In November, 1996, California voters enacted Proposition 215, making it legal to grow and use cannabis, with a doctor’s approval, for medical purposes. Prop 215 didn’t create a record-keeping system because the authors didn’t trust the government and didn’t want to generate a master list of cannabis users. So, over the course of the past decade, a vast public health experiment has been conducted in California but no state agency has been tracking doctors who approve cannabis use or patients who medicate with it.

To assess the results in the absence of data garnered by the government, O’Shaughnessy’s surveyed doctors associated with the Society of Cannabis Clinicians. The SCC was founded by Tod Mikuriya, MD, in 2000 so that doctors monitoring their patients’ use of cannabis could share data for research purposes (and, alas, respond to threats from federal and state authorities). More than 20 doctors have attended SCC meetings, which are held quarterly. Philip A. Denney, MD, is the current president.

“Approve,” not “recommend,” is the apt term, since more than 95 percent of the patients consulting specialists had been self-medicating previously.

Twenty-one doctors with cannabis-oriented practices were interviewed briefly by phone in the Fall of 2006. Of these, 14 responded to an emailed questionnaire. (One responded on behalf of colleagues at nine offices.) Between them, physicians associated with the SCC have approved cannabis use by approximately 160,000 patients. “Approve,” not “recommend,” is the apt term, since more than 95 percent of the patients consulting specialists had been self-medicating previously.

**Survey Questions**

1. How many patients will have received your approval to use cannabis through October 2006?
2. What percentage had been self-medicating with cannabis prior to consulting you?
3. With what medical conditions have they presented? List top five and approximate percentage (total cannot exceed 100%).
4. What results do patients report? How does cannabis appear to work? Does it reduce or omit conventional medications?
5. What medications has cannabis enabled your patients to stop taking or cut back on?

**Physician Responses**

Tod Mikuriya, MD (Berkeley), was the first California doctor to specialize in cannabis consultations. In the early 1990s his interviews with members of the San Francisco Cannabis Buyers Club documented Dennis Peron’s observation that patients were using cannabis to treat a surprisingly wide range of medical problems. Mikuriya advocated extending legal protection to cannabis users treating “…any other illness for which marijuana provides relief.”

Approvals issued to date: 8,684.

Previously self-medicating: 99%

Cancer, i.e. use: Analgesic/immunomodulator 41%

Antispasmodic/anticonvulsant 29%

Antidepressant/Anti-anxiety 27%

Harm reduction substitute: 4%

Results reported are dependent on the condition and symptoms being treated. The primary benefit is control without toxicity for chronic pain and a wide array of chronic conditions. Control represents freedom from fear and oppression. Control — or lack thereof — is a major element in self-esteem.

With exception of control, with freedom from fear of incapacity, quality of life is improved. The ability to abort an incapacitating attack of migraine, asthma, chronic pain, and muscle spasms, improved appetite, and mental ease.

From many people with cancer and AIDS come reports that cannabis has saved their lives by giving them an appetite, the ability to keep down their medications, and mental ease. No other drug works like cannabis to reduce or eliminate pain without significant adverse effects. It evidently works on parts of the brain involving short-term memory and pain centers, enabling the patient to stop dwelling on pain. Cannabis helps with muscle relaxation, and it has an anti-inflammatory action. Patients with rheumatoid arthritis live better with cannabis than without.

Spasticity cannot be treated more quickly or efficiently than with cannabis.

Other rheumatic diseases similarly show remissions. Spasticity cannot be treated any more quickly or efficiently than with cannabis. Other, again, without significant adverse effects. Patients who suffer from migraines can reduce or omit conventional medi- cations as their headaches become less frequent and less severe.

About half of the patients with mood disorders find that they are adequately treated with cannabis alone while others reduce their need for other pharmaceuticals. In my opinion, there is no better drug for the treatment of anxiety disorders, brain trauma and post-concussion syndrome, ADD and ADHD, obsessive compulsive disorder, and post-traumatic stress disorder.

Patients with Crohn’s disease and ulcerative colitis are stabilized, usually with comfort and weight gain, while most are able to avoid use of steroids and other potent immunomodulator drugs. People who were formerly dependent on alcohol, opiates, amphetamines and other addictive drugs have had their lives changed when substituting with cannabis.

Patients with end-stage renal disease on dialysis and those with transplanted kidneys show mental ease, comfort, and lack of significant graft-versus-host incompatibility reactions in my small series. Diabetes report slightly lower and easier-to-control blood sugar levels, yet to be studied and explained.

Sleep disorders are typically improved, with longer and deeper sleep without any hangover or significant adverse effects. Medical cannabis tends to relieve the symptoms of chronic pain and spasticity in patients with multiple sclerosis. Many patients with multiple sclerosis report that their condition has not worsened for many years while they have been using cannabis regularly. MS and other neurodegenerative diseases share the common benefits of reduced pain and muscle spasms, improved appetite, improved mood and fewer incontinence problems.

Many patients with epilepsy are adequately treated with or without the use of other anticonvulsants.

Patients with skin conditions associated with systemic diseases such as psoriasis, lupus, dermatitis herpetiformis, etc.

**The Context of Prohibition:**

The Journal of Cannabis in Clinical Practice

Winter/Spring 2007

Medical Marijuana in California, 1996-2006

For 10 years a vast public-health experiment has been conducted in the nation’s most populous state. What have doctors learned about the medical efficacy and safety of cannabis?

By Tod Mikuriya, Jeffrey Hergenrather, Philip A. Denney, Frank H. Lucido, David Bearman, Claudia Jensen, Tom O’Connell, Marian Fry, William Toy, Robert Sullivan, Hanya Barth, William Eidelman, Helen Nunberg, William Courtney, Christina Paololetti et al

Jeffrey Hergenrather, MD (Sebastopol) is a former general practitioner who has been conducting cannabis consultations since 1999.

Approvals issued: 1,430

Prior self-medicating: 99%

Conditions treated with cannabis:

- Chronic pain (62%)
- Depression and other mental disorders (30%)
- Intestinal disorders (12%)
- Harmful dependence (10%)
- Migraine (9%) are the most common conditions being treated. A breakdown appears in the box on page 5.

**What Patients Report**

A cannabis specialist soon becomes aware of two remarkable facts. The range of conditions that patients are treating successfully with cannabis is extremely wide; and patients get relief with the use of cannabis that they cannot achieve with any other pharmaceuticals.

The testimony should be heard on a daily basis from people with serious medical conditions are moving and illuminating. From many people with cancer and AIDS come reports that cannabis has saved their lives by giving them an appetite, the ability to keep down their medications, and mental ease.

No other drug works like cannabis to reduce or eliminate pain without significant adverse effects. It evidently works on parts of the brain involving short-term memory and pain centers, enabling the patient to stop dwelling on pain. Cannabis helps with muscle relaxation, and it has an anti-inflammatory action. Patients with rheumatoid arthritis live better with cannabis than without.

Spasticity cannot be treated more quickly or efficiently than with cannabis.

Other rheumatic diseases similarly show remissions. Spasticity cannot be treated any more quickly or efficiently than with cannabis. Other, again, without significant adverse effects. Patients who suffer from migraines can reduce or omit conventional medications as their headaches become less frequent and less severe.

About half of the patients with mood disorders find that they are adequately treated with cannabis alone while others reduce their need for other pharmaceuticals. In my opinion, there is no better drug for the treatment of anxiety disorders, brain trauma and post-concussion syndrome, ADD and ADHD, obsessive compulsive disorder, and post-traumatic stress disorder.

Patients with Crohn’s disease and ulcerative colitis are stabilized, usually with comfort and weight gain, while most are able to avoid use of steroids and other potent immunomodulator drugs. People who were formerly dependent on alcohol, opiates, amphetamines and other addictive drugs have had their lives changed when substituting with cannabis.

Patients with end-stage renal disease on dialysis and those with transplanted kidneys show mental ease, comfort, and lack of significant graft-versus-host incompatibility reactions in my small series. Diabetes report slightly lower and easier-to-control blood sugar levels, yet to be studied and explained.

Sleep disorders are typically improved, with longer and deeper sleep without any hangover or significant adverse effects. Many patients with multiple sclerosis report that their condition has not worsened for many years while they have been using cannabis regularly. MS and other neurodegenerative diseases share the common benefits of reduced pain and muscle spasms, improved appetite, improved mood and fewer incontinence problems.

Many patients with epilepsy are adequately treated with or without the use of other anticonvulsants.

Patients with skin conditions associated with systemic diseases such as psoriasis, lupus, dermatitis herpetiformis, etc.

continued on page 4

continued on page 4

---

The authors are medical doctors practicing in California. Three requested anonymity.

continued on page 4

---

Copyright 2007, 2012 by O’Shaughnessy’s. All rights reserved. Address reprint requests to editor@beyondthc.com

---

**$4.25**

---

**O’Shaughnessy’s**

The Journal of Cannabis in Clinical Practice

Winter/Spring 2007

---

---

---

---

---

---

---
Mikuriya from page 1

Relief from the burden of chronic ill health, psychological protection enhances a salutary self-perception.

Alteration in the perception of and reaction to pain and muscle spasticity is a unique property of cannabis therapy. Patients reports are diverse yet contain common elements. 100% report that cannabis is safe and effective. Return for follow-up and renewal of recommendation and approval confirms safety and efficacy.

Cannabis seems to work by promoting homeostasis in various systems of the body. Its salient effects are multiple and varied.

They include—

- Restoration of normal functioning of the gastrointestinal tract with normalization of peristalsis and restoration of appetite.
- Normalizing circadian rhythm, which relieves insomnia. Sleep is therapeutic in itself and synergistically helps with pain control.
- Easement of pain, depression, and anxiety. Cannabis as an antineoplastic and antidepressant in modulates emotional reactivity and is especially useful in treating post-traumatic stress disorders.

Patients treated for ADHD (ICD-9 Categories 314.00, 314.01, 314.8): 92

Patients using cannabis as a substitute for alcohol: 683.

The slow poisoning by alcohol with its sickening effects on the body, psyche, and family can be relieved by cannabis.

Medications no longer needed?

Opioids, sedatives, NSAIDS (non-steroidal anti-inflammatoris), and SSRI antidepressants are commonly used in smaller amounts or discontinued. These are all drugs with serious adverse effects.

Opioids and sedatives produce depression, demotivation, and diminished motility. Weight gain and diminished function are common effects. Cognitive and emotional impairment and depression are comorbid conditions. Opioids’ adverse effect of producing constipation with dyspepsia, and gastric irritation. Pruritus is also an issue for some. Circadian rhythms are disrupted with sleep disorders and chronic sedation caused by these agents. Dependence and withdrawal symptoms are more serious than with sedatives.

Opioids are undoubtedly the analgie of choice in treating acute pain. For chronic pain, however, I recommend the protocol proposed by a doctor named Fron-mueller to the Ohio Medical Society in 1859: primary use of cannabis, resorting to opiates for episodic worsening of the condition. Effective and maximized, tolerance and adverse effects are minimized. (Neither cannabis nor human physiology has changed since 1859.)

NSAIDS can be particularly insidious for those who do not immediately react with gastric irritation and discontinue the drug. Chronic irritation with bleeding may produce serious morbidity. Most often, the dyspepsia produced is suppressed with antacids or other medications. Many patients tolerate this acute Intermittent use but not chronic use.

SSRIs, if tolerated, coexist without adverse interaction. Some SSRIs use cannabis as synergistic in

Out of the ordinary conditions?

While all pain reflects localized immunologic activity secondary to trauma or injury, the following atraumatic autoimmune-immune disorders (listed by ICD-9 code) comprise a group of interest:

- Crohn’s disease 555.9
- Ankylosing spondylitis 720.2
- Melenchoitis 733.99
- Pernicopha 277.1
- Tellusiasia 282.4
- Sclerosis 714.0
- Easement of pain, depression, and anxiety empowers.

Mainstream doctors frequently report to prevent adverse effects by prescribing additional drugs. Instead of negating the problem, they often complicate it. Prevaling practice standards encourage polypharmacy—the use of multiple drugs, usually five or more.

Conditions Treated With Cannabis as per Prop 215

I record diagnoses as ICD-9 numbers, based on the International Classification of Diseases, Ninth Revision. This list, based on Proposition 215 disease categories, aggregates the diagnoses for numerous conditions such as cancers, lower back pain, and neck pain, though there are many different causes and diagnoses within these groups. –J.H.

Cancer (94 patients, 7%) includes all malignancies, chemotherapy con-

Anorexia (42 patients, 3%) includes anorexia and the more severe condi-

AIDS (2%) categorize under infectious diseases (159 cases, 1%), along with Viral hepatitis C (8%), Viral hepatitis B (0.5%), Lyme disease (0.5%), Herpetic infections (<0.5%)

Chronic pain (97 patients, 62%). This is an incomplete file for picture pain syndromes, many of which fall into the categories of arthritis, rheumatic disease, neurogenerative diseases and intestinal disorders. My pain cases fall into two broad categories, chronic pain (44%), and inflammatory musculoskeletal conditions (18%). Suffice it to say that the groupings do not represent clear etiologies (causes).

Chronic pain can be broken into lower back pain (21%); neck pain (13.5%); fibromyalgia (3.5%); neuropathy of the peripheral nervous system (0.5%); chronic back pain (0.5%); gynecological pain (2%); TMJ (1%); and other pain syndromes (1%), includ- ing phantom limb syndrome and myofascial pain syndrome.

Inflammatory musculoskeletal conditions include shoulder pain and rotator cuff syndrome (4%), pain (3%), carpal tunnel syndrome (2.5%), plantar fasciitis (1%), tenosynovitis (1%), forearm, wrist, and hand pain (1%), and other (2%), including reflex sympathetic dystrophy, Dupuytrens contractures, thoracic outlet syndrome, cubital tunnel syndrome, and Legg Calve Perthes disease.

Spasticity (70 patients, 5%) includes quadriplegia (2%), paraplegia (1%), other paralysis (1%), cerebral palsy and muscular dystrophy (0.5%), other tremors and spams (0.5%)

Sensory organ disorders (50 cases, 3%), comprising glaucoma (2%) and others (1%), including blindness, tinnitus, Meniere’s disease, and diabetic retinopathy.

Arthritis (331 patients, 23%), includes degenerative or osteoarthritis (4.5%), post-traumatic arthritis (5.5%), hip arthritis (3%), knee and lower extremity arthritis (6.5%), shoulder arthritis (3%), and others (0.5%)

Migraine (129 patients, 9%) includes classical migraine (7.5%), cluster headaches (1%), of other (0.5%)

Other illnesses (1160 patients, 81%) categorized as:

A) Mental disorders (30%): depression, major, reactive and unspecified (11%); anxiety disorder (5.5%); post-traumatic stress disorder (5%); bipolar disorder (2.5%); brain trauma and post concussion syndrome (2%); ADD (1%) and others (3%) including obsessive compulsive disorder, agoraphobia, panic attacks, dysmenorrhea, Tourette’s syndrome and others.

B) Intestinal disorders (12%) includes: Gastroesophageal reflux disease (3.5%); irritable bowel syndrome, (3%); inflammatory bowel disease (1.5%); Crohn’s and ulcerative colitis and gastritis (1%); peptic ulcer disease (1%); celiac disease (0.5%); pancreatitis (0.5%); and others (1%), notably esophageal spasm, diverticulitis, and nonulcer dyspepsia.

C) Harmful dependence (10%) on tobacco (3%), opioids (2%), alcohol (2.5%) and others (2.5%), including amphetamines, cocaine, mixed depen- dence and polypharmacy.

D) Organ failure (7.5%) includes diabetes, kidney failure, kidney trans- plants, dialysis, liver failure, adrenal failure, thyroid diseases.

E) Insomnia (6.5%)

F) Rheumatic diseases (5%), including rheumatoid arthritis (1.5%) and others (2.5%) including lupus, ankylosing spondylisis, spondelerosis, psoriatic arthitis, interstitial cystitis, Sjogren’s, chronic fatigue syndrome, Behget’s syndrome, polymyalgia rheumatica, optic neuritis, and unspecified arthitis disease.

Neurogenerative diseases (3%) such as multiple sclerosis (2.5%) and others (0.5%) including amyotrophic lateral sclerosis, Parkinson’s disease, Charles Marie-Tooth disease and senile dementia.

Airway disease (3%) includes: asthma, sleep apnea, COPD, and chronic sinusitis.

I) Obesity (1.5%)

J) Epilepsy (1%) includes: grand mal, partial complex.

K) Pioriasis and other skin disorders (1%)

Over the years that I have specialized in cannabis thera-
be more troubling to the novice than to the experienced user. For some people cannabis can induce dry mouth, unsteady gait, mild incoordination, and short-term memory loss, all of which are transient. These effects are reportedly trivial compared to those observed on prescription by pharmaceutical alternatives.

Cannabis use is steadily finding ac-
ceptance in society. Still, for many it remains awkward if not unpracti-

cal in the workplace. People whose jobs require multi-tasking such as pilots, dri-
vers, surgeons, switchboard operators, and many professionals find the intox-

cating effects of cannabis inappropriate in the workplace, and therefore reserve their use for after work.

Due to Prohibition, Califor-
nia growers have been denied the tools of analytical chem-
istry to test the cannabinoid contents of their plants. This has impeded the development of strains aimed at treating various conditions.

Strains
Cannabis is a complex, un-patentable plant with vast pharmacologic potential. Different strains contain different mixes of cannabinoids and terpenes that give them distinct qualities. Some strains energize you; others put you to sleep. Many patients, when they find a strain that suits their needs, try to obtain it on a regular basis. Unless they are growing their own or having your patients try to rely on growers and distributors to reproduce and make available the preferred strain from year to year.

As a result of Prohibition, California grow-
ers have been denied the tools of the analytical chemistry to test the cannabinoid contents of their plants. This has im-
peded the development of strains aimed at treating various conditions.

Nevertheless, patients continue to educate themselves about cannabis as medicine and how best to use it. Over the years that I have specialized in cannabis therapies, highly informative reports by patients have been substantiated and ex-
plained by findings from research centers around the world.

Demographics:
Gender: 62% male, 38% female.
Ages range from 14 to 86 years old.
The male mean age is 45.9 years with a median of 46. The female mean age is 47.4 with a median age of 48 years.
The graphs of the age and gender distribution are similar with the excep-
tion that there is a bump in the leading edge of male patient population as compared to the females, which I ac-
count for by young men’s work injuries, sports injuries, motor vehicle accidents, and problems stemming from military 

service, including injuries and post-
traumatic stress disorder.
The vast majority of patients in my practice are of Caucasian / Indo-European descent, with only about 1% African-American, 2% Native American, 1% Pacific Island-
ers, and 2%

Frank Lucido, MD (Berke-
ley) is a family practitioner who began advi-
ging patients’ use of cannabis soon after the passage of Prop 215. He 
considers about 900 cannabis con-
sultants per year including follow up visits.

Cannabis use was alcolohism. Many 

Cannabis for Dilantin and remaining of seizure medication by substituting 

O’Shaughnessy’s and unique individual.

Dr. Hergenreder with his mother at the Patients’ Own Time in Santa Barbara, April 2006.

Frank Lucido, MD (Berkeley) is a family practitioner who began advising patients’ use of cannabis soon after the passage of Prop 215. He conducts about 900 cannabis consultations per year including follow up visits.

Cannabis use was alcoholism. Many recovering alcoholics are using cannabis for chronic anxiety and/or depression, so to some extent they are substituting it as a treatment for problems they previ-
ously self-treated with alcohol. Because cannabis can damage the liver and cause destructive behavioral changes, cannabis use is righ-
tly termed “harm reduction.”

Marijuana, MD (Cool) Mollie Fry graduated from UC Irvine School of Medi-
cine in 1985 and began her career as a family practi-
cener. She stopped practicing in 1991 to home school her children. After 

Drug use reduced?

Chronic pain patients report reduced use of opiates, NSAIDs, muscle relax-
ants, sleeping pills.

Psychiatric and insomnia patients use fewer tranquilizers, SSRI anti-
 depressants, and sleeping pills.

Neurologic patients reduce use of opi-
ates, muscle relaxants, NSAIDs, triptans and other migraine headache remedies.

Unusual conditions treated?

Gulf War Syndrome. Patient uses cannabis to mitigate chronic neuropathic pain from nerve damage, chronic nausea, and migraine, as well as PTSD from his experiences in combat.

Cancer (2%-3%), Glaucoma (1%-2%), Post-traumatic injuries, etc. Others 

Previously self-medicated:

>3,000 99%

900 0%

<18 5%

18-20 4%

80-89 1%

50-59 89

Demographics:
Gender: 62% male, 38% female.
Ages range from 14 to 86 years old.
The male mean age is 45.9 years with a median of 46. The female mean age is 47.4 with a median age of 48 years.
The graphs of the age and gender distribution are similar with the excep-
tion that there is a bump in the leading edge of male patient population as compared to the females, which I ac-
count for by young men’s work injuries, sports injuries, motor vehicle accidents, and problems stemming from military service, including injuries and post-traumatic stress disorder.

The vast majority of patients in my practice are of Caucasian / Indo-European descent, with only about 1% African-American, 2% Native American, 1% Pacific Islander, and 2%
Philip A. Denney, MD
(Redding, Fortuna, Redwood City, CA)

spent most of his career as a family practice physician before specializing in cannabis consultations in 1998.

Demographics:
- Age: 40-60 years old 60%
- African-American 20%, Hispanic 10%, Asian 10%, Native American 2%
- Median income: $40,000 to $50,000 40%, $50,000 to $74,999 30%, $75,000 or more 30%
- Working poor 27%, Working/middle class 20%, Upper middle class 20%, Upper class 13%
- Hispanic 30%, Black 4%, Asian 2%

Results reported: Cannabis is non-toxic and therefore quite safe. Dosing is easy, involving self-titration, and there is no “hangover” effect. We do not see any depressant or disinhibiting effects.

Benefits:
- Pain relief 90%
- Sleep 85%
- Appetite 70%
- Mood 70%
- Anxiety 65%
- Depression 50%
- ADD/ADHD 40%
- MS 30%
- Neuropathic pain 20%
- Insomnia 15%
- Chronic pain 15%
- Migraine 10%
- Fatigue 10%
- Other 10%

Side effects:
- cotton mouth 90%
- dry eyes 90%
- mild euphoria 80%
- increased appetite 70%
- drowsiness 50%
- anxiety 25%
- mild paranoia 10%

Adverse effects?
- None common (c. 1%), none “serious.”

Weight gain, tolerance, anxiety (related to potential theft from an outdoor garden), dry mouth, and daytime sleepiness are infrequent. Anxiety, red eyes. All described in response to my inquiry (not spontaneous). None reported in stopping cannabis use.

Demographics (estimates):
- Gender: Male 75%, Female 25%
- Age: 40-50 years old 60%
- Age: >60 20%
- <20 20%

Ethnicity: Caucasian (gringos) 64%, Hispanic 30%, Black 4%, Asian 2%

Economic status: Very poor 10%, Poor 27%, Working/middle class 50%, Well off 10%, Very wealthy 3%

Approximately 8-10% of my patients are “officially” disabled by criteria of MediCare, California, or the military.

Robert Sullivan, MD
(Redding, Sacramento, Lake Forest), has specialized in cannabis consultations in partnership with Dr. Denney since March 2004. Sullivan spent more than 20 years in the practice of Emergency Medicine.

Approvals issued: 6,000

Previously self-medicating: 98%

Conditions treated:
- Pain (50%); neck, 20%; (other 20%)
- Insomnia 30%
- Depression 15%
- Seizures 1%
- Bipolar disorder 5%
- Asthma 4%
- Neuropathic pain 4%
- HIV 3%
- Lupus 3%
- MS 3%
- Harm reduction 1%

Results reported:
- All patients seen for renovations report improvement — symptoms stable or relieved, 76% much improved — able to reduce use or eliminate other medications, better able to handle problems. 85% report improvement in work and/or home life and general happiness.
- Cannabis works therapeutically by treating present symptoms and prophylactically by preventing onset of symptoms.
- Drug use reduced: Opiates, muscle relaxants, antidepressants, hypnotics (for sleep), antidepressants, neuroinflammatories, anti-migraine drugs, GI meds, prednisone (for asthma, arthritis).

Unusual conditions:
- Paroxysmal Atrial Tachycardia.
- Two patients refractive to conventional therapy. Both did their own experiments (using and then not using cannabis) to confirm efficacy.

- Medical Marijuana — One patient reported successfully treating the symptoms of this mysterious condition, often dismissed as psychogenic. Possibly related to Crohn’s disease, a side effect of using cannabis to reduce dosage of prescription medication; 49% of patients using cannabis for chronic pain were previously prescribed an opioid (such as hydrocodone) by their personal physician.

Helen Nunberg, MD, MPH
(Santa Cruz), was a family practitioner for more than 20 years before getting a Master’s Degree in Public Health in 2003. She began doing cannabis consultations in 1998 and has been the medical director of MediCann, a statewide chain of clinics. This report is based on a review of 1,800 patients’ files drawn from nine MediCann clinics.

Approvals issued to date >53,000

Previously self-medicating: 96%

Diagnostic Groups:
- 71% of patients report marijuana relieves or reduces chronic pain. Most common diagnoses in this group are low back pain, muscle spasm, neck pain, degenerative arthritis, and degenerative disc disease with radiculopathy.
- 29% use marijuana for mental health. Most common diagnoses: anxiety, obsessive-compulsive disorder, depression, attention deficit disorder (ADD), situational stress, and post-traumatic stress.
- 23% use for insomnia; of those, 38% have insomnia due to pain.
- 16% report relief of gastrointestinal symptoms, the most common being nausea, anorexia, abdominal pain, Hepatitis C, Irritable Bowel Syndrome, and gastrointestinal reflux.

Usage: 1/3 cup of extract (58% THC) every 4 hours is precisely the effect that chronic marijuana patients usually report decreases of 50%. Meds, prednisone (for asthma, arthritis). Many report case, cannabis significantly helped to reduce symptoms and increase functioning.

- Attention Deficit Disorder (ADD) is not uncommon in my practice. That cannabis enhances the ability to focus is not that well known in public discussion.
- Hypoactivity — Cannabis helped enough to reduce other medications.

Comments re strains and dosage:
- Changing strains helps postpone tolerance. High-dose patients are more likely to develop tolerance. I leave the characterization of effects of specific strains to cannabis dispensaries and patients, but feel this is an extremely important step.

- Adverse reactions:
  - None common (c. 1%), none “serious.”

Weight gain, tolerance, anxiety (related to potential theft from an outdoor garden), dry mouth, and daytime sleepiness are infrequent. Anxiety, red eyes. All described in response to my inquiry (not spontaneous). None reported in stopping cannabis use.

Demographics (estimates):
- Gender: Male 75%, Female 25%
- Age: 40-50 years old 60%
- Age: >60 20%
- <20 20%

Ethnicity: Caucasian (gringos) 64%, Hispanic 30%, Black 4%, Asian 2%

Economic status: Very poor 10%, Poor 27%, Working/middle class 50%, Well off 10%, Very wealthy 3%

Approximately 8-10% of my patients are “officially” disabled by criteria of MediCare, California, or the military.
Tom O’Connell, MD (Oakland) had a successful career as a thoracic surgeon, including 13 years in the U.S. Army. In 2001 he came out of retirement to conduct cannabis consultations. He soon concluded that there was pressure on patients to emphasize somatic rather than psychiatric problems, and designed his interview to evaluate through the prescribing doctor. Approvals issued: >2,000 Percentage already self-medicating? I cannot honestly answer this question. In the context of their initial interview — and they had used previously. Number of truly naive patients: zero.

Conditions being treated? Patients are self-medicating to treat symptoms. The most common are Stress, anxiety, and depression (90%), Insomnia, chronic or recurrent (90%), Pain, chronic or recurrent, from various sources (50%).

Inability to eat breakfast (40-50%) Migraine (10.15%)
Other common conditions (2-5%) include Irritable Bowel Syndrome, Fibromyalgia, Seizure disorder, GERD, Diabetes (type 1 and 2) and Viral hepatitis C. Most hepatitis patients were not sick enough to be treated. For those completing treatment, cannabis was extremely helpful in allowing them to tolerate the troublesome side effects of Interferon.

Of the named condition they have been treated for by conventional medi-
cine: (1) bipolar disorder 20-30% (2) ADD 15% (3) some form of anxiety disorder 15% (4) excessive drinking 10%

Results reported? Cannabis is very safe, reliable, and durable over the long haul. Medications reduced/discontinued? Vobicin and other opioids; lithium; Klonopin; various sleep aids; and the whole gamut of psychotropic medications from Prozac to Xanax. I don’t tell patients to stop taking anything, but I will suggest they discuss it with their prescribing doctor. I have the feeling that most don’t.

Out of the ordinary conditions? I have encountered many unusual situations in which (now very familiar) symptoms were eventually treated successfully with cannabis.
Comments re strains and dosage? Some patients are very knowledgeable about strains and dosages; most are not. The same with cannabis history and other aspects of lore. The majority are only vaguely aware that there is a reform movement and know almost nothing of the politics. That “reform” doesn’t speak to them is clear to me.

Demographics

<table>
<thead>
<tr>
<th>Year of Birth</th>
<th>Patients by Birth Cohort</th>
</tr>
</thead>
<tbody>
<tr>
<td>1946-1955</td>
<td>4.5%</td>
</tr>
<tr>
<td>1956-1965</td>
<td>17.0%</td>
</tr>
<tr>
<td>1966-1975</td>
<td>26.5%</td>
</tr>
<tr>
<td>1976-1985</td>
<td>35.5%</td>
</tr>
<tr>
<td>1986 &amp; up</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

“Reform” groups should acknowledge that cannabis use by adolescents is widespread and sustained. Instead of results suggest most, if not all, of those who became chronic cannabis users did so to treat a wide variety of both psychotropic and somatic symptoms. What remains unknown is the degree to which their profile is representative of the much larger “recreational” market.
Implications of the 10-Year Survey

Marijuana prohibition is part of a broader disconnect from nature that we, the people, have been sold in the name of progress.

Reports of cannabis-using pain patients reducing their opioid intake by 50% is just one study showing the enormous potential of cannabis for medical use. Patients using cannabis to reduce dosages of prescription medications; 67% report using cannabis to reduce dosing of medication; 49% of patients using cannabis for chronic pain were previously prescribed an opioid (such as hydrocodone) by their personal physician.

Is it any wonder that the corporate drug manufacturers oppose legalization of cannabis for medical use? Cannabis is the anti-drug! Reports of cannabis-using pain patients reducing their opioid intake by 50% that perfectly with studies showing that lab animals need half the opioids to achieve pain relief when also treated with a synthetic cannabinoid.

Marijuana prohibition is part of a broader disconnect from nature that we, the people, have been sold in the name of progress. Synthetic pharmaceuticals are said to be "pure," even though their side-effects can be horrific unto death. A tremendous sales force is in place to promote their use and suppress the competition. In the U.S. today, the medical establishment and government itself are extensions of the corporate sales force.

America needs more farmers and fewer sales people. And we need to start diagnosing the causes of our problems instead of just treating symptoms.