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A Day in the Life of a Cannabis Consultant

By Philip A. Denney, M.D.

Ah! Southern California, another day of glorious sunshine. I'm up early and at the office before 8 a.m. for what promises to be a busy day. We've scheduled 32 patients but expect our usual 20% dropout rate. Unfortunately, many people remain frightened about getting a physician's approval to medicate with cannabis. They summon the courage to make an appointment, then get cold feet.

The phone starts ringing before I've finished making tea. An appeals attorney requests a letter to a judge regarding a patient's use of cannabis while on probation. This turns out to be a complicated case that will require me to confront the bias of law enforcement. I agree to write a letter. The day has officially begun!

The next call is from a patient requesting help convincing his workers compensation carrier to continue paying for his cannabis. Again, a very complex issue and again I agree to write a letter.

My staff arrives with their usual energy and good humor, the office comes alive with focused activity. I return a phone call from a patient with questions she had meant to ask during her recent visit —could her chronic fatigue be the result of Toxoplasmosis caught from her cat? I sensed that she, like many patients, is not comfortble with her diagnosis and is anxious to find something "curable."

I also return a call from a patient with questions about how much concentrated cannabis he is allowed to possess. This is another complicated topic with no easy answers. We discuss the issue for a few minutes and I give him some names and numbers of knowledgeable attorneys.

The medical office of Denney & Sullivan (I alternate weeks with my partner, Robert Sullivan, M.D.) is in a business park in suburban Orange County. There's a waiting/reception area, two examining rooms and an office where we keep our records and I can talk on the phone and do paperwork. The examining rooms have a desk, chairs for the patients, an examination table, a blood pressure cuff, otoscope, tongue blades, etc., the standard equipment you'd find in most doctor's offices.

We begin the exam by greeting the patient and taking a medical history-which can be straightforward or extensive depending on the circumstances and whether it's a new or established patient. New patients get a review of systems and complete family history and social history. Those who have the most obvious problems are the easiest to evaluate.

We do a head-to-toe physical exam. In most cases this can be fairly rapid: we observe behavior and mental status, look in the ears, eyes, and throat, we palpate the neck, we listen to the lungs, we listen to the heart, we check for enlarged lymph nodes, check the reflexes and balance. We ask patients to stand, squat, walk on heels and toes, and so forth. We do a more focused exam if the complaint calls for one.

***Photos by A. Peri** are used with permission of patients and not juxtaposed to their descriptions.*

For example, if someone has a complaint of carpal tunnel syndrome, we would look for neurological evidence of that.

The vignettes that follow briefly summarize my interaction with patients on an unexceptional Monday in March of this year.

He prefers cannabis to narcotics: "I hate how the pills make me feel."

The first patient is Mr. C.M., a 51-year-old construction superintendent, who has a history of chronic back pain following four failed spinal surgeries resulting in a multilevel fusion. He prefers cannabis to narcotics: "I hate how the pills make me feel." He uses about one quarter ounce per week.

Ms. S.M., the next patient, is a 21-year-old retail clerk who continues using cannabis for her Bipolar Affective Disorder. She reports great success with cannabis and has been able to eliminate all of her psychotropic medications. Her dose is stable at one quarter ounce per week. Her affect and mood are normal, she looks healthier than she did on her previous visit; she is happier.

I'm reminded that the privilege of being a physician comes with the daunting task of staying current.

Mr. Z.R. is a 44-year-old research technician who uses cannabis for chronic low back pain secondary to Degenerative Disc Disease. He uses one quarter ounce per week and reports that cannabis allows him to reduce his narcotic use by at least one half.

Mr. B. S. is a 53-year-old musician who suffers from Chronic Gastritis resulting from radiation treatment of a gastric lymphoma. He reports that cannabis not only helps his abdominal pain but stimulates his appetite as well. He uses one half ounce per week and happily reports being able to discontinue all narcotics.

Mr. S.J. is a 30-year-old cashier who uses cannabis to successfully treat a generalized anxiety disorder and insomnia. He uses one quarter ounce/week and prefers cannabis to Xanax which made him feel "hung over."

Mr. G.G. is a 50-year-old boilermaker with long-term Cluster Headache and neck pain following a work accident. He uses one ounce of cannabis per week for pain and sleep and states that regular cannabis use decreases the frequency of headache. We spend a long time discussing the potential risks of anabolic steroid use for body-building.

I'm reminded that the privilege of being a physician comes with the daunting task of staying current. I'm still a family doctor and even in my new specialty practice, am often called upon to discuss a wide variety of healthcare concerns.

I'm now 20 minutes behind schedule. I pause to take a call from a distraught mother whose disabled son (our patient) has been arrested on methamphetamine charges. He claims it wasn't his.

The next patient is Ms. N.A., a 23-year-old retail manager who uses cannabis for chronic right knee pain following an Anterior Cruciate ligament repair. She uses one eighth ounce per week primarily for sleep and much prefers it to previously prescribed narcotics. (Are we beginning to see a pattern here?)

Mr. L.L. is a 26 year old construction engineer with chronic mid-back pain following multiple spinous process fractures and chronic anxiety. He uses one quarter ounce per week for pain and sleep and also finds that cannabis eliminates the need for narcotics.

Mr. S.J. is a 50-year-old pressman who uses cannabis for chronic bilateral knee pain following multiple surgeries for Anterior Cruciate ligament repair. Mr. J uses cannabis orally by making "tea." We discuss the relative inefficiency of his method for extracting cannabinoids but he is very happy with the results and states that a single dose provides long-term relief!

Mr. C.P. is a 24-year-old importer who sustained a complex facial injury at age 17. He underwent orbital reconstruction and is left with daily headaches for which he has previously been prescribed a wide variety of pain meications. He uses one quarter ounce of cannabis per week and only has to use narcotics "occasionally."

Mr. B.M. is a 53-year-old stage manager with Chronic Migraine Headache since his teens. He finds he must use cannabis as soon as possible after symptoms begin in order for it to be effective. If he waits too long "it doesn't work." He also reports that regular use of small amounts of cannabis significantly reduces the frequency of headache. (These findings are very consistent with reports from most other migraine sufferers who use cannabis.) He uses no other medication.

It is now noon. If I hustle, I may get lunch.

Mr. H.J. is a 23-year-old telecommunications computer consultant who has a history of Chronic Hematemesis (vomiting blood) with abdominal pain and weight loss. Despite an extensive evaluation by his primary care doctor, no cause could be found and he was told it was "stress." Mr. H.J. finds cannabis to be very helpful to decrease pain and nausea and to increase appetite. He uses one ounce per week and claims it is far superior to any other medication he has used.

Ms. B.M. is a 44 year old homemaker with a long term diagnosis of Myasthenia Gravis. She continues to use one half ounce per week of cannabis to treat a tremor. The tremor is related to her use of Mestinon, the medication used to treat her disease. We discuss the emotional impact of her disease and I'm uplifted by her positive attitude.

While I was with the previous patient a process server arrived to serve a subpoena. He was angry that my staff would not interrupt me and apparently made some disparaging comments. He was asked to leave and did so reluctantly when the patients in the waiting room offered to help him find the door.

I grab a second cup of tea and return

two calls —one to an attorney regarding my expert testimony in a Ventura County marijuana case, and one to a Medical Review Officer to discuss the urine-drug-test results of a patient. I carefully explained that under California law, a qualified patient has the right to use cannabis and therefore the test is and should be read as negative for illegal drugs. This is a difficult concept for the drug testing industry to accept.

A medical review officer is a physician hired by an employer to determine whether a drug screen is positive or negative for an illegal drug. For example, if a patient was taking a prescribed narcotic pain medication —Vicodin, for example— the lab would find opiates in the specifment and can't tell if they are there legally or illegally. Enter the trusty MRO, who calls the patient for clarification. If the patient can prove a legitimate prescriptiion, the drug test if resported as "negative" for

continued below

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illegal drugs.

This is exactly what should happen if patients have physicians' approval for medical cannabis use. Unfortunately, this remains a significant problem because most MROs especially those outside of California, refuse to accept California law, instead citing the federal position that cannabis has no legitimate use.

MROs and the drug-testing industry need as many positive tests as possible to justify their position that the American way of life is at risk because of rampant, illegal drug use. To combat this evil, they must test everyone from unborn babies to residents of nursing homes. Cannabis is the perfect answer to their prayers because it is widely used and is easily detectable for many weeks.

Mr. B.J. is a 51-year-old chauffeur who uses cannabis for chronic upper back pain. He denies specific trauma but his x-rays show severe degenerative changes with bone loss. He is encouraged to ask his physician for specialty referral. Again, I note that cannabis allows Mr. J to use no prescription pain medication.

Mr. P.G. is a 52-year-old decorator with a complex injury to the right knee and a 30-year history of heroin addiction. He has used cannabis very successfully to manage pain and to maintain longterm abstinence. He uses up to two ounces per week and denies any adverse effects. I literally applaud patients who are recovering from destructive addictions. P.G. describes the struggles he's had and we're both moved to tears. I have doubts I would be as successful overcoming such difficulties... My patients continue to teach me humility. Hearing their stories is one of the great privileges of being a doctor, and not a day goes by that I don't hear one that moves me deeply.

My receptionist has ordered lunch from Ameci's, a nearby restaurant. Between bites of a killer calzone, I speak with a patient who had his recommendation seized by the police (I'll issue a duplicate) and a probation officer regarding the use of cannabis while under court supervision. She was pleasant enough, but despite my diligent effort to explain that cannabis use is legal under California law, even under court supervision, she wasn't getting the message. I promised to write her my thoughts on the subject.

There would be no need for practices such as ours if mainstream physicians understood the safety and efficacy of cannabis and were unintimidated by law enforcement.

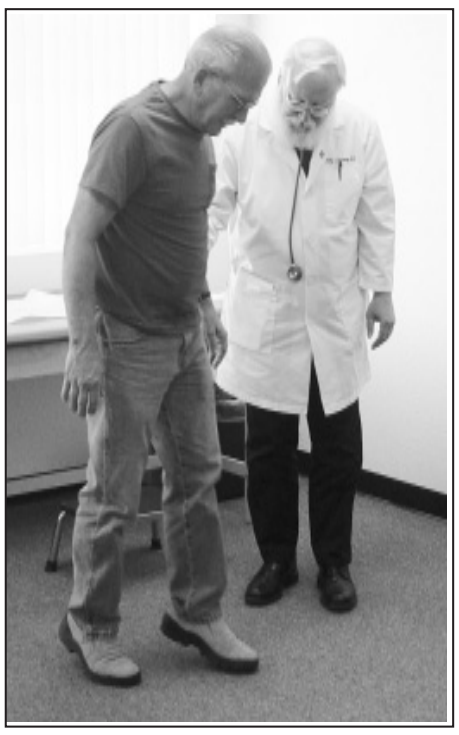
Back to work!

Mr. A.M. is a 40-year-old chef with Chronic Atrial Fibrillation. He is on multiple cardiac medications which cause insomnia. He uses one quarter ounce per week of cannabis for sleep, which works well. His cardiologist approves his use of cannabis but won't write a recommendation —a common situation, unfortunately. There would be no need for practices such as ours if mainstream physicians understood the safety and efficacy of cannabis and were unintimidated by law enforcement.

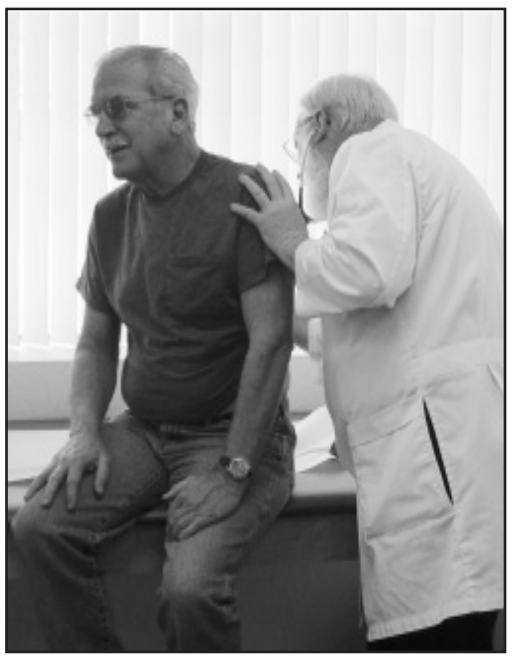
Ms. G.C. is a 42-year-old oncology nurse who uses cannabis for chronic nausea. She has had access to every anti-emetic available and states that cannabis "works better than anything." She is chagrined that she didn't use cannabis sooner despite her cancer patients' insistence that she try it.

Doesn't that say it all?

Mr. M.T. is a 59-year-old old disabled by Parkinson's Disease. He continues to use cannabis for muscle spasm particularly at night. I'm impressed once again by our patients' grace and dignity in the face of devastating illness. He uses one eighth ounce per week of cannabis because it is all he can afford. How sad that the war on drugs supports the high price for an herb that now costs more than gold!



Mr. K.L. is a 56-year-old old disabled human resources manager with long term PTSD and panic disorder. He uses one half ounce per week of cannabis for anxiety and to help him sleep. He also uses Xanax and Klonopin. A considerable amount of time was spent discussing the use of cannabis in light of documented Coronary Artery Disease and tobacco use. I told him it made no sense for him to smoke anything and that nicotine addiction and heart disease made it uncomfortable for me to approve his cannabis use. We discussed tobacco cessation and set a stop date. He agreed to use cannabis by vaporization and to call me with his progress. The risk/benefit analysis is difficult in these situations, however I feel strongly that the risk of imprisonment is higher than the risk of cannabis.



Mr. K.B. is a 24-year-old photographer whose records doument long-term Tourette's Syndrome. He continues to use cannabis, one half ounce per week in foods. "Cannabis allows me to lead a normal life." Such a simple statement yet so profound! I continue to be impressed by how effective cannabis is in treating Tourette's Syndrome. It's a rare condition, I've seen at most 10 patients, but they all tell me essentially the same thing: "Cannabis allows me to lead a normal life."

Mr. R.C. is a 55-year-old insurance broker who continues cannabis for chronic neck pain following a complex fracture with multilevel fusion. He uses one quarter ounce per week, no narcotics. He continues to surf regularly.

Mr. G.R. is a 30-year-old student who uses cannabis for chronic right knee pain following ACL repair. (The tendon graft site is very painful.) He uses one ounce per week without problems.

Ms. C.L. is a 41-year-old disabled dental technician who sustained multiple spinal fractures in a boating accident (T-11, T-12 and L-1). She uses cannabis for pain and has been able to stop all narcotics. She notes marked improvement in quality of life.

More phone calls! I speak with a pain management physician who wants to refer patients and to a union attorney about drug testing issues.

A second process server arrives, this time more friendly and gives me the papers with a smile. This starts a familiar routine that wastes an enormous amount of my time. I find dealing with the legal system the most stressful part of my practice. I testify frequently in court and lose sleep, hair and stomach lining each time.

The last patient of the day has arrived —Ms. C.A. a disabled 59-year-old truck driver who continues cannabis for Fibromyalgia. Her dose is stable at one ounce pre week and she states she doesn't know what she would to without it. We talk trucks, my favorite subject.

All in all, a typical day. We saw 24 patients over the course of nine and a half hours (approximately 24 minutes per patient).

A few more phone calls regarding cannabis growing guidelines, police searches, lost recommendations and, last but not least, a person who wanted to get in the "cannabis dispensing" business. I told her I was not involved with dispensaries and recommended she hire a good attorney.

All in all, a typical day. We saw 24 patients over the course of nine and a half hours (approximately 24 minutes per patient). Eighteen were male, 6 were female. Thirteen were new patients and there were 11 renewals. The average age was 41.7 years and the most common diagnosis was chronic pain (14 of 24). As usual there were a wide variety of other diagnoses including Lymphoma, Tourette's, PTSD, Myesthenia Gravis, Parkinson's Disease, Heroin addiction, Fibromyalgia and panic disorder. It's 6:15 by the time I finish my notes, do the accounting and head for our apartment at the beach.

More fun tomorrow!