Not a pill person? More a "disease person"?

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WHEN PATIENTS who have high blood pressure say, "I'm not a pill person," do they mean, "I'm more of a disease person"?

Of course not. It's not that they're okay with the chronic condition or potentially suffering its complications. No, they fear the risks of the medication more than the disease risks.

Think of the alarming package insert. The important safety information. The fast talk at the end of drug ads on TV. The neighbor's tale of nasty side effects.

But where are the countervailing warnings of doing nothing—the risks of the disease itself? Without a clear side-by-side comparison, how can patients accurately weigh side effects versus disease complications?

Some 28% of patients who are newly prescribed a medication for high blood pressure do not fill the prescription at all—not even once. Of those who do fill at least once, only about half continue to refill for an entire year, many having quit against medical advice, often within the first three months.

This medication nonadherence is not due primarily to drug cost, as is often assumed. Offering free medication improves these numbers by only a little. Places with significantly lower drug costs than the US show similar nonadherence rates.

What is it about medication risk that tends to scare people more than a disease does? Drug risk often presents itself quickly, while disease risk is meted out more slowly (which is less scary). In the case of poorly controlled or uncontrolled high blood pressure, there is slow-motion trauma. An ensuing stroke or heart attack may not occur until years later.

The fact that chronic medications tend to offer long-term benefits poses a psychological challenge: We prefer our benefits now rather than later. Then there's the distaste for anything "unnatural," especially as offered by Big Pharma. But what is worse: an unnatural pill or a natural cerebral blood clot?

Beyond the barrier of risk perception, the annoyances of starting a medication may turn people off. Until the promise of personalized medicine comes true, we're often stuck experimenting with different drugs and doses to find the right mix for the right patient. This can require multiple visits to the physician and pharmacy … and the feeling of being a guinea pig.

What we're left with, then, are drugs that can work well and many patients who prefer to live with disease risks. The development of more effective and safer drugs would be ideal—as would the development of better drug alternatives, so that we wouldn't have to be pill people at all. But for now, if we want to improve outcomes and lower healthcare costs, we'll need to come up with more creative ways to clarify risk all around.

A gateway drug to less pain and suffering

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DID YOU HAPPEN to catch the one question that got passed from speaker to speaker like a lit joint during the first Democratic presidential debate: "If elected president, would you legalize medical marijuana?" Talk about peer pressure. Every candidate, even those who claim never to have smoked pot, drew a deep breath before exhaling a clear-headed position. The short answer was a repetitious yes.

Brushing partisan politics aside, let's imagine medical marijuana's being prescribed to patients as a legitimate treatment option. Will all hell break loose at CVS and Express Scripts, like some maniacal scene straight out of *Reefer Madness*? Not likely, according to those in the know.

Anecdotal reports from physicians, parents and patients (like me) suggest that the therapeutic benefits of marijuana-derived cannabidiol, the non-psychoactive form, are quite real.

Topping the list of potential medical uses are intractable epilepsy, chronic pain, cancer, schizophrenia, PTSD, traumatic brain injury, arthritis, diabetes, neuropathic pain, spasticity, multiple sclerosis, hypertension, HIV and the nausea and vomiting associated with chemotherapy. Among others. Once substantiated, the sweeping range of therapeutic properties attributed to cannabidiol—analgesia, anti-inflammatory, anti-emetic, anti-ischemic, anti-oxidant, anxiolytic and others—would present like a drug marketer's smorgasbord.

The mountains of evidence should provide stable footing for companies like GW Pharma, makers of cannabinoid-derived Sativex and the investigational orphan drug Epidiolex. The AMA, American Epilepsy Society and American Academy of Pediatrics, along with advocacy groups like Cure Epilepsy and the Epilepsy Foundation, have all issued positioning statements on the use of medical marijuana, calling for increased access and additional research.

These prestigious groups don't stand alone. A January 2010 ABC News poll showed that 81% of Americans believed that medical cannabis should be legal in the United States. In December 2014, Congress and the Obama administration "quietly" ended the federal prohibition on medical marijuana. As of October 2015, 25 of 50 states have legalized medical cannabis. If that's any indication of things to come, legalization for research purposes and therapeutic use is less a matter of when and more a matter of how soon.

But before we all get our hopes too, well, high, here's a small dose of reality. Currently, the Drug Enforcement Administration has blacklisted all forms of cannabis. Naturally, the usual questions will need to be answered before anyone seeks FDA approval much less a prescription.

Medicinal cannabis won't work for everyone. Nor should it have to. For the many people who swear by it, medical marijuana isn't just blowing smoke.