



life beyond wheels

Rx for Pot:

Is Medicinal Marijuana Coming of Age?



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MEDICINE OR MENACE? 24

It seems like ages since cannabis sativa emerged as a widespread recreational drug in the 1960s. Despite the federal government's ongoing war on drugs since then, 14 states now have medical marijuana programs, and more seem sure to sprout in the near future. Has the time come to push pot nationally as legitimate medicine? By AARON BROVERMAN

Cover and Contents photos by Mark Braunstein



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(BULLY PULPIT)

“This is the best science
has to offer?”



Walk 'n Roll

Recently I read an article in *Parade* magazine about a robot-like product that the author claims, for now, “represents the best science has to offer paraplegics.” Yet another device designed by a well-meaning inventor who thinks all paras want is to stand and walk again, no matter how awkward, noisy and impractical the invention. Sorry, but I just don’t buy it, and won’t, not for \$30,000-\$40,000.

Before you cast me as an embittered old cripple who curses fate daily for his unbearable loss, hear me out. What galls me is the way *Parade* packages the invention: “Prescription Hope/Restoring the Power to Walk.” I’ve written before about the first article I ever saw like this, published in the *L.A. Times* in 1966, which introduced functional electrical stimulation — in those days called bioelectric engineering. That pioneering concept, now 44 years old, was more forward-thinking than this recent option, mainly because it had the ability to restore muscle tone and was a novel use of a mainframe computer — with potential to be miniaturized and refined many times over.

This latest invention is essentially a pair of motorized hinged-knee braces that require the use of forearm crutches and is powered by a backpack (battery and computer) that weighs 10 pounds. The author writes that “even for experienced users, walking with the technology is an ungainly process,” and slow. A helper must steady the user when he loses his balance. This is the best science has to offer?

In defense of the inventor, a para, the motorized bracing system may well offer some of us a much-needed way of moving about, within limited settings, while standing. But as long as forearm crutches are needed to maintain balance, the user’s hands are useless. Shouldn’t scientists, who see human hands as an evolutionary development, look for means of restoring walking that do not sacrifice one’s hands? In fact, shouldn’t scientists be looking for ways to restore function in quads as well as paras?

Fret not, they are. Research at the cellular level, with or without stem cells, continues to point the way to partial restoration on a practical level, and real

hope. But the author of the *Parade* article is stuck in the past. He writes: “Stairs and curbs are insurmountable. Store and restaurant doors and aisles are often too narrow for wheelchairs. Even washing dishes at a standard kitchen sink means that a paraplegic must first strap on a special brace to hold his body upright.” What? No more curb cuts, no incline platform lifts, no 36-inch doors or roll-under sinks? No ADA? No common sense?

Apparently the author is unaware of both social engineering and civil rights. I’d like to give him a ride in my new custom TiLite TR — with its Spinergy Extreme Sport Light rims, Schwalbe Marathon Plus tires, Frog Legs suspension casters and ROHO JetStream Pro carbon fiber back. Then I’d give him an injection that temporarily paralyzes his legs, help him strap on “the best science has to offer” and challenge him to a dishwashing contest at the sink of my choice. Afterwards, I’d see how many circles I could roll around him while he “walks” back to the nearest chair.

— TIM GILMER



Volume 21, Issue 199

“Best Lifestyle
Coverage, 2006”
— *Utne Reader*

Published monthly by NO LIMITS COMMUNICATIONS INC.
P.O. Box 220, Horsham, PA 19044

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EDITORIAL SUBMISSIONS P.O. Box 1287, Wilmington, NC 28402

POSTMASTER: Send address changes to New Mobility, P.O. Box 220, Horsham, PA 19044. Subscription rates: \$27.95/year; \$35.95/year in Canada; \$67.95/year international via airmail.

New Mobility (ISSN 1086-4741), Volume 21, Issue 199, is published monthly by No Limits Communications Inc. Copyright 2010, all rights reserved. Reproduction without permission of any material contained herein is strictly prohibited. We welcome comments; we reserve the right to edit submissions.

Periodicals postage at Horsham, PA and additional mailing offices.

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Rx FOR POT?

BY AARON BROVERMAN

Since his 1990 accident, Mark Braunstein, an incomplete para, has lived alone in a house in the woods in Connecticut — doing his own housekeeping and laundry, growing a garden and cooking — while remaining self-sufficient as a writer and college librarian. But his passion for growing vegetables is not the only horticultural activity that is important to him. Braunstein has smoked half a gram of homegrown pot — one joint's worth — every night after dinner since 1991. Without his nightly spliff, he says he wouldn't be able to use his crutches to walk the trails around his home because spasms would pop his legs from his braces. He also wouldn't be able to drive without hand controls because an errant leg spasm could send him careening off the road. "I have remained productive not despite marijuana," he says, "but because of it."



Braunstein never used pharmaceutical drugs in the 17 years before his accident and has refrained from using prescribed drugs since then. "I didn't want to be a zombie." Instead, he relied on his own high pain threshold while looking for a natural alternative. Through the disability grapevine and experimentation, Braunstein discovered pot was the only thing that alleviated both spasms and pain — and the only side effect was euphoria. "I also have a high tolerance for euphoria," he quips.

These days it seems America has a higher tolerance for the notion that marijuana is medicine. Fourteen states currently have some form of medical marijuana legislation, and the list is likely to grow. Add to that the Obama administration's pledge to cease raids on dispensaries that comply with state laws, and publicly it seems all is now hunky-dory for those who need cannabis to treat



Mark Braunstein: productive because of pot.

“One of the problems is the police try to play doctor, deciding who’s sick enough and who isn’t.”

— Richard Lee

their ailments. However, even if you’re lucky enough to live in one of the 14 states that have approved use of medicinal marijuana, the rules vary so widely between states that restrictions instituted to prevent abuse and criminality have begun to work against those who legitimately need a dose of the herb to get through the day.

Medicinal users have been dealing with the unintended consequences of a legislative patchwork that, on the federal level, classifies marijuana as a class-one narcotic while more and more states sanction its use for approved conditions. Predictably, many medicinal users are calling for full recreational legalization as the only way to clear the bureaucratic bottleneck that often halts access to what they consider their treatment of last resort.

THE MAYOR OF OAKSTERDAM

California’s legal right to medical marijuana was forged in civil disobedience, with an underground distribution network established long before it became the first state to make it law in 1996. Many who were a part of this network are still incarcerated to this day. Under the Bush administration, dispensaries were being raided every other day. “Now it’s much more of a zoning issue,” says Richard Lee, the paraplegic marijuana activist known for building a libertarian slice of Amsterdam in downtown



Richard Lee

Oakland. “Some cities and counties have voted against dispensaries in their communities because they don’t have to have them,” he says.

Lee is also the dean of Oakland University, where students learn everything about cannabis from court rulings to cultivation. Now he’s leading the campaign for taxing and regulating the drug because even though the state has some of the most permissive marijuana laws in the country — approving treatment for migraines, chronic pain and anything recommended through the written or oral endorsement of a doctor — medicinal users still face major hurdles.

Even though the minimum restriction of 8 grams of dried bud, six mature plants and 12 immature plants can be expanded at a doctor’s discretion, Lee says this frequently doesn’t translate on the street. “One of the problems is the police try and play doctor, deciding who’s sick enough and who isn’t.” But as Lee and the 56 percent of voters who support his initiative are aware, this is just a symptom of a much larger problem. Since marijuana is illegal and not recognized as having medical value federally, it is not regulated by the

WHAT THE RESEARCH SAYS

The effects of marijuana on multiple sclerosis have been studied more frequently than other conditions. The December 2009 issue of *BMC Neurology* reviewed six randomized, double-blind and placebo-controlled MS-and-marijuana trials. Of the total of 481 participants, those taking cannabis noted a decrease in their symptoms. “The subjective experience of symptom reduction was generally found to be significant,” reported the authors from the Global Neuroscience Initiative Foundation of Los Angeles. The key word is “subjective.” Many studies have reached similar conclusions, but attempts to objectively measure spasm reduction in particular have yielded inconclusive results, perhaps because the visual measurement tool used, the Ashworth scale, is not sensitive enough to document relatively small but significant changes.

To date, the largest study on MS subjects — not included in the above review — was the 2003 CAMS study that included 667 participants. Subjects reported improvement in pain, spasms and sleep disturbance even though objective corroboration was absent. However, a follow-up study a year later was particularly encouraging, suggesting that cannabis “is potentially neuroprotective and involved in synaptic plasticity.” In other words, it may slow central nervous system degeneration and brain lesions. Reduction of bladder symptoms has also been reported. However, other trials have shown cannabis to have a negative effect on cognitive skills. So the question remains: How much is safe, and for how long?

One especially promising possibility is reduction in neuropathic pain, sometimes called central pain, which is notoriously difficult to control and affects those with MS, SCI and other central nervous system conditions.

Beneficial effects of therapeutic pot use are difficult to study for reasons other than the subjective/objective disparity. Most subjects know when they are receiving the real thing rather than a placebo. Marijuana is complex, yielding some 60 compounds, and approval of research trials faces federal opposition as long as it remains classified as a dangerous drug. Also, potency varies, as does the overall effect of different methods of ingestion. All these factors clearly point to the need for more research and relaxed approval by the federal government.

In the meantime, it’s up to individual states to decide whether pot is medicine or menace.

Food and Drug Administration like other prescription drugs.

"Marijuana cannot be prescribed, it can only be recommended," Lee says. This means there is no official standard dosage. The "correct amount" is arbitrarily decided through physician recommendation and word-of-mouth anecdote, opening the door for potential abuse and unjustifiable restriction by state authorities. To that end, in January 2010, the California Supreme Court ruled the state possession restrictions unconstitutional because they were not decided on by the voters. Even the American Medical Association reversed its hardline position and now recommends further study of the plant's medical properties. Until that coincides with an FDA standard, how much is adequate for treatment is purely subjective. "With legalization you can get a lot better control," Lee says. "You get labeling and you can test for strength — the amount of THC." (See sidebar, page 25.)

In 2009 Lee appeared in a CNBC documentary on the business of marijuana. Not only did the film show illegal grow-ops choking off the natural beauty of California's national parks, it also alleged that caregivers were using their designation as essentially gardening assistants for their disabled and sick clients in order to go into business for themselves and sell their own crops back to their clients at street value. "To a degree, that's still going on. Even the dispensaries can't lower the price too far because it promotes resale on the black market," Lee says. "If cannabis were legal, it would lower the price and eliminate this practice."

And this is not happening in California alone. Braunstein alleges that the practice is also common just over the border from him, in Rhode Island. "They won't say this to the media, but one of the problems was designated growers were exploiting the situation and selling it to patients at \$400 to \$500 an ounce." Joanne Leppanen, associate director of the Rhode Island Patient Coalition, denies this claim, saying just the opposite. "All the big seizures where the guy who gets caught with marijuana, weapons and cocaine and just happens to have a medical card — they

get all the attention. What doesn't get attention," she says, "are these pockets of health care systems here that operate non-profit and will show up at your door, buy your equipment and grow your plants at no cost to you, beyond expenses." According to Leppanen, some will even contact her and offer their extra bud to people who need it. Also, she says, selling at street value can result in a revoked card.

"With legalization, you get a lot better control. You get labeling, and you can test for strength."

— Richard Lee

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Only a handful of insurance companies reimburse medical marijuana expenses, and those are in California.

MEDICINAL USERS NOT TYPICAL POTHEADS

Ellen Smith is not a stereotypical pot-head looking for an excuse to get high. She's a Rhode Island suburban mother who became the 200th medicinal user, and now the state has over 1,000 registered users since pot became legal in 2006. Smith has two rare terminal conditions. Ehlers-Danlos syndrome is slowly destroying the connective tissue in her

muscles and has started on her organs. Sarcoidosis produces granulomas in her lungs. "The pain specialist looked at my medical records and realized I'm allergic to everything else, so he signed me up."

Though she's unsettled by the stigma the drug carries, she is very happy that marijuana helps her sleep. Since her lungs are too shot to smoke it, she ingests an oil form of pot every night before going to bed. She says she has been very fortunate with support but has heard of growers exploiting other medicinal users. "Caretakers are taking it on and are doing it for selfish reasons. They really don't care enough to share it with the people who need it. They want to say they're a caretaker, but they really technically only want it for themselves."

Smith has had her plants stolen on two occasions. Until recently, when dispensaries were finally allowed, growing her own plants was the only legal way she could get her medicine, and still is. "People need help, there are older ladies in the community who can't grow it themselves and are not in the position to go down to the corner and get some." Paperwork needs to be filed and background checks need to be done before anyone will have access, and there will only be three compassion centers across the state. "Right now we're taking applications from those who want to open a compassion center," says Leppanen.

Luckily, Smith and her husband were able to catch the high school kids who stole their medicinal goods. "They apologized up and down. I said, 'You have no idea the night of terror you put us through, and more importantly, you need to go back to school and spread the word that this my medicine, this is my lifeline, and without it, I don't have a life.'"

And Smith barely has the means to pay for it. Forced to retire as a teacher, she couldn't collect Social Security because her employer wasn't paying into it. Of course, even if she received it, her medicine is illegal under the federal system, so it wouldn't qualify as a prescription drug benefit despite the fact that many people drop their prescription drugs in favor of marijuana. "I deduct all my cultivation expenses on my tax return. I believe it's legal," she says. Only a handful of insurance companies

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reimburse medical marijuana expenses, and those are in California. It's up to the states to figure out how to support those with low incomes, and they don't have the support of programs like Medicaid.

"The state will require that compassion centers have plans for those with lower income built in, because over half of our clients are living on \$700 a month," Leppenan says. In fact, an anonymous source says that those applying for food stamps have been including marijuana as part of their out-of-pocket medical expenses, and that clerks have been greenlighting the practice under the table.

DECRIMINALIZATION: DOORWAY TO LEGALIZATION?

On Jan. 11 New Jersey became the newest state to approve medical marijuana, and one of only six states, along with Rhode Island, that have legislated dispensaries. However, New Jersey has one of the most conservative interpretations of medical marijuana legislation in the country. Only six Alternative Treatment Centers will be erected across the state, and those authorized to take advantage of them will not be permitted to grow their own plants. In order to qualify at all, people will have to either win the diagnosis lottery or have a year to live. Only 10 conditions, including those critically terminal, are approved for medicinal use.

Under these restrictive rules, Smith's dual diagnosis doesn't qualify, and neither does the cover-all of chronic pain, which was on the original proposal. "The list was more than decimated," says Ken Wolski, a registered nurse and CEO of the Coalition for Medical Marijuana in New Jersey. Those who qualify have access to only 2 ounces a month, less than the federal government gives in its own investigative drug program. And those people have been getting 2 ounces a week for over 25 years. "We had argued that 2 ounces was an insufficient amount, but that was a compromise to get the bill passed. We think that 2 ounces a month will probably meet the needs of half the qualified patients," Wolski says. In stark contrast, both Oregon and Washington allow a medicinal user to have up to 24 ounces in possession.

In New Jersey, marijuana specialists will not be able to recommend it to their clients as specialists in other areas do with their medications. Recommending doctors must be from the state and have an existing relationship with the patient. Some think New Jersey's strict regulations could also be a catalyst for federal legislation.

"This bill may very well serve as a model for the rest of the country. We

"I deduct all my cultivation expenses on my tax return. I believe it's legal."

— Ellen Smith

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States Allowing Medicinal Marijuana

State (year passed) & possession limit	Approved conditions
Alaska (1998) 1 oz., 6 plants (3 mature, 3 immature)	Cachexia, cancer, chronic pain, epilepsy and other disorders characterized by seizures, glaucoma, HIV or AIDS, multiple sclerosis and other disorders characterized by muscle spasticity, and nausea. Other conditions are subject to approval by the Alaska Department of Health and Social Services.
California (1996) 8 oz., 18 plants (6 mature, 12 immature) Has dispensaries.	AIDS, anorexia, arthritis, cachexia, cancer, chronic pain, glaucoma, migraine, persistent muscle spasms, including spasms associated with multiple sclerosis, seizures, including seizures associated with epilepsy, severe nausea; other chronic or persistent medical symptoms.
Colorado (2000) 2 oz., 6 plants (3 mature, 3 immature) Has dispensaries.	Cancer, glaucoma, HIV/AIDS positive, cachexia; severe pain; severe nausea; seizures, including those that are characteristic of epilepsy; or persistent muscle spasms, including those that are characteristic of multiple sclerosis. Other conditions are subject to approval by the Colorado Board of Health.
Hawaii (2000) 3 oz., 7 plants (3 mature, 4 immature)	Cancer, glaucoma, HIV/AIDS; a chronic or debilitating disease or medical condition or its treatment that produces cachexia or wasting syndrome, severe pain, severe nausea, seizures, including those characteristic of epilepsy, or severe and persistent muscle spasms, including those characteristic of multiple sclerosis or Crohn's disease. Other conditions are subject to approval by the Hawaii Department of Health.
Maine (1999) 2.5 oz., 6 plants	Epilepsy and other disorders characterized by seizures; glaucoma; multiple sclerosis and other disorders characterized by muscle spasticity; and nausea or vomiting as a result of AIDS or cancer chemotherapy.
Michigan (2008) 2.5 oz., 12 plants	Cancer, glaucoma, HIV, AIDS, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, agitation of Alzheimer's disease, nail patella, cachexia or wasting syndrome, severe and chronic pain, severe nausea, seizures, epilepsy, muscle spasms, and multiple sclerosis.
Montana (2004) 1 oz., 6 plants	Cancer, glaucoma, or positive status for HIV/AIDS, or the treatment of these conditions; a chronic or debilitating disease or medical condition or its treatment that produces cachexia or wasting syndrome, severe or chronic pain, severe nausea, seizures, including seizures caused by epilepsy, or severe or persistent muscle spasms, including spasms caused by multiple sclerosis or Crohn's disease; or any other medical condition or treatment for a medical condition adopted by the department by rule.
Nevada (2000) 1 oz., 7 plants (3 mature, 4 immature)	AIDS; cancer; glaucoma; and any medical condition or treatment to a medical condition that produces cachexia, persistent muscle spasms or seizures, severe nausea or pain. Other conditions are subject to approval by the health division of the state Department of Human Resources.
New Jersey (2010) 2 oz., 0 plants Has dispensaries.	Seizure disorder, including epilepsy, intractable skeletal muscular spasticity, glaucoma; severe or chronic pain, severe nausea or vomiting, cachexia, or wasting syndrome resulting from HIV/AIDS or cancer; amyotrophic lateral sclerosis (Lou Gehrig's disease), multiple sclerosis, terminal cancer, muscular dystrophy, or inflammatory bowel disease, including Crohn's disease; terminal illness, if the physician has determined a prognosis of less than 12 months of life or any other medical condition or its treatment that is approved by the Department of Health and Senior Services.
New Mexico (2007) 6 oz., 16 plants (4 mature, 12 immature) Has dispensaries.	Severe chronic pain, painful peripheral neuropathy, intractable nausea/vomiting, severe anorexia/cachexia, hepatitis C infection, Crohn's disease, post-traumatic stress disorder, ALS (Lou Gehrig's disease), cancer, glaucoma, multiple sclerosis, damage to the nervous tissue of the spinal cord with intractable spasticity, epilepsy, HIV/AIDS, and hospice patients.
Oregon (1998) 24 oz., 24 plants (6 mature, 18 immature) Has dispensaries.	Cancer, glaucoma, positive status for HIV/AIDS, or treatment for these conditions; A medical condition or treatment for a medical condition that produces cachexia, severe pain, severe nausea, seizures, including seizures caused by epilepsy, or persistent muscle spasms, including spasms caused by multiple sclerosis. Other conditions are subject to approval by the Health Division of the Oregon Department of Human Resources.
Rhode Island (2006) 2.5 oz., 12 plants Has dispensaries.	Cancer, glaucoma, positive status for HIV/AIDS, Hepatitis C, or the treatment of these conditions; a chronic or debilitating disease or medical condition or its treatment that produces cachexia or wasting syndrome; severe, debilitating, chronic pain; severe nausea; seizures, including but not limited to, those characteristic of epilepsy; or severe and persistent muscle spasms, including but not limited to, those characteristic of multiple sclerosis or Crohn's disease; or agitation of Alzheimer's disease; or any other medical condition or its treatment approved by the state Department of Health.
Vermont (2004) 2 oz., 9 plants (2 mature, 7 immature)	Cancer, AIDS, positive status for HIV, multiple sclerosis, or the treatment of these conditions if the disease or the treatment results in severe, persistent, and intractable symptoms; or a disease, medical condition, or its treatment that is chronic, debilitating and produces severe, persistent, and one or more of the following intractable symptoms: cachexia or wasting syndrome, severe pain or nausea or seizures.
Washington State (1998) 24 oz., 15 plants	Crohn's disease, hepatitis C with debilitating nausea or intractable pain, diseases, including anorexia, which result in nausea, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms, or spasticity, when those conditions are unrelieved by standard treatments or medications.

certainly hope that New Jersey's model will influence the federal government to change its way of looking at marijuana as a Schedule 1 drug," says Wolski. That's because New Jersey will model dispensaries on pharmacies. Every aspect of their non-profit operation will be subject to state regulation and oversight by the Department of Health and Senior Services. Amounts will be recorded and monitored by the Department of Law and Public Safety — the same way other narcotics distributed to the public are monitored.

The 14 states with medical marijuana programs account for about a quarter of the nation's population, and another dozen are considering it. Besides California, Washington state (where it's already decriminalized) has a bill for full legalization that is currently on hold. If legalization were a reality at any level, there would need to be some differentiation between recreational and medical use. "It would be our job to make sure that provisions are still made to subsidize those people using it as medicine. They still need to be protected," Leppanen says.

Despite talk of national legalization, the battle for medical marijuana legislation still continues at the state level. With only a prescription sheet from a doctor in Amsterdam, Braunstein is forced to get his dosage from a street dealer for \$200 an ounce (\$400 for the good stuff). His home state of Connecticut has yet to make his treatment into law. "In 2007 we were so close, the bill passed both the Senate and the House before eventually being vetoed by the governor," he says. Braunstein has been front and center the entire time. He'll no doubt testify before the legislature once again when the bill makes the rounds, since Connecticut Gov. Jodi Rell announced she will not seek re-election in 2010.

But Braunstein is looking ahead. He knows the real victory lies in legalization. "It will put to rest the whole medicinal thing — you won't have to go through all this. Medicinal was the first step, recreational is the next step. Just legalizing it medicinally is obviously not enough."

Ellen Smith summarizes the pro-legalization viewpoint: "As with alcohol and any other drug, there are certain

people who will become addicted. And there are going to be kids that are going to try and get it. But that problem exists with alcohol and prescription drugs, so it's not like we don't know how to deal with that in this country. What have we been waiting for?" **MM**

Aaron Broverman is a freelance journalist living in Toronto. His work has appeared in Abilities Magazine, This Magazine, Digital Spy.com and AOL Canada's WalletPop blog.

The 14 states with medical marijuana programs account for about a quarter of the nation's population.

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