Changing Medical Marihuana Regulations: What Role for Rheumatologists?

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Five hundred years ago, tobacco was hailed as the panacea treatment of almost any illness, including rheumatism. Brought from the Americas to Europe by early explorers, kings and their courts sang the praises of this magic herb, initiating a lucrative business that continues to thrive today. Sadly, it has taken a few centuries to recognize the serious health consequences of tobacco. Taking into consideration current issues surrounding marihuana, perhaps the world is at a tipping point similar to that of tobacco half a millennium ago? Cannabis, popularly touted as a product with multiple medicinal effects, has been catapulted into disease management by a groundswell of public advocacy. With scant scientific evidence, regulatory bodies worldwide have proceeded to legalize this substance for medicinal use.

Why Should Rheumatologists Have an Interest in Cannabis?

Firstly, the human cannabinoid system is an important player in pain, inflammation and immunological mechanisms. Secondly, patients with rheumatic complaints are seeking information about cannabinoids, with some self-medicating or accessing cannabis via the current Canadian regulations. However, there is not a single randomized controlled trial examining dosing, efficacy or side effects of cannabis in patients with rheumatic diseases.[1] It is therefore not surprising that two-thirds of the CRA membership who answered a recent survey expressed poor confidence in their knowledge of cannabinoids, with 70% recommending against cannabis use for rheumatic complaints.[2] Similar concerns were raised by family physicians in Colorado, with less than a fifth supporting use of medical cannabis.[3]

Risks Related to Cannabis

Contrary to public belief, inhaled cannabis is not innocuous. The risks can be categorized as immediate effects on cognition, psychomotor function, cardiovascular effects and mood, and long-term risks for mental health, pulmonary function, cancer risk, and drug dependence.[4]

The essence of a therapeutic effect for persons with rheumatic complaints is symptom relief with maintained function. The immediate psychiatric effects of anxiety, suicidal ideation, and acute psychosis are the most recognized, but effect on cognition requires special attention.[5,6] Even in regular young recreational users, psychomotor impairment persisted for up to five hours following acute administration.[7] Acute cannabis use was associated with at least twice the risk of serious and fatal motor vehicle collisions.[8] Health Canada has warned that driving may be impaired for up to 24 hours following acute consumption.[9]

Long-term risks can only be extrapolated from studies of recreational users, with chronic respiratory disease and lung cancer identified. Risk for lung cancer was doubled for young cannabis users in a recent 40 year longitudinal study controlled for cigarette smoking.[10] Mental health risks include depression, unmasking of serious psychiatric disease, and true addiction, reported as a cumulative incidence of 37.2% for young recreational users.[11-13] The true motive for use requires careful scrutiny, with the possibility that some patients may be misusing a medical diagnosis to access cannabis.

New Canadian Regulations Regarding Medical Cannabis

As of April 1st 2014, Canadian regulations regarding medicinal cannabis will change with implementation of the *Marihuana for Medical Purposes Regulations*. Under the previous *Marihuana Medical Access Regulations* (*MMAR*), physicians who provided the medical justification for a patient to apply to Health Canada to possess and/or grow cannabis were required to inform the patient of risks and benefits, but did not provide a traditional prescription. The new

regulations will require physicians to take full responsibility for the prescription of cannabis, by completing a "medical document", a euphemism for a prescription, stating the daily dose and duration of use for up to one year. The new regulations do not require failure of conventional treatments, nor a specific diagnosis.

Primum non nocere echoed in The Hippocratic Oath as "abstain from doing harm" is the foundation of ethics codes that govern medical practice. This ethic is reinforced by the Canadian Medical Protective Association (CMPA) in the context of prescriptions. In simple terms: before prescribing any treatment, a physician should have sufficient knowledge of the treatment; there should be a scientific knowledge of the risks and benefits of the treatment, including what is known and unknown about the treatment. A meaningful consent discussion must occur between physician and patient and be fully documented in the medical record. Finally, it is the legal obligation of a physician to comply with the regulations of their provincial licensing body.

Advocates for easier access to medical cannabis cite legal decisions, with some claiming a constitutional right to use the product for health reasons. This is a misconception. In 2000, the Ontario Court of Appeals in *R. v. Parker* concluded that a blanket prohibition against marihuana was unconstitutional because it did not allow use by people with valid medical justification. The federal government then instituted the MMAR in 2001 to comply with this ruling. A decade later, in *R. v. Mernagh*, an Ontario Superior Court judge erred when interpreting the ruling in *Parker* to conclude that people afflicted with serious illnesses have an automatic right to medical marihuana. The Ontario Court of Appeals overruled this interpretation in 2013, reinstating the necessity for persons applying for exemptions to lead evidence that there is indeed a true medical need. As physicians will now be the only gatekeepers, these legal considerations remain pertinent. Physicians are not legally obligated to prescribe medical cannabis on patient request, nor are they violating the *Canadian Charter of Rights and Freedoms* when refusing prescription. Rather, physicians are in their rights to practice evidence-based medicine, and are obliged to adhere to their ethics codes and regulations.

What Recommendations Can Be Provided to the Rheumatology Community?

In consideration of patient needs, the law and ethics that govern medical practice, and in light of current scientific knowledge, cannabis should be reserved for those few extreme situations where a patient experiences insufferable pain not responsive to treatments currently available. In the absence of the rudiments of standard scientific evidence, without knowledge of recommended dosing, and with important concerns for maintained function and long-term effects, any prescription for cannabis is in conflict with medical ethics, unless based on compassionate grounds. As caring physicians we must not be swept away by the pressure of advocacy. Forcing physicians to adopt practices that violate the ethical codes of the practice of medicine is untenable.

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