"Democracy needs the facts" —George Seldes

O'Shaughnessy's

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Encouraged by 9th Circuit's *Conant* Ruling, More California Doctors Approve Cannabis Use

Orange County Gets a Medical Group Specializing in Cannabis Evaluations

By Fred Gardner

Since November 1996, California law has authorized physicians to recommend cannabis in the treatment of a wide range of serious medical conditions. As of Spring 2004, by *O'Shaughnessy's's* estimate, at least 100,000 patients have obtained physician approvals to do so.

We extrapolated from the number of Oregonians —more than 10,000— who had obtained physician approval as of Jan. 1, 2004. (The state of Oregon maintains a registry of medical marijuana users and physicians who authorize its use; California does not.)

Twelve doctors associated with the California Cannabis Research Medical Group—all but one from the northern part of the state— have issued approximately half of those approval letters.

Proprietors of dispensaries in Oakland and San Francisco report a marked increase in approvals issued by non-CCRMG doctors following a recent decision by the U.S. Supreme Court in the *Conant v. Walters* case.

Philip A. Denney, MD, calls the *Conant* decision "a key factor" in his decision to open an office in Orange County.

The background

In December 1996 Drug Czar Barry McCaffrey and other federal officials threatened to revoke the prescription-writing licenses of California doctors who discuss cannabis as a treatment option with their patients.

UCSF AIDS specialist Marcus Conant, MD, and co-plaintiffs immediately sought an injunction to prevent the government from carrying out the threat.

"The war on drugs has become the war on physicians," said co-plaintiff Virginia Cafaro, MD. But the tide was about to turn with respect to cannabis.

In April 1997 federal judge Fern Smith issued a temporary injunction protecting Conant and his fellow physicians from the federal threat. In 2000 federal judge William Alsup made the injunction permanent.

After the Bush Administration challenged the injunction, the 9th Circuit U.S. Court of Appeals upheld it in on First Amendment grounds: a doctor and patient discussing the medical use of marijuana, the Court ruled, are exercising a constitutional right to free speech.

In October 2003 the U.S. Supreme Court declined to review the 9th Circuit decision. The permanent injunction became more permanent. [And isn't it just like The Man to go around calling his evanescent institutions "permanent?"]

Denney to Orange County

On Feb. 9, Philip A. Denney, MD—who formerly practiced in Loomis, a town East of Sacramento— started seeing patients at a "cannabis evaluation practice" in Lake Forest, a city at the intersection of Freeways 5 and 405 in Orange County.

If the demand for cannabis consultants in Southern California is as great as Denney anticipates, he hopes to interest other physicians in the new specialty, which he defines as "determining whether a patient has a serious medical condition that could be treated safely and beneficially with cannabis."

Denney recruited Robert E. Sullivan, MD, a former associate in Sacramento, to join him in Orange County.

Denney says that even 100,000 patients represents "a very small subset of the population that could be helped by cannabis if knowledgeable doctors were available throughout the state."

Denney says that "even 100,000 patients" estimated to have used cannabis medicinally in California "represents a very small subset of the population that could be helped by cannabis if knowledgeable doctors were available throughout the state."

For most of his 27-year career Denney was a family practitioner. In the late 1990s, having become aware that doctors who approved cannabis in treating conditions other than AIDS or cancer were few and far between, he began studying the available medical literature and corresponding with specialists in the field.

In January, 1999, Denney opened an office in Loomis, specializing in cannabis evaluations.

"It was obvious when we had our practice in Loomis," says Denney (the 'we' refers to his wife Latitia, who manages his office), "and people kept showing up from all 58 counties, that there was a tremendous need and demand throughout the state."

A related need, according to Denney, is for a continuing medical education course that would bring California doctors up to speed on a subject they learned nothing about in Medical School.

Retreat, Advance

By the fall of 2002 Denney had approved cannabis use by some 8,000 patients and decided he would take early

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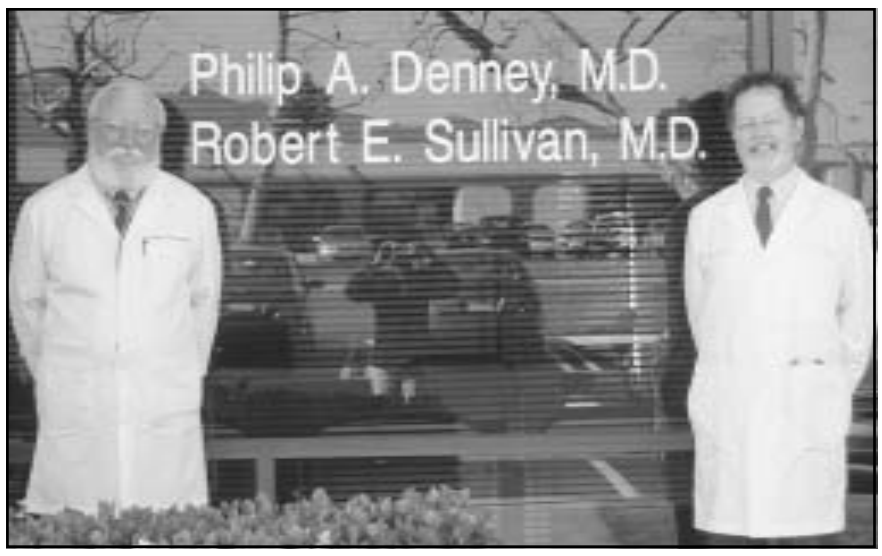
Behind the Orange Curtain



DOCTORS DENNEY AND SULLIVAN outside their office in Lake Forest on Feb. 9, 2004, the day they launched their practice. PHOTO BY LATITIA DENNEY

USC Keck School of Medicine Takes the Lead

Cannabis in the Curriculum

"Any pain-management training that does not have information about cannabis is committing malpractice." —Claudia Jensen, MD

On Feb. 13 students and faculty from the University of Southern California Keck School of Medicine put on a half-day program devoted to the clinical uses of cannabis and the relevant pharmacology. Some 30 first- and second-year medical students attended the history-making event in McKibben Hall, which was organized by Rolando Tringale, a second-year medical student, and Claudia Jensen, MD, a Ventura pediatrician who is an Instructor in the Department of Family Medicine.

Rolando Tringale, a 2nd-year student at USC Keck School of Medicine, helped organize Jensen's course on the medical uses of cannabis.

Jensen teaches "Introduction to Clinical Medicine," in which first-year students learn how to take a patient's history and conduct a physical exam.

Since the Fall semester of 2001 Jensen has spent a full day in the ICM class talking about cannabis and bringing in patients for students to interview.

"They're open-minded and well educated," she says of her students. "And they actually go on to teach their colleagues the truth about cannabis. That's why Rolando wanted to do this presentation." (Tringale had taken Jensen's ICM class last year.)

The Feb. 13 program started with first-person accounts from patients. Jensen had invited Ishmael Gayes, "a paraplegic —a very beautiful, intelligent, spiritual black man who was shot in the back over a woman when he was 17;" chronic pain patient Lisa Cordova Schwarz, LVN; and glaucoma patient Jim Carberry. Bill Britt, an activist from Long Beach who has post-polio syndrome and epilepsy, also described his use of cannabis.

Joseph Miller, PhD, Associate Professor of Cell and Neurobiology, discussed the pharmacology and biochemistry of the body's own cannabinoid receptor system, which is activated by THC and other compounds in the plant.

Miller's research has been funded over the years by the National Institute on Drug Abuse (NIDA). "He's not a medical marijuana proponent," says Jensen,"he's not in the movement. He's just an honest man with a balanced, truthful perspective about drugs who was willing to be a speaker."

Associate Professor of Psychology Mitch Earleywine, PhD, discussed the question of safety. Earleywine, the author of *"Understanding Marijuana"* (Oxford, 2002), said that medical users could minimize negative consequences by vaporizing instead of smoking. Earleywine also advocates "keeping dosage at a level that relieves symptoms but doesn't create any impairment" and "monitoring for any signs of craving that might indicate tolerance or withdrawal."

Earleywine has found that "the people who run into dependence problems with cannabis are the ones who are drinking a lot of alcohol." He recommends that medical cannabis users avoid alcohol consumption.

Attorney William Logan explained Proposition 215 —now California's

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Medical School Class *from page one*

Health & Safety Code Section 11362.5— and recounted the court rulings that affect its implementation.

Jensen's talk —"Integration of Cannabis Treatment into the Practice of Medicine," a version of what she teaches the first-year students— delved into questions such as:

• How do you tailor a history and physical to a medical marijuana patient?

• What dose and strain and route of administration should a patient use?

She also discussed "the advantages and disadvantages of having medical marijuana patients in your practice."

Jensen's Approach

Regarding dose and route of administration, Jensen says, "I make a decision based on what their medical problem is, the duration of the effect that they need, the strength of the effect that they need, and the quality of the effect that they need. And then I advise them what to use based on what other patients have taught me. One of the biggest problems is that I'm not getting this information from scientific sources, I'm trusting the patients. This is a unique field of medicine, where the doctors are actually learning from the patients.

"Instead of relying on data from placebo-controlled, double-blind clinical trials conducted in some far-off academic ivory tower, it's from talking to the patients and finding out what they do and how does that work?

"It's folk medicine with a trained listener who applies principles of science. Basically, I'm doing my own studies."

Indica or Sativa?

Jensen regrets that California physicians have no way of analyzing the actual cannabinoid content of the various strains patients are using. "Based on what I've learned from patients," says Jensen, "The Indicas seem to be better for pain, for insomnia and to calm their nerves. The Sativas seem to work better to elevate mood and energy levels. But I see a higher incidence of patients who are nervous and have anxiety and rapid heart rate and also a high incidence of heartburn.

"I talk to them about how to pay attention to what they're using. I tell them, "don't just buy any street weed. Find out, what are you smoking? White widow? Chronic? Hindu Kush? Romulan? Know the name of it and try to develop your own quality control standards because we can't go to a textbook for that."

To Tell the Truth

"How many of you use marijuana?" Jensen asked. She says, "Probably seven students raised their hands. I told them 'I am very proud of you having the courage and the integrity to tell the truth, because that's what this conference is about.'" Jensen also asked how many had or knew somebody who had a condition treatable by cannabis. About 90% raised their hands.

Physicians can help patients overcome social ostracism and embarrassment, says Jensen. "When a physician takes responsibility for advising a patient on cannabis as a medication, it helps legitimize for the patient that what they're doing is okay."

Physicians themselves face ostracism for issuing cannabis approvals. "There's this unspoken attitude," says

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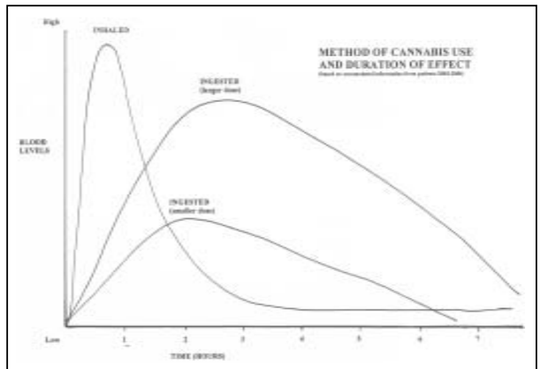


EFFECTS OF INHALING AND EATING CANNABIS are compared. Clinical effect (vertical scale) is based on reports from patients.

Dr. Jensen's Syllabus

Integration of Cannabis Treatment Into the Practice of Medicine

I. Why is it important to evaluate and treat patients with cannabis?

A. PATIENT ADVOCACY

1. Safety profile; efficacy; quality of life
2. Abandonment by healthcare providers
3. Social ostracism, embarassment
4. Legal jeopardy

B. THE PATIENTS NEED GUIDANCE

1. No standard of care in the community; cutting edge of medicine; need for physicians to gain education, wisdom
2. Patient population; medical issues are "serious;" neuropsychiatric consequences of cannabis use.

C. IT'S THE LAW!

II What are the disadvantages of treating with cannabis?

A. LEGAL JEOPARDY

1. Physician exposure
   a. Courage/focus of patient advoacy
   b. Medical Board of California
   c. Drug Enforcement Administration
   d. Social/Professional ostracism
   e. Recreational use
2. Trusting your patient —the only field in medicine where you are expected to distrust your patient.

B. INFORMATION VACUUM

(the only field in medicine where the patient routinely has more knowledge than the physician)

C. RESPONSIBILITY

1. Lots of paperwork
2. Patients may require legal support

III. Advantages of having cannabis patients

A. TO DO A *REAL* COMPLETE HISTORY AND PHYSICAL EXAM; NO NEED TO DEPEND ON THIRD-PARTY PAYERS (AT THIS TIME)

B. TO DEVELOP TRUSTING PATIENT RELATIONSHIPS

C. TO EDUCATE PATIENTS, COLLEAGUES, PUBLIC

D. TO IMPLEMENT SIGNIFICANT HEALTH CHANGES/ HEAL

E. A CHANCE TO *THINK AND LEARN*

IV. Implement Personal Standards of Care

A. LEARN HOW TO USE CANNABIS AS A MEDICATION

1. No instruction manual
   "Understanding Marijuana" by Mitch Earleywine, PhD;
   website of the Cannabis Research Medical Group (drtod@mikuriya.com)
2. Follow the law
3. Think. Adapt to your patient and yourself.
4. Develop an intake procedure that works for you.

B. CONDUCT A COMPLETE HISTORY AND PHYSICAL EXAMINATION

1. Chief complaint
2. History of the present illness —Pay particular attention to why the patient has chosen to use cannabis over other medications.
3. Past medical history —Be thorough with all the routine questions, plus:
   a) childhood
   b) Parenting, abuse
   c) Academic performance, hyperactivity
   d) Socialization
   e) Mental health
4. Review of Systems —Take the time to ask about each system, especially pulmonary and neuropsychiatric
5. Family history —Routine questions probably enough in most cases.
6. Social history —the most critical part of the history. Include all routine questions with additional focus on:
   a) Other substance use
   b) Legal encounters, arrests, incarcerations, jail time, parole, probation
   c) Support systems (spouse and children, especially)
   d) Disability
   e) Miliatry history
   f) Work history, employment
   g) Education
   h) Exercise, recreation
   i) Travel history
7. Physical Examination —May be complete physical exam or focused specialist exam
   a) General appearance
   b) Nutrition
   c) Hygiene
   d) Activity
   e) Attitude
   f) Level of consciousness
8. Data collection
   a) Medical records documenting medical condition
   b) Mental health records
   c) Legal/arrest record
   d) Laboratory (if appropriate)

V. Develop an Impression/Assessment

A. DOES THE PATIENT HAVE A SERIOUS MEDICAL PROBLEM?

Is the patient able to live a functional life without medication?

VI. Evaluate treatment options ("Plan")

A. HAS THE MEDICAL PROBLEM EVER BEEN SUCCESSFULLY TREATED WITH CANNABIS?

You must rely on anecdotal as well as scientific evidence because of the history of "scientific research" in the United States (not always factual: Cannabis is classified Schedule I, no known medical uses)

B. DOES THE "SAFETY/EFFICACY" RATIO WARRANT APPROVING CANNABIS?

C. IS CANNABIS COMPATIBLE WITH THE PATIENT'S OTHER MEDICATIONS?

D. CHOOSE A DELIVERY METHOD

1. Inhaled: shorter half-life, "higher" peak effects
   a) water pipe/ bong
   b) Pipe
   c) Joints
   d) Blunts
   e) Vaporizers
2. Ingested: longer half-life, more generalized well-being.
   a) Marinol (Solvay Pharmaceuticals)
   b)Fat-based food (brownies, "mother's milk," etc.)
   c) Sublingual tinctures, sugar-based drops
   d) Teas
   e) Candies
   f) Hash-oil meds
3. Compresses: topical administration

E. CHOOSE A CANNABIS STRAIN

1. *Cannabis sativa*
   a) Seems to work better with mood, energy, thinking problems (e.g., depression, attention deficit disorder, anorexia)
   b) Keeps patients awake at night
   c) Can increase anxiety, heart rate, heartburn
   d) More affordable
2. *Cannabis Indica*
   a) Superior with somatic disorders: Pain, insomnia, spasticity
   b) Outrageously expensive (more than gold per ounce)
3. Hybrids

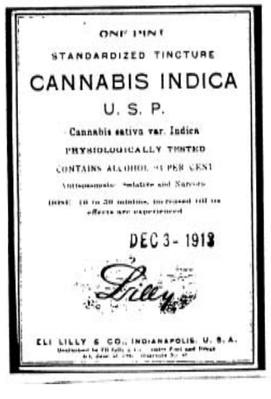
F. "CHOOSE" A DOSE (MOST PATIENTS HAVE ALREADY DONE THIS FOR YOU)

1. ADHD and chronic pain patients need the most medication (generally an ounce or more per week)
2. Insomnia, anxiety, nausea patients seem to need less (impossible to predict)
3. Most chronic pain and ADHD patients are grossly under-treated. Chronic pain patients may be able to wean off narcotics entirely.

G. ARRANGE FOLLOW-UP BASED ON THE PATIENT'S MEDICAL CONDITION/EXPERIENCE WITH CANNABIS.

VII Make a commitment

A. GIVE YOUR PATIENT A WRITTEN LETTER OF YOUR INTENT TO SUPPORT HIM/HER.



Med School Class *from previous page*

Jensen, "—'she's not a real doctor, she takes care of cannabis patients.' I'm the 'pot doc.' On the other hand, I get referrals from all the local doctors —psychiatrists and family medicine and oncology doctors sending me patients because they don't want to treat them."

Jensen thinks that many physicians who themselves use cannabis are "uncomfortable writing notes because they don't want to attract any attention to themselves. They don't want to take the chance because somebody might come and say 'Let's test your urine.' There is a significant proportion of physicians who smoke pot surreptitiously. They're afraid to write notes because they don't want to be in anybody's database. So, the whole thing boils down to patient advocacy vs. social ostracism. Cannabis-using physicians are afraid to come out of the closet. And it's really a problem—it's harmful to the patients."

Jensen laments the "information vacuum" in which clinicians monitor their patients' use of cannabis. "This is the only field of medicine where the patient routinely has more knowledge than the physician. As a scientist, that's a bitter pill to swallow. I can't go to a reference textbook. Where do you go for information on something that you're not allowed to have information on?"

Another disadvantage: lots of paperwork.

Jensen urges students to "remember what you went into medicine for is to be an advocate for patients. You have to have the courage to do that even if it's not socially acceptable."

She hopes that patients will "educate their famiy and friends —tell them the truth— so they can use this as medication without sneaking around in the back room."

Jensen had invited —after getting administrative approval to do so— Richard Davis, proprietor of the USA Hemp Museum, who brought samples of hash, hash oil and other cannabis-based products, as well as some plant strains (in jars), providing, for some of the students, a first exposure to the once-prohibited herb.

Jensen says that the USC administration has been supportive of her efforts to introduce cannabis into the curriculum. Althea Alexander, Clinical Instructor for Educational Affairs, attended the Feb. 13 conference and expressed gratitude to the patients who took part. Alexander regretted that the event had been scheduled for the getaway day of President's Day week-end; there would have been a much heavier turnout, she said, on an ordinary Friday.

"I don't think cannabis should be an elective. I think it should be required training."

Jensen hopes that next year the conference will be held in October, "when the students are freshest," and that it will be a requirement. (This year's was not offered for credit.) Jensen had an insight about "elective" classes when she was in med school at the start of the 1980s. "I took an elective on 'Sexual Desensitization' and the only students who went to it were the students who were comfortable with sexuality. All of the really up-tight people avoided it. So I don't think cannabis should be an elective. I think it should be required training."

CME class coming soon?

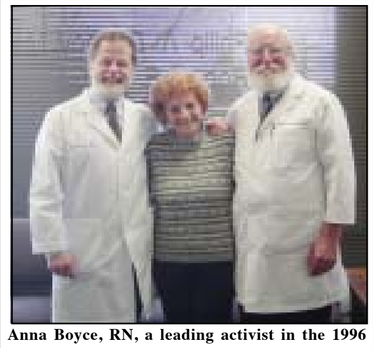
Jensen has also given thought to developing a continuing medical education program for physicians, none of whom learned a thing about cannabis in medical school. (Doctors are obligated to earn a certain number of CME credits annually.) She has proposed to the administration that USC offer a CME course on cannabis. Professor of Clinical Instruction Alan Abbott told her he was amenable and would look into possible funding.

Jensen thinks her colleagues in the medical profession will take steps to educate themselves on the subject of cannabis only when they are obligated to. And she has a strategy to obligate them. "The Medical Board of California has dictated that physicians have to take 12 hours in pain management in order to maintain their licensure. My position is that any pain management presentation that any physician takes is inadequate if it does not include discussion about cannabis and cannabis compounds. The Medical Board should take the position that cannabis teaching needs to be integrated into those pain management sessions that physicians are already required by law to attend."

Jensen is a pediatrician whose special interest is in cognitive function and development. She branched into treating adults as a result of her interest in cognition. She says that with every patient she tries to figure out "the habits that are keeping them sick."

Jensen spends an hour seeing each new patient. She learned recently that she is under investigation by the Medical Board for allegedly providing substandard care to three ADHD patients (whose cannabis use she approved).

Denney to Southern California *from page 1*



Anna Boyce, RN, a leading activist in the 1996 campaign to legalize marijuana for medical use, welcomes Sullivan and Denney to Orange County.

PHOTO BY LATITIA DENNEY

retirement. He transferred his practice (to William Turnipseed, MD) and devoted himself to reading, gardening, spending time with his family, and doing all the projects that needed doing on his hilltop spread in rural Greenwood. But Denney didn't entirely withdraw from the fray —he helped defend colleagues under attack by the Medical Board of California, and he kept abreast of the medical literature and cannabis-related political developments.

In May 2003 Denney appeared before the Board to protest the investigation of nine doctors specializing in cannabis consultations. "When you mention that nine investigations is a small number, you must consider the effect of those investigations on the rest of the physicians in California," Denney reminded the Board. "The sanction of even one physician will have a dramatic impact on the practices of all others." (Denney himself has never been investigated by the Board, a fact he attributes to the rigor with which he takes histories, reviews records, and conducts physical exams.)

"Patients come to a medical cannabis consultant seeking the answer to one specific question," Denney explained. "'Do I have a medical condition for which cannabis might be a useful treatment?'"

Denney also served as an expert witness in defense of Tod Mikuriya, MD —one of the cannabis specialists whom the Medical Board's Enforcement Division had chosen to prosecute. Denney reviewed the relevant files and testified that Mikuriya had elicited enough information in each case to justify approval of continued cannabis use. Mikuriya's practice should not be evaluated by the same standards as a conventional practice, Denney said. Prohibition had left the medical profession un-educated and frightened and law enforcement biased. "Patients come to a medical cannabis consultant seeking the answer to one specific question," Denney explained. "'Do I have a medical condition for which cannabis might be a useful treatment?'" Denney faulted the Board for not issuing guidelines relevant to such situations.

Denney calls the October 2003 decision by the U.S. Supreme Court to let stand the ruling in the *Conant v. Walters* case "tremendously encouraging." The right of doctors to discuss all treatment options with their patients is protected by the First Amendment. Federal authorities are permanently enjoined from threatening or punishing California physicians who approve cannabis use by their patients.

Denney says that "more than 95%" of the patients to whom he has issued approvals had been self-medicating with cannabis before consulting him.

Denney says that "more than 95%" of the patients to whom he has issued approvals had been self-medicating with cannabis before consulting him. The conditions with which they present, he estimates, are: chronic pain (50%); neurologic (20%); psychiatric, including ADHD and as a "harm reduction" substitute for alcohol (15%); gastro-intestinal (10%); other (5%).

Denney says none of his patients have reported serious adverse reactions or drug interactions. "Cannabis has been used medicinally for thousands of years," Denney says, "and has a remarkably benign side-effect profile."

Denney and Sullivan can be reached at 949-855-8845. Their new office is located at 22691 Lambert St. Suite 504, Lake Forest, CA 92630.

As we go to press…

Jensen Invited to Congressional Hearing

Claudia Jensen, MD, and Oregon osteopath Phil Leveque have been invited to appear before the House Government Reform Subcommittee on Criminal Justice, Drug Policy and Human Resources.

The Subcommittee is chaired by Rep. Mark Souder, an Indiana Republican who wrote the bill that cuts off financial aid from students convicted of "drug crimes" (including marijuana possession in high school). Souder's proudest accomplishment of 2003 was legislation reauthorizing the Drug Czar's office and its operations for five more years.

The Souder aide who's organizing the April 1 hearing says that the committee's interest in Jensen stemmed from an *L.A. Times* article that focused on her recommendation of cannabis for ADHD patients —including a teenager. Jensen's colleagues assume Souder's purpose is to show pro-cannabis clinicians in a bad light and to develop neo-prohibitionist legislation. Little bureaucrats from the Marijuana Policy Project are urging her (and Dr. Leveque) to decline the invitation to appear.

But Jensen says she relishes the chance to discuss the safety and efficacy of cannabis in the hallowed halls of Congress, and she is not reluctant to tell Rep. Souder about the teenager whose cannabis use she authorized.

She plans to bring her two daughters, ages 16 and 13, who have never seen Washington, D.C.