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Choosing Between a Rock and the Pot Place

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Abstract

In the evolving field of medicinal cannabis, there are many questions and concerns broached by patients to which health care providers cannot respond with anything other than anecdotal evidence. Many simple knowledge gaps persist due to barriers to high-quality research at the institutional and state levels: barriers that, in turn, stem from the federal designation of cannabis as an illegal substance. These perspectives of a California-based pain physician on the approach to the cannabis-curious pain patient highlight the necessity of a change in the classification of cannabis to streamline research as to the benefits and risks of this now ubiquitous substance.

Keywords: cannabinoid analgesia; public policy; drug abuse; medical marijuana; pain; opioids

One of the most challenging aspects of practicing pain medicine in California is the ambiguity surrounding that omnipresent substance: cannabis. It is now legal both medically and recreationally along the entire West Coast of the United States. However, I often feel conflicted when asked by patients for recommendations regarding cannabis given the substance's oddly illicit federal status. The sequela of this increasingly common query is a protracted discussion with the patient of the knowns and the cumbersome quantity of unknowns regarding cannabis. However, the internal monologue I inevitably endure after each of these encounters, although less time-consuming, is more emotionally draining.

To navigate the first hurdle, I am obliged to explain to my perplexed patients that I am prohibited by federal law not only from prescribing cannabis, but also from giving conclusive dosing instructions. Although the current body of literature suggests that lower levels of THC (5–10%) are more effective for analgesia, the vast majority of products available in states where cannabis is legal contain >15% THC.[1] This is alarming to patients, who typically wish to avoid psychotropic effects. My uncomfortable hedging thus consists of encouraging the use of vaporized cannabis for easier titration, reiteration of the adage "start low and go slow," and a flimsy reference to the D.A.R.E. program to acknowledge the persistent stigma surrounding the substance.

The next challenge is a silent struggle; I must disguise the fact that I had a conversation with the patient about cannabis in a vague bullet point in my note stating: other adjuvant substances discussed, risks and benefits outlined in detail. I include this phrase to ensure I do not repeat my initial dialogue to the patient on a subsequent visit. Nothing erodes credibility like repeating a memorized discourse rife with litigation-averse phrases to a patient population that is among the most avid of note takers. However, I do not explicitly document that cannabis was discussed because the drug enforcement administration (DEA) classifies it as a Schedule 1 illicit substance with no therapeutic benefit, like heroin, rather than a Schedule 2 substance, such as oxycodone or cocaine, with known addictive potential but possessing medicinal qualities.

Patients are also increasingly requesting to use cannabis (Schedule 1) as an adjunct in opioid (Schedule 2) reduction,[2] and in contrast to my initial spiel, my response to this question is always woefully improvised. Regions where laws increase access to cannabis enjoy reduced morbidity from opioids and reduced total opioid use,[3] but direct evidence for[4] and against[5] a cannabis-aided opioid wean ends up negating any concrete conclusion regarding its efficacy. Pain specialists in private practice are reluctant to even mention cannabis let alone entertain a cannabis-assisted opioid wean given the legal ramifications of prescribing a controlled substance to a

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patient who is using a federally illicit therapy.[6] Already scrutinized by multiple governing bodies, opioid prescribers opt for prudence and avoid aberrant urine drug screens in the medical record. On occasion, to circumvent discovery, the physician may perform the customary screen while omitting the test for THC. This willful ignorance is far from bliss.

During discussions at national and local meetings, pain physicians in both private practice and academic centers will concur that cannabis is markedly safer than opioids. However, it is also a far less potent analgesic. Despite protection from the first amendment to discuss cannabis, we possess scant evidence-based medicine on which to base our recommendations. Presently, clinicians are electing to continue patients on opioid regimens, thus further contributing to the Scylla of the opioid epidemic, rather than permit use of an anecdotally effective and ostensibly safe alternative: cannabis.

Working for a large university hospital system, I generally feel more protected from litigation than private practice pain physicians. However, given that most of my colleagues within the University of California system disavow cannabis (on the record, anyway), my recommendation to patients in this regard is generally equivocal, or I endorse one of the few Food and Drug Administration-approved CBD products. Strong evidence for either substance is profoundly lacking, but based on published studies and anecdotes from my patient cohort, I consider cannabis a much more effective analgesic than CBD alone. After years of delay, the DEA has proposed an amendment that would allow study of additional strains of cannabis consumed in the clinical setting under tight regulation by the federal government.[7] This amendment would expand scientific investigation of the effects of cannabis while still classifying it as a drug with no currently accepted medical use, which is manifest hypocrisy.

Now more than ever, clinical researchers require an avenue to evaluate the effect of cannabis on a multitude of pain generators and medications. Our ability to study cannabis is currently thwarted by hospital institutional review boards that, understandably, do not permit therapy with federally illicit substances in human subjects. Cannabis products as sold in dispensaries do not meet Schedule 1 exemption requirements and, therefore, cannot be investigated, even by scientists with a license to study cannabis. These studies are necessary to quell fear that cannabis is dangerous when combined with opioids, a common refrain although most evidence is reassuring,[4] and will also give clinicians a framework upon which to base our medical recommendations. After years practicing as a California-based pain physician, I feel I can counsel patients when and if a pain state is amenable to cannabis treatment, but my advice is rendered with a dose of ambivalence. The gaps in our knowledge base are maintained by myriad barriers that could be overcome by simply reclassifying cannabis from a Schedule 1 to a Schedule 2 substance. This long-overdue regulatory change is imperative and will allow us to better characterize cannabis, the mysterious Charybdis.

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Abbreviations Used

CBD = cannabidiol
DEA = drug enforcement administration
THC = tetrahydrocannabinol
UC = University of California