THE MERCY NEWS REPORT

Justice Department Reverses Policy on Cannabis Businesses

New Memo Clears Way for State-Regulated Medical Cannabis Distribution

On August 29, the U.S. Department of Justice issued new guidance to federal prosecutors, telling them medical cannabis dispensaries should no longer automatically be considered targets for prosecution. The memo from Deputy Attorney General James M. Cole to all U.S. Attorneys reverses previous policy, which had said anything involving more than an individual patient or caregiver was worth pursuing, regardless of whether those involved were compliant with state medical cannabis laws.

That previous policy had prompted several U.S. Attorneys to threaten elected state officials and state employees with criminal prosecution or civil asset forfeiture or both if they implemented regulations or licensing for distributing medical cannabis to patients as part of state law. As a result, several states suspended implementation of dispensary regulations, and Washington's governor cited those threats when she vetoed a licensing system for dispensaries in 2011. The new guidance from

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Sanjay Gupta Sorry for Misleading Public about Medical Cannabis

One of nation's most well-known and respected physicians, the neurosurgeon Dr. Sanjay Gupta, apologized repeatedly last month for being part of "systematically misleading" the American public on the dangers and benefits of medical cannabis. The public apologies were part of both television interviews and an essay he published in advance of his CNN documentary on medical cannabis that featured reporting from around the world.

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Massachusetts on Track for Dispensaries by 2014

Qualified patients in Massachusetts should be able to obtain their medicine in licensed dispensaries by the new year, if the Department of Public Health (DPH) stays on its implementation schedule. Last month marked the end of Phase I for applications to operate a Registered Marijuana Dispensary (RMD) in the state, and DPH has several applicants. "The department continues to demonstrate a commitment to patient needs by moving forward quickly and thoughtfully with the

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ACNA Position Statement on Concurrent Cannabis and Opiate Use

– by Ed Glick

Introduction: The American Cannabis Nurses Association supports the monitored and controlled use of cannabis in conjunction with opiate administration for patients (either human or animal) who are suffering from severe pain, intractable pain, severe neuropathy or pain associated with terminal illness.

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"Health Before Happy Hour" Campaign in Washington

Medical cannabis patients in Washington State are urging the legislature and Governor Jay Inslee to support legislation based on Senate Bill 5073, a 2011 measure on distribution that was partially vetoed by then-Governor Christine Gregoire. The grassroots campaign, launched with help from ASA, addresses concerns about the effects of Washington's Initiative 502,

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The MERCY News Report is an all-volunteer, not-for-profit project to record and broadcast news, announcements and information about medical cannabis in Oregon, across America and around the World.

For more information about the MERCY News, contact us.

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www.MercyCenters.org
Check it out!

MERCY On The Tube!

in Salem, Oregon area thru Capital Community Television, Channel 23. Call In – **503.588-6444 - on Friday at 7pm**, or **See us on Wednesdays at 06:30pm, Thursdays at 07:00pm, Fridays at 10:30pm and Saturdays at 06:00pm. Visit – http://mercycenters.org/tv/**

About MERCY – The Medical Cannabis Resource Center

MERCY is a non-profit, grass roots organization founded by patients, their friends and family and other compassionate and concerned citizens in the area and is dedicated to helping and advocating for those involved with the Oregon Medical Marijuana Program (OMMP). MERCY is based in the Salem, Oregon area and staffed on a volunteer basis.

The purpose is to get medicine to patients in the short-term while working with them to establish their own independent sources. To this end we provide, among other things, ongoing education to people and groups organizing clinics and other Patient Resources, individual physicians and other healthcare providers about the OMMP, cannabis as medicine and doctor rights in general.

The mission of the organization is to help people and change the laws. We advocate reasonable, fair and effective marijuana laws and policies, and strive to educate, register and empower voters to implement such policies. Our philosophy is one of teaching people to fish, rather than being dependent upon others.

Want to get your Card? Need Medicine Now? Welcome to The Club!

MERCY – the Medical Cannabis Resource Center hosts Mercy Club Meetings **every Wednesday** at - **1745 Capital Street NE, Salem, 97301** – from **7pm to 9pm** to help folks get their card, network patients to medicine, assist in finding a grower or getting to grow themselves, or ways and means to medicate along other info and resources depending on the issue. **visit – www.MercyCenters.org - or Call 503.363-4588 for more.**

The Doctor is In ... Salem!

*** MERCY is Educating Doctors on signing for their Patients; Referring people to Medical Cannabis Consultations when their regular care physician won't sign for them; and listing all Clinics around the state in order to help folks Qualify for the OMMP and otherwise Get their Cards. For our Referral Doc in Salem, get your records to – 1745 Capital Street NE, Salem, 97301, NOTE: There is a $25 non-refundable deposit required. Transportation and Delivery Services available for those in need. For our Physician Packet to educate your Doctor, or a List of Clinics around the state, visit – www.MercyCenters.org - or Call 503.363-4588 for more.**

Other Medical Cannabis Resource NetWork Opportunities for Patients as well as CardHolders-to-be. * whether Social meeting, Open to public –or- Cardholders Only * visit: http://**mercycenters.org/events/Meets.html** **!** Also Forums - a means to communicate and network on medical cannabis in Portland across Oregon and around the world. **A list of Forums, Chat Rooms, Bulletin Boards and other Online Resources for the Medical Cannabis Patient, CareGiver, Family Member, Patient-to-Be and Other Interested Parties. * Resources > Patients (plus) > Online > Forums *** Know any? Let everybody else know! Visit: http://**mercycenters.org/orgs/Forums.html** and Post It!

<continued from JUSTICE DEPARTMENT REVERSES POLICY ON CANNABIS BUSINESSES, page 1 > DOJ says the opposite: state and local officials can only avoid federal interference if they ""implement strong and effective regulatory and enforcement systems" that reflect what it lists as eight federal enforcement priorities.

"Respect for state cannabis laws and local enforcement is what this Administration has promised from the beginning, and we hope federal prosecutors take the new DOJ memo to heart," said ASA Executive Director Steph Sherer. "But the President can do much more to stop the wasteful, unjust interference with medical cannabis laws, including supporting the bipartisan efforts in Congress."

Part of the regulatory framework the DOJ says it wants to see is control over how money is handled, but for the last several years the DOJ has systematically blocked dispensary access to banking and credit card processing, and earlier in the month the Drug Enforcement Adminis-tration, a branch of the DOJ, told armored car companies they cannot service dispensaries and other medical cannabis businesses. When questioned about it by the media, a DOJ official who insisted on anonymity said Attorney General Eric Holder told the governors of medical cannabis states on a conference call last Thursday that the Justice Department is "actively considering" how to handle banking. The official told the Huffington Post that banks are unlikely to be prosecuted at this time for money laundering if they provide services to state-licensed businesses.

The memo does not change any law, nor does it preclude prosecution of any individual or business, as the U.S. Attorneys' offices are autonomous, and federal prosecutors make independent decisions about which cases to pursue. A spokesperson for U.S. Attorney for the Northern District of California Melinda Haag, who has been relentless in trying to shut down two of the largest and most respected dispensaries in the country, said the memo would have no effect on their efforts. Both of the dispensaries have complied with state and local regulations and have the support of elected officials in their community. Threats of criminal prosecution and asset forfeiture by U.S. Attorneys have closed more than 600 dispensaries in California, Colorado and Washington over the past two years, even though no state law violations were alleged.

The latest memo is the first official federal response to initiatives approved last November by voters in Colorado and Washington that made cannabis possession and use legal for all adults.

The memo states the DOJ will not attempt to challenge those laws directly at this time. The DOJ has never attempted to challenge any medical cannabis laws, though the government tried to overturn Oregon's assisted suicide statute as a violation of the federal Controlled Substances Act, but that was rejected by the U.S. Supreme Court in 2009 when the court ruled in Gonzales v. Oregon that the CSA cannot preempt state laws unless there is a "positive conflict" in which state law required actions specifically prohibited by federal law.

Both Colorado and Washington have separate, long-standing medical cannabis programs. Currently 20 states and the District of Columbia allow medical cannabis use by qualifying patients, and many of those states have or are instituting regulated systems for distribution that limit the number of producers and providers, despite the threats from federal prosecutors.

Deputy AG Cole, who authored the latest guidance, also authored the 2011 memo that walked back the DOJ's 2009 directive from that had said it would not be a wise use of resources to prosecute individuals in compliance with state medical cannabis laws. ASA estimates the federal government has expended over $500 million to block the implementation of state medical cannabis laws.

More information:
DOJ memorandum from Deputy Attorney General Cole -
http://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf
ASA Report on the cost of federal enforcement -
http://www.safeaccessnow.org/downloads/WhatsTheCost.pdf
ASA's Peace for Patients Campaign -
http://peace4patients.org/

SOURCE = Americans for Safe Access (ASA) - Monthly Activist Newsletter - SEPTEMBER 2013 * Volume 8, Issue 9 ***** *1322 Webster Street, Ste. 402 * Oakland, CA 94612 * **info@AmericansForSafeAccess.org*** *510-251-1856 * **AmericansForSafeAccess.org***

New Federal Policy on Sentencing, Compassionate Release

More medical cannabis prisoners may see freedom soon, if the Department of Justice makes good on a new strategy outlined by U.S. Attorney General Eric Holder last month. Speaking at the annual meeting

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Currently more than two-dozen federal medical cannabis patients and providers are serving sentences for violating federal marijuana laws, despite being in compliance with the laws of their respective states. Among these prisoners is Jerry Duval, recently sentenced to a mandatory minimum of ten years in federal prison for cultivating medical cannabis, even though he is a seriously ill kidney-pancreas transplant patient registered with the Michigan state program. Incarcerating him in a federal medical prison is expected to cost U.S. taxpayers more than $1.2 million.

"Imprisoning medical cannabis patients such as Jerry Duval is both extraordinarily expensive and shockingly unjust," said ASA Executive Director Steph Sherer. "We encourage Attorney General Holder to facilitate the compassionate release of all nonviolent federal medical cannabis prisoners."
ASA estimates the costs associated with the federal government's interference with state medical cannabis programs at $500 million and rising.

More Information:
Text of the ABA speech by Attorney General Holder - http://www.justice.gov/iso/opa/ag/speeches/2013/ag-speech-130812.html
Peace for Patients campaign - http://peace4patients.org/
ASA's "What's the Cost?" report - http://www.safeaccessnow.org/downloads/WhatsTheCost.pdf

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<continued from SANJAY GUPTA SORRY FOR MISLEADING PUBLIC ABOUT MEDICAL CANNABIS, page 1 > "I mistakenly believed the Drug Enforcement Agency listed marijuana as a schedule 1 substance because of sound scientific proof," Dr. Gupta wrote. "They didn't have the science to support that claim, and I now know that when it comes to marijuana neither of those things are true. It doesn't have a high potential for abuse, and there are very legitimate medical applications. In fact, sometimes marijuana is the only thing that works."

ASA, which is currently appealing to the US Supreme Court the DEA's rejection of the latest rescheduling petition on cannabis, hosted an online event immediately following the airing of the documentary. Featuring many of the same guests as the documentary, as well as additional experts in the medical cannabis field, that follow-up discussion expanded on why Dr. Gupta now says it is "irresponsible" to deny patients access to medical cannabis. The ASA event is archived on the ASA YouTube page. > http://www.youtube.com/SafeAccess

In 2009, Dr. Gupta was the leading candidate to become President Obama's first Surgeon General until he withdrew from consideration.

More Information:
"Why I Changed My Mind on Weed" by Dr. Sanjay Gupta - http://www.cnn.com/2013/08/08/health/gupta-changed-mind-marijuana
ASA's follow-up to Dr. Gupta's documentary - http://www.youtube.com/SafeAccess

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<continued from MASSACHUSETTS ON TRACK FOR DISPENSARIES BY 2014, page 1 > process," said Matthew J. Allen, Executive Director of the Massachusetts Patient Advocacy Alliance, "Today patients are one step closer to safely accessing their medicine."

Under the Massachusetts program, RMDs must cultivate the medicine they provide to patients. In the first year of the program, DPH may approve up to 35 applications, with at least one dispensary in each of the state's 14 counties, and a maximum of five locations per county. DPH can increase that number if it determines patient demand warrants more.

DPH has set a tentative date of Sept. 18 to announce which applicants are eligible for Phase II of the process. An information session on Phase II has been set for Sept. 20, from 10am-1pm at a location to be announced.

More Information:
DPH program webpage - http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/medical-marijuana/

Delaware Moves Forward with Dispensaries

Delaware got the jump on the Department of Justice announcement on medical cannabis, when its governor announced the day before that he was endorsing a dispensary program despite threats from federal prosecutors.

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<continued from previous page> The move came more than two years after Gov. Jack Markell suspended implementation of Delaware's medical marijuana program over warnings from the Department of Justice that state officials could be subject to prosecution. The state currently has more than 20 registered patients but no approved means of distribution.

The state will begin the process next year of finding an operator for a single "compassion center" which would cultivate and distribute cannabis to registered patients, though the 2011 bill mandated a dispensary in each of the state's three counties. Centers will be limited to 150 plants and no more than 1,500 ounces of medicine.

"The sensible and humane aim of state policy in Delaware remains to ensure that medical marijuana is accessible via a safe, well-regulated channel of distribution to patients with demonstrated medical need," Markell said in announcing the plan.

More Information:
MERCY in Delaware -
http://mercycenters.org/links/Delaware.html

Illinois Implementation Conference a Success

Americans for Safe Access and Local 881 of the United Food and Commercial Workers (UFCW) union sponsored a conference in Chicago last month to review Illinois' new medical cannabis law and plan for implementation.

The conference, which was free and open to the public, brought together patients, caregivers, cultivators, lab experts, and dispensary operators and workers to consider all aspects of HB1, the Illinois "Compassionate Use of Medical Cannabis Pilot Program" Act, including the rights and responsibilities it establishes and what needs to be done to ensure the law will protect and benefit Illinois patients and be renewed. The HB1 takes effect January 1, 2014 and expires in four years.

HB1, which passed the Illinois House in April and the Senate in May, creates a framework to protect physicians and qualified medical cannabis patients from arrest and prosecution. HB1 specifies 33 debilitating medical conditions for which patients may obtain approval from a physician to use medical cannabis. Qualifying patients may possess up to 2.5 ounces which must be obtained from one of what are slated to be 60 "registered dispensing organizations."

"Passing a law is just the first step in ensuring safe and legal access," said ASA Executive Director Steph Sherer, who presented at the conference. "Stakeholders have to come together to ensure the law is implemented with patients needs in mind."

More Information:
HB1, the Compassionate Use of Medical Cannabis Pilot Program Act -
http://www.ilga.gov/legislation/98/HB/PDF/09800HB0001eng.pdf

<continued from "HEALTH BEFORE HAPPY HOUR" CAMPAIGN IN WASHINGTON, page 1 > which passed last November, on the state's patients and their access under the original Medical Use of Cannabis Act.

"Washington was one of the first states in the nation to recognize that patients under a physician's care have the right to use medical cannabis," said ASA Executive Director Steph Sherer. "The needs of this vulnerable population are distinctly different from those of other users, and it's vital that elected officials understand the differences."

As Washington's Liquor Control Board moves forward with plans to fully implement I-502 and open retail stores across the state, some officials have suggested that medical marijuana should be folded into the adult-use system. Mark Kleiman, a UCLA professor hired to help implement I-502, says competition from medical cannabis could cut expected revenues in half.

"Washington voted for medical cannabis to show compassion, not generate revenue," said Kari Boiter, ASA's 2012 Medical Cannabis Advocate of the Year. "Our state is essentially prioritizing profits over patients."

Medical marijuana has been authorized under state law since 1998. Almost 15 years later, the state's policy remains unclear when it comes to dispensing medicine. Patients also lack the basic legal protections from arrest and prosecution.

In the CNN documentary "Weed," Dr. Sanjay Gupta outlined the need to cultivate CBD-rich strains and described why such varieties are unlikely to exist in a recreational marketplace.

More Information:
Advocates' letter to Governor Inslee, kicking off campaign -
http://org.salsalabs.com/o/182/p/dia/action3/common/public/?action_KEY=14121

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Additionally, any patient on long-term opiate therapy should be evaluated for cannabis therapy to lessen the risk of adverse events associated with opiates. This position is justified by the evidence base of use patterns, the in-vitro research demonstrating the interaction of endocannabinoid receptors with opiate receptors, the potential severity of adverse events associated with long-term opiate use and the ethical responsibility of health care practitioners to advocate on behalf of their patients.

Pain and Conventional Treatments

Pain is the neurological process that provides internal communication via nerve cells indicating an injury or disease. Pain is a cardinal symptom of many disease processes especially if it is associated with tissue or organ nerve damage.

Pain impulses are carried through nerve fibers which are present in all tissues and organs, and exist in huge numbers in the central nervous system. The CNS is composed of the spinal cord and the brain. The peripheral nervous system (PNS) contains nerves located in the arms, legs, skin and other parts of the body outside the brain and spinal cord. Neurotransmitters like serotonin, dopamine, adrenalin and glutamate, are released by receptors in the cell, in response to specific nerve impulses which trigger their activity. The anatomy of a nerve cell is arranged in order to carry sensory impulses from one cell to another and into the brain and motor impulses from the brain back to a specific area.

There are many different qualities and types of pain. Pain may also be non-physical in nature, arising from psychological trauma or mental illness. Phantom limb pain, for instance, is the perception of pain in an appendage (arm or leg) which has been amputated. Intractable pain is excruciating pain which is unresponsive to medical or pharmacologic interventions.

Analgesics are a class of drugs which (are intended to) block or reduce the movement of pain signals to the brain, reducing the perception of pain. There are many different types of analgesics- including opiates- which treat many different types and intensities of pain. Prescribers attempt to match the analgesic to the pain in the lowest effective dose. As the severity of the pain increases, so does the potency of the drug prescribed. Severe pain, by definition, is pain which defies easy control. The pain cycle often results in escalating doses of one pharmaceutical, until it fails to adequately control the pain or the side effects become excessive. This is followed by a different and more potent analgesic. The side effects and toxicities increase in proportion. Patient's suffering from severe pain- like migraines, neuropathy or cancer, present a huge challenge to prescribers because the pain continues often for the patient's entire life and involve potentially lethal doses of analgesics over a long time period. Large doses of opiates additionally render many patients unable to effectively function, further reducing quality of life.

Morphine is considered the standard for the most severe pain. It comes in many forms and dosages and combinations with other agents which are meant to synergistically work with the morphine at lower doses. Morphine activates specific receptors which release endorphins. It has very potent central nervous system activity, blocking pain signals in the brain. It can also depress the vital functions of the CNS, like breathing. High doses of morphine can also impair liver function and sensory function and result in constipation. From 1999 to 2010, the number of U.S. drug poisoning deaths involving any opioid analgesic (e.g., oxycodone, methadone, or hydrocodone) more than quadrupled, from 4,030 to 16,651 per year, accounting for 43% of the 38,329 drug poisoning deaths and 39% of the 42,917 total poisoning deaths in 2010.(1)

Analgesic Properties of Cannabis

Cannabis is effective as an analgesic due to its potent CB1 receptor binding activity in both peripheral and central nervous system nerve pathways. When inhaled, it rapidly crosses the blood brain barrier. Researchers have demonstrated that cannabinoids reduce hyperalgesia- or increased sensitivity to pain- through activation of CB1 receptors at the site of injury.(2) Endocannabinoid receptor activity represents a parallel, separate, but interconnected pain modulation system with the opioid receptor system in the CNS.(3,4,5) The foundation of the endocannabinoid system is the activity of CB1 and CB2 receptors which cause the release (or inhibit) a complex cascade of endocrine, hormonal or cellular chemicals from the brain or tissues themselves.

This is the "homeostatic regulatory function" of the endocannabinoid system which help patients "relax, eat, sleep, forget and protect"(6). CB1 receptors are mainly located in the brain and CB2 receptors are located throughout the body in enormous numbers, especially immune system tissues.

Cannabinoid receptors may be activated either by the internal endocannabinoid signaling process with anandamide or 2-AG (arachidonyl glycerol)- which all mammals synthesize- or activated through the administration of exogenous cannabinoids found in the cannabis plant. In essence, the cannabis plant has co-evolved over millions of years with humans to produce homeostatic regulatory chemicals nearly identical to those humans and animals produce themselves.

The neurochemical receptor binding actions of cannabinoids have been described in detail through animal modeling experiments. Cannabinoids interact with serotonergic, dopaminergic, glutaminergic, opioid neurotransmitters, and inflammatory processes. Δ-9-THC reduces serotonin release from the platelets of humans suffering migraine thus inhibiting the pain signals triggered by serotonin.

Clinical considerations with cannabis and opioid co-administration

Any patient suffering from serious pain conditions should be evaluated for cannabis use. Many analgesics are combined with synergistic compounds in order to

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Cannabis is no exception. A clinician whose patient is requesting or using cannabis should consider the patient's total pain management program especially the total dosage of opiates, muscle relaxants (flexeril) or benzodiazepines in long-term pain management and the adverse experiences, if any, resulting from high doses. (Documentation of changes in prescription amounts over time after initiating cannabis treatment is easily accomplished. Examination of previous prescription records presents an opportunity to retrospectively determine the therapeutic value of cannabis if the clinician knows when the patient began using it.) Patient's commonly report a decrease of opiate use from 1/3 to ½ as well as increased functional ability. Some patients eliminate the use of opiates nearly completely. There is no documented data indicating that concurrent use of opiates and cannabis increases adverse outcomes.

Adverse events and contraindications from cannabis/cannabinoids do occur. Most significantly, worsening or precipitation of psychosis. Anxiety or panic reactions may sometimes occur to naive users or patients ingesting substantial doses by mouth. There is no known lethal overdose recorded. Additionally, cannabis (like opiates) may mask underlying diseases.

It may also adversely influence the metabolism of other drugs the patient may be using. Cannabis has a long history of use as a harm-reduction substitute for addiction to other substances. Co-occurring substance abuse may or may not be a contraindication to the use of cannabis. A detailed understanding of pharmacological, medical and social circumstances will provide guidance to clinicians. Cannabis Hyperemesis Syndrome has been documented in a small number of long-term cannabis users. Users report colicky abdominal pain, recurring nausea and vomiting, with symptom resolution upon abstinence. The etiology of this disorder is unknown and the occurrence is rare.

Clinician guidelines should include evaluating the risks and benefits of all treatments relative to one another (as well as presence and severity of co morbid substance abuse). Clinician guidelines should not include coercive drug tests based solely on a patient's report of cannabis use. The standardized use of detailed "pain contracts" with mandatory- or unannounced- drug screens should be reserved for only those patients who have significant compliance issues which have been demonstrated over time. The general use of coercive pain contracts undermines the patient's trust in the physician and fosters miscommunication and deception. "Agreements" (as opposed to contracts) with patient's to monitor and document analgesic use over time with the addition of cannabis allows a working relationship with the prescriber which fosters trust.

In the event that a patient's drug screen indicates the presence of cannabinoid metabolites, an enlightened health care provider will engage in a detailed discussion with the patient in order to determine the underlying reason for the use of cannabis and if it is improving the quality of life of the person. A patient's report that he/she "feels better" after they use cannabis should not be detrimental, since the homeostatic regulatory functions of cannabis generally improve comfort.

The refusal of a clinician to discuss with or seriously evaluate the use of cannabis specifically in relation to that person's underlying medical diagnoses violates the clinicians' practice guidelines which include detailed evaluation of the patient's condition through an educated understanding of the complexity of their circumstances and knowledge of different treatments.

Cannabis has been used as an analgesic for 5000 years.(7) As restrictive laws give way to sensible regulation, its use as a medicine will increase, because patients are unable or unwilling to tolerate potent pharmaceuticals, or cannot afford them. All clinicians should be undertaking an education in endocannabinoid therapeutics in order to gain the understanding of this complex system. Clinicians should also understand route-dependant metabolism, federal and state legal barriers, strain evaluation processes, safe handling considerations, research advancements, novel cannabinoid drug development and dosing options- like vaporizers.

The American Medical Association's Code of Medical Ethics, Opinion 1.02 - The Relation of Law and Ethics(8) reads, in part:

"Ethical values and legal principles are usually closely related, but ethical obligations typically exceed legal duties. In some cases, the law mandates unethical conduct." "In exceptional circumstances of unjust laws, ethical responsibilities should supersede legal obligations."

The federal ban of the use of medical cannabis by patients may be interpreted as an ethical dilemma for physicians, compounded by the DEA prescriptive authority which may be revoked, rendering the clinician incapable of practice. Physicians and Nurse Practitioners must weigh these factors. The unwillingness of federal legislators and regulators on all levels to change the scheduling of cannabis represents an unconscionable and inhumane obstacle to cannabis patients, researchers and clinicians. Ethical principles of medical practice require clinicians to work actively to eliminate these injustices and advocate for an intelligent federal policy which does not victimize suffering people and waste tax revenues in the process.

Endocannabinoid therapeutics represents a subspecialty of medicine. The guidelines of clinical practice require "evidence- based" practice resting on the principles of science and ethics. Endocannabinoid therapeutics has evolved to the point where it meets these requirements of practice.

Article SOURCE = American Alliance for Medical Cannabis *(AAMC).* September **2013 Newsletter * *Contact them at* 44500 Tide Ave · Arch Cape, OR 97102 *or by visiting* - http://www.letfreedomgrow.com**

The Modern World –

by Arthur Livermore

Forty-three years ago the Controlled Substances Act was passed, the Drug Enforcement Administration was created, and the war on marijuana began. I was in my first year of medical school and had just smoked marijuana for the first time. After getting a biology degree at Reed College, I was curious about cannabis. I searched the medical school library for information about cannabis and found only statements that it was a "drug of abuse". What does that mean? It doesn't tell you anything about what it does. What are the effects of marijuana?

We now know that marijuana has many uses. A recent report from the Center for Medicinal Cannabis Research (CMCR) in California has proven that smoked marijuana is effective in treating chronic nerve pain and muscle spasms in patients who were not adequately treated by other medicines. This government supported research confirms the results of previous studies. Those who scoff at the medical effectiveness of Cannabis don't have a leg to stand on.

Our Federal laws must change to accept reality. Marijuana is an effective medicine. Political resistance to removing criminal sanctions from the use of marijuana will not be tolerated. Discrimination against people who possess marijuana is ending. Discrimination against people who grow marijuana is ending. Discrimination against people who like marijuana is ending.

But how do we get the change we must have to complete this journey? It is not enough to say that the States should be free to regulate medical marijuana. Federal law must change. The Medical Marijuana Patient Protection Act must be passed.

You can help by sending letters, emails, faxes and calling your Senators and Representatives. Tell them that you are upset by the actions of the DEA (Drug Enforcement Administration). Tell them that it's not OK to arrest people who are legally growing and distributing medical marijuana.

With the addition of New Hampshire and Illinois this year, we now have medical marijuana laws in 20 states and the District of Columbia. This year Oregon is writing the rules which will allow people to buy medical marijuana at licensed dispensaries. We will be able to help people by identifying the cannabinoids in various strains of cannabis. The natural cannabinoid delta-9-tetrahydrocannabivarin (Delta-9-THCV) decreases seizure activity in a rat model of epilepsy. Which variety of marijuana has the highest THCV level? Cannabidiol (CBD) has anti-psychotic properties. Which strain is the best source of CBD? Right now, there is no way to find out except by trial and error. With licensed dispensaries, we will be able to have each strain tested. Patients will be able to buy marijuana that they know will work for their condition.

Young people today are discovering that marijuana is good medicine for psychological problems. Soldiers returning from Iraq and Afghanistan find that cannabis relieves the symptoms of Post-Traumatic Stress Disorder (PTSD). Many people find that it helps them deal with their anger. Marijuana improves cognitive ability in patients with bipolar disorder and schizophrenia. It helps people with obsessive-compulsive disorder to forget, and to laugh, at their own obsessions and compulsions. Marijuana treats the anxiety, lack of attention and impulsivity associated with Attention Deficit / Hyperactivity Disorder (ADHD) and it works better than any other medicine for many autistic children as well as adults.

Washington and Colorado have legalized marijuana for all adults. This change allows people to use marijuana in social situations as an alternative to alcohol. People who have problems with alcohol will be able to deal with social anxiety by using marijuana instead of alcohol.

Arresting people for marijuana makes no sense. But we arrested more than 800,000 people for marijuana in 2008 and every year we are arresting more people than the year before. Legal marijuana will allow law enforcement to spend their time and resources on violent behavior. Marijuana is known for its ability to calm agitated people. Alcohol is known for the violent behavior that excessive use can cause.

Marijuana is an attitude adjustment. It stimulates creative thinking. In addition to its physical effects, marijuana helps people psychologically. It enables people to feel a sense of well-being.

So much of what we are told about marijuana is based on false assumptions. A new federal research project is looking for a negative effect of THC in mice. Recently, the NIDA (National Institute of Drug Abuse) stated that they were not interested in funding research intended to find positive effects of marijuana. Since the NIDA controls all marijuana research in the US, we must rely on scientists in other countries to look for the benefits of marijuana. Our tax dollars are being spent on moralizing under the guise of medical research.

We cannot afford the financial and social cost of marijuana prohibition. We can limit the recreational use of marijuana by minors, but our current policy makes it easier for minors to get marijuana than alcohol or cigarettes. An ineffective policy does not deserve to survive. Our marijuana policy has not reduced teen marijuana use. It has increased it. We cannot continue to pretend that good intentions are all that matters. The cannabis plant has many valuable uses. It makes no sense to ignore the benefits of cannabis, hemp, marijuana in the modern world.

SOURCE = American Alliance for Medical Cannabis *(AAMC).* September **2013 Newsletter * *Contact them at* 44500 Tide Ave · Arch Cape, OR 97102 *or by visiting* - http://www.letfreedomgrow.com**