Medical Marijuana Briefing Paper

For thousands of years, marijuana has been used to treat a wide variety of ailments. Until 1937, marijuana (Cannabis sativa L.) was legal in the United States for all purposes. Presently, federal law allows **only three Americans** to use marijuana 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 marijuana 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 marijuana's therapeutic uses.

MEDICAL VALUE

Marijuana 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 nausea and appetite loss;
- Reduction of intraocular (within the eye) pressure;
- Reduction of muscle spasms; and
- Relief from chronic pain.

Marijuana is frequently beneficial in the treatment of the following conditions:

AIDS. Marijuana 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 marijuana increases the ability of patients to stay on life-extending treatment. (See also CHRONIC PAIN below.)

HEPATITIS C. As with AIDS, marijuana can relieve the nausea and vomiting caused by treatments for hepatitis C. In a study published in the September 2006 *European Journal of Gastroenterology & Hepatology*, patients using marijuana were better able to complete their medication regimens, leading to a 300% improvement in treatment success.

GLAUCOMA. Marijuana can reduce intraocular pressure, alleviating the pain and slowing—and sometimes stopping — damage to the eyes. (Glaucoma is the leading cause of blindness in the United States. It damages vision by increasing eye pressure over time.)

CANCER. Marijuana 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. Marijuana can limit the muscle pain and spasticity caused by the disease, as well as relieving tremor and unsteadiness of gait. (Multiple sclerosis is the leading cause of neurological disability among young and middle-aged adults in the United States.)

EPILEPSY. Marijuana can prevent epileptic seizures in some patients.

CHRONIC PAIN. Marijuana can alleviate chronic, often debilitating pain caused by myriad disorders and injuries. Since 2000, seven published clinical trials have found that marijuana effectively relieves neuropathic pain (pain cause 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 yearlong trial in Canada that was published in 2015 found that marijuana reduced chronic pain and had a reasonable safety profile.

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 marijuana is useful for treating migraine, menstrual cramps, alcohol and opiate addiction, autism with self-injurious or aggressive behavior, post - traumatic stress disorder, and depression and other debilitating mood disorders.

Marijuana could be helpful for millions of patients in the United States. Nevertheless, other than for the four people with special permission from the federal government, medical marijuana 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 marijuana — 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 marijuana; and
- Arrests, fines, court costs, property forfeiture, incarceration, probation, and criminal records.

BACKGROUND

Prior to 1937, at least 27 medicines containing marijuana 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 marijuana. Dr. William C. Woodward of the American Medical Association opposed the Act, testifying that prohibition would ultimately prevent the medical uses of marijuana.

The Controlled Substances Act of 1970 placed all illicit and prescription drugs into five "schedules" (categories). Marijuana 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 marijuana. Of course, at the time of the Controlled Substances Act, marijuana had been prohibited for more than three decades. Its medical uses forgotten, marijuana was considered a dangerous and addictive narcotic.

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

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

As the word spread, more and more patients started self-medicating with marijuana. However, marijuana's Schedule I status bars doctors from prescribing it and severely curtails research.

THE STRUGGLE IN COURT

In 1972, a petition was submitted to the Bureau of Narcotics and Dangerous Drugs — now the Drug Enforcement Administration (DEA) — to reschedule marijuana to make it 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 Schedule II or lower could eventually enable doctors to prescribe it to their patients. But top DEA bureaucrats rejected Judge Young's ruling and refused to reschedule marijuana. 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 marijuana in Schedule I.

However, Congress has the power to reschedule marijuana via legislation, regardless of the DEA's wishes. A U.S. Senate bill — the Compassionate Access, Research Expansion, and Respect States (CARERS) Act — would reschedule marijuana while preserving state medical marijuana programs and exempting those participating in them from federal criminal laws.

TEMPORARY COMPASSION

In 1975, Robert Randall, who suffered from glaucoma, was arrested for cultivating his own marijuana. 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 marijuana from the government.

The program was grossly inadequate at helping the potentially millions of people who need medical marijuana. Many patients would never consider the idea that an illegal drug might be their best medicine, and most who were fortunate enough to discover marijuana'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. The IND program remains in operation only for the three surviving, previously approved patients.

PUBLIC AND PROFESSIONAL OPINION

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

- Since 1996, a majority of voters in Alaska, Arkansas, Arizona, California, Colorado, the District of Columbia, Florida, Guam, Maine, Massachusetts, Michigan, Mississippi, Missouri Montana, Nevada, North Dakota, Oklahoma, Oregon, South Dakota, Utah, and Washington State have voted in favor of ballot initiatives to remove criminal penalties for seriously ill people who grow or possess medical marijuana.
- An April 2018 Quinnipiac University poll found that 93% of Americans believe medical marijuana should be allowed.
- Organizations supporting some form of physician-supervised access to medical marijuana 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 use of marijuana 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 marijuana use. Thirty-six states (17 through their legislatures and 19 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 marijuana 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 marijuana 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 marijuana.

U.S. CONGRESS: THE FINAL BATTLEGROUND

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

The U.S. Supreme Court's June 2005 decision in *Gonzales v. Raich* preserved state medical marijuana 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. However, Pres. Donald Trump has signaled his disagreement with enforcement targeting state-legal marijuana businesses. Moreover, amendments to government funding bills passed since 2014 have prevented the Department of Justice from using funds to interfere with state medical marijuana laws. However, these amendments may be revisited in future budgets, and medical marijuana remains illegal under federal law, creating numerous complications — including with many banks being unwilling to do business with dispensaries.

Efforts to obtain FDA approval of marijuana also remain stalled. Though some small studies of marijuana have been published or are underway, the National Institute on Drug Abuse — the only legal source of marijuana for clinical research in the U.S. — has consistently made it difficult (and often nearly impossible) for researchers to obtain marijuana for their studies. At present, it is effectively impossible to do the sort of large-scale, extremely costly trials required for FDA approval. Recent calls to expand federal marijuana production in order to facilitate further research have had positive results, but obtaining permission for studies remains difficult.

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 medical marijuana without fear of arrest and imprisonment.
