EXECUTIVE SUMMARY

Marijuana and Medicine

Assessing the Science Base

Janet E. Joy, Stanley J. Watson, Jr., and
John A. Benson, Jr., *Editors*

Division of Neuroscience and Behavioral Health

INSTITUTE OF MEDICINE

NATIONAL ACADEMY PRESS
Washington, D.C. 1999

NATIONAL ACADEMY PRESS • 2101 Constitution Avenue, N.W. • Washington, D.C. 20418

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This study was supported under Contract No. DC7C02 from the Executive Office of the President, Office of the National Drug Control Policy.

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This report has been reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise, in accordance with procedures approved by the National Research Council's Report Review Committee. The purpose of this independent review is to provide candid and critical comments that will assist the Institute of Medicine in making the published report as sound as possible and to ensure that the report meets institutional standards for objectivity, evidence, and responsiveness to the study charge. The review comments and draft manuscript remain confidential to protect the integrity of the deliberative process. The committee wishes to thank the following individuals for their participation in the review of this report:

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JACK BARCHAS, Cornell University Medical College;
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VIRGINIA V. WELDON, Washington University.

While the individuals listed above have provided constructive comments and suggestions, it must be emphasized that responsibility for the final content of this report rests entirely with the authoring committee and the Institute of Medicine.

Preface

Public opinion on the medical value of marijuana has been sharply divided. Some dismiss medical marijuana as a hoax that exploits our natural compassion for the sick; others claim it is a uniquely soothing medicine that has been withheld from patients through regulations based on false claims. Proponents of both views cite "scientific evidence" to support their views and have expressed those views at the ballot box in recent state elections. In January 1997, the White House Office of National Drug Control Policy (ONDCP) asked the Institute of Medicine to conduct a review of the scientific evidence to assess the potential health benefits and risks of marijuana and its constituent cannabinoids. That review began in August 1997 and culminates with this report.

The ONDCP request came in the wake of state "medical marijuana" initiatives. In November 1996, voters in California and Arizona passed referenda designed to permit the use of marijuana as medicine. Although Arizona's referendum was invalidated five months later, the referenda galvanized a national response. In November 1998, voters in six states (Alaska, Arizona, Colorado, Nevada, Oregon, and Washington) passed ballot initiatives in support of medical marijuana. (The Colorado vote will not count, however, because after the vote was taken a court ruling determined there had not been enough valid signatures to place the initiative on the ballot.)

Information for this study was gathered through scientific workshops, site visits to cannabis buyers' clubs and HIV/AIDS clinics, analysis of the relevant scientific literature, and extensive consultation with biomedical and social scientists. The three 2-day workshops—in Irvine, California; New Orleans, Louisiana; and Washington, D.C.—were open to the public and included scientific presentations and individual reports, mostly from patients and their families,

about experiences with and perspectives on the medical use of marijuana. Scientific experts in various fields were selected to talk about the latest research on marijuana, cannabinoids, and related topics. (Cannabinoids are drugs with actions similar to THC, the primary psychoactive ingredient in marijuana.) In addition, advocates for and against the medical use of marijuana were invited to present scientific evidence in support of their positions. Finally, the Institute of Medicine appointed a panel of nine experts to advise the study team on technical issues.

Public outreach included setting up a Web site that provided information about the study and asked for input from the public. The Web site was open for comment from November 1997 until November 1998. Some 130 organizations were invited to participate in the public workshops. Many people in the organizations—particularly those opposed to the medical use of marijuana—felt that a public forum was not conducive to expressing their views; they were invited to communicate their opinions (and reasons for holding them) by mail or telephone. As a result, roughly equal numbers of persons and organizations opposed to and in favor of the medical use of marijuana were heard from.

Advances in cannabinoid science over the last 16 years have given rise to a wealth of new opportunities for the development of medically useful cannabinoid-based drugs. The accumulated data suggest a variety of indications, particularly for pain relief, antiemesis, and appetite stimulation. For patients, such as those with AIDS or undergoing chemotherapy, who suffer simultaneously from severe pain, nausea, and appetite loss, cannabinoid drugs might offer broad spectrum relief not found in any other single medication.

Marijuana is not a completely benign substance. It is a powerful drug with a variety of effects. However, the harmful effects to individuals from the perspective of possible medical use of marijuana are not necessarily the same as the harmful physical effects of drug abuse.

Although marijuana smoke delivers THC and other cannabinoids to the body, it also delivers harmful substances, including most of those found in tobacco smoke. In addition, plants contain a variable mixture of biologically-active compounds and cannot be expected to provide a precisely defined drug effect. For those reasons, the report concludes that the future of cannabinoid drugs lies not in smoked marijuana, but in chemically-defined drugs that act on the cannabinoid systems that are a natural component of human physiology. Until such drugs can be developed and made available for medical use, the report recommends interim solutions.

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C*o-Principal Investigators*

Acknowledgments

This report covers such a broad range of disciplines—neuroscience, pharmacology, immunology, drug abuse, drug laws, and a variety of medical specialties including neurology, oncology, infectious diseases, and ophthalmology—that it would not have been complete without the generous support of many people. Our goal in preparing this report was to identify the solid ground of scientific consensus, and steer clear of the muddy distractions of opinions that are inconsistent with careful scientific analysis. To this end, we consulted extensively with experts in each of the disciplines covered in this report. We are deeply indebted to each of them.

Members of the Advisory Panel, selected because each is recognized as among the most accomplished in their respective disciplines (see page iii), provided guidance to the study team throughout the study—from helping to lay the intellectual framework to reviewing early drafts of the report.

The following people wrote invaluable background papers for the report: Steven R. Childers, Paul Consroe, Howard Fields, J. Richard Gralla, Norbert Kaminski, Paul Kaufman, Thomas Klein, Donald Kotler, Richard Musty, Clara Sanudo-Pena, C. Robert Schuster, Stephen Sidney, Donald P. Tashkin, and J. Michael Walker.

Others provided expert technical commentary on draft sections of the report: Richard Bonnie, Keith Green, Frederick Fraunfelder, Andrea Hohmann, John McAnulty, Craig Nichols, John Nutt, and Robert Pandina.

Still others responded to many inquiries, provided expert counsel, or shared their unpublished data: Paul Consroe, Geoffrey Levitt, Raphael Mechoulam, Richard Musty, David Pate, Roger Pertwee, Clara Sanudo-Pena, Carl Soderstrom, J. Michael Walker, and Scott Yarnell.

Miriam Davis, consultant to the study team, provided excellent written material for the chapter on cannabinoid drug development.

The reviewers for the report (see page iv) provided extensive, constructive suggestions for improving the report. It was greatly enhanced by their thoughtful attention.

Many of these people assisted us through many iterations of the report. All of them made contributions that were essential to the strength of the report. At the same time, it must be emphasized that responsibility for the final content of report rests entirely with the authors and the Institute of Medicine.

We would also like to thank the people who hosted our visits to their organizations. They were unfailingly helpful and generous with their time. Jeffrey Jones and members of the Oakland Cannabis Buyers' Cooperative, Denis Peron of the San Francisco Cannabis Cultivators Club, Scott Imler and staff at the Los Angeles Cannabis Resource Center, Victor Hernandez and members of Californians Helping Alleviate Medical Problems (CHAMPS), Michael Weinstein of the AIDS Health Care Foundation, and Marsha Bennett of the Louisiana State University Medical Center.

We also appreciate the many people who spoke at the public workshops or wrote to share their views on the medical use of marijuana (see Appendix A).

Jane Sanville, project officer for the study sponsor, was consistently helpful during the many negotiations and discussion held throughout the study process.

Many Institute of Medicine staff members provided greatly appreciated administrative, research, and intellectual support during the study. Robert Cook-Deegan, Marilyn Field, Constance Pechura, Daniel Quinn, and Michael Stoto provided thoughtful and insightful comments on draft sections of the report. Others provided advice and consultation on many other aspects of the study process: Clyde Behney, Susan Fourt, Carolyn Fulco, Carlos Gabriel, Linda Kilroy, Catharyn Liverman, Dev Mani, and Kathleen Stratton. As project assistant throughout the study, Amelia Mathis was tireless, gracious, and reliable.

Deborah Yarnell's contribution as Research Associate for this study was outstanding. She organized site visits, researched and drafted technical material for the report, and consulted extensively with relevant experts to ensure the technical accuracy of the text. The quality of her contributions throughout this study was exemplary.

Finally, the Principal Investigators on this study wish to personally thank Janet Joy for her deep commitment to the science and shape of this report. In addition, her help in integrating the entire data gathering and information organization of this report were nothing short of essential. Her knowledge of neurobiology, her sense of quality control, and her unflagging spirit over the 18 months illuminated the subjects and were indispensable to the study's successful completion.

Contents

The contents of the entire report, from which this Executive Summary is extracted, are listed below.

Executive Summary

Public opinion on the medical value of marijuana has been sharply divided. Some dismiss medical marijuana as a hoax that exploits our natural compassion for the sick; others claim it is a uniquely soothing medicine that has been withheld from patients through regulations based on false claims. Proponents of both views cite "scientific evidence" to support their views and have expressed those views at the ballot box in recent state elections. In January 1997, the White House Office of National Drug Control Policy (ONDCP) asked the Institute of Medicine (IOM) to conduct a review of the scientific evidence to assess the potential health benefits and risks of marijuana and its constituent cannabinoids (see the Statement of Task on page 8). That review began in August 1997 and culminates with this report.

The ONDCP request came in the wake of state "medical marijuana" initiatives. In November 1996, voters in California and Arizona passed referenda designed to permit the use of marijuana as medicine. Although Arizona's referendum was invalidated five months later, the referenda galvanized a national response. In November 1998, voters in six states (Alaska, Arizona, Colorado, Nevada, Oregon, and Washington) passed ballot initiatives in support of medical marijuana. (The Colorado vote will not count, however, because after the vote was taken a court ruling determined there had not been enough valid signatures to place the initiative on the ballot.)

Can marijuana relieve health problems? Is it safe for medical use? Those straightforward questions are embedded in a web of social concerns, most of which lie outside the scope of this report. Controversies concerning the nonmedical use of marijuana spill over into the medical marijuana debate and obscure the real state of scientific knowledge. In contrast with the many dis-

agreements bearing on social issues, the study team found substantial consensus among experts in the relevant disciplines on the scientific evidence about potential medical uses of marijuana.

This report summarizes and analyzes what is known about the medical use of marijuana; it emphasizes evidence-based medicine (derived from knowledge and experience informed by rigorous scientific analysis), as opposed to belief-based medicine (derived from judgment, intuition, and beliefs untested by rigorous science).

Throughout this report, *marijuana* refers to unpurified plant substances, including leaves or flower tops whether consumed by ingestion or smoking. References to "the effects of marijuana" should be understood to include the composite effects of its various components; that is, the effects of tetrahydrocannabinol (THC), which is the primary psychoactive ingredient in marijuana, are included among its effects, but not all the effects of marijuana are necessarily due to THC. *Cannabinoids* are the group of compounds related to THC, whether found in the marijuana plant, in animals, or synthesized in chemistry laboratories.

Three focal concerns in evaluating the medical use of marijuana are:

1. Evaluation of the effects of isolated cannabinoids
2. Evaluation of the risks associated with the medical use of marijuana
3. Evaluation of the use of smoked marijuana

EFFECTS OF ISOLATED CANNABINOIDS

Cannabinoid Biology

Much has been learned since the 1982 IOM report *Marijuana and Health*. Although it was clear then that most of the effects of marijuana were due to its actions on the brain, there was little information about how THC acted on brain cells (neurons), which cells were affected by THC, or even what general areas of the brain were most affected by THC. In addition, too little was known about cannabinoid physiology to offer any scientific insights into the harmful or therapeutic effects of marijuana. That all changed with the identification and characterization of cannabinoid receptors in the 1980s and 1990s. During the last 16 years, science has advanced greatly and can tell us much more about the potential medical benefits of cannabinoids.

CONCLUSION: At this point, our knowledge about the biology of marijuana and cannabinoids allows us to make some general conclusions:

- Cannabinoids likely have a natural role in pain modulation, control of movement, and memory.
- The natural role of cannabinoids in immune systems is likely multifaceted and remains unclear.
- The brain develops tolerance to cannabinoids.
- Animal research demonstrates the potential for dependence, but this potential is observed under a narrower range of conditions than with benzodiazepines, opiates, cocaine, or nicotine.
- Withdrawal symptoms can be observed in animals, but appear to be mild compared to opiates or benzodiazepines, such as diazepam (Valium®).

CONCLUSION: The different cannabinoid receptor types found in the body appear to play different roles in normal human physiology. In addition, some effects of cannabinoids appear to be independent of those receptors. The variety of mechanisms through which cannabinoids can influence human physiology underlies the variety of potential therapeutic uses for drugs that might act selectively on different cannabinoid systems.

RECOMMENDATION 1: Research should continue into the physiological effects of synthetic and plant-derived cannabinoids and the natural function of cannabinoids found in the body. Because different cannabinoids appear to have different effects, cannabinoid research should include, but not be restricted to, effects attributable to THC alone.

Efficacy of Cannabinoid Drugs

The accumulated data indicate a potential therapeutic value for cannabinoid drugs, particularly for symptoms such as pain relief, control of nausea and vomiting, and appetite stimulation. The therapeutic effects of cannabinoids are best established for THC, which is generally one of the two most abundant of the cannabinoids in marijuana. (Cannabidiol is generally the other most abundant cannabinoid.)

The effects of cannabinoids on the symptoms studied are generally modest, and in most cases, there are more effective medications. However, people vary in their responses to medications, and there will likely always be a subpopulation of patients who do not respond well to other medications. The combination of cannabinoid drug effects (anxiety reduction, appetite stimulation, nausea reduction, and pain relief) suggests that cannabinoids would be moderately well suited for particular conditions, such as chemotherapy-induced nausea and vomiting and AIDS wasting.

Defined substances, such as purified cannabinoid compounds, are preferable to plant products, which are of variable and uncertain composition. Use of defined cannabinoids permits a more precise evaluation of their effects, whether in combination or alone. Medications that can maximize the desired effects of cannabinoids and minimize the undesired effects can very likely be identified.

Although most scientists who study cannabinoids agree that the pathways to cannabinoid drug development are clearly marked, there is no guarantee that the fruits of scientific research will be made available to the public for medical use. Cannabinoid-based drugs will only become available if public investment in cannabinoid drug research is sustained and if there is enough incentive for private enterprise to develop and market such drugs.

CONCLUSION: Scientific data indicate the potential therapeutic value of cannabinoid drugs, primarily THC, for pain relief, control of nausea and vomiting, and appetite stimulation; smoked marijuana, however, is a crude THC delivery system that also delivers harmful substances.

RECOMMENDATION 2: Clinical trials of cannabinoid drugs for symptom management should be conducted with the goal of developing rapid-onset, reliable, and safe delivery systems.

Influence of Psychological Effects on Therapeutic Effects

The psychological effects of THC and similar cannabinoids pose three issues for the therapeutic use of cannabinoid drugs. First, for some patients—particularly older patients with no previous marijuana experience—the psychological effects are disturbing. Those patients report experiencing unpleasant feelings and disorientation after being treated with THC, generally more severe for oral THC than for smoked marijuana. Second, for conditions such as movement disorders or nausea, in which anxiety exacerbates the symptoms, the anti-anxiety effects of cannabinoid drugs can influence symptoms indirectly. This can be beneficial or can create false impressions of the drug effect. Third, for cases in which symptoms are multifaceted, the combination of THC effects might provide a form of adjunctive therapy; for example, AIDS wasting patients would likely benefit from a medication that simultaneously reduces anxiety, pain, and nausea while stimulating appetite.

CONCLUSION*:* The psychological effects of cannabinoids, such as anxiety reduction, sedation, and euphoria can influence their potential therapeutic value. Those effects are potentially undesirable for certain patients and situations, and beneficial for others. In addition, psychological effects can complicate the interpretation of other aspects of the drug effect.

RECOMMENDATION 3: Psychological effects of cannabinoids such as anxiety reduction and sedation, which can influence medical benefits, should be evaluated in clinical trials.

RISKS ASSOCIATED WITH MEDICAL USE OF MARIJUANA

Physiological Risks

Marijuana is not a completely benign substance. It is a powerful drug with a variety of effects. However, except for the harms associated with smoking, the adverse effects of marijuana use are within the range of effects tolerated for other medications. The harmful effects to individuals from the perspective of possible medical use of marijuana are not necessarily the same as the harmful physical effects of drug abuse. When interpreting studies purporting to show the harmful effects of marijuana, it is important to keep in mind that the majority of those studies are based on *smoked* marijuana, and cannabinoid effects cannot be separated from the effects of inhaling smoke from burning plant material and contaminants.

For most people, the primary adverse effect of *acute* marijuana use is diminished psychomotor performance. It is, therefore, inadvisable to operate any vehicle or potentially dangerous equipment while under the influence of marijuana, THC, or any cannabinoid drug with comparable effects. In addition, a minority of marijuana users experience dysphoria, or unpleasant feelings. Finally, the short-term immunosuppressive effects are not well established but, if they exist, are not likely great enough to preclude a legitimate medical use.

The *chronic* effects of marijuana are of greater concern for medical use and fall into two categories: the effects of chronic smoking, and the effects of THC. Marijuana smoking is associated with abnormalities of cells lining the human respiratory tract. Marijuana smoke, like tobacco smoke, is associated with increased risk of cancer, lung damage, and poor pregnancy outcomes. Although cellular, genetic, and human studies all suggest that marijuana smoke is an important risk factor for the development of respiratory cancer, proof that habitual marijuana smoking does or does not cause cancer awaits the results of well-designed studies.

CONCLUSION: Numerous studies suggest that marijuana smoke is an important risk factor in the development of respiratory disease.

RECOMMENDATION 4: **Studies to define the individual health risks of smoking marijuana should be conducted, particularly among populations in which marijuana use is prevalent.**

Marijuana Dependence and Withdrawal

A second concern associated with chronic marijuana use is dependence on the psychoactive effects of THC. Although few marijuana users develop dependence, some do. Risk factors for marijuana dependence are similar to those for other forms of substance abuse. In particular, antisocial personality and conduct disorders are closely associated with substance abuse.

CONCLUSION: A distinctive marijuana withdrawal syndrome has been identified, but it is mild and short-lived. The syndrome includes restlessness, irritability, mild agitation, insomnia, sleep EEG disturbance, nausea, and cramping.

Marijuana as a "Gateway" Drug

Patterns in progression of drug use from adolescence to adulthood are strikingly regular. Because it is the most widely used illicit drug, marijuana is predictably the first illicit drug most people encounter. Not surprisingly, most users of other illicit drugs have used marijuana first. In fact, most drug users begin with alcohol and nicotine before marijuana—usually before they are of legal age.

In the sense that marijuana use typically precedes rather than follows initiation of other illicit drug use, it is indeed a "gateway" drug. But because underage smoking and alcohol use typically precede marijuana use, marijuana is not the most common, and is rarely the first, "gateway" to illicit drug use. There is no conclusive evidence that the drug effects of marijuana are causally linked to the subsequent abuse of other illicit drugs. An important caution is that data on drug use progression cannot be assumed to apply to the use of drugs for medical purposes. It does not follow from those data that if marijuana were available by prescription for medical use, the pattern of drug use would remain the same as seen in illicit use.

Finally, there is a broad social concern that sanctioning the medical use of marijuana might increase its use among the general population. At this point there are no convincing data to support this concern. The existing data are consistent with the idea that this would not be a problem if the medical use of marijuana were as closely regulated as other medications with abuse potential.

CONCLUSION: Present data on drug use progression neither support nor refute the suggestion that medical availability would increase drug abuse. However, this question is beyond the issues normally considered for medical uses of drugs and should not be a factor in evaluating the therapeutic potential of marijuana or cannabinoids.

USE OF SMOKED MARIJUANA

Because of the health risks associated with smoking, smoked marijuana should generally not be recommended for long-term medical use. Nonetheless, for certain patients, such as the terminally ill or those with debilitating symptoms, the long-term risks are not of great concern. Further, despite the legal, social, and health problems associated with smoking marijuana, it is widely used by certain patient groups.

RECOMMENDATION 5: **Clinical trials of marijuana use for medical purposes should be conducted under the following limited circumstances: trials should involve only short-term marijuana use (less than six months); should be conducted in patients with conditions for which there is reasonable expectation of efficacy; should be approved by institutional review boards; and should collect data about efficacy**.

The goal of clinical trials of smoked marijuana would not be to develop marijuana as a licensed drug, but rather to serve as a first step toward the possible development of nonsmoked, rapid-onset cannabinoid delivery systems. However, it will likely be many years before a safe and effective cannabinoid delivery system, such as an inhaler, is available for patients. In the meantime, there are patients with debilitating symptoms for whom smoked marijuana might provide relief. The use of smoked marijuana for those patients should weigh both the expected efficacy of marijuana and ethical issues in patient care, including providing information about the known and suspected risks of smoked marijuana use.

RECOMMENDATION 6: Short-term use of smoked marijuana (less than six months) for patients with debilitating symptoms (such as intractable pain or vomiting) must meet the following conditions:

- **failure of all approved medications to provide relief has been documented;**
- **the symptoms can reasonably be expected to be relieved by rapid-onset cannabinoid drugs;**
- **such treatment is administered under medical supervision in a manner that allows for assessment of treatment effectiveness; and**
- **involves an oversight strategy comparable to an institutional review board process that could provide guidance within 24 hours**

of a submission by a physician to provide marijuana to a patient for a specified use.

Until a nonsmoked, rapid-onset cannabinoid drug delivery system becomes available, we acknowledge that there is no clear alternative for people suffering from *chronic* conditions that might be relieved by smoking marijuana, such as pain or AIDS wasting. One possible approach is to treat patients as *n*-of-1 clinical trials, in which patients are fully informed of their status as experimental subjects using a harmful drug delivery system, and in which their condition is closely monitored and documented under medical supervision, thereby increasing the knowledge base of the risks and benefits of marijuana use under such conditions.

STATEMENT OF TASK

The study will assess what is currently known and not known about the medical use of marijuana. It will include a review of the science base regarding the mechanism of action of marijuana, an examination of the peer-reviewed scientific literature on the efficacy of therapeutic uses of marijuana, and the costs of using various forms of marijuana versus approved drugs for specific medical conditions (e.g., glaucoma, multiple sclerosis, wasting diseases, nausea, and pain).

The study will also include an evaluation of the acute and chronic effects of marijuana on health and behavior; a consideration of the adverse effects of marijuana use compared with approved drugs; an evaluation of the efficacy of different delivery systems for marijuana (e.g., inhalation vs. oral); an analysis of the data concerning marijuana as a gateway drug; and an examination of the possible differences in the effects of marijuana due to age and type of medical condition.

Specific Issues

Specific issues to be addressed fall under three broad categories: the science base, therapeutic use, and economics.

Science Base

- Review of the neuroscience related to marijuana, particularly relevance of new studies on addiction and craving
- Review of the behavioral and social science base of marijuana use, particularly an assessment of the relative risk of progression to other drugs following marijuana use
- Review of the literature determining which chemical components of crude marijuana are responsible for possible therapeutic effects and for side effects

Therapeutic Use

- Evaluation of any conclusions on the medical use of marijuana drawn by other groups
- Efficacy and side effects of various delivery systems for marijuana compared to existing medications for glaucoma, wasting syndrome, pain, nausea, or other symptoms
- Differential effects of various forms of marijuana that relate to age or type of disease

Economics

- Costs of various forms of marijuana compared with costs of existing medications for glaucoma, wasting syndrome, pain, nausea, or other symptoms.
- Assessment of differences between marijuana and existing medications in terms of access and availability.

RECOMMENDATIONS

RECOMMENDATION 1: Research should continue into the physiological effects of synthetic and plant-derived cannabinoids and the natural function of cannabinoids found in the body. Because different cannabinoids appear to have different effects, cannabinoid research should include, but not be restricted to, effects attributable to THC alone.

Scientific data indicate the potential therapeutic value of cannabinoid drugs for pain relief, control of nausea and vomiting, and appetite stimulation. This value would be enhanced by a rapid onset of drug effect.

RECOMMENDATION 2: Clinical trials of cannabinoid drugs for symptom management should be conducted with the goal of developing rapid-onset, reliable, and safe delivery systems.

The psychological effects of cannabinoids are probably important determinants of their potential therapeutic value. They can influence symptoms indirectly which could create false impressions of the drug effect or be beneficial as a form of adjunctive therapy.

RECOMMENDATION 3: Psychological effects of cannabinoids such as anxiety reduction and sedation, which can influence medical benefits, should be evaluated in clinical trials.

Numerous studies suggest that marijuana smoke is an important risk factor in the development of respiratory diseases, but the data that could conclusively establish or refute this suspected link have not been collected.

RECOMMENDATION 4: Studies to define the individual health risks of smoking marijuana should be conducted, particularly among populations in which marijuana use is prevalent.

Because marijuana is a crude THC delivery system that also delivers harmful substances, smoked marijuana should generally not be recommended for medical use. Nonetheless, marijuana is widely used by certain patient groups, which raises both safety and efficacy issues.

RECOMMENDATION 5: Clinical trials of marijuana use for medical purposes should be conducted under the following limited circumstances: trials should involve only short-term marijuana use (less than six months); should be conducted in patients with conditions for which there is reasonable expectation of efficacy; should be approved by institutional review boards; and should collect data about efficacy.

If there is any future for marijuana as a medicine, it lies in its isolated components, the cannabinoids and their synthetic derivatives. Isolated cannabinoids will provide more reliable effects than crude plant mixtures. Therefore, the purpose of clinical trials of smoked marijuana would not be to develop marijuana as a licensed drug, but rather to serve as a first step toward the development of nonsmoked, rapid-onset cannabinoid delivery

systems.

Continued

RECOMMENDATIONS *Continued*

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- **failure of all approved medications to provide relief has been documented;**
- **the symptoms can reasonably be expected to be relieved by rapid-onset cannabinoid drugs;**
- **such treatment is administered under medical supervision in a manner that allows for assessment of treatment effectiveness; and**
- **involves an oversight strategy comparable to an institutional review board process that could provide guidance within 24 hours of a submission by a physician to provide marijuana to a patient for a specified use.**