

Virtual Mentor

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Physicians, Medical Marijuana, and the Law

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Charlotte's Story

After attempting to treat their daughter Charlotte's daily seizures for three painful years to no avail, the Figi family was nearly out of options and hope. Five-year-old Charlotte suffers from Dravet Syndrome, a rare and severe form of epilepsy that cannot be controlled by medication [1]. The Figis had tried nearly every treatment short of brain surgery or a medically induced coma to alleviate Charlotte's seizures, including a variety of medications that did little to reduce the seizures, left Charlotte "doped out," and had the potential to become addictive. By the age of five, Charlotte was experiencing nearly 300 seizures a week and had lost the ability to talk, walk, and eat. The Figis, who had been against marijuana use, discovered an online video of a California boy who had a severe form of epilepsy like Charlotte's. The video showed the boy receiving a marijuana concentrate (oil) which seemed to alleviate his seizures [1]. The oil was high in cannabidiol (CBD), the therapeutic agent in marijuana, rather than delta-9-tetrahydrocannabinol (THC), the psychoactive agent that produces the "high," so the oil could be used therapeutically while intoxicating the user no more than the medications Charlotte had already tried [1, 2].

The Figis contacted hundreds of doctors who refused to recommend marijuana for Charlotte, either because of her age, their opinions of the plant's efficacy, or fears of violating federal law [1]. Finally the Figis found two doctors, Margaret Geddy and Alan Shackelford, who were willing to recommend marijuana for Charlotte. Though both had reservations about administering such a powerful and federally illegal substance to such a young child, the alternatives seemed far worse. Dr. Geddy explained that it was a rather easy decision to give marijuana to a developing child when she had suffered so much brain damage and multiple brushes with death from constant seizures. The Figis received the recommendation and obtained the oil. The first time Charlotte received the oil, she went from having 300 seizures a week to having just one [1]. Unfortunately, high-CBD plants were in short supply—CBD has been bred out of marijuana plants over the past several decades, as growers sought to increase THC levels to produce a more powerful high [1-3].

That's when the Figis met with the Stanley family, owners of one of the largest marijuana dispensaries in Colorado. The Stanleys had a strain that was high in CBD and low in THC and thus unpopular with regular patients because it lacked psychoactive effects. After hearing Charlotte's story, the Stanleys modified their existing strain to create one extremely high in CBD, naming it Charlotte's Web. Charlotte still receives the oil twice a day. She has only a few seizures a month and

is now able to walk and talk again [1]. Since Dr. Sanjay Gupta gave national attention to Charlotte's story in his CNN program explaining why he changed his opinion on medicinal marijuana, more than 100 families from 43 states have relocated to Colorado to treat their children with Charlotte's Web [4].

It's plausible that if Drs. Geddy and Shackelford had not been willing to recommend marijuana to Charlotte, her life would have been markedly worse, if not prematurely ended, and the miracle strain known as Charlotte's Web would not exist. Furthermore, if it weren't for Dr. Gupta's reporting of the story, many families would not have had the courage or even the idea to travel to another state to treat their children's seizures [5].

Possibly the greatest effect of Charlotte's story was the changing of social opinion on medicinal marijuana. Since Charlotte's tale was told back in August 2013, eleven states have passed legislation legalizing high-CBD oils, which will give the 9,000 patients on the waiting list a better chance of obtaining it [5]. When such debilitating conditions afflict children, families—and legislators—appear more open to the idea of trying radical, less invasive treatment options [1, 6].

Concerns about Medicinal Marijuana's Status

There are several barriers to physicians' prescribing marijuana for medical use. Although it remains illegal under federal law and is classified as a schedule 1 drug under the Controlled Substances Act (CSA) [7], 23 states and the District of Columbia have decriminalized its use for medicinal purposes [8]. Discrepancies between federal and state medicinal marijuana laws have placed doctors—and patients—in a difficult situation: to provide their patients with medicinal marijuana, doctors must risk violating federal law and, potentially, the revocation of their Drug Enforcement Agency (DEA) licenses [3]. For example, physicians in Massachusetts have been extremely slow in writing recommendations for patients [9]. This delay is partly fueled by visits from DEA agents to physicians who were involved with dispensaries. Several such physicians reported that the DEA issued an ultimatum to them: sever ties with the medical marijuana industry or risk losing your DEA license for prescribing controlled substances [10].

Currently, it is illegal for physicians (even in states where medicinal marijuana is legal) to *prescribe* the drug because it is schedule 1, and prescribing it would constitute aiding and abetting the acquisition of marijuana, which could result in revocation of DEA licensure and even prison time [11]. However, in states where medicinal marijuana is legal, doctors can write a *recommendation* for the plant, after determining and certifying that the patient suffers from one of the conditions that the state's law deems to warrant medicinal marijuana [11]—generally debilitating conditions such as cancer, glaucoma, multiple sclerosis, and HIV/AIDS [12]. This recommendation “loophole” was upheld by the US Court of Appeals for the Ninth Circuit in *Conant v. Walters*, which decided that a physician's discussing the potential benefits of medicinal marijuana and making such recommendations constitute protected speech under the First Amendment [13]. The court reasoned that

doctors should not be held liable for conduct that patients might engage in after leaving the office and that open and unrestricted communication is vital in preserving the patient-doctor relationship and ensuring proper treatment [11, 13].

Once the physician writes the patient a recommendation for medicinal marijuana, the patient must register with his or her state's database to obtain a marijuana patient ID card, after which he or she can pick up medicinal marijuana from a dispensary [14]. In most states, possession of the identification card allows a patient to obtain, possess, or grow medicinal marijuana without violating state law but provides no shield against violations of federal law, which trumps state law based upon the supremacy clause [15]. Federal legislation that would protect patients in states where medicinal marijuana is legal is pending [16].

Concerns about Evidence

Though many patients seek access to medicinal marijuana, some doctors are reluctant to recommend it due to a dearth of hard clinical data regarding its efficacy in treating certain conditions [9]. Marijuana's schedule 1 status makes it difficult to conduct research because any cultivation, clinical testing, or research on it must attain the extremely rare approval of the federal government [17], and only one organization, the National Center for Natural Products Research at the University of Mississippi, is authorized by the federal government to manufacture marijuana [18]. This creates a vicious circle: marijuana is schedule 1 and has no currently accepted medical use in treatment because there is no data on its safety and efficacy; there is no data because marijuana is schedule 1 and clinical testing is restricted [19].

Dispensing Concerns

Aside from the lack of data on efficacy, some doctors are reluctant to recommend a drug whose form, contents, dosage, and type cannot be specified, as they would be in a typical drug prescription [14]. The amount of marijuana the patient can obtain is limited by state law [20]. The type of marijuana and mode of delivery is determined by the recommendations of dispensary employees [9]. Furthermore, because of its dual legal status, the product and its growing and cultivation are largely unregulated and unstandardized. This can lead to safety concerns; there have been incidents of pesticides, molds, and other contaminants, the consumption of which could lead to serious health problems, being found on plants [21].

Intraprofessional Consequences of Legal Inconsistencies

In states where medicinal marijuana is legal, but a majority of physicians are reluctant to write recommendations, an influx of "pot docs" is often seen, reflecting a commercialization of medical marijuana recommendations [3]. These are physicians who primarily treat a variety of ailments for which marijuana is recommended, and they often advertise their businesses as being centered on medicinal marijuana [3]. This is a concern to some in the states whose medicalization movements were predicated on the belief that medicinal marijuana would only be available to a limited number of people with debilitating conditions and would not facilitate recreational use of the drug [8, 12]. Proponents of medicalization argue that doctors

often prescribe drugs for off-label purposes, thus strict limits on ailments warranting recommendations would unduly restrict patients' access to the medicine [8].

But many states expand their covered ailments beyond such extreme conditions [8]. Because, for example, California's law about the conditions for which marijuana use is allowed includes a catchall "or any other illness for which marijuana provides relief" provision [12], pot docs are able to write prescriptions for problems such as anxiety, insomnia, and chronic pain [3, 8]. Some physicians feel that these pot docs cheapen the profession by acting as quasimedical drug dealers who make money by providing their patient with an easy, accessible high, rather than treating a serious ailment [3].

Some states are trying to avoid this by requiring that recommending physicians have an existing bona fide clinical relationship with the patient who is seeking the recommendation [9, 14]. Of course, this requirement, while protecting the legitimacy of the recommendation, may create tension within the patient-doctor relationship when patient desires medicinal marijuana but the physician will not recommend it, either for reasons having to do with its therapeutic potential, lack of control over the dosage patients receive, or overall objections to its use [6].

One last objection that physicians in some states have with medicinal marijuana is the lack of regulation regarding clinical training on the medical and legal aspects of the new laws [14]. Massachusetts was the first state to require that physicians take a two-hour course before they could recommend medicinal marijuana to their patients [22]. Doctors generally prescribe only drugs that have been rigorously tested, their clinical results reported in published articles, and information about indications for their use, the mechanisms by which they achieve results, and their expected side effects available in package inserts or the *Physicians' Desk Reference*. None of these resources for information about the efficacy, dosing, or regulations that come from FDA-approved drugs are available for medical marijuana [22].

A Turning Tide

Stories like Charlotte's successful treatment and Dr. Gupta's change of heart have helped shift opinions—especially those of physicians—regarding medicinal marijuana. A study reported in April 2014 by *WebMD* surveyed 1,544 doctors in 12 specialties and 48 states [23] and found that 56 percent of those surveyed believed that medicinal marijuana should be legalized nationally and 69 percent believe it can deliver real benefits for certain treatments and conditions. The majority of positive responses came from oncologists and hematologists, probably because of marijuana's use in treating cancer-related pain, counteracting nausea, and stimulating appetites reduced by chemotherapy [23]. Furthermore, a study published in the *Journal of Adolescent Health* in 2014 reviewed data measuring drug use and the perceptions of adolescents and found that legalizing medicinal marijuana at the state level causes no measured increase in youth marijuana use, thus addressing a key concern of those who oppose medicinal marijuana [24]. As more states legalize marijuana and others continue to expand and refine their regulations, physicians will

likely play an important role as trusted sources for evidence on clinical efficacy and side effects and have a responsibility to be informed on the topic [3].

In late May of 2014, the Republican-controlled House of Representatives voted to block the federal government and its agencies from interfering with physicians, patients, and dispensaries acting in compliance with state medicinal marijuana laws [16]. Approval from the Senate would help settle conflicts between state and federal law [16].

Furthermore, the FDA announced in June 2014 that it will begin the process of reevaluating marijuana's schedule 1 status [17]. This is good news for physicians concerned about the lack of data on marijuana; if its classification were lowered to schedule 2, more studies on its efficacy could be conducted and doctors would have a larger pool of data regarding its potential uses and side effects from which to draw judgments about its use [19]. As more states expand their laws, more patients consume the drug, and more data becomes available, physicians will become more confident about using medical marijuana.

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