

## **A Regional Response to the Marihuana Medical Access Regulations**

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In 2001 Canada became the first country to allow the use and growth of marihuana for personal use by people with terminal illness and serious medical conditions. This has created a dilemma not only for individual physicians, but also for palliative care programs that need to be consistent in management approaches across all settings including the home, palliative care units, acute and chronic care institutions.

Section 56 of the Controlled Drug and Substances Act (CDSA) provides the Minister of Health with the discretionary power to grant exemptions from the Act under exceptional circumstances. These exemptions can include the use, possession and production of marihuana for personal medical use if there is shown to be medical necessity. The Court of Appeal of Ontario challenged this process on July 31, 2000. The Court rendered its decision in the case of a man who uses marihuana to control epileptic seizures, and had been charged with possession under the CDSA. The Court upheld the 1997 lower court decision to stay the charges on constitutional grounds and raised issues relating to Section 56 of the CDSA. These included concerns about the extent of the discretionary powers given to the Minister, as well as concerns about transparency of the process, and lack of definition of the term "medical necessity". Therefore, the Court declared the prohibition of marihuana under the CDSA of no force and effect. The declaration of invalidity was suspended for one year in order to give Parliament sufficient time to amend the legislation to comply with the Charter of Rights. This led to the development of new Regulations, which came into effect July 30th, 2001.

"The regulations establish a compassionate framework to allow the use of marihuana by people who are suffering from serious illnesses where conventional treatments are inappropriate or not providing adequate relief of the symptoms related to the medical condition or its treatment, and where the use of marihuana is expected to have some medical benefit that outweighs the risk of its use" - Office of Cannabis Medical Access - Division of Health Canada.

The regulations described three categories of patients (1). Category 1 is for terminally ill patients with a prognosis of less than 12 months where other conventional treatments have failed. Category 2 includes patients with specific symptoms associated with conditions such as cancer, AIDS, multiple sclerosis, and arthritis. Category 3 is for other situations where two medical specialists declare that other conventional treatments have been unsuccessful. An information bulletin is available to help physicians to complete the application form, although at the present time this does not include any recommendations on dosage.

The Alberta Medical Association expressed the concern of many physicians in a letter to the (previous) Minister of Health that stated: - "These regulations announced by Health Canada are unacceptable because there has not been thorough and rigorous scientific testing. This, in turn, may negatively affect the physician-patient relationship. Patients may believe that they could benefit from the use of marihuana for one of a number of conditions or that they may be able to obtain marihuana for recreational use through their physicians." Further objections include the

fact that the use of marihuana as medicine is not evidence-based, and there are no clinical practice guidelines in place, including appropriate dosage. In addition physicians have no knowledge of product potency or consistency, placing them in an untenable position.

A further difficulty is due to the fact that there are few clinical trials on smoked marihuana available in the literature (2, 3) and none are in palliative care patients. There are many studies on the cannabinoids and there is possible evidence for its use in chemotherapy induced nausea and vomiting (4, 5, 6, 7, 8, 9), in glaucoma (10), in spasticity associated with multiple sclerosis (11, 12), in certain neuropathic pain syndromes (13, 14, 15), in anorexia/cachexia associated with HIV/AIDS and cancer (16, 17, 18), and asthma (20). At present the indications for commercially available synthetic cannabinoids are for chemotherapy-associated nausea and for the cachexia associated with AIDS.

In considering these circumstances it is apparent that research in the palliative care population is needed as regulations have antedated adequate knowledge in this area. Discussion with palliative care physicians and nurses in the Edmonton area suggests that clinical circumstances requiring prescriptions for inhaled marihuana would be exceptional. In addition the current use, attitudes and demand for marihuana as medicine in our health region is completely unknown. Further, it is easy to imagine the difficulty that will arise when a patient approved for inhaled marihuana use in the home requires admission to a palliative care unit, or an acute or chronic care facility.

As a result the Edmonton Palliative Care Program has taken the position that until such time as stronger evidence is available and some of the practical problems involved with patients using inhaled marihuana are addressed, we will not support the application for permission to use marihuana for medical purposes under the new Regulations.

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