

Integrating Medical Cannabis in Geriatric Primary Care: A Viable Path?

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Older adults frequently contend with polypharmacy, chronic pain, sleep disturbances, and anxiety, often without adequate relief from conventional therapies. This complex clinical picture drives interest in alternative treatments, including medical cannabis. The question for primary care clinicians remains whether such integration is feasible and beneficial within existing practice models.

KEY TAKEAWAYS

- **The Pivot:** Medical cannabis can be safely and effectively integrated into geriatric primary care, offering an alternative for chronic symptom management.
- **The Data:** Patients reported significant improvements in pain, sleep, and anxiety scores, with a low incidence of serious adverse events.
- **The Action:** Clinicians should consider structured integration models for medical cannabis, particularly for older patients with refractory symptoms, while maintaining rigorous monitoring.

Managing chronic conditions in older adults presents a persistent challenge for primary care. Polypharmacy, drug-drug interactions, and age-related physiological changes complicate treatment decisions, particularly for symptoms like chronic pain, insomnia, and anxiety. Many conventional pharmacotherapies carry significant side effect burdens in this vulnerable population, prompting a search for safer, effective alternatives. Medical cannabis has emerged as a potential option, but its integration into routine primary care, especially for geriatric patients, has lacked clear guidance and established models.

A recent initiative explored the feasibility and impact of embedding a medical cannabis clinic directly within a geriatric primary care practice. This model aimed to provide comprehensive, physician-supervised access to cannabis-based treatments for older patients with various chronic ailments. The patient cohort comprised individuals aged 65 and older, presenting with conditions such as chronic neuropathic pain, osteoarthritis, fibromyalgia, anxiety disorders, and sleep disturbances, all of whom had either failed conventional treatments or experienced intolerable side effects. The primary objective was to assess the safety and efficacy of medical cannabis in this population, alongside the operational viability of the integrated clinic model. The initiative was led by a multidisciplinary team including geriatricians, pain specialists, and pharmacists, ensuring a holistic approach to patient care and medication management.

Designing an Integrated Care Model

The integrated clinic operated on a referral basis from within the primary care practice, allowing for seamless patient transitions and shared medical records. Patients underwent a thorough initial assessment, including a detailed

medical history, current medication review, and a comprehensive geriatric assessment. This initial evaluation identified contraindications, potential drug interactions, and established baseline symptom severity using validated scales for pain (Visual Analog Scale, VAS), sleep quality (Pittsburgh Sleep Quality Index, PSQI), and anxiety (Generalized Anxiety Disorder 7-item scale, GAD-7). The clinical team then developed individualized treatment plans, specifying cannabis product types (e.g., oils, capsules, vaporized flower), cannabinoid ratios (e.g., THC:CBD), and titration schedules. Education on administration methods, potential side effects, and legal considerations formed a critical component of the initial consultation. Follow-up appointments were scheduled at 1, 3, and 6 months, with ongoing monitoring of symptom scores, adverse events, and medication adherence. The Oxford Handbook of General Practice provides a useful framework for integrating novel therapies into existing primary care structures, emphasizing patient safety and evidence-based decision-making. This structured approach aimed to mitigate risks associated with cannabis use in older adults, such as cognitive impairment, falls, and cardiovascular events, which are particularly concerning in this demographic.

Patients received guidance on starting with low doses and titrating slowly, a common strategy for cannabis initiation in older populations to minimize adverse effects. The most frequently recommended products were those with balanced THC:CBD ratios or CBD-dominant formulations, reflecting a cautious approach to psychoactive effects. The clinic also provided access to a dedicated pharmacist who offered counseling on drug interactions, particularly with commonly prescribed geriatric medications like anticoagulants, benzodiazepines, and opioids. This pharmacist played a crucial role in ensuring safe co-administration and identifying opportunities for deprescribing other medications as cannabis therapy progressed. The average starting dose for THC was 2.5 mg per day, gradually increasing based on patient response and tolerability, while CBD doses typically began at 10-20 mg per day. The emphasis was always on achieving therapeutic benefit with the lowest effective dose, a principle central to geriatric pharmacotherapy.

Clinical Outcomes and Safety Profile

Patients who completed the 6-month follow-up reported notable improvements across several key domains. Mean pain scores, measured on a 0-10 VAS, decreased from a baseline of 7.2 to 3.8 ($P < .001$) at 6 months. This reduction represented a clinically meaningful change for many individuals, allowing for improved mobility and quality of life. Sleep quality also improved significantly, with mean PSQI scores dropping from 14.5 to 7.1 ($P < .001$), indicating fewer sleep disturbances and better overall sleep satisfaction. For anxiety, mean GAD-7 scores decreased from 12.1 to 5.5 ($P < .001$), moving many patients from moderate to mild anxiety categories. These improvements were consistent across various underlying conditions, suggesting a broad symptomatic benefit of medical cannabis in this geriatric cohort. The observed effects were generally sustained throughout the 6-month observation period, with no evidence of tachyphylaxis requiring significant dose escalation.

The safety profile was generally favorable, with most adverse events being mild and transient. The most common side effects included dry mouth (18%), dizziness (12%), and mild sedation (9%). These events typically occurred during the initial titration phase and often resolved with dose adjustment or continued use. No serious adverse events, such as falls, hospitalizations directly attributable to cannabis, or significant cognitive decline, were reported during the 6-month period. One patient discontinued treatment due to persistent dizziness, and two others stopped due to perceived lack of efficacy. This low discontinuation rate (3%) suggests good tolerability and patient satisfaction with the treatment. The careful initial assessment and slow titration strategy likely contributed to this favorable safety profile, minimizing the

risks often associated with cannabis use in older populations. Regular monitoring of vital signs, cognitive function, and fall risk assessments were integral to the safety protocol, allowing for early detection and management of any emerging concerns.

But the open-label design is the obvious caveat. Without a placebo arm, it is difficult to definitively separate the pharmacological effects of cannabis from the placebo effect or the Hawthorne effect, where patients improve simply by receiving increased attention and care. The study also relied on patient-reported outcomes, which are inherently subjective and can be influenced by expectation bias. While validated scales were used, objective measures, such as actigraphy for sleep or functional assessments for pain, would have strengthened the evidence. The relatively small sample size (N=85) and single-center nature of the initiative also limit the generalizability of these findings to broader primary care settings or diverse geriatric populations. Furthermore, the long-term effects of medical cannabis use in older adults, particularly regarding cognitive function and cardiovascular health, remain an area requiring further investigation. The study's 6-month duration, while sufficient for initial safety and efficacy signals, does not address these longer-term considerations. The specific cannabinoid profiles and delivery methods used in this clinic may also not be representative of all medical cannabis products available, making direct comparisons challenging. The lack of a standardized dosing regimen across all patients, while personalized, introduces variability that can complicate interpretation of aggregate efficacy data.

Operational Feasibility and Future Directions

Integrating the medical cannabis clinic into the existing primary care infrastructure proved operationally feasible. The electronic health record system was adapted to include cannabis-specific documentation, streamlining patient management and communication among the care team. Staff training was essential, covering cannabis pharmacology, legal regulations, and patient counseling techniques. The clinic demonstrated that with appropriate resources and a structured approach, primary care practices can effectively incorporate medical cannabis services. This model reduced the need for external referrals to specialized cannabis clinics, which are often geographically distant or have long waiting lists, thereby improving access to care for older patients. The financial sustainability of such models, however, requires careful consideration of reimbursement policies and clinic overheads. The initial investment in staff training and system modifications was significant, but the long-term benefits in terms of patient outcomes and reduced polypharmacy may offset these costs. The ability to manage these patients within their established primary care relationship also fostered greater trust and continuity of care, which is particularly important for older adults.

This initiative provides a blueprint for other primary care practices considering similar integration. Key success factors included strong physician leadership, a dedicated multidisciplinary team, comprehensive patient education, and robust safety protocols. The experience highlighted the importance of ongoing research to establish optimal dosing, cannabinoid ratios, and long-term safety profiles for specific geriatric conditions. Future studies should incorporate randomized controlled designs, larger patient cohorts, and objective outcome measures to build a more definitive evidence base. The potential for medical cannabis to reduce reliance on opioids and other high-risk medications in older adults is a particularly compelling area for further investigation. The integration also underscored the need for clear regulatory frameworks and professional guidelines to support clinicians in prescribing and monitoring medical cannabis effectively. Without these, widespread adoption of such integrated models will remain challenging, despite the demonstrated patient

benefits. The next step involves replicating this model in diverse primary care settings to assess its scalability and adaptability, while simultaneously gathering more robust, long-term data on patient outcomes and cost-effectiveness.

CLINICAL IMPLICATIONS

The integration of a medical cannabis clinic into a geriatric primary care practice offers a pragmatic solution for managing chronic symptoms in older adults. Clinicians often face a difficult choice between ineffective conventional treatments and those with unacceptable side effect profiles. This model suggests a viable third path, allowing for physician-supervised cannabis therapy within a familiar care setting.

For primary care physicians, this means a potential expansion of their therapeutic toolkit, particularly for patients with refractory pain, sleep disturbances, or anxiety. The structured approach, emphasizing low-dose initiation and careful monitoring, appears to mitigate many of the safety concerns associated with cannabis use in the elderly. It also underscores the value of a multidisciplinary team, including pharmacists, in navigating complex polypharmacy and potential drug interactions.

The industry must recognize the growing demand for evidence-based cannabis products tailored to specific patient populations, especially older adults. This includes developing formulations with precise cannabinoid ratios and consistent dosing, alongside robust clinical data. Without this, the medical community will continue to rely on observational studies and anecdotal evidence, hindering broader acceptance and integration into mainstream medicine.

Patients, particularly those with multiple comorbidities and a history of adverse drug reactions, stand to benefit from this integrated approach. It provides access to an alternative therapy under the guidance of their trusted primary care physician, potentially reducing their reliance on multiple prescription medications. The challenge remains in ensuring equitable access and affordability, as medical cannabis is not universally covered by health insurance.

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