Special Guest Editorial

Federal Foolishness and Marijuana

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The advanced stages of many illnesses and their treatments are often accompanied by intractable nausea, vomiting, or pain. Thousands of patients with cancer, AIDS, and other diseases report they have obtained striking relief from these devastating symptoms by smoking marijuana.[1] The alleviation of distress can be so striking that some patients and their families have been willing to risk a jail term to obtain or grow the marijuana.

Despite the desperation of these patients, within weeks after voters in Arizona and California approved propositions allowing physicians in their states to prescribe marijuana for medical indications, federal officials, including the President, the secretary of Health and Human Services, and the attorney general sprang into action. At a news conference, Secretary Donna E. Shalala gave an organ recital of the parts of the body that she asserted could be harmed by marijuana and warned of evils of its spreading use. Attorney General Janet Reno announced that physicians in any state who prescribed the drug could lose the privilege of writing prescriptions, be excluded from Medicare and Medicaid reimbursement, and even be prosecuted for a federal crime. General Barry R. McCaffrey, directory of the Office of National Drug Control Policy, reiterated his agency's position that marijuana is a dangerous drug and implied that voters in Arizona and California had been duped into voting for these propositions. He indicated that it is always possible to study the effects of any drug, including marijuana, but that the use of marijuana by seriously ill patients would require, at the least, scientifically valid research.

I believe that a federal policy that prohibits physicians from alleviating suffering by prescribing marijuana for seriously ill patients is misguided, heavy-handed, and inhumane. Marijuana may have long-term adverse effects and its use may presage serious addictions, but neither long-term side effects nor addiction is a relevant issue in such patients. It is also hypocritical to forbid physicians to prescribe marijuana while permitting them to use morphine and meperidine to relieve extreme dyspnea and pain. With both these drugs the difference between the dose that relieves symptoms and the dose that hastens death is very narrow; by contrast, there is no risk of death from smoking marijuana. To demand evidence of therapeutic efficacy is equally hypocritical. The noxious sensations that patients experience are extremely difficult to quantify in controlled experiments. What really counts for a therapy with this kind of safety margin is whether a seriously ill patient feels relief as a result of the intervention, not whether a controlled trial "proves" its efficacy.

Paradoxically, dronabinol, a drug that contains one of the active ingredients in marijuana (tetrahydrocannabinol), has been available by prescription for more than a decade. But it is difficult to titrate the therapeutic dose of this drug, and it is not widely prescribed. By contrast, smoking marijuana produces a rapid increase in the blood level of the active ingredients and is thus more likely to be therapeutic. Needless to say, new drugs such as those that inhibit the nausea associated with chemotherapy may well be more beneficial than smoking marijuana, but their comparative efficacy has never been studied.

Whatever their reasons, federal officials are out of step with the public. Dozens of states have passed laws that ease restrictions on the prescribing of marijuana by physicians, and polls consistently show that the public favors the use of marijuana for such purposes.[1] Federal authorities should rescind their prohibition of the medicinal use of marijuana for seriously ill patients and allow physicians to decide which patients to treat. The government should change marijuana's status from that of a Schedule 1 drug (considered to be potentially addictive and with no current medical use) to that of a Schedule 2 drug (potentially addictive but with some accepted medical use) and regulate it accordingly. To ensure its proper distribution and use, the government could declare itself the only agency sanctioned to provide the marijuana. I believe

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that such a change in policy would have no adverse effects. The argument that it would be a signal to the young that "marijuana is OK" is, I believe, specious.

This proposal is not new. IN 1986, after years of legal wrangling, the Drug Enforcement Administration (DEA) held extensive hearings on the transfer of marijuana to Schedule 2. In 1988, the DEA's own administrative-law judge concluded, "It would be unreasonable, arbitrary, and capricious for DEA to continue to stand between those sufferers and the benefits of this substance in light of the evidence in this record."[1] Nonetheless, the DEA overruled the judge's order to transfer marijuana to Schedule 2, and in 1992 it issued a final rejection of all requests for reclassification.[2]

Some physicians will have the courage to challenge the continued proscription of marijuana for the sick. Eventually, their actions will force the courts to adjudicate between the right of those at death's door and the absolute power of bureaucrats whose decisions are based more on reflexive ideology and political correctness than on compassion.

References

1. Young F.L. Opinion and recommended ruling, marijuana rescheduling petition. Department of Justice, Drug Enforcement Administration. Docket 86-22. Washington, D.C.: Drug Enforcement Administration, September 6, 1988.
2. Department of Justice, Drug Enforcement Administration, Marijuana scheduling petition: denial of petition: remand. (Docket No. 86-22) Fed Regist 1992;57(59):10489-508.

Editor's Note: The Doctor's Dilemma

Compassion, as defined in the dictionary, is the feeling of "sorrow for the distress of another, with the desire to help." Indeed, it is this feeling of compassion that unifies us as physicians, and that motivates us to continue to practice the art of medicine day by day.

The understanding that medicine is not strictly scientific intercourse, but an art form as well, has permitted us as physicians to use our best judgement in the care of patients when faced with a dilemma.

In recent years, governmental constraints have posed a different type of dilemma before our medical community—one with far-reaching horns capable of mortally wounding our nation's strong medical profession, and by extrapolation, our patients. Today's two-pronged conundrum is this: can we continue to treat patients with compassion and best judgement while still remaining in compliance with new law?

Letters to the Editor

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I have always had the utmost respect for your causes and crusades. I have followed and praised your work for historic preservation and avoidance of sun radiation. I am, therefore, saddened by your support and crusade for physician assisted suicide.

Physicians and healers. Tradition has banned assisted suicide since the time of Hippocrates. Physician assisted suicide is a slippery slope, very slippery. I fear what it will lead to. I believe that we, the profession, can do a much better job in relieving the pain and suffering of the dying patient. I hope to work toward an improvement in physician skills in this area.

I was moved to write this after getting a consult letter from you with Hemlock Society info inserted. I cannot support you on this one, in fact I'll fight you every inch of the way.

John H. Houk MD

I noted with interest that in your 1/97 editorial of the HMJ the Blue/Black Ribbon panel had an absence of physicians who are on the front lines of decision making such as pediatric surgeons, trauma surgeons, oncologists, oncologic surgeons, neonatologists, intensivists, etc.

These are the ones who interface with the public and are intimately involved with pulling or not "pulling the plug" (also transplant surgeons).

I, and I'm sure other of similar stripe, would be willing to serve.

Walter K.T. Shim MD