When pot means no prescription for pain

By Tara bannow /

Published Aug 10, 2015 at 12:16AM

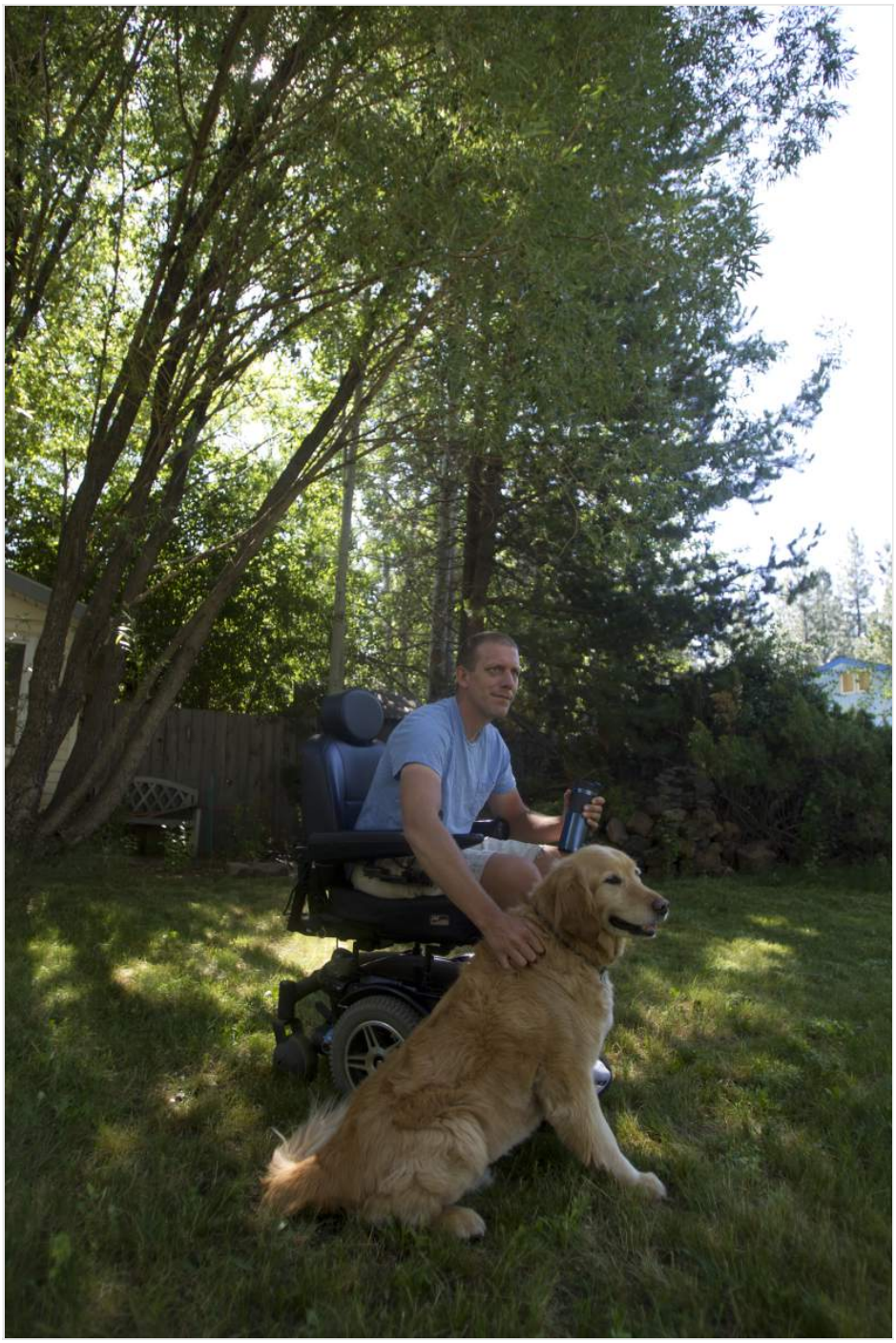
For as long as he was able, Jabe Couch was a runner.

“I ran all the time,” said the 35-year-old Bend resident. A Bend native, he considers himself an “original Bendite to the core,” which could explain his enthusiasm for physical activity.

At 23 years old, however, Couch noticed that toward the end of his runs, he would start stumbling. That seemed weird. By the time he got into his doctor’s office, he had been trying to run through a knee injury that wasn’t letting up. An MRI scan revealed a large region at the top of his spinal cord where the protein covering the nerves had been damaged — attacked by Couch’s own immune system.

“There was no denying what it was,” he said.

Couch said his doctor diagnosed him with primary progressive multiple sclerosis, a form of MS that tends to make it even more difficult to walk or hold jobs compared with other forms of the disease, partly because it attacks the spinal cord more than the brain. And unlike other forms of MS, there are no medications for primary progressive MS.



Medical marijuana patient Jabe Couch pets Tucker, his neighbors Golden Retriever, in the front yard of his home in Deschutes River Woods. Couch says marijuana has dramatically improved his multiple sclerosis symptoms. *Andy Tullis / The Bulletin*

Couch said his doctor put him on drugs to stop his immune response, and when those made him depressed, the doctor prescribed antidepressants. They didn't work. For the pain, he said his doctor gave him Vicodin and Oxycontin, to which Couch became addicted.

Meanwhile, Couch suffered through terrible pain in his legs and uncontrollable leg spasms. He said he even lost control of his bladder function and had to wear an external catheter.

It hadn't occurred to Couch to use marijuana to ease his symptoms. At the time, he was working in the

logging industry, and a co-worker — who told Couch he was sick of watching him struggle to walk because of his MS — handed him a joint. He gave it a shot.

Within minutes, Couch said, the pain in his legs went from an eight or a nine on a one-to-10 scale to a one. It wasn't until about a year and a half later he learned about eating marijuana instead of smoking it.

Since then, his leg spasms have nearly vanished, except for the really hot days, and he no longer uses the catheter. Couch's doctor was not available for comment.

Couch said he no longer feels constantly ill or tired. In fact, he said, most days, he has too much energy. His wife, standing next to Couch in their front yard in Deschutes River Woods, rolled her eyes in agreement.

"It stopped it dead in its tracks," Couch said of marijuana's effect on his MS symptoms.

Couch still uses a wheelchair, but he said he's very active and can lift himself out of his wheelchair and into another chair on his own.

"It saved my life, hands down," he said.

'We're scientists'

Countless patients suffering from debilitating conditions such as MS, arthritis and post-traumatic stress disorder have made extraordinary claims about how using marijuana reversed the course of their medical conditions and turned their lives around for the better. Many report marijuana relieves physical pain better than powerful prescription opiates and even allowed them to stop taking the medications.

But the medical research thus far has not reached the same level of enthusiasm. In many cases, no study or doctor can support or explain the often outlandish anecdotes about how marijuana cured patients' cancer or restored their vision, for example.

Even for its more common applications, marijuana has shown only modest results. A recent scientific review of 79 studies found only moderate evidence it helps with chronic pain and the muscle spasms that are a hallmark of MS.

And yet, the claims keep coming.

That puts doctors — who are scientists, heavily reliant on data — in a difficult position. Do they trust the anecdotal evidence of countless people who say marijuana saved them, or do they go by what the scientific literature says?

The answer for most has been to avoid the subject entirely, especially because the U.S. Drug Enforcement Agency still considers marijuana a Schedule I controlled substance. Even in states such as Oregon that have legalized medical and recreational marijuana, doctors still face the threat of losing their licenses or prescribing privileges if they're found to have recommended marijuana to patients.

A major point of contention among doctors, medical marijuana users and advocates is doctors' refusal to prescribe opiate pain medications to patients who use marijuana. Many doctors feel that since both marijuana and opiates are sedatives, their combined effects could produce severe impairment. Prescribing the drugs to marijuana users also could expose doctors to legal liability if the patients are injured as a result. Patients argue that using marijuana eventually allows them to get off most or all of their opiates, but that it can be a gradual transition.

It's an unfortunate landscape for patients, who often feel intimidated about discussing marijuana use with their doctors, even if it's their sole therapy for chronic pain or other conditions. Even if doctors are open to the idea, they often don't know enough about the drug to discuss its use.

We should not be in a position of moralizing whether people should be using cannabis or not. We're scientists. We should look at the facts.
— Dr. Christian Le

Dr. Christian Le said he left his position as medical director of hospitalist medicine for St. Charles Health System a few years ago to launch Green Earth Medicine, a practice whose central focus is helping patients obtain medical marijuana and educating them about its use.

For much of his professional career, Le said, he viewed marijuana skeptically, as many doctors do, until he said he just couldn't keep ignoring the stories about how marijuana turned patients' lives around.

"After a while, I said, 'You know, it just can't be that there are hundreds upon hundreds of patients experiencing the placebo effect,'" he said.

In a country where nearly half the states allow medical marijuana, doctors have a responsibility to become educated on the subject, Le said.

"We should not be in a position of moralizing whether people should be using cannabis or not," he said. "We're scientists. We should look at the facts."

Le's Oregon medical license is listed as inactive by the Oregon Medical Board, a move Le said he made voluntarily in late 2014 so he could focus more on managing his practice, which includes two practicing physicians, and marijuana education and research.

He no longer personally signs the attending physician's statements, which patients are required to have a physician sign in order to participate in the Oregon Medical Marijuana Program, and instead dedicates his time to managing his clinics and providing education on marijuana use. Maintaining an active license is expensive, and the drug's federal classification restricts licensed physicians from discussing marijuana treatment options with patients, Le said.

Dropped from meds

For nearly a dozen years, JD Schwerdtfeger relied on a potent mix of Oxycontin, Dilaudid and morphine to keep his pain under control. The Navy Special Forces veteran said his Veterans Affairs doctors told him no surgery existed that could fix his severe pain, which stemmed from nerve damage, a bad hip and back, colon inflammation and gout, a form of arthritis. The VA declined to discuss Schwerdtfeger's case through a spokesman, who said privacy laws preclude the agency from discussing patients' medical issues.

For about eight years, Schwerdtfeger has been a member of the Oregon Medical Marijuana Program. Marijuana helps in a number of ways, he said. First, it gives him an appetite — something the pain pills further diminished.

"When you're cramping and you don't feel good, the last thing you want to do is eat," he said. "Without it, I don't know if I would eat enough to take care of myself because I just can't be bothered with it."

Post-traumatic stress disorder further complicates the 61-year-old Salem resident's daily life, he said. But whenever he feels a panic attack coming on, he takes a seat and smokes marijuana, which he said either prevents the attack or greatly lessens its severity.

Medical marijuana patients

Oregon's 1,682 state-licensed physicians with current medical marijuana patients were serving 71,317 medical marijuana patients as of April 2015.

Conditions that yield medical marijuana prescriptions by incident

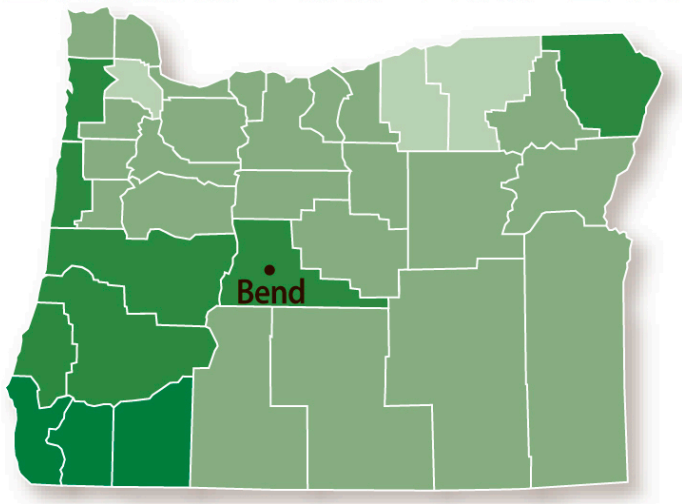
Severe Pain	66,364
Persistent muscle spasms*	18,875
Nausea	9,704
Post traumatic stress disorder	4,231
Cancer	3,886
Seizures**	1,907
Cachexia	1,163
Glaucoma	1,075
HIV/AIDS	777
Agitation related to Alzheimer's	84

*Including but not limited to those caused by Multiple Sclerosis
**Including but not limited to epilepsy

*Patient data as of April 2015, population data based on 2014 census estimates

Medical marijuana patients per 1,000 residents by county, 2015*

More than 30 | 20-30 | 10-20 | < 10



County	Patients	Patients per 1,000 pop.
Deschutes	3,616	21
Jefferson	348	16
Crook	384	18

NOTE: Gilliam, Sherman and Wheeler counties had combined patient data to protect privacy

Source: Oregon Medical Marijuana Program

Click image to view in window you can zoom

Schwerdtfeger said marijuana works so well, it's helped him get off most of his pain medications. Many people who use marijuana for pain, including a handful interviewed for this article, say it allowed them to stop using all or most of their pain medications. Schwerdtfeger said he still takes the "bare minimum" of morphine, but he's been off Oxycontin and Dilaudid for at least a year.

"I don't like taking pharmaceuticals," he said. "I've been taking them for a number of years and there are so many side effects and other things that it's just not worth it."

Nonetheless, for several years Schwerdtfeger used both therapies — marijuana and narcotic painkillers — to help him through his days, a practice he said his VA physician permitted. That is, until August 2013, when his usual doctor transferred to another facility and Schwerdtfeger was assigned to a different doctor.

A month before seeing him, Schwerdtfeger said the new doctor cut off all of his prescriptions — even his sinus medication — and told him the only way he could get them back was to surrender his medical marijuana card, agree to random drug tests and attend weekly Alcoholics Anonymous meetings.

"I don't even drink," Schwerdtfeger said.

The VA Portland Health Care System — which includes large medical centers in Portland and Vancouver, Washington, and several outpatient clinics in Oregon, including in Bend — does not have an umbrella policy that precludes its providers from prescribing pain medications to patients who are using marijuana.

Rather, they can decide on a case-by-case basis.

Many doctors are uncomfortable allowing patients to use both drugs, as their combined sedative effects could lead to significant impairments. Most doctors who prescribe opiates, especially pain specialists, make their patients sign so-called pain agreements that include the stipulation they not use marijuana, or they will lose their prescriptions.

Schwerdtfeger said his new doctor, whom the VA did not make available for comment, told him that since there was no way for her to know the strength of Schwerdtfeger's marijuana or how much he was using, there was the possibility he could overdose if it were used with his other medications. He said that shows her lack of understanding about marijuana.

The withdrawals were unbearable, Schwerdtfeger said, and he was sick for a month without the pain medication he had come to depend on. In fact, that's part of the reason he said he doesn't take most of them anymore: He doesn't want a doctor to have that much control over his well-being.

Schwerdtfeger penned a four-page letter of complaint to the VA. Within hours, he said, the problem was fixed.

"I have no criminal record of any kind," Schwerdtfeger wrote in his letter to the VA. "I haven't even had a parking ticket for more than 30 years and I am sick and tired of being treated like a criminal because I believe in the medical benefits of Cannabis!!!"

Fewer opiates for marijuana users?

Rules that prevent patients who use marijuana from receiving opiates are very common, especially among doctors who specialize in pain management.

"Usually if you tell your doctor you're a cannabis patient, they kick you out," said Willy Bogoger Jr., a medical marijuana patient for five years. "They don't care what you're using it for. They don't care what your frequency is."

Willy Bogoger Jr. holds a plate filled with different types of marijuana that he uses in his home in Tumalo. He said using marijuana has allowed him to stop using prescription pain medications. *Andy Tullis / The Bulletin*

Bogoger uses marijuana to relieve chronic pain from a number of conditions. He has avascular necrosis in his right hip, he said, which is when bone tissue dies due to lack of blood supply, and arthritis in both knees. He also said he needs to have both of his shoulders replaced — the side effect of lots of heavy lifting while working as a contractor and a chef — plus he suffers from post-traumatic stress disorder and anxiety.

“I’m a mess,” said the 47-year-old Tumalo resident.

Bogoger, whose doctors were unavailable for comment, said marijuana relieves his pain, gives him an appetite (something the pain meds took away) and puts him in a better mood. But since he’s been using it, doctors have refused to prescribe him pain medication. He said doctors look at his records, which show years of pain medications and — more recently — marijuana use, and assume he’s a drug addict trying to get high, Bogoger said.

Many large health care providers have blanket policies around marijuana use and opiates that all of their providers must follow.

St. Charles Health System, for example, has a policy that says doctors cannot prescribe opiates to patients found to be using marijuana, either for medicinal or recreational purposes, said Dr. Rob Ross, St. Charles’ medical director of community health strategy. St. Charles also discourages its providers from signing the attending physician’s statements that allow patients to use medical marijuana, he said.

There are rare exceptions, such as cancer patients for whom no alternatives provide relief, Ross said.

“The evidence behind marijuana is not particularity strong for many things in medicine,” Ross said, “and so our main concern is keeping people safe.”

Ross said St. Charles is reviewing that policy, which was put in place in fall 2013, and there is a possibility it could be changed.

Bend Memorial Clinic, by contrast, has a policy that requires pain management agreements between patients and providers. The policy does not explicitly preclude providers from prescribing opiates to patients using marijuana, but it encourages providers to discuss the dangers of mixing prescribed medications with other substances, BMC spokeswoman Katy Sparks wrote in an email.

BMC does not preclude its providers from signing attending physician’s statements.

Catastrophic consequences

Kathryn Keener, a 63-year-old La Pine resident, used to take a medley of prescription medications every day to control the pain stemming from her sciatica, nerve pressure that causes pain from the lower back down the legs.

“You can’t even walk; sometimes you can’t even move,” she said.

She’s been a member of the Oregon Medical Marijuana Program since September. In less than a year, she said she’s been able to switch to using marijuana exclusively to manage her pain and has stopped taking any pharmaceutical pain medications.

That puts Keener among the countless chronic pain patients, including several interviewed for this article, who say using marijuana allowed them to get off all or most of their pharmaceutical pain medications.

A 2011 study of about 1,600 medical marijuana patients in California found half reported using the drug as a substitute for prescription drugs. As of April, 93 percent of patients on Oregon’s medical marijuana program said they used marijuana for chronic pain.

“I’m thrilled about that, and I would think other physicians would be stoked,” said Dr. Stephen McLennon, a physician who went from working at a hospital in The Dalles for 25 years to now seeing marijuana patients at Mothers Against Misuse and Abuse (MAMA) clinics in The Dalles, Portland and Bend. “I don’t think doctors in general like prescribing those medications because of all the problems associated with them.”

“I’ve just been thrilled to death to not have to eat that poison,” Keener said. “It was not working.”

Cannabinoids, the chemical compounds in marijuana that activate receptors throughout the body, share pharmacological properties with prescription opiates. Both have sedative effects that could increase if combined. The effects of mixing the two aren't completely understood in the scientific literature.

Unlike morphine, which allows a doctor to know exactly how many milligrams a patient is getting, doctors can't know exactly how much marijuana a patient is getting, said Dr. Andrei Sdrulla, an assistant professor of anesthesiology and perioperative medicine in Oregon Health & Science University's School of Medicine.

"There is a concern they're going to be overly sedated and it's going to potentially have catastrophic consequences if you add more sedating medications," he said.

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> *— Dr. Andrei Sdrulla, assistant professor at OHSU*

Several documents on the Oregon Medical Board's website designed for doctors involved in pain control explicitly advise against prescribing opiates to patients using marijuana, including OHSU's guidelines for safe opioid prescribing, and similar guidelines from the Oregon Medical Group. State law says doctors must maintain written documentation of their discussions with patients about the goals of their opiate use.

All of this, coupled with the federal criminalization of marijuana, contributes to a wealth of reasons to fear the drug if you're a doctor.

Much of the fear stems from examples of state medical boards fining and punishing doctors who are found to have prescribed opiates to patients who use marijuana, especially if those patients were driving while impaired or overdosed, said Dr. Lynn Webster, past president of the American Academy of Pain Medicine and currently a pain medicine researcher in Salt Lake City. Doctors have also been sued, he said.

"It is the acts that have occurred in front of medical boards and mostly in courts that have been heard by physicians, and that has created the chilling effect," he said.

For his part, Webster advocates for reclassifying cannabinoids as Schedule II drugs, which have a slightly lower potential for abuse than Schedule I drugs and are recognized as having some medical value.

The DEA, which requires physicians to register in order to prescribe controlled substances such as opiates, could revoke doctors' prescribing privileges, said Kathleen Haley, executive director of the Oregon Medical Board.

That said, no law in Oregon precludes doctors from prescribing opiates to patients using marijuana.

"There is no law about it, but it is, I think, the wisdom of those who practice in the field that it is not

advised," she said.

Docs in the dark

Laura Borgelt never expected to become the University of Colorado-Denver's go-to marijuana expert.

The professor of clinical pharmacy and family medicine has served on six recreational and medical marijuana task forces in her state, studying and crafting guidelines around things like pregnancy and breastfeeding, dosing and labeling. (Recreational use became legal in Colorado in 2012, while medicinal use has been legal since 2001.)

It all started roughly seven years ago. A medical resident at the university was describing to Borgelt her conversation with a patient, a breastfeeding mother. The patient told the resident she smoked a joint per day, which the resident responded was "probably completely fine," Borgelt recalls.

"As I was listening to her talk about this patient, in my own mind, I thought, 'I don't think that's right, but I'm not certain it's wrong,'" she said. "It just kind of created this concept of, 'I've got to learn the answer.'"

The answer, observational research has since shown, is the psychoactive effects of tetrahydrocannabinol (THC) in marijuana could negatively impact the developing brain, Borgelt said. The connection still isn't well understood — and it would be unethical to study, given the drug's potential harms — so Borgelt helped draft guidance for doctors and patients that advises against marijuana use during pregnancy and breastfeeding.

Still, Borgelt says, doctors in Colorado continue to see patients who use marijuana while pregnant, often to help with nausea or vomiting.

"There are women who believe that it is a natural and/or safe option for them," she said.

Now that Colorado's laws opened the floodgates for more marijuana use, the state has convened a number of task forces to try to get ahead of potential public health issues that could arise. For example, the state has seen an increase in children consuming edible marijuana products disguised as typical candies or baked goods, which the state has tried to remedy by enforcing new labeling rules.

Health leaders in Oregon are trying to identify similar issues here and prepare for them as best they can.

But even as officials work to educate the public about marijuana, most doctors know very little about the drug, even while their own patients rely on it as their primary therapy for conditions such as chronic pain, multiple sclerosis or depression.

Some of the lack of knowledge can be explained by the lack of solid research supporting marijuana's

medicinal value. Its classification as a Schedule I drug makes it very difficult to study, as Webster, with the American Academy of Pain Medicine, learned when he tried to get DEA permission to do so. The DEA must inspect the study site and protocol, a process that can take up to a year and cost tens of thousands of dollars, he said.

We still have a lot of gaps that need to be filled. I think that puts doctors in difficult positions because they want to be able to provide information to their patients that they know is correct and accurate.
— Laura Borgelt, professor at University of Colorado Denver

In many cases, much of doctors' dealings with patients who use marijuana are based on their personal opinions about marijuana, given that the evidence around its use is inconclusive, Borgelt said.

"We still have a lot of gaps that need to be filled," she said. "I think that puts doctors in difficult positions because they want to be able to provide information to their patients that they know is correct and accurate."

The research that has been done hasn't yielded clear answers.

A systematic review of 79 medical marijuana studies published in the Journal of the American Medical Association in June found moderate evidence supports the drug's use to treat chronic pain and the muscle spasms and stiffness common in multiple sclerosis. Of lower quality, the study found, was the evidence to suggest the drug helps with nausea, vomiting, weight gain (such as for those with HIV infection), sleep disorders and Tourette syndrome.

In response to the study, two Yale University physicians not involved in the research, Deepak Cyril D'Souza and Mohini Ranganathan, penned an editorial asking whether medical marijuana laws put the cart before the horse by allowing for widespread use before its medical benefits are fully established. The physicians also highlighted the unknown effects of the more than 400 compounds, including flavinoids and terpinoids and about 70 cannabinoids, found in marijuana.

Sdrulla, of OHSU, said other studies have also found no benefit. He has a skeptical perspective on marijuana use among his pain patients.

"If it's working so well, then why does the patient still have a lot of pain?" he said. "From my perspective as a pain physician, I don't feel like the marijuana works well for most types of pain."

VA lets its docs decide

The VA Portland Health Care System does not have a policy that precludes its physicians from prescribing opiate pain medications to patients who are using marijuana. All patients prescribed the drugs, however, are drug-tested. If patients are found to be using marijuana, doctors could choose to stop prescribing pain

medications, but that's determined on a case-by-case basis, said Dr. David Coultas, chief of staff for the Portland VA system.

"I think it would be potentially very disruptive to the doctor-patient relationship to just have a blanket statement and to tell doctors how they need to practice," he said.

Some research has found people who use marijuana recreationally are more likely to abuse other drugs and use pain medications prescribed to someone else. Nearly half of patients who used marijuana recreationally also used other nonprescribed drugs, most commonly pain medications and sedatives, compared with one-third non-marijuana users, according to a 2013 report by Quest Diagnostics, a company that provides lab testing and other services.

Coultas said he thinks it's unfair to assume patients who use marijuana are abusing their pain medications, but he believes that's where blanket policies that preclude allowing patients to use both come from.

Several people interviewed agreed with Coultas that such policies do more harm than good.

Borgelt, of UC Denver, said some larger hospitals and health systems in Colorado that have such policies are now reconsidering them. She said she is a firm believer in the power of shared decision-making between patients and providers, wherein doctors and patients work collaboratively toward health goals, rather than doctors telling patients what to do.

"If a patient knows they're going to get in trouble if they admit this, I guess it really creates a bind for that open communication to occur," she said.

And while it's true both marijuana and opioid pain medications have sedative effects, it's possible there is a safe space for patients who use marijuana in the context of the medications, Borgelt said. In fact, some of the patients she and her colleagues have seen have been able to use fewer opiates because of using marijuana, she said.

Several patients interviewed for this article said they were able to get off of all or most of their pain medications after they started using marijuana, a sentiment echoed by a handful of providers who specialize in certifying patients through Oregon's medical marijuana program.

States with medical marijuana laws have nearly 25 percent fewer opioid deaths on average compared with those without such laws, according to a 2014 study in JAMA Internal Medicine. The rates of overdose deaths generally decreased over time, the study found.

Dr. Marcus Bachhuber, the study's lead author and a fellow at the Robert Wood Johnson Foundation

Clinical Scholars Program at the University of Pennsylvania, said it could be the fewer opioid deaths are partly the result of patients supplementing their opioid use with marijuana, and therefore using fewer opioids. Other small studies have found people use fewer opioids when also using marijuana, he said.

Policies that preclude patients from using both make people feel uncomfortable talking to their doctors about marijuana use, even if it's important to them, Bachhuber said.

"I think a lot of doctors don't create an environment where patients feel like it's a safe space to talk about these issues," he said, "and it's not just drugs; it's other things as well."

My sense is that as it becomes legal in the state of Oregon, the medical community will start addressing it at more of a state level or maybe even a national level.
— Dr. Andrei Sdrulla, assistant professor at OHSU

'Paperwork for money'

Now that recreational marijuana use is legal in Oregon, Sdrulla said its increased use could push the medical profession to address fundamental questions about the drug that are currently going unanswered. Sdrulla said he'd like to see national evidence-based guidelines developed around how to talk to patients about marijuana use and address safety issues.

"My sense is that as it becomes legal in the state of Oregon, the medical community will start addressing it at more of a state level or maybe even a national level," he said.

Webster, of the American Academy of Pain Medicine, said he thinks, if anything, recreational legalization will only add to the fear among doctors of more scrutiny of their businesses, especially pain specialists.

Several pain specialists in Bend, including doctors at Bend Memorial Clinic, The Center Orthopedic & Neurosurgical Care & Research and Bend Spine & Pain Specialists, declined requests for comment. Webster said that's not surprising, as they're caught between a rock and a hard place when it comes to marijuana. On one hand, they're concerned about federal government scrutiny if they appear too supportive of its use, while they also could be subject to loud criticism from marijuana users and advocates if they come out as being opposed to its use, he said.

Perhaps the best public statement they can make, Webster said, is simply to "be silent."

Some medical marijuana advocates have also expressed concern the legalization of recreational use could dissolve the medical sector, which Le, of Green Earth Medicine, said has significant flaws but is also necessary.

As much as he advocates for the use of marijuana for medicinal purposes, Le voted against the legalization of recreational use in Oregon. That's because he believes there are major problems with the medical

marijuana industry that must be solved.

For one, because so many primary care physicians refuse to sign patients' approval documents for Oregon's medical marijuana program, patients are forced to see doctors who specialize in medical marijuana approvals. That means relatively few doctors in Oregon sign hundreds of approvals for the medical marijuana program, and they tend to work out of what Le calls "signature mills." These doctors might have between five and seven minutes to sign the paperwork for each patient, which means they're probably not doing much to assess patients' needs or educate them on its use, he said.

Le learned this from briefly working at one such clinic himself before surrendering his license.

"It was barely enough time for me to review records and fill paperwork out, so there was obviously no interaction between doctor and patient, no relationship like that," he said. "I realized after a few months of doing work with them that, 'OK, this is not a legitimate clinic. This is paperwork for money.'"

In Le's practice, some patients only want a doctor to sign the documents that allow them to use medical marijuana. Others want more explanation around how to use the drug for their specific ailments, he said. Le said he is mainly worried if doctors aren't sharing important information with new users and following up with them periodically, they'll wind up with strains that won't help them. Most of what's sold in dispensaries is high-THC strains.

"My concern is that many of those patients who would normally be sitting here to get that information from me are not going to come here; they're just going to go to a dispensary and assume that the kid behind the counter is just going to give them some weed and that's going to treat their cancer," he said. "They're just going to go home and smoke pot, get high — maybe get too high — get freaked out and never touch the stuff again."

'They don't want to get high'

Bogoger, the medical marijuana patient, wants to dispel the "Cheech and Chong" stereotype about marijuana users: that they're lazy stoners who wear tie-dyed shirts, play video games and eat Ding Dongs.

"That generation of pothead is gone," he said. "The '70s are gone."

It's not just the way marijuana users look that's changed; it's how they use the drug, Bogoger said. People using medical marijuana for chronic pain, as he is, generally are not trying to get high. They tend to use strains that are higher in cannabidiol, or CBD, the cannabinoid in the drug that doesn't produce a high, but that many believe has therapeutic properties. The other main cannabinoid in marijuana is tetrahydrocannabinol, or THC, which produces most of the drug's psychoactive effects. Bogoger said he prefers a strain that's more than 11 percent CBD, which is a high proportion of CBD.

Willy Bogoger Jr. holds a plate filled with different types of marijuana at his home in Tumalo. *Andy Tullis / The Bulletin*

Le said he's constantly disputing assertions from friends and colleagues that medical marijuana patients are just trying to get high.

"They have stacks of medical records," he said. "Look at the number of surgeries they've had, the number of drugs their doctors have put them on, and then look at how they respond to cannabis."

It's also a misconception that most medical patients are smoking marijuana, Le said. The most effective way to ingest marijuana for medicinal use is orally, through liquid tinctures or oils, he said.

Couch, for example, said he uses a form of oil produced from marijuana extract that's high in CBDs. His daily regimen includes getting up at 5 a.m. and, shortly after, collecting the residue from vaporized marijuana into a tea bag, adding turmeric and cinnamon, and letting the mixture seep into his coffee. He also bakes marijuana into cookies and desserts, but only eats them after 4 p.m., once he's ready to relax.

"People who are smoking pot and calling it medicine need to take a long look at what they're doing," he said.

Sandee Burbank heads Mothers Against Misuse and Abuse, a provider that operates several clinics in Oregon, including one in Bend, that help patients access marijuana and teaches them to use it safely and effectively. The clinics distribute pamphlets with information on how marijuana interacts with other drugs, its different forms, how long it takes for the effects to set in and how long the effects last. An entire page is dedicated to trying marijuana for the first time.

When medical marijuana first was legalized, she said, everyone thought they were limited to smoking it or eating it. Now, she said, there are tinctures that can be taken orally or rubbed on the skin. Patients who use the tinctures don't get the same high effect as they would if they smoked marijuana, Burbank said. That's attractive to many of her clinics' patients, whose average age is 58.

"They don't want to get high," she said. "They're here to see us because most of them have access to all kinds of drugs, and the side effects are so severe, and they just want to get relief without having those side effects." •