COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO

POLICY STATEMENT #8-16

Marijuana for Medical Purposes

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LEGISLATIVE REFERENCES: *Access to Cannabis for Medical Purposes Regulations*, SOR/2016-230; R. v. Mernagh, 2011 ONSC 2121; *Regulated Health Professions Act*, 1991, SO. 1991, c. 18.; *Health Professions Procedural Code*, Schedule 2 of the *Regulated Health Professions Act*, 1991, S.O. 1001, c.18; Ontario Regulation 114/94 made under the *Medicine Act*, 1991, S.O. 1991, c.30.; *Health Care Consent Act*, 1996, S.O. 1996, c. 2, Sched. A.

REFERENCE MATERIALS: Health Canada, *Information for Health Care Professionals: Cannabis (marihuana, marijuana) and the cannabinoids*; College of Family Physicians of Canada, *Authorizing Dried Cannabis for Chronic Pain or Anxiety: Preliminary Guidance*; Kahan, Meldon, et al. (2014). Prescribing Smoked Cannabis for Chronic Noncancer Pain: Preliminary Recommendations. *Canadian Family Physician*, 60, 1083-1090.

COLLEGE CONTACTS: Physician Advisory Service

Marijuana for Medical Purposes

INTRODUCTION

The Government of Canada's *Access to Cannabis for Medical Purposes Regulations (ACMPR)*[1] establish the legal framework that enables patients to obtain authorization to possess marijuana for medical purposes.

Under these regulations, physicians have primary responsibility for the decision to authorize patient use of marijuana for medical purposes.[2] Physicians enable patients to access a legal supply of marijuana by completing a medical document that functions like a conventional prescription.

While conclusive evidence regarding the safety and effectiveness of marijuana as a medical treatment is limited, many patients, physicians, and researchers have voiced support for the cautious and compassionate use of marijuana, particularly where other therapeutic options have been exhausted and failed to alleviate the patient's symptoms. Furthermore, court rulings have required reasonable access to a legal source of marijuana for medical purposes when authorized by a physician.[3]

In keeping with the College's mandate to serve and protect the public,[4] this policy sets out expectations for physicians relating to the prescribing of marijuana for medical purposes.

These expectations are grounded in the principles of medical professionalism set out in the Practice Guide, and take into account the best available evidence regarding the medical use of marijuana.

PRINCIPLES

The key values of professionalism articulated in the *Practice Guide* – compassion, service, altruism and trustworthiness – form the basis for the expectations set out in this policy. Physicians embody these values and uphold the reputation of the profession by:

1. Acting in the best interests of their patients;
2. Demonstrating professional competence, which includes maintaining the medical knowledge and clinical skills necessary to prescribe appropriately;
3. Collaborating effectively and respectfully with patients, physicians and other health-care providers;
4. Avoiding or appropriately managing conflicts of interest;[5] and
5. Participating in the self-regulation of the medical profession by complying with the expectations set out in this policy.

PURPOSE & SCOPE

This policy sets out the College's expectations of all physicians who prescribe marijuana for medical purposes.

1. *Access to Cannabis for Medical Purposes*, SOR/2016-230.
2. The *ACMPR* authorize both physicians and nurse practitioners to prescribe marijuana for medical purposes; however, to date the College of Nurses of Ontario has not permitted their members to prescribe.
3. R. v. Mernagh, 2011 ONSC 2121.
4. Section 3(2) of the *Health Professions Procedural Code*, Schedule 2 of the *Regulated Health Professions Act*, 1991, S.O. 1001, c.18 (hereinafter *HPPC*).
5. For more information on conflicts of interest, please see Part IV of the General, O. Reg., 114/94, enacted under the *Medicine Act*, 1991, S.O. 1991, c. 30 (hereinafter *Medicine Act, General Regulation*).

TERMINOLOGY

Marijuana: Throughout this policy, the terms "marijuana" and "marijuana for medical purposes" should be understood to mean not only dried marijuana, but also any other form of marijuana that is legally permitted by the current legislation.

Medical document: The *ACMPR* require that patients obtain a medical document completed by an authorized healthcare practitioner in order to access a legal supply of marijuana for medical purposes. The medical document contains information that would normally be found on a prescription, including the patient's name, the physician's name and CPSO number, the daily quantity of marijuana to be used by the patient, and the period of use, among other information.[6]

Prescription: Throughout this policy, the term "prescription" should be understood to include the completion of a medical document in accordance with the *ACMPR*.

POLICY

It is the College's position that the medical document required under the *ACMPR* is equivalent to a prescription.

Physicians who prescribe marijuana must comply with the expectations set out in this policy as well as the expectations and guidelines for prescribing that are set out in the College's Prescribing Drugs policy. Physicians must also ensure compliance with the *ACMPR* and any other relevant College policies, including, but not limited to, the Dispensing Drugs, Complementary/Alternative Medicine, and Telemedicine policies.

1. Before Prescribing

Physicians must always practise within the limits of their knowledge, skills and judgment[7], and never provide care that is beyond the scope of their clinical competence.[8] As with any treatment, physicians are not obligated to prescribe marijuana if they do not believe it is clinically appropriate for their patient.[9]

Assessing the appropriateness of marijuana for the patient

Before a physician may prescribe marijuana, he/she must carefully consider whether it is the most appropriate treatment for their patient.[10] As part of this process, physicians must weigh the available evidence in support of marijuana

6. Section 8 of the *Access to Cannabis for Medical Purposes Regulations*.
7. Sections 2(1)(c), 2(5), O. Reg. 865/93, Registration, enacted under the *Medicine Act*, 1991, S.O. 1991, c.30; Changing Scope of Practice policy; The Practice Guide.
8. This expectation applies to all non-emergent situations. In emergency situations, physicians may be permitted to act outside their scope of expertise in some circumstances. See the Physicians and Health Emergencies policy for more detail.
9. Physicians may sometimes have difficulty addressing patient disagreement with a decision not to prescribe marijuana. Recommendations for communicating with patients about this decision can be found in Kahan, Meldon, et al. (2014). Prescribing Smoked Cannabis for Chronic Noncancer Pain: Preliminary Recommendations. *Canadian Family Physician*, 60, 1083-1090.
10. While conclusive evidence regarding the safety and effectiveness of marijuana is currently limited, there are a number of resources physicians can consult for more information. These include, among others: Health Canada's *Information for Health Professionals* webpage; the College of Family Physicians of Canada's *Authorizing Dried Cannabis for Chronic Pain or Anxiety: Preliminary Guidance*; and Kahan, Meldon, et al. (2014). Prescribing Smoked Cannabis for Chronic Noncancer Pain: Preliminary Recommendations. *Canadian Family Physician*, 60: 1083-1090. Physicians must be mindful that resources may become outdated as further research is undertaken in this field.

against other available treatment options, including the oral and buccal[11] pharmaceutical form of cannabinoids.

Physicians must also consider the risks associated with the use of marijuana, which may include, among others, a risk of addiction, the onset or exacerbation of mental illness, including schizophrenia, and – when smoked – symptoms of chronic bronchitis.[12]

Physicians are expected to comply with the applicable standard of practice when assessing the risk of marijuana to their patients and take such steps as are clinically indicated in the specific circumstances of each case to mitigate those risks. The published literature with respect to marijuana provides some general guidance as to some of the recommended components in such a risk assessment. These include, among others, an assessment of each patient for their risk of addiction and substance diversion,[13] and an assessment of risk factors for psychotic disorders, mood disorders, and other mental health issues that may be affected by the use of marijuana.

Prescribing to patients under the age of 25

Current evidence strongly suggests that children, adolescents, and young adults who consume marijuana are at a greater risk than older adults for marijuana-associated harms, including suicidal ideation, illicit drug use, cannabis use disorder, and long-term cognitive impairment.[14] Given the potentially severe nature of these risks, physicians must not prescribe marijuana to patients under the age of 25[15] unless all other conventional therapeutic options have been attempted and have failed to alleviate the patient's symptoms.

Even after all other conventional therapeutic options have been exhausted, physicians must still be satisfied that the anticipated benefit of marijuana outweighs its risk of harm.

Obtaining consent

In order to authorize any therapeutic intervention, physicians must always obtain valid and informed consent in accordance with their legal obligations[16] and the College's Consent to Medical Treatment policy.

In keeping with these obligations, physicians who prescribe marijuana must advise patients about the material risks[17] and benefits of marijuana, including its effects and interactions, material side effects, contraindications, precautions, and any other information pertinent to its use. As part of this discussion, physicians must caution all patients who engage in activities that require mental alertness that they may become

11. Buccal pharmaceutical cannabinoids include oromucosal sprays.
12. For a more complete overview of the adverse health effects associated with the consumption of marijuana, please see: Volkow, N.D, et al. (2014). Adverse Health Effects of Marijuana Use. *The New England Journal of Medicine.* 370(23): 2219-2227.
13. Physicians who wish to find further guidance with respect to preventing prescription drug abuse and assessing patients for their risk of addiction should refer to the National Opioid Use Guideline Group, *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain* and the Specific Issues in Prescribing: Narcotics and Controlled Substances section of the College's Prescribing Drugs policy.
14. For more information, please see Volkow, N.D, et al. (2014). Adverse Health Effects of Marijuana Use. *The New England Journal of Medicine.* 370(23): 2219-2227, Health Canada's *Information for Health Professionals* webpage, the Centre for Addiction and Mental Health's *Cannabis Policy Framework*, and the College of Family Physicians of Canada's *Authorizing Dried Cannabis for Chronic Pain or Anxiety: Preliminary Guidance.*
15. Current evidence suggests that children, adolescents, and young adults are at a higher risk of experiencing the harmful effects of marijuana. This may be because their brains are still undergoing a process of neural development, during which they are more vulnerable to the harmful effects of certain chemical compounds found in marijuana. Until the effects of marijuana on the developing brain are better understood, all patients within the period of neural development – which continues from the prenatal period until the mid 20's – must be considered higher risk for marijuana-related harm.
16. *Health Care Consent Act, 1996*, S.O. 1996, c. 2, Sched. A.
17. The material risks that must be disclosed are risks that are common and significant, even though not necessarily grave, and those that are rare,

impaired while using marijuana.[18]

Furthermore, the College recommends that physicians explain to the patient the extent and quality of the evidence that informs their understanding of the appropriateness of marijuana for their clinical condition.

2. When Prescribing

Determining a safe and effective dose

Unlike conventional pharmaceutical products, marijuana is available in a variety of strains and formulations that vary significantly in their potency and chemical composition. Furthermore, research suggests that there are significant differences among patient sensitivities to the psychoactive and therapeutic effects of marijuana. For these reasons, determining a safe and effective dose for each patient may be challenging.

Absent established clinical guidelines, physicians must proceed cautiously: the College recommends that physicians initiate treatment with a low quantity of marijuana[19] and only prescribe marijuana that is low in the psychoactive compound tetrahydrocannabinol (THC).[20] Where the initial prescription proves ineffective, physicians may incrementally increase the quantity prescribed and/or substitute marijuana with a higher concentration of THC until a dose is reached that achieves symptom management while causing minimal euphoria or cognitive impairment.

In order to ensure that the above expectations are met, physicians must specify on every prescription the quantity of dried marijuana to be dispensed to the patient as well as the percentage of THC it must contain.

Managing the risk of abuse, misuse and diversion

Marijuana, like many other conventionally prescribed drugs, carries with it a risk of abuse, misuse and diversion. As the risks posed by marijuana are not fundamentally different from those posed by other controlled drugs, physicians are advised to follow the guidelines for managing the risk of abuse, misuse and diversion of narcotics and controlled substances set out in the Prescribing Drugs policy.

As with any drug, physicians who prescribe marijuana must monitor patients for any emerging risks or complications. Prescribing must be discontinued where marijuana fails to meet the physician's therapeutic goals or the risks outweigh the benefits.

The College also recommends that physicians

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but particularly significant. In determining which risks are material, physicians must consider the specific circumstances of the patient and use their clinical judgment to determine the material risks.

18. An important consideration is the impact that the consumption of marijuana may have on an individual's ability to safely operate a motor vehicle. The consumption of marijuana has been correlated with an increased risk of traffic accidents based on epidemiological studies. For more information on the impact of marijuana on driving, please see: Neavyn, M, Blohm, E, & Babu, K. (2014). Medical Marijuana and Driving: A Review. *American College of Medical Toxicology*. DOl l0.1007/s13181-014-0393-4.
19. While there are currently no established clinical guidelines setting out appropriate dosages for marijuana in any formulation, more information on dosing can be found on Health Canada's *Information for Health Professionals* webpage and the College of Family Physicians of Canada's *Authorizing Dried Cannabis for Chronic Pain or Anxiety*: Preliminary Guidance document.
20. Tetrahydrocannabinol (THC) is the primary psychoactive compound found in marijuana. It is responsible for the "high" that users experience when consuming marijuana, but may also be responsible for some of marijuana's beneficial therapeutic effects. At high levels, THC has been correlated with marijuana-related harm and is more likely to produce undesirable psychoactive effects in patients. While some commercially available formulations of marijuana contain THC concentrations as high as 30%, the College of Family Physicians of Canada's *Authorizing Dried Cannabis for Chronic Pain or Anxiety: Preliminary Guidance* document suggests that current evidence does not support prescribing marijuana with a THC concentration greater than 9%.

who prescribe marijuana first require patients to sign a written treatment agreement.[21] This agreement must contain, at minimum, a statement from the patient that they: will not seek marijuana from another physician or any other source; will only use marijuana as prescribed; will store their marijuana in a safe and secure manner; and will not sell or give away their marijuana. It is recommended that the treatment agreement contain a statement that if the agreement is breached, the physician may decide not to continue prescribing marijuana to the patient.

3. Charging Fees

The College considers the medical document authorizing patient access to marijuana to be equivalent to a prescription. Prescriptions, together with activities related to prescriptions, are insured services. Accordingly, physicians must not charge patients or licensed producers of marijuana for completing the medical document, or for any activities associated with completing the medical document, including, but not limited to: assessing the patient; reviewing his/her chart; educating or informing the patient about the risks or benefits of marijuana; or confirming the validity of a prescription in accordance with the *ACMPR*.

Physicians who are unsure about what services they may charge for are advised to refer to the College's Block Fees and Uninsured Services policy and the OHIP Schedule of Benefits for further guidance.

21. Treatment agreements are formal and explicit agreements between physicians and patients that delineate key aspects regarding adherence to the treatment. A sample treatment agreement can be found in the College of Family Physicians of Canada's *Authorizing Dried Cannabis for Chronic Pain or Anxiety: Preliminary Guidance* document.

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MARIJUANA FOR MEDICAL PURPOSES

College of Physicians and Surgeons of Ontario
80 COLLEGE STREET, TORONTO, ONTARIO M5G 2E2