



California Society of Addiction Medicine
"The Voice for Treatment"

CSAM's Position on Medical Marijuana

The California Society of Addiction Medicine remains troubled by several aspects of the current framework within which marijuana is considered and distributed as medication in California.

Issues requiring further attention include:

- Marijuana has never been submitted to the FDA process to determine its safety profile, to outline its side effect profile, and to validate its efficacy in a variety of disease conditions;
- A lack of standardization and lack of information regarding strength and dose;
- The most common mode of administration (smoking) remains problematic for most physicians, who have been trained to discourage smoking in all forms;
- Marketing that surrounds marijuana (e.g., "cosmic super weed") remind physicians of historic forms of snake oil medicines that promised to cure whatever ails you; and,
- Members of our society of addiction medicine have considerable experience with individuals who seek us out to help with their addiction to marijuana, which (along with strong data from research laboratories) leaves us quite skeptical of marijuana users' claims that their medicine is without any harmful effects or addictive potential (much as Purdue Pharma was guilty of minimizing the risk of addiction associated with OxyContin).

Nevertheless, two basic facts remain regarding medical marijuana that CSAM considers important enough to issue formal statements clarifying our position:

I. Physician Role in Recommending Medical Marijuana

The California Society of Addiction Medicine strongly urges all physicians who recommend the medical use of marijuana be held to all accepted medical standards of practice adopted by the California Medical Board in 2004 for recommending or approving any medication, including:

1. History and good faith examination of the patient
2. Development of a treatment plan with objectives
3. Provision of informed consent including discussion of side effects
4. Periodic review of the treatment's efficacy
5. Consultation, as necessary

6. Proper record keeping that supports the decision to recommend the use of marijuana

Furthermore:

- If a physician recommends or approves the use of medical marijuana for a minor, the parents or legal guardians must be fully informed of the risks and benefits of such use and must consent to that use.
- It is incumbent upon a physician recommending marijuana to consult with the patient's primary treating physician or obtain the appropriate patient records to confirm the patient's underlying diagnosis and prior treatment history.
- The physician should determine that medical marijuana use is not masking an acute or treatable progressive condition, or that such use will lead to a worsening of the patient's condition.

Failure to meet these standards of medical practice when recommending marijuana, an addictive psychoactive substance, should be treated by the California Medical Board with the same level of concern as failure to meet standards of medical practice in prescribing other addictive medications.

RATIONALE:

1. "There is no question marijuana can be addictive; that argument is over. The most important thing right now is to understand the vulnerability of young, developing brains to... cannabis"¹
2. 9% of those who try marijuana develop dependence²
3. Approximately half of the individuals who enter treatment for marijuana use are under 25 years of age³
4. Marijuana withdrawal symptoms include irritability, anger, depression, difficulty sleeping, cravings, and decreased appetite⁴
5. Withdrawal symptoms adversely impact attempts to quit and motivate use of marijuana or other drugs for relief⁵

II. The Basis for Cannabinoid Therapeutics

Scientific research has discovered an extensive system of nerves within the brain that communicate with each other using the same basic chemistry found in marijuana. The THC (tetrahydrocannabinol) and similar molecules in marijuana are able to affect the brain by mimicking our natural neurotransmitters and flooding receptor sites with stimulation. All the cannabinoid-based areas of the brain are subsequently activated beyond normal physiological levels. This is generally enjoyable for most people.

The question of whether there is medicinal value in stimulating, or reducing, activity in cannabinoid-based portions of the brain depends on three things:

1. Specific areas of the brain where cannabinoid chemistry is concentrated and the functions served by these areas
2. The specific disease and symptoms being treated
3. Side effects produced by the treatment — essentially a “medical cost/benefit analysis”

In addition there are also cannabinoid receptors found throughout the body, on nerves, blood cells, on organs, and throughout all stages of embryonic development. The potential for cannabinoid therapeutics must also look at the direct impact on these receptors as well.

The following statement identifies physiologic functions that are naturally controlled by our body’s internal cannabinoid system, and therefore can potentially be modified by medicinal use of cannabinoid stimulants and blockers in order to relieve the suffering caused by disease. It also provides CSAM’s perspective on the most effective framework for medicalizing cannabinoid therapeutics.

A. CSAM recognizes that a role has been established for the body’s natural cannabinoid chemistry in regulating many facets of memory, pain, emotions, appetite, motor activity, digestion, attention, higher order executive functions, reward/addiction, the immune system, and reproductive activity.

B. Multiple illnesses affecting these functions, such as dementia, chronic pain, anxiety, PTSD, wasting syndrome, spasticity, diarrhea, irritable bowel syndrome, the nausea/vomiting of chemotherapy and applications still being explored in research labs, are likely to benefit from medications based on our body’s inherent cannabinoid chemistry.

C. The new cannabinoid medications being developed will range from ones that directly stimulate cannabinoid receptors (similar to THC), to ones that prolong the effect of our natural cannabinoid chemistry (similar to how most antidepressants work), to ones that block the receptors in order to reduce the

activity of our cannabinoid system. Medications will also be developed that can target only portions of our cannabinoid system without affecting the whole system (for example, reducing pain in the body without affecting the brain).

D. Therefore, CSAM views “medical marijuana” as a flawed concept for multiple reasons.

1. Administering any medication via drawing hot smoke into the lungs is inherently unhealthy
2. While use of vaporizers, sprays and tinctures solve problems inherent in smoking, treatment of illness without standardized dose or content of the medication remain a safety issue
3. If the public wants to legalize marijuana, there is no reason to force physicians to be gatekeepers in a manner that enables liberal access to marijuana but generally fails to uphold accepted standards of practice for recommending a potentially addicting medication/drug.

E. CSAM supports a bifurcation of the two concepts of legalizing marijuana, leaving that question to the California voters, and the medical value of cannabinoid-based medications, leaving that question to the Food and Drug Administration. We are convinced that eventually properly researched medications, with well-researched indications and side effect profiles will become available to physicians for use in the treatment of disease and the relief of suffering.

F. If the citizens of California choose to legalize marijuana for 21-year-old adults, then physicians would no longer be forced to act as de facto gatekeepers to legitimize anyone’s use as “medical.” CSAM will strongly oppose access to marijuana for anyone under 21 for public health reasons, based on the continuing neurological development of the adolescent brain and its increased risk of addiction.

1 - Nora Volkow, NIDA Director, *Los Angeles Times*, 4/26/04

2 - Budney, Alan, et al, Marijuana Dependence and Its Treatment, *Addiction Science & Clinical Practice*, Dec, 2007

3 - Dependence and Its Treatment, *Addiction Science & Clinical Practice*, Dec, 2007)

4 - Budney, Alan, et al, Review of the Validity and Significance of Cannabis Withdrawal Syndrome, *Am J Psychiatry* 2004; 161:1967–1977

5 - Copersino et al., Cannabis Withdrawal Among Non-Treatment-Seeking Adult Cannabis Users, *Am J Addiction*, 2006 Jan-Feb; 15(1):8-15