THE RxProfessor

Q&A on Marijuana

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Mark 'RxProfessor' Pew
National speaker & author on the intersection of chro...

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I had the privilege of conducting a national webinar on February 21 entitled "Marijuana Momentum – Implications for Work Comp." It was hosted by One Call Care University and attended by 1,207 people around the country. This was actually my sixth national webinar thru OCCU (another one scheduled for May 23 on physician dispensing) who have been great sponsors and supporters of my content. Given the number of attendees I was not able to answer all of the questions, many of which were insightful, so following are my answers (aka my personal opinions) on those overflow questions. Enjoy.

1. *Are motor skills as well as thinking and judgement effected and for how long when under the use of marijuana?* **MP: It depends upon the person, but in general terms probably and unknown. That is why driving stoned is a really bad idea because it requires all three (motor skills, thinking, judgment).**

2. *I live in Missouri. What exactly does it mean that there is "limited" medical MJ approval?* **MP: HB 2238 was passed in 2014 that allowed hemp to be used for epilepsy. The MO legislature passed HB 2213 last April that would allow a vote to broaden the scope slightly but it failed to pickup enough signatures to make it to the ballot. I'm sure there will be efforts again in the future to expand conditions and access.**

3. *You seem like you are a staunch advocate of marijuana but many people now addicted to other drugs identify it as their gateway. I have seen this dynamic first hand in my immediate family. Is their addiction due to some type of coincidental biological/genetic factor or do they look for other drugs after the*

but someone who tries to deal with subjects objectively. My personal opinion is that cannabis can be medicinal for some people with some conditions at some points in time. I also agree that it can be addictive (just like alcohol, opioids, gambling, and coffee) – but not everybody becomes addicted or even dependent. I also agree it could be a gateway drug as users develop a tolerance to the "high" and need ever increasing more potency (just like opioids) – but not everyone uses and moves onto other drugs. There is broad consensus that addiction is a disease influenced not only by the drugs but biological and sociological / environmental considerations as well. But as with opioids, most people are not addicted – they are dependent (suffering some level of withdrawal symptoms upon disuse). I believe all intoxicants create physical and psychological dependent / addiction opportunities but not everyone develops it (otherwise everyone who ever had opioids after surgery would have problems). There are various tools that that doctors should use before prescribing to identify red flags and understand tendencies , but obviously that's not the case with marijuana where it use is self-procured, dosing is self-determined and the mitigation of risks is self-managed.

4. *Could a claim handler approving and paying a labor code approved marijuana from the claim file create conditions that could result in Federal Prosecution of violation of a Federal law?* **MP: In theory that is possible because as long as marijuana is Schedule I and illegal, it is a federal crime (i.e. money laundering) to engage in the transaction. That is the argument used by proponents in various states to add prohibition of reimbursement - it could put the claims handler or supervisor or CFO or Chief Claims Officer at risk. Unless the Federal government changes course and decides to enforce that (which is possible given the statements made by Attorney General Sessions), it appears to be a hollow threat and likely not something you'll need to worry about.**

5. *Isn't part of the problem with the studies being due to the Schedule 1 designation, it is not available to scientists for study?* **MP: Yes, that is a limitation because there aren't incentives for studies (how will Big Pharma make back its investment) and there is limited marijuana to study (although the DEA decision last Summer opened up "manufacturing" / growers beyond the University of Mississippi). Read my blogpost "Marijuana science still half-baked (?)" for more background. I've heard that's why there is a focus on doing research in Israel, primarily financed by US $'s.**

6. *Is 2013 the most recent date that the AMA has announced a position on medical marijuana use?* **MP: As far as publication, I believe so. However, they post (undated) their current position online.**

7. *If there are FDA approved alternatives to Cannabis, are these also addictive?* **MP: In some cases, absolutely. For example, opioids being used for**

the medications for glaucoma are potentially addictive. So it depends upon the drugs being used. Which furthers the talking point that opioids are addictive and more dangerous than marijuana. The one constant is that FDA approved drugs for these typical qualifying conditions for medical cannabis are manufactured more reliably than marijuana (which, in some states, is as "buyer beware" as if still buying illegally from the street).

8. *If researchers could grow a particular strain with a known percentage of efficacy, couldn't they replicate results and come up with dosage recommendations?* **MP: Yes. Which goes back to research. Given enough time and studies and dollars, I believe at some point in the future there could be a recommended strain, delivery method and dosing for specific conditions (i.e. if you're in Parkinson's Stage One or Stage Two). What makes it unknown to some degree at this point is the lack of that research.**

9. *How do these regulations work with DOT regulations? Under DOT Regulations we are able to do post-accident drug testing as long as the employee was ticketed.* **MP: As far as I know, the DOT mandates a drug-free workplace with a zero-tolerance policy. That should enable (or mandate) pre-employment and post-accident testing to ensure there are no intoxicants (marijuana, opioids, alcohol, etc.) that produce impairment. Also, since those DOT requirements are a Federal program, not necessarily at the state level, it resides where marijuana remains illegal / Schedule I. You probably know more about DOT than I do but that's how I understand it.**

10. *What effect will the trend to not drug screen post injury effect the affirmative defense of intoxication?* **MP: In some states the burden of proof is on the employer to prove intoxication while in other states it's on the individual. If it's the former, and there is no drug testing, then there likely is no way to prove intoxication. I personally think it's a mistake to forego drug testing, either pre-employment or post-accident, but there are many companies and industries (e.g. the agricultural industry in California) legitimately struggling with how to hire and retain enough employees to fulfill the company's mission.**

11. *In reference to the "impaired workforce" concept, what are the legal ramifications if there are other workers injured as a consequence of a potentially impaired worker?* **MP: I would guess that's different for each state's associated civil laws and Work Comp statutes. I also think it would be impacted by the unique H/R policies at each employer in regards to liability. That is what makes the job of a H/R Manager or Risk Manager so difficult, especially in companies that are multi-state.**

12. *How is marijuana labeled dangerous or best as a last resort when there's not one reported death vs ~200/day for prescription medications that we don't even know the long term effects of?* **MP: There have been documented deaths in Colorado from over dosing (i.e. eating more than recommended) of an edible**

into accounts, you are correct that death from marijuana is dramatically lower than for opioids. I suppose "danger" could be a subjective term. If one person has been smoking weed for years and has a good job, never gravitated towards more potent drugs, is mentally aware and socially adjusted, and could stop at any time if they wanted to with no negative effects (I've seen too many stories to say this isn't legit) – you could say it's not dangerous. For another person, smoking weed has become a gateway to other drugs that started them on a pathway to personal destruction (I've seen too many stories to say this isn't legit) – you could say it is dangerous. The problem with any intoxicant – marijuana, opioids, alcohol (heroin is different; NIDA reports that 23% of people who try heroin become addicted) – is that nobody can be sure how they'll react. The best option, in my opinion, is to consume no intoxicants.

13. *The number of chronic pain patients is increasing also. Wouldn't chronic pain itself be an impairment?* **MP: It certainly can be, if it's disabling to the point where the person cannot perform ADL (activities of daily living). That may be a physical impairment – literally not being able to stand up for more than five minutes – or it could be a psychological impairment – their attitudes about pain limit their willingness to be active.**

14. *The Federal Department of Agriculture has a patent on using Marijuana as a medicinal drug. Why would the Federal Government classify Marijuana as a schedule 1 drug like Meth or Cocaine (no medicinal benefit), when one of their departments owns the right to use it in a medicinal way? It's almost as if the Government will come in and regulate it at such a high rate that mom and pop shops (I.E. Colorado or Oregon) will have to close down, and the government will throw the bone to Big Pharm. The government would never snub Big Pharm due to the amount of money they lobby. Colorado saw a massive decrease in opioid prescriptions written. I think it is easy to be anti-weed, but pro-legalization. A perfect example of the hypocrisy of our government with their protection of big pharma, is AMA's statement "For every disease and disorder for which marijuana has been recommended, there is a better, FDA-approved medication."* **MP: You make an interesting point. And why I said during the webinar that the decision to make marijuana illegal in 1937 and 1969 was largely political, and any decision to make it legal is largely political. Not on its merits, but on what people think.**

15. *Is there a quantifiable amount of marijuana that can be considered as causing impairment much like there is for alcohol (.08BAC)?* **MP: Yes. There is a growing consensus that 3.1-4.5 ng/mL (oral) and 3.3-4.5 ng/mL (smoked) plasma levels = 0.05 g% blood alcohol concentration (BAC). Of course, that's a blood draw, which is an invasive test compared to a urine test or taking a hair sample. For more information, read "Marijuana in the Workplace: Guidance for Occupational Health Professionals and Employers."**

processing? For example if a claimant states they are a user while working for a company that does not allow marijuana use? **MP: In my opinion, recreational use of marijuana is completely different than medicinal use and should be treated differently. It should be treated purely as intoxication, just like alcohol or cocaine or street oxycodone. If they do not live/work in a state that has a medical cannabis program, or they do but are not a registered medical user (which requires doctor(s) to confirm it is "reasonable and necessary" for a qualifying condition), then I would classify it as recreational use. If a company does not allow marijuana use, and it's clearly stated as such in their policies, then there should be zero tolerance for recreational use.**

17. *If impairment is for 7-8 hours after use, is there a quantitate test (such as for alcohol) that would tell testers if you test at a certain level you are impaired, if below a certain level you are not impaired but it is just in your system?* **MP: Yes. There is a growing consensus that 3.1-4.5 ng/mL (oral) and 3.3-4.5 ng/mL (smoked) plasma levels = 0.05 g% blood alcohol concentration (BAC). Of course, that's a blood draw, which is an invasive test compared to a urine test or taking a hair sample.**

18. *If people under 25, especially children are subjected to 2nd hand marijuana smoke could it affect them neurologically?* **MP: It certainly can. Every individual is different, biologically and psychosocially, but I would think second-hand smoke from marijuana would be as dangerous as second-hand smoke from tobacco (I've heard that marijuana smoke is actually more dangerous than cigarette smoke, first or second hand). That's why most states with medical cannabis programs do not allow smoking but focus on vaping, edibles, oils and tinctures.**

19. *It is my understanding that cannabinoids other than THC, like cannabidiol (CBD), are the efficacious compounds in cannabis. Since cannabis strains vary greatly in THC and CBD content, is there any mechanism to control which strains of cannabis are available to the patient? Can we direct that only high-CBD/low-THC strains be dispensed to patients?* **MP: Before Florida expanded their medical cannabis program last November, their requirement was for Low-THC (0.8% or less of THC and 10% or more of CBD). CBD has been particularly effective against seizures (like the Dravet Syndrome that impacted Charlotte Figi) and does not produce euphoria (which helps advocates when making the argument for its use). From what I understand, other conditions (like Alzheimer's) only respond to THC or a mixture of THC and CBD. Because the level of THC is increasing and CBD is decreasing to create a more potent high around the country, I assume there are ways for growers to somehow manufacture and control that. Given enough time and studies and dollars, I believe at some point in the future there could be a recommended strain, delivery method and dosing for specific conditions (i.e. if you're in Parkinson's Stage One or Stage Two). And as that becomes**

"guidelines" (for the lack of a better term) in what to recommend.

20. *Do you anticipate a method of determining impairment relating to cannabis use in employers that report to DOT? (Dept. of Transportation) or even impairment while driving class A, CHP, etc. current "breathalyzer" is there something being developed for cannabis?* **MP: Because everyone knows presence <> impairment for marijuana, there are a variety of educational institutions and for-profit companies pursuing the ability to distinguish. There are some breathalyzers that are in testing (even on the road with police), There is the blood draw (3.1-4.5 ng/mL (oral) and 3.3-4.5 ng/mL (smoked) plasma levels = 0.05 g% BAC) that at some point could be commoditized like diabetes pin-prick testers. There are obviously already field sobriety tests that are observable in performance and behavior. If the Federal government does not change their approach to enforcement (as implied by new Attorney General Sessions that recreational marijuana should be viewed as illegal regardless of individual state law), there will be momentum – even a mandate – to bridge the gap of presence and impairment on the road and at the job.**

21. *In states w/medicinal use approval- if MD/practice decide negatively on whether to prescribe is this primarily based on funding/regulations set forth by the Federal DEA b/c it is still illegal federally?* **MP: The decision by a doctor to recommend / not recommend medical cannabis is an individual decision that is likely influenced by their personal opinion. I know some doctors who believe it is medicine and given the appropriate circumstances (e.g. it replaces opioids for pain and benzos for anxiety) they would deem it "reasonable and necessary." I know other doctors that under no circumstance would they recommend a drug with no dosing guidelines and that can be addictive (those doctors are typically in the detox/rehab field, who see the impact of addiction and dependence on intoxicants). It's possible some doctors may decide to recommend / not recommend based on illegality at the Federal level (FYI … In no state is it ever "prescribed" because that starts tying it to a DEA overseen process, but instead "certified" or "recommended"). Some doctors would be as objective as possible and look at the research and interpret the results as to efficacy, deciding whether it is appropriate or not. Personal use, and positive or negative reaction to it, likely would also inform a doctor's opinion. It's my opinion that the decision by a doctor to recommend / not recommend will be based on the filter they use to form their opinion.**

22. *Just like the addiction from narcotic use, are there pharmacological provisions made for addictions from medical marijuana use?* **MP: As far as I know, tools used to help people shake their addiction to opioids, alcohol, heroin, etc. could also be likely used for an addiction to marijuana. Obviously, some of those drugs are more dangerous (the only three outcomes from heroin use is rehab, jail or death) than others so the tools wouldn't be exactly the same. But those tools include Rx options (e.g. naltrexone has been used for several years**

not aware of anything specific to marijuana but that doesn't mean it doesn't exist.

23. *We have seen an increase in CBD being prescribed for insomnia due to chronic pain. Are there any findings that CBD oil is effective for insomnia?* **MP: I have not seen insomnia as a specific targeted or qualifying condition. However, the use of marijuana for chronic pain and anxiety – both of which can impact the ability to sleep – is being accepted more widespread. So it's possible that is a "side effect" from use, to help the person relax so they can go to sleep.**

24. *Are there studies on efficacy as it relates to CRPSII and those whose opiate receptors are depleted?* **MP: I am not sure about CRPS. However, New Mexico's medical cannabis program advisory board recommended last year that "opiate use disorder" be added to the list of qualifying conditions, citing evidence that it should be part of that treatment. As far as I know, that recommendation has not yet been formally accepted.**

Do you have different opinions? Or more questions? If so, I'd definitely like to hear from you. This issue, and the conversation surrounding it, is not going away any time soon.

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