



Medical Use of Marijuana in Palliative Care

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Marijuana has been documented to provide relief to patients in palliative care. However, healthcare providers should use caution when discussing medical marijuana use with patients. This article features a case study that reveals the complexity of medical marijuana use. For oncology nurses to offer high-quality care, examining the pros and cons of medical marijuana use in the palliative care setting is important.

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Historically, marijuana has been used as a natural remedy for various ailments. Examining the pros and cons of the medical use of marijuana in the palliative care setting is important for oncology nurses and advanced practice nurses (APNs).

Marijuana History and Use

Cannabis, or marijuana, is an herb used by humans for centuries and is the most commonly used drug in the world (United Nations Office on Drugs and Crime [UNODC], 2011). Early prescribers for cannabis recommended eating the seeds for nutritional value and smoking the plant to relieve pain, vomiting, convulsions, and spasticity (Bostwick, 2012).

Studies have shown that delta-9 tetrahydrocannabinol (THC) is the principle psychoactive, or hallucinogenic, component in cannabis (UNODC, 2011). Smoking marijuana allows for maximum rapid absorption into the lungs, whereas oral ingestion provides erratic absorp-

tion (Green & de Vries, 2010). Once THC binds to cannabinoid receptors in the brain, side effects may include appetite stimulation, decreased anxiety, relief of nausea and vomiting, diminished spasticity, relief from pain (neurogenic in nature), and decreased intraocular pressure (Joffe & Yancy, 2004).

Cancer is a qualifying indication for medical marijuana use in states that have legalized it (Bowles, O'Bryant, Camidge, & Jimeno, 2012) (see Table 1). For oncology palliative care use, marijuana may control pain, increase appetite, and decrease nausea and vomiting. However, antiemetic guidelines do not support THC, synthetic or inhaled, as first-line therapy (Bowles et al., 2012).

Marijuana and the Legal System

Prior to 1937, marijuana in the United States was frequently prescribed for an array of ailments. However, when cannabis was outlawed in 1937, marijuana began to

be portrayed negatively (Millhorn et al., 2009). Since then, society has not fully accepted marijuana for medicinal use.

The Drug Enforcement Agency (DEA) continues to maintain a conservative stance on cannabis use, calling for it to be classified as a schedule I drug. Rescheduling it to a schedule II drug would reflect the “known medicinal value of marijuana while acknowledging the importance of proper medical supervision and accepting that more research is necessary into the side effects and possible dangers of medical marijuana use” (Rendall, 2012, p. 338).

Federal policy states cannabis possession is a criminal offense (DEA, 2011). The American Medical Association notes it would support marijuana rescheduling if doing so would facilitate research and development of cannabinoid-based medicine (Hoffman & Weber, 2010). Physicians and APNs may recommend marijuana use, but if officially prescribed or dispensed, practitioners may be federally charged with aiding and abetting (Hoffman & Weber, 2010). Rescheduling marijuana would enable oncology APNs to prescribe the drug, allowing for regulation and appropriate dispensing techniques.

Legal use of marijuana is a state-level decision. Because federal law prohibits possession of marijuana, patients who possess marijuana are still subject to federal criminal charges (Hoffmann & Weber, 2010). In the United States, 18 states and the District of Columbia have legalized marijuana so far (National Conference of State Legislatures, 2013). In those states, patients are allowed to use and possess small quantities of marijuana for medical purposes (Hoffman & Weber, 2010). State laws, however, do not regulate marijuana's quality or potency, and most do not address how to obtain the drug (Hoffman & Weber, 2010).