

Chapter 6: Cannabis-using Patients and the Medical System



Working with the doctor

The Oregon Medical Marijuana Act (OMMA) has created a unique role-reversal for Oregon's patients and doctors. Physician knowledge has traditionally guided patient/doctor relationships. The physician, as the authority on medical matters, diagnoses diseases and prescribes pharmaceuticals and treatments. The OMMA

changed all that.

Cannabis-using patients are now in the position of advocating for their Cannabis use to a physician who, in many instances, knows less about it than the patient, or is opposed to it. This role-reversal has been difficult for patients and doctors for different reasons.

Many patients have become accustomed to simply carrying out their doctor's orders without questioning the justification or educating themselves on the disease and medical options. This complacency comes at a price, since the patient who doesn't actively participate will not be in a position to know and understand why the doctor suggests a particular treatment.

The ideal physician/patient relationship is one of collaboration. In this relationship the physician listens to and accepts the patient's reports and tailors a medical regimen to those needs. Relying on the physician's educated judgement, the informed and involved patient can then follow medical regimens in a more intelligent manner. The OMMA strengthens this collaborative relationship by its reliance on communication.

Doctors may be reluctant to participate

Participation in the Medical Marijuana Program has strengthened the doctor/patient relationship for those willing to participate. Many patients, however, find their physician unapproachable or in opposition to a request for a medical Cannabis recommendation. Since Oregon's marijuana registry program is voluntary, physicians are *not required to participate*. Doctors may refuse to participate for a number of reasons. Some physicians have strong philosophical objections to Cannabis use and will not provide the documentation that allows the patient direct entry into the medical marijuana registry. Some physicians even refuse to make a chart note acknowledging the patient's assertion of therapeutic efficacy. Another commonly stated objection is the lack of medication control and monitoring of the drug.

The physician may say that Cannabis is not indicated as a treatment for the particular condition, an assertion that may be accurate.



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Writing a detailed “story” that describes the specific symptoms followed by a point-by-point evaluation of how Cannabis helps each symptom will give the physician (and patient) a clear understanding of its medical usefulness.

(There are two legitimate medical contraindications to Cannabis: *liver failure* and serious *respiratory disease*. Cannabis may also interfere with metabolism of other drugs like Theophylline. Physicians should know these issues.)

A doctor who believes that the patient is physically or emotionally unprepared to safely navigate the many issues involved is unlikely to consent to participation in the Medical Marijuana Program. In this case, the burden is on the patient to “prove” to the doctor’s satisfaction that s/he is capable of responsibly and safely using Cannabis.

Physicians also commonly refuse to participate because of the fear of federal investigation of their practice. Since a doctor’s livelihood is dependent upon Drug Enforcement Administration (DEA) prescription privileges, doctors might fear that they could be forced from practice for helping a single patient obtain the registry card. While not a legitimate concern, it is understandable given the “big stick” approach followed by federal drug enforcement. Oregon physicians should be reassured by the complete lack of federal intervention into physician practice. Indeed as of 2001 there were over 500 physicians enrolled for 1500 patients, with no record of physicians being harassed or intimidated by DEA agents.² (The insignificant possession limits written into the OMMA also minimize the importance to federal law-enforcement agencies which usually emphasize investigating large commercial Cannabis operations.)

Patients will hopefully appreciate that all of these concerns are valid to some degree. The patient should be willing to patiently work through the objections with the doctor. If the overall relationship is considerate and of value, patients would do well to consider the physician’s point of view. If the relationship is based on an attitude of superiority by the physician, the patient may have to pursue other options.

Documenting use of Cannabis and keeping records

In the future, Cannabis-based inhalers, transdermal patches and elixirs (if not herbal Cannabis for smoking) will be easily available by prescription. Unfortunately, today, patients must too often convince the physician that they use Cannabis medically and not recreationally. One way to do this is by documenting Cannabis use.

Patients should clearly communicate to the physician their need for and use of Cannabis, (verbally and then in writing). Physicians want and need to know specifics: Does the target symptom decrease consistently with regular use? What is the dosage and how frequently is it used? Are there any negative effects the patient has noticed? Are there collateral benefits like decreased anxiety or better sleep? Ultimately, the patient should be willing to *keep records* and communicate their experience. Writing a detailed “story” that describes the specific symptoms followed by a point-by-point evaluation of how Cannabis helps each symptom will give the physician (and patient) a clear under-

standing of its medical usefulness. This written record should be given to the physician with instructions to place it in the chart as a permanent part of the medical record. This will demonstrate clearly to the physician that Cannabis is helping the patient, and can act as a legal protection to establish legitimate medical use in a court hearing. If the patient is not registered in the Medical Marijuana Program, physician documentation of medical use, or a letter from the patient to the doctor in the medical record will establish that the patient has communicated this use to the doctor. This may establish legitimate medical need and allow the patient access to the other two legal defenses: the *affirmative defense* and the *choice-of-evils defense*. If the medical record does not contain *any* reference to medical Cannabis use then the patient carries the entire burden of proving it.

This is why patients should insist that the doctor make chart documentation, even if it is to oppose the patient's request to use Cannabis. (An intentional omission of medical discussions and documentation jeopardizes the patient's legal position vis-a-vis medical Cannabis use [and violates the physician's legal requirement to document important medical information]). If the chart does contain a physician statement opposing the patient's Cannabis use (or the doctor refuses to write any chart note at all) the patient should write a statement detailing the benefits obtained by its use. The patient should make at least two copies of this paper. One copy should be sent to the physician's office along with a cover letter asking that the paper be included as a permanent part of the patient's medical record. The other copy should be added to the patient's files for use as a legal support of an attempt to take a "substantial step" to accommodate the law.

(Patients should request and receive copies of their entire medical record including progress notes, orders, lab results, history and physical and diagnostic tests. Physicians are sometimes reticent about providing this information; however, patients have the legal right to access copies of their medical record if they complete a release of information form. By reading the progress notes, the patient will discover exactly what the doctor says about his/her medical use of Cannabis.)

Collecting medical research

Patients should also be prepared to collect medical research about their particular condition. (Physicians in the 19th century knew about and prescribed Cannabis widely. This ongoing process of education ended in the 1930's when Cannabis was criminalized. As a result physicians today know little about it. Doctors, like the rest of America, have been brainwashed by half a century of government propaganda demonizing Cannabis.)

Collecting research about a medical condition can be time-consuming, but it will give the physician valuable information. If the research demonstrates value at controlling the patient's symptoms then the physician will (hopefully) be more receptive. (See Chapter 4 for



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It is essential that patients communicate their knowledge and commitment to the doctor to elicit support—using Cannabis is not a passive process.



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Physician refusal to document these discussions [about the patient’s experience with Cannabis] in the patient’s progress notes is unconscionable.

articles describing some important research findings.) The bottom line is that *patients are the educators*.

The uncooperative doctor: “No” means “not yet”

Patients faced with an uncooperative physician must decide how to proceed. It is essential that patients communicate their knowledge and commitment to the doctor—using Cannabis is not a passive process. It involves issues of procurement, communication, safety, monitoring, feedback with the physician and legal considerations.

Patients need to understand indications and contraindications, side effects and preexisting health conditions that may influence Cannabis’ utility. Possible contaminants also are a factor to consider for those who use Cannabis.

The process of cultivating Cannabis involves a whole host of issues that are different from any other medical regimen the doctor or patient has faced. (See Appendix F for a “Cannabis Drug Information Sheet”.)

Additionally, the patient is required to follow through with the application procedure, a process that takes time and energy. The patient must have a high degree of commitment to follow these different issues and communicate with the doctor. If a patient is not willing or able to maintain in-depth monitoring of Cannabis use as it relates to the medical condition (and doesn’t have a designated primary caregiver to do so), s/he probably should not use it.

Many physicians will eventually provide the written documentation if the patient perseveres in this education process. Patients should not take “no” for an answer, but continue broaching the subject with every office visit.

If the physician completely refuses to discuss medical Cannabis with the patient, or if s/he dismisses the issue without serious consideration, the patient should evaluate the relationship as a whole and decide whether or not to continue with that physician. Here again, patients must convincingly assert their experience with Cannabis and be willing to keep the discussion going. A physician who disregards the patient’s practical judgment or lectures about the perils of drug abuse is unlikely to be swayed. (Since physician knowledge and support are key to entry into the registry card system, a patient who lacks it may be unable to legally utilize the other defenses written into the OMMA. These legal defenses are discussed in Chapter 2.) Physician refusal to document these discussions in the patient’s progress notes is unconscionable.

Patients should be willing to discuss and try alternatives to Cannabis prior to obtaining a registry card. Many physicians are willing to accept a trial of dronabinol (Marinol) before supporting Cannabis use.⁴ (See Chapter 3 for a discussion of Marinol and Cannabis.)

Well-informed patients will be in a position to understand physician recommendations as well as justify their own medical Cannabis use. If an established treatment like Marinol adequately treats the symptom then the patient’s medical need has been met. If it fails then

the case is bolstered to move on to other treatments. (The OMMA was written to promote Cannabis use for those who have exhausted their medical options. According to the law, therefore, it should not be the *first* alternative tried, but the *last*. This wording belies the point that Cannabis is probably a safer medical treatment than many pharmaceuticals. The language was inserted by the framers of the OMMA to accommodate *political* realities not as a statement of relative safety.)

Patients may want to submit an incomplete application to the Oregon Health Division knowing that it will eventually be rejected, lacking a doctor's documentation. *The OMMA expressly protects applicants who have submitted an application to the Division, from the post-marked date.* This application carries the same legal protection as a registry card *until the application is rejected.* Since the processing time for applications can range from weeks to months, this will "buy" the patient some time. The application also serves to establish an attempt at compliance for the patient and may help document medical use. Again, the critical element is a documentary trail that the patient must create, first with the physician, then with the Oregon Health Division. The more supporting documentation the patient can produce, the greater the legal protection. Patients should always have this documentation at hand in case they are contacted by police. (They must also be in compliance with all provisions of the Act regarding behavior.)

If the patient chooses to use Cannabis without the physician's support, s/he should carefully read the Oregon Attorney General's Guidelines (Appendix C) and plan a defense before the officer knocks at the door.

Finally, the patient can search for another physician. There are a few physicians in Oregon who will openly write medical documentation for patients whom they don't follow on an ongoing basis. Patients should contact networks of other patients and find the names of physicians who cooperate. Patients should normally not go to an unknown doctor and simply ask for the documentation. Virtually all physicians require an ongoing serious relationship. The search for a physician should be in the context of the entire medical relationship, not as a "drug-seeking" patient.

Working with a physician can be a struggle, or it can be gratifying. The physical, emotional and financial burdens of disease create great stress and hardship for patients *and* doctors. This is an inherently stressful arrangement for everyone involved. Patience, collaboration, mutual consideration and respect allow the relationship to progress to patients' benefit. The physician is an expert in human physiology and disease. The patient is an expert in symptoms and suffering. This is why patients must be willing to work with and educate the physician. And the physician must be willing to listen and sometimes acquiesce to the patient's expert judgement. Patient efforts are breaking new ground for those who will be benefited in the future.



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Patients should be persistent, not rude. Some physicians acquiesce to the patient's request for medical Cannabis documentation after repeated office visits.



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Future changes in the OMMA should include broadening the range of medical professionals who can legally provide documentation to include nurse practitioners, chiropractors or naturopaths. This will take some of the burden off physicians and decrease the difficulty that too many patients face in obtaining support from the "gatekeeper".

Guidelines for nurses and patients

After the passage of OMMA in November 1998, the Oregon Medical Association (OMA), representing physicians, issued guidelines describing how physicians may respond to patients who are requesting their help in applying to the Oregon Medical Marijuana Act.⁵ (See Appendix E.) The OMA guidelines, however, do not address nursing issues, which are arising as medical Cannabis users integrate into health-care settings.

Unfortunately, nursing organizations in Oregon didn't follow suit. As of 2001, more than two years after the passage of the Oregon Medical Marijuana Act, neither the Oregon Board of Nursing nor the Oregon Nurses Association have yet made recommendations or nursing practice guidelines, although both organizations have studied the issue.

Physicians (or nurse practitioners) usually prescribe a drug and conduct an initial PARQ (Procedure, Alternatives, Risks, Questions) conference to educate the patient on the drug's safe use. Nurses are responsible for the safe administration of a medication, monitoring and documenting its effect, and communicating this information to the physician. Nurses have more opportunities for detailed monitoring and patient teaching due to their frequent and lengthy contact. This raises several nursing issues, among them: legal boundaries between registered and unregistered patients, confidentiality, in-hospital and out-of-hospital issues, and nurses as patients. These nursing issues also directly relate to how any Cannabis-using patient will be able to function in a hospital or assisted living facility. Nurses who interact with Cannabis-using patients face situations that relate to the nature of the nurse/patient relationship and a nurse's practice requirements. Without policy guidelines for the nursing care of Cannabis-using patients, nurses and patients must "take care of themselves."

Acute care settings (hospitals)

The distinction between *registered* (legal use) and *unregistered* (illegal use) is important in situations surrounding hospitalized patients. If a hospitalized patient expresses the desire or intent to use Cannabis, the nurse caring for that patient should first determine if the patient is registered with the Medical Marijuana Program. If so, then the nurse may, as part of her continual teaching responsibility, provide medication information about Cannabis. Documentation of the patient's medical use of Cannabis would be included the nurse's notes. Nurses might also describe the patient's reasons for using Cannabis and any other specifics the patient can report including side effects.

A copy of the registry card should be attached to the chart if the patient has it in his or her possession. The registry card *SHOULD NOT* be confiscated or withheld from the patient.

If the patient *is not* registered with the Oregon Health Division but says that s/he uses Cannabis for a medical reason the nurse needs to recommend that the patient speak with the physician about registering, and document that conversation in the nurse's notes. If an unregistered patient brings Cannabis into the hospital the drug should be handled according to hospital policy. This usually means confiscation, documenting its presence and notifying the nursing supervisor.

Registered or not, a patient needing to smoke Cannabis should be informed of the smoking policy of the hospital. (For years, nurses have been quietly supporting patients by encouraging them to “step outside” to smoke.) At this time hospital policies in the United States prohibit smoking of Cannabis on hospital grounds.⁶ Hospitalized patients may be encouraged to take the drug by a different route, such as eating or drinking, without violating state laws or smoking prohibitions. However, this still would be a violation of hospital policies prohibiting the use of *Schedule One* drugs. Ultimately, hospital policies prohibiting use of Cannabis will have to be revised in order to meet patient needs and conform to Oregon law. Standardized Cannabis preparations like tinctures, inhalers and transdermal patches will one day reduce the need for patients to smoke the drug and will allow more comfortable integration of Cannabis use in hospitals.

A registered patient may legally possess up to one ounce of Cannabis. Legal Cannabis should not be confiscated or turned over to law-enforcement officials. If legal Cannabis cannot be taken home by the patient's designated primary caregiver it should be labeled with the patient's name and date, and sent to the pharmacy for secure storage. (Only designated primary caregivers or other registered patients can legally possess Cannabis. Therefore, the nurse must not give the Cannabis to anyone who is not registered. It would be preferable for the pharmacy to store it and return it upon discharge.) Most nurses will treat “illegal” Cannabis as dictated by hospital policy. This usually means turning the Cannabis over to law-enforcement. (Nurses should be aware that a non-registered patient still has access to the affirmative defense. Thus, even if the patient is not registered with the medical marijuana program, the patient may still be “legal”.) If the (unregistered) patient suffers from a debilitating medical condition covered under the act, compassion would dictate the return of the Cannabis to the patient upon discharge with a recommendation that the patient register in the Medical Marijuana Program.

Nurses in contact with Cannabis-using patients should be aware that any *information about a patient's Cannabis use is strictly confidential and privileged* since it is medical information protected under Oregon law.



Nurses have more opportunities for detailed monitoring and patient teaching due to their frequent and lengthy contact.



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Long-term care settings (nursing homes, skilled nursing facilities and group homes)

Long-term care facilities present different issues. Since patients convalesce for long periods it is necessary to provide situations where they may be allowed to smoke. In general, patients will need to restrict Cannabis use to private rooms or designated smoking areas where others are not in contact with second-hand smoke. Nurses in frequent and close contact with patients smoking Cannabis should shield themselves from second-hand smoke. One way to do this is by agreeing on a time for nursing cares which does not conflict with the patient's need to medicate. Open windows, if possible.

(One of the problems long-term, home and hospice nurses face with second-hand smoke is the possibility that they will develop detectable levels of cannabinoid metabolites in their urine. Environmental exposure is unlikely to result in psychoactive effects. Drug tests for cannabinoids, however, do not measure intoxication, only the presence of Delta-nine-tetrahydrocannabinol [THC] metabolites, which may remain detectable for days or weeks after exposure. Nurses who are drug tested and found to possess THC metabolites [generally 50 ng/dl] are subject to harsh legal and employment consequences.) Unfortunately, *the Oregon Board of Nursing does not recognize any legal reason for a nurse to test positive for THC.* Nurses who find themselves in frequent and close contact with Cannabis-smoking patients should document this fact in their notes and make copies for their records. They should also be aware that these notes are confidential medical information.

Many long-term care facilities in Oregon are forming policies to assist their Cannabis-using patients. Nurses working in these locations are advised to consult the policy. They should also monitor and educate patients, just as they would with any other drug. Additionally, the institutional policy may require the nurse to dispense the Cannabis to the patient, or assist the patient with its use. Nurses in long-term care facilities should consider themselves within the law, especially if the institutional policy requires their assistance.

Home health settings

Some nurses care for Cannabis-using patients in a home setting where evidence of Cannabis use is visible. The distinction between registered and unregistered usage can create problems for the nurse and patient. A non-registered patient is breaking Oregon law by using Cannabis. A nurse who assists him/her with Cannabis use is "aiding and abetting" the commission of a crime.⁷

Additionally, an unregistered patient who (illegally) uses Cannabis while under the care of a home health nurse presents difficulties regarding record-keeping and confidentiality. *Documenting illegal behavior places the nurse in the position of collecting evidence*, which could be used in a court to convict the patient of illegal drug activity. Failing to document significant medical issues constitutes a willful charting

omission on the nurse's part. Thus, the distinction between registered and unregistered use puts the nurse at considerable risk and may prevent adequate care of all Cannabis-using patients, especially those who use it illegally. This problem would best be addressed by the State Board of Nursing. Until that happens, the safest course of action for the nurse is to advise the unregistered patient to consult his/her physician about registering with the Oregon Health Division, and document the conversation.

A nurse may choose to document the patient's use of Cannabis with the understanding that *chart documentation may allow the patient to claim the affirmative defense* if charged with a Cannabis-related crime. (The affirmative defense allows unregistered patients to escape conviction if they have taken *substantial steps* to comply with the law. Nursing documentation of appropriate medical use *may* be a "substantial step.") The nurse must understand that she/he might be called to testify in court to verify the chart documentation. *The nurse may also choose to not document any Cannabis-related behavior; however, this is a violation of the scope of practice rules.* The nurse should consult institutional policies addressing confidentiality and record keeping.

Registered patients are somewhat better protected. The nurse may conduct follow-up teaching about Cannabis' effects, just as would be done with any drug. Since the patient is in compliance with Oregon law, the presence of paraphernalia and Cannabis at the patient's residence does not jeopardize the nurse's ability to provide care and document that care.

A nurse may refuse to care for a Cannabis-using patient for reasons of "conscience." In that circumstance, the nurse may follow institutional policies regarding withdrawing from the care of a patient. Refusing to care for a patient who is engaged in legal medical behavior may put the nurse in a position of having to justify that decision, especially if the patient's behavior poses no health or safety risk to the nurse.

Nurses as patients

A nurse suffering from a debilitating medical condition, like any other citizen, may apply for a registry identification card from the Oregon Health Division, which, if issued, permits the use of Cannabis. The use of therapeutic Cannabis poses issues that will need to be addressed by the Board of Nursing and the nurse's employer. The nurse who uses medical Cannabis will test positive for cannabinoid metabolites and will have to challenge the institutional policy that, at this time, does not differentiate legal from illegal Cannabis use. The nurse should obtain and read policies of the institution regarding the use of illegal substances and mind-altering pharmaceuticals. Generally, hospital policies forbid a nurse from working when behaviorally or cognitively impaired by the use of any substance. Thus, the nurse who has used Cannabis within the past six to eight hours should consider not working unless tolerance to the psychoactive effects has developed.



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By placing Cannabis within the policy guidelines of psychoactive drugs, the nurse and institution can agree on what constitutes safe practice.



The OMMA forbids licensing boards (like the Board of Nursing) from disciplining a nurse for their own medical use of Cannabis (or for assisting a registered patient to use Cannabis)...

By placing Cannabis within the policy guidelines of psychoactive drugs, the nurse and institution can agree on what constitutes safe practice.

The OMMA forbids licensing boards (like the Board of Nursing) from disciplining a nurse for his/her own medical use of Cannabis (or for assisting a registered patient to use Cannabis):

Limits on professional licensing board's authority to sanction licensee for medical use of marijuana. No professional licensing board may impose a civil penalty or take other disciplinary action against a licensee based on the licensee's medical use of marijuana in accordance with the provisions of ORS 475.300 to 475.346 or actions taken by the licensee that are necessary to carry out the licensee's role as a designated primary caregiver to a person who possesses a lawful registry identification card issued pursuant to ORS 475.309.

The license to practice nursing is issued by the Oregon State Board of Nursing, a state agency. Any nurse who is registered as a patient or designated primary caregiver is thus protected. Unfortunately, this language only protects the nurse from disciplinary actions initiated by the Oregon Board of Nursing, not the nurse's employer. *Possession of an OHD registry identification card will not protect the nurse from employment disciplinary actions including employment termination and forced drug treatment.* A nurse in this situation should consult a lawyer. None-the-less, any nurse who suffers from a debilitating medical condition and uses Cannabis should apply for a registry card and also consult an attorney. Eventually, institutional policies will catch up to state law.

Since Marinol, the prescription form of the THC molecule, has been down-scheduled to *Schedule Three* in the Controlled Substances Act, it is more widely available. The use of prescribed Marinol will result in a THC positive reading on any urine drug test, and will also be considered a violation of hospital policies as they are presently written.

Until institutional policies regarding Cannabis use differentiate legal from illegal use (and the Oregon Board of Nursing issues guidelines which clarify the scope of practice), nurses should be advised that they are at risk for employment and/or legal sanctions for any and all actions related to contact with patients who use Cannabis as a medicine, whether those patients are registered or not. Nurses should be aware that institutional policies have not kept up with Oregon State law. Thus, acting either as a nurse who educates the patient, as a designated primary caregiver, or as a registered patient, nurses should understand that many important issues have yet to be resolved. Until the Board of Nursing adapts the *Standards and Scope of Practice for the Licensed Practical Nurse and Registered Nurse* to reflect legal Cannabis use, nurses who interact in any way with Cannabis-using patients put themselves and their patients at risk.

This situation will not be fully resolved until legal penalties for Cannabis use are finally abolished.

Footnotes

¹ With the complete legal and social isolation of Cannabis, physicians today are unsure of how to proceed with patient requests. Many physicians are also understandably reluctant to recommend a drug which lacks FDA approval. Heavy-handed political pressure originating from federal authorities (most notably the Office of National Drug Control Policy) also intimidates physicians who depend on federal licensure through the Drug Enforcement Administration to prescribe drugs listed in Schedules 2 through 5 of the Controlled Substances Act. Without this prescriptive authority a physician is unable to effectively practice medicine.


² In response to the 1996 passage of Proposition 215 in California, federal authorities threatened to investigate and revoke DEA licenses of doctors who participated. Some physicians were actually investigated and intimidated, prompting physician groups to file and obtain in federal court an injunction forbidding interference in a physician's right to discuss valid medical treatments with their patients. Since then, the DEA has avoided investigations against doctors who participate in state medical marijuana programs.

³ Physicians in the 19th century were educated about Cannabis' therapeutic value through their extensive experience and research of it. This is mostly due to the efforts of one man, W. O. O'Shaunassey, a physician practicing in Calcutta, India. Dr. O'Shaunassey carefully documented his patients' use of Cannabis for many conditions and published his findings in medical journals in England. As word of clinical usefulness grew, standardized Cannabis preparations were manufactured and sold as elixirs in the U.K. and U.S. Common uses were for pain, spastic disorders, insomnia, anxiety, dysmenorrhea, alcoholism, and opiate addiction. The passage of the Marihuana Tax Act in 1937 began the process of increasing restriction, which culminated in Cannabis' placement in *Schedule One* of the Controlled Substances Act in 1971. Research and physician education ceased.


⁴ Marinol (trade name for dronabinol) is composed of the synthetic THC molecule, which is encapsulated in a sesame seed oil base. Marinol was moved from *Schedule Two* to *Three* in the Controlled Substances Act in 1999, thereby making it more widely prescribable by physicians. It is indicated for anorexia and weight loss in patients with AIDS and nausea and vomiting in patients undergoing cancer chemotherapy.

⁵ The guidelines are also available from the Oregon Medical Association by calling 503/226-1555.


⁶ In Holland, hospitals allow smoking Cannabis in certain situations. In the United States, sympathetic nurses quietly encourage the patient to step outside the hospital and smoke in a private location. There is an argument to be made that in a private room, a patient may be allowed to smoke Cannabis with safety allowances, although the non-smoking trend in the United States makes this possibility remote in the near future.



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⁷ *The [Oregon] Standards and Scope of Practice for the Licensed Practical Nurse and Registered Nurse* defines behavior which “fails to conform to the legal standard and accepted standards of the nursing profession.”

Among the provisions is:

Aiding, abetting, or assisting an individual to violate or circumvent any law, rule or regulation intended to guide the conduct of nurses... (851-45-015) (2) (I).

Providing medical instruction on the use of Cannabis could be considered as assisting any Cannabis-using patient to violate federal law. Acting as a designated primary caregiver certainly does but again only as regards federal but not state law in Oregon. (See note 2 above.)