Medical Marijuana, Part 5: A Word to My Fellow Christian Physicians

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This last post is for my colleagues: physicians, physician assistants, nurse practitioners, and pharmacists who follow Jesus and who are being asked, more often every year, to certify, recommend, or at least tolerate a patient's use of cannabis. If you are not a clinician, you are welcome to read along, but I am going to write in the shorthand we use with each other.

Two years ago I wrote a version of this for a state medical journal and it was declined as too controversial. I understand why. What I have to say cuts against both the enthusiasts and the abstainers. So let me be clear at the outset about what this post is and is not.

It is not an argument that you should recommend cannabis. The Christian Medical and Dental Associations' position, that a prudent physician recommends only FDA-approved, pharmaceutical-grade cannabinoids with established dosing and monitoring, and that a dispensary product "is not medicine," is a defensible position held by physicians I respect, and I will tell you below how to hold it graciously in practice.

It is a set of guardrails for the colleague who has already concluded, as many in the forty medical states have, that some of his patients are going to the dispensary regardless, and that the choice in front of him is not whether they use cannabis but whether a physician is involved when they do. For that colleague, this is harm reduction, and harm reduction is honorable medicine. We do it every day with alcohol, tobacco, and opioids.

First, the legal ground has shifted under you

Until this spring, a physician who recommended cannabis was recommending a Schedule I substance and relying on a 2002 Ninth Circuit decision, *Conant v. Walters*, which held that the First Amendment protects a physician's right to discuss and recommend marijuana to a patient. That remains good law.

But the April 2026 rescheduling order changed your practical position in a way most physicians have not absorbed. State-licensed medical marijuana is now a Schedule III controlled substance under federal law, and the order specifies that a state-authorized medical marijuana certification is sufficient to permit dispensing, provided it includes the patient's name and address, is dated and signed on the day of issuance, and identifies the issuing practitioner. In other words, your certification is now functioning as the federal instrument that makes a Schedule III dispensing lawful. That is closer to a prescription than anything we have written before, and it should be treated with the same seriousness.

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Three practical consequences. First, know your state's current rules for certifying practitioners, because several states are revising them in light of the federal change. Second, call your malpractice carrier and ask, in writing, whether cannabis certification is covered and under what conditions. Third, if you are employed, read your employer's policy. Some health systems prohibit certification outright. And remember that recreational marijuana remains Schedule I. Nothing you sign makes that lawful.

The Federation of State Medical Boards published model guidelines for recommending cannabis in 2016. They are dated in places but the framework holds: a bona fide physician-patient relationship, a documented history and exam, a diagnosis that is on your state's list, a discussion of risks and alternatives, a written treatment plan, informed consent, follow-up, and a prescription drug monitoring program check. If you certify patients on any other basis, you are running a card mill, and you know it.

Before you certify anyone: what the evidence supports

I laid out the evidence for patients in Part 3. Here is the physician's version, combining the ratings of Cochrane, NatMed, the DC Center for Rational Prescribing, and the American Society of Pain and Neuroscience, cross-checked against the 2023 *BMJ* umbrella review and the AHRQ living review's final 2025 update.

Conditions with reasonably good evidence for cannabinoids:

- Chemotherapy-induced nausea and vomiting (dronabinol and nabilone; FDA-approved).
- Seizures in Lennox-Gastaut, Dravet, and tuberous sclerosis complex (Epidiolex only).
- MS-associated spasticity (nabiximols; moderate GRADE evidence).
- Chronic neuropathic pain, with the AHRQ caveats: small short-term benefit from balanced or THC-dominant products, no benefit from CBD-dominant products, no data beyond six months, and common dizziness, sedation, and nausea.
- HIV/AIDS-associated anorexia and cachexia (dronabinol; FDA-approved).

Conditions with some evidence, generally rated "possibly effective" or "treatment adjunct" by one or two sources and "insufficient" by others: cancer-related pain, fibromyalgia, rheumatoid arthritis pain, non-MS spasticity, sleep disturbance in chronic illness, PTSD, Tourette syndrome, and refractory epilepsy outside the three approved syndromes. There is also observational evidence that cannabis co-administration may allow lower opioid doses in chronic pain, but no randomized trial has shown it.

Conditions with no or insufficient evidence: acute pain, alcohol use disorder, dementia, bipolar disorder, inflammatory bowel disease (both Crohn's disease and ulcerative colitis), depression, glaucoma, migraine, Parkinson's disease,

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psychosis, and schizophrenia. Several of these are on state qualifying lists. A state list is not an indication.

IBD deserves a note, because it moved tiers this year and because your patients are using cannabis for it whether you know it or not. Older sources gave ulcerative colitis a "possibly effective" rating for quality of life. In June 2026 a University of Florida group, working with FDA co-authors as part of the rescheduling evidence review, published a systematic review of all controlled studies of THC-containing cannabis for IBD. Four small RCTs, all at high risk of bias. No consistent improvement on any outcome measured more than once. No effect on remission in three trials, and no effect on endoscopic scores in two. Their conclusion is that current evidence does not support these products as a substitute for approved therapies. That is where I now put it.

If a patient's condition is in the third group, I would not certify, and I would say why. If it is in the second group, I would certify only after standard therapy has failed and only with the patient's clear understanding that the evidence is thin.

Screening: who should not get your signature

This is where the 2021 safety review by MacCallum, Lo, and Boivin in the *European Journal of Internal Medicine* earns its keep. Read it before your next certification. Their framework, in summary:

Contraindicated. Age under 25, with narrow exceptions such as pediatric epilepsy and palliative care. Current or past cannabis use disorder or other substance use disorder. Pregnancy, planned pregnancy, or breastfeeding. Personal or strong family history of psychosis, schizophrenia, or bipolar disorder. Unstable cardiovascular disease, recent MI or stroke, or significant arrhythmia. Significant respiratory disease if inhalation is contemplated.

Relatively contraindicated, proceed only with precautions. Anxiety and mood disorders. Cardiovascular risk factors. Current tobacco or vape use. Significant hepatic impairment. Concurrent sedating or cognitively impairing medications. Driving and safety-sensitive occupations.

Proceed with heightened caution. Older adults, the immunocompromised, chronic kidney disease, polypharmacy, and any patient on a drug with a plausible interaction. THC and CBD are both substrates and inhibitors within the CYP450 system, CBD notably of CYP3A4 and CYP2C19, and there are several hundred documented or predicted interactions, including with warfarin, clobazam, some antidepressants, and many sedatives. Run every candidate through a cannabis-specific interaction checker such as Penn State's CANN-DIR, and document that you did.

The 2025 cardiovascular data I cited in Part 3, a doubling of cardiovascular death in the *Heart* meta-analysis and markedly elevated MI and stroke rates in younger users in the JACC Advances cohort, have moved cardiovascular risk up my list since I first drafted this. I now ask about it the way I ask about tobacco before prescribing a combined oral contraceptive.

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Product and route

The MacCallum review's recommendations are simple. Oral oil is preferred for most patients because it eliminates respiratory risk and permits accurate dosing. If rapid onset is genuinely needed, for example for breakthrough pain, vaporized dried flower is preferred over smoking or over vaping extracts in an electronic device. Concentrates should be avoided for contamination, dosing, and potency reasons. For sprays, suppositories, topicals, and edibles, the safety evidence is insufficient to recommend.

Two additions. First, specify the product characteristics you are recommending, at minimum the THC:CBD ratio and the route, and write it down. Dispensary staff are not clinicians and will otherwise sell whatever is on promotion. Second, know your state's testing requirements for potency and contaminants. They vary widely, and enforcement is uneven. MacCallum's group published a separate clinical framework for evaluating cannabis product quality in *Cannabis and Cannabinoid Research* in 2022 that is worth keeping on hand.

Dosing: the consensus protocols

The best available dosing guidance comes from a 2021 modified Delphi consensus of twenty global experts, published in the *Journal of Cannabis Research*, for chronic pain. Its logic transfers to most indications. The panel started with CBD-predominant products because CBD is well tolerated, non-euphoric, and low risk, and added THC only if needed. Three protocols:

Conservative, for frail, elderly, palliative, psychiatrically vulnerable, or polypharmacy patients. Begin a CBD-predominant product at 5 mg once daily. Titrate CBD by 10 mg every two to three days to goal or to 40 mg per day. If needed, add THC at 1 mg per day and titrate by 1 mg weekly to a maximum of 40 mg per day.

Routine, for most patients. Begin CBD-predominant at 5 mg twice daily. Titrate CBD by 10 mg every two to three days to goal or to 40 mg per day. If needed, add THC at 2.5 mg per day and titrate by 2.5 mg every two to seven days to a maximum of 40 mg per day.

Rapid, for severe pain requiring urgent management or for patients with significant prior cannabis experience. Begin a balanced THC:CBD product at 2.5 to 5 mg of each once or twice daily. Titrate by 2.5 to 5 mg of each every two to three days to goal or to a THC maximum of 40 mg per day.

Divide daily doses into two to four administrations during titration. Seek expert consultation before exceeding 40 mg of THC daily. And remember the panel's own warning: cannabis use disorder and THC's psychoactive complications must be considered even at low doses.

The clinical principle behind all three is the one you already know. Start low, go slow, and use for as short a time as possible. Cannabis pharmacokinetics

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vary enormously between individuals, so two patients on the identical product will not have the identical response.

Monitoring, and knowing when to stop

Set measurable goals before the first dose: a pain score, a function score, hours of sleep, number of spasms. See the patient at two to four weeks, then at least every three months. At each visit assess benefit against those goals, adverse effects, driving, work, and mood. Screen for cannabis use disorder with a validated instrument such as the CUDIT-R, and ask directly whether the patient is using more than recommended or seeking a high. Check the PDMP if your state includes cannabis, and check it for the sedatives and opioids that don't mix with THC regardless.

Define a stopping point in advance and put it in the chart. If the patient has not reached a meaningful fraction of the agreed goal in eight to twelve weeks, the trial has failed, and continuing it is not medicine. Taper rather than stop abruptly in daily users, since withdrawal is real. And if a patient develops cyclic vomiting, new psychiatric symptoms, or evidence of a use disorder, stop, treat, and document.

Counsel every patient, and document that you did, on driving (no driving for at least six hours after inhalation and longer after oral use), on federal drug testing and safety-sensitive employment, on the still-unsettled firearms question, on secure storage away from children and pets, and on not crossing state lines with the product.

If you decline to recommend

Many of you will read all of this and conclude, with CMDA, that you should not certify at all. I want to say plainly that this is a legitimate exercise of conscience and clinical judgment, not cowardice. Here is how to hold it well.

Tell the patient your position and your reasons, briefly and without a sermon. Offer what you can: the FDA-approved cannabinoids where indicated, and everything else in your armamentarium for the underlying condition. If the patient intends to proceed anyway, do not fire them. Offer a referral to a colleague who certifies, and keep the relationship, because you want to be the physician they tell the truth to when the cannabis stops working or starts causing trouble. Ask about it at every visit the way you ask about alcohol. And treat cannabis use disorder when you find it, with the same compassion and the same seriousness you would give any other addiction.

That last point applies to all of us, whichever path we take. Roughly three in ten of the patients using cannabis in your practice meet criteria for a use disorder. Most have never been asked. And it is not only the addiction question that goes unasked. When University of Florida gastroenterologists surveyed 108 cannabis users in their own IBD clinic in 2026, nearly nine in ten said it improved their quality of life and many said they had cut back on opioids. The

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lead investigator's comment to Healio was that cannabis use for symptom control is common in IBD, is rising with legalization, and is often not discussed in clinic visits. Those patients are on your schedule. They are managing a chronic disease with a drug that interacts with their other medications, and they have decided you don't need to know. Ask.

A closing word

Luke, the beloved physician, traveled with Paul and wrote a third of the New Testament. We have no record that he refused to treat anyone, and no record that he ever compromised the truth to make a patient comfortable. That is the standard. Be honest about what the evidence shows. Be honest about what it doesn't. Be careful with every signature. And love the patient in front of you, whether or not you sign.

The bottom line for clinicians

- Your certification now functions as the federal instrument for a Schedule III dispensing. Check your state rules, your carrier, and your employer before you write another one.
- Certify only for conditions with at least reasonable evidence, after standard therapy has failed, and never on a state list alone.
- Screen with the MacCallum framework, run an interaction check, and treat cardiovascular and psychiatric history as hard stops.
- Oral, CBD-predominant, low and slow, with THC added only if needed and capped at 40 mg daily without expert consultation.
- Set goals and a stopping point in advance, monitor at two to four weeks and every three months, and screen for use disorder every time.
- Declining to certify is a faithful option. If you decline, keep the patient and keep asking.

This post is intended for licensed clinicians and reflects the literature and regulations as I understand them in late September 2026. It is not a substitute for your own clinical judgment, your state's rules, or your professional liability carrier's guidance.

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