The Benefits of Medical Cannabis:

A Special Interview with Dr. Allan Frankel

By Dr. Joseph Mercola

DM: Dr. Joseph Mercola

AF: Dr. Allan Frankel

DM: Marijuana has been legalized in a number of states and most likely will be in the near future. Are you fully aware of what the benefits of this particular substance are? Hi, this is Dr. Mercola, helping you take control of your health. Today I am joined by Dr. Allan Frankel, a physician who practices in California, where the medicinal use of marijuana has been in place for some time. He has quite a bit of expertise on that, and he’s going to share that with us today. Welcome and thank you for joining us, Dr. Frankel.

AF: Thank you so much for having me, Dr. Mercola.

DM: Just to provide our viewers with a little bit of your background… Can you tell us a little bit about your background on how you first became interested in this, because you really do have quite an incredible expertise in this area.

AF: People who have known me in the last 10 years are surprised when I tell them I never personally even tried cannabis before, 11 years ago. Even though I’m a child of the ‘50s and ‘60s and I was involved actually in medical cannabis in the ’70s and early ’80s at UCLA through glaucoma trials and some cancer work, I had never personally used cannabis. I’ve always seen it as a medicine.

Eventually, I got interested in it. I thought my tool box was getting too small for typically issues with patients related to anxiety, pain, or the common issues where we just had inadequate medications. I saw the cannabinoid future was something that was bright. Seven years ago, I kind of picked up my formal white coat and sprayed a little green on it, I guess.

DM: Now, you started a company called Green Bridge Medical Services that actually is responsible for producing cannabinoid extracts. Is that correct?

AF: Not really.

DM: Okay.

AF: Green Bridge Medical is my professional corporation just like I was at Westside Internal Medicine for 27 years. Green Bridge Medical is my medical office. We see patients there, we do research there, and a lot of physician and other outreach patient education. It became mandatory ultimately.

This is something we can talk about if you wish to try to figure out a way of getting dose-consistent, repeatable medicines to people. You really can’t do that as a doctor in the cannabis world. It’s typical to do that as a doctor really in any world other than the pharmaceutical world. There were measures of… I mean, it’s a complicated process as a physician in particular, working inside the medical system to work
outside the medical system to make these dose-consistent extracts available. But that’s ultimately what started this to become very, very interesting, I would say, four and a half to five years ago.

The first two years, it was more of the typical “I would recommend this strain and that strain.” It was very dissatisfying. I didn’t really feel I was helping as many people as I might have. I’m an internist; I’m a board-certified internist. Dosing is everything. I mean, if a patient comes in and sees me, and they have Condition A, we go through a history and an exam, and we come up with something that’s called a treatment plan. It doesn’t matter whether it’s federal prescription or a recommendation. Whether you’re a physical therapist, you’re an occupational therapist, you’re a psychotherapist, you’re an internist, whatever – or you’re a plumber, you’re a mechanic – you give people a treatment plan.

To consider practicing medicine without a treatment plan seemed insane, and I could no longer do it. I started with different groups where I could be a volunteer, [like] at a collective where they can make medicine. We just twisted enough arms openly to find places that would do it the way a number of us felt it should be done. It took a lot of arm-twisting.

**DM:** We’ll get into more of the specifics in a bit. But before we do that, I just want to establish the indications for this, because there are a number of our viewers who will look at the use of marijuana as a gateway drug. That is really inappropriate that you could consider using this. I’m wondering if you could briefly summarize the indications for the use of medical cannabis.

**AF:** I think that any intervention, regardless of how benign (I would say in my 35 years of medical experience, cannabis should be considered a benign substance overall), there are potential uses and abuses of anything. If we have children who are smoking cannabis, whether they’re doing it and escaping issues (which can be an issue), or they’re using cannabis to try and medicate themselves or self-medicate, which is very, very common, they should be able to reach out and talk to an adult more easily and try to figure out if this is the safest way to do it.

I would not say that cannabis is never indicated for minors. I treat children with seizure disorders. However, do I think a 13- or 14-year-old should be smoking weed? No. That’s just not reasonable. I don’t think they should be drinking alcohol. The minor issue to me should just be off the table. We’re not interested in talking about minors using substances. There are brain development issues that go into the late teens and early 20s. If I don’t see there’s a reason to use any substance, I won’t use a substance.

For me, we’re just talking about the real solid indications. The issue of abuse and neglect is there. I think it’s relatively small. I think [the claim that] it is a gateway drug has been pretty soundly proven not to be correct. I mean, you can make water a gateway drug. You can make anything a gateway drug. I think if cannabis was connected or had been connected with gateway [drug] activity in some way, it would be more likely to be through illegal manners and illegal channels. Even with collectives, they’re not going to be offering these children other drugs there.

Even if cannabis to some extent is a gateway drug (which I do not believe it is), even if it is, it should be legalized to protect the gateway [drug] issue, because legalization opens up communication.

**DM:** Sure.

**AF:** With communication, you get better care.

**DM:** Well, and then you have the whole other issue of safety when comparing it to the traditional drug model. As we’re recording this interview, it was recently announced, or just announced, that a study found that 800,000 people were killed in Europe from inappropriate recommendations of beta blockers in those undergoing non-cardiovascular surgeries. Eight hundred thousand people dead in five years, and that’s just in Europe. I don’t think that many people are dying from cannabis.
AF: No. Actually, there’s one little factoid that’s just slipped in here, which is my favorite new fact. I learned this in British Columbia University at a conference: cannabidiol (CBD) and certain types of these strains that we’ll talk about have been cultivated (what I mean by “cultivated” is grown in rows like agriculturally) since prior to the last Ice Age in Northern Europe. That’s a long time. These seeds 25,000 years ago traveled south with these seeds and cultivated them again 20,000 years ago.

DM: Is there any indication what they were using it for back then? Was it more for fibers rope or clothing, or were they actually using it for the psychiatric component?

AF: Even back then, there were two very distinct groups of strains. There’s a lot of confusion – and that confusion is not going away – between hemp and cannabis. I don’t know if this is the time to go [into this].

DM: Sure.

AF: They are the same species. They are subspecies, because they would mate with one another. That’s the definition of a species. But they are extremely different plants in most ways. The thing that [they have] most in common, other than their genetic background, is they both have CBD. Hemp by definition (legal definition) will not have more than 0.3 percent tetrahydrocannabinol (THC) in it. But now we have a number of cannabis strains that are definitely cannabis. It’s a different…

If you look at a cannabis plant up close and you look at hemp plant, they don’t look the same. You walk through a field of cannabis plants… This is actually a very important point. If you walk next to one cannabis plant, if you walk into any of my friends’ or most of my friends’ apartments, you’re going to smell an intense cannabis aroma. If you walk into a hemp field, you smell hemp. You might have a trace of recognition of some cannabis scent. That’s a trace.

The smell is not just about smell. The scents, the terpenes, the flavonoids, these are what’s called the entourage of effective cannabis, making it a very, very complex and very rich plant. It’s very different from having just plain molecular CBD or hemp, where you’re missing all the terpenes or virtually all the terpenes and flavonoids. It’s weak. When I tend to use… When I try hemp products versus cannabis products, they’re flat. It just doesn’t have the embodiment, plus the dosing is totally different.

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When they talk more about it now than later, if I have one key point to tell anybody in the audience, it’s that when you’re looking in the literature, a dosing of cannabidiol (CBD), it matters up to 100-fold difference whether you’re talking about dosing in studies with the molecule of CBD or dosing in studies with all the entourage of the average 550 molecules per plant of medical cannabis. It’s very different.

We’ve had many, many, many patients take five or 10 milligrams of CBD either from hemp or molecular that we get from different labs in England versus five to 10 milligrams of whole-plant CBD. I mean, it’s almost overmedicating. It’s very different. It’s different for seizure patients. It’s different for pain patients. I’m sure it’s different for cancer patients. These terpene profiles end up being probably much more important than the cannabinoid profiles ultimately.

DM: There are basically two different plants that have cannabis. I don’t recall. Which one did you say was grown 25,000 years ago? Was it the hemp or was it the cannabis?

AF: Probably all of them existed before. I don’t know the exact… I’m not sure anybody knows the exact year.

DM: Sure, but it’s a long time. It’s hard to figure out things past 5,000 [years], let alone 20,000.
AF: Even before I went to medical school. It doesn’t matter. It doesn’t matter. But hemp and cannabis have been different. The fact that they remain the same species is pretty amazing. But it’s been for an extremely long time.

DM: Okay.

AF: Way before our country.

DM: You mentioned that you treat patients. This is your primary practice. You treat patients with cannabis.

AF: Yes.

DM: That’s pretty much your specialty.

AF: Yes.

DM: Some of the patients are seizure patients and others are those with autism. [It’s] certainly for pain relief. Cancer, I would imagine, would be some of those. Maybe you can expand on what the profiles of some of your patients [are], you know, what a typical day looks like and the type of patients that you’re treating.

AF: A day in the life of Allan Frankel?

DM: Right.

AF: It’s... You have no idea. I have the most exciting, wonderful life I’ve ever had. I mean, I’ve been blessed my whole life. I really believe that. But being able to do this as a side note has been the biggest blessing of my life. What a gift.

Let’s see, an average day. Let’s take today other than the interview, although that’s becoming kind of typical. Usually, on average, I see one child with parents and grandparents, like [what] I saw this morning.

This child, for example, this morning was an autistic child with a pretty bad seizure disorder. But her main issue right now is acting out anger stuff. These autistic kids can have a lot of self-inflicted wounds and externally inflicted wounds. Part of the discussion with that patient was, “All right, well, what about CBD for the seizures?” It will help with the seizures.

The rage behavior really, in my experience, requires a little bit more THC, and that’s the very tip of a very long discussion about, you know. Everybody is thinking that THC is now an orphan molecule; it is not an orphan molecule. It is critically, critically important. You need to know where to use it and to balance it.

Back to my patient. That patient will be getting mostly CBD. She’ll get a little… That’s a little extract that will allow her to give her child a little THC for outbursts, dosed by the milligrams. You know how many milligrams that kid will get. It’ll be one or two milligrams of THC. And then they’ll contact me afterwards, just the way doctors are comfortable doing this and our patients are comfortable.

After this interview, I’ve got a Stage IV cancer patient coming in who I’ve spoken to on the phone. He’s kind of the typical patient who has some symptoms that they want help with in chemotherapy relief. But they also want to use cannabinoids as part of their anti-cancer program, as an adjuvant therapy.
I know many have heard about the claim of cures. I think… I’ve been practicing medicine 35 years, and I don’t think I’ve cured a single person. I think I’ve helped many people. I think I’ve helped many people live longer, have better lives, have remissions of diseases, and many, many things.

But cures? I don’t know if it’s currently in our realm. To talk about a cure for cancer from anything at this point when we’ve been dealing with this for a couple of years is silly. It just doesn’t make any sense, and it scares people. But that’s another group. What am I seeing? Occasionally, we’ll see these dramatic, dramatic results. With no other therapy, with 40 to 60 milligrams of cannabinoids a day, the tumors virtually disappear. You definitely see that. But that is not the most common thing we see.

The most common thing that we’re seeing in our group is tumors shrinking. Or one tumor, let’s say, a met, a metastasis, disappearing in one positron emission tomography (PET) scan in January, something else coming back six months later on the other side, and then six months later, it’s gone. And then something pops up.

To me, it’s making me think more like every other disease in medicine where we’ve gone from where it becomes a fatal illness to more and more managed. HIV, in many of our lifetimes, we’ve watched it go from a virtually, universally fatal disease to a disease that is not cured (at this point, it might be). But it is certainly managed very, very, very well.

DM: It can also be used as part of a natural cocktail. I mean, there’s no reason one needs to use cannabis therapy for cancer as a monotherapy.

AF: No!

DM: They can use a whole variety of approaches.

AF: It’s one element. And if anything… Honestly, I was the straightest doctor for the most years. I’ve always opened up to alternative stuff. I guess I was using cannabis in the ‘70s with patients. I was pretty straight-laced with this. It just got to the point where, yeah, you need to try anything that makes sense. Patients, I love working with patients. One of the reasons I want to be involved with your site here is you’re encouraging people to learn for themselves. These doctors sometimes are not as always open as they might be to things they don’t understand, and that’s obviously not a good thing.

DM: The primary aspect that we encourage people to do is to take control of their health, because it’s their own responsibility to not rely necessarily on what medical professionals are telling you, because they have a history of not doing running it right a large percentage of the time. At least double-check. We’ve got the Internet. This is the 21st century.

AF: That’s right. We don’t know enough.

DM: Okay. You also mentioned that it’s for cancers. Is there any other?

AF: Yeah, the common disorders being common, there can be a whole bunch of people. Usually, they’re middle-aged with mood disorders, pain disorders, and degenerative neurological disorders. I’m seeing much more than when I practiced general internal medicine – multiple sclerosis patients and Parkinson’s patients. I’ve had several…

Not that this is the most common illness in the world, but I think you’ll find this interesting. Recently, I’ve had two dystonia patients, where they had myofascial spasms that were extremely severe. With two milligrams of whole-plant CBD three times a day, they’re now, after a week to 10 days, back to a normal life after 14 years of various neurosurgeries, 10 medications, and you know, blah, blah, blah. I’m looking
forward to a time when a dystonia patient… Now it’s going to happen. This guy is referring another dystonia patient who was just diagnosed.

Before we start doing a bunch of other stuff, why not just try a little CBD? I mean, it’s hard to make an argument against that. We don’t have to get rid of everything else; just open up one more safe avenue of treatment. [It’s] not complicated.

**DM:** Sure. Go ahead.

**AF:** These degenerative neurological patients make up another big group now, because there’s so many of them.

**DM:** Now, one of your passions or concerns (“pet peeve” is not going to be the best term for it) is that a number of clinicians who practice with cannabis tend not to be as diligent as you are and conscientious about the precision of the dose in what they’re prescribing. You had kind of referenced it earlier with milligrams of certain extracts. I’m wondering if you could touch on that topic and expand, because it seems to be an important point. I’m not familiar with the range of physicians who are using this – we could talk about that, too. But I think you have a very useful perspective to share.

**AF:** I think I know a lot of physicians in this field, and a lot of them are my good friends. I believe there’s a huge misunderstanding based out of fear that recommending a treatment plan, recommending a dosage, recommending… If patients can have a bottle in their hand and they’re going to press it once, twice, or whatever, they need to know what’s coming out and the doctor needs to know what’s coming out. There’s this false notion (I think I can very safely say it’s false) that doctors cannot recommend dosage because of this federal [law against] aiding and abetting with cannabis. It’s not true. It’s just not true.

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The medical board, whom I’m very familiar with, is looking for treatment plans. Actually, some doctors are going through some issues right now that part of the way they’re going to get hopefully their harder case lessen is by coming up with treatment plans for cannabis. If you imagine the jury somewhere going after a doctor who was telling his patients, “Take two milligrams of this, four milligrams of this. I have this evidence for it, blah, blah, blah. Call me back, and then let’s talk and see how you’re doing” because that was the wrong thing to do, it’s impossible. It’s impossible. I think it’s fear. I kind of got into this. It was my own…

**DM:** You’re saying that a number of doctors who use this are afraid of recommending specific, precise doses and that it tends to be more of the common case, the rule rather than the exception?

**AF:** I hope this doesn’t come out wrong, and I so wish this wasn’t the case. As far as I know, nobody else is talking about this stuff. If anybody [thinks] that I’m wrong, please call me. Please call me because I’m lonely. I’m tired of talking grams with people. I want to talk milligrams with some people who have clinical experience with it.

**DM:** That’s a powerful statement, too, because not everyone is familiar with the metric system as healthcare professionals are. But by stating that, you’re suggesting that patients are getting not 10, not 100, but a thousand times more dose than they need?

**AF:** I think there are times that happens. I think no. When doctors don’t do dosing, who ends up doing the dosing in this field? Growers. Now, I love many growers. I do a lot of growing myself and seed development. But you can’t expect a grower to be figuring out measured-dose sprays. We should expect a grower to figure out what base of units they sell by which are grams. Yes, it could be 50 to 100 times more than it should be.
In my opinion, if it’s a [inaudible 22:37]-type dose of 500 to 1000 milligrams of THC per day. But very commonly, it could be a seizure patient where they’re using a different type of oil or they’re just using doses or starting at doses that… For example, dosing per pound with cannabis – unless somebody can show me some data that that’s the way to do it – there’s nothing in the literature I can find that shows that it should be dosed that way.

DM: Interesting. That’s important. That’s not unlike most of the medications.

AF: Right. In adult doses, there are not many medications that we dose by pound. We now have about 120 seizure disorder kids, if you look at the surveys, across the board. The average dose is 37 milligrams per day, and there’s no relationship with body size.

DM: Is that CBD or THC?

AF: CBD.

DM: Okay.

AF: Whole plant.

DM: Maybe you can differentiate that, because many people may not know the difference. If you could describe the difference between CBD and THC.

AF: Yeah. THC is the molecule that we’ve all heard of. Many of us have tried it. It makes us feel stoned. There are many other molecules in cannabis that enhance that or detract from that. But THC is a major molecule that gets us stoned.

CBD, cannabidiol, is a major molecule, as major as THC, that is… I’m not going to say it’s more healing, but it’s not stony. It is psychoactive. People say it has no psychoactivity. But since it helps with anxiety and mood disorders, I mean, to me, as a physician, that's psychoactivity, but no stoniness.

What happened in the ‘60s and ‘70s was that due to desires for psychedelia, the changes in the war in Vietnam, and the war on drugs with Nixon, the types of strains that were available, and the demand for psychedelia changed… Before we knew it, CBD, because people had never heard of it, it got bred out. Cannabis became this entirely stony medicine still with medicinal value but with a lot less, because you took out half of the medicine without knowing it.

Now in the last five to six years, there were a group of us and other groups around the world. We didn’t really know if we would find CBD-rich strains anymore, but we have. Now there’s lots of it, and there are many different varieties of it. We keep bringing back. Every week or two we bring back a strain whose genes haven’t seen the light of day for God knows how long. They’re beautiful plants.

There are just two plants that I’m recently now excited to mate. I’m a doctor, so I use the word “mate.” Pollinate, right? Mate seeds. I “mate” these two plants in the laboratory. They were at different locations. At the laboratory, I just happened to be looking at these two different strains, and two of them were identical chemistry. I mean, identical, which is partly a random chance thing. But it was just… It was like, “Woah.”

DM: By identical chemistry, what do you mean by that?

AF: I mean that in the early phase of these plants, when there are still no flowers, just leaves, you can test leaves for CBD, THC, tetrahydrocannabinolic acid (THCA), you know, blah, blah – more and more and more tests. They will be pretty good predictors of what the final plant will be when it’s done, which saves a lot of time. I got these two lab values on these two plants, and I was able to get the two plants. One is a
male and one is a female (you can’t tell that from the lab), and they look like siblings. We’re going to cross them. My expectation is we’re going to get… This is one of those situations where at times you’re looking for a lot of inbreeding. We’re looking for serious, serious inbreeding.

**DM:** With respect to harvesting, obviously, as you mentioned, there are these materials that are in the plant leaves. But the vast majority of the concentration is in the flowers, in the buds.

**AF:** Yes.

**DM:** Which occur later. Can you comment on that and how much higher the levels are?

**AF:** Yeah. The actual levels in the leaves are low. If they had very elevated levels, people would be smoking more leaves, right? But the ratio of CBD to THC, to cannabigerol (CBG), or whatever in the leaf is exactly what the final plant, in the flower or in the bud, is going to be. The difference will be richer terpenes, smell, and scents in much, much more concentrated levels.

But if you’re looking for a plant that’s a 24:1 CBD to THC plant, and you can find out at two weeks rather than at five months, it saves a lot of time. Learning that in the last couple of years and having worked with those numbers as the plant matures… It’s a completely different way of developing seed genetics, because it’s coming from frankly an internist who figured out how to do this, because as a city boy, you know.

**DM:** Sure.

**AF:** When I saw pollen for the first time, I said, “Wow, it works.” The seeds start forming. They’re growing. Some of my grower friends come by and country friends. They just laugh at me and I laugh at myself. I’m like, “Wow, you really can make seeds. It actually works in ground and dirt.” Yeah, city boy.

**DM:** Now, you had mentioned earlier the difference between hemp and cannabis, primarily that hemp didn’t have any THC. But if you’re really using therapeutically the CBD, can hemp be utilized for that purpose? Or do you work with hemp plants at all for the CBD?

**AF:** I won’t work with hemp plants. It’s just because there’s no time to. There’s no reason for me to work with hemp plants. There’s absolutely, from a medicinal value, no advantage at all from hemp. Even from getting just CBD, if you’re willing to neglect all the terpenes and flavonoids, your typical hemp plant is three to four percent CBD. The plant that we’re using right now to extract CBD from, which is the medical cannabis plant, is 19 percent.

**DM:** Okay, it’s not sufficient.

**AF:** No. The water and the dirt, everything is the same. Just because in other countries it’s cheaper to grow hemp, it doesn’t mean it would be cheaper to grow hemp here – it’s the same price. Water is the same. Power is the same. There’s no reason. The only reason hemp is becoming a “big deal” in the medical cannabis field right now is that it’s not actually skating through an FDA regulation. CBD is Schedule I. Period. End of story. They’re just not doing anything with it. But the only reason people are using hemp as opposed to cannabis is they feel they can get away with it as a market tool. That’s it. There’s no possible advantage.

**DM:** For those who don’t know what Schedule I is, that’s the most highly restricted narcotic that you can get. It requires a… That’s not even available like the typical prescription, which is Schedule II.

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**AF:** No.
DM: This is not available by prescription.

AF: That even though it is patented by the federal government, it has no medicinal value.

DM: That’s the definition of Schedule I.

AF: Right.

DM: Which we know needs to be adjusted and modified for the use of cannabis, because it’s just blatantly wrong.

AF: By the way, I think cannabis shouldn’t be rescheduled. I think cannabis should be descheduled. How could we have a plant on a schedule? Really, because what if it’s an all-THC plant? What if it’s an all-CBD? What if we find some other psychoactivity? How do we… If you take the Physicians’ Desk Reference (PDR) and take every product (I think it spreads around the whole world, like in the equator maybe once or twice), none of them looks like a plant to me. This is the only one, and it’s not one medicine. One entry with one data ID or MDI cannot be applied for cannabis, because you could take…

For example, we’re actually right now making different medicines. With cannabis plants, as they mature, the flowers get darker and darker. There’s traditional time when you’re just supposed to pick them. Of course, what we’ve done is we picked them at different times in large amounts, ground them all together so we can get very good represented samples, and see what happens in the last few weeks of flowering.

The medicine changes a lot in the last three weeks. You can make more sedating medicine by letting it just stay on the vine three weeks longer. Even how long you let it grow makes it a very different medicine, a noticeably different medicine.

DM: Why don’t you walk us through the process of what occurs from harvesting to the point where you’re able to actually hand out a prescription to a patient? I mean, are you collecting this material from growers? Are you growing it yourself? What does the extraction process look like? How do you quantify it and measure it, and how is it administered? I mean, do people smoke it? Do they eat it? What are the different dosages?

AF: Let’s start with the patient. You’ve got a patient who has anxiety, you have a patient with seizure, you have a patient with pain, and you have a patient with whatever. You know that you’re going to need… In the end, our goal is to have dose-consistent sprayable or generally oral buccal, some oral dosing, oral-buccal medicine. At the very end of the day, if a patient comes in, they can go somewhere and get an ounce of medicine. Every time they activate the sprayer, they get the known milligrams of cannabinoids and terpenes that their doctor suggests.

Knowing that is the goal, it wasn’t, “Okay, that’s the goal. Go get a plant and do it.” It’s been a process, and it continues to be a process.

But I think a good way perhaps to answer your question is that it starts with picking the genetic strains of cannabis. We’re always looking to get better ones to use now. We’re always looking for ones that… We don’t know if they’re better, but they’re different – there’s a whole other discussion. We’re doing it in tissue culture in California and Canada, so we can have a whole plethora of these profiles ultimately.

Let’s say we’ve got six or seven different types of genetic plants that can be grown for the next year’s medicine supply for the patients. Those are genetically proven. We have not yet, because we don’t have the resources, checked DNA. But we get really good lab identification. Labs have gotten very, very, very good. The plants are grown by a number of different growers. A number of our patients are growers. For
example, the seizure kids’ parents often will grow a few plants, because some of the collectives now will take the plants and barter them for extract.

**DM:** That’s legal in California?

**AF:** Yes. That’s actually the way it’s supposed to work. I mean, to me, that’s the way the whole thing is supposed to work. The collectives that we work with, they’ll give… I’m saying “we”; it’s not “me.” I’m not a part of the collective. I’m just a lonely unpaid adviser just trying to help this work.

**DM:** What is a collective?

**AF:** A collective is a legal… I’ll put it as, according to the California State Law of ’96, a group of patients that can grow and share medicines together.

**DM:** Okay.

**AF:** In whatever state it is, it’s the legal entity that allows patients to grow and share medicine.

**DM:** They have to sign up for this to be a member of this collective?

**AF:** Right. Any patient person at any state can become a member.

**DM:** Okay.

**AF:** We’ve got these different plants that are being grown or being tested. They mature, and they get harvested. The plants are reaped. Plants are retested and then are put into batches according to their CBD, THC, and terpenes.

**DM:** Who does the testing? The grower?

**AF:** No. It’s done in the case… I’d be happy to… Can I put a plug in for somebody?

**DM:** Sure.

**AF:** The Werc Shop in Southern California in Pasadena. Dr. Jeffrey Raber, his brother, and a group [of other physicians] are I think considered by most (not by all I’m sure, but certainly by myself) to be the best laboratory probably in the country for doing cannabis studies. We do a lot of work with Dr. Raber. The plants are tagged. At the end, you do the things that you’d want to do to make sure that what you think you have is what you have. You prove what you have.

Now, we have a bunch of crushed-up plants in groups by maybe all the 2:1 CBD, all 4:1, or whatever. It depends. There are a lot of details that go into this. That crushed cannabis is tested again for everything from analytics, CBD and THC levels to molds, fungus, pesticides – you know, everything.

You need to separate the health oil from the plant material. Different people do it differently. I prefer subcritical carbon dioxide extraction, which is a mouthful. Basically, it’s not the most efficient and it’s for sure the most expensive. But it’s the cleanest way to do it. It’s the only “chemical” that’s going into this, carbon dioxide, which...

**DM:** We use that for some of our supplements, too, and I couldn’t agree more. It really is spectacular.

**AF:** It’s spectacular. You do not end up with black green oils; you end up with a gold, gold oil. Cannabis oil is gold – you know, orange, reddish gold. It’s gorgeous. That’s tested again. And then it’s diluted into either grapeseed oil or a couple of new oils we’re experimenting with, so that we have fixed 15
milligrams of CBD per milliliter, which ends up being three milligrams of whole-plant CBD per spray in a pure CBD 1 and a pure THC1, it would be three milligrams of THC. In a mid-range one, it would be one-and-a half of each.

DM: And the spray is sprayed in the mouth, under the tongue sublingually?

AF: Yeah, oral mucosally.

DM: Oral mucosally. I’m confused as to actually who does this extraction. Is there a third-party manufacturer involved with this?

AF: There are five parties involved. There are two separate chemists. In the cannabis world, putting everybody together under one roof is the last thing people want to do. That’s the first thing, because of the efficiency, that people want to do in any totally legal industry. But I’ll tell you it’s working out better this way, because to try to get one good lab, one good analytic chemist, one good extraction chemist, one of any of these is really difficult. If you had a group that was working together, to keep that group together would never happen, because the people…

You know what, maybe this doesn’t sound as nice. It’s just that this is what it is. This has really been a very illegal world. The people who have been working in this for decades, they’re used to dealing in a way that they don’t consider dishonesty, lying, or whatever. It’s a weird, weird industry to come work in. Having these individuals… I can know a person… As a doctor, I’m going to understand somebody better as an individual than I am going to as a CO2 extractor when I’m getting to know them. I picked people, and that became the group of scientists that led it. That group hasn’t changed; everybody else has changed.

DM: This is the group you use or others use?

AF: I guess the people in our group use our group. I’m not sure if anybody can.

DM: All right. That’s interesting. This is the way other groups established their ability to acquire the product that they can recommend for the patients?

AF: Yes.

DM: Okay. It’s actually kind of complex.

AF: Yeah, it has to be. To be able to make medicine at this level, it’s a collaborative effort just like it would be… You think about it all: if this is what we think today, I mean, at least what we think today is the best way to do it. This is the simplest way to do it. You can’t do it any simpler.

[----- 40:00 -----]

DM: Okay. Now, as you know, Colorado had just passed (it actually went into effect just a few weeks prior to this interview) the recreational use of marijuana. But an interesting artifact of that process was that because it’s classified as a Schedule I drug, no bank will work directly with the people who are selling this. It’s a cash business. These volumes of cash are very large. It becomes a real challenging effort to run a business without, you know, people coming and trying to use all those shotguns to steal your cash. I’m wondering if they have the same restrictions in California, where you’re doing this medically, and if you do not work with the banks and if it’s a cash-only procedure.

AF: That’s a very good point. Yeah, it’s the exact same problem. That’s one of the really, really big reasons I want to be dealing just with dosable, repeatable, consistent meds that could be distributed and bottled, which you didn’t need to store. And no, the groups that are dealing with these, they don’t take
credit cards. You know how patients are paying? They get sent out the medicine. They send a check when they receive it.

**DM:** Okay.

**AF:** Okay, that’s a warm and fuzzy feeling in this field. It’s a warm and fuzzy feeling anywhere nowadays. The collectives do fine, because the medicines are good. If the medicine doesn’t work and somebody doesn’t pay you once, who cares? It’s not about this. It’s just a very different… I’m proud of the work these people have done.

**DM:** That’s just, you know, really terrific. Maybe you can comment on the fact that… How long has the medical use of cannabis been in effect in California?

**AF:** The law was passed in ‘96. That’s really when it started.

**DM:** Nearly 20 years. [It’s been] 18 years.

**AF:** Yeah. It certainly changed and evolved, and it’s going to evolve a lot more. It’s quite an interesting road. You know, now in Washington, the feds are kind of squeezing the liquor board to try get rid of medical, which is… I know. You heard me correctly. You heard me correctly. There’s all this fuss out there now. We hear more about Colorado. But what’s going on in Washington is this federal issue where…

**DM:** This is the state of Washington, not the…

**AF:** Yes, the state of Washington.

**DM:** Where it’s also legal. Actually, I think that was passed for recreational use, too.

**AF:** Yes, it’s the same.

**DM:** Yeah, same as Colorado.

**AF:** Exactly. The feds are attempting to make a point that it’s too confusing to have two systems, and they want to get rid of medical. Now, which begs the question: why would they want to get rid of medical? I didn’t tell you what I think the answer is.

**DM:** Sure.

**AF:** They want it. This is a huge market. They have so many patents and all these stuff that broke the licenses of the pharmaceutical companies. I mean, pharma doesn’t… Nobody knows how pharma can do something that requires a thousand different extracts. It’s just not a pharma world. But for them to let go of this? No. And you know, GW Pharmaceuticals, they’re good people. They’re not bad people. But pharmaceutical companies don’t always play nicely with others.

**DM:** They certainly have a clearly documented history of doing that.

**AF:** I would love to share. I would share the seeds with them. I’d share everything with them if they would let us share. Maybe that’s what will happen. I hope.

**DM:** It clearly is competition. There’s just no question about it.

**AF:** There’s no question.
DM: The last thing they need is another therapy that’s going to be taking away from their bottom line and revenues.

AF: My peer actually advises me not to write on our success rates too much.

DM: What’s the rationale for that?

AF: Definitely more people angry.

DM: Oh, okay, create more enemies.

AF: Yeah.

DM: That’s the unfortunate reality. But it’s interesting that it has started to gain traction. There are a number of states. I haven’t kept up with the legislation; perhaps you have. If you have, maybe you can comment on it.

AF: Twenty.

DM: Twenty states where it’s used for medical purposes?

AF: Yeah.

DM: And then two for recreational.

AF: Right. Although I’ve heard that in a couple of other states, some people are using it recreationally at times.

DM: Well, We’re talking about legal use.

AF: I know.

DM: That’s the issue. But it is a challenge, because it’s a crime in all the rest of the states. In 48 states, it’s a crime to use it recreationally. It’s a crime with no victims. It’s a victimless crime. It’s clogging up the legal system, putting people into jail, and just wrecking the whole system needlessly. It’s just a challenge that exists when it shouldn’t.

AF: It’s so crazy. I haven’t told anybody yet – this just happened this morning. There was a patient of mine who got into trouble for carrying for somebody else a pound of trim to be extracted or whatever. She actually ended up before I’m seeing her spending a few weeks in jail for one pound of trim. Today I saw her and met with her probation officer. She’s become a CBD grower. A few short months. We were actually joking with the probation officer here in the office about growing CBD in prisons. I mean, why not? We could do a lot of good things. I think we are watching… I do believe we are watching the end of prohibition.

DM: It seems like it’s going in that direction. I’m not familiar with this, but there are a number of states that are considering passing legislation. I think there’s…

AF: There are more than five or six.

DM: Yeah.

AF: It’s going to be over 25 pretty soon. I think Obama coming out wasn’t the strongest statement in the world, but it was… He didn’t have to come out and say anything. At least favorably comparing it to alcohol is something.
We know that 85 or 95 percent of people in the country are in favor of medical use and 58 or 59 percent are in favor of legalization. It’s still three years until the next election. It’s going to be in the mid to high 60s. There’s no choice anymore. If you want to win an election three years from now, you’re going to have to be pro-cannabis. I just don’t see you [how] can’t win except in a few red states, otherwise. And I’ll tell you, some of the red states…

I dealt with a consultation from Louisiana this morning, where they want to start growing CBD seeds and are working with the politicians there. Just saying, “Here are seeds. Get them distributed.” We’re seeing governors in Florida, New Jersey, and Utah actually talking about making deals about getting strains even if it might be strained from Colorado. Those are very interesting discussions. I don’t know for sure what’s happening on that. But I do make the offer: if any governor in the 50 states wants absolutely free – as long as I can do it legally – any of these high-ratio CBD strains for the kids, I can make it happen. No cost.

DM: By “high-ratio CBD,” you mean there’s very low THC, mostly medicinal.

AF: Yeah, hemp-level THC.

DM: Okay.

AF: They’re available. They’re free for anybody in the US who wants some of it. I can legally give it to them.

DM: That’s terrific. Thanks for making that offer.

Can you describe the process of what it looks like for patients who believe they have a condition that may benefit from the use of cannabis? Are there preset conditions within the law? Does it vary by state? Is it up to the description of the physician whether or not they get it? How does the process look like? Once they’re identified as a medical cannabis patient, how does that change? Can they grow these themselves once they become part of this collective?

AF: A patient or a human being 18 [years old] and over with a parent in California can get a medical cannabis card recommendation letter if they or any physician or doctor of osteopathic medicine (D.O.) agree. It doesn’t have to be any specific condition. In other states, it’s very, very, very specified. In California, there are 12 conditions. But then it says “or any condition agreed upon by the doctor and patient,” which kind of opens it up quite a bit.

DM: [Inaudible 49:03].

AF: Yeah. I mean, I don’t think…

DM: You get a medical cannabis card.

AF: You get (it’s called) a card or a letter. You have the authority, your ticket ride to go to whatever collective you want and pretty much select what medicine you want. Now, that is exactly what the good, the bad, and the ugly is. I love free choice, but we need free choice with education. There’s just virtually zero, zero education going on in any place that I see in the collectives. I mean, there are random places here and there that make effort but minimal, really minimal.

DM: What does the typical patient who decides that they would like to benefit from the medical use of cannabis look like? Do they wind up seeing a physician like yourself? Or do they go through another process and just randomly experiment with the collectives?

AF: Yeah. Again, I wish I had more colleagues that I could speak to about this and who I could learn from. But right now I think we all know that the majority of people giving out recommendations are
giving out permission slips, which I’m glad people get. I mean, at the very least, they don’t get in trouble for it. But they could do a lot better. These are patients I see all the time. I don’t think it’s difficult to imagine. I think most people are actually quite aware of this that they get permission to go get what they want, which is cool.

[----- 50:00 -----]

But they have no information. They don’t know where to get the information. And the collectives, even if they have scattered information (which is not common; it really is unbelievably ignorant stuff that goes on there) they don’t have the products or the dosing. They still don’t know what to do.

The doctors have to take over responsibility – or somebody else. Somebody in the healthcare profession is going to need to learn and have experience with dosing – in addition to our group – and help make it available to people. That’s what has to happen. I don’t think it’s very complicated.

DM: So, there are not many groups like yours in California that are actually prescribing medical-grade sprays that are very precisely measured and regulated.

AF: As far as I know, sadly and tragically, I’m the only one who’s doing it.

DM: Wow, I didn’t realize that you were that unique. I thought at least there were a number of clinicians.

AF: There were a couple of other docs I know who have called once or twice and wanted to know what they would use for a particular condition. But to the best of my knowledge from all the information with collectives… We look and I do look at all the doctors, because I am again looking for doctors who want to work with us doing this. By the way, it’s a good business, and it’s going to be a big business.

DM: Well, sure. It’s an emerging business, too, in other states. Have you made any efforts to seek to educate these growers and the collectives about this?

AF: Yes, a lot of them.

DM: Have they been responsive to that?

AF: Sometimes, and recently more and more. The collectives, less and less. I don’t spend much time with them, because I just – I hate to say this – waste my time. But there are more physician groups, and you know, interviews. Obviously this is a unique situation, which I, by the way, am grateful for. Thank you. But there are more opportunities. I’ve given a couple of continuing medical education (CME) lecture videos and have talked in Laguna. But we really haven’t yet…

This is the beginning kind of our coming out. We’ve been staying pretty low-key for a number of years. I think what happens in new industries is we all get… I’m as excited as anybody in any new industry. But then when you want to get everything out there, you just don’t have enough below you. If somebody scratches the surface, then there’s nothing left. We’ve been building for years. I think you will be hearing about us more. I think.

DM: I hope so. Now, both of us are not big fans of the pharmaceutical industry. But on the other hand, they do have some good characteristics: they can really put together high-quality extracts and very precise high-quality controls. I mean, they’ve got that down to the science. They really do. They study well. It’s not tampered with in any way. There’s nothing better. They’re really the industry leaders in this.

AF: Yes.
DM: What are your thoughts on collaborating with them in some way? I mean, obviously your group is doing absolutely well. The whole process is legal. But they just view you as a competition. Why can’t they make their own oil and sell it? It would seem to me a great business opportunity.

AF: GW Pharmaceuticals has certainly been doing that for a number of years. They have limited products that are…

DM: Is that a California firm?

AF: No, that’s a British pharmaceutical company.

DM: Okay.

AF: But they’re distributed in Canada. They’re distributed in six countries. It’s a 1:1 CBD-THC whole plant extract. It’s a very good medicine. It’s expensive. The problem with pharmaceutical… The problem with everything in relation to CBD – this is one of the important points I’d to emphasize – is I think we’re going to find ultimately that CBD is a nutritional supplement for everybody. The worrying we do… You cannot worry, I don’t want to overstate that. But I’ll tell you, I don’t think I am. If people take a couple of milligrams of whole-plant CBD, the spinning stops. That’s obviously one of the more common uses of CBD.

DM: That’s for anxiety disorders.

AF: It’s amazing.

DM: It’s absolutely pervasive.

AF: Actually just worrying, just the worrying. We’ve all had situations where our loved one comes up to us, sees us worrying, and says, “Hey, dear, you’ve done everything you can. You should stop worrying.” We want to punch them, because if we could stop worrying, we would stop worrying, and we can’t stop worrying. We know that it’s a problem.

But when you take CBD, which many of my patients, including myself, have done many times, it’s not that you don’t have issues or concerns, or you’re oblivious. You’re not stoned at all; you’re just able to make things go where you want. They go back like in a different folder, different directories. If you want to pull them out again, it comes back. For the most part, it works that way.

Sometimes, my assistant and I if we know it’s going to be a bad traffic thing, we’ll take a milligram or two of CBD before driving. It’s not psychoactive, and traffic doesn’t bother us at all.

DM: It may be a way that cultures for thousands of years have learned to manage their stress.

AF: I think we were all using this a hundred years ago, and then hemp was yanked away. I think there, if they had hemp for food, there was CBD in it. Again, I wasn’t there. But my guess is that everybody had CBD in their diet up until a hundred years ago or mostly.

DM: Really? It was hemp. So, hemp was a food product? I mean, it clearly is now – hemp seeds.

AF: Right. Hemp seeds didn’t have CBD, but the flowers do. People a hundred years ago for sure were dealing with whole plants. I don’t think there’s any doubt there. They were dealing with whole plant hemp for those tens and tens of thousands of years. They would get enough CBD just through their skin most likely.

DM: Interesting.
AF: We are missing all of that, and I don’t think that’s good. CBD appears in some of the newest data to help protect our DNA epigenetic layer. That’s important stuff for all of the toxins that we have in our environment. I don’t think we have less toxins now, and we’re missing on one of the major protectants that we used to use for this. That’s a double whammy.

DM: That’s interesting. With respect to the availability of the product, many people will be purchasing these oils now. You have mentioned that your group uses the supercritical CO2 extraction. That’s not an inexpensive extraction process. Most of these collectives or manufacturers that are providing you, I don’t think [they’d] be using that. I’m wondering…

AF: Again, by the way, just in case any of them are listening, you don’t have to buy your own machine. The groups we’re using actually don’t own their own machine.

DM: Oh, that’s interesting, because they’re pricey machines.

AF: Right. I know. Way too many people are pricing machines. There are reasons to buy; there are reasons to [not buy]. For example, any collective that wants to can work with a CO2 extractor, grow their own medicine, and give a percent of that medicine to the extractor in exchange for the extraction. To me, that makes all the sense in the world. That’s how we try to run most of the work here.

DM: That’s just excellent, because the problem – or the alternative to that rather – is that they’re going to use some type of volatile organic solvent.

AF: Exactly.

DM: Which may be quite toxic like hexane, hexadecane, or butane. What are you seeing out there? What is typically used to do the extraction?

AF: You mean by bulk?

DM: What people are using, what people currently are purchasing today, when they’re not getting a product that’s derived with this CO2 extraction process?

AF: We know that 60 to 70 percent of the oils that are tested... Now, if you’re a collective and you send, let’s say, your oils to the Werc Shop to Dr. Raber, that means probably you’re a step above the people who aren’t testing. That’s an assumption. But if you’re willing to test and you’re willing to spend money, to me that’s a pretty good idea that you’re probably better than the average.

Of the groups that test, 60 to 70 percent of them come back with contaminants of butane, hexane, isopropanol – you know, these bad stuff. And then if you think about the people who aren’t testing, all of them are doing that. Yes.

I tell every patient, “If you don’t see milligrams per ml or milligrams per gram on the container, it’s one of two things: (1) it was not tested, which is definitely possible and likely, or (2) it was tested but the results were so bad they couldn’t put the results on the label. To me, it means a lot to have a label on the bottle. At least you can hold that person to something. If they don’t even put a claim to something on it, it’s complete insanity at this point.

DM: That may have a real nice name to it but nothing else.

AF: That’s it, yes.

[----- 1:00:00 -----]
DM: Percentage-wise, that sounds like it would be the vast majority of the product being sold out there. Maybe, what, 95 or 98 percent of products is not tested and has residues of these toxic solvents.

AF: The bud isn’t going to but the oils.

DM: Okay. Any oil.

AF: Yes.

DM: Any extracted process. Do you find that there’s any difference from the CBD or the THC components to the way it’s ingested? Will there be a different effect if you swallow it versus smoking it? I think that’s a common question that many people have.

AF: Yes. Those are the most common. Whether it’s inhaled, smoked, or vaporized just to clean up some of the tar [versus oral], it’s very, very rapid and short-lasting. Oral, it’s the most unpredictable. It’s the most delayed. It can take up to two hours to kick in. But if dosed appropriately, you can have a once-a-day dosing with an edible.

DM: Interesting.

AF: Yeah. Most edibles – and I think everybody knows somebody who had a brownie and who thought they need to go to the emergency room because they were paranoid... What happens with edibles, as opposed to oral mucosal spray where it’s being absorbed inside the mouth directly into the bloodstream when you swallow…

Let’s talk THC now. When you swallow THC, it goes into your stomach (it’s part of an edible obviously), it has to go through [hepatic lipid metabolism 1:01:37-38]. When a hydroxyl group, an OH group, is added to it, the THC becomes five times as sticky to the receptors in the brain and has a much longer half-life. It [inaudible 1:01:52] around forever.

DM: Interesting. So, the ingestion of the product is oral.

AF: Once a day.

DM: Right.

AF: I’m actually becoming optimistic. I didn’t want to put it on… I’d like to say something but I don’t want to use this term on air.

DM: Okay, that’s fine. Do it later because we’re recording now.

AF: We’re talking about routes of administration.

DM: Right.

AF: Oral is taking longer, but on the other hand giving much, much longer benefits or negative effects depending upon the balance and dosing of cannabinoids. But it can be dosed.

About a year and a half ago, we’re looking up online what the oral dose is to make somebody stoned, and we couldn’t find it. It’s not that difficult of a study to do, right? Now I realize: who would have been in a situation, who could have gotten approved to get a study done to see how much it takes to get ripped? Who had access to dosed THC? I couldn’t think of any situation other than us that would have that.
So, we made up all these liquid edibles. Ten of them were five milligrams, 10 milligrams, and 20 milligrams. We got people take it that way. They would know how many milligrams they took. If they have to label things after that, it worked. You can dose it. You just have to actually measure it.

DM: What was the typical dose that’s required for the THC?

AF: Ten to 20.

DM: Ten to 20.

AF: For some.

DM: For some.

AF: Compared to what a lot of them were getting.

DM: What do most people take when they use it orally?

AF: Very quickly. A person would get in trouble with 50 to 100.

DM: Oh. What are some of the complications? What happens when someone “gets in trouble?” Just paranoid?

AF: Yeah, paranoia.

DM: Paranoia is almost always an overdose effect?

AF: I think always – and nausea and vomiting. I think they’re pretty sick.

DM: How about anorexia?

AF: I think that’s in question. Because when people are smoking low-dosed THC, it’s very common to get the munchies.

DM: The munchies, right.

AF: However, if you get the munchies and you continue taking more THC, they go away. Secondly, which is actually to me more interesting because I hate to tell people, “Smoke until you don’t have the munchies”… It doesn’t seem necessary. That’s just not good advice ever.

DM: Sure.

AF: For me, I don’t want to gain more weight. If I get the munchies, I just continue smoking. But CBD is a major appetite suppressor.

DM: Interesting.

AF: Major.

DM: At about what dose?

AF: Several milligrams, 105.

DM: Wow, several milligrams, and if it’s taken orally. Now, when you use it through the oral mucosal, would that be considered an oral application?
AF: No matter how you take it, it’s an appetite suppressor.

DM: Okay. Just a few milligrams a day is a powerful appetite suppressor.

AF: Maybe a couple of times a day.

DM: Okay. You had mentioned earlier I guess you have to have a large enough dose, you can take it orally once a day.

AF: Right. I haven’t written much about it. I’m not sure how to handle it. Another cannabinoid, THCb (which we know is out there; we just haven’t found a plant yet so we can grow it), is almost… I don’t want to say it’s fixed. But combining in studies where they put THCb and CBD together, metabolic syndrome is tremendously well-managed. Even with CBD with type 2 diabetes. There are a lot of patients…

I now have to give warnings to my patients who are taking oral agents to carry something with them when they start CBD. A percentage of them have to actually not just decrease their dose, they have to stop it, the Metformin.

DM: Interesting. That is fascinating. Have you seen any other surprising effects of the CBD? That’s pretty much undocumented. I’m sorry?

AF: Dental pain.

DM: Dental pain. That’s right. I’ve heard that on your previous presentation.

AF: Yeah. That turns out to be extremely real. Because people wouldn’t come into my office as an internist or as a cannabis doctor and say they’re there for toothache. But if they happen to get some sprays, on their way home or their way to the dentist, often their pain went away, they start calling, because they think, “Hmmm… Allan should know.” That was one thing that we found. That was quite sort of double-blind. Now we’ve given it and recommended it for many, many people. And it works within a minute. It’s very quick for dental pain.

DM: You apply it topically or orally?

AF: Just right on the tooth. Spray it right on the tooth.

DM: Interesting.

AF: That’s why the patients notice. We were giving it to them under their tongue for their anxiety, and then their toothache went away.

DM: Now, obviously it’s not curing the toothache.

AF: No.

DM: It’s certainly a far safer alternative than taking…

AF: It’s a temporary measure.

DM: Any oral analgesics. The most common one for that would be Tylenol with codeine or hydrocodone. We now know that FDA got clear warnings, massive warnings that just came out a few weeks ago, that when you combine these opiates with acetaminophen, you have a massive increase of toxicity in the kidney and liver. But none of that with CBD.
AF: Sunburn.

DM: Sunburn, topically?

AF: Yeah. I live at the beach. My friends who live down there – I mean, I have a lot of friends. If somebody gets sunburned, I would sometimes see them. I’m a guy. I’m a single guy. I’m a normal guy. If an attractive woman with sunburn comes up to you and you have a spray that you think can help, what are you going to do as a doctor, as a Good Samaritan? Offer it.

In the beginning, I just sprayed it on half of their backs. I just sprayed one half. The next day, they would call. Basically it wouldn’t quite turn tan the first day. But the burn went away overnight compared to the other side. Now we have lots of patients who are just using it for sunburn. I would suggest people to not get sunburned, but if you…

DM: Sure, absolutely. That’s still going to happen even with all the strongest of choices in the world. Now, what we typically recommend as another natural therapy for that is the gel of a fresh aloe plant. It would be interesting to combine the two.

AF: That’s actually really interesting. That’s a great product idea.

DM: Yeah. Actually, aloe is a phenomenal immunostimulant if taken orally if you have the fresh gel. It has a relatively bland, maybe less-than-pleasant taste. But if you combine it with a fresh lime or a small orange, it becomes quite a pleasant drink.

AF: Is it oil-based?

DM: No. It’s almost all water-based. It’s a real mucilaginous gel. It’s just phenomenal. I grow [aloe]. I have about three dozen plants in my yard. They’re not mature yet. But my intention is to get one leaf a day once they mature. You could get an 18-inch leaf. It’s a phenomenal product. It’s another healing plant.

AF: There are many healing plants. As you and I both know, there have been a number of pharmaceutical purchases of healing plants in the Amazon. Yeah, this whole plant medicine stuff is still… Even though I’m in the middle of this whole thing with cannabis, it still seems so foreign to me since I’m such a classically trained doctor. But I got to tell you…

[----- 1:10:00 -----]

DM: Go ahead.

AF: I don’t think I’ve ever practiced better medicine. I don’t think I’ve ever given better advice. I really don’t.

DM: It would seem that you might get in trouble with the medical board because of some of the things that you’re doing.

AF: I did. I just did.

DM: Why don’t you tell us your challenges? Because that seems to be the natural consequence of going against the grain, the standard of care so to speak.

AF: It’s just wrapping up. I actually had a hearing on it yesterday, wrapping up four years of probation work. For two years, I wasn’t able to practice. The trial and the summaries I bet are all well-documented
online. I think the majority of the people believe. Even though I’m not saying that nothing happened at all. This was primarily a cannabis issue, so we treated it as a cannabis issue.

It was an amazing event for me to go through this. I’m still finishing this difficult, challenging time. But it made me that much more committed to this. I don’t know that I would have been able to do this work had this not happened to me. I don’t know that I could have appreciated it. I don’t think that my balance in life was right. I don’t want to… This is not to shake down anybody. This was an opportunity for me that I was able to take advantage of and I’m really pleased of.

**DM:** That’s a very healthy perspective. You know I’m no stranger to the medical boards either. Even though I haven’t seen a patient for seven or eight years, I’m regularly brought to their attention because of something I write. We’re supposed to have the freedom of speech in this country. But when you write about thermography and mammography in the same article, they want to take your license away. I’m just telling people the truth. They don’t like that. I always win.

**AF:** I’m here to document that to no end. No, they don’t.

**DM:** Yeah. I always win. But it becomes a pricey consequence. I’m usually spending 50,000 to 100,000 dollars to get resolved, with legal fees. But that’s part of the price of telling the truth and letting more people know it. We’re up against some pretty challenging forces that are powerful. They have very deep pockets, and you know, they’re there to preserve their self-interest. That seems to be the nature of the game.

I think those are pretty much most of the things we wanted to discuss. Is there something else you’d like to summarize or mention that we forgot?

**AF:** I think we should wrap up because patients have been waiting for a few minutes.

**DM:** Okay.

**AF:** Do you think you have enough?

**DM:** Yeah, I think so. Well, Allan, thank you for that. We hope this information helps a lot of people.