeat in November.

Medical leadership refuses to support BM 67

Contrary to the spirited vocal opposition promoted by Oregon's law-enforcement community, state medical organizations were subdued, non-committal and largely inconsequential in the statewide medical marijuana discussion. Neither the Oregon Medical Association (representing physicians) nor the Oregon Nurses Association (representing nurses) endorsed Ballot Measure 67.

The Oregon Medical Association House of Delegates debated a resolution opposing the OMMA in April 1998 at their semi-annual meeting. An emotionally-charged debate ensued with physicians on both sides arguing the merits of the language and the possible effects upon physician practice. A compromise finally passed by inserting language that neither endorsed nor rejected BM 67. This neutralized the opposition. Thus, the largest physician organization in Oregon essentially begged out of the issue, leaving a few vocal doctors to debate.



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Neither the OMA nor the ONA acknowledged the human rights violations implicit in "criminal" laws that harmed patients.



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...the ONA House of Delegates voted 60% to 40% to reject language supporting medical Cannabis...



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These two organizations like legislatures, politicians and drug-war zealots were unable to squarely face an issue that was common sense to most Americans.

In similar fashion, in 1998 the Oregon Nurses Association (ONA) took the course of least resistance by reiterating the 1997 House of Delegates position that stated:

Oregon Nurses Association supports continued research and current documentation on the medicinal use of marijuana where other drugs have not been effective.

One nurse, Ed Glick, joined at the convention by Sandee and Jennifer Burbank from Mothers Against Misuse and Abuse (MAMA), and Elvy Musikka presented information and advocated for passage of a supportive resolution. (Ms. Musikka attended as one of the handful of “legal” patients in America who receive monthly cans of low potency marijuana cigarettes from the U. S. Government.) Convention opposition formed around the Nurse Assistance Network (NAN), a shadowy ONA organization supporting a policy of forced drug-treatment of nurses in coordination with the Oregon Board of Nursing’s “Nurse Monitoring Program.” The NAN position parroted most of the common objections such as that there is:

...no conclusive evidence that smoked marijuana is the most effective treatment... (and that) ...marijuana is also considered a gateway drug to other illegal drug use, particularly amongst adolescents. (written comments, 1998 ONA Convention)

The floor debate included a motion to replace the ONA’s 1997 position with the Oregon Medical Association language. This motion failed. Ultimately, the ONA House of Delegates voted 60% to 40% to reject language supporting medical Cannabis and continued their “research not access” position instead.

Ultimately, medical organizations in Oregon refused to support Cannabis-using patients. Neither the Oregon Medical Association nor the Oregon Nurses Association acknowledged the human rights violations implicit in “criminal” laws that harmed patients. These two organizations like legislatures, politicians and drug-war zealots were unable to squarely face an issue that was common sense to most Americans.

The OMMA becomes Law

So, in spite of, or perhaps because of opposition from nursing, physician, law-enforcement, drug-treatment, governmental, and fundamentalist Christian organizations, the OMMA was approved by Oregon voters 54% to 45%. Ballot Measure 57 (Recrim) was defeated 59% to 37%, or 22 percentage points. OMR’s “just say no” campaign describing the costs of increased prosecution and jailing of pot smokers resonated with the voters. Voter Power’s monumental effort to register 10,000 voters motivated young people to vote in large numbers.

The momentum begun by California’s Proposition 215 in 1996 swept through Oregon, Washington, Alaska, Nevada, and Arizona in 1998. The Federal Government’s worst fears were realized as a “states rights” rebellion in the west. Every state that voted on the issue

approved medical Cannabis. This legislative trend has continued.

The approval by Oregon voters of Ballot Measure 67 cemented the political process begun in California. After the 1996 approval of Proposition 215 the “Feds” began saber rattling. The 1998 initiative victory in Oregon was greeted by stunned silence and occasional grumbling by drug-czar McCaffery that “medical practice shouldn’t be determined by initiative.”

Within a few weeks of the election, Oregon Attorney General Hardy Myers convened a “work group” made up mostly of law-enforcement representatives. This work group developed initial guidelines that were subsequently enlarged and expanded. The recommendations described the three legal defenses available to patients. Part two of the recommendations addressed the “presumptive indications” which officers could use to determine if the marijuana was for legitimate medical use. (These guidelines advise officers to conduct an investigation at the time of contact to determine if the situation is covered under the law before destroying plants, making an arrest, or obtaining a search warrant. It also suggests that officers investigate the claim of medical use by asking specific and detailed medical questions without placing that person under arrest or obtaining a release of medical information.)⁶

In December of 1999 the Attorney General released revised and expanded guidelines for local law-enforcement. These revised guidelines addressed the changes passed by 1999 Oregon legislature in the form of House Bill 3052 (see Appendix C).

Administrative rule-making hearings

At around the same time, the Oregon Health Division conducted the Advisory Committee on Medical Marijuana Act Administrative Rules. Section 15 of the OMMA required the Division to write administrative rules (OAR’s) to implement the Act. A Committee composed of many of the proponents and opponents of the Act met in January, March and April of 1999. The draft OAR’s were circulated on the second meeting and a public hearing was conducted on the third.

Major issues discussed and resolved included organizing a streamlined and inexpensive registration system. Draft versions of the Medical Marijuana Program forms were discussed and created. There was much discussion of two main areas involving law-enforcement: the registry card system information database and investigative procedures. These discussions eventually concluded that police could call the OHD only for individual verification of the information included on the registry card.⁷

Investigation processes were discussed which attempted to determine at what point the state police would be called to investigate. The OHD expressed a desire to *not* be involved in the investigation process and that the State Police was the more appropriate agency. They did say that they would make a referral to the Oregon State Police if there was “strong indication” of abuse of the law.



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The final rulemaking hearing occurred at the State Office Building in Portland...on April 15, 1999.



The topics included the \$150 cost of the card—an astounding amount to many patients.



Another interesting issue revolved around the definition of mature plants.

The final rulemaking hearing occurred at the State Office Building in Portland in a public meeting room on April 15, 1999. The meeting was attended by upwards of 100 people, mostly speaking for humane implementation of the law. Media organizations didn't attend. Little word of the event was broadcast. The testimony by many patients was powerful and heart wrenching. Patient after patient relayed the pain they endured at the hands of the legal system. Many times the meeting facilitator had to divert the speakers from describing the details of their medical conditions and back to the subject of the rules.

The topics included the \$150 cost of the card—an astounding amount to many patients. (During panel deliberations the OHD had suggested a \$50 annual fee. This fee was increased to \$150 because of an inability to secure general funding from the legislature.) Another interesting issue revolved around the definition of mature plants. This botanical description was important because the law allows for only “three mature plants” at any time. The characteristics of floral maturity were clearly expressed by several speakers. The Division decided upon an inadequate definition suggested by a botanist at Oregon State University:

Floral maturity will be said to have occurred when flowers are readily observable on the plant.

As several speakers pointed out, floral maturity is a specific biochemical process that occurs long after flowers are observable. The importance of harvesting for maximum cannabinoid concentration was explained, to no avail.

Lastly, the definition of who could be a “designated primary caregiver” was discussed at length. The Health Division's position was that the legally defined role of caregiver should encompass more than just growing Cannabis for the patient. However, patients spoke out forcefully, describing caregivers that generally do perform a single function. The Health Division eventually decided to omit a requirement that the designated caregiver serve some additional function thus recognizing that supplying Cannabis to the patient was indeed a “significant responsibility.”

The final public meeting was attended mostly by patients and proponents. There were few, if any, police officers present, and minimal OHD staff. The only medical organization in attendance was the ONA which voiced an opinion that past use and legal considerations should be factored in when issuing cards.

The powerful outpouring of emotional testimony at the meeting swayed the Health Division towards the patient's position in several important issues. By formalizing an administrative structure for the OMMA the OHD gave life to it.

House Bill 3052

One would have thought that the Republican legislature would have been chastened by two legislative defeats on the same subject, at

the same election. Not so. Within weeks of the start of the 1999 legislative session, law-enforcement groups met with their Republican sympathizers in Salem. Their goal was “to correct the flaws” of the OMMA. The OMMA hadn’t even been implemented. The Multnomah County DA’s office and Portland City Attorney spear-headed the effort.

The revisions included a raft of deletions and additions, which would have had the effect of shifting the burden of proof back towards the patient. Proposed changes included:

- Requiring that any grow location be written on the registry card;
- Deletion of OMMA Section 1, which states that possession of a registry card...“shall not alone constitute probable cause to search the person or property of the cardholder..”
- Replacing Section 1 to **require** inspection of the grow location by law-enforcement or the OHD up to **three times per year**;
- Eliminating the requirement that police agencies must care for plants;
- Adding wording which forbids medical Cannabis use by inmates or prisoners;
- “Clarifying” plant possession limits to 7 plants in any location.

The discussions between law-enforcement representatives and OMR were detailed and intense. OMR steadfastly refused to bargain away key protections and threatened to return to the initiative process to overturn unacceptable changes. HB 3052 was the culmination of these efforts. Changes that were subsequently agreed upon included:

- Changing terminology from “parent or legal guardian” to “custodial parent or legal guardian;”
- Disallowing Cannabis use in a correctional facility by prisoners;
- Eliminating law-enforcement responsibility to maintain live plants.

The two alterations, however, that had the greatest impact on the law dealt with language “clarifications” around where marijuana could be cultivated, and pre-trial notification of an intent to use the affirmative defense. The affirmative defense notification required that the defendant had to make written notice to the District Attorney of an intention to invoke the affirmative defense within five days of trial. It also required him or her “to state the reasons why the defendant is entitled to use the affirmative defense.”

HB 3052’s language “clarifications” regarding grow locations were intended to specify exactly where and how much Cannabis the person could cultivate. It stipulated that Cannabis could not be cultivated

“at a place other than one address for the property under control of the patient and one address for property under control of the primary caregiver,” or, *“at more than one address.”*



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HB 3052 was dutifully signed into law by Governor Kitzhaber on July 21st, 1999...



HB 3052 made few changes in the OMMA that would benefit patients. It did create more obstacles for them. It could have been far worse.



In 2000, the patient database contained over 1200 patients, 500 caregivers and 450 physicians.

These two contradictory statements served only to confuse the intent of the original language but remained in the final bill.

HB 3052 was dutifully signed into law by Governor Kitzhaber on July 21, 1999 and became effective on that date because language was inserted stating that the act “being necessary for the immediate preservation of the public peace, health, and safety, an emergency is declared to exist.” It is ironic that an “emergency” existed because patients had legal protection from cruel laws. This same emergency invocation was inserted in HB 2267, the 1979 bill which failed in that year. HB 3052 made few changes in the OMMA that would benefit patients. It did create more obstacles for them. It could have been far worse.

The registry card program

And so, nearly 20 years after the first attempts to legislatively protect Cannabis-using patients, the Oregon Health Division began issuing “registry identification cards.” This registry program was begun from scratch with no example in the United States to guide it. It required a Herculean effort in order to be implemented as it swirled in a political, medical and legal world. Into this crucible walked Kelly Paige, an OHD employee.

Ms. Paige, who had not previously been involved in the medical marijuana movement, suddenly found herself designing and managing the registration process for an exponentially growing number of patients. Within a 3-month time period, she coordinated the creation of a computerized data base; filing and tracking systems; forms and form letters; and operating procedures for researching patient applications, contacting doctors, issuing cards, responding to law enforcement inquiries and maintaining financial records.

Under her tireless effort, the Medical Marijuana Program has become a model for other states facing this task. Most importantly, this program finally does what legislators were unable to do, carve out a legal protection for Cannabis using patients. In the future, Cannabis will certainly be rescheduled out of Schedule One of the federal Controlled Substance Act. When it is, patients and health care providers will express amazement that patients suffered as much at the hands of police as of disease. Those days are fast approaching.

On May 1, 1999, the first registry card was issued. By June the number of patients grew to over 50. The growth of the program continued and increased. In 2000, the patient database contained over 1200 patients, 500 caregivers and 450 physicians. By 2001 there were over 1500 patients, 900 caregivers and 500 physicians registered in the program.

A statement by Martin Wasserman, M.D., administrator of the Oregon Health Division, summed up the program’s first year:

A number of states allow the medical use of marijuana, but Oregon was the first to implement a statewide registration system for patients. Our first-year review shows the system is

working as it was intended. A substantial number of qualified patients and their physicians are using it, and only a very few inquires from law enforcement officials regarding patients have occurred.



By 2001 there were over 1500 patients, 900 caregivers and 500 physicians registered in the program.

Footnotes

¹ Oregon HB 2970 required: “A statement from the person’s attending physician recommending the therapeutic use of marijuana.” The OMMA requires “...written documentation from the person’s attending physician stating that the person has been diagnosed with a debilitating medical condition and that the medical use of marijuana may mitigate the symptoms or effects of the person’s debilitating condition.”

² Any law passed by the Oregon Legislature may be referred back to voters for approval or rejection by collecting sufficient signatures to place it on the next election ballot. The law does not take effect until voters decide its fate.

³ The first Debilitating Medical Conditions Advisory Panel met in May and June of 2000. It was convened to consider nine petitions for eight conditions, all of them psychiatric in nature. (See Chapter 8.)

⁴ George Soros, Peter Lewis and John Sperling are three wealthy philanthropists who have contributed funding, through charitable and non-profit organizations, to drug-law reform and substance harm prevention programs that the U.S. Government refuses to fund. Most State initiatives have benefited through expertise and financial support provided by these organizations.

⁵ This provision was subsequently removed by the 1999 Oregon legislature in HB 3052.

⁶ Police in Oregon often use the “knock-and-talk” method to gain entry into homes or obtain confessions. This method does not require a search warrant if the person gives consent for the search or agrees to answer questions. Patients are advised to not volunteer information or give permission for a search without contacting an attorney or the OHD. (Chapter 2 describes knock-and-talk searches.)

⁷ The information on the registry card includes name and address, and whether or not the person is registered with the Marijuana Registry Program.

Chapter 8: The Debilitating Medical Conditions Advisory Panel



Background for adding new conditions

Among the many provisions of the Oregon Medical Marijuana Act (OMMA) is one for petitioning to add new conditions, which if approved would then allow Cannabis to be used to treat that condition. It reads:

Any person may submit a petition to the Division requesting that a particular disease or condition be included among the diseases and conditions that qualify as debilitating medical conditions under ORS 475.302. (ORS 475.334)

Petitions for new conditions

The Oregon Health Division (OHD) convened an *advisory panel* in February of 2000 to review nine petitions requesting the inclusion of eight new conditions on the list of debilitating medical conditions. (Two petitions were submitted for PTSD.) All nine petitions were submitted by either the patient or a family member of a person suffering from the disorder in question. These petitions, all for the inclusion of psychiatric conditions, were:

- schizophrenia,
- schizoaffective disorder,
- bipolar disorder,
- anxiety with depression,
- post traumatic stress disorder (2 petitions),
- insomnia with anxiety,
- agitation associated with Alzheimer’s disease, and
- attention deficit disorder.

The petition to include agitation related to Alzheimer’s disease was submitted by the wife of the man suffering from this disease. Two of the petitioners were already registered with the Health Division’s Medical Marijuana Program for *physical* ailments but maintained that Cannabis also helped their *psychiatric* disorder.

Panel members

The advisory panel included four physicians, two nurses, a medical Cannabis patient, a patient advocate, the Medical Marijuana Program manager and a panel facilitator. Four panel members were original framers and proponents of the OMMA.



Any person may submit a petition to the Oregon Health Division requesting that a particular disease or condition be included among the diseases and conditions that qualify as debilitating medical conditions...



...nine petitions requesting the inclusion of eight new conditions on the list of debilitating medical conditions... were submitted by either the patient or a family member of a person suffering from the disorder in question.



The advisory committee met three times in four weeks with half, or all-day meetings.

The members of this panel included: Richard Bayer MD, one of the two Chief Petitioners to Ballot Measure 67 (OMMA) and its primary spokesperson; Joshua Boverman MD, a psychiatrist practicing at OHSU; Edward Glick RN, a psychiatric nurse and medical Cannabis proponent; Teresa Keane RN, PNP, as an *ad hoc* member; Amy Klare, a consumer advocate who was also centrally involved in the OMMA campaign; Martin Lahr MD, representing Grant Higginson MD, the State Health Officer; Stormy Ray, a patient and second Chief Petitioner for Ballot Measure 67 and Kathleen Weaver MD. Neither Drs. Weaver, Lahr, Boverman nor Nurse Keane had prior experience with the OMMA.

The facilitator of the committee was Daniel Harris PhD. Kelly Paige, the Medical Marijuana Program Manager was also present and acted as a resource person and panel coordinator. Ms. Paige and Dr. Harris were not voting members.

The advisory panel meetings

The advisory committee met three times in four weeks with half, or all-day meetings. The first meeting on February 14 was taken up by a description of the panel's responsibility and function, including the *Charge* issued by the State Health Officer, Dr. Grant Higginson:

After thoroughly and objectively reviewing and evaluating the available evidence according to an agreed upon protocol in common, each member of this Panel is to advise the State Health Officer regarding whether or not the petitioned condition(s) should be included in the definition of "debilitating medical condition" for purposes of the Oregon Medical Marijuana Act.



During the first meeting the group discussed the parameters for evaluation, including what criteria justified the decision...[this] included "Duties and Responsibilities of Expert Panel Membership," the "*Charge*," "Evidence Grading," and "Evaluation Criteria."

During the first meeting the group discussed the parameters for evaluation, including what criteria justified the decision. This decision-making process and documentation included "Duties and Responsibilities of Expert Panel Membership," the "*Charge*," "Evidence Grading," and "Evaluation Criteria." Each of these described a different evaluation scheme—some based upon scientifically rigorous investigative protocols, others reflecting the evaluator's assessment of the *evidentiary* value. Thick packets of information were handed out including numbered copies of the actual petitions and supporting documentation. The collected research grew from meeting to meeting until it comprised 400 pages—some of it unrelated to the issue. (Strict confidentiality was maintained for medical files and duplication of patient petitions was prohibited.)

At the first meeting, personal positions emerged. Discussion to clarify the actual meaning of "objective" evaluation criteria culminated in the direction by the facilitator, Mr. Harris, that each member should evaluate the petitions based upon what *s/he believed* to be an objective standard. This evaluation could be based upon clinical research,

medical experience, patient testimony and/or historical observation. Significantly, panel members were repeatedly advised to evaluate the petition, not the patient, since the determination would be a medical standard that required sufficient basis.

The second all-day meeting on March 20 was spent listening to the testimony from petitioners and experts. It was unclear to some in the first meeting that “experts” (other than the petitioners themselves) would be presenting testimony at the second. It was with some surprise that six speakers representing OHSU, National Alliance for the Mentally Ill (NAMI), The Oregon Office of Mental Health Services, the Oregon Office of Alcohol and Drug Abuse Programs and the Oregon Psychiatric Association, testified in complete opposition to all petitions. These opinions were countered by one lone speaker from the Office of Consumer Technical Assistance who suggested that affective disorders (like bipolar and anxiety) were valid uses of Cannabis, but that psychosis was not. This speaker was the only person to differentiate mood disorders from thought disorders in his comments or recommendations. The arguments in opposition ranged from descriptions of the deleterious effects of Cannabis on substance use disorders, to a claim that there was not a sufficient clinical research base to justify their inclusion. The most extreme example of this position, retreating into pure and unfounded opinion, was:

Typically, regular users of marijuana have an untreated mental illness... Calling marijuana medicine for mental illness is pure newspeak, convincingly calling a thing it's opposite to baffle and confound.

Jason Renaud, Executive Director of NAMI of Multnomah County (written and verbal comments, March 20, 2000.)

The appearance of “experts” nearly all opposed to psychiatric inclusions, raised questions as to how expert testimony was solicited. (In an attempt to not politicize the proceedings, the Division decided to not hold public hearings. This was predicated on the fact that confidential medical information was being discussed.) At the members’ urging, Dr. Harris allowed an additional week to accumulate additional expert testimony. Thus, the information base continued to expand until the end.

During the afternoon all of the petitioners were heard from, five in person and three by telephone. Their testimony was unpolished yet sincere as they each described significant improvement in their psychiatric symptoms from Cannabis use. The petitioner with bipolar disorder described that he had remained out of the hospital for 11 years because Cannabis controlled his mood swings. The two petitioners suffering from PTSD both described Cannabis’ antianxiety effects that diminished the intensity of traumatic life-events. The petitioner for Alzheimer’s agitation described in detail her husbands escalating confusion and anxiety and the clear sedative effect which smoking Cannabis



Significantly, panel members were repeatedly advised to evaluate the petition, not the patient, since the determination would be a medical standard that required sufficient basis.



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The third meeting of the Debilitating Medical Conditions advisory panel ...consisted of review of the process and discussion of panel-member conclusions.



...concern was also expressed about the limited time that was allowed to process and write about the evidence.



The group did...achieve some uniformity in conclusions. Of the eight panel members, five recommended adding mood disorders like depression or anxiety to the list of covered conditions.

created. The petitioner for attention deficit disorder described his medical condition as profoundly incapacitating to the point where he suffered from mental collapse from a racing mind. This syndrome prevented him from engaging in the computer programming work that made his living. Cannabis controlled the debilitating nature of these symptoms and allowed him to engage in complex cognitive functioning. All the petitioners described the failure of pharmaceuticals to control their symptoms. Each person had relied heavily on sedatives—particularly benzodiazapines like Ativan and Xanax—in an unsuccessful attempt to control symptoms.

Predictably, the testimony was persuasive to proponents on the panel and was not persuasive to opponents. Few minds were changed, and the committee resumed discussions about the “weight” that should be given to patient reports.

The third meeting of the Debilitating Medical Conditions advisory panel was held on March 27, 2000, seven days after the patient and expert testimony meeting. It consisted of review of the process and discussion of panel-member conclusions. Members had accumulated around ten pages of additional written testimony in support of Cannabis’ psychiatric use. This information was added to the evidence base. These papers consisted mostly of statements in support of inclusion by nationally known medical Cannabis experts, notably, Drs. Lester Grinspoon and Tod Mikuriya, and Nurse Mary Lynn Mathre.

At this meeting, concern was also expressed about the limited time that was allowed to process and write about the evidence. (The advisory committee was pushed to complete work in barely four weeks. The OHD took more than two months to make a determination.) The disparate readings of the evidence corresponded closely to the ingrained prejudices brought to the task by some members. Skeptical doctors remained skeptical, citing a lack of research evidence. Proponents emphasized humanitarian and historical evidence. The group did, however, achieve some uniformity in conclusions. Of the eight panel members, five recommended adding mood disorders like depression or anxiety to the list of covered conditions. Two physician members suggested the complete rejection of all petitions and one physician recommended that agitation related to Alzheimer’s disease should be the only addition to the list of covered conditions, for compassionate reasons.

The OMMA was written to include both *symptoms* and *diseases* in the list of debilitating medical conditions. Thus, the task-force members had the prerogative to recommend for (or against) inclusion of a *disease* condition or a *symptom* classification. Doctor Bayer was perhaps the strongest proponent of symptom-based listing versus disease-based listing. He suggested that including *affective* symptoms onto the list would give the greatest possible flexibility to physicians. (Affective symptoms are anxiety, agitation, hopelessness, and sadness among others.)

**Panel Member Recommendations (and Strength of Recommendations)
for Each Petition to Add [Yes/as Disease or Symptom] or Not Add [No] a Condition
to the List of Debilitating Medical Conditions**

Petitioned -for Condition	Panel Member (*)							
	Rick Bayer, MD	Joshua Boverman, MD	Ed Glick, RN	Teresa Keane, RN PMHNP	Amy Klare	Martin Lahr, MD	Stormy Ray	Kathy Weaver, MD
Schizophrenia	No (Strong)	No (Weak)	Yes/D	No (Weak)	No (Weak)	No (Strong)	Yes	No (Strong)
SchizoAffective Disorder	No (Strong)	No (Weak)	Yes/D	No (Weak)	No (Weak)	No (Strong)	Yes	No (Strong)
Bipolar Disorder	Yes/S (Weak)	No (Inc)	Yes/D	Yes/D&S (Strong)	Yes/S	No (Inc)	Yes	No (Strong)
Anxiety (with Depression ⁽⁺⁾)	Yes/S (Strong)	No (Inc)	Yes/D	Yes/D&S (Strong)	Yes/D (Strong)	No (Inc)	Yes	No (Strong)
Post Traumatic Stress Disorder	No (Weak)	No (Inc)	Yes/D	Yes/D (Strong)	Yes/D (Strong)	No (Inc)	Yes	No (Strong)
Insomnia (with Anxiety)	Covered under Anxiety	No (Inc)	Yes/D	Yes/D&S (Strong)	Yes (Strong)	No (Inc)	Yes	No (Strong)
Attention Deficit Disorder	No	No (Inc)	Yes/D	Yes/D (Weak)	Yes/D (Strong)	No (Inc)	Yes	No (Strong)
Agitation of Alzheimer's Disease	AD - No Agitation Yes/S	No (Inc)	Yes/D & S	Yes/S (Weak)	Yes/D (Strong)	Yes/D (Weak)	Yes	No (Strong)

(*) Teresa Keane, PMHNP, participated in the panel's process and served as an unofficial alternate member.

(+) Dr. Bayer broke anxiety with depression into 2 separate conditions and completed a separate worksheet for each one. His recommendation for depression is Yes/S (Strong).

**(from Medical Marijuana Advisory Panel Report to
the Oregon Health Division - April 14, 2000)**



...on June 15, the OHD released its conclusions. The list of Debilitating Medical Conditions would immediately be expanded to include “agitation related to Alzheimer’s disease.”

As can be seen in the table of conclusions (previous page), individual panel recommendations varied widely. Doctors Weaver and Boverman rejected all petitions. Nurse Glick and patient Ray approved all petitions. Doctor Lahr (the State Health Officer’s designee) rejected all petitions except *agitation due to Alzheimer’s disease*. Patient advocate Klare and nurse Keane made identical recommendations, suggesting the inclusion of all conditions except *schizophrenia* and *schizoaffective disorder*. Doctor Bayer rejected all of the *conditions* but supported the inclusion of *symptoms* of anxiety (with depression) bipolar disorder and agitation of Alzheimer’s disease.

Final written recommendations were collected on March 29 and forwarded to the State Health Officer a few days later with a final report. (This report, along with some panel-member individual recommendations is available on the Oregonians for Medical Rights website: <http://www.teleport.com/~omr/>.)

Ten weeks later, on June 15, the OHD released its conclusions. The list of Debilitating Medical Conditions would immediately be expanded to include “agitation due to Alzheimer’s disease.” This corresponded exactly to Dr. Lahr’s (the State Health Officer designee) suggestion. All other conditions were rejected with Dr. Higginson citing a “lack of solid clinical research” showing efficacy and safety. In his comments Doctor Higginson also stated:

While there is a lack of sufficient science-based evidence to support adding [a]nxiety to the list at this time, the Health Division is going to further study this issue by conducting a physician survey and by looking into the possibility of supporting clinical trials.

(Oregon Department of Human Services press release, June 14, 2000)

(As of December 2000, neither the physician survey nor clinical trial has been implemented.)

This concluded the process of determining inclusions to the OMMA that had begun with nine psychiatric petitions.

Psychiatric conditions will one day be included on the list of covered conditions. This will require new (research) evidence showing usefulness. Nevertheless, the Debilitating Medical Conditions Advisory Panel broke new ground by, for the first time, asserting that Cannabis has psychiatric uses. This new medical and legal standard will hopefully limit the prosecution of Cannabis-using patients in Oregon who claim psychiatric benefit.

The “risk/benefit” analysis for psychiatric use

The research base used by the Debilitating Medical Conditions Advisory Panel to evaluate psychiatric conditions consisted of a large volume of material. The fact that all of the submitted petitions dealt with psychiatric use, in itself emphasizes the understanding among



Psychiatric conditions will one day be included on the list of covered conditions... the Debilitating Medical Conditions Advisory Panel broke new ground by, for the first time, asserting that Cannabis has psychiatric uses.

Neuropsychiatric Conditions Reported Helped by Cannabis
International Classification of Diseases 9 - CM -1996
1990 - 1999

Tod H. Mikuriya, M.D.

Psychotherapeutic: Antidepressant/Anxiolytic

Senile Dementia	290.0
Delerium Tremens	291.0
Organic Affective Syn.	293.83
Organic Brain Syn., chronic	294.8
Schizophrenia(s)	295.x
Schizophrenic Episode, acute	295.4
Schizoaffective Disorder	295.7
Mania	296.0
Manic Disorder, recurrent	296.1
Menopausal Depression	296.2
Major Depression, Recurrent	296.3
Bipolar Disorder, manic	296.4
Bipolar Disorder, depressive	296.5
Bipolar Disorder	296.6
Bipolar Disorder, unspec.	296.7
Paranoid State, simple	297.0
Anxiety Disorder	300.0
Panic Disorder	300.01
Hysteria	300.1
Obsessive Compulsive Dis.	300.3
Dysthemic Disorder	300.4
Neurasthenia	300.5
Paranoid Personality Dis.	301.0
Transient Sleep Dis.	307.41
Persistent Insomnia	307.42
Psychogenic Pain, unspec.	307.80
Tension Headache	307.81
Psychogenic Pain	307.89
Acute Stress Reaction	308.3
Depressive Reaction, prolonged	309.1
Post Traumatic Stress Dis.	309.81
Adjustment Reaction, other	309.89
Adjustment Reaction, unspec	309.9
Pschogenic PAT	316.0
Narcolepsy	347.0
Insomnia	780.52
Chronic Fatigue Syndrome	780.7

Harm reduction substitute

Alcoholism	303.0
Opiate Dependence	304.0
Sedative Dependence	304.1
Cocaine Dependence	304.2
Amphetamine Dependence	304.4
Drug Dependence, unspec.	304.9
Alcohol Abuse	305.0
Tobacco Dependence	305.1

Antispasmodic Anticonvulsant

Post Polio Syndrome	138.0
Psychogenic Pylorospasm	306.4
Bruxism	306.8
Stuttering	307.0
Tourette's Syndrome	307.23
Frontal Lobe Syn.	310.0
Org. Mental Dis: Head Injury	310.1
Nonpsychotic Organic Brain Dis.	310.8
Brain Trauma	310.9
Intermittent Explosive Disorder	312.34
ADD	314.0
ADD w/o Hyperactivity	314.00
ADD w/ Hyperactivity	314.01
ADD, other	314.8
Parkinsons Disease	332.0
Huntingtons Disease	333.4
Cerebellar Ataxia	334.4
Motor Neuron Disease	335.2
Amytrophic Lateral Sclerosis	335.20
Multiple Sclerosis	340.0
Cerebral Palsy	343.9
Flaccid Hemiplegia, Dominant Side	342.01
Quadriplegia(s)	344.0x
Paraplegia(s)	344.1x
Monoplegia, Lower Dominant Limb	344.31
Paralysis, unspecified	344.9
Epilepsy(ies)	345.x
Grand Mal Seizures	345.1
Limbic Rage Syndrome	345.4

Courtesy of Dr. Tod Mikuriya



Legitimate concerns about substance dependence (among the mentally ill) appears to be the greatest single limitation to Cannabis' use in psychiatry.



"risk/benefit analysis" ...determines if any therapy is effective enough to warrant its use.



The *perception of relative benefit* is usually best made by the patient as a self-report.



Research into Cannabis ...must compare *its risks relative to accepted psychiatric treatments* along with its reputed benefits.



In time, the acceptance of Cannabis as a treatment for anxiety, bipolar disorder and depression will increase, as health care providers interact with Cannabis-using patients.

patients that Cannabis has clear psychiatric applications. Doctor Tod Mikuriya's Neuropsychiatric Conditions table reinforces this widely held belief (see previous page).

There is general agreement that Cannabis can exacerbate underlying psychiatric symptoms in some vulnerable patients. Research indicates that paranoid or psychotic people who use Cannabis may experience an increase in disease symptoms. This is often combined with "self-medication" with alcohol, tobacco and other drugs.

Legitimate concerns about substance dependence (among the mentally ill) appears to be the greatest single limitation to Cannabis' use in psychiatry. Unfortunately, these beliefs have prevented an assessment of Cannabis *within the context of conventional drug-therapy and disease morbidity*. They have also prevented definitive clinical research, which would establish whether or not Cannabis falls within the accepted medical parameters for safety and efficacy. This medical standard—"risk/benefit analysis"—determines if any therapy is effective enough to warrant its use. In western medicine the "risk" portion is considered secondary to "benefit" since virtually all pharmaceuticals and medical treatments carry potential for harm, including serious injury and death. The accepted standard, therefore is whether or not any treatment benefits the patient. The *perception of relative benefit* is usually best made by the patient as a self-report. (This may not be true in psychotic patients who suffer from delusional thoughts.) Research investigation is usually initiated by these reports. Thus, the extensive reporting of psychiatric efficacy cannot be dismissed as mere "self-reports." (The State Health Officer used the "risk" standard to justify not including most of the petitioned conditions, without factoring in the baseline standard of risk for all other pharmaceuticals or benefit to the patient.) Research into Cannabis, therefore, must compare *its risks relative to accepted psychiatric treatments* along with its reputed benefits. An analysis of this sort will show that many patients suffering from *physical* and *psychiatric* diseases derive a *net* benefit through antianxiety, appetite stimulant, sedative and a decrease in pharmaceutical use. Any research, which does not make this distinction, should be seriously suspect.

Cannabis' expanding uses

In time, the acceptance of Cannabis as a treatment for anxiety, bipolar disorder and depression will increase, as health care providers interact with Cannabis-using patients. Physicians and nurses know that Cannabis is widely used by mentally ill patients. In the context of alcohol, methamphetamine and heroin use, Cannabis is of less concern. Nevertheless, there is little support within the mental health system for using Cannabis as a medicine.¹ (During the DMC Advisory Panel testimony there was no professional medical organization in Oregon expressing support for its use. In fact, none of the medical organizations differentiated between *primary thought [Axis 1] disorders* like schizophrenia and *Affective [Axis 2] disorders* like anxiety or depression.)

Mental health uses of Cannabis are expanding as physical uses expand. Patients do not draw the distinction between physical and emotional suffering that the American medical establishment does. Cannabis easily fits within the medical context of safety and efficacy. Patients know it. They also know that Cannabis pharmacologically acts as an antianxiety agent and sedative. This effect may be common to both psychiatric and physical afflictions, and may account for the vast list of physical and emotional diseases which Cannabis is used to control.

The controversy surrounding the use of Cannabis to treat mental illness reflects the deep divisions between patients and health care providers in Oregon and around the United States. Additionally, this differentiation alienates many mentally ill patients who perceive the mental health system as capricious and authoritarian. Thus, NAMI (ostensibly an organization professing itself as an association *for* the mentally ill) advocates a position which continues to stigmatize mentally ill people from physically ill people, all the while asserting a position of support for them.

The prosecution of ill patients for using *any* drug to relieve truly debilitating symptoms is not consistent with medical ethics of compassion or medical science. In the future when these arbitrary social and medical barriers disappear, mentally ill patients will integrate more successfully into medical systems. Around that time, medical Cannabis will be considered a valuable psychiatric addition to the pharmacopoeia, as it once was.

Footnotes

¹During the Debilitating Medical Conditions expert testimony session, the National Association for the Mentally Ill (better known as NAMI) offered not one, but two strongly-worded testimonials against the use of Cannabis for any psychiatric condition.



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The controversy surrounding the use of Cannabis to treat mental illness reflects the deep divisions between patients and health care providers in Oregon and around the United States.



...many mentally ill patients... perceive the mental health system as capricious and authoritarian.

Selected psychiatric research citations

NOTE: The following is a listing of selected research citations having particular relevance to Cannabis' psychiatric uses. This list is not complete, but it does indicate that Cannabis has psychiatric as well as physical effects. Citations are only listed once, though many of the citations fit more than one symptom or disease category. These studies also encompassed much more information than is reported here. Interested parties are encouraged to obtain the study for more complete information.

Psychosis

1. *A retrospective study of symptom patterns of cannabis-induced psychosis* [Imade et. al. (1991). Acta Psychiatr Scand 83: 134-136.]

Medical records and case notes of 272 psychotic patients attempted to discover “*whether there are any similarities between cannabis psychosis on the one hand and schizophrenia and mania on the other...*” The researchers concluded: “*it was not possible to demonstrate a consistent pattern of symptoms typical of cannabis psychosis.*”

2. *Anti-psychotic Effect of Cannabidiol* [Letter to the editor, Journal of Clinical Psychiatry, 56:10, October 1995.]

Single-case experimental study of cannabidiol administration for 26 consecutive days to an acutely psychotic woman documented improvement as measured by a decrease in psychotic symptoms on the Brief Psychiatric Rating Scale (BPRS) as well as a decrease in Haldol administration.

3. *Towards a Cannabinoid Hypothesis of Schizophrenia: Cognitive Impairments Due to Dysregulation of the Endogenous Cannabinoid System* [Emrich et. al. (1997). Pharmacology Biochemistry and Behavior; Vol. 56: No. 4, pp. 803-807.]

Discusses neurochemistry of schizophrenia and historical overview of research into cannabinoid receptor system in humans. Presents results of experimental study of 40 subjects (13 schizophrenia patients) comparing visual projections before and after administration of Cannabis resin. (Cannabis resin was not administered to psychotic patients.) This research concluded that: “*a subgroup of schizophrenic syndromes may pathogenetically be related to a functional disturbance of the endogenous cannabinoid/andamide system.*”

4. *Elevated endogenous cannabinoids in schizophrenia* [Leweke et. al. (1999). Clinical Neuroscience; Vol. 10: No. 8, pp. 1665-1669.]

Excellent discussion of brain neurochemistry. Research study where cerebrospinal fluid (CSF) is examined in ten schizophrenic patients and eleven non-schizophrenic patients. Analysis showed that endogenous cannabinoid concentrations were significantly higher in schizophrenic patients than in controls. This lends support to a hypothesis that

schizophrenia may in part be due to chemical signaling malfunctions involving the endogenous cannabinoid signaling (receptor) system.

5. *Mesolimbic dopaminergic decline after cannabinoid withdrawal* [Diana et. al. (1998). Proceedings of the National Academy of Science, Vol: 95, pp. 10269-10273.]

Research study where rats were chronically treated with THC followed by administration of cannabinoid antagonist SR 141716A. Administration of cannabinoid antagonist precipitated intense withdrawal symptoms. Abrupt termination of THC failed to produce a withdrawal syndrome. Results indicate that withdrawal from chronic cannabinoid administration is associated with reduced dopaminergic transmission in the limbic system.

6. *Toward a rational pharmacotherapy of comorbid substance abuse in schizophrenic patients* [Krystal et. al. (1999). Schizophrenia Research 35, s35-s39.]

Review of factors contributing to comorbid substance use in schizophrenic patients. ETOH (alcohol) most common drug used followed by Cannabis. The article compares “*self-medication hypothesis*” with “*comorbid addiction vulnerability hypothesis*.” Use of non-prescribed substances may increase Extrapyridamal Symptoms (EPS) or decrease them. Article indicates an association between Cannabis use and psychotic symptoms in vulnerable populations.

7. *Cannabis and Schizophrenia: A Longitudinal Study of Swedish Conscripts* [Andreasson et. al. (1987). The Lancet, pp. 1483-1486.]

Fifteen year study of 45,000 Swedish conscripts concluded that heavy Cannabis use (>50 times) could be an independent risk factor for development of schizophrenia but admitted that Cannabis use still accounts for a minority of cases of schizophrenia.

8. *American Psychiatric Association Policy on the Medical use of Marijuana* [1997.]

Recommends further research, and compassion for the ill; recommends FDA drug-approval process be followed.

9. *Marijuana and Medicine: Assessing the Science Base*; [1999. Institute of Medicine, pp. s105-109.]

Research review concludes: “*The association between marijuana and schizophrenia is not well understood.*” Also describes that schizophrenics prefer marijuana to cocaine for unknown reasons but “*this raises the possibility that schizophrenics might obtain some symptomatic relief from moderate marijuana use*”, “*but compared with the general population, people with schizophrenia....are likely to be at greater risk for adverse psychiatric effects.*”

10. *Psychiatric symptoms in cannabis users.* [Thomas (1993). British Journal of Psychiatry, 163: pp. 141-149.]

Unknown research format concludes: “*The evidence that cannabis has a causative role in chronic psychotic or affective disorders is not convincing, although the drug may modify the course of an already established illness.*”

11. *The use of cannabis as a mood stabilizer in bipolar disorder; anecdotal evidence and the need for clinical research.* [Grinspoon, et. al. (1998). Journal of Psychoactive Drugs, 30(2), pp. 171-177.]

Case histories indicating a number of patients find Cannabis useful in treatment of their bipolar disorder. “*The potential for cannabis as a treatment for bipolar disorder unfortunately can not be fully explored in the present circumstances.*”

12. *Substance use among the mentally ill: Prevalence, Reasons for Use, and Effects on Illness* [Warner, et. al. (1994). American Journal of Orthopsychiatry, 64(1): pp. 30-39.]

Literature review and interview of 55 subjects conducted by an independent researcher. Researchers state: “*The two-year admission rate was significantly lower among those whose drug of preference was marijuana ...compared to the remainder of the sample, including nonusers.*” “*most subjects who preferred marijuana and reported anxiety, depression, insomnia, or physical discomfort...perceived the substance as relieving those symptoms.*”

Bipolar disorder

1. *Substance Abuse and Bipolar Comorbidity* [Sonne, et. al. (1999). The Psychiatric Clinics of North America Newsletter, Vol.22: Number 3.]

Literature survey describing the high association between bipolar disorder and substance use issues. It repeatedly emphasizes cocaine and ETOH as associated features with bipolar disorder. No mention of Cannabis as comorbid feature with severe effects (unlike cocaine, ETOH).

2. *DSM-4 Diagnoses associated with class of substances,* [Diagnostic and Statistical Manual of Mental Disorders, 4th ed. pp177.]

A one-page table compares major mental illnesses with associated substances including Cannabis. It indicates that Cannabis use is not associated with mood disorders, is associated with psychotic disorders.

3. *Cannabis- THC and Bipolar Disorder* [Marijuana and Medicine: Assessing the Science Base (1999 Institute of Medicine, pp. 108, 126.)

A. Describes “the psychological effects of cannabinoids, such as anxiety reduction, sedation, and euphoria can influence their potential therapeutic value.” (pp. 109.)

B. Describes the side-effect profile as “within the risks tolerated for many medications.” (pp. 126.)]

Anxiety with depression

1. *Cannabis Indica in 19th-Century Psychiatry* [Carlson (1974). American Journal of Psychiatry, 131: 9, pp. 1004-1007.]

A study of the history and usage of Cannabis indica. The article makes frequent reports that indicate Cannabis was widely prescribed by physicians in Europe and America for depressive and anxious symptoms. The... *“review of the drug’s physiological and psychological effects reveals that most of the effects reported in the 1960’s were known to writers of the 19th century, when the drug was alternately considered a cure for and a cause of insanity.”* *“Frequently cited as a sedative, a hypnotic, or a soporific, [C]annabis was widely prescribed for insomnia.”* *“With the widespread reports of the pleasant and cheerful stimulating effects of the drug and its reduction of horrible feelings and fears, it was inevitable that cannabis was to be subjected to extensive trial in the treatment of melancholia.”*

2. *[Delta-9] Tetrahydrocannabinol in Depressed Patients* [Kotin, et. al. (1973). Archives of General Psychiatry, Vol. 28: pp. 345-348.]

Double blind clinical trial of THC in eight patients suffering from depression, over a period of seven days failed to produce significant euphoria or antidepressant effect. Two patients experienced severe anxiety reactions.

3. *Haschish in Melancholia* [Polli (1972). Medical Times, Vol: 100, No. 7, pp. 236-238.]

A single case study in the 1860’s of a physician using a Cannabis preparation to successfully treat a woman with severe, incapacitating depression with what appeared to be psychotic features. According to the author the treatment lasted 10 days with steadily increasing doses. The cure was permanent.

4. *The Management of Treatment Resistance in Depressed Patients with Substance Use Disorders* [Nunes, et. al. (1996). The Psychiatric Clinics of North America, Vol. 19: No. 2, pp. 311-327.]

Discusses depression and comorbid substance use with evaluation of depression and comorbid substance use and treatment recommendations. Case studies are described. It recommends a *“harm reduction”* approach and emphasizes the debilitating effects of ETOH and cocaine. There is one reference to Cannabis as being perceived by patients as being harmless.

5. *Advertisement for Cannabis U.S.P. (American Cannabis) fluid extract* [Parke, Davis & Company 1929-1930 physicians’ catalog of the pharmaceutical and biological products, p. 82.]

An advertisement for a Cannabis-based fluid extract of 80% alcohol, which was distributed to physicians. *“Extensive pharmacological and clinical tests have shown that its medicinal action cannot be distinguished*

from that of the fluid made from imported East Indian cannabis.” “Narcotic, analgesic, sedative.”

6. *Do patients use marijuana as an antidepressant?* [Gruber et.al. (1996). Depression 4(2): pp. 77-80.]

The authors “*present 5 cases in which the evidence seems particularly clear that marijuana produced a direct antidepressant effect. If true, these observations argue that many patients may use marijuana to “self-treat” depressive symptoms.*”

Anxiety disorders (insomnia with anxiety, agitation/anxiety associated with Alzheimer’s disease)

1. *Ranking of risks of 6 commonly used drugs* by Dr. Jack Henningfield (NIDA) and Dr. Neal Benowitz (UCSF) [New York Times, August 1994, C3.]

In rankings of nicotine, heroin, cocaine, caffeine, and Cannabis, Cannabis is rated least serious in withdrawal symptoms, least serious in reinforcement, least serious in tolerance, least serious in dependence, and moderately intoxicating (alcohol rated most serious.)

2. *Expert Testimony:* correspondence from Dr. Tod Mikuriya.

Dr. Mikuriya states: “*The persons who suffer from PTSD in my practice who medicate with Cannabis have discovered that the drug is by far the most effective in controlling the symptoms of anxiety attacks and insomnia.*”

3. *Cannabis Use and Cognitive Decline in Persons under 65 Years of Age* [Lyketsos, et. al. (1999). American Journal of Epidemiology, Vol 149: No. 9, pp. 794-800.]

This study analyzed 1,318 persons over twelve (12) years through the Mini-Mental State Exam. It concluded: “*There were no significant differences in cognitive decline between heavy users, light users, and nonusers of cannabis.*”

4. *Marijuana and Medicine: Assessing the Science Base* [1999. Institute of Medicine, pp. 5.]

Executive summary conclusion: “*The psychological effects of cannabinoids, such as anxiety reduction, sedation and euphoria can influence their potential therapeutic value. Those effects are potentially undesirable for certain patients and situations and beneficial for others.*”

5. *Cannabisprodukten im deutschen Sprachraum {The use of Cannabis products in Germany}* [1999. Forsch Komplementarmed Suppl. S3: pp. 28-36.]

170 subjects participated in an anonymous standardized survey. Questionnaires of 128 respondents were included. Among most frequent mentioned indications for using Cannabis were the following: Depression (12%), Sleeping disorders (4.8%).

6. *A Survey of 100 Medical Marijuana Club Members* [Harris, et. al. (no date). Drug Dependence Research Center, UCSF]

One hundred Cannabis Club members were surveyed as to their reasons for using Cannabis. Users: *“perceived marijuana to be more effective with less severe side-effects than other treatments.”* A history of substance abuse or dependence was present in 87% and of other psychiatric disorders in 83%.

Post-traumatic stress disorder PTSD

1. *Factors relating to current marijuana use by Vietnam War veterans in recovery from addiction to other drugs or chemicals of abuse* [Newton, et. al. Department of Veterans Affairs Research and Development Information System (RCS 10-0159).]

An anonymous questionnaire was given to veterans treated in the Stratton VA Medical Center. It was based upon staff observations that Vietnam combat veterans discontinued their use of alcohol and illicit drugs except Cannabis. Results indicated that the PTSD group more often used Cannabis to:

- a. Help with sleep;
- b. decrease nightmares;
- c. prevent bad thoughts of the past; improve self-esteem

The authors conclude: *“data support the contention that marijuana can be used for ‘self medication’ of psychiatric problems.”*

2. *Acute administration of the CB-1 cannabinoid receptor antagonist SR 141716A induces anxiety-like responses in the rat.* [Navarro, et. al. (1997). NeuroReport 8: pp. 491-496.]

Rats were administered SR 141716A, a cannabinoid antagonist. The results indicate that the CB-1 receptor antagonist SR 141716A elicited defensive responses in rats in two behavioral models of anxiety, suggesting the existence of an endogenous cannabinoid tone involved in regulation of the emotional responses

Insomnia with agitation

1. *Action of Cannabidiol on the Anxiety and other Effects Produced by [delta-9] THC in Normal Subjects* [Zuardi, et. al. (1982). Psychopharmacology 76: pp. 245-250.]

The objective of this research was to determine whether CBD exerts an antianxiety effect in persons treated with THC, in eight volunteers. The author’s state: *“It was verified that CBD blocks the anxiety provoked by THC, however this effect was also extended to other marijuana-like effects and to other subjective alterations.”*

2. *Summary of 2,480 medical marijuana patients interviewed by Dr. Tod Mikuriya* [Submission to the Association for Cannabis Medicine.]

This paper summarizes ICD classifications for diseases and categorizes the data according to mentions of Cannabis use. The results indicate

that: “2.9% of Dr. Mikuriya’s medical Cannabis patients have a primary diagnosis of insomnia.” According to the table, 26% of his patients comprising 660 patients use Cannabis for mood disorders including depression, anxiety disorder, attention deficit disorder, and panic disorder.

3. *[Delta-9] THC an an Hypnotic: An Experimental Study at Three Dose Levels* [Cousens, et. al. (1973). *Psychopharmacologia (Berl.)* 33: pp. 355-364.]

THC was found to significantly decrease the time it took healthy insomniacs to fall asleep. Three dosage levels were tried with nine subjects tested once a week for six weeks. The most effective dose was the 20-mg. level.

Medical Cannabis Resources in Oregon

The following list of Oregon advocacy, governmental and legal organizations is intended to support and assist patients, or others who are looking for information about medical Cannabis in Oregon.

Listing on this page *is not* an endorsement of the organization. Every attempt has been made to accurately relay information. The author apologizes to any organization that has been incorrectly listed or omitted. Any inaccuracies will be corrected in the next edition.

Berger, Leland — Attorney At Law

950 Lloyd Center, PMB 3
Portland, OR 97232-1262
Phone: 503/287-4688
Fax: 503-287-6938

The practice emphasizes appeals and all other post-conviction matters in Oregon and Federal Courts, along with the defense of Medical Marijuana Program patients and drug policy reform education and advocacy.

Eugene Cannabis Grow-Op

PO Box 10445
Eugene, OR 97440
Phone: 541/ 484- 6558

Eugene Cannabis Grow-op is working to implement and expand the OMMA by establishing ethical and quality control guidelines. It serves Eugene-area patients and providers.

The Hemp Cookbook: From Seed to Shining Seed,

available at:

www.efn.org/~eathemp

Farmacy

The Farmacy
PO Box 242
Forestville, CA 95436
Phone: (707) 568-0945
E-mail: info@farmacy.org
Website: www.farmacy.org

Farmacy provides professional services for the seriously ill.

HIV Alliance

1966 Garden Avenue
Eugene, OR 97403
Phone: (541) 342-5088
Website: www.hivalliance.org
Contact: Valerie Haynes, RN

What we do...

- Educate thousands of students and other community members every year about the facts of HIV, how it is transmitted, and how it can be prevented;
- Run the Sana Needle Exchange Program to help intravenous drug users avoid infecting themselves with HIV or spreading it to others;
- Provide health care and social services to our HIV-infected clients and their families;
- Support our clients and their loved ones with nourishing food, activities and peer encouragement through Acorn Center.
- Reach out to at-risk men and women through events, on the streets and with other agencies.

Mothers Against Misuse and Abuse (MAMA)

2255 State Road
Mosier, OR 97040
Phone: 541/ 298-1031
Fax: 541/ 298-2842
E-mail: MAMA@mamas.org
Website: www.mamas.org

Contact: Sandee Burbank, Director

(MAMA)—continued

MAMA, a non-profit organization founded in 1982, provides a holistic approach to the many aspects of substance use. The current national focus on illegal drugs as the “BAD” drugs gives the false impression that legal drugs are safe and “good”. Research shows that in today’s society there are high levels of alcohol abuse, prescription drug misuse and abuse, and great harm caused by excessive consumption of nicotine, caffeine and over-the counter drugs.

MAMA offers guidelines for evaluating a drug’s benefits and risks, including both health risks and legal risks. MAMA advocates for programs promoting life management skills, such as adult literacy, parenting, conflict resolution, etc.

Medi-juana

PO Box 11008
Portland, OR 97211
Phone: 503/284-2589
Email: Medijuana@yahoo.com
Contact: Hannah Westphal

Medi-juana is a community-based organization operating to end the suffering of those who are otherwise legally able to produce and use marijuana as medicine, but are hampered by their physical and financial limitations, the environment they live in, and a lack of knowledge of the remedies available to them.

Oregon State Health Division / Oregon Medical Marijuana Program

Oregon Health Division
800 NE Oregon Street, St. 640
PO Box 14450
Portland, OR 97293-0450
Phone: 503/731-8310
Fax: 503/ 731-4080
E-mail: kelly.paige@state.or.us
Website: www.ohd.hr.state.or.us/hclc/mm/
Contact: Kelly Paige

The Medical Marijuana Program is operated by the Oregon Health Division, under the Oregon Department of Human Services. The objective of the program is to register qualified Oregon patients in the Medical Marijuana Program. Contact the Medical Marijuana Program for application forms and info.

National Organization for the Reform of Marijuana Laws (NORML)

National NORML
1001 Connecticut Ave NW #1010
Washington, DC 20009
E-mail: natlnorml@AOL.com
Website: www.norml.org

Portland OREGON chapter of the National Organization for the Reform of Marijuana Laws (Pdx-NORML)

Pdx NORML
P.O. Box 11694
Portland, OR 97211
Phone: (503) 777-9088.
E-mail: PdxNORML@pdxnorml.org
Website: <http://www.pdxnorml.org>
Contact: Perry Stripling

Locally, the Portland chapter of the National Organization for the Reform of Marijuana Laws works to implement OMMA and spread the word about medical marijuana. Through the Oregon example Pdx NORML hopes to educate the public to the reality about the medical use of Cannabis as opposed to federal propaganda.

Oregon Medical Marijuana Network

Phone: 503/626-0498
E-mail: Medpot13@gte.net
Contact: Diane Densmore

Patients Out of Time

1472 Fish Pond Road
Howardsville, VA 24562
Phone: 804/ 263-4484
Fax: 804/ 263-6753
Website: www.medicalcannabis.com
Contact: Mary Lynn Mathre, RN

Patients Out of Time is a national non-profit organization that is dedicated to the education of health care professionals and the public about therapeutic Cannabis.

SOMM-NET (Southern Oregon Medical Marijuana Network).

Brookings, Oregon
Phone: 541-469-9999
E-mail: brotherbob90@hotmail.com
Website: www.sommnet.org
Contact: Robert 'Brother Bob' Walker

SOMM-NET aids patients in registering with the OMMA and disseminates information on research, growing cannabis and other needs of the ill.

Voter Power

Phone: 503/786-1905 Phone 2: 541/670-3382
Email: Johns@rosenet.net
Contact: John Sajo

Voter Power is established to advocate for reasonable, fair, and effective Cannabis laws and policies and to educate, register and empower voters to implement these policies.

Stormy Ray Foundation

The Stormy Ray Foundation Cardholder Network
Website: www.stormyray.org
Email: info@stormyray.org
Phone: 1-866-278-6769 & 1-877-600-6767
Fax: 425-969-1958

The mission of The Stormy Ray Foundation Cardholder Network is to facilitate, educate, legislate, research, and promote the legal use of medical marijuana in order to create a higher quality of life for patients for whom this God-created herb was intended. We have assisted hundreds of patients and their caregivers in successfully registering for the OMMA program and establishing their medical marijuana gardens. We do this by fostering a network of OMMA cardholders so they may share their collective knowledge and resources. We are a referral source for the Oregon Health Division and we maintain a close relationship with the OMMA Program manager's office as well as other organizations throughout the state of Oregon.

Ken Brown's Medical Marijuana Website

Phone: 541-334-6284.
E-mail: your-oregon@att.net
Website: <http://home.att.net/~medical-marijuana-websites-and-more/>
Contact: Ken Brown

Ken Brown's Medical Marijuana Website offers a large number of informational resources and links to many (most) of Oregon's medical Cannabis resources. Additionally, he has set up news and discussion groups.

Michaels, Brian — Attorney At Law

259 East 5th Avenue, Suite 300
Eugene, OR 97401
Phone: 541/ 687-0578
Fax: 541/ 686-2137
Contact: Sephra Oare

Brian Michaels—continued

Brian Michaels offers free consultations with regard to the OMM program and registration process (packets are also available at the office). He also provides free legal representation for current OMM card holders that may find themselves with “police situations.” Please send our office any printed material or information for us to add to our medical marijuana library.

Appendix

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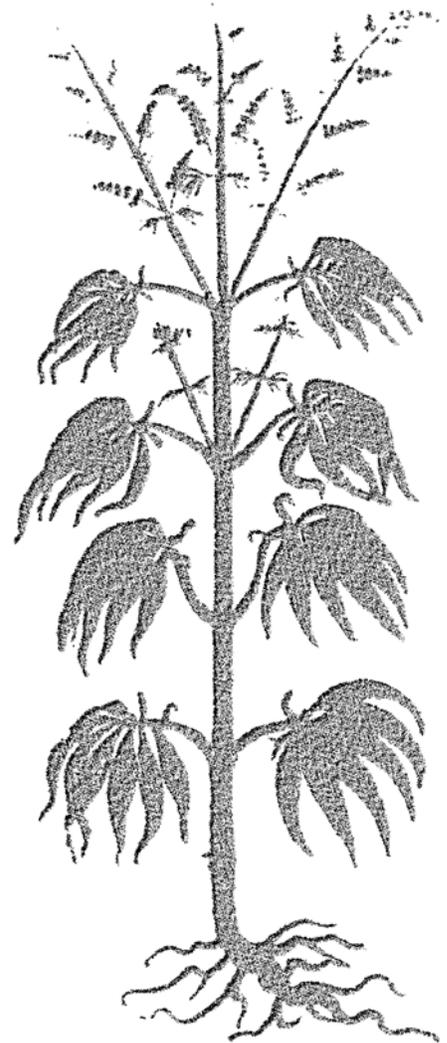
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Guidelines for Completing the Application for Registration in the Oregon Medical Marijuana Act Program

- 1) Please complete Part A of **the Application Form**. **Please provide a copy of a** photo identification card as requested. If information on the front of the card is not current (for example, if your address has changed) please also photocopy the back of the id.

If a person over the age of 18 provides assistance to you, and you would like for that person to also receive a registration card, please complete Part B of the form, and provide a copy of photo i.d. of the primary caregiver. [Note: there is no additional fee for a primary caregiver registration card.]

Completion of Part C is optional. Please be sure to sign your name in Part D.

- 2) Your physician must be an MD or a DO licensed to practice in Oregon under ORS 677. He or she must provide signed, valid, written documentation stating that you are his/her patient, that you have been diagnosed with a debilitating medical condition covered by the Act, and that the medical use of marijuana may mitigate the symptoms or effects of your condition. This documentation may be in the form of a copy of your chart notes, a letter, or the attached **Attending Physician's Statement** form. [Note: chart notes or a letter must include all elements of the **Attending Physician's Statement** form.]
- 3) If you are a minor (under the age of 18), your parent or guardian must complete the **Declaration of Person with Primary Custody of a Minor** form. The form must also be notarized.
- 4) In order for your application to be complete, a **fee of \$150** must be paid by check or money order. Please make payable to: **Oregon Health Division** and send payment with your application forms and/or other materials.

All information will be verified. Upon receipt of a complete application, you will be issued a medical marijuana registration card by the Oregon Health Division. Please call Kelly Paige at (503) 731-8310 if you have any questions.

**DECLARATION OF PERSON WITH PRIMARY CUSTODY OF A MINOR
TO PARTICIPATE IN
Medical Marijuana Act Program**

MAIL FORM TO: Oregon Health Division, Center for Environment and Health Systems
800 NE Oregon Street Portland, OR 97232

Instructions: Please complete all required information in order to comply with the registration requirements of the Oregon Medical Marijuana Act. This form is required in addition to the patient application form if the patient is under 18 years of age.

Please contact the Oregon Health Division if you need this material in an alternative format.

DECLARATION

I _____, do hereby declare:
(Print or Type Name)

1. That I am the person with primary custody of

_____ Applicant's Name

2. The applicants attending physician has explained to the applicant and to me the possible risks and benefits of the medical use of marijuana.

3. I consent to the use of marijuana by the applicant for medical purposes.

4. I agree to serve as the applicant's primary caregiver.

5. I agree to control the acquisition of marijuana and the dosage and frequency of use by the applicant.

SIGNATURE OF PERSON WITH PRIMARY CUSTODY:

ADDRESS:

TELEPHONE NUMBER

CITY, STATE AND ZIP CODE:

Subscribed to before me on this _____ day of _____

Notary Signature _____

Seal\Stamp

Notary Instructions: If notary is using a raised seal, indicate in which state you are registered as a notary and the date your commission expires. Notary signature and seal must appear on this form. Do not attach a separate notary statement.

OREGON MEDICAL MARIJUANA ACT(HB 3052)

475.300 Findings. The people of the state of Oregon hereby find that:

- (1) Patients and doctors have found marijuana to be an effective treatment for suffering caused by debilitating medical conditions, and therefore, marijuana should be treated like other medicines;
- (2) Oregonians suffering from debilitating medical conditions should be allowed to use small amounts of marijuana without fear of civil or criminal penalties when their doctors advise that such use may provide a medical benefit to them and when other reasonable restrictions are met regarding that use;
- (3) ORS 475.300 to 475.346 are intended to allow Oregonians with debilitating medical conditions who may benefit from the medical use of marijuana to be able to discuss freely with their doctors the possible risks and benefits of medical marijuana use and to have the benefit of their doctor’s professional advice; and
- (4) ORS 475.300 to 475.346 are intended to make only those changes to existing Oregon laws that are necessary to protect patients and their doctors from criminal and civil penalties, and are not intended to change current civil and criminal laws governing the use of marijuana for nonmedical purposes. [1999 c.4 s.2]

Note: 475.300 to 475.346 were adopted by the people by initiative petition but were not added to or made a part of ORS chapter 475 or any series therein. See Preface to Oregon Revised Statutes for further explanation.

475.302 Definitions for ORS 475.300 to 475.346. As used in ORS 475.300 to 475.346:

- (1) “Attending physician” means a physician licensed under ORS chapter 677 who has primary responsibility for the care and treatment of a person diagnosed with a debilitating medical condition.
- (2) “Debilitating medical condition” means:
 - (a) Cancer, glaucoma, positive status for human immunodeficiency virus or acquired immune deficiency syndrome, or treatment for these conditions;
 - (b) A medical condition or treatment for a medical condition that produces, for a specific patient, one or more of the following:
 - (i) Cachexia;
 - (ii) Severe pain;
 - (iii) Severe nausea;
 - (iv) Seizures, including but not limited to seizures caused by epilepsy; or
 - (v) Persistent muscle spasms, including but not limited to spasms caused by multiple sclerosis; or
 - (c) Any other medical condition or treatment for a medical condition adopted by the division by rule or approved by the division pursuant to a petition submitted pursuant to ORS 475.334.
- (3) “Delivery” has the meaning given that term in ORS 475.005.
- (4) “Designated primary caregiver” means an individual eighteen years of age or older who has significant responsibility for managing the well-being of a person who has been diagnosed with a debilitating medical condition and who is designated as such on that person’s application for a registry identification card or in other written notification to the division. “Designated primary caregiver” does not include the person’s attending physician.
- (5) “Division” means the Health Division of the Oregon Department of Human Services.
- (6) “Marijuana” has the meaning given that term in ORS 475.005.
- (7) “Medical use of marijuana” means the production, possession, delivery, or administration of marijuana, or paraphernalia used to administer marijuana, as necessary for the exclusive benefit of a person to mitigate the symptoms or effects of his or her debilitating medical condition.
- (8) “Production” has the same meaning given that term in ORS 475.005.
- (9) “Registry identification card” means a document issued by the division that identifies a person authorized to engage in the medical use of marijuana and the person’s designated primary caregiver, if any.
- (10) “Usable marijuana” means the dried leaves and flowers of the plant *Cannabis* family *Moraceae*, and any mixture or preparation thereof, that are appropriate for medical use as allowed in ORS 475.300 to 475.346. “Usable marijuana” does not include the seeds, stalks and roots of the plant.
- (11) “Written documentation” means a statement signed by the attending physician of a person diagnosed with a debilitating medical condition or copies of the person’s relevant medical records. [1999 c.4 s.3]

Note: See note under 475.300.

475.305 [1977 c.636 s.1; 1979 c.674 s.1; repealed by 1993 c.571 s.30]

475.306 Medical use of marijuana; limits on amount possessed, delivered or produced. (1) A person who possesses a registry identification card issued pursuant to ORS 475.309 may engage in, and a designated primary caregiver of such a person may assist in, the medical use of marijuana only as justified to mitigate the symptoms or effects of the person’s debilitating medical

condition. Except as allowed in subsection (2) of this section, a registry identification cardholder and that person's designated primary caregiver may not collectively possess, deliver or produce more than the following:

- (a) If the person is present at a location at which marijuana is not produced, including any residence associated with that location, one ounce of usable marijuana; and
 - (b) If the person is present at a location at which marijuana is produced, including any residence associated with that location, three mature marijuana plants, four immature marijuana plants and one ounce of usable marijuana per each mature plant.
- (2) If the individuals described in subsection (1) of this section possess, deliver or produce marijuana in excess of the amounts allowed in subsection (1) of this section, such individuals are not excepted from the criminal laws of the state but may establish an affirmative defense to such charges, by a preponderance of the evidence, that the greater amount is medically necessary to mitigate the symptoms or effects of the person's debilitating medical condition.
- (3) The Health Division shall define by rule when a marijuana plant is mature and when it is immature for purposes of this section. [1999 c.4 s.7]

Note: See note under 475.300.

475.309 Registry identification card; issuance; eligibility; duties of cardholder. (1) Except as provided in ORS 475.316 and 475.342, a person engaged in or assisting in the medical use of marijuana is excepted from the criminal laws of the state for possession, delivery or production of marijuana, aiding and abetting another in the possession, delivery or production of marijuana or any other criminal offense in which possession, delivery or production of marijuana is an element if the following conditions have been satisfied:

- (a) The person holds a registry identification card issued pursuant to this section, has applied for a registry identification card pursuant to subsection (9) of this section, or is the designated primary caregiver of a cardholder or applicant; and
 - (b) The person who has a debilitating medical condition and his or her primary caregiver are collectively in possession of, delivering or producing marijuana for medical use in the amounts allowed in ORS 475.306.
- (2) The division shall establish and maintain a program for the issuance of registry identification cards to person who meet the requirements of this section. Except as provided in subsection (3) of this section, the division shall issue a registry identification card to any person who pays a fee in the amount established by the division and provides the following:
- (a) Valid, written documentation from the person's attending physician stating that the person has been diagnosed with a debilitating medical condition and that the medical use of marijuana may mitigate the symptoms or effects of the person's debilitating medical condition;
 - (b) The name, address and date of birth of the person;
 - (c) The name, address and telephone number of the person's attending physician; and
 - (d) The name and address of the person's designated primary caregiver, if the person has designated a primary caregiver at the time of application.
- (3) The division shall issue a registry identification card to a person who is under 18 years of age if the person submits the materials required under subsection (2) of this section, and the custodial parent or legal guardian with responsibility for health care decisions for the person under 18 years of age signs a written statement that:
- (a) The attending physician of the person under 18 years of age has explained to that person and to the custodial parent or legal guardian with responsibility for health care decisions for the person under 18 years of age the possible risks and benefits of the medical use of marijuana;
 - (b) The custodial parent or legal guardian with responsibility for health care decisions for the person under 18 years of age consents to the use of marijuana by the person under 18 years of age for medical purposes;
 - (c) The custodial parent or legal guardian with responsibility for health care decisions for the person under 18 years of age agrees to serve as the designated primary caregiver for the person under 18 years of age; and
 - (d) The custodial parent or legal guardian with responsibility for health care decisions for the person under 18 years of age agrees to control the acquisition of marijuana and the dosage and frequency of use by the person under 18 years of age.
- (4) A person applying for a registry identification card pursuant to this section may submit the information required in this section to a county health department for transmittal to the division. A county health department that receives the information pursuant to this subsection shall transmit the information to the division within five days of receipt of the information. Information received by a county health department pursuant to this subsection shall be confidential and not subject to disclosure, except as required to transmit the information to the division.
- (5) The division shall verify the information contained in an application submitted pursuant to this section and shall approve or deny an application within thirty days of receipt of the application.
- (a) The division may deny an application only for the following reasons:
 - (i) The applicant did not provide the information required pursuant to this section to establish his or her debilitating medical condition and to document his or her consultation with an attending physician regarding the medical use of marijuana in connection with such condition, as provided in subsections (2) and (3) of this section; or
 - (ii) The division determines that the information provided was falsified.

(b) Denial of a registry identification card shall be considered a final division action, subject to judicial review. Only the person whose application has been denied, or, in the case of a person under the age of 18 years of age whose application has been denied, the person's parent or legal guardian, shall have standing to contest the division's action.

(c) Any person whose application has been denied may not reapply for six months from the date of the denial, unless so authorized by the division or a court of competent jurisdiction.

(6)(a) If the division has verified the information submitted pursuant to subsections (2) and (3) of this section and none of the reasons for denial listed in subsection (5)(a) of this section is applicable, the division shall issue a serially numbered registry identification card within five days of verification of the information. The registry identification card shall state:

- (i) The cardholder's name, address and date of birth;
- (ii) The date of issuance and expiration date of the registry identification card;
- (iii) The name and address of the person's designated primary caregiver, if any; and
- (iv) Such other information as the division may specify by rule.

(b) When the person to whom the division has issued a registry identification card pursuant to this section has specified a designated primary caregiver, the division shall issue an identification card to the designated primary caregiver. The primary caregiver's registry identification card shall contain the information provided in paragraph (a) of this subsection.

(7)(a) A person who possesses a registry identification card shall:

- (i) Notify the division of any change in the person's name, address, attending physician or designated primary caregiver; and
- (ii) Annually submit to the division:

(A) Updated written documentation of the person's debilitating medical condition; and

(B) The name of the person's designated primary caregiver if a primary caregiver has been designated for the upcoming year.

(b) If a person who possesses a registry identification card fails to comply with this subsection, the card shall be deemed expired. If a registry identification card expires, the identification card of any designated primary caregiver of the cardholder shall also expire.

(8) A person who possesses a registry identification card pursuant to this section and who has been diagnosed by the person's attending physician as no longer having a debilitating medical condition shall return the registry identification card to the division within seven calendar days of notification of the diagnosis. Any designated primary caregiver shall return his or her identification card within the same period of time.

(9) A person who has applied for a registry identification card pursuant to this section but whose application has not yet been approved or denied, and who is contacted by any law enforcement officer in connection with his or her administration, possession, delivery or production of marijuana for medical use may provide to the law enforcement officer a copy of the written documentation submitted to the division pursuant to subsections (2) or (3) of this section and proof of the date of mailing or other transmission of the documentation to the division. This documentation shall have the same legal effect as a registry identification card until such time as the person receives notification that the application has been approved or denied. [1999 c.4 s.4; 1999 c.825 s.2]

Note: See note under 475.300.

475.312 Designated primary caregiver. (1) If a person who possesses a registry identification card issued pursuant to ORS 475.309 chooses to have a designated primary caregiver, the person must designate the primary caregiver by including the primary caregiver's name and address:

- (a) On the person's application for a registry identification card;
- (b) In the annual updated information required under ORS 475.309; or
- (c) In a written, signed statement submitted to the division.

(2) A person described in this section may have only one designated primary caregiver at any given time. [1999 c.4 s.13]

Note: See note under 475.300.

475.315 [1977 c.636 s.2; 1979 c.674 s.2; repealed by 1993 c.571 s.30]

475.316 Limitations on cardholder's immunity from criminal laws involving marijuana. (1) No person authorized to possess, deliver or produce marijuana for medical use pursuant to ORS 475.300 to 475.346 shall be excepted from the criminal laws of this state or shall be deemed to have established an affirmative defense to criminal charges of which possession, delivery or production of marijuana is an element if the person, in connection with the facts giving rise to such charges:

- (a) Drives under the influence of marijuana as provided in ORS 813.010;
- (b) Engages in the medical use of marijuana in a public place as that term is defined in ORS 161.015, or in public view or in a correctional facility as defined in ORS 162.135 (2) or youth correction facility as defined in ORS 162.135 (6);
- (c) Delivers marijuana to any individual who the person knows is not in possession of a registry identification card;
- (d) Delivers marijuana for consideration to any individual, even if the individual is in possession of a registry identification card;
- (e) Manufactures or produces marijuana at a place other than one address for property under the control of the patient and one

address for property under the control of the primary caregiver of the patient that have been provided to the Health Division; or
(f) Manufactures or produces marijuana at more than one address.

(2) In addition to any other penalty allowed by law, a person who the division finds has willfully violated the provisions of ORS 475.300 to 475.346, or rules adopted under ORS 475.300 to 475.346, may be precluded from obtaining or using a registry identification card for the medical use of marijuana for a period of up to six months, at the discretion of the division. [1999 c.4 s.5; 1999 c.825 s.3]

Note: See note under 475.300.

475.319 Affirmative defense to certain criminal laws involving marijuana available to cardholder. (1) Except as provided in ORS 475.316 and 475.342, it is an affirmative defense to a criminal charge of possession or production of marijuana, or any other criminal offense in which possession or production of marijuana is an element, that the person charged with the offense is a person who:

(a) Has been diagnosed with a debilitating medical condition within 12 months prior to arrest and been advised by his or her attending physician the medical use of marijuana may mitigate the symptoms or effects of that debilitating medical condition;

(b) Is engaged in the medical use of marijuana; and

(c) Possesses or produces marijuana only in the amounts allowed in ORS 475.306 (1), or in excess of those amounts if the person proves by a preponderance of the evidence that the greater amount is medically necessary as determined by the person's attending physician to mitigate the symptoms or effects of the person's debilitating medical condition.

(2) It is not necessary for a person asserting an affirmative defense pursuant to this section to have received a registry identification card in order to assert the affirmative defense established in this section.

(3) No person engaged in the medical use of marijuana who claims that marijuana provides medically necessary benefits and who is charged with a crime pertaining to such use of marijuana shall be precluded from presenting a defense of choice of evils, as set forth in ORS 161.200, or from presenting evidence supporting the necessity of marijuana for treatment of a specific disease or medical condition, provided that the amount of marijuana at issue is no greater than permitted under ORS 475.306 and the patient has taken a substantial step to comply with the provisions of ORS 475.300 to 475.346.

(4) Any defendant proposing to use the affirmative defense provided for by this section in a criminal action shall, not less than five days before the trial of the cause, file and serve upon the district attorney a written notice of the intention to offer such a defense that specifically states the reasons why the defendant is entitled to assert and the factual basis for such affirmative defense. If the defendant fails to file and serve such notice, the defendant shall not be permitted to assert the affirmative defense at the trial of the cause unless the court for good cause orders otherwise. [1999 c.4 s.6; 1999 c.825 s.4]

Note: See note under 475.300.

475.323 Effect of possession of registry identification card or designated primary caregiver card on search and seizure rights. (1) Possession of a registry identification card or designated primary caregiver identification card pursuant to ORS 475.309 shall not alone constitute probable cause to search the person or property of the cardholder or otherwise subject the person or property of the cardholder to inspection by any governmental agency.

(2) Any property interest possessed, owned or used in connection with the medical use of marijuana or acts incidental to the medical use of marijuana that has been seized by state or local law enforcement officers shall not be harmed, neglected, injured or destroyed while in the possession of any law enforcement agency. A law enforcement agency has no responsibility to maintain live marijuana plants lawfully seized. No such property interest may be forfeited under any provision of law providing for the forfeiture of property other than as a sentence imposed after conviction of a criminal offense. Usable marijuana and paraphernalia used to administer marijuana that was seized by any law enforcement office shall be returned immediately upon a determination by the district attorney in whose county the property was seized, or his or her designee, that the person from whom the marijuana or paraphernalia used to administer marijuana was seized is entitled to the protections contained in ORS 475.300 to 475.346. Such determination may be evidenced, for example, be a decision not to prosecute, the dismissal of charges, or acquittal. [1999 c.4 s.8; 1999 c.825 s.5]

Note: See note under 475.300.

475.325 [1977 c.636 s.3; 1979 c.674 s.3; repealed by 1993 c.571 s.30]

475.326 Attending physician; limitation on civil liability and professional discipline. No attending physician may be subjected to civil penalty or discipline by the Board of Medical Examiners for:

(1) Advising a person whom the attending physician has diagnosed as having a debilitating medical condition, or a person who the attending physician knows has been so diagnosed by another physician licensed under ORS chapter 677, about the risks and benefits of medical use of marijuana or that the medical use of marijuana may mitigate the symptoms or effects of the person's debilitating medical condition, provided the advice is based on the attending physician's personal assessment of the person's medical history and current medical condition; or

(2) Providing the written documentation necessary for issuance of a registry identification card under ORS 475.309, if the documentation is based on the attending physician's personal assessment of the applicant's medical history and current medical condition and the physician has discussed the potential medical risks and benefits of the medical use of marijuana with the applicant. [1999 c.4 s.9]

Note: See note under 475.300.

475.328 Limits on professional licensing board's authority to sanction licensee for medical use of marijuana. No professional licensing board may impose a civil penalty or take other disciplinary action against a licensee based on the licensee's medical use of marijuana in accordance with the provisions of ORS 475.300 to 475.346 or actions taken by the licensee that are necessary to carry out the licensee's role as a designated primary caregiver to a person who possesses a lawful registry identification card issued pursuant to ORS 475.309. [1999 c.4 s.10]

Note: See note under 475.300.

475.331 List of persons issued registry identification cards and designated primary caregivers; disclosure. (1) The division shall create and maintain a list of the persons to whom the division has issued registry identification cards pursuant to ORS 475.309 and the names of any designated primary caregivers. Except as provided in subsection (2) of this section, the list shall be confidential and not subject to public disclosure.

(2) Names and other identifying information from the list established pursuant to subsection (1) of this section may be released to:

(a) Authorized employees of the division as necessary to perform official duties of the division; and

(b) Authorized employees of state or local law enforcement agencies, only as necessary to verify that a person is a lawful possessor of a registry identification card or that a person is the designated primary caregiver of such a person. [1999 c.4 s.12]

Note: See note under 475.300.

475.334 Adding diseases or conditions that qualify as debilitating medical conditions. Any person may submit a petition to the division requesting that a particular disease or condition be included among the diseases and conditions that qualify as debilitating medical conditions under ORS 475.302. The division shall adopt rules establishing the manner in which the division will evaluate petitions submitted under this section. Any rules adopted pursuant to this section shall require the division to approve or deny a petition within 180 days of receipt of the petition by the division. Denial of a petition shall be considered a final division action subject to judicial review. [1999 c.4 s.14]

Note: See note under 475.300.

475.335 [1977 c.636 s.4; 1979 c.674 s.4; repealed by 1993 c.571 s.30]

475.338 Rulemaking. The division shall adopt all rules necessary for the implementation and administration of ORS 475.300 to 475.346. [1999 c.4 s.15]

Note: See note under 475.300.

475.340 Limitations on reimbursement of costs and employer accommodation. Nothing in ORS 475.300 to 475.346 shall be construed to require:

(1) A government medical assistance program or private health insurer to reimburse a person for costs associated with the medical use of marijuana; or

(2) An employer to accommodate the medical use of marijuana in any workplace. [1999 c.4 s.16]

Note: See note under 475.300.

475.342 Limitations on protection from criminal liability. Nothing in ORS 475.300 to 475.346 shall protect a person from a criminal cause of action based on possession, production, or delivery of marijuana that is not authorized by ORS 475.300 to 475.346. [1999 c.4 s.11]

Note: See note under 475.300.

475.345 [1977 c.636 s.5; 1979 c.674 s.5; repealed by 1993 c.571 s.30]

475.346 Short title. ORS 475.300 to 475.346 shall be known as the Oregon Medical Marijuana Act. [1999 c.4 s.1]

Chapter 475

1999 EDITION

Controlled Substances; Illegal Drug Cleanup; Paraphernalia; Precursors

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		475.960	PENALTIES
			Failure to report precursor substance
			Failure to report missing precursor substances
			Illegally selling drug equipment

**RECOMMENDATIONS FOR THE IMPLEMENTATION
OF THE OREGON MEDICAL MARIJUANA ACT**

(As amended by the 1999 Legislative Assembly)

Issued by the Attorney General, December 15, 1999

I. BACKGROUND.

A. The Oregon Medical Marijuana Act (hereafter, the Act) provides several ways in which a claim of medical need may be raised by a person suspected or accused of unlawfully possessing, manufacturing or delivering marijuana. These are:

1. An “exception” from the criminal laws prohibiting possession, delivery or production of marijuana and related offenses, which applies to persons who have received a registry identification card from the Oregon Department of Health or who have a pending application for a card (Section 4 of the Act).
2. An “affirmative defense” to a charge of unlawful possession, delivery or manufacture of marijuana, which applies to a person who “[h]as been diagnosed with a debilitating medical condition within 12 months prior to arrest and been advised by his or her attending physician the medical use of marijuana may mitigate the symptoms or effects of that debilitating medical condition.” The defendant would be required to prove the affirmative defense by a preponderance of the evidence after filing a notice of intent to rely on it (Section 6(1) of the Act; 1999 Or Laws, ch 825, § 4; ORS 161.055(2)).
3. A “defense of choice of evils,” by which the person asserts that marijuana possession, delivery or manufacture is “necessary as an emergency measure to avoid an imminent public or private injury” and “[t]he threatened injury is of such gravity that, according to ordinary standards of intelligence and morality, the desirability and urgency of avoiding the injury clearly outweigh the desirability of the injury sought to be prevented” by the marijuana laws. The state would be required to disprove the defense beyond a reasonable doubt, but the defense is available only to persons who have taken a substantial step to comply with the Act. (Section 6(3) of the Act; 1999 Or Laws, ch 825, § 4; ORS 161.055(1); 161.190; 161.200).

B. Effective dates. The “exception” from the criminal laws, and the registration system upon which it is based, took effect on May 1, 1999. (Section 19 of the Act). However, both the “affirmative defense” and the “defense of choice of evils” apply to conduct that occurred on or after December 3, 1998. (Section 19 of the Act). The 1999 amendments to the Act, which are described throughout these recommendations, took effect on July 21, 1999. (1999 Or Laws, ch 825, § 6)

C. Effect on Marijuana Investigations. The Act places a substantial burden on law enforcement officers to anticipate potential medical use claims and to determine their validity in the initial stages of an investigation.

1. The criminal law “exception” for persons who engage in the medical use of marijuana under the terms of a valid registry identification card, or a pending application for a card, is apparently intended to preclude arrest, citation or search.
2. The “affirmative defense” of medical need can be raised by persons who have not been issued a registry identification card, or even applied for one. (Section 6 of the Act).
3. Except as noted in the next paragraph, the Act prohibits law enforcement officers from harming, neglecting, injuring or destroying any property connected with the medical use of marijuana. If the district attorney or a court determines that a medical use defense applies, the Act mandates that seized usable marijuana and paraphernalia be returned to the person from whom it was seized. (Section 8 of the Act; 1999 Or Laws, ch 825, § 5).
4. A law enforcement agency has no responsibility to maintain live marijuana plants if they have been “lawfully seized.” (Section 8 of the Act; 1999 Or Laws, ch 825, § 5). However, in this regard, an officer should exercise care to ensure that live plants are not seized from a person who is excepted from the criminal laws.

D. Recommendation: An officer should try to determine the applicability of the criminal law “exception” before doing any of the following:

1. Making a warrantless arrest, search or seizure based on probable cause;
2. Seeking a search or arrest warrant;
3. Seizing growing marijuana plants or other property that is likely to deteriorate while in police custody;
4. Destroying marijuana or other property; or
5. Seizing property for civil forfeiture.

II. DETERMINING THE APPLICATION OF THE CRIMINAL LAW EXCEPTION.

A. The criminal law “exception” does not apply if:

1. The person does not have a current, valid registration as a patient or primary caregiver, and does not have a pending application for registration; or
2. Regardless of registration, the person has engaged in certain disqualifying conduct specified in the Act.

B. Statutory Disqualifications: The criminal law “exception” does not apply to any person – even one who is validly registered under the Act – if the person has engaged in any of the following activities:

1. Driving under the influence of marijuana;
2. Using marijuana in a public place, in public view, or in an adult or youth correctional facility;

[“Using” includes merely possessing marijuana. (Section 3(7) of the Act). Literal application of this definition would prohibit a patient or primary caregiver from transporting marijuana from place to place, even though the person is properly registered and the quantity being transported is within the permissible limit. Therefore, in consultation with the appropriate prosecuting attorney, law enforcement agencies should adopt policies for officers to follow if a registrant is encountered while transporting a lawful quantity of marijuana from one place to another.]

3. Delivering marijuana, either with or without consideration, to someone who the person making the delivery knows is not a registrant;
4. Delivering marijuana for consideration to any person, including a registrant;

[See discussion regarding Seeking Evidence of Sales, page 11.]

5. Manufacturing or producing marijuana at an address that is not under the control of the registrant (either patient or primary caregiver) or that has not been provided to the Health Division;

[This disqualifying factor means that medical marijuana must be grown on property in which the grower has a property interest, for example, as an owner, as a purchaser or as a lessee. Marijuana production on public forestland and much private forestland would not comply with this requirement and, therefore, marijuana growing in those locations would be subject to seizure and destruction. This disqualifying factor also means that the grower must provide the Health Division with the address of the growing site. Any change in address must be provided to the Health Division within 30 days. OAR 333-008-0040.]

6. Manufacturing or producing marijuana at more than one address; or
7. Possessing, delivering or producing marijuana in amounts that, between the patient and the primary caregiver collectively, exceed the following limits:

- a. If the person is present at a location at which marijuana is not produced, including any residence associated with that location, one ounce of usable marijuana;

b. If the person is present at a location at which marijuana is produced, three mature plants, four immature plants and one ounce of usable marijuana for each mature plant.

i. Section 7 of the Act does not expressly state whether a different limit applies when several registrants are present at a single location where marijuana is being produced. The Act can be interpreted to limit the total amount of marijuana grown on that location to seven plants. This interpretation is premised on the assumption that each registrant at the location simultaneously possesses the same marijuana.

Alternatively, the Act may be interpreted to permit seven growing plants for each registrant who is present at the growing site. In consultation with the appropriate prosecuting attorney, law enforcement agencies should adopt policies for officers to follow when multiple registrants are encountered at the same location.

ii. Section 7 of the Act does not expressly state whether a different limit applies when one person is the primary caregiver for multiple patients. Under one interpretation, a primary caregiver may not exceed the seven-plant limit on property under his or her control, regardless of the number of patients under his or her care. Accordingly, if the primary caregiver for three patients is growing three mature plants and four immature plants for one patient on property that is under the control of the primary caregiver, the marijuana for the other two patients must be grown on property that is under the control of the patients themselves. Under this interpretation, the criminal law exception does not apply to any growing site that exceeds the seven-plant limit. This was the understanding of the legislative working group that developed the 1999 amendments to the Act.

Under another interpretation, section 7 refers to the relationship between the primary caregiver and a single patient. Since primary caregivers are allowed multiple patients, each caregiver-patient pair is permitted to “collectively” possess seven growing plants.

Caveat: Even if a person is engaging in one of these disqualifying activities, the person may still raise the choice of evils defense if the person has taken a substantial step to comply with the Act. Therefore, if the person is either a registrant or an applicant, it is advisable to also seek evidence relating to this anticipated defense. See discussion regarding Anticipating Other Medical Marijuana Defenses, page 10.

C. Determining Registration Status. If none of the above disqualifying factors is present, the only means for determining the applicability of the criminal law “exception” is to ascertain whether or not the person holds a current, valid registry identification card issued by the Health Division or has a pending application for a card.

1. Seeking Warrants and Seizure Orders. Before seeking an arrest or search warrant, or a civil forfeiture seizure order, an officer should first (if possible) check the Health Division registry to determine whether the person under investigation, or another closely associated person, has applied for or been issued a registry identification card. The Health Division registry can be contacted by telephone at (503) 731-4011 x640. The regular hours for the registry are 8:30 a.m. to 5:00 p.m., Monday through Friday. Be aware, however, that only one staff person is available to manage all aspects of the Division’s responsibilities under the Act and the 1999 amendments.

a. If the Health Division registry indicates that the person under investigation is currently registered or has an application pending, or that the place where marijuana is being grown is listed as a medical marijuana growing site, no warrant or seizure order should be sought, unless evidence exists of conduct that would disqualify the person from the criminal law exception (see factors described above).

b. If it is necessary to seek a warrant at a time when the registry cannot be contacted, the supporting affidavit should explain why registration status cannot be determined and why the application must be made before that determination can be made.

2. Stops and Encounters – Warrantless Arrests and Searches. Before making a warrantless arrest or issuing a citation for a marijuana offense, or making a warrantless search or seizure based on probable cause, an officer should first ask the person why he or she is growing or possessing marijuana. (This should be an open-ended question that does not suggest a response.)

a. Non-registrants: If the person claims medical use, but has not applied for or obtained a registry identification card from the Health Division:

- i. The criminal law exception does not apply and, if probable cause exists, the officer may take action appropriate to the circumstances, e.g., arrest or citation.
- ii. It is recommended that the officer also conduct additional investigation for evidence relevant to a potential affirmative defense or choice of evils defense. See discussion below regarding Anticipating Other Medical Marijuana Defenses, page 10.

b. Registrants: If the person presents a registry identification card, as either a patient or primary caregiver:

- i. Valid card. A person who “holds” a valid, current registry identification card is excepted from the criminal laws of this state relating to marijuana possession and manufacture, and is not subject to arrest, citation or search for those offenses, unless the person has engaged in disqualifying conduct described above. See discussion of Statutory Disqualifications, page 3.

[It is unclear whether a registrant must be in physical possession of his or her registration card to be excepted from the criminal laws. Therefore, when a person under investigation claims to be a registrant, but is unable to present a registry identification card, it is recommended that an officer make every reasonable effort to verify the person’s status before an arrest, search or seizure.]

- ii. Expired card. The expiration date is printed on the card. A registrant is required to annually update the registration information on file with the Health Division. This includes submitting “[w]ritten documentation to reconfirm the person’s debilitating medical condition.” OAR 333-008-0040. If the registrant fails to comply with this requirement before the expiration date, the card is deemed expired. (Section 4(7) of the Act; OAR 333-008-0040).

A person who is relying on a registry identification card that has expired is a non-registrant and is, therefore, subject to arrest or citation. In such cases, however, an officer should conduct additional investigation to determine whether the person has engaged in conduct that would eliminate or support a potential affirmative defense (see discussion of Statutory Disqualifications, page 3) or evidence otherwise relevant to a potential choice of evils defense. See discussion below regarding Anticipating Other Medical Marijuana Defenses, page 10. An officer should also determine whether the person is an applicant for a new registry identification card. See discussion of Applicants below, page 8.

[In many cases, a person who has previously qualified for a card probably will be able to successfully assert the affirmative defense or the choice of evils defense.]

- iii. Accurate Identifying Information on the Card. A registrant must give notice to the Health Division within 30 days of a change of name, address or primary caregiver. OAR 333-008-0040.

An officer should ask the registrant if the registrant’s name and address, and the name of the primary caregiver listed on the card are current. An officer should also compare the registry card information with the registrant’s ODL or other ID. If this information is not current, an officer should ask when these changes occurred, whether the person notified the Health Division, and, if so, when

The law provides no specific penalty for failing to provide timely notice of these changes. But if the address or the primary caregiver has changed, and notice has not been given to the Health Division, an officer should investigate whether the registrant, or the current or former primary caregiver, is disqualified from the criminal law exception. [Remember that a person cannot rely on the criminal law exception if he or she is growing marijuana at an address that has not been provided to the Health Division.] A person who is disqualified from the criminal law exception is subject to arrest or citation.

See discussion of Statutory Disqualifications, page 3. In any event, an officer should note any changes and submit them to the Health Division.

iv. Registry Verification. In every case, it is advisable to verify the status of the registry identification card with the Health Division, either at the time of the encounter with the registrant or at a later time. The results of that verification may require a follow-up interview with the registrant.

v. Suspended Card. If the registry identification card is suspended, the officer should try to establish whether the registrant is aware of the suspension.

A person who is relying on a registry identification card that is suspended is a non-registrant, and, therefore, is subject to arrest or citation. In such cases, however, an officer should conduct additional investigation to determine whether the person has engaged in conduct that would eliminate or support a potential affirmative defense (see discussion of Statutory Disqualifications, page 3) or evidence otherwise relevant to a potential choice of evils defense. See discussion below regarding Anticipating Other Medical Marijuana Defenses, page 10.

c. Applicants: Copies of documentation submitted to the Health Division to apply for a registry identification card have the same legal effect as a registry identification card until the person receives notice that the application has been approved or denied. (Section 4(9) of the Act). In other words, a person who presents copies of application documents is excepted from the criminal laws governing marijuana possession and manufacture, and is not subject to arrest or citation, unless it is determined that the person has received notice of denial or has engaged in conduct that disqualifies the person from the criminal law exception. See discussion of Statutory Disqualifications, page 3.

i. If the person presents copies of application documents, the officer should check the Health Division registry to determine the status of the application. [Remember that an application can be filed with the county health department, which is required to forward it to the Health Division. (Section 4(4) of the Act). Applications filed in this manner may not appear on the registry for a significant length of time after filing.]

ii. Copies of application documents should be treated as a valid registry identification card unless:

Health Division records indicate that the person has received notice of denial;

The person admits that the Health Division has denied the application;

The application was submitted less than six months after a previous application was denied (Section 4(5)(b) of the Act); or

The application is more than one year old. [A registry identification card is deemed expired if the registrant does not annually submit updated registration information to the Health Division. (Section 4(7) of the Act).]

iii. If the person claims to have filed an application for a registry identification card, but does not present copies of application documents, the person is not excepted from the criminal law relating to marijuana production and manufacture, but may still claim the affirmative defense or the choice of evils defense.

In such cases, an officer should conduct additional investigation to determine whether the person has engaged in conduct that would eliminate a potential affirmative defense (see discussion of Statutory Disqualifications, page 3) or evidence otherwise relevant to a potential choice of evils defense. See discussion below regarding Anticipating Other Medical Marijuana Defenses, page 10.

This investigation should include a check with the Health Division registry for evidence of an application.

d. Persons with Forged Documents: A person who makes or knowingly tenders a false registry identification card or application documents should be investigated for the crime of forgery. ORS 165.002-165.022.

Additionally, the officer should notify the Health Division regarding these false documents. The Health Division may deny an application for a registry identification card if the application contains falsified information. (Section 4(5); OAR

333-008-0030). It may also suspend a registry identification card if the card was obtained by fraud. OAR 333-008-0070(3)(a).

III. ANTICIPATING OTHER MEDICAL MARIJUANA DEFENSES.

A. Seeking Evidence Regarding Medical Condition.

[Investigation of this issue may not be necessary if the suspect presents a valid registry identification card or a copy of a pending application for a card.]

1. Why is the person growing or possessing marijuana (This should be an open-ended question that does not suggest a specific answer.)
2. If the person claims medical use, an officer should ask:
 - a. Has the person submitted documentation to the Oregon Health Division
 - b. Has the person ever been diagnosed with a “debilitating medical condition” (which includes cancer, glaucoma, HIV positive status, AIDS, cachexia, severe pain, severe nausea, seizures, and persistent muscle spasms) What condition or conditions When was the diagnosis made

[To establish the affirmative defense, the person must prove by a preponderance that he or she has been diagnosed with a debilitating medical condition within 12 months prior to the arrest. (1999 Or Laws ch 825, § 4(1)(a)). The choice of evils defense does not specifically require this showing; but a person who raises that defense must show that he or she has taken a substantial step to comply with the Act. 1999 Or Laws ch 825, § 4(3). Arguably, this means, at a minimum, that the person has obtained a diagnosis of a debilitating medical condition.]

- c. What is the name of the person’s doctor(s) How long has the person been treated by the doctor What is the name and address of the clinic, hospital or health organization where the doctor is employed Has the person’s doctor indicated that marijuana may mitigate the effects of the person’s condition
- d. Will the person sign a waiver to release his or her medical records
- e. How long has the person suffered from the condition What are the symptoms for which the person uses marijuana Why does the person prefer to use marijuana instead of other medical practices

B. Seeking Evidence Regarding the Amount of Marijuana Grown or Possessed.

How much marijuana does the person use What volume does the person use on a daily, weekly, monthly and yearly basis Did the person’s doctor say that this amount was necessary

[If the amount of marijuana manufactured or possessed exceeds the presumptive limits established by the Act (see page 4), the person cannot establish the affirmative defense unless the person proves by a preponderance that “the greater amount is medically necessary as determined by the person’s attending physician to mitigate the symptoms or effects of the person’s debilitating medical condition.” 1999 Or Laws ch 825, § 4(1)(c).]

C. Seeking Evidence of Sales.

The criminal law exception and the affirmative defense are not available to a person who has delivered marijuana for consideration. Additionally, however, evidence that the person has been selling marijuana should be relevant for rebutting the choice of evils defense.

1. Is there evidence that the person has been engaging in the sale of marijuana: scales, packaging materials, records of drug sales, cash

2. Is the size and sophistication of the grow operation consistent with personal use Is the person using an amount of electrical power that greatly exceeds the amount necessary to grow seven plants

3. Financial Resources.

a. Is the person (or person's spouse or partner) employed With whom How long What is the person's (spouse or partner's) monthly or yearly income from this employment

b. Does the person have other sources of income: rental property, stocks, bonds, legal settlement, inheritance How much What is the name and address of the source Did the person declare this income when filing state and federal tax returns

c. What are the person's (or person's spouse or partner's) debts Does the person (or spouse or partner) own his or her own home, vehicle(s) or business Is the person's home or business mortgaged Does the person have any other outstanding loans or debts: car loans, credit cards, judgments, unpaid taxes What is the name and address of the person's lenders and other debtors What is the rate of repayment

D. Seeking Evidence Regarding Other Relevant Circumstances.

1. Is the person in possession of other unlawful controlled substances

2. Has the person committed other offenses

3. Does the person have a history of arrests or convictions for marijuana offenses

IV. SEIZURE AND DESTRUCTION OF MARIJUANA PLANTS.

As stated above (page 2), the Act prohibits law enforcement officers from harming, neglecting, injuring or destroying any property connected with the medical use of marijuana. It also provides, however, that “[a] law enforcement agency has no responsibility to maintain live marijuana plants lawfully seized.”

Assuming that all the requirements of an otherwise lawful seizure have been met (e.g., search warrant or an exception from the search warrant requirement), the seizure of plants found at a grow that exceeds the presumptive limits under the Act is a “lawful seizure,” and officers are not required to maintain the live plants. However, under some circumstances, such as when multiple registrants are residing at the same growing site, or when a person who is producing marijuana claims to be the primary caregiver for multiple registrants, it may be difficult to ascertain whether the number of marijuana plants at a particular location is within or is in excess of the limits established by the Act. See discussion above on pages 3-4.

Moreover, even when the criminal law exception does not apply, any person charged with manufacturing or possessing these plants may later establish the affirmative defense or the choice of evils defense. This may include proof of a medical need to grow marijuana in amounts that exceed the presumptive limits of the Act.

Accordingly, each law enforcement agency should develop a policy governing the destruction of live marijuana plants when a growing site exceeds the seven-plant presumptive limit.

The following are policies that agencies may wish to consider:

A. Seize only enough small cuttings of marijuana to conduct confirmatory testing. Document the extent of the grow through photography or videotaping. Do not harvest or otherwise destroy growing plants and do not seize or destroy the growing equipment.

B. If there are more growing plants than the number specified in Section 7(1) of the Act (three mature plants and four immature plants), harvest all plants in excess of the specified number, but do not seize or destroy the growing equipment.

[This was the preferred policy within the legislative working group that developed the 1999 amendments to the Act (1999 Or Laws, ch 825)].

C. If there are significantly more growing plants than the number specified in Section 7(1) of the Act, harvest all growing plants (on the assumption that medical use defenses are not valid as to any part of the grow).

[This policy may seem justified when the number of growing plants greatly exceeds the presumptive limit established by the Act, when other unlawful controlled substances are also being possessed or manufactured, or when there is evidence that marijuana is being sold.]

It is always prudent to obtain consent from the appropriate person before destroying live marijuana plants.

Oregon Department of Justice
1162 Court Street NE Salem, OR 97310 (503) 378-4400
E-mail: doj.info@state.or.us

Updated: 07/19/2000

OREGON MEDICAL MARIJUANA ACT

AFFIRMATIVE DEFENSE NOTIFICATION FORM

Note: This form, or another written statement, must be filed and served upon the prosecuting attorney not less than five (5) days before the trial.

**This form serves notice on the District Attorney of _____
County of the undersigned patient’s intention to use the Affirmative Defense
as provided for in the Oregon Medical Marijuana Act.**

**I, _____, hereby serve upon District Attorney
_____, this notice of intention to use the Affirmative
Defense in my pending trial.**

The specific reasons why I am entitled to use this defense are as follows:

_____.

**The factual basis for this defense includes the following studies, which
demonstrate that my medical condition is helped through my use of
cannabis: _____**

_____.

Additionally, the benefits of my cannabis use include: _____

_____.

Patient Signature: _____

Date Submitted: _____ Trial Date: _____

5210 S.W. Corbett Avenue
Portland, Oregon 97201-3897
(503) 226-1555 • Fax (503) 241-7148
<http://www.OrMedAssoc.org>
oma@ormedassoc.org



OREGON MEDICAL ASSOCIATION GUIDELINES

(Adopted April 25, 1999)

WHEN PATIENTS WANT TO USE MARIJUANA FOR MEDICAL

PURPOSES - HOW PHYSICIANS SHOULD RESPOND

Oregon's medical marijuana law was passed by the voters in November, 1998. It exempts certain persons from state criminal penalties for the production, possession, delivery, or administration of marijuana or paraphernalia used to administer marijuana provided they comply with very detailed requirements. Oregon's law is unique in that the state health division is charged with creating a means by which candidates for exemption from prosecution are given registry identification cards so that state law enforcement officials can readily determine their exempt status. Oregon physicians figure into the law because unless the patient has the required "written documentation" from their "attending physician," they are not eligible for this exemption.

This law poses several important legal dilemmas for members. Physicians who comply cannot be prosecuted criminally by state authorities. However, nothing prevents the federal government through the Drug Enforcement Administration from taking action against physicians for "aiding and abetting" the commission of a federal crime. To underscore the seriousness of this situation, consider this February 27, 1997 response of federal officials to a request from the California Medical Association regarding that state's medical marijuana law:

"...Physicians may not intentionally provide their patients with oral or written statements in order to obtain controlled substances in violation of federal law. Physicians who do so risk revocation of their DEA prescription authority, criminal prosecution, and exclusion from participation in Medicare, and Medicaid programs."

In a March 8, 1999 letter, OMA asked these officials for clarification of the above statement. OMA's letter poses the following question:

"Do statements in patient charts that the person has been diagnosed with a debilitating medical condition and that the use of medical marijuana may mitigate the symptoms or effects of the

When Patients Want to Use Marijuana for Medical Purposes ***Page two***

debilitating medical condition constitute written statements in order to enable [their patients] to obtain controlled substances in violation of federal law?”

OMA has not yet received a response. Pending that response, physicians are advised that they are at risk unless they limit their activities to those identified below.

A second and equally serious dilemma arises when physicians provide their patients with a discussion of the possible risks and benefits associated with the use of marijuana for medical purposes. To the extent that such discussions occur, physicians need to know that nothing in the law prevents patients, or their legal representatives if they die, from bringing claims against physicians alleging failure to disclose all the viable alternatives and material risks of using medical marijuana. This is particularly important because patients must be suffering from a “debilitating medical condition” at the time the discussions occur. Patients with already compromised physical conditions make riskier candidates. If they suffer a bad outcome coincidental to their use of medical marijuana, they may try to blame their “attending physician.”

- I. Physicians are not obligated to participate.
- II. If the patient requests it, physicians should do ONLY the following things in order for their patients to benefit from Oregon’s law permitting medical use of marijuana.
 - A. Determine whether the patient suffers from a “debilitating medical condition.” If the patient does not qualify this should be documented in the patient’s chart.
 - B. If they do suffer from a debilitating medical condition, document that fact in the patient’s chart.
 - C. Determine whether the use of medical marijuana “may mitigate symptoms or effects of the person’s debilitating medical condition.” If you tell the patient that its use may not mitigate symptoms or effects, then this should be documented in the patient’s chart.
 - D. If you tell the patient that “use of medical marijuana may mitigate symptoms or effects”, document that this conversation occurred in the patient’s chart.

When Patients Want to Use Marijuana for Medical Purposes
Page three

- E. Perform a PARQ conference and document it in the patient’s chart.
- III. Physicians SHOULD AVOID any of the following:
- A. AVOID providing your patients with information about where they can obtain medical marijuana.
 - B. AVOID talking with anyone by telephone or in person who offers to help your patient obtain marijuana.
 - C. AVOID writing anything in support of the patient’s desire for medical marijuana other than that the patient suffers a “debilitating medical condition” and that “medical use of marijuana may mitigate symptoms and effects...”
 - D. AVOID writing anywhere but in the patient’s chart. This means not supplying the patient with a letter or form signed by the physician.
 - E. ABOVE ALL AVOID writing this information on a prescription.

As long as the discussions and documentation concerning the use of medical marijuana occur just between a physician and a patient in a medical office setting and the information conveyed is no more than that which is required to fulfill the physician’s part in the patient’s process of gaining exemption from criminal prosecution, OMA believes that the risk of federal intervention is minimized. This is because the foregoing actions are consistent with traditional physician functions of diagnosing, and documenting advice and counsel. They also meet the definition of the law’s requirement of “written documentation” of the patient’s debilitating medical condition. At the same time they are inconsistent with the actions described in the federal government’s letter to the California Medical Association. However, unless and until the federal government provides OMA with a response to its March 8, 1999 letter seeking clarification of the government’s position on Oregon’s law, no physician is fully protected.

(Adopted by the Oregon Medical Association House of Delegates, April 25, 1999)

CANNABIS (MARIJUANA) PATIENT DRUG INFORMATION SHEET

Patient Name: _____ **Date:** _____

Dosage: _____

NOTE: Cannabis is classified under Schedule 1 of the Federal Controlled Substances Act. It is prohibited from use, possession, or cultivation by federal law.

Cannabis is the botanical name for the plant made of 2 main strains: *indica* and *sativa* both known for intoxicating or euphoric effects. Cannabis is a woody, annual, dioecious plant which grows outdoors in many countries and is also prized for pulp (called hemp). Cannabis seeds are a valuable nutritional substance containing many beneficial nutritional supplements. Other names for cannabis include Indian Hemp, Marijuana, marihuana, bhang, reefer, ganja, and bud.

Indications: Cannabis has been used for centuries as a medicine for a long list of ailments. More recent research has shown several beneficial medical effects including:

- *intraocular pressure reducing effects benefiting those with glaucoma;*
- *appetite stimulant effects in those suffering from nausea or wasting syndrome;*
- *antiemetic effects in people undergoing chemotherapy or radiation;*
- *anti spasmodic effects in those experiencing muscle spasms or diseases like multiple sclerosis;*
- *analgesic effects which interrupt receptor nerve impulse transmission of pain signals at the location of injury.*

Side effects: Most common side-effects include increased heart rate dry mouth, somnolence, euphoria. Less common include panic symptoms, hyperventilation. There is scant evidence of dosage-related mortality.

Contraindications: Use not recommended if patient has liver failure, substance dependence issues, cardiac function abnormalities like angina, or respiratory disease like COPD. (Due to inhaling as the route.)

Route: Cannabis can be inhaled (smoked) eaten as liquid or food, elixir or via the rectal route as a suppository. It is smoked in pipes or rolled into cigarette papers, called joints. Pipes deliver a higher level of cannabinoids in relation to combustion by products. Smoking irritates lungs and bronchial mucosa. Eating in food slows absorption and effect making it more difficult to titrate dosage. Wait 2-3 hours after eating. Eating requires double or triple dosage to smoking due to stomach acid metabolism. Eating not indicated for anti-nausea effects. Can be baked in food with moderate loss of potency. Effects are route dependent due to differential metabolism.

Dosage: 3-6 mg by mouth, 2-4 if smoked, (50 mcg/10 kg). Higher cannabinoid content reduces dosage requirements.

Onset/Duration: Inhaling: onset is 2-10 minutes, peak blood level 30 minutes, duration 1-3 hours

Eating: onset is 1 1/2 - 3 hours, peak blood level 2 hours, effective duration 4-6 hours.

Patient teaching: Teach patient to carefully “titrate” dosage of any unknown variety by using small dosage until therapeutic effects are quantifiable. Inspect all cannabis for bugs, debris, or infections like mold. Discard contaminated cannabis. Baking cannabis in oven at 200 degrees for 15 minutes will kill pathogens. Use in conducive “set” and “setting,” —relaxed, safe and comfortable surroundings.

DO NOT operate machinery or automobiles immediately after using cannabis.

Naive users may experience panic symptoms—racing heart and increased anxiety. Treat by drinking 20 oz. of water. Reassure and pay attention to heart rate. Panic symptoms subside in 1-2 hours. Do not use alcohol concurrently with cannabis due to additive effects.

Use smallest effective dose especially with unknown varieties. Eating or inhaling the same variety may result in substantially different effects. Many states have passed laws eliminating criminal and civil sanctions on ill people who use cannabis. These include: Alaska, Washington, Oregon, California and Arizona. Be aware that cannabis use, cultivation and possession remain illegal under federal Law. As with all medicines keep out of the reach of children. Report effects to your health care provider.

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OREGON MEDICAL MARIJUANA ACT-

Designated Primary Caregiver Agreement

NOTE: This document describes an agreement between two people. The “patient” is a person legally authorized under the OMMA to use, possess, transport and grow cannabis for the amelioration of “debilitating medical conditions” and possess a certificate to do so (called a “registry identification card”) issued by the Oregon Health Division. The “Designated Primary Caregiver” is a person who is engaged by the patient to cultivate, possess, deliver and assist the patient with his or her use of cannabis. The caregiver is also issued a certificate by the Oregon Health Division.

There is one critical element, which must exist for this sensitive relationship to work: trust. Each party must enter into the agreement with honest intentions. The caregiver is expected, and required to produce cannabis *at no cost* to the patient. The patient must understand the practical limitations of the law, which may mean that the caregiver is unable to supply the patient’s entire needs.

Termination of Agreement

Each person agreeing to participate in this arrangement acknowledges and understands that either person, for any reason may terminate the DPC/ patient relationship, if the Oregon Health Division and other party are notified. Termination of this arrangement shall require the DPC to return his/her registry identification card to the Oregon Health Division as required by law. Neither person is required to give a reason for withdrawing. No further obligations are required or implied upon termination of the contract.

Liability Release

Each person agrees to hold the other person blameless and without legal or medical liability for individual actions which may result in legal or other problems, so long as those actions are undertaken as a good faith effort to protect the health and safety of the patient consistent with the purposes and protections of the OMMA. It is understood by all parties that the Federal government prohibition of cannabis represents a risk to those who participate in the Oregon Health Division Medical Marijuana Registry Program.

Confidentiality

Each person involved in this agreement pledges to guard the identity of the other and not make public statements or disclosures about actions or behaviors of the other without consent, or unless required to do so by court order or subpoena. Furthermore, each person represents that he/she is not a member of or acting under the direction, control or instance of any law-enforcement agency, and that participation in this agreement is in no way connected to any law-enforcement operations, undercover or otherwise, through local, county, state or federal law-enforcement agencies. Caregivers are also forbidden by Oregon law to divulge sensitive and confidential medical information concerning the patient without proper written authorization.

OMMA caregiver agreement page 2

(Patient complete below)

I, _____ hereby give permission to: _____, to grow, possess, and transport cannabis for my medical use. I am in possession of a legally obtained Medical Marijuana Program registry identification card issued by the Oregon Health Division. I understand that this agreement represents a good faith effort on the part of my designated primary caregiver to produce sufficient quantities of cannabis for my medical use, but understand and acknowledge that my designated primary caregiver may not be able to supply my entire needs.

Furthermore, I release my designated primary caregiver from any and all liability for medical or legal problems which may occur to me as a result of my use of the cannabis I am supplied with, as long as he or she has made a good faith effort to adhere to the provisions of the OMMA and protect my health and safety.

I have read, understand and agree to comply with the above statements.

(Designated primary caregiver complete below)

I, _____ hereby give permission to _____, to register me as a "designated primary caregiver" with the Oregon Health Division's Medical Marijuana Program. I agree to follow all provisions of the Oregon Medical Marijuana Act. I will not request nor expect compensation in any form from the patient for the cannabis I supply. I also will not divert cannabis to any other person without the patient's permission. I further acknowledge that I will make reasonable efforts to ensure the purity and safety of all cannabis I supply to the patient.

I have read, understand and agree to comply with the above statements.

If agreement is invoked in State other than Oregon please note here:

Patient Signature: _____ Date: _____

DPC Signature: _____ Date: _____

Registrant Card Number: _____ Caregiver Card Number: _____

Copies: Patient, DPC

Copyright: Edward Glick RN, Contigo-Connmigo- 1999. Form may be reproduced and used by any patient or Designated Primary Caregiver who is in possession of a valid Registry Identification Card issued by the Oregon Health Division, or another states' valid registry identification card. All other reproduction prohibited without consent of author. Form may be downloaded at: www.or-coast.net/contigo

Oregon Medical Marijuana Act Anonymous
Renewal Questionnaire

Instructions: All medical systems (should) incorporate follow-up information collection in order to improve quality. The Oregon Health Division is no different. Completing this brief survey will assist the Division to document the value of the Medical Marijuana Program and improve its services to you, the patient. Complete and send this survey to the address below. Or, if you are reading the Internet edition, just click on the e-mail link below for easy transmittal to Contigo-Connigo. Use the back of the page to describe any issues. If you are willing to meet with media representatives, write your name in the space provided. Otherwise, do not write your name. Copies of all surveys will be forwarded to the Oregon Health Division. Any confidential information you provide will be protected. Thank-You.

Date: _____ Age: _____ Card Number: _____ Sex: M/F

1. What disease/symptom are you registered for?
2. How does cannabis help you?
3. Do you know the variety of cannabis you use? Identify:
4. How many times a day do you use cannabis?
5. Do you smoke or eat it? How much?
6. Do you have enough to meet your needs?
7. Have you had any theft of your medicine or plants? (Please describe)
8. Have you been contacted by law-enforcement officers?
9. If "yes", were you treated fairly?
10. Has your use of cannabis changed your use of other medications?
11. Have you noticed problems from using cannabis? (Please describe)
12. Is the \$150 fee a hardship for you?
13. Do you have a designated primary caregiver?
14. Is your doctor supportive of your cannabis use?
15. How can the Medical Marijuana Program better meet your needs?

If you are willing to occasionally meet with media representatives for interviews please print your name here: _____

(Oregon Health Division Staff will contact you before passing on your name.)

**E-mail link: gina@proaxis.com. U.S.Mail: Edward Glick, RN/39234 Hwy 99W
Monmouth, OR/97361**

NOTICE

These premises are permitted to grow medical cannabis in compliance with **Oregon Medical Marijuana Act** under the statutory authority of a permit issued for the production and possession of cannabis for medical uses by the Oregon Health Division.

Law enforcement personnel and others are hereby advised that the presence of cannabis plants under these circumstances does not constitute probable cause for any entry made upon these premises or application for warrants made for the purpose of searches or the removal of plants or other materials. You are advised to contact the Oregon Health Division at 503-731-4011, ext. 640, to verify this permit and the authorized holder's name and address.



OREGON HEALTH DIVISION

Medical Marijuana Program
800 N.E. Oregon Street
Portland, Oregon 97232

Permit No. _____ Issued to: _____ Date: _____

MEDICAL CANNABIS

For medical use only.



NAME: _____

DATE: _____

MEDICAL CANNABIS

For medical use only.



NAME: _____

DATE: _____

MEDICAL CANNABIS

For medical use only.



NAME: _____

DATE: _____

MEDICAL CANNABIS

For medical use only.



NAME: _____

DATE: _____

MEDICAL CANNABIS

For medical use only.



NAME: _____

DATE: _____

MEDICAL CANNABIS

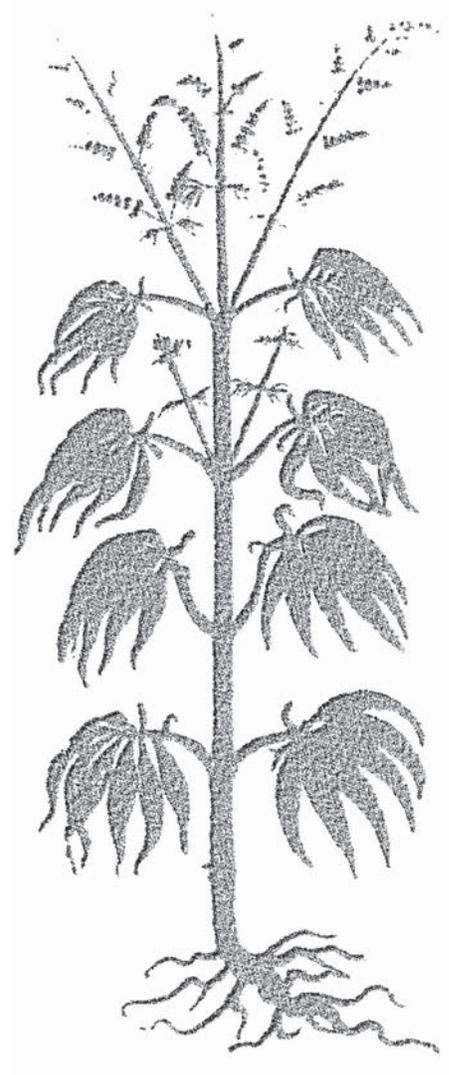
For medical use only.



NAME: _____

DATE: _____

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