

Potential Objections to Medical Marijuana

SAFETY, EFFECTIVENESS, THERAPEUTIC AND PALLIATIVE BENEFITS:

Objection: There is little trustworthy evidence that smoked marijuana actually works.

Reply: In a White House-commissioned 1999 report, the National Academy of Sciences' Institute of Medicine, in a review of the current science at the time, found extensive scientific evidence verifying that marijuana has medical value for patients suffering from pain, nausea, appetite loss, and other symptoms of illnesses such as cancer, multiple sclerosis, and HIV/AIDS. The IOM report stated, "Nausea, appetite loss, pain, and anxiety are all afflictions of wasting and all can be mitigated by marijuana ... there are patients with debilitating symptoms for whom smoked marijuana might provide relief." Subsequent studies since the 1999 Institute of Medicine report, including randomized, double-blind, placebo-controlled clinical trials, continue to show the therapeutic value of marijuana in treating a wide array of debilitating medical conditions, including relieving medication side effects and thus improving the likelihood that patients will adhere to life-prolonging treatments for HIV/AIDS and Hepatitis C. Marijuana was also shown to be effective at alleviating HIV/AIDS neuropathy, a painful condition for which there are no FDA-approved treatments. That is why, in January 2008, the American College of Physicians – the second-largest physician group in the country – called for marijuana to be reclassified under federal law to allow physician prescriptions, citing "marijuana's proven efficacy at treating certain symptoms and its relatively low toxicity."

Objection: Marijuana is an addictive drug that poses significant health consequences to its users.

Reply: Marijuana and cannabinoids have a generally excellent safety profile. Unlike many medicines, acute lethal overdoses of marijuana have not been reported, and research has not documented increased mortality attributable to chronic use. Concerns about immunological impairment have not been borne out in research with AIDS patients. No medications are without risk; however, medical marijuana is relatively benign compared to many routinely prescribed drugs. The American College of Physicians noted marijuana's "relatively low toxicity" in its January 2008 statement. Further, the American Public Health Association's official position statement on medical marijuana states, "[M]arijuana has an extremely wide acute margin of safety for use under physician supervision and cannot cause lethal reactions ... greater harm is caused by the legal consequences of its prohibition than possible risks of medicinal use." And, in its 1999 study, the Institute of Medicine concluded that "Compared to most other drugs ... dependence among marijuana users is relatively rare."

Objection: Smoked marijuana is a known carcinogen with hundreds of well- documented negative effects.

Reply: In fact, the largest and most well-controlled studies have consistently found that marijuana smokers don't have higher rates of lung cancer or other typically tobacco-related cancers. A 2006 NIDA-funded case-control study co- authored by Dr. Donald Tashkin — one of the world's foremost experts on the respiratory effects of illicit drugs — found no increased risk of lung cancer among even the heaviest marijuana smokers. Indeed, there was a trend toward lower lung cancer risk among even heavy marijuana smokers as compared to non-smokers, though the difference did not reach statistical significance. One possible explanation for this is the growing body of evidence documenting the anti-tumor actions of cannabinoids. Also, a 1997 Kaiser Permanente epidemiological study of 65,000 subjects showed no increase in lung or other tobacco-related cancers due to marijuana smoking, suggesting the potential

of a favorable risk/benefit ratio for smoked medical marijuana in some chronic and/or painful conditions. It is worth noting in this context that the phrase “smoked marijuana” is a red herring. Marijuana need not be administered by smoking: It can be taken in food, tea, or through a smokeless vaporizer. Vaporization technology, discussed in the American College of Physicians’ position paper, has been shown to achieve the drug delivery benefits of inhalation — rapid action and ease of dose titration — without the harmful combustion products contained in smoke.

Objection: Marijuana can cause schizophrenia.

Reply: Concerns have been raised in recent years regarding associations between marijuana use and acute psychosis and schizophrenia. While marijuana users have higher rates of psychotic symptoms or diagnosed psychosis than non-users, the relative risk remains modest, and increased rates of marijuana use in the U.S. and Australia during the 1970s and 1980s did not lead to increased incidence of schizophrenia. Overall, the evidence suggests that marijuana use can precipitate psychosis in vulnerable individuals but is unlikely to cause the illness in otherwise normal persons. Use of cannabinoids in patients with a family or personal history of psychosis should generally be avoided until more is known.

PROTECTING DOCTORS AND PATIENTS:

Objection: The mere existence of medical marijuana access laws puts both patient and physician in harm’s way.

Reply: Medical marijuana access promotes physician autonomy to recommend the evidence-based medical treatment that is best for a patient, without legal punishment. Organized medicine should recognize the difference between licensing a drug for marketing and simply exempting patients using marijuana in state-sanctioned programs under the advice and supervision of a physician from criminal prosecution. Federal courts have upheld the right of physicians to recommend marijuana to patients, and physicians in the 13 medical marijuana states who follow appropriate standards of care when recommending marijuana have not experienced difficulties.

Objection: There is no clear reason why the American Medical Association and other physician groups should support patient protection for legitimate medical marijuana users in the 13 state-sanctioned programs.

Reply: Existing AMA policy already affirms the protection of physicians practicing in medical marijuana states from federal prosecution for discussing and recommending medical marijuana to their patients. It does not, however, extend protection to the patients themselves in medical marijuana states, an important omission that warrants addressing by the AMA. In addition to arrest, fines, and confiscation of property and legally obtained supplies of medical marijuana, patients and their families have been subjected to DEA “SWAT team” style invasions of their homes and the sudden discontinuation of their medical marijuana treatment. This can lead to exacerbation of chronic pain, wasting, and other serious medical conditions previously controlled by medical marijuana. Subjecting seriously ill patients to arrest and prosecution constitutes cruel and unusual punishment, which is why the editor-in-chief of the *New England Journal of Medicine* called the federal ban on the medical use of marijuana “misguided, heavy-handed, and inhumane.” Federal law makes no distinction between those who possess or grow marijuana for medical purposes and those who are using it recreationally: the same penalties apply. The possession of a single marijuana cigarette can result in a sentence of up to one year, while the cultivation of a single marijuana plant can

produce a sentence of up to five years. [<http://www.justice.gov/dea/agency/penalties.htm>]

Objection: We don't know what the general physician sentiment on this issue is.

Reply: In a 2005 poll conducted by HCD Research and the Muhlenberg College Institute of Public Opinion of 922 U.S. office-based physicians weighted by specialty and geography, 74% disagreed that “the federal government should be able to prosecute those who use, grow, or obtain marijuana prescribed or recommended by their doctor for chronic pain within the guidelines of state law.”

Objection: Supporting any form of medical marijuana access is politically risky for physician organizations.

Reply: Across the country and with increasing frequency, public opinion polls — and actual votes at the ballot box — show that support for medical marijuana is overwhelming, steadily rising, and cuts across demographic and party lines. A 2004 AARP poll showed that 72% of seniors support medical marijuana, and a 2005 Gallup poll found that 78% of Americans support “making marijuana legally available for doctors to prescribe in order to reduce pain and suffering.” Not one of the state medical marijuana laws passed since 1996 has been repealed. Indeed, when legislatures have made changes to these laws, it has generally been to extend and expand them. For example, in 2002, Maine increased the amount of medical marijuana that patients are allowed to possess. In 2007, Vermont expanded the list of conditions covered under the program and increased the number of marijuana plants that patients could legally grow. These are not the sorts of actions that legislators take when a law is unpopular.

Objection: The American Medical Association is a leader in organized medicine and their policy on medical marijuana is clear, consistent, and sufficient at this time.

Reply: The Connecticut newspaper *Guilford Courier* interviewed AMA spokesperson Robert Mills (Office of Media Relations) and reported on July 15, 2005, that “the AMA recommends keeping marijuana [unchanged] as a controlled substance ‘pending the outcomes of studies to prove the application and efficacy of marijuana and other related cannabinoids’” but, in contrast, Mills and an American Cancer Society spokesman “both mentioned that patients afflicted with cancer and other painful medical conditions should not be prosecuted for trying to alleviate their suffering.” Furthermore, the AMA is a member organization of the Accreditation Council for Continuing Medical Education (ACCME). Medical colleges and hospitals accredited by the ACCME have awarded AMA PRA Category 1 Credits to physicians attending conferences and CME events focusing on medical marijuana clinical therapeutics and research. The AMA defines the content of CME as “the body of knowledge and skills generally recognized and accepted by the profession as within the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public.”

Objection: Marijuana use can cause psychosis in some people and, if a patient who had a recommendation from a physician commits a violent act, that physician could be subject to criminal prosecution.

Reply: Thousands of physicians have recommended medical marijuana to tens of thousands of patients in the 13 states where it is sanctioned by law. There have been no recorded cases of a psychotic reaction by a patient to marijuana that have resulted in a physician being put at legal or criminal risk for issuing such a recommendation. A great many prescription medicines can cause adverse psychiatric reactions, some much more commonly than the putative link between marijuana and psychosis. This is the sort of risk that physicians manage every day by appropriately evaluating, screening, and monitoring patients.

Objection: If wider access were allowed to medical marijuana for legitimate patients, there would be an increase in the amount of marijuana-related car crashes and fatalities.

Reply: As with the use of any medication, common sense and personal responsibility must prevail. Literally hundreds of prescription and over-the-counter drugs — taken every day by millions of Americans — can cause drowsiness or slowed reactions and should not be used while driving. We do not deny patients who need these medicines the relief they need because driving while taking them is contraindicated; instead, we expect them to use common sense. Medical marijuana patients should be held accountable to the same standards and laws as those who take any medicine with the potential to impair coordination and decision-making. One-fifth of the U.S. population now lives in states with medical marijuana laws, but there is no published evidence indicating that the medical use of marijuana has led to an increase in motor vehicle accidents in any of these states.

Objection: Increased medical marijuana access would lead to decreases in workplace productivity.

Reply: There is no reason to believe that this is the case, and some reason to believe that the opposite is true. No medical marijuana law requires employers to accommodate marijuana use in the workplace. Many patients, however, report that marijuana, by providing improved relief of nausea, pain, loss of sleep, and other symptoms, allows them to work more productively than they could before beginning a medical marijuana regimen. And some have found that their marijuana regimen actually allowed them to return to work, when without using marijuana they had been too ill to do so.

CHILDREN, GATEWAYS, AND DIVERSION:

Objection: Affirmative positions supporting medical marijuana endanger our children and encourage abuse of the drug.

Reply: Of the 13 medical marijuana states, 11 now have data on teen marijuana use from both before and after the medical marijuana laws were passed. Adolescent marijuana use has not risen in a single one of these states [http://www.mpp.org/assets/pdfs/general/TeenUseReport_0608.pdf]. Instead, it has declined since medical marijuana became legal. For example, in California — the state where tales of abuse appear to be most common — the state-sponsored California Student Survey found that 34.2 percent of ninth graders reported having used marijuana in the past six months in 1995-96, the last survey before California's medical marijuana law, Proposition 215, passed. This represented a near-doubling from the 1991-92 survey. Teen marijuana use began to decline in the 1997-98 survey, the first conducted after Prop. 215 passed. By 1999-2000, past-six-months marijuana use by ninth graders had plunged to 19.2 percent, and it has declined even further since then. [http://safestate.org/documents/CSS_11_Tables.pdf] The American College of Physicians notes, "Opiates are highly addictive yet medically effective substances and are classified as Schedule II substances," but "there is no evidence to suggest that medical use of opiates has increased perception that their illicit use is safe or acceptable."

Objection: Marijuana is a gateway drug to harder substances, and therefore medical marijuana use will lead to dangerous drug use.

Reply: In science, the distinction between correlation and causation is crucial. The "gateway theory" has been roundly debunked by many credible sources. According to a 2006 study commissioned by the British Parliament, "the gateway theory has little evidence to support

it despite copious research.” The Institute of Medicine has concluded, “There is no evidence that marijuana serves as a stepping stone [to other drugs] on the basis of its particular physiological effect.” The American College of Physicians noted in February 2008, “Marijuana has not been proven to be the cause or even the most serious predictor of serious drug abuse. It is also important to note that the data on marijuana’s role in illicit drug use progression only pertains to its non-medical use.” In any case, it is absurd on its face to cite a supposed “gateway effect” for patients who are already routinely prescribed opiates and other highly addictive, potentially deadly narcotics. Medical marijuana is a safe alternative for patients whose other options are not as reliable or effective.

Objection: Medical marijuana laws create opportunities for diversion to illegal markets.

Reply: Recent press reports have indicated that the DEA is continuing to close down medical marijuana dispensaries (“buyers’ clubs”). Reports emphasize the large volume of marijuana being cultivated by some dispensaries and the risk of diversion to illegal sales outside of the medical marijuana patient community. While these risks are not trivial, neither is the ongoing problem of diversion of prescription drugs to illicit uses— and yet we do not deny patients who need these drugs appropriate relief because of such abuse. The best way to ensure that medical marijuana is not diverted to illicit uses is through appropriate regulation and control, but federal law enforcement efforts have actually hampered and interfered with attempts by state and local governments to implement such controls. The AMA could encourage state and local governments to develop stronger systems of licensing and oversight of medical marijuana production. It could also call upon the federal government either to participate constructively in such regulation or get out of the way of state efforts to do so.

THE DIFFICULTIES AND OBSTACLES OF DOING RESEARCH:

Objection: The American Medical Association and others already have pro- research positions on medical marijuana.

Reply: The current research climate for marijuana has created a significant chilling effect for researchers wanting to pursue FDA-approved clinical and basic research on the safety and efficacy of medical marijuana. While existing AMA policy recommends that NIDA should provide medical marijuana for all FDA-approved clinical and basic research studies in the U.S., this recommendation has gone unheeded by NIDA, which has refused to supply medical marijuana to several privately-funded, FDA-approved research projects and has delayed initiation of other projects (including those approved and funded by NIDA) for several years. A more strongly worded position that specifically recommends marijuana’s reclassification under federal law and/or the licensing of private medical marijuana production facilities that meet all regulatory requirements to produce pharmaceutical- grade marijuana for use exclusively in federally-approved research would provide a solution to the current no-win situation. It is entirely appropriate for organized medicine to respond to the current legal limbo to help create a positive climate for increased research.

Objection: There have been many federally-sanctioned studies on the medical use of marijuana in the past decade. These studies are continuing today, and they will continue in the future.

Reply: On the contrary, only a handful of medical marijuana studies have been allowed to proceed, and only one is presently underway. These have been small pilot studies, and while they have been consistently successful, the federal government is actively obstructing the type of medical marijuana studies that would be needed to obtain FDA approval. Most notably,

a group of researchers at the University of Massachusetts at Amherst has been seeking to conduct formal trials for years, but the Drug Enforcement Administration is blocking their efforts. The researchers are trying to create a facility to grow specific marijuana strains under controlled, reproducible conditions to test marijuana's efficacy for various indications. Such research is essential for FDA approval, but the DEA has refused to approve such a facility.

Objection: There haven't been any double-blind, placebo-controlled studies proving marijuana's effectiveness.

Reply: Despite the many difficulties in acquiring marijuana for research, in 2007, Dr. Donald Abrams of the University of California, San Francisco, published just such a study that found marijuana to be safe and effective at treating peripheral neuropathy, which causes great suffering to HIV/AIDS patients. There are no FDA-approved treatments for peripheral neuropathy, which is notoriously resistant to treatment with conventional pain medications. In the UCSF study, marijuana was clearly shown to give relief. In this randomized, double-blind, placebo-controlled trial, a majority of patients had a greater than 30 percent reduction in pain after smoking marijuana. In another randomized, double-blind, placebo-controlled study published in April 2008 by the *Journal of Pain*, marijuana was found to be effective at relieving neuropathic pain from a variety of causes, including diabetes, multiple sclerosis, and spinal injury.

Objection: There has been no research on non-smoked delivery systems for marijuana.

Reply: The IOM expressed concern about the health risks of smoking and urged development of a "nonsmoked, rapid-onset cannabinoid drug delivery system," but noted that in the meantime, "we acknowledge that there is no clear alternative for people suffering from chronic conditions that might be relieved by smoking marijuana, such as pain or AIDS wasting." The answer to the IOM's concerns about smoking is vaporizers, which take advantage of the fact that cannabinoids vaporize at a temperature well below that at which marijuana burns. Vaporizers allow patients to inhale cannabinoid vapors without smoking, achieving the same rapid action and easy dose titration without the tars and other irritants found in smoke. Several studies of such devices have now been published. In a study of one such device, the Volcano, researchers confirmed that the device works as intended, stating, "What is currently needed for optimal use of medicinal cannabinoids is a feasible, nonsmoked rapid-onset delivery system. With the Volcano, a safe and effective delivery system appears to be available to patients." [www.cmcr.ucsd.edu/geninfo/abrams_vap_abs_1.pdf]

Objection: Sativex® will be approved soon.

Reply: Sativex® is a concentrated extract of the components of natural marijuana that has been developed for sublingual use to counter pain associated with advanced cancer and pain/spasticity associated with multiple sclerosis. An FDA-approved clinical study for advanced cancer pain is underway. Additional studies will likely be needed prior to approval by the FDA, making it likely that Sativex® would not be available in the U.S. for at least three more years. Meanwhile, many thousands of people are already obtaining significant symptom relief with medical marijuana in the 12 states with medical marijuana programs, but they are still subject to federal prosecution and intimidation. Sativex may well prove to be a useful product, but it has been shown to have drawbacks. It takes far longer to reach peak blood levels than inhaled marijuana, and the alcohol-based spray has been associated with oral lesions.