

# *The Oregon Medical Marijuana Guide*

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



*Edward Glick, RN*

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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](http://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

# The Oregon Medical Marijuana\* Guide

## A Resource for Patients and Health Care Providers

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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

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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*

