



HPNA Position Statement Medical Cannabis

It is the position of HPNA that palliative nurses are familiar with the current literature about medical cannabis to facilitate effective communication about medical cannabis with patients and families. This includes distinguishing medical (also known as therapeutic) cannabis, cannabis-derived Food and Drug Administration (FDA)-approved medications, and cannabis utilized for recreational purposes. Additionally, palliative nurses should know the laws of the state in which they practice and be aware of quality concerns and adverse effects of medical cannabis.

When making decisions about the use of cannabis, the overall patient care goal should be excellent symptom management, including for those receiving palliative care or hospice care. The role of nurses includes teaching patients and families about medications they are administering. Nurses may be asked about their knowledge of, opinion about, or experiences with non-formulary substances, including cannabinoids, most often marijuana, cannabis and cannabidiols (CBD). An evidence base exists to inform the nurses' education of patients and families, though more research is needed.

Patients' goals and choices for symptom relief must be fully understood. Patients should be offered FDA approved medications to manage disease states and symptoms but patient's preference for medical cannabis should be considered when formulating a treatment plan. Nurses should possess research informed knowledge and resources to educate patients about cannabis.

Clinical Practice

- Palliative nurses should be prepared for conversations about cannabis. Any use of cannabis or its derivatives prescribed as a medicine should be held to the same standards as any other medication, including indication, dose, frequency, reasons for continuation, and reasons for discontinuation; all indications must be based on scientific evidence for safety and efficacy. Like any other medicine or procedure, treatment should be provided in the context of informed consent and a patient-provider relationship.
- Palliative nurses should ask patients about their use of medical (therapeutic) cannabis and their reasons for using it.^{1,2} Nurses should also inquire about patients' recreational use (including the many forms in which cannabis is used) and should document the patient's responses in the medical record as part of medication reconciliation. Although not an approved medication, clinicians should know if patients are utilizing cannabis or other substances for symptom management, disease treatment, or for recreational purposes.



- Palliative APRNs cannot legally prescribe medical cannabis, as it is a Schedule I drug, however, they can certify the appropriateness of cannabis use within the confines of their state's laws. This certification is not a prescription, but, rather, is a statement indicating the individual meets the qualifications in that state to obtain medical cannabis from a dispensary.³
- Nurses should understand and distinguish FDA approved cannabis derived medications from other cannabis products. Cannabis derivatives have been developed into FDA approved medications, including dronabinol and nabilone (synthetic delta-9-tetrahydrocannabinol (THC) for HIV/AIDS-related anorexia and chemotherapy-induced nausea and vomiting (CINV)), and cannabidiol (Epidiolex[®]) for treatment of seizures related to Lennox-Gastaut and Dravet syndromes. Nabiximols (Savitex[®]) contains THC and CBD in a 1:1 ratio; it is indicated for treatment of spasticity in people with multiple sclerosis.⁴ In Canada it is also approved for neuropathic pain secondary to multiple sclerosis and advanced cancer pain.⁵ Though approved in many other countries, nabiximols is not yet approved in the U.S.⁶
- Nurses should not recommend use of CBD products until safety and efficacy are demonstrated through high quality research. The research on CBD is sparse. High quality research has only been conducted on the FDA approved CBD product Epidiolex[®]^{1,7} and the combination THC:CBD product nabiximols (Savitex[®]) that is not available in the U.S. Results from these studies cannot be safely extrapolated to provide information about the CBD that individuals can purchase from multiple sources. Many over-the-counter (OTC) products may not even contain CBD.⁸
- Some patients and families spend a relatively large amount of money in the pursuit of cannabis products, sometimes believing they are medications to cure disease or manage symptoms. The costs can be prohibitive. Considerations of cost are an important part of discussions with patients and families, as the burdens for some are not insignificant.

Education

- Nurses must be familiar with the evidence regarding the effects of cannabis use, including adverse effects of cannabis, cannabis use disorder, cannabis hyperemesis syndrome, effects of vaping injuries, and potential side effects that may affect cognition, judgements, driving or operating equipment. There is a paucity of providers qualified and willing to guide patient and family decision making about cannabis use.⁹ Thus, nurses should have resources, including colleagues to whom they can refer, to help patients and family with decision making.
- Nurses must be competent in sharing information with patients and families about the effects of, and professional standards regarding cannabis.
- Nurses must provide ongoing education to patients and families as they make choices about their health care.

Policy and Advocacy



- Palliative nurses must know their state laws regarding the legal use of cannabis, both for therapeutic and recreational use.
- Palliative nurses should advocate for the rescheduling of marijuana. Unless marijuana is removed as a Schedule I controlled substance, research will continue to be hampered, making it difficult to guide patients and families, and perhaps limiting the development of efficacious therapies.

Research

- Nurses must understand that more research is needed regarding cannabis to understand its therapeutic use, the effect of exogenous cannabis, and the benefits of, and contraindications for its use.
 - Many endogenous cannabinoids (endocannabinoids) have a role in homeostasis, analgesia, fear responses, and stress modulation.^{10,11} Further research is needed to understand the effects of exogenous cannabis on the endocannabinoid system.¹¹
 - Cannabis is composed of at least 85 cannabinoids and 483 chemical compounds; their effects are largely unknown. Research is necessary to understand the potential therapeutic uses, and potential adverse effects of these cannabinoids and chemical compounds.^{11,12}
 - High quality evidence about the benefits of cannabinoids is lacking.^{13,14} Research is needed to assess the efficacy and adverse effects of cannabis and its derivatives. Research should be broad, including THC, CBD and other cannabinoids, and encompass a range of strengths and formulations.

Definition of Terms

Endocannabinoid System (ECS): discovered in 1964 when scientists isolated THC.¹⁵

Endocannabinoids and their receptors are abundant throughout the body in the central nervous system, gastrointestinal tract, peripheral nervous system, immune system, skin, bone, and most organs. Endocannabinoids have a role in many disorders and may serve as a protective mechanism. They may help provide homeostasis and may have a role in basic functions such as eating, sleeping and relaxing,¹⁶ as well as roles in control of stress, fear, anxiety,¹⁰ inflammation, insulin sensitivity, and fat and energy metabolism.¹⁵

Cannabis: the genus of the plants *Cannabis sativa*, *Cannabis indica*, and *Cannabis ruderalis* from which THC and CBD are derived. The term is often used interchangeably with the word marijuana¹⁷

Marijuana: often used interchangeably with “cannabis.” Terms such as “medical marijuana”, “medicinal marijuana”, “therapeutic cannabis”, or “medicinal cannabis” differentiate cannabis intended for therapeutic purposes from recreational use (i.e., recreational marijuana or

recreational cannabis). Marijuana is currently a Schedule I controlled substance, thus not recognized as having any medicinal use; this classification places marijuana in a category of drugs with high abuse potential and lack of adequate data regarding its use for medicinal purposes.¹⁶



Schedule I Drugs: Drugs, substances, or chemicals defined as drugs with no currently accepted medical use and a high potential for abuse. Some examples of Schedule I drugs are 4-methylenedioxymethamphetamine (ecstasy), heroin, lysergic acid diethylamide (LSD), marijuana (cannabis), and methaqualone (Quaaludes), and peyote.¹⁸

Schedule II Drugs: Drugs, substances, or chemicals with accepted medical uses, but with a high potential for abuse. Some examples of Schedule II drugs are amphetamine and dextroamphetamine, cocaine, fentanyl, hydrocodone, hydromorphone, meperidine, methadone, methylphenidate, morphine, and oxycodone.¹⁸

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This statement reflects the best available evidence at the time of writing or revisions.

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