Cannabis Classification Prevents Adequate Research

Change does not come easily to the medical community. In 1847, after witnessing countless post childbirth and surgical deaths, Dr. Ignaz Philipp Semmelweis did some experiments and realized that if physicians washed their hands, it could prevent most incidents of "childbed fever," along with the infections that invariably occurred after surgeries. His absurd notion made him the laughingstock of the medical community, even after several studies were published that showed the practice could reduce the incidence of the aforementioned maladies to below 1%. Dr. Semmelweis had a nervous breakdown at the age of 47 and was committed to a mental institution. He died 14 days later, after being beaten senseless by the guards.

In this same spirit, many traditional Western doctors still remain stubbornly planted in their stance that marijuana is a dangerous street drug that has no medical value. Fortunately, like Dr. Semmelweis, other physicians have reconsidered their thinking in the face of obvious beneficial results. Thanks to these forward-thinking medical professionals, a dialogue is now open on the therapeutic value of cannabis.

In a recent article in *The NE Journal of Medicine*, those on both sides of the MM issue debated the case of a 31-year-old woman who was suffering from chronic regional pain after a sports injury. Multiple treatments, including several opioids, regional and sympathetic nerve blocks, transcutaneous nerve stimulation, lidocaine salves, behavior modification and acupuncture, had all failed. The question now: Should medical marijuana be considered as a treatment option?

First up was Benjamin Caplan, MD, a Tufts graduate who completed his residency at Boston Medical Center and specialized in family medicine. As an advocate for medical marijuana, he created the CED Foundation, dedicated to combating the stigmas associated with the use of cannabis. In his assessment, he noted that the complex pain the patient was experiencing is multidimensional and that the long-term effects were exacerbated by therapy failures, lack of sleep and stress. He explained the need to address the whole being of the woman, not just her current physical symptoms. He referred to the therapeutic anti-inflammatory and neuroprotective effects of cannabis. He mentioned that different formulations could be administered orally to avoid possible toxic effects of smoke. He cited that "trials in humans have shown measurable effects of cannabinoids in alleviating chronic pain, with an acceptable safety profile. Experimental research … provides reassuring support on safety."

In conclusion, Dr Caplan stated, "Cannabis is an appealing option to address the frustration expressed with the inefficacy, side effects and addictive nature of opioids. Although many people use cannabis for pain relief, the prevalence of addiction and the risk of overdose are low."

In the opposing corner was Edgar Ross, MD, a graduate of Wayne State University School of Medicine who specializes in anesthesiology and pain medicine in Boston, Mass. He opened with the point that "enthusiasm for medical marijuana has been based largely on anecdotal information." He acknowledges that cannabinoid compounds are almost certainly safer than long-term opioid therapy, and admits that various studies do suggest that the analgesic potency of cannabinoids is roughly similar to that of codeine, but cautions that side effects of dizziness, dry mouth, dysphoria, appetite stimulation and short-term memory loss may interfere with established rehabilitation treatments and psychological therapies. Dr. Ross also questioned the safety and reliability of delivery systems and cited a lack of standardization of cannabinoids in MM.

He concluded, "Multidisciplinary treatment programs based on a modern rehabilitation model are considered to be highly effective for the management of chronic pain of all types … a multidisciplinary program should be tried; this approach is more likely to be beneficial in the long term than medical marijuana, which is an unproven treatment with poorly defined toxic effects, safety and efficacy. In addition, the likely side effects of medical marijuana use are exactly the ones that the patient is hoping to avoid."

Both sides brought up valid points, but a significant and recurring caveat in Dr. Ross's arguments was the lack of clinical evidence to either support the positive outcomes or provide info on long-term side effects. Opposing doctors use that argument over and over, and on the face, it's a valid point. Mere heresay is not enough to warrant FDA approval; however, what ought to be posted directly next to that argument is this: It is not possible at this time in the United States to legally conduct clinical research on medical marijuana. Why? Because approved studies must be sanctioned and supplied by government, and the government will not release Schedule 1 drugs for medical research. At present time, marijuana is still classified as a Schedule 1 drug, a list which includes heroin, LSD, peyote and ecstacy. Schedule 1 drugs are considered high risk, with no counterbalancing medical benefits; as such, they are banned from medical practice.

It is time that the government and medical community acknowledge that there is enough "unofficial" evidence on the efficacy of medical marijuana to mandate a change in the Schedule 1 classification of cannabis. The remedy for conflict over medical marijuana is obvious: Before any valid conclusions are drawn on either side of the this debate, it is absolutely necessary that clinical trials be allowed to support or refute any the claims that have been made, and the potentials that have yet to be explored.