

Commentary

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Recommendations for “Medical Marijuana” Regulations Regarding the Role of Physicians

Fifteen states and the District of Columbia have passed laws, by ballot initiative or legislation, establishing an affirmative defense against state laws prohibiting marijuana possession and use for individuals whose physicians have recommended that they use marijuana for certain medical conditions. Although these measures do not change the legality of marijuana from the perspective of international drug control treaties or under Federal law, they permit marijuana to be readily available through dispensaries, local grow operations and, in some states, “caregivers.”

State and local jurisdictions are attempting to cope with a number of disturbing consequences of these laws. At the most basic level, state laws allowing the use of marijuana for medical purposes must ensure that 1) only seriously-ill patients who have exhausted other treatment options are permitted access to these products; 2) these patients receive high quality care and supervision from their treating physicians; 3) marijuana products are tested for quality and potency in licensed laboratories by qualified individuals; and 4) strict procedures are implemented from the physician’s office to point of distribution and use by the intended patient to detect and deter marijuana abuse and diversion to others in the community. Because these laws encourage the use of marijuana for medical purposes and because physicians are the gatekeepers for access to medical marijuana, the role of physicians in this process is of great importance.

The American Society of Addiction Medicine (ASAM) recently published a comprehensive review of marijuana’s potential as a medicine,¹ the problems associated with the use of this commonly abused drug, and its public policy recommendations² for medical providers and prescribers. ASAM is the national organization of physicians specializing in addiction medicine. This organization is uniquely qualified to make recommendations concerning treatments for addiction and policies for drugs that are abused, including marijuana. The ASAM review includes nuanced comments regarding medical providers and prescribers about working with patients who seek to use the untested, crude marijuana plant as an adjunct to care provided by physicians. Despite the recommendations of ASAM that physicians “stand down” from recommending the use of this unapproved herbal material as a medical treatment, the ASAM White Paper acknowledges the reality that some physicians are now recommending marijuana to treat various conditions.

In concert with the existent reality described in the ASAM White Paper, the Institute for Behavior and Health, Inc. (IBH) sets forth the following guidelines for the role of physicians. These are derived from ASAM’s White Paper and are intended to be useful for physicians who choose to work with patients using marijuana, as well as for future state legislation and for state authorities who are monitoring the practice of medicine to protect the public health.

The Role of Physicians

In the context of the various state laws that permit the use of marijuana, a substance that is not approved as all other medicines are by the Food and Drug Administration (FDA) and that remains illegal under federal law, the role of physicians in recommending the use of marijuana is of intense concern. Guidelines for physicians are needed to not only ensure that their medical decisions are informed to provide the best patient care, but also to ensure that appropriate procedures have been followed to protect physicians from potential litigation. Physicians who recommend marijuana to patients may expose themselves to civil litigation from marijuana users who have adverse outcomes³ and to others harmed by these patients' marijuana use, such as those injured in highway crashes. IBH suggests that before recommending the use of marijuana products, physicians should be required to have an established physician-patient relationship covering at least one-year's duration. The physician should function as the patient's primary treating physician for the condition for which the use of marijuana is considered, and should have comprehensively assessed and documented the patient's health and level of functioning, in particular the patient's history of alcohol and nonmedical drug use. In exceptional circumstances, the physician may be a *bona fide* specialist to whom the patient has been referred by the patient's treating physician – again, for consultation, diagnosis, or treatment of the condition for which the patient seeks to use marijuana. The patient's medical records should substantiate these physician-patient relationships. **A physician should not serve as a “medical marijuana specialist,” or conduct a practice that is solely or significantly comprised of issuing marijuana recommendations.**

As a condition of recommending the use of marijuana, physicians should be required to have, in addition to their medical license, a state license to prescribe controlled substances, as well as a dispensing/prescribing registration issued by the Federal Drug Enforcement Administration (DEA). They should be required to register with the state medical marijuana program and annually to report to the state board of medicine the number of recommendations for patient marijuana use that they have issued. The state board should be empowered to disclose this information to the office of the state Attorney General. If the number of patients for whom recommendations are issued by a medical practice annually exceeds 20, the state Attorney General and/or the state medical board should be required automatically to investigate the practice to ensure that the appropriate standard of care is being met. In states with prescription monitoring programs, a physician's recommendation should be reported, tracked, and accessed in the same manner as a prescription for a controlled substance. These measures would deter and detect abuse and diversion, including “doctor shopping.”

A physician should recommend the use of marijuana only after the patient has tried all relevant medications approved by the FDA as well as non-pharmaceutical treatments appropriate for their conditions. Such treatments would include dronabinol (Marinol) and nabilone (Cesamet), synthetic cannabinoids for oral administration that are FDA approved. Marinol has been available by prescription to treat loss of appetite, weight loss and to control nausea in the seriously ill since being approved by the FDA in 1985. Cesamet is also used to treat chemotherapy-induced nausea and vomiting for patients who do not respond to conventional antiemetics as well as for the treatment of weight loss for patients with AIDS. The patient's medical record should indicate whether/why those medications/interventions were not adequate to relieve the patient's symptoms.

When considering marijuana as a treatment option for a patient, the physician must adhere to all established professional tenets of proper patient care. The physician must be able to demonstrate that

he/she is well-informed about the scientific literature addressing the use of marijuana for the particular medical condition in question, and that he/she understands the risks and adverse effects of different methods of administering marijuana, recognizing that patients with chronic conditions are often better managed by extended release formulations. Inhalation (in the form of vaporization) should be recommended only for those few patients with intractable cancer-related breakthrough pain or other acute symptoms with unpredictable onset. Physicians should never recommend the use of smoked marijuana due to its well-documented pulmonary and other harms. The physician should document in the patient's medical records that he/she has 1) warned the patient that the use of marijuana may hinder the patient's ability to drive a vehicle or operate other dangerous machinery and 2) explained the health risks of marijuana.

After recommending the use of marijuana, physicians should be required to re-examine (face-to-face) and assess their patients regularly, at minimum once every three months in order to deter abuse and diversion and detect dependence. The physician should be required to record the daily dose of marijuana that the patient consumes, the method of consumption, and the patient's source of marijuana. If upon reassessment of the patient's health status, the physician determines that marijuana is no longer a necessary or appropriate treatment; the physician should so notify the patient in writing and, where permissible under state and federal law, file notice with the state medical marijuana program.

Physicians must establish and document that a patient does not suffer from a substance use disorder, or have a history of misuse of marijuana or other psychoactive and addictive drugs. If a patient has a substance use disorder, or a history of other drug misuse, physicians should be required to verify with ongoing random drug tests that the individual has become stably abstinent from the use of alcohol and other drugs of abuse. If the patient has previously abused, or been dependent upon, marijuana, the physician should not recommend marijuana as a therapeutic option, since renewed abuse/dependence cannot be detected through drug tests.

These are the very basic recommendations with regard to the important role of physician in medical marijuana programs. By establishing these guidelines for physicians, IBH is not endorsing medical marijuana or the role of physicians in the use of marijuana for the treatment of any disorder. Instead, IBH continues to support research that is consistent with the FDA review and approval process, on marijuana's individual chemicals or standardized whole or partial plant extracts, for the purpose of developing potential new prescription medications. If any such chemicals are identified, IBH supports their by nontoxic routes of administration in dose-controlled formulations that are approved by the FDA. This is the standard for all other medicines, especially those widely subject to abuse. Marijuana, the nation's most widely used illegal drug, should be held to these standards.

For more information on the Institute for Behavior and Health, Inc., visit www.ibhinc.org.

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¹ American Society of Addiction Science. (2010). The role of the physician in “medical” marijuana. Available: <http://www.asam.org/pdf/Advocacy/MedMarijuanaWhitePaper20110314.pdf>

² American Society of Addiction Science. (2010). Public policy statement on medical marijuana. Available: <http://www.asam.org/MedicalMarijuana.html>

³ Voth, E. (2001). Guidelines for prescribing medical marijuana. *Western Journal of Medicine*, 175(5), 305-306. Available: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1071601/pdf/wjm17500305.pdf>