



Maryland Medicine

The Maryland Medical Journal Volume 18, Issue 3



Medical Cannabis Comes to Maryland:

What Physicians Need to Know



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I N S I D E



This issue of *Maryland Medicine* presents a discussion of the use of medical cannabis in Maryland.

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Working Toward Solutions to the Opioid Crisis as a MedChi Priority

INCOMING PRESIDENT'S MESSAGE

Gary Pushkin, MD
@medchipresident

It is an honor to serve as President of MedChi, the Maryland State Medical Society. It's ironic that the first issue of *Maryland Medicine* since my installation is dedicated to medical marijuana. While I won't be writing medical marijuana recommendations any time soon, I personally think more research and study needs to occur. However, I do realize some physicians want to use and work with the product, and I respect that MedChi needs to play a role making their work as safe and legal as possible.

What I do want to work on while President is the opioid crisis. That's why as President-elect I encouraged the creation of the MedChi Opioid Task Force and currently chair this important group. The first item on the Opioid Task Force's agenda was to ask physicians and hospitals to review the automated controlled substance "standing orders" within and throughout the electronic health record (EHR) ordering systems because the EHR system may populate standing orders automatically as options for recommended dosages.

The Opioid Task Force has sent letters to Maryland hospitals and physicians suggesting (1) that the physicians' standing orders be reduced to the minimum dosages and quantities necessary, or (2) that practices remove any automated dosage and quantity in the physicians' EHR ordering system. The Opioid Task Force has asked physicians, administrators, hospitals, and clinics to work together to adjust standing orders. This small adjustment could help prevent patients from receiving a higher dosage or quantity than necessary, and may prevent diversion or other problems.

Last summer, MedChi worked to remind all physicians who prescribe opioids to register with the Prescription Drug Monitoring Program (PDMP) by July 1, 2017. This program monitors physicians' opioid prescribing practices and compares physicians according to specialty. While the Board of Physicians cannot mine the data, other parties (e.g., dispensers, insurers, and the Maryland PDMP program) have access to the data and are actively tracking this information.

I am looking forward to a productive year as MedChi President. While I will be focused like a laser on positive proactive solutions to opioid policy, we will continue with the other important work of MedChi and to be your advocate and your resource.

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OUTGOING PRESIDENT'S REMARKS

Stephen J. Rockower, MD
@medchipresident

I started my speech last year with a poem:

I met a stranger in the night whose lamp had ceased to shine.
I paused and let him light his lamp from mine.
A tempest sprang up later on that night that shook the world about.
And when the storm was over, my lamp was out.
But back to me that stranger came; his lamp was burning fine.
He held to me his precious flame, and rekindled mine.

I went on to talk about how I learned to pay it forward, from my high school French teacher to Sir William Osler. We are here, as Dr. Osler taught, to heal the sick and alleviate suffering. We have learned to pass the flame of our knowledge and empathy to those we care for, and to each other. We must never lose sight of that goal, as we are the keepers of the flame.

We spoke last year about methods of communication. I am happy to say that the Zoom system of connecting physicians for meetings is running fairly smoothly. Most of the time, the meetings are well attended, and people on line are participating, especially when they can hear well. The technology has saved many of us hours on the road, gallons of gas, and has saved MedChi money in lowered food costs. We have had Board meetings entirely by Zoom, and more are being planned for this year. The legislative meetings had a somewhat higher challenge of the acoustics of Osler Hall, but we are continuing to work on that.

Speaking of legislation, we had many successes this year. The pharmaceutical Price Gouging Bill was passed despite the Governor's reservations. It still needs implementation, but we in Maryland are proud of being the first in the nation to try to bring pharmaceutical prices under control. We maintained the 94 percent of Medicare payment for Medicaid patients. We have continued to actively negotiate aspects of the Waiver and the All-Payer System to improve our lives and those of our patients. We continue to work with the administration to reduce the risks and consequences of opioid addiction. We successfully implemented a law prohibiting Maintenance of Certification as a condition of licensure. We warded off inroads by the trial lawyers to triple payouts in malpractice claims. We warded off inroads from non-physicians who wanted to greatly increase their scope of practice. Environmentally, we banned antibiotics from animal feed except for specific medical indications, and we banned fracking in Maryland.

Later today, we will consider many resolutions to set our agenda for the coming year. Our Reference Committee met by Zoom earlier in the week to consider them, especially the

many fine resolutions from our Medical Student Section. I commend them for their work and efforts. I urge all of you to continue being involved here and in Annapolis, as so much of what controls our lives originates in Annapolis. You have heard me say many times, "If You are in Medicine, You are in Politics." Maintaining contacts with legislators is the best way to continue to get out our message, and influence the decision makers. A year from now will be an election, and interested parties are already making plans and formulating policies. I'll again make my plea to be generous to MMPAC and AMAPAC, as those are the vehicles by which our priorities are transmitted to the legislators in Annapolis and in Washington.

MedChi continues to face many challenges, but has many bright spots. Dr. Pryor will outline the budget, which, thanks to Gene and Lawrence's fine work, is not as scary as it was last year, but still presents a challenge. The Agency is in flux, but heading in a good direction. Membership continues to be a challenge, and Susan D'Antoni and Ginger Tinsley have been working on innovative membership models. The Center continues to do fine work helping troubled physicians, and to present the history of medicine in varied formats from lectures to digitization.

I need to thank all of those who have helped along the way. First and foremost is my wife, Ann Sablosky, who has put up with the insanity of my calendar. It has never been, "Which nights are you out this week?" but rather, "Are you home any night this week?" Hopefully, we'll get to spend more quality time together next year. I can't thank my co-presidents enough, Drs. Buckley and Pushkin, for being there to aid in the decisions and remind me when I am going off the deep end to the left. I may ignore them, but I thank them for reminding me. The staff of MedChi is invaluable to keep it running. I can't mention everybody's name, but Gene, Debbie, Cathy, Lawrence, Ginger, Melanie, Colleen, and so many others are instrumental in keeping the lights on and wheels running.

This time of the year in the Jewish tradition is a time of reflection and of introspection. We have a prayer, "Shehechyanu," which gives thanks for our lives and our circumstances, and for allowing us to reach this season. I thank you all for the confidence you've had in me to make me your president. I hope I've lived up to the task. As I turn over the reins to Dr. Pushkin, I wish him all the best of luck. As a wise philosopher, Garrison Keillor, said, "Be Well. Do Good Work, and Keep in Touch."

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EDITOR'S CORNER

Bruce M. Smoller, MD

We live in an era of rapid change. I suspect that every person in every age as far back as Galen of Pergamon has made such a statement! We all suffer from a sort of parallax distortion, our lives packed with events and changes that appear to be rapid and insurmountable. If we could climb on top of our lives and watch the parade over many decades, the machine gun pace of change would leaven out a bit and we could follow the arc of trends to either stability or death.

The arc of electronic health records (EHR) has reached neither stability nor death. As a matter of fact, it hasn't reached, it appears, a level anywhere even near good. Recent citations regarding studies of EHR usage seem to point to the fact that anywhere from 38 minutes to 2 hours a day have been added to a physician's daily burden of useless nonclinical work. I want to emphasize the word **NONCLINICAL**. This additional burden, added to the hours that are devoted to the reason we became physicians, carries no bonus for our patients or our practices. It is also, of course, a major player in physician burnout. It doesn't look like it's simply a byproduct of change...it looks like it is here to stay, knocking out private practice as an option for many of us.

Who benefits then? Well, let me count the ways. The makers and sellers of EHR.

Gee, what a surprise. The policy wonks at Medicare mining statistics, the consultants who try to fix the problem but know deep at heart, this is not fixable. The only question that now matters at trial is this: Was the physiciancide premeditated or not? I don't even want to go there.

When Andy Slavitt, former acting administrator of the Centers for Medicare and Medicaid Services, said, "We have lost the hearts and minds of our doctors," he wasn't kidding. He was just gutsy enough to say it. Unfortunately, we are not a union shop. We rely on organized medicine to help us through these troughs, but organized medicine is about helping us adapt. It does that well. What it doesn't do well in the brief arc of time we get to practice, is to rapidly assess, and say "No, we won't do it; it doesn't work." Maybe that's not possible. Maybe I'm wrong and there are some electronic systems out there that don't bankrupt our physicians and work for their benefit and the ultimate benefit of our patients. If so, please write and let me know. Otherwise, EHR looks like a giant tool to ensure the consolidation of our industry and economic benefit to those vendors and consultants who have touted its miraculous nature. If we have time, it will tell.

We present in this issue of *Maryland Medicine* what I believe to be a well-

grounded sober discussion of another change coming...the use of marijuana by prescription, a new industry which promises to be lucrative to growers and dispensers but could be a minefield for the physician who believes that marijuana has many uses.

In my readings, I could only come up with three solid indications for medical marijuana, but there are those who would argue that literature (which is close, I believe, to anecdotal) suggests medical marijuana has much broader usage. I believe we are rushing into this, but I can understand others who say it is time. *Maryland Medicine* is not taking an editorial position. We present in this issue an honest appraisal of its pros and cons as this trend is taking off.

As is the case with alcohol, marijuana has a large downside. However, prohibition often does not work and produces its own problems. I would have preferred for legislators to legalize it generally, and leave the physician out of this, but the people have chosen and I am anxious to see the results of this arc.

There are big changes coming to *Maryland Medicine* soon. In the next issue I will let you know about those changes. Until then, I hope your arcs of change are for the best.

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Cannabis: An Overview and Update for Physicians

George Kolodner, MD



Introduction and History

Cannabis is a plant whose psychoactive components have been used for religious, recreational, and medical purposes since the beginning of recorded time. Enough is still unknown about this complex substance that much disagreement exists about its safety and usefulness. This article attempts to summarize the current state of scientific knowledge about cannabis that would be relevant to practicing physicians. It is based on my review of the available literature as well as my clinical work as an addiction psychiatrist. However, I have no direct experience with prescribing cannabis for medical purposes.

To date, 545 compounds, including 104 cannabinoids have been identified in cannabis, of which the primary psychoactive ingredient—delta9-tetrahydrocannabinol (THC)—is the best known. Cannabidiol (CBD), which exists in inverse proportion to THC in different strains of cannabis, has medically useful properties of its own and appears to moderate some of the effects of THC. The identification of THC in 1964 led to the discovery of an endocannabinoid system that has an extensive presence in both the central nervous system and the peripheral tissues. Two cannabinoid receptors, of which THC is a partial agonist, have been identified along with two endogenous ligands. The latter act as “retrograde neuromodulators” of many neurotransmitters. New research is focused on how the endocannabinoid system regulates mood, pain, appetite, and immunological response.

Recreational and Commercial Use

The recreational use of cannabis originated in the Middle and Far East regions of the world. In the United States, interest in the psychoactive properties of cannabis was limited until the 1920s, when its use became popular among jazz musicians and in the bohemian subculture, as well as among Mexican immigrants in the West. In the 1960s, a wider social group that included

middle-class professionals used cannabis, which became associated with social protest. Use peaked in the late 1970s, declined to a low in the early 1990s, and has gradually increased since then.

Oral intake of “edibles” has become increasingly popular, but the most common route of administration is by smoking, which provides the most potent impact on the central nervous system (CNS). Advances in growing techniques have led to THC concentrations in cannabis cigarettes increasing from 3 percent to as high as 20 percent. THC concentrations of up to 80 percent are available in the form of a wax, which is vaporized and inhaled in a practice known as “dabbing.”

Formulating policy issues about the legality of the plant is complicated by the fact that it is also a source of fiber, rope, and birdseed. Known for these purposes as “hemp,” its commercial uses led to its being widely cultivated in the United States from colonial times through the Second World War, although hemp is now illegal.

Dangers and Problem Use

There is no consensus data about safe levels of cannabis use. Because no cannabinoid receptors are present in the CNS respiratory center, there have not been any recorded overdose deaths. Respiratory depression has been reported in infants.

Problems from the use of cannabis occur at three levels: acute, chronic, and addictive.

Acute: Impaired driving that leads to automobile accidents, especially when combined with alcohol, is the largest acute problem. The long half-life of THC makes the legal determination of intoxication problematic. Delayed negative effects of short-term use also have been documented, such as on the performance of airline pilots in a flight simulator, twenty-four hours after a single exposure.

Chronic: All psychoactive substances have a more deleterious effect if the CNS is still under development. Relatively recent well-conducted prospective studies show that heavy, chronic use before the age of eighteen can lead to a possibly permanent nine-point reduction in IQ as well as other cognitive deficits. Findings have shown that newborns whose mothers used cannabis regularly during pregnancy have lower birth weights.

There is strong evidence of an association between cannabis, especially heavier use, and schizophrenia and other psychoses. However, most experts think that a causal relationship has not yet been established. Evidence is lacking for the once widely accepted concept that cannabis caused an “amotivational syndrome,” as well as for the “gateway hypothesis,” which suggests that cannabis is singularly responsible for a progression to more serious forms of drug problems.

Addictive: The potential for a Cannabis Use Disorder to take over the life of users has been well documented. The likelihood is at the lower end of the addiction spectrum. An Institute of Medicine study determined that 9 percent of those who are exposed to cannabis become addicted. This compares to 9 percent for benzodiazepines, 15 percent for alcohol, 17 percent for cocaine, 23 percent for heroin, and 32 percent for tobacco. The evidence for a physical withdrawal syndrome (insomnia, anxiety, craving, and anorexia) is strong enough for Cannabis Withdrawal Syndrome to have been added to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Withdrawal is usually manageable with symptomatic medication, and some studies have demonstrated the usefulness of pharmaceutical synthetic THC when the syndrome is more severe.

Medical Use

Cannabis was introduced into Western medicine in the mid-nineteenth century and was part of mainstream medicine in the United States for many years. Included in The United States Pharmacopeia from 1850 to 1942, it was produced by the major pharmaceutical companies as a liquid extract of the plant. William Osler, MD, a skeptic about the effectiveness of most medications, wrote in all the editions of his famous textbook that cannabis was “probably the most satisfactory remedy” for migraine headaches. Although overprescribing and diversion were not problems, a series of legal and administrative actions, beginning with the Marijuana Tax Act of 1937, gradually reduced the clinical use of cannabis. Finally, its placement in Category I of the Controlled Drug Substances Act of 1970 made the prescribing of cannabis illegal.

Although medical cannabis is legalized in twenty-nine states and CBD in an additional eighteen, all components are still Schedule I substances and therefore federally illegal. The Supremacy Clause of the Constitution holds that in cases of such conflict, the federal law holds. The Obama Administration adopted a policy of “cooperative noninterference,” whereby the federal law would not be enforced. The new Administration, however, has raised questions as to whether it will continue this informal policy.



Available preparations are of two types:

1. **Pharmaceutical.** Synthetic THC (dronabinol) and a synthetic analogue of THC (nabilone) are Schedule III and Schedule II medications, respectively, are manufactured by pharmaceutical companies, and are approved by the Food and Drug Administration (FDA) for nausea secondary to cancer chemotherapy as well as anorexia and wasting. The oral tablets and liquid are prescribed by physicians and dispensed by pharmacies. An oral mucosal spray of a THC and CBD combination (nabiximols) is available in many countries, with approval pending in the United States.
2. **Artisanal (“medical marijuana”).** The whole plant and its extracts are produced by licensed growers and sold in licensed dispensaries. Physicians can recommend but not prescribe because of its Schedule I status.

Sorting out the conditions for which cannabis is effective can be difficult, given the variety and extremity of claims. The strongest evidence exists for a modest level of benefit for chronic pain, chemotherapy-induced nausea and vomiting, and patient reports of spasticity resulting from multiple sclerosis. Much interest exists regarding seizures, anxiety, insomnia associated with medical disorders, IBS, and PTSD, but there are insufficient high-quality studies to draw conclusions.

Research

Of all the Schedule I substances, access to cannabis for research purposes is the most limited. Researchers complain that it is the only substance for which a single source exists for federally funded studies, and that THC concentrations equivalent to street preparations are not available. As of this writing, legislative and administrative actions to remedy this situation have not been effective. Furthermore, most of the federal research is funded through the National Institute of Drug Abuse and is therefore focused on the negative effects of cannabis. No agency is charged with exploring its potential medical benefits. As a result, the preponderance of cannabis research is currently being done outside of the United States.

Continued on page 12

The Physician's Dilemma

Enthusiasm for the medical use of cannabis has increased pressure on physicians to address an issue about which they are not adequately informed. Barriers to research have interfered with gaining new information, and what has been discovered is not generally being taught in medical schools.

Physicians are accustomed to medications of known quality and potency manufactured by pharmaceutical companies regulated by the FDA, for which prescriptions are filled by professionally trained pharmacists. For cannabis, only three products are available for this traditional path. By contrast, for "medical marijuana," the physician recommends rather than prescribes. "Medical marijuana" is produced by artisans, is distributed by a system of dispensaries subject to political pressures, and is then regulated by a process for quality and potency that is currently under development. The status of medical cannabis in Maryland is still evolving. (The best source for current information is the Maryland Medical Cannabis Commission: mmcc.maryland.gov.)

As research expands regarding the medical usefulness of cannabis, the pressure will increase on physicians to provide professional guidance to patients about appropriate use. Physicians should get involved by educating themselves about the substance and urging governmental and professional organizations to remove unreasonable restrictions on scientific research and pharmaceutical development.

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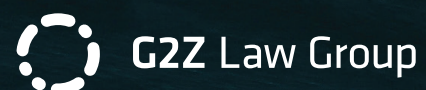
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Legal Considerations as Medical Cannabis Arrives in Maryland

Gene M. Ransom III, Esq.

Several years ago Maryland passed legislation creating a framework for medical cannabis. After years of wrangling, lobbying, litigation, and legislative changes, the first grower and dispenser licenses have been awarded. Maryland physicians now can register with the Maryland Cannabis Commission, which poses a series of legal and practice related questions.

Under Maryland law, a physician has the same professional obligation to medical cannabis patients as he or she does to any other patient. Physicians are not required to register or qualify any patient for medical cannabis, and should only recommend a treatment if appropriate. A physician considering this opportunity will first ask about legal risk. Maryland law is pretty clear and allows physicians to recommend cannabis as long as the physician is registered with the Maryland Medical Cannabis Commission.¹

Federal law is more complicated. Cannabis is not legal under federal law. However, a federal appellate court, in a ruling left standing by the Supreme Court in 2002, prohibits the federal government from either revoking a physician's license or conducting an investigation.² In the 2009 Cole Memo, the U.S. Department of Justice directed federal prosecutors not to prosecute providers and patients who comply with state law. In addition, in December 2014, Congress specifically barred the Department of Justice from spending any funds that interfere in the implementation of medical cannabis programs in various states (including, specifically, Maryland). However, because federal protections are not as clear as a federal statute, physicians should understand the inherent risks.

Once a physician has made the decision to register with the Commission, Maryland law lays out clear guidelines that must be followed. First, a physician must have a "bona fide provider-patient relationship." The patient's condition must be severe, other medical treatments must have been ineffective, and the medical use of cannabis expected to reasonably relieve the symptoms. The Maryland Cannabis Commission explains a "bona fide" relationship under Maryland law:

"Essentially it is a treatment or counseling relationship between a provider and patient in which the provider reviews the patient's relevant medical records, completes an in person assessment of the patient's medical history and current medical condition, creates and maintains medically standardized records, expects to monitor patient program and takes any medically indicated action to follow up."

Maryland law also specifically states which conditions qualify for a medical cannabis recommendation.³



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 - a. Cachexia, anorexia, or wasting syndrome;
 - b. Severe or chronic pain;
 - c. Severe nausea;
 - d. Seizures; or
 - e. Severe or persistent muscle spasms.

The statute gives the Commission the power to name additional conditions through a petition process.

How often a physician must see a patient is left up to the physician. However, the statute requires, at minimum, that the provider perform an in-person evaluation once every 365 days to continue to issue a written certification to the patient, with additional evaluation to be performed at the discretion of the provider. The physician has the power to amend or revoke a certification on medical grounds, if the patient no longer meets the physician's inclusion criteria, or if the patient now meets the provider's exclusion criteria (e.g., abuse or diversion).

Maryland has enacted various requirements for growers and dispensers, and physicians cannot take anything of value from other sectors of the industry. MedChi suggests that recommending physicians have no relationship with dispensers or growers, and is working on a list of recommenders that will be public, since a dispenser cannot refer. MedChi is working to help practices deal with general legal and business issues related to this new opportunity. If you would like help, or would like to serve on the MedChi Cannabis Task Force, please contact MedChi today.

References

1. Maryland Annotated Code Article—Health—General. Title 13. Miscellaneous Health Care Programs. SUBTITLE 33.
2. *Conant v. Walters*, 309 F. 3d 629, 633-634 (9 Cir. 2002), cert. denied, 540 U.S. 946 (2003).
3. Maryland Annotated Code Article—Health—General. § 13-3304. Certifying physician registration, registration requirements, medical conditions, physician compensation, procedures.

Gene M. Ransom III, is the CEO of MedChi, The Maryland State Medical Society. He can be reached at gransom@medchi.org and on twitter @GeneRansom.

The Medical Use of Cannabis

Francisco Ward, DO

The relationship between humans and cannabis dates back before recorded history, thus qualifying as an act of nature rather than a learned dysfunctional behavior. Civilizations since ancient times have cultivated cannabis for human consumption, building components, or fuel. Use of cannabis in spiritual and healing rituals and as medicine has paralleled human progression.

Physicians are at the crossroads of society and cannabis. Initially, state laws introduced cannabis products through “medicinal” channels and, ultimately, legalization. Maryland is attempting to develop a “medical cannabis” distribution network. Those following the process more closely have seen a very turbulent roll out.

Today the cannabis is “in the ground,” and soon the dispensaries will be open for business. The news has spread, and patients are asking their physicians “medical cannabis” questions. What do we do?

In Maryland, a physician must register with the Maryland Medical Cannabis Commission (MMCC) to validate a patient’s sixteen-digit registration number that provides access to a “medical cannabis dispensary.”

If a physician chooses not to register with the MMCC, patients interested in medical cannabis will be referred by a physician to a reputable certifying physician, or guided by “word on the street” or some social medium platforms. All clinical physicians should familiarize themselves with at least one MMCC certifying physician, just as they would for patients who need any other resource or need to see a specialist.

Physicians should take the time to familiarize themselves with the MMCC and the Comar Regulations to comply with the rules set forth by the MMCC. The physician certifies to the MMCC that the patient (or caretaker) meets the guidelines and otherwise qualifies

to access a licensed dispensary to obtain “medical cannabis products”. A key provision to consider is that a staff member of the dispensary will actually decide which products to recommend for the patient’s stated symptoms. This provision is important to consider because in transferring medical judgment to a non-physician it impacts the physician’s pledge to “do no harm.”

Mitigating the Risk to Your Practice

Disparities between federal and state law addressing the production, distribution, and use of cannabis exist. Banking, insurance, marketing, and liability are key areas influencing whether a physician participates in the MMCC as part of the primary professional Tax I.D. number (EIN) or chooses to set up an alternate EIN from which to participate.

Choosing an alternative EIN from which to practice will protect the practice from potential exposure to federal banking restrictions. Banks are federally regulated and are prohibited from doing business with an entity that participates in the commerce of a Schedule I “drug.” Compliance officers have opined that the entity does not have to actually touch marijuana (production, distribution, storage, trade) to be restricted. Registration with MMCC and a willingness to recommend or certify patients for medical cannabis is grounds to have your banking access restricted.

You should contact your medical malpractice insurer before making a decision to participate as a certifying physician. Ask your insurance provider whether you should use your current EIN or create a new one for participating in the MMCC program. There are many unknowns regarding litigation resulting from any potential patient adverse event caused by the use of “medical cannabis” as offered by the MMCC.

The corporate structure chosen will affect your approach to marketing outlets. Many social media and marketing platforms restrict images and words related to cannabis.

Insurance companies follow both federal and state compliance guidelines. Many do not accept “medical cannabis” for payment, while others may have internal guidelines affecting the physician in the panel.

Physicians can either provide MMCC patient recommendations or certifications for their established internal patients or see new patients specifically seeking a recommendation for medical cannabis. Those choosing to only recommend for established patients are often more comfortable with not creating a separate EIN. Physicians marketing to new patients who are interested in “medical cannabis” are more likely to create a separate EIN. The decision to form a new EIN should be made with advice from a malpractice carrier, banker, lawyer, and accountant.

Physicians should consider alternatives to participation in the MMCC. Drugs like Marinol have been FDA approved since 1985 and available with a prescription (Schedule III) for decades. Cannabidiol from HEMP has been legally available for years without a prescription as a nutritional supplement. Using Cannabidiol and/or other FDA-approved cannabinoids allows physicians to provide access to “medical cannabis.”

Take the time to educate yourself about the risk and benefits of cannabinoids. Understand the risk to mental health, misuse, abuse, and diversion. Review the primary source literature to update your understanding of the clinical applications of various cannabinoids. Develop a bona fide physician–patient relationship. Have a process in place to monitor your patient’s response to any “cannabis” product and to determine who is and is not a candidate for a “medical cannabis” recommendation or certification. Use of consents, treatment agreements, clinical algorithms, daily usage logs, and standardized addiction screening are encouraged.

Francisco Ward, DO, is Co-Chair of the MedChi Medical Economics Committee and Chair of the Medical Cannabis Task Force. He can be reached at medicannelite@gmail.com.



MedChi Website Provides Medical Cannabis Resources for Physicians

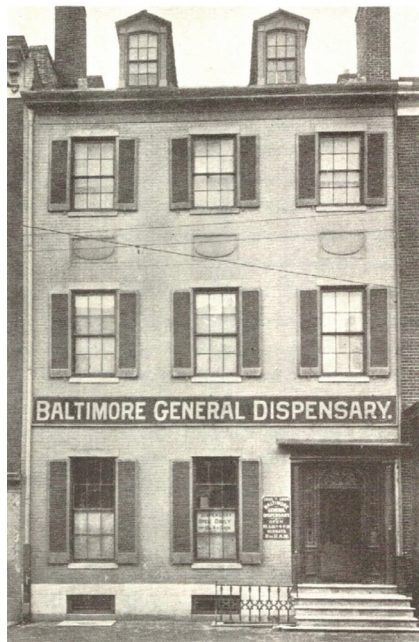
MedChi has launched www.medchi.org/medcan to keep physicians in Maryland informed on current and proposed policy and legislation that will affect those who recommend cannabis to patients.

The site includes a list of Medical Cannabis Recommenders in Maryland. This list is available to the public and the Maryland Medical Dispensary Association. If you would like to be listed as a recommender, you must be in good standing with the Board of Physicians, MedChi, and the Maryland Medical Cannabis Commission.

Contact Ginger Tinsley, at gtinsley@medchi.org, or at 410.539.0872 ext. 3330, if you would like to be listed as a recommender or to participate in MedChi’s Medical Cannabis Task Force.

Cannabis and Modern Medicine: Dispensaries in American History

Mary Ellen Leuver



The charitable history of dispensaries throughout the United States exemplifies how Americans came together to provide basic medical care for the poor. The Baltimore General Dispensary, begun in 1801, provided charitable out-patient medical care to nearly 1 million people throughout the city for more than 150 years. In the 21st century, new dispensaries are forming throughout

the United States with a new objective—to provide medical cannabis—and creating concerns for a generation of physicians unfamiliar with a system that disappeared from the American medical landscape long ago.

While there are many concerns about the physician's relationship to dispensaries, the primary concern is with physicians "recommending" cannabis to patients without a prescription.

Physicians worry about the related ethical and practical questions: how can you recommend a drug (cannabis) without a specific prescription for potency, strain, or dosage? How can you, as a "recommending" (as opposed to prescribing) physician, ensure that your patients are well directed in their purchasing and use of cannabis through dispensaries? How do you learn more about the dispensaries and their personnel as your patients venture out alone to find one medication among the hundreds of strains for a drug you have recommended? What about the drug interactions of varying strains if you are not "prescribing" a specific strain or potency?

American medical history is both instructive and inspiring for modern day physicians venturing into the uncharted territory of recommending drugs that have not been cleared for the market first by the U.S. Food & Drug Administration (FDA).

Dispensaries, like the 1801 Baltimore General Dispensary, offered acute care for the poor masses and easy access to physicians for an increasing number of Americans.

According to records, patients would wait for hours in crowded waiting rooms for a brief visit with a physician.

The physician would write a number on a piece of paper that the patient would turn in to the pharmacy housed in the dispensary for medication.

With most 19th century "prescriptions," physicians had little control over what the pharmacist eventually dispensed to the patient. Patients might or might not follow the physician's prescription, dosing, and therapeutic regimen. Nineteenth-century dispensaries seem to resemble modern-day American medicine in which physicians are not the exclusive purveyors of advice and care. Before a physician was consulted, the women of the household—whose medical armamentarium was similar to that of the physician until the turn of the 20th century—would attempt treatment by calling on family knowledge. If the women of the family were unable to help, midwives, bonesetters, homeopaths, naturalists, and others might be consulted, with university-trained physicians being the last option.

The demise of the dispensary came with the twentieth-century expansion of out-patient and advanced laboratory skills in hospitals. In the 19th century, hospitals were in-patient care centers exclusively for the poor. At a time when paying patients were seen in the comfort of their own homes, nursed in their bedrooms, and unwilling to be examined by novice or unknown physicians, the dispensary and hospital provided not only charitable relief, but also instructive training for medical students.



By the 1950s, dispensaries had largely disappeared from the American medical landscape. Even before the decline of dispensaries, physicians and pharmacists worked together to consolidate the prescription of medications in America.

At the turn of the 20th century, in response to a growing opioid epidemic, physicians in the federal government and across states sought to ban the mail ordering of products

that contained heroin, opium, and cocaine. Physicians and pharmacists developed a system by which physicians prescribed detailed descriptions of medications that pharmacists exclusively dispensed and sold. Physicians stopped selling medications, pharmacists gained control over the market, and mail-order “patent medicines” were outlawed. A system of specific prescriptions—with more federal lab testing of medications ensuring not only patient safety but also near-complete scientific data on medications—was developed over the last 100 years.

With the rise of cannabis dispensaries given authority by state governments, modern physicians face a novel predicament. Physicians must rely on others to advise their patients, while dispensing products that have vastly different properties and potencies.

To confront this dilemma in the past, physicians banded together with pharmacists to better understand and control the medications they prescribed.

The future of medical cannabis—whether it is state physicians and dispensary operators working to maximize the therapeutic benefits of cannabis or physicians alone within their own states creating cannabis prescription guidelines—is unknown. The historical impulse is to regulate and prescribe.

The current recommendation system, put in place by state legislators, harkens back to a time before scientific medicine. Many modern physicians who are scientists at the core of their education are uncomfortable with the guidelines. To recommend a drug with confidence, physicians have a need for answers regarding interactions, potency, and strain. Physicians themselves must organize to solve the debate over prescription versus recommendation at America’s newest medical dispensaries.

Mary Ellen Leuver is a doctoral candidate in the History of Science & Medicine at Yale University specializing in bioethics and the history of infectious diseases. She consults on medical history at the University of Maryland School of Medicine. She can be reached at m.e.leuver@gmail.com.

Maryland Medical Dispensary Association (MDMDA) Founded

The Maryland Medical Dispensary Association (MDMDA) is the first organization that will promote the common interests and goals of medical cannabis dispensaries in Maryland. MDMDA is a professional trade association advocating for laws, regulations, and public policies that foster a healthy, professional, and secure medical cannabis industry in our state. MDMDA works on the state and local level to advance the interests of licensed dispensaries as well as to provide a forum for the exchange of information in the Medical Cannabis Industry. For more information, please contact Michael F. Chiaramonte, MD (michael@mdmda.org).

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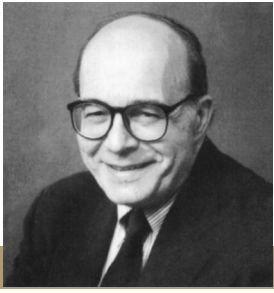
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Influenza

CLASSIC WORD ROUNDS

Barton J. Gershen, MD
Editor Emeritus

In 1742, a febrile illness erupted in Rome, spread to the Italian countryside, and ultimately ravaged most of Europe. It was accompanied by fever, cough, and muscular discomfort, and bequeathed an exceptionally high mortality. Physicians were unable to explain the origin of this frightening and obscure illness, but many believed the disease was provoked by some malevolent astral interference. In other words, the disease was under the *influenza* (Italian: the “influence”) of the stars. And thus a disease was named.

Prior to the age of enlightenment and the discoveries of a burgeoning scientific culture, the revelations of crystal-gazers, astrologists, palmists, auspex, and other diviners, often tendered (foolish) explanations for otherwise incomprehensible phenomena. For example, the Rickettsial disease **Typhus** was originally believed to arise from malignant atmospheric fumes (Greek *typhos*, “smoke, vapor”). And the Plasmodial disease **Malaria** was thought to originate from the miasmatic gases rising from fetid, decaying swamps (Italian *mal*, “bad,” + *aria*, “air”). Unfortunately, the taxonomists had missed the true malarial vector, the *Anopheles* mosquito, whose larvae were silently growing in those putrid swamps. To this day, many diseases have been stamped with their original misconceived names, remnants of medicine’s imprecise youth.

Contagious diseases that affect a percentage of the population greater than is customary, particularly those with numbers of patients that grow exponentially, are called **epidemic** (Greek *epi*, “upon,” + *demos*, “people”; that is, “prevalent within the population”). *Demos* may be found in **democracy** (Greek *kratia*, “power or rule”; that is, “rule by the people”) and **demography** (Greek *graphein*, “to write”; that is, vital statistics or “writing about people”).

A **pandemic** indicates a disease that has spread over the entire world, a global illness (Greek *pan*, “all,” + *demos*, “people”), such as the 1918 influenza, and the HIV **contagion** (Latin *contingere*, “to contact,” which in turn derives from *com*, “together,” + *tangere*, “to touch”; that is, to “touch together,” a common means of infectious spread, especially among sexually transmitted diseases). *Tangere*, “to touch,” may be found in such words as **tangent** (“touching a point along a line”) and **tangible** (“discernible by touch”).

An earlier pandemic, the infamous “Black Death,” erupted in 1348. Italian merchants, returning from China, were ambushed by Tartars in the village of Caffa, a trading post on the Black Sea. The Tartars, were suddenly decimated by an outbreak of plague, and they were forced to withdraw. Before leaving, however, they catapulted their dead over the barricades and onto the streets of Caffa. Thus infected, and incubating the dread pathogen, the unwitting merchants sailed back to the port of Venice. As a

consequence, plague was introduced into Italy and quickly spread across the European continent. Before that pandemic ended, 50 percent of Europe’s population had died of the disease.

The most malignant form of plague is septicemia, which often causes disseminated intravascular coagulation (DIC). Dark ecchymotic blotches usually appear on the victim’s face and hands, giving rise to the epithet the “**Black Death**.” The etiology of this illness was unknown to the 14th-century physicians. However, they quickly realized that, following exposure to plague, an incubation period was fundamental to its development. Therefore, the port of Venice imposed a period of detention on all incoming ships—impounding cargo, crews, and passengers for forty days before permitting them to disembark. Italian, *quaranta (giorni)*, forty (days), eventually evolved into the term **quarantine**.

Giovanni Boccaccio captured the essence of that plague in his celebrated book *The Decameron*, which narrates the plight of ten young men and women during the pandemic of 1348. His book recounted ten days in their lives, during which they escape the city of Florence, and flee to the relative safety of the countryside. On each day of that sojourn, members of the group told one story—ten stories for ten days, ultimately creating a book comprised of one hundred tales. The title *The Decameron* is therefore explained—from Greek *deca*, “ten,” + *hemera*, “days,”—ten days of the plague. (Greek *epi*, “upon or about,” + *hemera*, “day,” results in the term **ephemeral**, or something that is transient, lasting “about a day.”)

Another terrifying disease was smallpox, a pestilence described by the Chinese as early as the 12th century B.C. By the year 1700, Turkish physicians had demonstrated that inoculation of purulent material from a smallpox patient into a healthy individual usually prevented the disease. These physicians used pyogenic matter from patients with the milder form of smallpox, *variola minor*. Unfortunately, the healthy recipients would occasionally develop full-blown *variola major*. This technique, known as **variolation**, was introduced into England and its North American colonies, with limited success. Benjamin Franklin was one of its most enthusiastic supporters. However, the dangers of **variolation**, and the familiar medical caveat: “*primum non nocere*”—first of all do no harm—kept most physicians from utilizing the procedure.

(Latin *variola*, from *varius*, “varied or **spotted**,” from which we also derive such terms as **various**, **variant**, and **variety**. The term **pox** is an alternate spelling of the plural **pocks**, a **pock** being an Old English term for a “pocket or bag.” This word alludes to the skin marks left in the wake of the disease, which resemble small bags. The obsolete term **poke** [“pocket or purse”] derives from the same source, as found in the old expression “a pig in a poke.”)

Fortunately, about this time in England, a rural practitioner made an astute observation. Edward Jenner, a former student

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Classic Round Words ...

Continued from page 18

of John Hunter, recognized that a milkmaid who had previously experienced cowpox, did not develop smallpox when exposed to it. Jenner deduced that immunity to cowpox simultaneously conferred immunity to its more virulent relative. In May 1796, he examined a milkmaid, Sarah Nelmes, who had developed fresh cowpox lesions on her hands. Jenner removed purulent material from some of those lesions and inoculated Jamie Phipps, a healthy eight-year-old child.

Over the next nine days, the Phipps child developed a low-grade fever, mild discomfort, and a few cowpox lesions. Following the boy's complete recovery, Jenner inoculated the child with purulent material from a small pox patient, a clinical trial that certainly would not be permitted today. After a week of anxious scrutiny, Jamie Phipps remained healthy—his inoculation with cowpox had bestowed immunity to smallpox. Jenner performed this experiment on several individuals, all with identical results. He then published his historic paper, *An Inquiry into the Causes and Effects of the Variolae Vaccinae* (1802).

Smallpox vaccinations were soon standardized and ultimately have resulted in the complete elimination of that dread disorder. In 1977 the last case of natural smallpox occurred in Somalia, and in 1979 the World Health Organization officially declared the disease eradicated. The term **inoculate** derives from botany, referring to the transplantation of a bud or an "eye" onto a second plant (from Latin *in*, "onto," + *oculus*, "eye"). Subsequently, the

term has developed a metaphorical sense, to engraft a "budding" germ onto a host. The word **vaccine** and the disease **vaccinia** both derive from Latin *vacca*, "cow." (There is a familiar cliché often heard in western films, which derives from Spanish *vaquero*, "cowboy" [from Latin *vacca*]. *Vaquero* was apparently difficult for Americans to pronounce, so it was transfigured and rendered into American English as **buckeroo**.)

Finally, a word about the origin of the term **virus**. Borrowed directly from Latin, the word meant "slimy liquid or poison." In 1883, the German scientist Alfred Mayer was studying a disease of plants known as Tobacco Mosaic Disease. A plant infected with this virus develops stunted growth and a prominent mottling of its leaves (thus the name "mosaic"). Mayer clearly demonstrated that the disease was infectious by transmitting it from plant to plant. However, he was unable to identify any bacterial agent. In 1889, Martinus Beijerinck, a Dutch microbiologist, filtered material from an infected plant through a sieve with micropores too small to permit the passage of bacteria. Nonetheless, the ultrafiltrate was still able to infect healthy plants. Beijerinck called the infectious vector a filterable "virus"—a "poison" too small to be seen under light microscopy. It was not until 1933, when the first electron microscope was built, that a virus particle could be visualized. The influenza virus was the first to be photographed by humans.

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