My first experience with Minnesota’s medical cannabis program was with a patient with chronic pain that had not been relieved by multiple surgeries and medical treatments. As an occupational physician, I hesitate to use cannabis as a treatment option because of possible issues of work-related drug testing. My patient had not been working for several years and the pain was getting worse, making it difficult to do even simple activities at home. Could medical cannabis help?

Cannabis has been controversial in the United States for more than a century. Questions, concerns and fears about cannabis range from its alleged associations with Mexicans and blacks to competitive issues for pharmaceutical companies. Cannabis—also known as marijuana, pot, weed, ganja and dozens more street names—has been part of human history not just for centuries but for at least a couple thousand years, initially as an herbal medicine.

The first U.S. law criminalizing cannabis was the 1937 Marijuana Tax Act. In the 1960s, the use of cannabis as a recreational drug became more accepted. Nevertheless, the U.S. Drug Enforcement Agency classifies it as a Schedule I drug or a drug “with no currently accepted medical use and a high potential for abuse,” along with heroin, LSD and Ecstasy.

Recently, we have seen a resurgence of cannabis as a potential medical therapy, despite federal law restricting distribution and use. Today, 33 states allow cannabis to be used for medicinal purposes with a variety of limits.

Minnesota’s medical cannabis program is unusual for several reasons: it is administered by the Minnesota Department of Health (MDH), purely plant-based or smokable forms of cannabis are not offered, MDH collects patient-reported data on cannabis treatment outcomes and certification is limited to specific and objectively-defined conditions (other than chronic, intractable pain). MDH has made its program accessible to clinicians, who can certify patients online in a matter of minutes.

A potential use for cannabis is to help wean patients from opioids. Some researchers and clinicians worry about the possibility of replacing one addiction with another, but the search for a way to deal with the widespread and seemingly intractable opioid crisis appears to overshadow public health concerns about cannabis use. At least one insurer in Minnesota has paid for medical cannabis to support opioid replacement.

Medical cannabis is not a perfect solution, but may provide another option for challenging conditions. My original patient did not tolerate cannabis due to nausea, but I have since certified patients sparingly with mixed success. Given the limited clinical research into medical cannabis because of its federal illegality, empiric treatment trials such as with my patient may be one of the few ways to generate scientifically-relevant data.

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