Policy/Position Statement of the American Cannabis Nurses Association

Release Date: May 5, 2021

Resolution Regarding Workplace Drug-testing of Nurses for Cannabis

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Status: New Position Statement
Written by: ACNA Policy and Government Affairs Committee
Adopted by: ACNA Board of Directors

Purpose:

The purpose of this statement is to establish the American Cannabis Nurses Association's position regarding pre-employment, random drug-testing, and suspicion of intoxication practices. It outlines the rationale for eliminating drug-testing for cannabis in nurses, and proposes a more reliable method to test impairment before drug-testing.

Background

Cannabis, as an herbal medicine, has been documented at least 2700 years ago in Asia and subsequently documented in other parts of the world (Russo et al., 2008). Cannabis was recognized as a botanical drug and added to the United States Pharmacopoeia in 1850 and removed in 1942 (Brinckmann et al., 2020). Removal came because of multiple regulations and state laws that prohibited cannabis beginning in 1906 with the Pure Food and Drug Act and culminating in 1970 with the passage of the Comprehensive Drug Abuse Prevention and Control Act, making cannabis a schedule 1 drug (Siff, 2014).

Cannabis research continues to demonstrate the effectiveness of cannabis in the treatment of a multitude of medical conditions including, but not limited to, chronic pain, migraines, anorexia, nausea/vomiting, Post Traumatic Stress Syndrome (PTSD), Alzheimer's disease, sleep disorders, and opioid withdrawal (Choudry & Bhatt, 2017). Nurses experience these same medical conditions yet are denied the use of cannabis to treat their conditions due to employer workplace drug use and testing policies.

Nursing as a profession has an inherent risk of injuries and stress (American Nurses Association, 2010). Nurses experience work-related injuries at a higher rate than any other occupation. Most injuries are the result of bodily reactions/overexertion and falls/slips (American Nurses Association, 2010b). These types of injuries can result in chronic pain and muscle spasms for which cannabis has

demonstrated to be an effective and appropriate treatment (Choudry & Bhatt, 2017). By requiring pre-employment or random drug-testing, many companies may inadvertently institute barriers to obtaining and maintaining a sufficient and qualified workforce (White, 2018).

Pre-COVID predictions of nursing shortage were 154,018 Registered Nurses by 2020 and 510,394 Registered Nurses by 2030 (Zhang, Tai, Pforisch, & Lin, 2017). Both PTSD and loss of RNs through burnout have become a concern due to the COVID pandemic (Rainbow, Littzen, & Gelt, 2020, & Hemingway, 2021). Filling nursing positions will be harder in the years to come. Continuing pre-employment and random drug-testing serves only to exacerbate the growing gap.

The Drug-Free Workplace Act of 1988 requires a company that is contracted by or receiving grant funds from the federal government establish a drug-free workplace ("41 USC Ch. 81: Drug-free workplace," 1988). Healthcare systems and providers who accept care for a Medicare-covered patient do so as an agreement to receive compensation from the government for their services (Levy, 2021). The Act does not mandate drug-testing for any other types of employer (Doyle, 2020).

For States in which cannabis has been legalized, the approach to employee "Drug-testing" for cannabis varies from making "drug-testing" unconstitutional to allowing employers to self-determine their drug-testing policies without State government interference ("Employees' practical guide to requesting and negotiating reasonable accommodation under the Americans with Disabilities Act" n.d.). Nurses practicing in different States are subject to different laws regarding cannabis use for medicinal purposes during off-hours. Therefore, nurses in States that allow employers to self - determine drug-testing policies do not enjoy the same rights as their peers residing and working in those States that have created legislative protection for employees who use medical cannabis.

Drug-testing via urine is not a reliable source for determining impairment due to cannabis use. THC is stored in the fatty tissue and is known to remain in the body for at least 30 days. (Howard et al., 2020) Research has been unable to determine with certainty the length of time THC remains detectable in chronic and heavy users (Cary, n.d.). The concentration, amount, and route of administration can all impact impairment (Grabenauer, 2020). Therefore, urine drug-testing is inappropriate for testing impairment.

The Standard Field sobriety test uses the Horizontal Gaze Nystagmus, Walk and Turn test, and One-leg Stand test to determine alcohol impairment. The National Highway Traffic Safety Administration recognizes that this may not be adequate for identifying drug-related impairment. They recommend that additional testing be used for determining impairment (National Highway Traffic Safety Administration, 2018).

Nursing is a highly safety sensitive position requiring higher levels of cognitive and executive functioning abilities. The Paced Serial Addition Test (PSAT), the Digit Symbol Substitution test (DSS), the Divided Attention Test (DAT), and potentially the digital app called DRUID (Grabenauer, 2020, Phifer, 2017, & Karoly et al., n.d.), are better determinants for cognitive and executive functioning impairment.

Recommendations

Nurses should have safe access to therapeutic cannabis to treat documented medical conditions, such as but not limited to, PTSD, depression, sleep disturbances, chronic pain and anxiety, due to the physical and psychological demands of nursing.

Drug-testing for cannabis should be discontinued for nurses with a qualified documented medical condition.

Drug-testing for signs of impairment should include testing by a trained and qualified Medical Review Officer (MRO) or other designated medical professional using a validated test for cognitive impairment, not urine or blood level testing of THC.

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