Reefer Madness: Legal & Ethical Implications for Cannabis Use
National Guardianship Association October 15, 2017
Carol Manteuffel Nurse Attorney

Legal & Ethical issues about facilitating medical and recreational marijuana use

- Understanding the possible health benefits to clients
- How can cannabis benefit medical conditions
- How to avoid conflict of interest
- How to advocate for least restrictions on client’s freedom and rights
- How to maximize independence and personal needs and preferences
What Standards of Practice could be impacted by Medical Marijuana Use?

- Standard 3 – treating client with dignity
- Standard 5 – striving to enhance coordination with providers
- Standard 6 – adequate information in place of client
- Standard 7 – making informed decisions for client
  - best interest principle
  - evaluate reliable evidence of likely choices
- Standard 14 – making appropriate medical decisions
- Standard 15 – deciding when to withhold/withdraw use of medical/recreational marijuana

Standard 6: Do you have adequate information?

- Effects of marijuana on estimates of time/distance, attention, short memory wear off within 24 hours
- Marijuana is effective with epilepsy & AML symptoms
- MS spasticity has strongest data supporting use
- Regular use has lower suicide ideation/Attempts
- Pure cannabidiol (CBD) pills is better to treat MS than tetrahydrocannabinol (THC) pills and nabiximols
- Synthetic THC pills alleviate Huntington disease motor SX, Tourette syndrome severity
- Bradycardia w/in 2 hours is a diagnostic criterion of cannabis intoxication
- Cannabinoids undetectable in urine after 5 days
Medical Marijuana – “Medicine by Popular Vote”

- By 2015, marijuana use doubled among US adults
- Currently Colorado has more licensed medical marijuana businesses than any state.
- More than half of Americans live in a state that permits medical or recreational marijuana (26 states + DC).
- Public approval drives medical marijuana legalization efforts without the scientific data normally required to justify a introducing a new medication.

Long History of Cannabis use

- Mid 19th century to 1930s: physicians prescribing it for plethora of indications
- 1964: main ingredient THC (tetrahydrocannabinol) isolated
- 1970: Federal Govt classified it as Sched I substance, illegal and without medical value
- Post 1970: most widely used illicit recreational drug for pleasure/relaxation w/o addictive dangers of opioids
- 1990s: far-reaching modulatory activities of the endocannabinoid system in human body appreciated for pharmaceutical applications
- 1995: CA first of 23 states to legalize medical use
- 2000: CO legalized medical use
Why are we seeing an Increase in Medical Marijuana Use?

- CBS evening news
- Over 4 million baby boomers (only 14% of population) using MMJ for pain management/arthritis and sleep
  - grew up in the 60s and 70s
  - using MMJ too far a stretch from alcohol to relax
  - minimal side effects compared to opioids for pain management (use over 30% of all RX drugs)
  - easy to get, readily available in communities


Growers Advertisements: Multiple Health Benefits
Factors Impacting Decision to Use

Prior Drug Use
Legal in State
Use Medical Marijuana
Terminal Condition
Advertising by Growers

What decisions could/should Guardian make?

- **Standard 7** – what are the standards for making a decision to approve cannabis use for client?
  - goals
  - needs
  - preferences
  - best interests
  - reliable evidence for choices
- **Standard 14** – medical decisions are appropriate
  - clear understanding of medical facts
  - risks and benefits
Medical developments for MMJ - Risks vs Benefits:

- Development of Cannabidiol which is believed to be more effective than THC with less psychoactive effects
- MMJ industry has begun to mature and many product forms have been refined, particularly with “edibles”
- Medical research is now being conducted on a widespread basis by government grants
  Dr. Igor Grant, Chair of Dept of Psychiatry at Univ San Diego now has rare federal grant to research benefits of MMJ
- National Cancer Institute (Institute of Medicine) has recognized MMJ as a palliative remedy

Is Federal Position that cannabis is illegal changing?

- DOJ 2013 “Cole” memo did not list MMJ as an enforcement priority
- DEA 2011 response to petition to reschedule MJ was “insufficient clinical evidence”
- Congress has said DOJ may not use enforcement power to thwart states from implementing MMJ laws “Ogden memo” (redefined caregiver as an individual person)
- US Atty for CO in 2012 sent letters to MM businesses within 1000 feet of schools to close (all did close)
- HUD local option policy for subsidized housing projects
Legal Status of MMJ:

Illegal as Schedule I (no medical benefit)

Role of Guardian - goal to optimize medical/health care without compromising patient choice or right
Factors that impact Guardian’s decision

- What is age of client?
- What are medical issues of client?
- Are medical needs physical or mental?
- Is health care provider recommending medical use?
- Would it be medical or recreational use?
- What type of support system is in place?
- What is client’s psychiatric history?
- What is medical prognosis, expected life span?
- Is client working or living in community setting?

Marijuana Basics

- 420 chemicals in cannabis
- Primary psychoactive chemical is THC (delta-9 Tetrahydrocannabionol”)
- CB1 CNS pre-synaptic receptors
  cardiovascular and psychologist effects
- CB2 periphery
  immune function and inflammatory response
- Onset 30 mins to 2 hours, lasts 5-8 hours
- Lipophilic with release into blood intermittently
  CAN TEST POSITIVE LONG AFTER USE
How MM is metabolized & stored in body

Half life in blood is 20 hours
- THC & metabolites are highly soluble in lipids
- Absorbed in body fat
- Half life in body fat is days
- Drug tests + up to 45 days
- THC is sticky, attaches to hair follicles, testing can detect regular MM use for up to 3 years after cessation

Effect of Cannabinoids on Body

- BRAIN: anti-psychotic, anti-depressant, anti-inflammatory, neuroprotective
- EYES: vasorelaxant for glaucoma
- HEART: anti-atherosclerosis, anti-ischemic (prevents plaque buildup in arteries), anti-inflammatory
- STOMACH: anti-emetic, appetite control
- INTESTINES: anti-prokinetic
- HAND: analgesic for rheumatoid arthritis
- LEG: stimulating new bone growth and strengthening bones affected by osteoporosis
Evidence Based Benefits of MMJ

- 2011 study by ME Lynch and published in Br J Clin Pharmacology
- 766 patients with chronic non-cancer pain
- Significant analgesic effect
- Improved sleep
- Mild adverse events
- Improved independent ADL function
- Limitations: short trial duration, patients given only small samples

Chemotherapy Induced Nausea & Vomiting

- 1975, SE Sallan in NEJM
- 2004,, LA Parker et al Psychopharmacology
- Effective antiemetic during chemotherapy
- Very effective in suppressing nausea
- Paradoxically a hyperemesis syndrome can develop among chronic users
Multiple Sclerosis, Epilepsy & Movement Disorders

- 2014, BS Koppel et al Neurology
- Studies from 1948 to 2013
- Oral cannabis extract effective for spasticity
- THC probably effective
- Sativex (THC + cannabidiol) oral spray was put on FDA fast-track (used in UK, Canada)
- THC probably effective for central pain
- THC ineffective for tremors
- Unknown effect on other neurologic conditions

Inflammation

- 2013 G Esposito et al Phytother Res
- THC and cannabidiol induct apoptosis
  - inhibit cell proliferation
  - suppress cytokine production
- Current studies continuing with Cannabidiol due to lack of psychoactive effects for treatment of rheumatoid arthritis, ulcerative colitis and Crohn's disease
Evidence Lacking for...

- 2013, EE Lutge et al in Cochrane Database Syst Review
- Behaviors related to dementia
- HIV/AIDS – weight gain, improved mood and QOL but no rigorous evidence to support use, may worsen cognition
- EPILEPSY – findings highly debated
  - Charlotte's Web parents argue otherwise
  - 2/19 children seizure free
  - 8/19 children had 80% reduction in seizures
  - 6/19 children had 25-60% reduction in seizures
  - 3/19 benefited due to medical treatment of condition
  - 5/19 benefited due to substance use

Post Traumatic Syndrome Disease (PTSD)

- 2014 – Drug and Alcohol Dependence reported
  - 65% used for sleep and coping vs. 41% without PTSD
- 2014 – J. of Neuropsychopharmacology reported
  - synthetic cannabionoids given to rats after traumatic event changes brain centers to prevent psychological and behavioral symptoms of PTSD
- Federal govt approved a marijuana treatment for Veterans with PTSD at Univ of Arizona – initially delayed due to permissions issues with Natl. Inst. On Drug Abuse research farm (only federally sanctioned source of marijuana)
Colorado Approved Conditions

- Cancer
- Glaucoma
- HIV/AIDS

OR
- Chronic/debilitating disease/condition with 1 or MORE of:
  - cachexia
  - persistent muscle spasms
  - seizures
  - severe nausea
  - severe pain

Options other than using MMJ

- 2 FDA approved synthetic derivatives
  - Drobinol – Schedule III
  - Nabilone - Schedule II

- Liquid extract nabiximols (Sativex)
  - approved in 24 countries
  - Phase III trials
  - Primarily for MS muscle spasms
Role of Physician Authorizing MMJ in CO

- Physicians do not write a prescription
- Only authorizing patient to go to distributor for MMJ
- MMJ seller/distributor/grower decides

NOTE: a “serving size” of edible marijuana is
10 mg. of active THC equivalent to 60 mg. codeine

Physician Exam to Apply for MM card:

- Colorado resident with valid SSN
- Have a qualifying medical condition
- Receiving treatment for qualified medical condition
- PATIENT EXAMINED BY DOCTOR - HAS A BONA FIDE PHYSICIAN/PATIENT RELATIONSHIP
Colorado: Patient Possession Limits

- 2 ounces of usable marijuana

Colorado Restrictions:

- Patients: can grow/cultivate up to 6 plants
  - 3 or fewer can be flowering at a time
  - must obtain MMJ from licensed dispensary (or grow own)
- Caregivers: 18 yo or older, Colorado resident
  - not the patient’s physician
  - not have a primary caregiver of their own
  - submit caregiver acknowledgement form with patient’s medical marijuana registry application
  - only serve on patient/contact info on file
  - solely responsible for transporting MMJ to home
  - CDPHE/DEA informal rule allowing up to than 5 pts
Patient Safety: Today’s MMJ is more potent

- 1980 THC content was 2% 
- 2014 THC content was 26% (highest reported)

Patient Safety: How safe is MMJ?

- Many argue that MMJ is safer than opioids 
  - unable to overdose 
  - no respiratory depression 
  - estimated fatal dose of 15 grams which is much higher than heavy users consume in a day 
- Not the ‘cause of death’ – may be marijuana associated 
  CO 19 yo jumped to death after eating MJ cookie 
  CO man killed wife after eating candy containing MJ
Risks to monitor with MMJ use:

- Adolescents – dependence, psychosis, altered neurologic development, poorer educational outcomes, use of other illicit drugs, amotivational syndrome
- Users 2x more likely to report MVAs (5ng/ml THC blood levels = DUI)
- Cannabis most common illicit drug detected in drivers injured or killed in MVAs
- Dependence 9% if ever used
  16% if started using in adolescence
- Early age for 1st cannabis use more like to use heroin or cocaine later on

Risks to monitor with MMJ use:

- Hepatitis C progression due to steatosis
- Cannabis Hyperemesis Syndrome
- Arrhythmogenic, induces orthostatic hypotension, directly toxic to blood vessels
- Visceral adiposity, insulin resistance
- Nasopharyngeal carcinoma
- Cardiovascular – dose related increased in heart rate, increased rate of MI 4.8 x in the hour after use
- Gateway drug (ETOH, tobacco, cannabis, cocaine/heroin)
- Use before 18 yo were 2.4 x more likely to be diagnosed with schizophrenia (dose response)
Routes of Administration

- Oral
- Transdermal

What could you find in clients home?
Blurred Boundaries: Patient vs Guardian Role with MMJ

- Irrespective of CO/state law, manufacture, possession, distribution, and use of MMJ is a federal crime
- Collateral consequences to promoting MMJ use (ethical violations of patient choice/right to choose)

Limitation on Guardian:

- Cannot assist in obtaining, storing, using MMJ
- Cannot serve as primary care giver on MMJ registry
- Cannot use patient’s MMJ
- Cannot prepare MMJ for administration
- Cannot administer MMJ
- Cannot manage how client uses MMJ
- MUST KEEP GUARDIAN AUTHORITY & RESPONSIBILITIES SEPARATE FROM CLIENT ACTUAL USE
DON’T IGNORE GUARDIAN PRACTICE ISSUES

- Recognize prof boundaries
- Identify all consequences
- Know scope of authority
- Report issues to Court

Medical vs. Recreational Use?

- NGA Standards of Practice
- Standards 7 and 14
- Authorization by Court – Appointment
- If physician supports medical use, responsibilities to Court met more easily – Standard 2
Questions?
Carol Manteuffel  303 749 7287
carol.manteuffel@huschblackwell.com