Medical Cannabis Briefing Paper

For thousands of years, cannabis has been used to treat a wide variety of ailments. Until 1937, cannabis (Cannabis sativa L.) was legal in the United States for all purposes. Presently, federal law allows **only one American** to use cannabis as a medicine.

On March 17, 1999, the National Academy of Sciences' Institute of Medicine (IOM) concluded, "[T]here are some limited circumstances in which we recommend smoking cannabis for medical uses." The IOM report, the result of two years of research that was funded by the White House drug policy office, analyzed all existing data on cannabis's therapeutic uses. A subsequent, 2017 review by the now-renamed National Academy of Sciences, Engineering, and Medicine also supported cannabis' medical benefits.

MEDICAL VALUE

Cannabis is one of the safest therapeutically active substances known. No one has ever died from an overdose, and it has a wide variety of therapeutic applications, including:

- Relief from pain
- Relief from nausea and appetite loss; and
- Reduction of muscle spasms.

Cannabis has been beneficial in the treatment of the following conditions:

AIDS. Cannabis can reduce the nausea, vomiting, and loss of appetite caused by the ailment itself and by various AIDS medications. Observational research has found that by relieving these side effects, medical cannabis increases the ability of patients to stay on life-extending treatment. (See also CHRONIC PAIN below.)

AUTISM. Research has shown cannabis and its components can alleviate symptoms of autism including self-injury, anger, aggression, agitation, and depression, along with improvements in cognition, sensory sensitivity, attention, social interaction, and language.

CANCER. Cannabis can stimulate the appetite and alleviate nausea and vomiting, which are common side effects of chemotherapy treatment.

CROHN'S DISEASE. A placebo-controlled clinical trial that was published in 2013 found that complete remission was achieved in five out of 11 subjects who were administered cannabis, compared to one of the 10 who received a placebo.

MULTIPLE SCLEROSIS. Cannabis can limit the muscle pain and spasticity caused by the disease, as well as relieve tremors and unsteadiness of gait. (Multiple sclerosis is the leading cause of

neurological disability among young and middle-aged adults in the United States.)

EPILEPSY. Cannabis can prevent epileptic seizures in some patients.

CHRONIC PAIN. Cannabis can alleviate chronic, often debilitating pain caused by myriad disorders and injuries. Several published clinical trials have found that cannabis effectively relieves neuropathic pain (pain caused by nerve injury), a particularly hard-to-treat type of pain that afflicts millions suffering from diabetes, HIV/AIDS, multiple sclerosis, and other illnesses. In addition, a 2017 review by the National Academies of Sciences, Engineering and Medicine concluded there is conclusive or substantial evidence that cannabis alleviates chronic pain.

Each of these applications has been deemed legitimate by at least one court, legislature, and/or government agency in the United States.

Many patients and loved ones also report that cannabis is useful for treating migraines, menstrual cramps, alcohol and opiate addiction, post-traumatic stress disorder (PTSD), depression, and other debilitating mood disorders.

Cannabis is being recommended to millions of patients under state laws in the United States. Nevertheless, other than a single person with special permission from the federal government, medical cannabis remains illegal under federal law!

People currently suffering from any of the conditions mentioned above, for whom legal medical options have proven unsafe or ineffective, have two options:

1. Continue to suffer without effective treatment; or
2. Illegally obtain cannabis — and risk suffering consequences directly related to its illegality, such as:

- An insufficient supply due to the prohibition-inflated price or scarcity;
- Impure, contaminated, or chemically adulterated cannabis; and
- Arrests, fines, court costs, property forfeiture, incarceration, probation, and criminal records.

BACKGROUND

Prior to 1937, at least 27 medicines containing cannabis were legally available in the United States. Many were made by well-known pharmaceutical firms that still exist today, such as Squibb (now Bristol-Myers Squibb) and Eli Lilly. The Marijuana Tax Act of 1937 federally prohibited cannabis. Dr. William C. Woodward of the American Medical Association opposed the Act, testifying that prohibition would ultimately prevent the medical uses of cannabis.

The Controlled Substances Act of 1970 placed all illicit and prescription drugs into five "schedules" (categories). Cannabis was placed in Schedule I, defining it as having a high potential for abuse, no currently accepted medical use in treatment in the United States, and a lack of accepted safety for use under medical supervision.

This definition simply does not apply to cannabis. Of course, at the time of the Controlled Substances Act, cannabis had been prohibited for more than three decades. Its medical uses forgotten, cannabis

was considered a dangerous and addictive narcotic.

A substantial increase in the number of recreational users in the 1970s contributed to the rediscovery of cannabis's medical uses:

- Many scientists studied the health effects of cannabis and inadvertently discovered cannabis's medical uses in the process.
- Many who used cannabis recreationally also suffered from diseases for which cannabis is beneficial. By accident, they discovered its therapeutic value.

As the word spread, more and more patients started self-medicating with cannabis and dozens of states changed their laws to authorize it. However, cannabis's federal policy continues to bar doctors from prescribing it and severely curtails research. With cannabis federally illegal, patients in many states can still lose their jobs or housing for cannabis, insurance does not cover it, and non-U.S. citizens can face devastating consequences for using cannabis or working in the industry.

THE RESCHEDULING BATTLE

In 1972, a petition was submitted to the Bureau of Narcotics and Dangerous Drugs — now the Drug Enforcement Administration (DEA) — to reschedule cannabis to pave the way for it to eventually be available by prescription. After 16 years of court battles, the DEA's chief administrative law judge, Francis L. Young, ruled on September 6, 1988:

"Marijuana, in its natural form, is one of the safest therapeutically active substances known. ..."

"... [T]he provisions of the [Controlled Substances] Act permit and require the transfer of marijuana from Schedule I to Schedule II."

"It would be unreasonable, arbitrary and capricious for DEA to continue to stand between those sufferers and the benefits of this substance. ... "

Marijuana's placement in a lower schedule could eventually enable doctors to prescribe it to their patients. But top DEA bureaucrats rejected Judge Young's ruling and refused to reschedule cannabis. Two appeals later, petitioners experienced their first defeat in the 22-year-old lawsuit. On February 18, 1994, the U.S. Court of Appeals (D.C. Circuit) ruled that the DEA is allowed to reject its judge's ruling and set its own criteria — enabling the DEA to keep cannabis in Schedule I.

In August 2023, the U.S. Department of Health and Human Services (HHS) recommended reclassifying cannabis as a Schedule III drug. The DEA is expected to make the final decision sometime in 2024, on if federal law will finally acknowledge the reality that cannabis has medical value.

While rescheduling would have several benefits, including facilitating research, it would not change the status of state-legal dispensaries or a myriad of cannabis-based products that patients are using to treat their ailments. If the only thing the federal government does is reschedule cannabis, in a best-case scenario, each individual product could take millions in research and years in approval from the FDA. This is financially untenable. To harmonize state and federal law, and to make medical cannabis patients and providers conduct legal, Congress will need to act.

TEMPORARY COMPASSION

In 1975, Robert Randall, who suffered from glaucoma, was arrested for cultivating his own cannabis. He won his case by using the "medical necessity defense," forcing the government to find a way to provide him with his medicine. As a result, the Investigational New Drug (IND) compassionate access program was established, enabling some patients to receive cannabis from the government.

The program was grossly inadequate at helping the potentially millions of people who need medical cannabis. Many patients would never consider the idea that an illegal drug might be their best medicine, and most who were fortunate enough to discover cannabis's medical value did not discover the IND program. Those who did often could not find doctors willing to take on the program's arduous, bureaucratic requirements.

In 1992, in response to a flood of new applications from AIDS patients, the George H.W. Bush administration closed the program to new applicants, and pleas to reopen it were ignored by subsequent administrations. Over the decades, the small number of enrolled patients passed away. As of 2023, the IND program remains in operation only for one previously approved patient.

PUBLIC AND PROFESSIONAL OPINION

There is wide support for ending the prohibition of medical cannabis among both the public and the medical community:

- Since 1996, 38 blue, red, and purple states have passed comprehensive medical cannabis laws, both by citizen initiative and legislative action.
- An April 2021 Quinnipiac University poll found that 93% of Americans believe medical cannabis should be allowed.
- Organizations supporting some form of physician-supervised access to medical cannabis include the American Academy of Family Physicians, American Nurses Association, American Public Health Association, American Academy of HIV Medicine, Epilepsy Foundation, and many others.
- A 2013 scientific survey of physicians conducted by the *New England Journal of Medicine* found that 76% of doctors supported the use of cannabis for medical purposes. [J. Adler & J. Colbert, "Medicinal Use of Marijuana — Polling Results," *New England Journal of Medicine* 368 (2013): 30.]

CHANGING STATE LAWS

The federal government has no legal authority to prevent state governments from changing their laws to remove state-level penalties for medical cannabis use. Thirty-eight states (20 through their legislatures and 18 by ballot initiatives), four U.S. territories, and the District of Columbia have already done so. State legislatures have the authority and moral responsibility to change state law to:

- Exempt seriously ill patients from state-level prosecution for medical cannabis possession;

- Allow seriously ill patients safe access to medical cannabis from regulated dispensaries, and — ideally — also via home cultivation; and
- Exempt doctors who recommend medical cannabis from prosecution or the denial of any right or privilege.

Even within the confines of federal law, states can enact reforms that have the practical effect of removing the fear of patients being arrested and prosecuted under state law — as well as the symbolic effect of pushing the federal government to allow doctors to prescribe cannabis.

U.S. CONGRESS: THE FINAL BATTLEGROUND

State governments that want to allow cannabis to be sold in pharmacies or other regulated entities have been stymied by the federal government's overriding prohibition of cannabis.

The U.S. Supreme Court's June 2005 decision in *Gonzales v. Raich* preserved state medical cannabis laws but allowed continued federal attacks on patients, even in states with such laws. The Department of Justice indicated in 2009 and in 2013 that it would refrain from raids where activity is clearly legal under state law, but then-U.S. Attorney General Jeff Sessions rescinded those memos. But amendments to government funding bills passed since 2014 have prevented the Department of Justice from using funds to interfere with state medical cannabis laws. However, these amendments may be revisited in future budgets, and medical cannabis remains illegal under federal law, creating numerous complications — including many banks being unwilling to do business with dispensaries.

Efforts to obtain FDA approval of cannabis also remain stalled. Though some small studies of cannabis have been published or are underway, the National Institute on Drug Abuse has consistently made it difficult (and often nearly impossible) for researchers to obtain cannabis for their studies. At present, it is effectively impossible to do the sort of large-scale, extremely costly trials required for FDA approval — which would be required for each individual product or preparation.

In the meantime, patients continue to suffer. Congress has the power and the responsibility to change federal law so that seriously ill people nationwide can use and safely access medical cannabis without fear of arrest and imprisonment.
