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Also in this issue: "Responsible Research on Medical Marijuana," by Kevin F. Tulipana et al.

CHAPLAIN "DOS AND DON'TS" ON ORGAN DONATION

Jozef Zalot

This guide was developed in collaboration with LifeCenter Organ Donor Network (Cincinnati, OH) to offer chaplains a framework for the best possible course of action when they provide spiritual care to family members of patients who are potential vital organ donors.

During my experience as the regional director for ethics and spiritual care for a midwestern health care system, my chaplain posed a very practical but challenging question: "What should chaplains do, and not do, with regard to the family members of patients who are potential vital organ donors?"

Some organ procurement organizations (OPOs) may want to control the donation process. They are thus hesitant to invite in—let alone collaborate with—any "outsiders" who they believe might undermine the likelihood of procuring vital organs. So how should a chaplain respond when ministering to potential vital organ donors and their families? Should they speak with family members about donation? What should they say? Do OPOs want chaplains to speak with family members? Should there be limits to these conversations?

This can be a touchy area, because vital organ donation necessarily entails the death of the patient. This makes the relationship between chaplains and OPOs sometimes strained.

DOs

1. Do speak with family members about donation if the family brings up the subject.
   a. Important: Aside from the requirement that a certified designated requestor makes the actual request for organ donation, there is no federal law (check state ordinances) stating that a chaplain cannot have a conversation with family members about donation if the family initiates a discussion of the subject.
   b. Explain that the health care system supports organ (and tissue) donation (check system policies), and that donation is in accord with Catholic teaching (see dir. 63 of the USCCB *Ethical and Religious Directives*).
   c. Help families work through the religious and spiritual aspects of donation.
   d. Address ethical concerns the family may have concerning donation. Chaplains are encouraged to contact the site ethics committee, regional or system ethics leaders, or the NCBC for consultation.
   e. If the family expresses an interest in learning about organ donation or the desire to pursue it, inform the patient's nurse. The nurse will contact the OPO.
   f. Special considerations in the case of donation after circulatory death (DCD): DCD presents additional challenges in the organ donation process, because the decision to withdraw life support from the patient must precede the decision to donate.
      - The request for DCD must occur only after the patient's legal next-of-kin (proxy, surrogate, or legal representative), in consultation with the care team, has decided to withdraw care.
      - Chaplains are encouraged to work with OPO staff in discussing with the patient's legal next-of-kin the option of DCD. At the discretion of the care team, OPO representatives may be present during the withdrawal-of-care discussions to explain or answer questions about the DCD process.
2. Do support the organ procurement organization staff.
   a. When an OPO representative arrives on scene, let this representative know what (if anything) the family has already expressed about organ tissue donation. This helps the representative understand the family's values and concerns.
   b. An OPO family services team member will stay with the patient's family throughout the donation process. Chaplains play an integral role on the care team and should work in collaboration with the OPO family

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services team member to offer spiritual and other support to the family. The chaplain's work continues even after the formal consent for donation has been given. Chaplains should continue to offer support to the donor's family for as long as the family requests it.

c. Chaplains will offer spiritual support for the OPO staff when requested.

d. Special considerations regarding code status: Conflict can arise between an OPO's interest in maintaining a donor's full-code status (full resuscitative measures) and the family's wishes to withdraw care after further medical complications. To avoid such situations, the health care system and the OPO are encouraged to agree to the following:

- As long as a patient remains a viable donor, the patient will remain in full-code status. This information must be clearly conveyed to family members during the authorization process. However, depending on particular circumstances—for example, if the patient's condition becomes unstable or the patient's heart stops after the declaration of brain death and before the procurement of organs—the family can request a change of code status to allow the patient to die in peace. Both the health care system and the OPO will respect the family's decision.
- The health care system and the OPO agree that all donation-related conversations are family-driven. This means that all parties will seek to work with the (potential) donor's family members and not do anything that goes against the family's wishes.

DON'Ts

1. Don't initiate a conversation about organ donation with a potential donor's family.
   a. The Centers for Medicare and Medicaid Services requires that donation conversations be initiated only by trained designated requestors. OPO representatives are trained designated requestors; chaplains are not.
   b. Avoid conflicts of interest. Chaplains are part of the care team. A potential conflict of interest arises when a member of the care team—which is supposed to be focused on the best interests of the patient—initiates discussion of organ tissue donation.
2. Don't discuss specific medical issues concerning organ donation with family members.
   a. Chaplains should not discuss organ donation when there is still the possibility (however remote) that medical treatment can improve the patient's situation.
   b. Chaplains should not create false hope:
      - Through an extensive process of testing, the OPO determines which organs and tissues can be recovered. Chaplains do not want to give family members the impression that the patient is a viable donor before this has been determined.
      - Chaplains also do not want to create a situation in which family members experience a "second loss." This can occur when they are led to believe the patient is a viable donor, but after OPO testing is completed, it is confirmed that the patient is not.
3. Don't assume with family members that in cases of whole-brain death the decision to donate a patient's organs is the family's choice; it may not be. Individuals who are registered through their state donor registry have already made their donation decision; hence, their donation wishes are known. In such a case, the family is not being asked to make a decision about donation but instead is being called to honor their loved one's expressed wishes.

Responsible Research on Medical Marijuana

Kevin F. Tulipana, Kathleen Wilson, and Caroline Walker

There is little evidence to support the prescribing of marijuana as a sound medical practice, but there is also a general lack of research. Officially changing marijuana from a schedule I to a schedule II drug would promote controlled study, eliminate medical marijuana shops, and avoid a possible "cannabis epidemic" in the near future. Questions regarding marijuana's medicinal value will not be answered until there is extensive, reputable research, complete with required phases of clinical trials.

Benefits of Reclassification

The Comprehensive Drug Abuse Prevention and Control Act of 1970 effectively gives federal oversight of particular drugs and medications to the Food and Drug Administration (FDA). Shifting marijuana from schedule I to schedule II would not automatically translate into FDA approval for use. Any new drug formula would be subject to the rigors of FDA protocols.

If marijuana were approved in some form for patient use, regulatory control for prescribing and dispensing it or

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its by-products would shift from the existing state medicinal models to the long-established FDA regulatory models. Medical insurance would cover the cost of the drug, and prescriptions for marijuana or its by-products would be tracked in electronic medical records for all attending or referring medical personnel to observe.

Prescriptions would be written by members of the medical community under their FDA licenses to FDA-licensed pharmacies, which are subject to federal laws, inspections, and prosecution. These pharmacies, with their established oversight practices, would be no more likely to engage in illegal diversion of marijuana to black-markets than of any other controlled substances they dispense.

When adequately licensed, practitioners may prescribe medications that are classified as schedules II through IV. As a schedule I drug, cannabis has no currently accepted medical use in the United States, lacks safety standards for use under medical supervision, and is recognized as carrying a high risk for abuse.[1] Other drugs included in schedule I are heroin, LSD, peyote, and ecstasy. Many argue that cannabis does not deserve a schedule I classification. Nevertheless, federal regulation restricts cannabis and views medicinal marijuana as illicit and illegal.

Efforts at Decriminalization

State decriminalization efforts go as far back as 1973, but the most recent successful attempt occurred in 1996, when California legalized medical cannabis with Proposition 215 under the title of the Compassionate Use Act. A drug that is illegal in the eyes of the federal government, which has responsibility to regulate drugs through the authority of the FDA, was thus made legal by a state which, although it may provide regulation of licensing for practitioners, does not have authority to reclassify illegal drugs for a purportedly legitimate use. To date, twenty-nine states and the District of Columbia have laws legalizing medical cannabis.[2]

Efforts to decriminalize marijuana use have also occurred at the federal level. In 2009, US Deputy Attorney David Ogden issued a memo directing states not to utilize or focus federal resources on individuals using cannabis within the context of state law.[3] The Ogden memo, despite its open direction to the contrary, included a warning that states were not allowed to violate federal law. As one can imagine, this turning of a blind eye to federal law was confusing.

In 2011, another Obama-era US deputy attorney, James Cole, issued a memo that stated that commercial cultivation of cannabis, even for medicinal use, can be a legitimate focus of federal regulators and can be prosecuted under federal law.[4] Further confusing matters, Deputy Attorney General Cole issued another memo two years later stating again that federal prosecutors would not pursue infractions of the federal regulation of the illicit schedule I drug if states had laws that properly regulated its manufacture and distribution.[5] This tacit acceptance of contradictions between state and federal laws led to the widespread liberalization that now extends from medicinal to recreational use.

On January 4, 2018, Attorney General Jeff Sessions released a memo to all US attorneys rescinding the guidance of the Ogden and Cole memos.[6] With this memo, state and federal law were again unified. The Sessions memo also made it clear that the earlier Obama-era memos had been unnecessary, since the US attorneys already possess prosecutorial discretion without them.

Medical Marijuana and the Black Market

Specific compounds of cannabis do have medicinal effects. Tetrahydrocannabinol (THC) controls nausea in some users. There is a synthetic derivative of THC, dronabinol (Marinol, Syndros) that is manufactured and sold as a schedule III drugs. It is FDA approved for anorexia related to AIDS wasting syndrome as well as for refractory chemotherapy-induced nausea and vomiting. This beneficial effect may also be obtained by smoking or eating the cannabis plant.

Marijuana use can also cause acute reactions such as an altered sensorium and the long-term effects of potential neuropsychological disorders, including schizophrenia, depression, bipolar disorder, and respiratory complications, such as chronic bronchitis.[7] If cannabis is used for purposes that are appropriately ordered toward the promotion of health, the side effects may be tolerable.[8] Unfortunately, studies have shown that as many as 80 percent of medical cannabis users also use it recreationally, specifically for the mind-altering effects.[9]

Kimber Richter and Sharon Levy draw a parallel between tobacco and cannabis use and the associated pitfalls of legalization, marketing, and industrialization of these addictive products.[9] Before 1900, very few people used tobacco, and only 1 percent smoked manufactured cigarettes. By 1950, nearly 40 percent of the population smoked cigarettes. With this widespread use we began to see the enormous public health implications, including the explosion of lung cancer, cardiac disease, and related respiratory problems. The cannabis industry is following the same path, with increased industrialization, manufacturing, and the development of higher concentrations of THC in its products.

The rescinding of the Cole memorandum makes it clear that marijuana shops are now illegal under federal law. The social effect of the legalizations of medical marijuana, with its initial lack of regulation, and recreational marijuana, with its subsequent and significant abuse and increase in criminal activity, including emerging black-market enterprise, is well understood by many public officials.

Colorado has had to respond to these problems with additional law enforcement, ballot initiatives, and regulation. A report prepared by the Police Foundation and the Colorado Association of Chiefs of Police shows that Colorado was caught off guard as certain marijuana laws, initiatives, and case rulings translated into a period of rapid proliferation of marijuana cultivation, shops, and illegal

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activity, including substantial diversion of marijuana products to the gray and black markets.[10]

A Physician-Led Movement

Any call for the FDA to reevaluate its current classification must come from those, such as the American Medical Society or American Cancer Society, whose first interest is the welfare and medical needs of the vulnerable and not from those interested in advancing political agendas or securing candidate votes. Rigorous research into medical marijuana should be undertaken to establish its inherent value and discover its true benefits and harms.

Recent studies, though limited, indicate that marijuana may be useful in certain patient populations but also show that it is not a wonder drug.[11] Nor does it stop any disease process. There is evidence that it may be useful in symptom management among the chronically ill and debilitated. This seems to equate to some possible usefulness in palliative care or hospice settings. The American public and, in particular, those who are seriously or terminally ill deserve to know whether the promised benefits are true or whether their needs can be met by other, more appropriate means. The physician's understanding of the usefulness of medical marijuana must be rooted in evidence-based practice and research.

We therefore recommend (1) a moratorium on new state laws that allow cannabis use, both medicinal and recreational; (2) reclassification of cannabis as a schedule II drug; (3) focus and funding of adequate and appropriate research under the direction of the FDA; and (4) general education regarding the risks of marijuana use and misuse and the refutation of false or merely anecdotal medical claims, which have been driving the liberalization of cannabis use. These are necessary steps if we are to stop the promotion of an addictive and potentially dangerous drug that can clearly cause more harm than good.

Notes

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