

Smoke Screen: America's Drug Policy and Medical Marijuana

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I. INTRODUCTION

Marijuana has been used to ease the symptoms of numerous ailments for thousands of years and has been accepted as a means of treatment in the United States since the mid-19th century. California became the first state to prohibit the drug's possession or sale in the early 1900s. By virtue of its voters passing Proposition 215, which very publicly allows for the medical use of marijuana, California has become the focal point of a controversy pitting the federal government and its 1970 Controlled Substances Act (CSA)¹ against state legislatures and court decisions which have eased the availability of medical marijuana.

This article first explores the history of marijuana's therapeutic use and examines the federal government's position supporting its Schedule I classification under the CSA, while itself providing for a therapeutic program. The article then discusses state therapeutic use programs and judicial action, followed by an evaluation of the federal stance—is it politically motivated or based in science? Finally, a recommendation is made for a program of national distribution with clinical studies that should provide information to scientifically determine marijuana's medicinal effectiveness.

II. BACKGROUND

A. *Leading Up to the CSA*

Marijuana, or marihuana (*Cannabis sativa*), has been used medicinally for over 5,000 years,² recognized by U.S. physicians for its medicinal value as early as 1840,³ and included in the *United States Pharmacopoeia* as a treatment for lack of appetite until 1942.⁴ Marijuana use in the United States was not regulated by the federal or state governments until California prohibited its possession or sale in 1915.⁵ Virtually all of the states followed California's lead by the time the federal government, in a move opposed by the American Medical Association (AMA),⁶ initiated its first attempt to

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¹ Pub. L. No. 91-513, 84 Stat. 1242 (1970) (codified at 21 U.S.C. §§ 801 et seq. (1994)).

² See J. Wells Dixon, Case Note, *Conant v. McCaffrey: Physicians, Marijuana, and the First Amendment*, 70 U. COLO. L. REV. 975 (1999).

³ See Lester Grinspoon & James Bakalar, *Marihuana as Medicine, A Plea for Reconsideration*, 273 JAMA 1875 (1995) ("Between 1840 and 1900, European and American Medical Journals published more than one hundred articles on the therapeutic use of . . . marijuana. It was recommended as an appetite stimulant, muscle relaxant, analgesic, hypnotic, and anticonvulsant.").

⁴ See Dixon, *supra* note 2, at 976.

⁵ See Suzanne D. McGuire, *Medical Marijuana: State Law Undermines Federal Marijuana Policy—Is the Establishment Going to the Pot?*, 7 SAN JOAQUIN AGRIC. L. REV. 73 (1997).

⁶ See American Public Health Association, *Resolution on Medical Marijuana* 1, 2, Nov. 1995 (last visited Oct. 23, 1999) <www.druglibrary.org/schaffer/hemp/medical/apha.htm>.

“tax [marijuana] out of existence”⁷ with the Marijuana Tax Act of 1937.⁸

In 1951, the Boggs Act⁹ established mandatory prison sentences and significant monetary fines, penalties which subsequently were strengthened by the 1956 Narcotic Control Act.¹⁰ The CSA Schedule I¹¹ designation effectively prohibited marijuana’s medicinal use and ignited a controversy that remains today.

B. Federal Law and the CSA

1. Failing the “Currently Accepted Medical Use” Requirement

In 1972, the National Organization for the Reform of Marijuana Laws (NORML)¹² began its campaign to have marijuana reclassified as a Schedule II¹³ drug, which could then be legally prescribed.¹⁴ After years of legal wrangling, the Drug Enforcement Agency (DEA), formerly the Bureau of Narcotics and Dangerous Drugs, granted public hearings in 1986.¹⁵ NORML, the Physicians Association for AIDS, the Alliance for Cannabis Therapeutics (ACT),¹⁶ and the National Drug Strategy Network¹⁷ elicited testimony from numerous patients and physicians. In 1988, the DEA’s Administrative Law Judge, Francis L. Young, found the natural form of marijuana to be “one of the safest therapeutically active substances known to man” and ordered the marijuana plant reclassified as a Schedule II drug.¹⁸ This decision was overruled by the DEA, which issued “a final rejection of all pleas for reclassification in March 1992.”¹⁹

Arguing that “marijuana alleviates some of the side effects of chemotherapy for cancer patients, assists in the treatment of the eye disease glaucoma, and reduces

⁷ George J. Annas, *Reefer Madness—The Federal Response to California’s Medical-Marijuana Law*, 337 NEW ENG. J. MED. (1997) (last visited Oct. 23, 1999) <www.nejm.org/content/1997/0337/0006/0435.asp>.

⁸ Pub. L. No. 82-235, 65 Stat. 767 (1937) *as amended* by the Narcotic Control Act of 1956, Pub. L. No. 84-728, 70 Stat. 567, *cited* by Annas, *supra* note 7; *see also* McGuire, *supra* note 5, at 74 (“Designed to prevent nonmedical use, [the Tax Act] made cannabis so difficult to obtain for medical purposes that it was removed from the pharmacopoeia.”). Grinspoon & Bakalar, *supra* note 3, at 1875.

⁹ Pub. L. No. 82-235, 65 Stat. 767 (1951) *as amended* by the Narcotic Control Act of 1956, Pub. L. No. 84-728, 70 Stat. 567 (1956).

¹⁰ *See* McGuire, *supra* note 5, at 74 (citing the Narcotic Control Act of 1956).

¹¹ *See* 21 U.S.C.S. § 812 Schedule I(c)(10). Schedule I drugs are those that “1) have no therapeutic value, 2) are not safe for medical use, and 3) have a high abuse potential.” American Public Health Association, *supra* note 6, at 2. Other Schedule I drugs include LSD, heroin, and crack cocaine. NORML, *Medical Marijuana* (last visited Oct. 5, 2000) <www.norml.org/medical/index.shtml>. Under the CSA, hazardous drugs are classified, or scheduled, in one of five categories. As a Schedule I (most restricted use) drug, marijuana may be lawfully obtained and used only by doctors who submit a detailed research plan which is approved by FDA. Robin E. Margolis, *Marijuana Cannot Be Prescribed for Therapeutic Purposes*, 3 HEALTHSPAN 20, 21 (1994).

¹² NORML, founded in 1970, is aimed at achieving the complete legalization of marijuana. *See* McGuire, *supra* note 5, at 74 n.13.

¹³ Schedule II drugs, which include cocaine and morphine, are those that “can lead to drug abuse, but also [have] beneficial medical uses.” Margolis, *supra* note 11, at 21.

¹⁴ *See* Grinspoon & Bakalar, *supra* note 3, at 1875. The CSA permits the Attorney General to reclassify a drug which does not meet the criteria for the schedule to which it is assigned. The Attorney General has assigned this authority to the DEA Administrator. *See* Margolis, *supra* note 11, at 21.

¹⁵ *See* Grinspoon & Bakalar, *supra* note 3.

¹⁶ ACT was established in 1980 to end the federal prohibition on the medicinal use of cannabis so that the drug may be obtained by seriously ill patients. McGuire, *supra* note 5, at 75 n.14.

¹⁷ Organization founded by Eric E. Sterling, former counsel to the U.S. House of Representatives. McGuire, *supra* note 5, at 75 n.15.

¹⁸ *See* Grinspoon & Bakalar, *supra* note 3.

¹⁹ *Id.*

muscle spasticity in patients suffering from multiple sclerosis and other diseases of the central nervous system,"²⁰ ACT appealed the DEA Administrator's rescheduling denial to the D.C. Circuit.²¹ Writing the panel's opinion upholding the Administrator's decision, Judge James Buckley found that the order "had appropriately relied upon 'the testimony of numerous experts that marijuana's medical value has never been proven in sound scientific studies'" and had "reasonably accorded more weight to the opinions of these experts than to the anecdotal testimony" of lay witnesses and doctors brought forth by the petitioners.²²

The Administrator had relied on the DEA's five new criteria to dismiss the petitioner's claims that marijuana has an accepted medical use. Specifically, to meet the CSA's "currently accepted medical use" criteria:

- (1) a drug's chemistry must be known and reproducible; (2) there must be adequate safety studies; (3) there must be adequate and well-controlled studies proving efficacy; (4) the drug must be accepted by qualified experts; and (5) the scientific evidence that the drug has a currently accepted medical use must be widely available.²³

The court validated these new DEA standards, which demand "rigorous scientific proof" before reclassifying drugs, finding that the DEA had responded to the court's earlier criticisms concerning previously "illogical criteria."²⁴

Noting the lack of safety studies on human beings and an absence of well-controlled evaluations concerning the therapeutic value of marijuana, categories four and five could not be met.²⁵ Further, citing the marijuana plant's "highly variable chemical makeup" due to "[v]ariations in soil, geographical region, water, light, harvesting and storage conditions," raw marijuana fails part one of the CSA test—an individual plant's chemistry would not necessarily be "known and reproducible."²⁶

2. Smoking Marijuana Is an Unsafe and Unnecessary Delivery Method

Citing a lack of clinical studies demonstrating the effectiveness or therapeutic advantage of smoked marijuana over other substances, critics suggest that the promotion of smoked marijuana to help alleviate the pain and suffering is "[a] political attempt to exploit human suffering to legalize an illicit drug, [which] is shameful and irrespon-

²⁰ Margolis, *supra* note 11, at 21.

²¹ See *Alliance for Cannabis Therapeutics v. DEA*, 15 F.3d 1131 (D.C. Cir. 1994), cited by Margolis, *supra* note 11, at 20.

²² See Margolis, *supra* note 11, at 21.

²³ *Id.* at 21; see also McGuire, *supra* note 5, at 77.

²⁴ Margolis, *supra* note 11, at 21. The DEA had previously used an eight-part test set out in 54 Fed. Reg. 53,767 (1989). The test was reformulated when the court found it would be nearly impossible for a Schedule I drug to comply with parts four, five, and eight. These parts are as follows:

4. General availability of the substance and information regarding the substance and its use;
5. Recognition of its clinical use in generally accepted pharmacopeia, medical references, journals or textbooks;
8. Recognition and use of the substance by a substantial segment of the medical practitioners in the United States.

McGuire, *supra* note 5, at 76 n.30 (citing *Alliance for Cannabis Therapeutics v. DEA*, 930 F.2d 936, 940 (1991) (citing 54 Fed. Reg. at 53,767)).

²⁵ See *id.* at 78.

²⁶ *Id.* at 77.

sible.”²⁷ The critics continue, pointing out that smoked marijuana is more carcinogenic than tobacco and that synthetic tetrahydrocannabinol (THC), available in pill form (Marinol)²⁸ since 1986,²⁹ is the true “medical marijuana,” providing guaranteed purity without the tars, combustibles, and hydrocarbons produced by smoking.³⁰ Noting research showing that smoked marijuana “damages the heart, lungs, reproductive and immune systems,” that there is “a strong link between smoking marijuana and throat cancer,”³¹ that drivers under the influence of marijuana are ten times more likely to be involved in fatal traffic collisions than those under the influence of alcohol,³² and that regular, heavy marijuana use compromises the ability to learn and recall information by altering the brain’s normal neurochemical activity,³³ those opposing smoked marijuana point out that, among others, the AMA, American Cancer Society, the National Multiple Sclerosis Association, American Academy of Ophthalmology, the National Eye Institute, and former Surgeon General C. Everett Koop do not support a smoked delivery system.³⁴ Acknowledging that it may be difficult for a nauseated patient to swallow the Marinol pill, opposition to the smoked delivery system points out that an alternate delivery system, such as an inhaler, injection, suppository, or patch would be developed if sufficiently demanded, but that such demand does not exist.³⁵

3. Marijuana Is a “Gateway Drug”

Opponents of the medical marijuana movement cite national statistics indicating a doubling in marijuana use among twelve to seventeen-year-olds from 1994 to 1995³⁶ and a finding that fifty-five percent of fifteen to seventeen-year-olds admitted to drug rehabilitation programs were seeking treatment for marijuana.³⁷ Opponents argue that these statistics illustrate the point that “as our children become more accepting of drug use and less fearful of its consequences, they increasingly use marijuana and other drugs of

²⁷ Donald Vereen, *Is Medical Marijuana an Oxymoron?*, PHYSICIANS WKLY 1 (last visited Oct. 23, 1999) <www.whitehousedrugpolicy.gov/news/commentary/oped/1999/020199.html/>; see also McGuire, *supra* note 5, at 78; *The Issues Surrounding the Medicinal Use of Marijuana: Testimony Before the House Judiciary Committee Subcommittee on Crime*, 1997 WL 606318 (testimony of Ronald E. Brooks, Past President, California Narcotic Officers’ Association); *Hearing on Medical Uses of Marijuana: Testimony Before the Senate Committee on the Judiciary*, 1996 WL 687857 (F.D.C.H.) (statement of Senator Orrin G. Hatch (R-UT)).

²⁸ Marinol, available only by prescription, is “used only when other kinds of medicine do not work” to prevent nausea and vomiting caused by treatments with cancer medicines and as an appetite stimulant for AIDS patients.

²⁹ See McGuire, *supra* note 5, at 83.

³⁰ Vereen, *supra* note 27, at 1.

³¹ Testimony of Ronald E. Brooks, *supra* note 27. Mr. Brooks cites a University of California at Davis study to support this assertion. See *id.*

³² See *id.* Mr. Brooks does not cite any studies supporting this fatal accident claim. See *id.*

³³ *Testimony Before the House Judiciary Committee Subcommittee on Crime*, 1997 WL 606302 (F.D.C.H.) (statement submitted by Barry R. McCaffrey, Director, Office of National Drug Control Policy); see also Statement of Senator Orrin G. Hatch (R-UT), *supra* note 27. Curiously, however, Mr. McCaffrey fails to distinguish medical use from that of regular, heavy using abusers of the drug—in so doing, he clouds the issue and reduces the integrity of his argument against marijuana’s medical use. His argument is similar to comparing the medical use of morphine, a Schedule II opiate narcotic, to that of a person abusing opium or one of its derivative drugs.

³⁴ See Vereen, *supra* note 27, at 1; see also Statement of Senator Orrin G. Hatch (R-UT), *supra* note 27.

³⁵ See *id.* This argument leaves out the important point that some patients, who may wish to use marijuana, do not out of fear, because smoking the drug is illegal. See *Conant v. McCaffrey*, *infra* note 105.

³⁶ Statement of Senator Orrin G. Hatch (R-UT), *supra* note 27.

³⁷ Statement submitted by Barry R. McCaffrey, *supra* note 33.

abuse.”³⁸ It is argued that permitting its medicinal use sends a powerful, but erroneous message to children that marijuana use is beneficial—that the “Cheech and Chong” image will blind teenagers to the drug’s harmful side.³⁹

Critics also note that marijuana today is fourteen times more potent than marijuana smoked in the 1960s, and with over 360 chemicals affecting the brain, it is considerably more addictive, with over 100 addicts per month treated in San Francisco’s Haight Ashbury clinic alone.⁴⁰ Acknowledging that most young people who smoke marijuana do not become addicted to drugs, advocates of banning smoked medical marijuana argue that marijuana use can lead to the use of more serious drugs, including cocaine, heroin, LSD, and methamphetamine.⁴¹

Critics do not base these arguments on the effect of a complete legalization of marijuana, but predict that allowing marijuana to be legally grown and used for medical purposes will lead to an increased availability and general use of the drug, with diversion to the streets and black market trade.⁴² This point is illustrated by citing to studies conducted following the passage of California’s Proposition 215,⁴³ which indicate that illegal marijuana cultivation seizures increased by over 50 percent and found “dramatic increases in teen marijuana use.”⁴⁴

4. *The Federal Government’s Allowance for Compassionate Use*

The federal government has regulated drugs for nearly a century, and the Food and Drug Administration (FDA) has made few exceptions to its policy that only FDA-approved drugs may be used in treatment.⁴⁵ FDA became considerably more flexible

³⁸ *Id.*

³⁹ *See id.*

⁴⁰ *See* Testimony of Ronald E. Brooks, *supra* note 27. A 1994 Office of National Drug Control Policy (ONDCP) report indicated that more people were admitted to treatment for marijuana use than cocaine addiction. *See id.*

⁴¹ Statement submitted by Barry R. McCaffrey, *supra* note 33. A study conducted by the Center on Addiction and Substance Abuse at Columbia University found that 60% of children using marijuana before age 15 moved on to cocaine. This number reduced with age—only 20% of those who began to smoke marijuana after age 17 moved on to “hard” drugs. *See* Statement submitted by Barry R. McCaffrey, *supra* note 33.

⁴² *See* Statement submitted by Barry R. McCaffrey, *supra* note 33.

⁴³ Passed on November 5, 1996, the Compassionate Use Act of 1996, California Health & Safety Code section 11362.5 (West Supp. 1999), decriminalized the possession of small quantities of marijuana and allows physicians to discuss and recommend the medical use of marijuana to their patients. The statute does not provide that patients may simply buy the drug off the streets legally—instead, patients must grow the plants themselves or buy the drug from marijuana buyer’s clubs. *See* Dixon, *supra* note 2, at 978-79. *See infra* text accompanying note 72 for a discussion concerning the government’s injunction against buyer’s clubs.

⁴⁴ Testimony of Ronald E. Brooks, *supra* note 27.

⁴⁵ *See* Annas, *supra* note 7. This steadfast policy holds true, even for cancer and AIDS patients. In 1979, FDA convinced the Supreme Court that to allow terminally ill patients to take an unapproved drug would discourage them from taking approved drugs, which offered some chance of a cure. *See id.* In *United States v. Rutherford*, 442 U.S. 544 (1979), the Supreme Court determined that there was no “terminally ill” exception in the Federal Food, Drug, and Cosmetic Act and that absent a showing of Laetrile’s effectiveness in treating cancer, the expected therapeutic gain was offset by its potential to harm or cause death—“if an individual suffering from a potentially fatal disease rejects conventional therapy in favor of a drug with no demonstrable curative properties, the consequences can be irreversible.” *Id.* at 556. The argument against Laetrile, a term used generically “for chemical compounds similar to, or consisting at least in part of, amygdalin, a glucoside present in the kernels or seeds of most fruits” is different from the argument against medical marijuana in at least two respects. *Id.* at 549. First, Laetrile was not illegal in many states, as is crude marijuana; it simply had not been proven effective at curing cancer when other therapies were available. Second, probably in good part because marijuana use is stigmatized and illegal, it is not generally being used in place of

with AIDS patients during the Reagan Era, allowing the sale and use of unapproved drugs (only those undergoing clinical trials) if the drug was used to treat "a serious or immediately life-threatening disease."⁴⁶ Individual patients were also allowed to import unapproved medicines from other countries under the theory previously rejected by FDA and the Supreme Court—namely, that the terminally ill have nothing to lose and should at least have the hope of escaping death.⁴⁷

FDA also administers a compassionate use program. Begun in the 1970s, the Investigative New Drug (IND) program today provides approximately 300 marijuana joints, free of charge each month, to a group of eight individuals, nicknamed the "Acapulco Eight."⁴⁸ Under contract with the National Institute for Drug Abuse, the Research Institute of Pharmaceutical Services at the University of Mississippi grows up to 7,000 plants to supply the IND's compassionate use program, at an annual cost of \$250,000.⁴⁹ The existence of such a program evidences the federal government's willingness to make a low-key exception to its ban on the use of crude marijuana for medical purposes.

C. *Marijuana Policy Among the States*

1. *Legislative Action—Keeping It Low-Key*

While nearly every state has passed a controlled substances act, and many of these categorize drugs according to the federal schedule, thereby criminalizing the possession of marijuana for any purpose, numerous states, including Michigan,⁵⁰ do have therapeutic programs using the drug. Like the Michigan program, the Alabama,⁵¹ New York,⁵² and Massachusetts⁵³ legislatures, among others, created research-oriented studies which, while not lending credence to marijuana's effectiveness as a medical treatment, "embrace the therapeutic potential for marijuana in cancer and glaucoma treatment," which has been firmly rejected, at least publicly, by the federal government.⁵⁴ Perhaps anticipating difficulties in procuring marijuana from the federal govern-

other available treatments. Patients are not replacing chemotherapy or AIDS treatments with marijuana; they are using it, often as a last resort, to alleviate the wasting associated with these treatments and diseases. The argument against medical marijuana is rooted primarily in politics, not necessarily in science or the existence of proven alternatives to marijuana's symptom relief. Aside from those individuals proclaiming marijuana as a cure for various diseases, where proven alternatives exist, the analysis applied to Laetrile is not applicable to medical marijuana.

⁴⁶ Annas, *supra* note 7.

⁴⁷ *See id.*

⁴⁸ NORML, *supra* note 11, at 1-2.

⁴⁹ *See id.* at 1-2; *see also* McGuire, *supra* note 5, at 80 n.63.

⁵⁰ The Marihuana Controlled Substances Therapeutic Research Program of Michigan provides in part:

(1) There shall be established in the department a marihuana controlled substances therapeutic research program

(2) Participation in the marihuana controlled substances research program shall be limited to cancer chemotherapy patients and glaucoma patients who are certified to the department by a physician as being involved in a life-threatening or sense-threatening situation, and who is not responding to conventional medical treatment or when conventional medical treatment administered has proven to be effective, but the patient has incurred severe side effects

MICH. COMP. LAWS ANN. § 333.7335 (West 1999).

⁵¹ *See* ALA. REV. CODE ANN. §§ 20-2-110 to 2-120 (1996).

⁵² *See* N.Y. PUB. HEALTH LAW § 3397-a (1996).

⁵³ *See* MASS. ANN. LAWS ch. 94D, § 2 (Law. Co-op. 1996).

⁵⁴ McGuire, *supra* note 5, at 79-80 (citing the rejection of H.R. 4498, 97th Cong. (1981); H.R. 2232, 99th Cong. (1985); H.R. 2618, 104th Cong. (1995)).

ment, the Michigan legislature provided, as have other states, for alternate supplies, including criminal seizures, that meet purity requirements.⁵⁵

2. *The State Courts*

Defendants facing criminal prosecution for the possession or cultivation of marijuana for medical purposes often rely on the medical necessity defense.⁵⁶ The courts in states with therapeutic research programs almost universally reject this defense, finding that the drug is available legally through the program.⁵⁷ Decisions in states that do not statutorily recognize the medicinal use of marijuana nevertheless generally favor defendants who claim medical necessity.⁵⁸ In *Commonwealth v. Hutchins*,⁵⁹ however, the Massachusetts Supreme Court rejected the necessity defense, finding that while alleviation of the defendant's symptoms was important, it did not "significantly outweigh" potential harm to the public where the defendant's cultivation and use could be declared legal.⁶⁰

3. *California's Initiative Stirs the Waters*

Passed by a fifty-six to forty-four percent margin⁶¹ in 1996, California's Proposition 215 provides for the expansive use of marijuana for "diseases ranging from AIDS to migraine, and 'any other illness for which marijuana provides relief.'"⁶² The primary purpose of the statute is to protect a prescribed patient group from state criminal prosecution for the cultivation or possession of marijuana.⁶³ The statute also insulates the patient's primary care giver from state prosecution for recommending the medicinal use of marijuana.⁶⁴

⁵⁵ The Michigan statute provides in part:

(4) If federal sources do not provide supplies of marihuana adequate for patient use pursuant to this section and section 7336, the department shall approve the use of marihuana obtained from law enforcement agencies in this state, until adequate marihuana is received from federal sources. Any marihuana obtained from law enforcement agencies in this state shall be tested for purity and dosage by the department or a laboratory designated by the department

MICH. COMP. LAWS ANN. § 333.7335 (West 1999); see also McGuire, *supra* note 5, at 80-81.

⁵⁶ See McGuire, *supra* note 5, at 81. Necessity is often defined as a "controlling force; irresistible compulsion; a power or impulse so great that it admits no choice of conduct." *Id.* (quoting BLACK'S LAW DICTIONARY 1030 (6th ed. 1990)).

⁵⁷ See McGuire, *supra* note 5, at 87. A notable case allowing the necessity defense in a state with a therapeutic program is *Washington v. Diana*, 604 P.2d 1312 (Wash. Ct. App. 1979). Citing the fact that the defendant reasonably believed in the medical necessity, that the benefits of use outweighed the harm, and the fact that no other drug minimized the effects of multiple sclerosis as well as marijuana, the court found Diana not guilty. See *id.* at 1316-17, cited by McGuire, *supra* note 5, at 86.

⁵⁸ See McGuire, *supra* note 5, at 88.

⁵⁹ 579 N.E.2d 741 (Mass. 1991), cited by *id.* at 89.

⁶⁰ See *Hutchins*, *supra* note 59, at 745, cited by McGuire, *supra* note 5, at 89. In 1991, following the *Hutchins* decision, Massachusetts approved a controlled substances therapeutic program and in 1996 passed a bill providing a "prima facie defense to a charge of possession of marihuana . . . that the defendant is a patient certified to participate in a therapeutic research program . . . and possessed the marihuana for personal use pursuant to such a program." 1996 Mass. Adv. Legis. Serv. 271 (Law. Cop.), cited by *id.* at 90. The new law did not help Mr. Hutchins, as his diseases (Scleroderma, a connective tissue disorder and Raynaud's phenomenon, a circulatory disorder of blood vessels in the extremities) were not included in the therapeutic program. McGuire, *supra* note 5, at 90.

⁶¹ See Annas, *supra* note 7.

⁶² Compassionate Use Act of 1996, to be codified as CAL. HEALTH & SAFETY CODE § 11362.5, cited by McGuire, *supra* note 5, at 92.

⁶³ See Annas, *supra* note 7.

⁶⁴ See Compassionate Use Act of 1996, to be codified as CAL. HEALTH & SAFETY CODE § 11362.5(C)(2)(c).

4. *The White House Response*

The California statute's insulation from state prosecution for patients suffering from a wide range of complaints, including arthritis and migraine, and its invitation for federal and state officials to establish a distribution network, stirred up a hornet's nest at the White House.⁶⁵ Realizing that its approximately 700 agents⁶⁶ in California and Arizona⁶⁷ could not physically enforce the federal prohibition on marijuana use in those states in light of the new statutes, and expressing concern that the expansive uses of medical marijuana in the California law would send the wrong message to American youth, the White House vowed to oppose the state legislation.⁶⁸

Attorney General Janet Reno announced that federal law enforcement would retarget its resources on physicians recommending marijuana to their patients. The White House leverage included revocation of an offending physician's DEA registration and exclusion from Medicare and Medicaid program participation.⁶⁹ Filing suit⁷⁰ against Barry McCaffrey, the President's "drug czar," Donna Shalala, the Secretary of Health and Human Services, and Attorney General Janet Reno, a group of California physicians argued that preventing physicians from discussing available options with their patients amounted to a violation of the doctors' First Amendment rights and interfered with a bona fide patient-physician relationship.⁷¹ Keeping in mind that the California statute allowed only the recommendation, not prescription of marijuana, U.S. District Court Judge Fern M. Smith granted a preliminary injunction, forcing the DEA to abandon its threats against California doctors.⁷² Shielded from prosecution for recommending the drug, physicians still remain liable for any speech criminal in itself by virtue of a close relation to criminal activity. Physicians will still be prosecuted for acts "specifically intend[ed] to aid, abet, or conspire with their patients" to obtain marijuana.⁷³

Acknowledging that the injunction did not define the extent to which physicians may recommend marijuana use without exposing themselves to federal prosecution, the judge admitted that her decision did not leave "physicians with the level of certainty for which they had hoped."⁷⁴ Shortly after the February 14, 1997 filing of the *Conant* suit, the Assistant Secretary of Health and the Acting Assistant Attorney General submitted a letter to clarify the government's position.⁷⁵ In part, the letter stated that "[p]hysicians

⁶⁵ See McGuire, *supra* note 5, at 92; Annas, *supra* note 7.

⁶⁶ See Statement of Senator Orrin G. Hatch (R-UT), *supra* note 27.

⁶⁷ On November 6, 1996, Arizona voters adopted Proposition 200, The Drug Medicalization Prevention and Control Act, to be codified in pertinent part as ARIZ. REV. STAT. ANN. § 13-3412.01. McGuire, *supra* note 5, at 92-93. Broader than the California law, the Arizona Act permitted doctors to prescribe other Schedule I drugs, including heroin and LSD, to patients with glaucoma, cancer, multiple sclerosis, and AIDS. See *id.*, at 93. The Arizona legislature effectively repealed the Act in April 1997 as they amended the law to apply only to FDA approved drugs. Annas, *supra* note 7.

⁶⁸ See Annas, *supra* note 7.

⁶⁹ See *id.*

⁷⁰ See *Conant v. McCaffrey*, 172 F.R.D. 681 (N.D. Cal. 1997), *cited by* Dixon, *supra* note 2, at 980; Annas, *supra* note 7.

⁷¹ See Annas, *supra* note 7.

⁷² See *id.*; Dixon, *supra* note 2, at 980-81. Although enjoined from prosecuting physicians for recommending marijuana use, the government did secure a victory of its own in *United States v. Cannabis Cultivators Club*, 5 F. Supp. 2d 1086 (N.D. Cal. 1998). The court enjoined medical cannabis dispensaries providing marijuana to seriously ill patients or their primary caregivers because the dispensaries were not the drug's "ultimate users" and were thereby in violation of the CSA. See *id.* at 1101.

⁷³ See Annas, *supra* note 7.

⁷⁴ *Conant*, 172 F.R.D. at 701, *quoted by* Annas, *supra* note 7.

⁷⁵ See *Conant*, 172 F.R.D. at 686-87.

may not intentionally provide their patients with oral or written statements in order to obtain controlled substances in violation of federal law.⁷⁶

On March 8, 1999, the Oregon Medical Association (OMA) asked for clarification of the federal government's "clarification" letter to the California Medical Association, asking,

Do statements in patient charts that the person has been diagnosed with a debilitating medical condition and that the use of medical marijuana may mitigate the symptoms or effects of the debilitating medical condition constitute written statements in order to enable [their patients] to obtain controlled substances in violation of federal law?⁷⁷

Absent a federal response as of the April 25, 1999 adoption of its medical guidelines,⁷⁸ the OMA warned its physicians that they were in a tenuous position—at risk of federal prosecution or license restriction on one hand while exposed to claims from patients suffering a bad outcome associated with the use of medical marijuana on the other.⁷⁹ Recognizing that no physician is fully protected absent a federal response to the OMA's inquiry, the OMA created a list of "do's" and "do not's" to help its physicians balance the fine line of providing enough information to enable a patient to become registered while not invoking federal penalties.⁸⁰

⁷⁶ OREGON MEDICAL ASSOCIATION GUIDELINES, WHEN PATIENTS WANT TO USE MARIJUANA FOR MEDICAL PURPOSES: HOW PHYSICIANS SHOULD RESPOND (adopted Apr. 25, 1999) (last visited Oct. 23, 1999) <www.teleport.com/~omr/OMA_guidelines.html>.

⁷⁷ *Id.* Passed in November 1998, the Oregon medical marijuana law exempts persons from state criminal penalties for the "production, delivery, or administration of marijuana or paraphernalia used to administer marijuana provided they comply with very detailed requirements." *Id.* The Oregon law provides registry identification cards to qualified patients who receive "'written documentation' from their 'attending physician;'" these cards are relied on by state officials to determine exemption status. *See id.*

⁷⁸ *See id.*

⁷⁹ *See id.*

⁸⁰ *See id.* These recommendations concerning the medical marijuana program are as follows:

1. Physicians are not obligated to participate.
2. *If the patient requests it*, physicians should do ONLY the following things in order for their patients to benefit from Oregon's law permitting medical use of marijuana.
 - [a]. Determine whether the patient suffers from a "debilitating medical condition." If the patient does not qualify this should be documented in the patient's chart.
 - [b]. If they do suffer from a debilitating medical condition, document that fact in the patient's chart.
 - [c]. Determine whether the use of medical marijuana "may mitigate symptoms or effects of the person's debilitating medical condition." If you tell the patient that its use *may not* mitigate symptoms or effects, then this should be documented in the patient's chart.
 - [d]. If you tell the patient that "use of medical marijuana *may* mitigate symptoms or effects," document that this conversation occurred in the patient's chart.
 - [e]. Perform a PARQ [Physical Activity Readiness Questionnaire] conference and document it in the patient's chart.
3. Physicians SHOULD AVOID any of the following:
 - [a]. AVOID providing your patients with information about where they can obtain medical marijuana.
 - [b]. AVOID talking with anyone by telephone or in person who offers to help your patient obtain marijuana.
 - [c]. AVOID writing anything in support of the patient's desire for medical marijuana other than that patient suffers a "debilitating medical condition" and that "medical use of marijuana may mitigate symptoms and effects..."
 - [d]. AVOID writing anywhere but in the patient's chart. This means not supplying the patient with a letter or form signed by the physician.
 - [e]. ABOVE ALL AVOID *writing this information on a prescription.*

III. IS THE FEDERAL POLICY UP IN SMOKE?

A. *The Politics of It All*

Unable to block the six state referendums passed in recent years, Congress, using its oversight powers over the District of Columbia, did refuse to authorize funds to count a referendum vote in which D.C. voters approved the use of medical marijuana by a sixty-nine to thirty-one percent vote.⁸¹ In the meantime, the House, voting 310 to 93, passed a nonbinding resolution opposing the use of medical marijuana in D.C.⁸² A federal judge subsequently ruled that Congress violated the citizens' First Amendment right to free speech—to express their opinion. Critical of the congressional action, *Free Press* columnist Marianne Means wrote “[h]owever sympathetic members may have been to the agonies of the seriously ill, they were more interested in guarding against opponents who might accuse them of being soft on drugs, including cocaine. The Clinton White House stands with Congress on this. Politics is politics.”⁸³

The congressional vote is another indication that federal officials are out of step with the states, the general public, and even insurance companies.⁸⁴ In a *New England Journal of Medicine* editorial, Dr. Jerome P. Kassirer calls for federal authorities to follow the states' lead and rescind their prohibition on the medicinal use of marijuana, leaving it to physicians to prescribe the drug as a Schedule II narcotic.⁸⁵ Most likely, this request will not receive a warm reception in Washington—at least not a publicly visible one. And why not? “The federal government's reluctance to accept a legitimate medical use for marijuana stems from the extensive and exhaustive efforts it has expended since the Nixon Administration to prohibit and discourage recreational marijuana use, especially in adolescents”⁸⁶—a policy seeded in a cultural conflict between the “establishment” and “counterculture” forged in the 1960s.⁸⁷ Increasing the ante during the 1980s, President Reagan began using the U.S. Armed Forces, the FBI, and the CIA to enforce the Administration's drug policies. A 1991 study identified more than \$30 billion per year in public expenditures associated with America's drug war, with an annual DEA budget of \$1.2 billion.⁸⁸ The Clinton Administration has raised the stakes even higher, spending more money, increasing arrests, and lengthening prison sentences.⁸⁹

⁸¹ See Marianne Means, *Feds, Stay Out of D.C.'s Decisions*, DET. FREE PRESS, Sept. 30, 1999, at 13A.

⁸² See *id.*

⁸³ *Id.*

⁸⁴ See Seth Rosenfeld, *More Companies Insure for Medical Marijuana*, DET. NEWS, Sept. 12, 1999, at 9A. Some insurance companies in states allowing medical marijuana have recognized a legitimate property value in their insured's marijuana plants. In one instance a 71-year-old man suffering from prostate cancer, sciatica, and arthritis bought 13 young plants upon his psychiatrist's recommendation. The plants were subsequently seized, but returned when all charges were dropped by the Sacramento District Attorney. The seizing agents, however, had failed to water the young plants, worth \$6,500, and they died. The man's insurance firm reimbursed him under his homeowners policy's “trees, shrubs and other plants” provision. A Seattle man was reimbursed \$3,500 when his medical marijuana was stolen. In an informal poll, the San Francisco Examiner identified at least three insurers—Farmers, CGU of Boston, and State Farm, the country's largest home insurance provider, with 67 million policies—that will cover the loss of medical marijuana. See *id.* This is simply more evidence that the federal/state conflict has muddied the waters—we have the seizure of medical marijuana plants and paraphernalia whose owners turn around and are reimbursed by their insurance companies so they can go out and purchase new plants.

⁸⁵ See Jerome P. Kassirer, *Federal Foolishness and Marijuana*, 336(5) NEW ENG. J. MED. (last visited Oct. 5, 2000) <www.nejm.org/content/1997/0336/0005/0366.asp>.

⁸⁶ Dixon, *supra* note 2, at 999 (citing Gregg A. Bilz, *The Medical Use of Marijuana: The Politics of Medicine*, 13 HAMLIN J. PUB. L. & POL'Y 117, 117 (1992) (citing Ronald J. Ostrow, *Forty-Eight Percent of Cancer Specialists in Study Would Prescribe Pot*, L.A. TIMES, May 1, 1991, at A12)).

⁸⁷ See *id.*

⁸⁸ See *id.*

⁸⁹ See *id.* at 1000.

Spending \$15 billion in federal funds and \$33 billion in state funds to finance a war that statistically has only slightly reduced trafficking and drug use while incarcerating almost 1.5 million people (one-third of those for marijuana possession as of 1995),⁹⁰ the policy's success is uncertain. What is certain is that politicians feel they must prove to their constituents that they are "tough on crime." A laudable goal at its heart, it is readily apparent that those opposing medical marijuana attack its therapeutic benefits out of a fear that 1) opening the door to the drug's open medical use will lead to full legalization and 2) that their political opponents will seize the opportunity to paint them as soft on drugs.⁹¹ This is evident in that the therapeutic benefits of marijuana have rarely been debated objectively throughout the nation's long war on drugs.⁹²

In *United States v. Cannabis Cultivators Club*,⁹³ the defendant, trying to prove the government's "unclean hands"⁹⁴ in its move to enjoin the club's growing and providing of marijuana for medical purposes, pointed to a history of subversion on the government's behalf regarding the efficacy of medical marijuana.⁹⁵ The defendant cited a history of the federal government ignoring its own studies, the DEA's distribution of marijuana to the eight members enrolled in the Investigative New Drug Program, and the DEA's dismissal of its own administrative law judge's recommendation that marijuana be rescheduled.⁹⁶

The *Cannabis Cultivators* court noted in its decision that the DEA had, on December 17, 1997, referred a rescheduling petition to the Secretary of Health and Human Services for review in light of newly raised scientific and medical issues.⁹⁷ The court also expressed its expectation that the government act expeditiously.⁹⁸

B. *The Real Science*

Criticizing state ballot initiatives for playing on voters' emotions to bypass the rigorous process for drug certification, Barry McCaffrey, in his October 1, 1997 testimony to the House Judiciary Committee Subcommittee on Crime⁹⁹ stated "[t]he logic of the federal response is simple: federal law remains in effect, and science must prevail over ideology."¹⁰⁰ Mr. McCaffrey noted that for fifty years such a process has protected U.S. consumers from "snake oils, dangerous drugs, unproven substances and ineffective treatments," and that to exempt any drug from this process would undermine public confidence in the system.¹⁰¹ Characterizing marijuana as a "gateway" drug for young people, and highlighting the cancer risk of smoked marijuana, Mr. McCaffrey acknowledged FDA's flexibility in accelerating AIDS drug development while maintaining scien-

⁹⁰ See Dean Baum, *California's Separate Peace*, ROLLING STONE MAG., Oct. 30, 1997, at 43, cited by Dixon, *supra* note 2, at 1000 n.147.

⁹¹ Dixon, *supra* note 2, at 1000.

⁹² See *id.*

⁹³ 5 F. Supp. 2d 1086 (N.D. Cal. 1998).

⁹⁴ The "clean hands" doctrine states:

that one who seeks equity must come to the court without blemish This maxim "is a self-imposed ordinance that closes the doors of a court of equity to one tainted with an inequity or bad faith relative to the matter in which he seeks relief, however improper may have been the behavior of the defendant."

Id. at 1104.

⁹⁵ See *id.*

⁹⁶ See *id.* at 1104-05.

⁹⁷ See *id.* at 1105.

⁹⁸ See *id.* In response to the California referendum, the National Institutes of Health recommended marijuana research in the areas of wasting associated with AIDS, nausea caused by chemotherapy, glaucoma, and neuropathic pain. See Annas, *supra* note 7.

⁹⁹ Statement submitted by Barry R. McCaffrey, *supra* note 33.

¹⁰⁰ *Id.*

¹⁰¹ See *id.*

tific integrity and public health standards. He further stated that marijuana rescheduling may be appropriate if “sound medical research demonstrates that there are medical uses [even] for smoked marijuana.”¹⁰²

So, what is the science behind the rhetoric—are there truly beneficial uses for marijuana? Does smoked marijuana pose excessive risks? Is marijuana a “gateway” to addiction for American youth?

1. *The Medicinal Value*

Many patients using marijuana for nausea brought on by chemotherapy, wasting associated with AIDS, relief of interocular pressure associated with glaucoma, and spastic disorders do derive some significant benefits from marijuana use—enough of a benefit to risk a prison sentence.¹⁰³ The experiences of these patients are illustrated well by the story of former San Francisco Police Commissioner Jo Daly. Diagnosed with colon, ovarian, and lymphatic cancer, Daly was treated aggressively with chemotherapy.¹⁰⁴ In a sworn declaration to the *Conant*¹⁰⁵ court, Daly poignantly describes her treatment:

Each day, when I returned home from the hospital following treatment [,] . . . my whole body turned quite warm, as if a fever were coursing through me. My fingernails burned with heat. Invariably, I was overcome by a sudden wave of intense nausea—like a nuclear implosion in my solar plexus—and I rushed desperately for the bathroom where I would remain for hours, clutching the toilet and retching my guts out. I had no appetite. I could not hold down what little food that I managed to swallow. And I could not sleep at night.

My second session of chemotherapy was even more brutal than the first. My hair fell out. My gums swelled up and bled. My body racked with pain. I suffered extreme bouts of nausea an [sic] retching. And I found myself in a terrible state of despair . . . I was experiencing “cellular suicide.” . . . To calm my stomach, I ingested marijuana . . . during my stay in the hospital . . . Were it not for the marijuana I could not have eaten. And if I had not eaten, I would have become even weaker and very likely would have died . . .

The marijuana saved my life. But the illegal status of my medicine greatly exacerbated the stress of suffering a terrifying illness and undergoing a painful treatment.¹⁰⁶

Although moving, such testimony is merely anecdotal—it will not sway the DEA or the courts to reschedule marijuana.¹⁰⁷ In January 1997, however, the Office of National Drug Control Policy (ONDCP) commissioned the Institute of Medicine (IOM) to evaluate the myriad of small studies and claims — using only the dictates of science to act as

¹⁰² *Id.*

¹⁰³ See Kassirer, *supra* note 85.

¹⁰⁴ See Dixon, *supra* note 2, at 983.

¹⁰⁵ *Conant v. McCaffrey*, 172 F.R.D. 681 (N.D. Cal. 1997).

¹⁰⁶ Dixon, *supra* note 2, at 983 (quoting Declaration of Jo Daly, *Conant v. McCaffrey*, 172 F.R.D. 681 (N.D. Cal. 1997) (No. C97-0139 EMS), available at The Lindesmith Center, *Conant v. McCaffrey: Federal Class Action Lawsuit on Behalf of Physicians Who Recommend and Seriously Ill Patients Who Need Medical Marijuana* (last visited Feb. 10, 1999) <www.lindesmith.org/mmjsuit/conant.html>).

¹⁰⁷ Margolis, *supra* note 11, at 21; see also *supra* note 11 and accompanying text.

a mediator between those dismissing medical marijuana as a hoax and others portraying marijuana as the cure-all, soothing ailments from headaches to chemotherapy-induced nausea.¹⁰⁸

Although more than thirty symptoms reputedly were treated by various patients using marijuana, most of these were poorly studied and therefore not reviewed.¹⁰⁹ Use for other symptoms was backed by confirmed controlled medical trials. From these trials, the IOM researchers determined that marijuana's benefits are limited to symptom relief, which for most ailments are more effectively treated by drugs currently on the market.¹¹⁰ Cannaboids, however, were found beneficial for treating "pain, chemotherapy-induced nausea and vomiting, and the poor appetite and wasting caused by AIDS or advanced cancer" and often worked when other available medications failed.¹¹¹ Citing insufficient studies, the IOM found only weak support for the drug's efficacy in treating the symptoms of glaucoma, multiple sclerosis, migraines, or movement disorders, including Parkinson's disease and Huntington's disease. The IOM called for additional clinical studies in these areas, and in sum, noted that "we believe that cannaboids are an underutilized source of new drugs. Knowledge of cannaboid biology points to several new, potentially promising avenues for drug development. Basic research has revealed a variety of cellular and brain pathways through which therapeutic drugs could act on the cannaboid receptor systems."¹¹²

Synthetic tetrahydrocannabinol (THC), the active ingredient in marijuana, is available in pill form (Marinol) and is approved for the treatment of nausea brought on by chemotherapy and for wasting caused by AIDS.¹¹³ Cannabidiol, another chemical found in marijuana, has been identified by the National Institutes of Health as a drug potentially capable of protecting against brain damage caused by stroke.¹¹⁴ Working without the euphoric effects caused by smoking marijuana, the drug is a powerful antioxidant that has successfully protected rat brain cells from a toxic chemical produced during a stroke.¹¹⁵ The research has indicated, however, that smoking marijuana probably will not provide an effective dose of the compound.

THC's use in pain treatment is controversial because human studies have been inconclusive.¹¹⁶ Researchers at the University of California in San Francisco, however, appear to have found a way to enhance the effects of morphine and other opioids, while

¹⁰⁸ *Institute of Medicine, Marijuana and Medicine: Assessing the Science Base, March 17, 1999 News Conference* (opening statement of John A. Benson, Dean and Professor of Medicine Emeritus, Oregon Health Sciences University School of Medicine, Portland) (last visited Oct. 7, 2000) <www4.nationalacademies.org/news/nsf/(ByDocID)/F80B2CDD335F588285256775004A7148?OpenDocument>.

¹⁰⁹ *See id.*

¹¹⁰ *See id.* Nothing in FDA regulations requires that a drug be more effective than an existing drug for it to be approved. *See Annas, supra* note 7.

¹¹¹ *See* opening statement of John Benson, *supra* note 108. Marinol (synthetic Schedule II version of tetrahydrocannabinol, one of the active ingredients in marijuana) is used only after other medicines do not work.

¹¹² *Institute of Medicine, Marijuana and Medicine: Assessing the Science Base, March 17, 1999 News Conference* (opening statement of Stanley J. Watson, Co-Director and Research Scientist, Mental Health Research Institute, University of Michigan, Ann Arbor) (last visited Oct. 7, 2000) <www4.nationalacademies.org/news/nsf/(ByDocID)/F80B2CDD335F588285256775004A7148?OpenDocument>.

¹¹³ *See* Health News, *Medicinal Marijuana?*, NEW ENG. J. MED. (1996) (last visited Oct. 7, 2000) <onhealth.com/ch1/in-depth/item/item,2288_1_1.asp>.

¹¹⁴ *See* Katrina Woznicki, *Marijuana Chemical May Become Stroke Drug*, (last visited Nov. 12, 1999) <onhealth.com/ch1/briefs/item,4008.asp>.

¹¹⁵ *See id.*

¹¹⁶ *See* Ian D. Meng et al., *An Analgesia Circuit Activated by Cannabinoids*, 395 NATURE 381 (1998).

lowering the required dose.¹¹⁷ The study found that cannabinoids act on the same portion of the brain, the rostra ventromedial medulla, as do the opioid analgesics,¹¹⁸ but do not involve the opioid receptors. Because the same receptors are not involved, lower doses of both drugs can be given in combination, thereby reducing the side effects of morphine, which can include nausea and respiratory depression.¹¹⁹

2. *The Benefits and Risks of Smoked Marijuana*

Recognizing Marinol's availability, many patients and physicians prefer crude marijuana because the dosage and duration of effects are easier to control.¹²⁰ While one of the greatest advantages of medical marijuana is its "remarkable" safety,¹²¹ marijuana's future medical use does not involve smoking.¹²² Science supports the critics in their legitimate concern over the effect smoking has on the lungs—marijuana smoke carries even more tar and particulates than tobacco.¹²³

Recognizing that "cannabinoids are an underutilized source of new drugs," the IOM researchers acknowledge the benefits of rapid onset and more consistent results produced by inhaling the drug as opposed to the pill form.¹²⁴ The IOM researchers, therefore, recommend clinical trials aimed at developing an inhaler, whereby patients can receive the benefits of a quick delivery while avoiding the carcinogenic smoke.¹²⁵

3. *Is Marijuana a "Gateway" to Drug Addiction?*

The IOM also looked into the allegation that marijuana acts as a "gateway" to hard drugs, and further, whether legalizing the drug for medical purposes would increase marijuana use among the general population.¹²⁶ Contrary to statistics cited by the critics

¹¹⁷ Katrina Woznicki, *Scientists Look at Ways to Improve Pain Relievers*, (Sept. 24, 1998) (last visited Nov. 12, 1999) <onhealth.com/ch1/briefs/item,25237.asp>.

¹¹⁸ See Meng, *supra* note 116, at 381.

¹¹⁹ See *id.*

¹²⁰ See Grinspoon & Bakalar, *supra* note 3. "Because it is difficult to titrate a therapeutic dose of [Marinol], . . . it is not widely prescribed." Kassirer, *supra* note 85. Of more than 1,000 responding oncologists in a 1990 random sample of American Society of Clinical Oncology members, 44% had recommended marijuana and of those who had enough information to make a comparison felt that marijuana was more effective than Marinol while 13% felt the synthetic drug was superior to marijuana. See Annas, *supra* note 7.

¹²¹ See Grinspoon & Bakalar, *supra* note 3.

[Marijuana] has little effect on major physiological functions. There is no known case of a lethal overdose; on the basis of animal models, the ratio of lethal to effective dose is estimated as 40,000 to 1. By comparison, the ratio is between 3 and 50 to 1 for secobarbital and between 4 and 10 to 1 for ethanol.

Id. Also, as a matter of contrast, consider narcotic analgesics (pain relievers) including codeine and morphine—medical directives indicate that overdosing (even by simple double dosing) or the consumption of alcohol or other central nervous system depressants in conjunction with one of those narcotics could lead to death. See OnHealth, drug databases, Percodan (last visited Oct. 7, 2000) <onhealth.com/conditions/resource/pharmacy/multum0/item,73067.asp>.

¹²² See opening statement of Stanley J. Watson, *supra* note 112.

¹²³ See Grinspoon & Bakalar, *supra* note 3. However, this commentary notes that "[a]t present, the greatest danger in medical use of marijuana is its illegality, which imposes much anxiety and expense on suffering people, forces them to bargain with illicit drug dealers, and exposes them to the threat of criminal prosecution." *Id.*

¹²⁴ See opening statement of Stanley J. Watson, *supra* note 112.

¹²⁵ See *id.*

¹²⁶ See *id.* In fact, marijuana is "far less addictive and far less subject to abuse than many drugs now used as muscle relaxants, hypnotics, and analgesics." Grinspoon & Bakalar, *supra* note 3. Patients using narcotic analgesics such as morphine are warned not to suddenly stop taking the medicine after even several weeks of use without first checking with their doctor who may need to reduce the dosage gradually to lessen the chance of side effects caused by withdrawal. See OnHealth, drug databases, Percodan, *supra* note 121.

of medical marijuana use, the IOM study found that while marijuana use often precedes the use of hard drugs among abusers, nothing in marijuana leads to this progression.¹²⁷ Another study cited in the *New England Journal of Medicine* indicates that marijuana use is not a gateway to hard drug use by children, and moreover, research indicates that there is no evidence that use of the drug would increase in the general population if marijuana was legalized for medicinal purposes and regulated like other medications, including cocaine.¹²⁸

IV. RECOMMENDATIONS

The federal government's cited concern with the use of medical marijuana under state legislation, such as that enacted by California's Proposition 215, is that ideology has won out over true science—that the federal government will not reclassify marijuana as a Schedule II drug unless the DEA's following five criteria are met:

- (1) The drug's chemistry must be known and reproducible.
- (2) There must be adequate safety studies.
- (3) There must be adequate and well-controlled studies proving efficacy.
- (4) The drug must be accepted by qualified experts.
- (5) The scientific evidence that the drug has a currently accepted medical use must be widely available.¹²⁹

The federal government's current policy—waging war on physicians recommending and patients using marijuana—is going to get us nowhere. Without large-scale clinical studies, the therapeutic benefits of marijuana can neither be supported adequately to justify the drug's rescheduling nor can they be debunked, thereby reinforcing the government's proposition that this drug should remain in Schedule I.

Science over ideology is a very legitimate government position—the federal government, however, controls the keys to that science. Clinical trials are based on reproducible effects; therefore, the drug's chemistry must be consistent. True clinical trials cannot be conducted under programs such as California's, where individuals grow their own plants—the plant quality is simply too variable. Therefore, the federal government must mandate the use of marijuana grown under federal contract—plants grown under the same or similar biologic conditions. This sounds expensive, especially considering that \$250,000 is spent annually on the Acapulco Eight. It does not have to be free; patients can be required to pay their own way.¹³⁰

¹²⁷ See opening statement of Stanley J. Watson, *supra* note 112.

¹²⁸ See *id.*; Annas, *supra* note 7. The 1994 survey pointed out how statistics can be manipulated, noting: that 17 percent of current marijuana users said they had tried cocaine and only 0.2 percent of those who had not used marijuana had tried cocaine. One way to interpret these data is that children who smoke marijuana are 85 times as likely as others to try cocaine; another is that 83 percent of pot smokers, or five out of six, never try cocaine.

Id. Writing about the possibility that allowing marijuana for medical use would send the wrong message to children, *Boston Globe* columnist Ellen Goodman asked “[w]hat is the infamous signal being sent to [children]? . . . If you hurry up and get cancer, you, too, can get high?” *Id.*

¹²⁹ See Margolis, *supra* note 11, at 21.

¹³⁰ Under the Oregon Medical Marijuana Act program, patients pay a \$150 fee just to register for the program. This does not include the subsequent cost of marijuana.

Temporarily rescheduling marijuana as a Schedule II drug, the DEA could mandate labeling and packaging requirements currently applied to other Schedule II drugs. In addition, a registration program similar to that introduced in Oregon could be established.¹³¹ The holder of a registration card, with properly labeled marijuana, would be distinguished easily from an unauthorized user, thereby eliminating the possibility of confusion in the enforcement community. Availability of the contractor-produced drug also would eliminate the need for homegrown marijuana. The states then could restore criminal status to such production and disallow the medical necessity defense for possession of non-regulated marijuana.

As a Schedule II drug, with patients and researchers using biologically consistent material, legitimate clinical trials evaluating the therapeutic and psychological effects of cannabinoids could be completed in accordance with the IOM investigators' recommendations. Aimed at developing "rapid-onset, reliable, and safe delivery systems,"¹³² a successful product of these trials would eliminate another government concern, the smoking of marijuana. Eliminating smoked marijuana has a twofold benefit: 1) it eliminates the risk of cancer associated with marijuana combustibles; and 2) it addresses the federal government's concern that American youth will be confused into thinking that smoked marijuana is not harmful because it is used medicinally.

Others have recommended built-in sunset provisions when studies are completed for each disease.¹³³ Absent evidence indicating marijuana's effectiveness in alleviating symptoms of that specific ailment, the sunset provision would remove the disease from the list of approved medical uses, thereby canceling a physician's authorization to prescribe marijuana for the illness.

Following these recommendations should satisfy the government's science base requirement, namely the five criteria required for rescheduling. Although these recommendations in no way guarantee rescheduling, they do provide for a known and reproducible drug that will be studied safely and in well-controlled conditions. From these studies, qualified experts should be able to review verifiable information and determine if marijuana's components have a "currently accepted medical use."

Unfortunately, the current House bill providing for the medical use of marijuana¹³⁴ appears to fall short of requirements necessary to satisfy the DEA. The bottom line is that the bill, while rescheduling marijuana from Schedule I to II, allows for the very tenuous "recommendation" language of Proposition 215. The bill provides that no provision of the CSA or Federal Food, Drug, and Cosmetic Act will apply to the "prescription or recommendation" of marijuana by a physician for medical use.¹³⁵ The larger weakness is that while the National Institute of Drug Abuse is to make marijuana available for an IND study,¹³⁶ it fails to require that all prescribed or recommended marijuana come from a source with known biological purity and consistency. With this bill, we miss out on the opportunity to evaluate a very large study group and a myriad of ailments treated with regulated marijuana, instead relying solely on smaller-scale IND research.

¹³¹ See *id.*

¹³² Mike Mitka, *Therapeutic Marijuana Use Supported While Thorough Proposed Study Done*, JAMA, Medical News & Perspectives (last visited Nov. 12, 1999) <jama.ama-assn.org/issues/v281n16/ffull/jmn0428-1.html>.

¹³³ See McGuire, *supra* note 5, at 97.

¹³⁴ See H.R. 912, 106th Cong. (1999).

¹³⁵ See *id.* §§ (2)(a)(B)(1), (3)(a)(1).

¹³⁶ See *id.* § (4).

V. CONCLUSION

The federal government proclaims a science-over-ideology policy concerning the approval of new drugs; however, in the case of medical marijuana, it is apparent that politically motivated ideology is interfering with true science. Characterizing the federal government's response to California's Proposition 215, one author notes that the Administration's actions were not based "on rational medical discourse, but instead on a desire to achieve a rhetorical political advantage over those people who might criticize the administration for being 'soft on drugs.'"¹³⁷

Turning an apparent blind eye to the fact that over half of the states, and the federal government itself, have therapeutic programs, and state judicial interpretation allowing the necessity defense in many instances, the federal government's policy appears to foster ignorance of the possibilities for the therapeutic value of marijuana components in favor of appearing strong in the war against drugs. We travel to the ends of the world and expound the benefits of saving the uncharted rainforests because of the potential for medical uses developed from the plant life. We recognize the medicinal value of narcotics, including cocaine and opium, but we try to bury the medically-beneficial use of marijuana components because of a decades-old counter-cultural clash. It is time for a cease-fire, time to re-allocate resources to evaluate the science behind marijuana, and time to set aside the stigma.

¹³⁷ Dixon, *supra* note 2, at 980.

