I received a query the other day from Karen Hochberg, manager of public relations at the Oncology Nursing Society (ONS), asking if I could provide the name of an oncology nurse who had written about the use of marijuana for symptom management in patients with cancer. News was breaking just that day that the U.S. Supreme Court had decided that federal laws prohibiting growing marijuana superceded laws in 10 states that gave individuals the right to grow and use marijuana, free from risk of prosecution, to relieve a number of medical conditions, among them pain and nausea and vomiting resulting from cancer and its treatment. The seriousness of this decision notwithstanding, my first reaction was to smile. Once, I might have been that very nurse. In 1979, my colleagues Therese Andrysiak, RN, and Thomas Ungerleider, MD, and I authored an article on THC in relieving chemotherapy-induced nausea and vomiting, and the study patients were being recruited from the clinic I supervised. The THC was supplied in cigarette form from the U.S. government. It had been grown under special laboratory conditions, and the amount of THC in each cigarette was standardized. In those days, the best legal antiemetic available was prochlorperazine, which provided patients with little relief. Nevertheless, accruing patients to the THC study was a challenge. We were, in any case, excited to be doing this cutting-edge study patients were being recruited from the clinic I supervised. The THC was supplied in cigarette form from the U.S. government. It had been grown under special laboratory conditions, and the amount of THC in each cigarette was standardized. In those days, the best legal antiemetic available was prochlorperazine, which provided patients with little relief. Nevertheless, accruing patients to the THC study was a challenge. We were, in any case, excited to be doing this cutting-edge study.

The final study results were mixed. Some patients benefited whereas others were uncomfortable with the side effects. Today, THC can be supplied as an oral preparation, and smoking is not required. It continues to be effective for some patients, but with so many safe, legal, and effective medications available today, the number of patients who need to consider smoking marijuana for symptom relief is small. We do not have enough research to tell us who will benefit and why; therein lies a big part of the problem.

The campaigns in some states to allow the use of medicinal marijuana have been hard fought, and the Supreme Court’s decision is particularly difficult for proponents of those laws. The latest ruling really addresses the way in which the federal law is written and does not speak to whether the scientific basis for using marijuana is legitimate, but that distinction is often lost in the emotion of the situation. Even the Supreme Court judges who voted to uphold the federal government’s authority acknowledged that Congress would do well to address the matter. The dissenting judges argued more about state’s rights than about the medical issues involved. As it turns out, the science is very weak in this subject area, and we are left with a narrow decision about only one aspect—distribution and availability. For the time being, the legal question seems to have an answer, but the scientific, moral, and ethical dimensions remain unresolved.

In the end, I had no one to refer to Karen. We have not covered the topic in our journals, and a quick PubMed search turned up only a handful of related articles, many in relatively esoteric journals and most more than 10 years old. No nursing articles appeared at all. Although I am sure that some nurses are out there caring for patients who use marijuana to control their nausea or pain, I suspect that they, like their patients, keep a very low profile for obvious reasons. Those patients now will need to weigh their symptom control against the risk of potential arrest. For a patient waging a serious battle with a relentless disease process, these choices seem patently unfair. As oncology nurses, we need to consider adding our voice and point of view to the discussion.

Some serious questions remain: Why does smoking marijuana relieve certain symptoms in some individuals when other drugs fail? Why do some patients get adequate relief only from smoking this plant? What is the optimal “dose” for symptom relief? What are the side effects, and are they manageable? What are the health ramifications of smoking itself, and what is the risk/benefit ratio? Should we, as a society, condone the use of marijuana for patients with serious illness when we clearly put a value on preventing its recreational use? Assuming we are able to determine how it works and for whom, how do we standardize the quality of the product? How can we control its availability, or do we even have a role to play in this regard? Can we support the argument that says that many efficacious drugs are available for symptom relief and we simply do not need this product in our symptom management armamentarium even if, perhaps, a small subset of patients can achieve relief only with this drug?

Depending on the answers to these and other questions, oncology nurses may find themselves struggling personally and professionally to figure out where they stand. In the end, decisions likely will be made on an individual patient basis until lawmakers are pushed to address the issue in a meaningful way. Given the current political climate, my guess is that change will not come soon, leaving us in a difficult situation when patients or family members ask for advice. The best we can do is offer the facts as we know them, avoid condoning illegal behavior, and encourage a full, responsible, impartial, and scientific approach to rational decision making.

Reference

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