“Medical Cannabis”, now what?

The medical profession was strongly opposed to the legalization of “medical cannabis” based upon the complex and difficult situation implementation has created in many other states like New York and the move by California physicians to support full legalization in lieu of “medical cannabis”. However, when the legislature decided to take this action over the objections of physicians, it was a wise move to place administration in the State Health Department to grabble with such implementation to assure the citizens receive the most compassionate, safe and responsible care possible. However, it is going to need some help in terms of resources and clarifications.

To begin, it does not require a physician per se, to match an individual’s diagnosis and health indicators with a list of such parameters as determined by the State legislature in order to get a “cannabis card” - if that is the legislature’s intent. Privacy concerns aside, in today’s world of electronic medical records, information exchanges, patient portals and expanded standardized coding, the DMV or patient could easily verify the patient possessed the requisite “match” to receive a card. If that is the intent, only those without such a designation on the State’s list, would even have to seek a physician to add a “new” designation to one’s medical record. There will always be a few physicians willing to so and some states have actually set up electronic physician service centers willing to do so on-line – sort of like the old pill mills.

This should work well for those seeking cannabis for whatever reason who do not suffer from serious disease. However, seriously ill patients are a much different situation. No competent and responsible physician would issue a card for such a patient without reviewing the patient’s medical history and current treatment, especially if it involves mental health, pain management, “wasting” and addiction treatment. Such ongoing treatment could be seriously jeopardized and/or discontinued if the patient were to begin self-medicating with cannabis. Unless there are specific centers set up (like in New York) willing to integrate cannabis care with the ongoing care, this is not something most physicians would be willing to do and, in fact, it is dangerous and irresponsible to do so.

For example, take an item on the State’ list, HIV. To begin, HIV is not a disease. It is a lab test indicating a patient has – or has had – an “infection”. About 20 years ago it portended dire consequences for most individuals infected with the onset of AIDS and a list of very serious and usually fatal sequella. Today, many HIV victims lead full productive lives, primarily though the preventive use of medicines that suppress the “infection”, delaying or preventing AIDS and the horrible, associated, secondary conditions. I suppose an HIV patient whose viral load was well controlled could get a “card” and self-medicate with cannabis but I doubt many physicians would recommend it. If the patient’s infection, progressed to AIDS, the therapy would address the specific complications that can vary greatly. Thus, the designation HIV is virtually worthless in determining who might benefit from cannabis.

Another concern is the popular myth that cannabis can successfully replace opiates for severe pain. Addiction medical specialists insist such an association has not been proven and, in fact, adding cannabis to opiates can result in double addiction. I am not suggesting that cannabis

should not be tried in pain patients but at this stage it needs to occur under controlled research conditions. We do not need to be adding cannabis pill mills to those we are trying to eliminate for opiates.

Finally, early on, we need to define the human and monetary resources that are going to be required to responsibly, compassionately and safely implement the State legislative mandate. Given the poverty in West Virginia, if we are competently going to care for seriously ill patients by adding cannabis to the treatment regime, we need to identify the personnel, facilities and medication costs involved since most insurances, Medicare/aid, PEIA and the VA will not pay for such care.

There are other issues also such as the willingness of “carded”, but not seriously ill individuals, to accept non-smokable, non-edible cannabis or the consequences of converting permissible forms to those preferred, as well as the social costs of such use in non-seriously ill individuals. However, the clarifications noted and a business plan and budget would be a good place to start.

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