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POLICY FORUM

Veterans Health Administration Policy on Cannabis as an Adjunct to Pain Treatment with Opiates

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I am a disabled veteran, but I didn't fall prey to an enemy grenade; my story is much less exciting. Together with my motorcycle, I lost a battle with a coral-packed roadway on a rainy night in 1984 while serving on Guam. I survived thanks to navy doctors on the island to whom I will always be indebted for saving my life.

Over the coming weeks in an army hospital, I would deal with acute pain from my injuries that included shattered and broken bones and damage to parts of my small intestine, which were removed along with my spleen. The worst injury was a broken hip that never did heal. Avascular necrosis set in, leading to a total hip replacement. Over the years I have continued to have pain that only now is deemed long-term and [chronic](#).

I have had some excellent doctors inside and outside the VA who have guided me through many treatment options—dozens, in fact—some involving medications and some involving counseling. I tried many anti-inflammatory and otherwise nonnarcotic pain medications, some with very severe negative side effects, before settling on an opiate medication for my pain.

And then, in the mid-1990s, I discovered something amazing. Although opiates gave me relief from pain and allowed me to have some functionality, the dose I was prescribed for a long flight, for example, caused stomach problems that took days to resolve. It was on a trip abroad that I was first prescribed cannabis as an adjunct to my pain treatment. I found that, with [cannabis](#), I was able to use an amount of opiates small enough to reduce side effects while allowing me to function better than I did when taking the higher dose.

I have discovered I am not alone in finding cannabis helpful in reducing the amount of opiate medication I need to find adequate relief. I met a doctor in California who reported that, since the medical marijuana law there was enacted in 1996, many of his patients have said they were getting better pain relief using less opiates when they combined them with cannabis [1]. Years later, the first double-blind placebo-based cannabis trial results also seemed to support this effect [2], and, even more recently, cannabis's promise in lowering opiate overdose rates has come into focus [3].

One day at the VA hospital, I was handed a “[pain contract](#)” and instructed to sign it—a form my doctor received in a memo that threatened denial of my medication if I didn’t follow the rules outlined therein, including abstaining from all use of marijuana. When I took the document to my attorney I was advised that it couldn’t be a legal contract, since a contract must benefit both parties. And, since I was already receiving my medical care from the VA under federal law, I concluded that the VA couldn’t compel me to sign the document as a condition for receiving treatment. Much to my surprise, however, I was cut off from access to my prescribed pain medication and told that this situation would continue until I signed the form.

My standoff with the VA over the “pain contract” would lead to new national VA policy on medical marijuana and an end to the VA’s use of the document.

The first thing I discovered was a strong disconnect between what the memos on pain management meant to those who were writing them and how they were being perceived by those charged with their implementation. According to the Pain Management Directorate and the VA’s National Center for Ethics in Health Care (VHA Ethics), the memos on pain management were never supposed to be applied indiscriminately to all patients. The national VA officials seemed genuinely concerned that the policy was playing out at the clinic level in the way I described because, according to VHA Ethics, “no patient should be denied opioid therapy for chronic pain when that is otherwise clinically appropriate” [4].

I crafted and mailed a question to the VA’s leadership based upon the ethical standard that pain treatment should never be withheld punitively, to try to elicit a written response that could be used as guidance at the clinic level. The VA Undersecretary of Health’s answer was clear enough that in 2010 I was able to parlay it, through negotiation brought about by media attention, into a new national VA medical marijuana policy drawn from medical ethics concepts [5, 6].

Since the VA’s medical marijuana policy went into effect, the VA has thrown out the old “pain contract” and instituted a policy based upon informed consent to treatment, with a nonpunitive pain agreement that specifically mentions medical marijuana. If you study this new VA directive #1005 [7] and the associated handbook, you will see that drug testing is intended to improve communication between the doctor and patient and the patient’s signature is required because the VA considers long-term opiate use life-threatening enough to require written consent. The associated drug testing is never intended to be used for punishment.

But, given the lack of guidance from VA leadership on what to actually do when confronted with a patient testing positive on the drug test, it is no surprise that many doctors still think it is OK to dramatically alter a patient’s treatment plan for “violating

the rules.” The police are tasked with enforcing society’s rules; medical ethics requires doctors to focus on the needs of the patient [8-9].

The classification of cannabis as a Schedule I drug in the US is based on the assertion that it has no medical value. This is the main reason why [cannabis can’t be prescribed](#) and/or readily accessed for research. Veterans for Medical Cannabis Access supports several bills before Congress to change the schedule number of cannabis, which are only really necessary because the Drug Enforcement Administration has blocked routine changes to the schedule number of marijuana [10]. The VA medical marijuana policy revealed that VA doctors, as federal employees, are prohibited from assisting veterans with paperwork for state medical marijuana programs, so another of our federal efforts is focused on removing this restriction. It is important to note that the act of writing a medical recommendation for cannabis has been determined to be a free speech activity integral to the doctor-patient relationship protected by the US Constitution in *Conant v. Walters* [11]. At the state level, we have been assisting in drafting medical cannabis access laws and ensuring that existing laws cover conditions vets are likely to suffer from, like traumatic brain injury, posttraumatic stress disorder, chronic pain, and cancer. Our goal is simply to make sure all relevant treatment options are made available to the patient [12].

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Further Reading

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