AMA Backs Medical Marijuana for Research

BY MARY ELLEN SCHNEIDER

Over the past few years, there has been a sea change in how state governments and some physicians think about marijuana as a medicine.

Most recently, the American Medical Association's House of Delegates approved a policy recommending that the federal government review its classification of marijuana. Its current designation, as a Schedule I controlled substance, limits the ability of researchers to evaluate the drug's usefulness as a medical therapy, the AMA said. The new AMA policy states that the goal of the reclassification should be to ease the conduct of clinical research and the development of cannabinoid-based medicines and alternative delivery models.

But the policy also clearly states that the request for a federal review should not be seen as an endorsement of state-based medical cannabis programs or the legalization of marijuana.

The AMA joins other medical and public health organizations in favoring a reclassification of marijuana to encourage research. But the AMA's size and clout means people are taking notice of this recommendation, said Bruce Mirken, a spokesperson for the Marijuana Policy Project, an organization that advocates for the decriminalization of marijuana use.

"This shift is very significant, even though it was done with what you could safely call characteristic caution," Mr. Mirken said.

Although the AMA's position won't by itself cause a swift and dramatic political shift, Mr. Mirken said the AMA's previous opposition to a change in Schedule I classification was often seized on by opponents. "They can't really say that anymore," he said. "That, in the big picture, is significant and it may make it easier for more laws to be passed on the state level."

Since 1996, laws that allow for some type of medical use of marijuana have been enacted in 13 states: Alaska, California, Colorado, Hawaii, Maine, Michigan, Montana, Nevada, New Mexico, Oregon, Rhode Island, Vermont, and Washington. Additional states have enacted "symbolic" laws that recognize the value of medical marijuana but do not protect individuals from arrest, according to the Marijuana Policy Project, and more states are considering medical marijuana laws.

Another development that could open the door for more states to pass medical marijuana exceptions is a recent memorandum from the Department of Justice essentially advocating a hands-off policy on medical marijuana use in states where it is allowed. In the memorandum, issued in October, the DOJ told federal prosecutors in states with laws authorizing the medical use of marijuana not to focus their resources on enforcing the federal prohibition on marijuana. For example, the prosecution of cancer patients who use marijuana as part of a recommended treatment regimen is "unlikely to be an efficient use of limited federal resources," according to the document.

In California, where medical marijuana has been legal for more than a decade, some physicians feel they are in a precarious position. The California law states that physicians will not be punished for recommending marijuana to a patient for medical purposes. But even with the latest DOJ memo, federal enforcement is not uniform or predictable.

"That's a very uncomfortable position for a physician," said Dr. Melvyn Sterling, a palliative care specialist in Orange, Calif. Dr. Sterling said he would prefer to see the federal government explicitly decriminalize the prescription of medical marijuana so that physicians could feel free to prescribe whatever medication is most beneficial to patients.

Dr. Sterling said that he feels comfortable recommending marijuana as a treatment when his patients need it, but that he recommends it very rarely. "For the most part we have in our therapeutic armamentarium wonderfully effective drugs, and we're not dependent upon cannabinoids," he said.

In states that do allow physicians to recommend marijuana as a medical treatment, physicians should use caution, said Dr. Georges C. Benjamin, executive director of the American Public Health Association, which was an early supporter of more research into the medical use of marijuana. As with any other therapeutic option, physicians need to be thoroughly familiar with the drug, its utilization and side effects, contraindications, and drug-drug interactions.

"We ought to treat this like any other therapeutic drug," he said.

It is harder to follow that advice in California, where the onus is on patients to follow up with their physician when using marijuana as medicine, according to Dr. Denise Greene, a psychiatrist and addiction specialist in the Los Angeles region. In California, physicians may "recommend" that patients obtain marijuana to treat a medical condition; the patient then takes that recommendation to a dispensary. At most dispensaries, that "recommendation" does not need to be renewed or updated, she said.

The system gives the patient an open-ended pass to obtain marijuana, Dr. Greene said, especially since unlike traditional prescriptions, these recommendations aren't time- or dose-limited.

"We don't treat this like anything else," Dr. Greene said. "Physicians prescribe lots of other abusable drugs, but we pay attention to how much and how often and for what purpose they use those drugs."

Mr. Milken works for the Marijuana Policy Project. Dr. Sterling uses medical marijuana in the palliative care of patients. Dr. Benjamin works for the APHA, which supports research into the medical use of marijuana. ■

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State Eyes Gift Restrictions

New Jersey's Division of Consumer Affairs has called on state lawmakers to take a variety of steps, such as banning pharmaceutical company–sponsored meals for physicians, in an effort to curb doctors' conflicts of interest when they prescribe drugs. The division urged 22 reforms, most to be enforced by the N.J. Board of Medical Examiners, that would forbid physicians from accepting free trips, gifts, or meals and would require them to disclose any industry payments over $200 for consulting. However, the proposed regulations would continue to allow pharmaceutical representatives to distribute free drug samples. The consumer affairs division also urged new restrictions on the mining of prescriber-identifiable data and said it wants the lawmakers to ban the sale of such data.

FDA Told to Strengthen Monitoring

The Food and Drug Administration has begun to address weaknesses in its oversight of the safety of drugs once they're approved and marketed, but it still hasn't staffed the effort correctly, the Government Accountability Office said. Previously, the congressional watchdog agency reviewed the regulatory history of the drug Vioxx (rofecoxib), which was pulled from the market in 2004 after being linked to heart attacks and strokes. At that time, the GAO recommended changes in the FDA's program to monitor drugs after they are approved, including clarification of various offices' roles in that effort. However, the GAO said last month that the FDA still does not have a timetable for making those changes. The report called for a comprehensive plan showing which FDA office is responsible for monitoring approved drugs on the market.

Asthma Projects Are Launched

The National Heart, Lung, and Blood Institute has awarded 13 contracts to local organizations to test new evidence-based approaches to managing asthma. The 2-year contracts, worth $1.3 million in total, are part of the National Asthma Control Initiative, which is to strengthen collaborative efforts among patients and families, health care providers, and others involved in managing asthma. The 13 projects include a range of asthma interventions in diverse communities. For example, one will work to reduce asthma triggers in homes and schools, while another will provide Web-based training programs and in-person education for both patients and providers.

Health Centers Get $600M Boost

A total of 85 community health centers in more than 30 states will receive nearly $600 million in American Recovery and Reinvestment Act awards to support expansion through construction and renovation projects and acquisition of health information technology. The awards should help the centers care for more than 500,000 additional patients in underserved communities, said President Obama, who announced the initiative. At the same time, the Centers for Medicare and Medicaid Services will test the impact of the medical home practice model in community health centers, focusing on access, quality, and cost of care for Medicare beneficiaries, President Obama said. Up to 500 centers will eventually participate in the 3-year medical home demonstration, according to the CMS.

Information Tech Gets Funding Too

The recovery act also will fund $235 million in grants to strengthen the existing health information technology (HIT) infrastructure and increase information-exchange capabilities, according to the Department of Health and Human Services. The Beacon Community Program will fund 15 initiatives run by nonprofit organizations or government entities that already have HIT systems in place with wide adoption of electronic medical records. The goal is to show how cutting-edge HIT programs can improve quality, safety, efficiency, and population health while maintaining strong privacy and security measures, the HHS said. The results from the grant program will provide guidance for the use of electronic medical records throughout the United States, the primary goal of the federal government's HIT initiative, the agency said.

Transparency Law Falls Short

Uninsured patients in California are unable to obtain information about the cost of medical care at hospitals, despite recent state legislation designed to improve price transparency, according to a study published in the Journal of General Internal Medicine. For the study, researchers posed as low-income, uninsured patients and asked hospitals for price information. But they received estimates from fewer than one-third of the hospitals approached, and the prices given often were much higher than those allowed under California law, which forbids hospitals from charging the uninsured more for a service than the hospital is paid by a government health plan. In addition, the prices for procedures varied widely. "Few of the estimates we did receive allowed us to make an 'apples to apples' comparison between different hospitals," said lead author Dr. Kate Farrell of the University of Pittsburgh. The other researchers in the study are with the RAND Corp., the California HealthCare Foundation, and Brown University, Providence, R.I.

—Jane Anderson