THE MERCY NEWS REPORT

AARP Tries To Report Older Americans' Attitudes on Medical Marijuana

Survey Of Adults 45+ Produces Note-worthy Findings, But Publication Hindered

Last November, *AARP The Magazine* commissioned a telephone poll among a nationally representative sample of 1,706 adults aged 45 and older, asking them to respond to a series of statements on the subject of medical marijuana. What follows are some highlights of the survey, along with a brief summary of noteworthy findings for each:

I think that adults should be allowed to legally use marijuana for medical purposes if a physician recommends it. Support for legal medical marijuana was strongest in the West (82%) and Northeast (79%), and lowest in the Southwest (65%). Interestingly, there were no significant response differences among those of different age categories.

If a loved one was ill or suffering and marijuana eased their pain or condition, I would obtain marijuana for him or her.

<continued next page>

Another Option For Patients

MAMA is now scheduling appointments for **OMMP clinics** to be held in Portland, starting **Saturday, February 12th**. For more information contact them at mama@mamas.org -or- call: **503-233-4202**.

Mothers Against Mis-use and Abuse (MAMA) is a non-profit organization, founded in 1982, to provide a holistic approach to the many aspects of substance use. MAMA felt that the focus on illegal drugs as the "BAD" drugs, gave the false impression that legal drugs were safe and "good". Research showed that in today's society there are high levels of alcohol abuse, prescription drug misuse and abuse, and great harm caused by excessive consumption of nicotine, caffeine and over-the counter drugs.

For a long time it has been MAMA's dream to have a Portland office. The address is: 5217 SE 28th (Steele & 28th)

They will be offering their award winning drug education services and resuming their activities helping patients and doctors negotiate the often complicated process of certification for the Oregon Medical Marijuana Program. Any interested patients can leave a message on their machine and they will contact you shortly.

This effort took a number of dedicated people working together and MAMA wishes to thank all who helped on the project.

OMMP Interim Manager Announced

Mary Leverette, Special Projects Manager, has moved on to new projects in the Office of Public Health Systems. She is no longer acting manager of the Oregon Medical Marijuana Program. Grant Higginson - currently the State Health Officer & Director of the Oregon Health Division - remains in charge of the Oregon Medical Marijuana Program for now.

Dr. Higginson reported a perceived need to get an interim manager into the OMMP as quickly as possible to ensure program quality and personnel support, and the department feels fortunate in finding a qualified Program manager to accept a 6-month job rotation in this capacity.

RON PRINSLOW is a registered nurse by training and has been working in the Office of Public Health Systems for the last 18 years, most currently as the Supervisor in Health Care Licensing and Certification. Mr. Prinslow is reportedly excited about this opportunity to be in charge of a challenging program, and **<continued next page 7>**

The MERCY News Report is an all-volunteer, not-for-profit project to record and broadcast news, announcements and information about medical cannabis.

For more information about the MERCY News, contact us.

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Check it out!

The MERCY News is produced due to the efforts and expense of the members and staff of the

<continued from AARP REPORT, previous page> Younger respondents (63% of those 45-49) were more likely to agree with this statement, as were those who have smoked marijuana (74%).

Do you believe marijuana is addictive? While the majority of respondents support medical uses of marijuana, the majority also believe that marijuana is addictive. Women and older respondents (age 60 and older) were more likely to think marijuana is addictive than men and younger (under age 60) respondents.

I believe all marijuana use should be legalized. Younger respondents (34% of those 45-49) were more likely to agree with this statement, as were those who have smoked marijuana (44%). Older respondents (15% of those age 70 and older) were the least likely to agree. Responses across geographical regions did not differ significantly.

Have you ever smoked marijuana? Younger respondents (58% of those 45-49) were more likely to have smoked marijuana, with those 50-59 (37%) and 60-69 (15%) registering significant drop-offs in use. Considerably more men (39%) than women (21%) report having inhaled, and respondents in the West (32%) were more likely to have smoked marijuana than respondents in other regions.

Visit: http://www.aarpmagazine.org/health/Articles/a2005-01-18-mag-marijuana.html

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Urge AARP to Stand Up to Smear Attacks

Why did AARP, the 35 million member organization for people age 50 and over, pull an article on medical marijuana that was supposed to run in its magazine this month? Not because its readers weren't interested; a poll the group commissioned (click here) found that 72% of older Americans support an adult's right to use medical marijuana with a physician's recommendation, and 55% said they would obtain medical marijuana for a loved one in need.

AARP reportedly pulled the article when it was viciously attacked by a so-called "media watchdog" organization, Accuracy in Media, and fanatical anti-drug groups with a long history of engaging in malicious and dishonest attacks.

But you can help AARP stand firm in the face of this onslaught. By sending them a letter of support, you can demonstrate that the voices of those who champion informed discussion of controversial issues speak louder than the minority who seek to discredit them.

Please take action now to defend freedom of the press and the right of AARP to talk about issues that are important to its members. Visit:

http://actioncenter.drugpolicy.org/action/index.asp?step=2&item=24647&MS=aarp-aa

for details and action tools. Or call 1-888-OUR-AARP (1-888-687-2277), Monday – Friday, 7am – 12 midnight EST –or- Write AARP at 601 E. Street NW, Washington, DC, 20049

Medical marijuana cards abound

The number of Oregon patients allowed to use the drug soars to nearly 10,000, which some see as a success and others a problem

Nearly 10,000 Oregonians carry medical marijuana cards, about 20 times more than officials predicted when the program started six years ago.

The fee-based program, which gets no money from the state general fund, has grown so fast that it built up a cash surplus of nearly $1 million last year. To reduce the surplus, officials slashed the annual fee for a medical marijuana card from $150 to $55 this month. For Oregon Health Plan patients, the fee dropped to $20.

The number of cardholders has doubled in less than two years. Between 80 and 100 new or renewal applications arrive on a typical day, said Pam Salsbury, who manages the state's medical marijuana office in the Department of Human Services.

"I don't think anybody in their wildest dreams thought there would be this many people in the program," Salsbury said. "We're hearing from other states that have a program and wonder how we do it."

Critics say the unforeseen growth shows that medical marijuana cards can serve as a cover for recreational drug use. Defenders say it reflects growing acceptance, by doctors and patients, of marijuana as an alternative to mainstream medicine.

Oregon is one of 10 states where medical marijuana use is legal. The others are Alaska, California, Colorado, Hawaii, Maine, Montana, Nevada, Vermont and Washington. The laws vary widely. Oregon's Medical Marijuana Act, approved by voters in 1998, allows residents to use a small amount of marijuana for medical purposes. They must grow their own or designate a caregiver to do so for them.

A doctor must verify that the patient has a "debilitating medical condition" such as cancer, glaucoma or AIDS, or a symptom such as nausea or severe pain. The doctor's signature does not count as a prescription.

More than 1,500 Oregon doctors have signed at least one patient application, according to state figures through 2004. But 10 doctors account for two-thirds of the current and pending marijuana card requests.

Each of those 10 physicians has signed more than 100 applications, and the top two have signed 2,796 and 1,783 apiece. The state does not divulge the names of participating doctors.

"Loopholes for abuse"

"Unquestionably, people are taking advantage of a system that was created for individuals with medical problems," said Ken Magee, the Drug Enforcement Administration's agent in charge of operations for Oregon and Idaho.

The federal agency, he noted, considers marijuana a dangerous drug with no medicinal value.

Oregon's medical marijuana program has a "very lax system of review and oversight," Magee said. "The law is riddled with loopholes for abuse."

Qualifying conditions such as "severe pain" or "persistent muscle spasms" are so vague that they allow little rigorous control over misuse, he said.

More than 80 percent of the current cardholders cited severe pain on their applications. About 30 percent cited persistent muscle spasms, and 22 percent cited nausea. Applicants often give more than one medical reason. Colorado's 4-year-old medical marijuana program is modeled on Oregon's. Despite a larger population, Colorado has only 504 cardholders, about one-twentieth as many as Oregon.

After an Oregon patient's application for a medical marijuana card is complete, Salsbury said, the state sends the signing doctor a letter. The doctor must sign a second form verifying that he or she did see the patient and did approve the card request.

Once the application is complete and verified, she said, the state issues a card. Under the law, officials don't evaluate motives.

"That's not for us to question," she said.

State disciplines two doctors

Two doctors -- Dr. Phillip Leveque of Molalla and Dr. Larry Bogart of Roseburg -- have been disciplined by the Oregon Board of Medical Examiners for inappropriate recommendation of medical marijuana. The board regulates medical practice.

Leveque, an 81-year-old osteopath, had his license suspended in March and revoked in October. He said he had signed several thousand medical marijuana requests.

The board in October also stripped Bogart, a 66-year-old psychiatrist who said he has signed more than 1,000 medical marijuana applications during the past five years, of his ability to treat children, prescribe controlled drugs or sign marijuana card applications. He retains his license.

The Oregon Medical Association, the largest physicians group in the state, stayed neutral on the original medical marijuana law in 1998. The association opposed a ballot measure last November that would have broadened the law, easing restrictions on allowable limits and creating state-regulated dispensaries to sell marijuana to cardholders.

A federal appeals court in California ruled in 2003 against the Bush administration's bid to punish doctors who recommend medical marijuana to their patients. Since that court opinion, fewer doctors in Oregon are afraid to sign medical marijuana card requests, said Jim Kronenberg, the medical association's chief operating officer. <continued on next page>

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"We continue to encourage our members to be very circumspect about how they participate," he said. Doctors are urged to keep careful records and avoid even the appearance of prescribing an illegal drug.

Advocate sees more acceptance

John Sajo, who heads Voter Power, an advocacy group for medical marijuana users, attributed the rapid growth in the Oregon program to increasing acceptance by doctors. He said marijuana helps some patients avoid more potent and expensive prescription drugs.

"It's not just the patients saying they feel better," he said. "It's also the patients saying: 'And don't write me the morphine prescription anymore.' "

Others say marijuana is a "gateway drug" that can lead to using more addictive drugs.

"We're making a big mistake in making marijuana available," said Walt Myers, Salem police chief and head of Gov. Ted Kulongoski's task force on methamphetamine. "There are enough drugs on the market that will relieve the pain of any disease known to mankind, without resorting to marijuana."

CANNABIS: PRESCRIBING THE MIRACLE WEED; The Drug Can Be a Lifeline, and a Fortunate Few May Soon Get It on Prescription. But Why Has It Taken So Long?

I have had patients commit suicide because they said life had no meaning for them any more," says William Notcutt, an anaesthetist at James Paget Hospital in Great Yarmouth, Norfolk, on England's east coast. Notcutt specialises in treating patients in severe long-term pain. The causes are varied, ranging from spinal injuries to multiple sclerosis, but most of the patients have one thing in common: existing medicines don't help them.

"It's not just the pain, it's also what it does to your life," Notcutt says. "You've lost your job, you have financial problems, your spouse is fed up. I hear these heart-rending stories of people whose lives are crap."

If there is one thing more frustrating for a doctor than being unable to deal with a patient's problem, perhaps it is knowing that there is a drug that could help - but they are not allowed to prescribe it. For Notcutt that drug is cannabis. Many patients with difficult-to-treat conditions use cannabis to relieve their symptoms, but in most parts of the world that makes them criminals. Otherwise law-abiding citizens dislike having to get their treatments from drug dealers. And the quality of the medication they get that way is variable to say the least.

But in the next few weeks Canadian regulators will decide whether to approve an under-the-tongue cannabis spray called Sativex for multiple sclerosis (MS) patients. As the world's first prescription pharmaceutical made from marijuana, it would at last allow patients to get their therapy in a safe and consistent formulation. The product could become available in the UK in a year or so, and its British manufacturer, GW Pharmaceuticals, is expected to file for approval soon in Australia and New Zealand.

Sativex will not bring any miracle cures, and in countries like the US where official hostility to marijuana is ingrained, patients may have a longer wait for its benefits. All the same, the availability of a cannabis preparation as a prescription medicine will mark a milestone in a decades-long battle by doctors and patients for public acceptance of medical cannabis use.

Marijuana use has a long history. For thousands of years, people have been harvesting the seeds for food and oil, and making rope from the fibres.

The plant is used in traditional medicine all over the world to relieve pain and muscle spasms, to prevent seizures and to aid sleep. It may also alleviate nausea - though it can sometimes trigger nausea in new users - and it can boost appetite.

But the drug is best known for its effects on the mind: it is an intoxicant that makes people feel happy and relaxed, and over the past century its recreational use has become increasingly popular in the west. Cannabis is not very addictive and its harmful effects are mainly on the lungs, from smoking. In some users it can trigger delusions and hallucinations, and there is debate about whether it can cause longer-term psychiatric problems in a small minority. In the early 20th century, most western governments responded to what they saw as the growing menace of marijuana by outlawing it.

As for medicinal use, cannabis came to be seen as an obsolete herbal remedy with unpredictable potency. It disappeared from the US Pharmacopeia and National Formulary in 1941, and the British National Formulary in 1971.

Until the late 1980s, when Notcutt began investigating the medicinal use of cannabis, research on the drug was focused mainly on establishing its dangers to people who used it recreationally, or its effects on animals.

Notcutt's interest grew out of his wish to find something new to deal with his patients' chronic pain. He found repeated references to the drug in historical medical texts on pain relief, and a growing body of research on animals showed that the main active chemical of cannabis, tetrahydrocannabinol (THC), bound to specific receptors in the brain.

In 1982 a form of synthetic THC had been licensed for relieving nausea after cancer chemotherapy, so Notcutt's first step was to investigate this for pain.

He began a small trial in his worst-affected patients, mostly people with spinal injuries. Some of them said THC helped; some of them said it made them feel dreadful. Others said it wasn't as good as the "real stuff". Thus Notcutt was introduced to the

underground world of medical marijuana use. Even in sleepy Norfolk he found a small subculture of people who were getting what they viewed as an essential medicine from their local drug dealers. Notcutt began seeing growing number of MS patients, who said cannabis relieved their pain and muscle "spasticity" - spasms and stiffness - and helped them sleep. The next step, Notcutt says, was to find a better way to give the patients what they wanted. In the early 1990s he and his team began exploring how they might carry out a clinical trial of cannabis.

They immediately ran into difficulties, because of the drug's illegal status and the resulting haphazard supply chain. "Are you going to use any old thing that comes off the Felixstowe docks?" he asks. "What's the quality, how do you standardise it?" They also failed to come up with a safe and effective way to administer the drug. Taken orally, marijuana's potency varies markedly and it doesn't become effective for at least an hour.

Smoke it, and you inhale a bunch of cancer-causing chemicals just as you do when smoking tobacco.

In California, Donald Abrams, an HIV specialist at San Francisco General Hospital, was facing similar problems. He was interested in the possibility that cannabis could help people with AIDS stave off catastrophic weight loss. "They'd get loss of appetite and diarrhoea and just sort of waste away," Abrams says. "It was a terrible way to go." In 1992, synthetic THC was licensed for combating the nausea that is a symptom of AIDS, but, as with MS patients, many found marijuana more effective. Like the English patients, they faced supply problems. After a 70-year-old volunteer helper at his clinic was arrested for giving patients cannabis-laced brownies, Abrams decided to carry out a formal trial of marijuana.

If anything, he faced even stiffer opposition than Notcutt. In 1994 the team asked permission from the US Drug Enforcement Administration to obtain cannabis from a Dutch firm called Hortapharm but was turned down. They next approached the National Institute on Drug Abuse (NIDA), the only domestic body allowed to provide marijuana for research. Again they were rejected, partly because officials said they feared patients might sell their drugs on the street, and partly because the institute was more interested in investigating the harm from recreational cannabis use. A third proposal to NIDA, in 1996, was also turned down.

By then, official attitudes in the UK were showing signs of becoming more favourable to medicinal marijuana. Paradoxically, this stemmed partly from anti-drug sentiment. Increasing numbers of MS patients using marijuana were ending up in court, and many were given light sentences or effectively let off. Concerned that this was bringing drug laws into disrepute, the government started to make positive if cautious noises about legalising medicinal cannabis if a pharmaceutical form of it could be developed.

At the same time, medical research into cannabis was gaining respectability globally as details began to emerge about the cannabinoids our own bodies produce (see "Natural high"). But such research was almost entirely carried out by academics. What pharmaceutical firm would want to risk investing in such a politically controversial and financially uncertain field?

Enter Geoffrey Guy, a businessman with a background in pharmaceuticals who was looking for his next venture. Cannabis's long history ruled out the normal route for making money from a drug: by patenting it as a therapy. But Guy realised he could gain market exclusivity by developing a drug from cloned cannabis subspecies to which he owned the plant-breeders rights. Guy recalls that when he approached government officials for a licence to research his idea, they needed little convincing. "They were almost relieved that a company had turned up," he says. "I was pushing on a door that sprung open."

His new company, GW Pharmaceuticals, bought several strains of cannabis with consistent high drug yields from Hortapharm and by the late 1990s was growing and harvesting a crop of 5000 plants. To avoid the variable absorption of ingested cannabis, the firm decided to produce a spray to be applied under the tongue, where it would be quickly absorbed into the bloodstream. And so Sativex was born.

Notcutt agreed to carry out a clinical trial. But despite increasing public acceptance of the idea of using cannabis medicinally, he found it hard to get the study approved by his hospital.

It took about a year to get the go-ahead for a small three-month study in people, some with MS, for whom existing treatments were ineffective against chronic pain. The results, published last year (Anaesthesia, vol 59, p 440), showed that Sativex provided significant pain relief for 28 of the 34 patients in the study. GW began larger trials on people with MS or chronic pain, as well as pilot studies in people with cancer.

At this point GW began looking for a pharmaceutical company with the muscle and money to help market Sativex. Rumours circulating at the end of 2002 suggested that Guy was in talks with a major-league company, perhaps GlaxoSmithKline or AstraZeneca. Guy won't say, because before the deal was done, the firm got cold feet. They were spooked by the "c-word", Guy says. Cannabis was too controversial for the American board members. GW had to find another partner, and in May 2004 it finally struck a deal with the German-based multinational Bayer.

In the meantime, the larger clinical trials were starting to yield positive results. GW has applied for a licence from the Medicines and Healthcare Products Regulatory Agency (MHRA) to sell the drug in the UK. The MHRA has asked for a "confirmatory study", to prove that the reduction in muscle spasticity seen with Sativex brings meaningful benefits to patients. GW says this will take several months.

But it is in Canada, where patients can legally use cannabis for medicinal purposes, that Sativex is closest to being licensed. The preparation was given preliminary approval in December, and GW and the Canadian regulatory agency are now thrashing out exact terms for a licence to allow Sativex to be sold as a prescription drug. Assuming they **<continued on next page>**

<continued from previous page> reach agreement, Sativex could reach pharmacies within a couple of months. GW says it will be applying for licences in "other Commonwealth countries", probably Australia and New Zealand.

It may not be long before Sativex is joined by other cannabis preparations. A non-profit group, the Institute for Clinical Research in Berlin, Germany, is developing oral cannabis capsules, called Cannador. In November 2003 a study in 630 MS patients produced equivocal results (The Lancet, vol 362, p 1517). While the formal scoring system for measuring muscle spasticity indicated that Cannador performed no better than a placebo, the patients themselves felt it helped. Martin Schnelle, who conducted the trial, says that there are widely acknowledged problems with the formal scoring system used. "There are medicines that are already licensed for treating spasticity that have failed on this scale," he says. The group is planning a further study this year in which the patients' reports will be the main measure by which the drug's effectiveness is judged.

In the US, the NIDA has become more open to research on the benefits of cannabis, and Abrams is studying its ability to ease pain due to nerve damage in HIV, and nausea and vomiting after cancer chemotherapy. He is investigating a device called the Volcano, which heats cannabis to the point of vaporisation without burning it, which he says is less harmful than smoking it in a joint because it releases fewer carcinogens. While Abrams welcomes products like Sativex, he suggests that some people will always prefer marijuana to a commercial preparation - not least because they can grow it themselves.

But however cultural attitudes to street or home-grown cannabis change, its availability in standardised, licensed preparations such as Sativex and perhaps Cannador will be the key to its wider medical use. GW is planning studies of its possible benefits for people with a range of conditions from Crohn's disease to rheumatoid arthritis and heroin addiction. If positive, Canada's decision will signal a big change in the status of cannabis, says Philip Robson, the firm's medical director. "It's the dawning of a new clinical research era."

Feds Seek to Forfeit Family's Home for Growing Medical Marijuana

(California NORML Release - Jan 31, 2005) San Andreas, CA. In a flagrant violation of California's medical marijuana law, the federal government has filed to forfeit the home of a Calaveras county patient for cultivation. Wesley Crosiar, 52, received a federal forfeiture notice after sheriffs' deputies discovered 134 plants on his land off HawverValley Rd. Crosiar says he was growing for himself and a half dozen other personal acquaintances, and that he checked with the DA beforehand to be sure he was within legal SB 420 limits. "I wanted to make sure what I was doing was legal," he says.

Crosiar has no assets except for his home and five acres of land, which he acquired through his father's inheritance. He built the house himself and his been living there with his wife and four sons. Crosiar has no criminal record, but he has been involved in a dispute with county authorities over alleged building code violations. This is the first known case in which the government has sought to forfeit the home of such a small-scale medical marijuana grower. "I'm 52. It's taken my whole life and the inheritance of my father to get what I have, and now they want to take it away," says Crosiar. Observers suspect that the suit was initiated at the behest of the Calaveras sheriff's department, which has been notoriously hostile to Prop. 215.

California NORML denounces the case as an outrageous instance of drug enforcement abuse.

"To forfeit a family's home for medical marijuana makes a mockery of President Bush's call for an 'ownership society' based on freedom and liberty," says coordinator Dale Gieringer. " There's no way that a garden this size should be a federal case. This is a shameful attack on Prop. 215."

For more information contact Dale Gieringer of California NORML by phone (415) 563-5858 * e-mail: canorml@igc.org * or writing to: 2215-R Market St. #278, San Francisco, CA 94114.

<continued from OMMP Changes, pg 1 > looks forward to meeting key stakeholders. Informed stakeholders report they are excited about this change, see it as an opportunity to positively effect this challenging program, and look forward to working with Mr. Prinslow.

Other stuff from the Ron Prinslow file. From Gervais, Oregon, he is a Veteran and PSU Grad, Accounting major. Interviewed previously for the position when Ms. Leverette replaced Ms. Paige.

Motto is customer service and his first goal is reducing the timeline on Card turn-around. To do so - NOTE! Call In Hour Change. New Phone Bank hours. To better serve the card-holder community – really! – office phones will only be answered from 10am until 3pm.

What is happening is 20% of the people and their issues is taking up 80% of the resources trying to fully resolve each item to the callers complete satisfaction over the phone. Result is a backlog in the basic process of getting cards approved and out the door.

The OMMP office checked with OHP Food Stamps department, among others, on phone system call processing issues to come up with plans both short-term and long.

So, for a time, direct phone help will be restricted to the hours of 10am to 3pm. Outside those hours you can leave a message. You can also email or use the postal service if your need is not as immediate. Coming soon is more access for visitors as the program will attempt to secure meeting room space for that purpose.

Also announced:

- Office space issues solution forthcoming, they are planning for an August move.
- New and improved phone system at that time as well.
- Patient database (MS-Access) changeover development.
- Current staff 10, trying for more permanent hires.

And more. Well keep you posted. If you get any info, please let us know!

Dr. Higginson also stated that during this 6-month period, DHS/OMMP will recruit for a permanent OMMP manager. As in the past, the program will be seeking representation on the interview panel from our community partners including program advocates, law enforcement and the medical community.

In addition PAM SALSBURY of the Oregon Health Division has taken on responsibilities above her previous job duties and is currently acting as the OMMP Office Manager. This is a role the department has wanted to have in the program for a long time and they're hopeful this arrangement will continue into the future. They want to assure the community that they are interested in providing the very best in customer service.

The MERCY News team will do their best to keep you updated. To discuss or propose changes one can attend the public Administrative Review meetings hosted by the OMMP.

Last meeting opportunity was February 28, 2005 from 1pm to 4:30pm in Rm 918 at the Portland State Office Bldg, * 800 NE Oregon Street * Portland. We'll get copies of documents and stuff from the meetings –as we can - and post in our library. Next meeting will be around the week of May 16-23 and will be held in Salem, we believe. Keep you posted! You can also keep up on Public Meeting Notices by visiting the OMMP website at:

http://www.ohd.hr.state.or.us/mm/

To get full advantage, be fully informed. Read the text of (OMMA) the Oregon Medical Marijuana Act, and the other documentation available, to understand the legal conditions and restrictions which govern medical growing and use of cannabis in Oregon.

Other info, stats –

Budget report shows a beginning cash balance of $730,599 as of 7/03. Revenue since that time til 12/04 totals $1,340,082 for a resource total of $2,070,681 available. Total Expenses for the period are $872,881 giving the Program a cash balance of $1,197,871 as of 12/04. Needless to say, the program plenty of funds available. The effect of the Fee reduction on the balance will no doubt be closely observed.

The Statistics report shows 9,813 patients and 4,991 caregivers for a total number of 14,804 cardholders with 1,576 different physicians involved in the process. 5,011 new applications and 4,061 renewals were received from January 1, 2004 thru December 31, 2004 for a total of 9,072. We should see an effect from the Fee reduction on these numbers also.

Contacting the OMMP:

OHD - Oregon Dept. of Human Resources Health Division
800 NE Oregon Street, #21 * Portland, OR 97232-2162
(503) 731-4030 - Emergency phone number
(503) 731-8310 - Medical marijuana program office (Hrs
(503) 731-4080 - FAX * (503) 731-4031 - TTY (nonvoice)

Breakdown by Condition:

Condition	Count
Agitation due to Alzheimers	less than 50
Cachexia	426
Cancer	277
Glaucoma	199
HIV/AIDS	208
Nausea	2,227
Severe Pain	8,739
Seizures, including but not Limited to Epilepsy	364
Persistent muscle spasms, Including but not limited to those caused by Multiple Sclerosis	3,010

Dutch Patients Prefer Cannabis Cafés To Pharmacies

By Stephanie van den Berg, The Hague * **Source: Mail and Guardian** (Website: http://www.mg.co.za/mg/)

With legal cannabis readily available, the Dutch government's programme for issuing medical marijuana through pharmacies is losing money as stocks pile up because patients seem to prefer buying their stash at authorised cannabis cafés.

Even though cannabis use is decriminalised and marijuana is widely available in hundreds of cannabis cafés known as coffee shops, the Dutch government set up a programme for medical marijuana in September 2001.

It cited studies showing that marijuana can be used to reduce nausea and vomiting in patients undergoing chemotherapy and radiotherapy, to reduce tension in glaucoma patients and to improve the appetite of people infected with HIV or suffering from Aids.

The idea was that patients would prefer a prescription from the pharmacy with a guaranteed strength and quality than take their chances in the commercial coffeeshops but it didn't work out that way.

After a year and a half of the groundbreaking programme, the Dutch Minister of Health Hans Hoogervorst calculated in December last year that the programme generated a loss of almost 400 000 euros ($520 000) in 2004.

Of the estimated 10 000 to 15 000 patients who use cannabis for medical reasons, only 1 000 and 1 500 people have taken part in the medical cannabis programme. The health ministry scaled down its expected yearly sales from between 200kg and 400kg of marijuana to just 70kg.

The government will not yet term the programme a failure but said it is being re-evaluated and a decision on how to proceed would be taken after the summer. **<continued on next page>**

THE MERCY Medical Cannabis Resource Center NEWS REPORT

<continued from previous page> "It appears that doctors are not prescribing as much as we had estimated based on studies," said Bas Kuik, a spokesperson for the government regulated Bureau of Medical Cannabis (BMC).

To James Burton, who was one of the two officially recognised growers of medical marijuana until the government ended its contract with him this year, it is clear what is holding back the programme.

"Problem number one is the price. Medical marijuana is sold at some nine euros a gram while in a normal coffee shop you can get a gram of cannabis at 4,5 to 5 euros," Burton said.

"There is a market out there, just not at this price."

The American knows what he's talking about. As a glaucoma patient he uses marijuana to ease tension. He was jailed in the US for growing the herb before he moved to The Netherlands in 1991. "I thought I was in nirvana" because of the liberal Dutch policies on soft drugs, he said.

The use of cannabis has been decriminalised here since the 1970s and the sale allowed through authorised bars known as coffee shops.

Sales are limited to five grams a person and growing marijuana is forbidden.

One of the problems for patients related to the price of medical marijuana is that the Dutch national health service does not reimburse prescriptions and there are only a few private health insurers that do.

At the prices the government charges a 90g a month prescription like Burton has for his glaucoma costs more than 800 euros.

This is simply too much for most patients.

Kuik insisted that the BMC does not make any money from the medical marijuana and explained the mark-up was necessary because of tax, research, sterilisation, packaging and logistics.

He pointed to a possible other reason for the unpopularity of the medical marijuana.

"The medical cannabis is made to be inhaled in a steam treatment or infused and drunk like tea and not for smoking. Maybe that is a disappointment for people expecting to smoke it but of course the ministry of health cannot encourage smoking," he said. **Visit: http://www.cannabisnews.com/news/thread20203.shtml**

Spanish Pharmacies to Begin Selling Medical Marijuana

Some 60 pharmacies in Spain's Catalonia region are set to begin dispensing medical marijuana, Europa Press reported Tuesday. According to the regional director of health resources, Rafael Manzanera, the pilot program will be up and running before the end of April. Spain will thus join the Netherlands as a country where medical marijuana is available through pharmacies.

Eleven months ago, the Catalan regional government approved the idea in principle and, egged on by the Catalan pharmacists' association, which demanded it match its words with actions, it is now prepared to get the pilot project underway.

According to Manzanera, the project will enlist four Catalan hospitals and their pharmacies, and will eventually be expanded to include 60 pharmacy branches. The expansion will come once the benefits of the original program have been analyzed, said a spokesman for the Catalan health ministry.

The dispensing of medical marijuana will be limited to "combating the vomiting provoked by chemotherapy and the effects of anorexia in persons suffering from AIDS," said Manzanera. "It will also try to alleviate muscular problems related to Muscular Dystrophy, as well as chronic pain that does not respond to other kinds of therapies." Visit: http://stopthedrugwar.org/chronicle/373/catalonia.shtml

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Oregon State Activists & Orgs:

Alternative Medicine Outreach Program (AMOP**)** * ROSEBURG * 541.459-0542

Eugene Compassion Center 2055 W. 12th Ave., Eugene, OR 97402 * PH# (541) 484-6558 FAX (541) 484-0891 * Office Hours: Tuesday and Friday - Noon to 6pm * visit: **http://www.compassioncenter.net**

Mothers Against Misuse and Abuse (MAMA**)** * Local Patient advocacy as well as national Drug Policy Reform. * 5217 SE 28th (Steele & 28th) * Now holding clinics, contact them at **mama@mamas.org** -or- call: **503-233-4202**.

Oregon Green Free (OGF**)** * 11918 SE Division St., #122. * Portland, OR 97266 * 503.760-2671 * web: **http://www.oregongreenfree.com/**

Southern Oregon Voter Power (SOVP**)** * P.O. Box 1395 * Jacksonville, OR 97530 * 541.890-0100

The Hemp & Cannabis Foundation (THCf**)** * 4259 NE Broadway St. * PORTLAND (Hollywood dist) - call for an appointment: 503.235-4606 * **http://www.thc-foundation.org**