Drug Policy Forum of Kansas

Medical Marijuana Briefing Paper
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Excerpt from the Congressional Research Services, Report for Congress, *Medical Marijuana: Review and Analysis of Federal and State Policies* by Mark Eddy, updated January 13, 2006. Order code RL33211 from the Library of Congress.

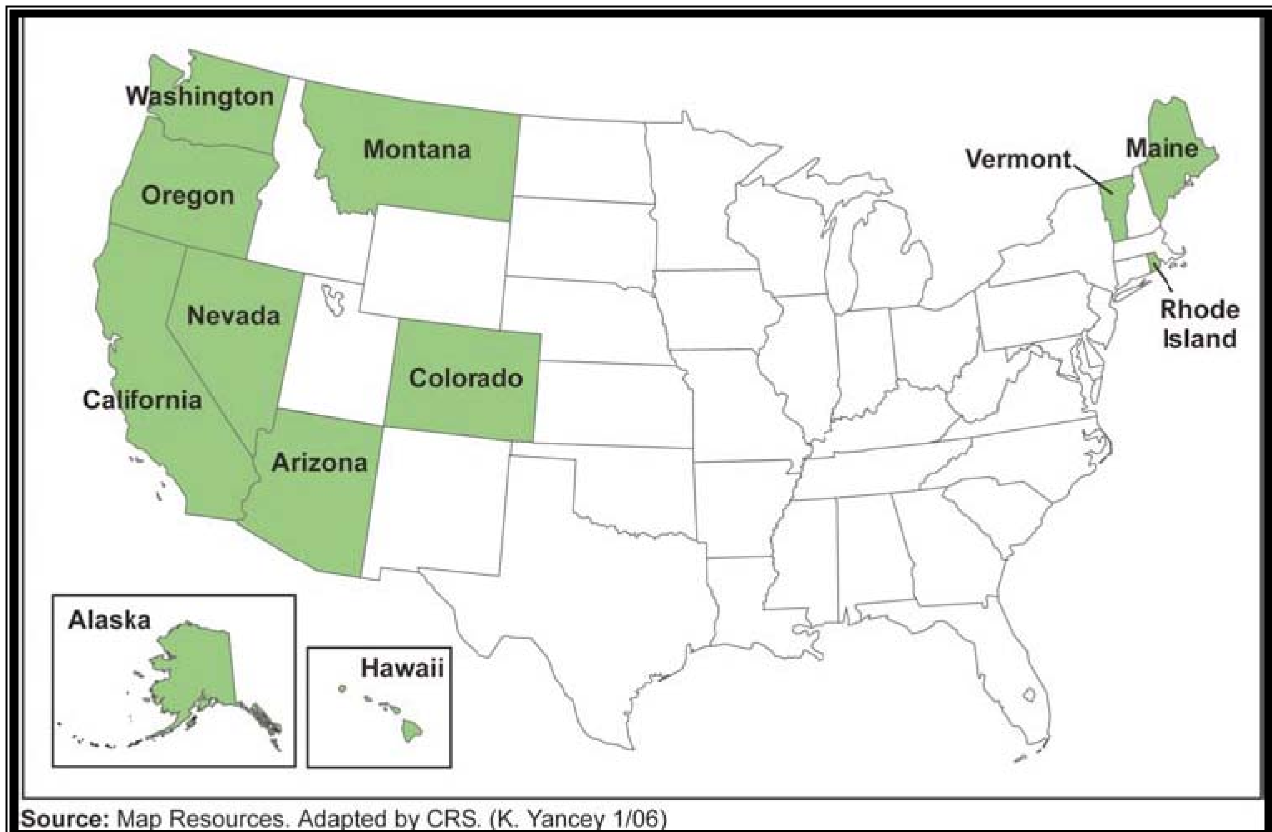
States Allowing Use of Medical Marijuana

Twelve states, covering about 22% of the U.S. population, have enacted laws to allow the use of cannabis for medical purposes. Maryland passed a medical necessity defense bill in '03.

These states have removed state-level criminal penalties for the cultivation, possession, and use of medical marijuana, if such use has been *recommended* by a medical doctor.

All of these states (except Arizona) have in place, or are developing, programs to regulate the use of medical marijuana by approved patients.

Patients in state programs may be assisted by caregivers, persons who are authorized to help patients grow, acquire, and use the drug.



Source: Map Resources. Adapted by CRS. (K. Yancey 1/06)

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Physicians in these states are immune from liability and prosecution for discussing or recommending medical cannabis to their patients in accordance with the law.

The state medical marijuana programs do, however, contravene the federal prohibition of marijuana. Medical marijuana patients, their caregivers, and other marijuana providers can, therefore, be arrested by federal law enforcement agents, and they can be prosecuted under federal law.

Marijuana Effectively Treats the Symptoms of Some Diseases

Proponents of medical marijuana point to a large body of reports and journal articles from around the world that support the therapeutic value of marijuana in treating a variety of disease-related problems, including:

- relieving nausea
- increasing appetite
- reducing muscle spasms and spasticity
- relieving chronic pain
- reducing intraocular pressure, and
- relieving anxiety

Given these properties, marijuana has been used successfully to treat the debilitating symptoms of the following:

- cancer and cancer chemotherapy
- AIDS
- multiple sclerosis
- epilepsy
- glaucoma
- anxiety
- and other serious illnesses such as arthritis, migraine, menstrual cramps, alcohol and opiate addiction, and depression and other mood disorders.

Statistics on Medical Marijuana Users

Determining exactly how many patients use medical marijuana with state approval is difficult. According to a 2002 study published in the *Journal of Cannabis Therapeutics*, an estimated 30,000 California patients and another 5,000 patients in eight other states possessed a physician's recommendations to use cannabis medically.

More recent estimates are much higher. The *New England Journal of Medicine* reported in August 2005, for example, that an estimated 115,000 people have obtained marijuana recommendations from doctors in the states with programs.

Public Opinion on Medical Marijuana

Voters have approved every medical marijuana initiative that has appeared on state ballots. Likewise, American public opinion has consistently favored access to medical marijuana by seriously ill patients. ProCon.org, a nonprofit and nonpartisan public education foundation, has identified 21 national public opinion polls that asked questions about medical marijuana from 1995 to the present. Respondents in every poll were in favor of medical marijuana by substantial margins, ranging from 60% to 80%.

Executive Branch Actions and Policies

IND Compassionate Access Program (1978). In 1975, a Washington, DC, resident was arrested for growing marijuana to treat his glaucoma. He won his case by using the medical necessity defense, forcing the government to find a way to provide him with his medicine. In 1978, FDA created the Investigational New Drug (IND) Compassionate Access Program, allowing patients whose serious medical conditions could be relieved only by marijuana to apply for and receive marijuana from the federal government.

Over the next 14 years, other patients, less than 100 in total, were admitted to the program for conditions including chemotherapy-induced nausea and vomiting (emesis), glaucoma, spasticity, and weight loss.

Then, in 1992, in response to a large number of applications from AIDS patients, the George H.W. Bush Administration closed the program to all new applicants.

Eight people remain in the program today and continue to receive their monthly supply of government-grown medical marijuana (300 cigarettes/month).

Approval of Marinol (1985). Marinol is the only cannabis-based drug approved by FDA for use in the United States. Made by Unimed, Marinol is the trade name for dronabinol, a synthetic form of delta-9-tetrahydrocannabinol (THC), one of the principal psychoactive components of botanical marijuana. It was approved in May 1985 for nausea and vomiting associated with cancer chemotherapy in patients who fail to respond to conventional antiemetic treatments.

In December 1992, it was approved by FDA for the treatment of anorexia associated with weight loss in patients with AIDS. Marketed as a capsule, Marinol was originally placed in Schedule II. In July 1999, in response to a rescheduling petition from Unimed, it was moved administratively by DEA to Schedule III to make it more widely available to patients.

DEA's Administrative Law Judge Ruling (1988). Congressional passage of the Controlled Substances Act in 1970 and its placement of marijuana in Schedule I provoked controversy at the time because it strengthened the federal policy of marijuana prohibition and forced medical marijuana users to buy marijuana of uncertain quality on the black market at inflated prices,

subjecting them to fines, arrest, court costs, property forfeiture, incarceration, probation, and criminal records.

These concerns prompted a citizens' petition to the Bureau of Narcotics and Dangerous Drugs (BNDD) in 1972 to reschedule marijuana and make it available by prescription. The petition was summarily rejected.

This led to a long succession of appeals, hearing requests, and various court proceedings. Finally, in 1988, after extensive public hearings on marijuana's medicinal value, the chief administrative law judge of the Drug Enforcement Administration (the BNDD's successor agency) found that "the provisions of the [Controlled Substances] Act permit and require the transfer of marijuana from schedule I to schedule II," which would recognize its medicinal value and permit doctors to prescribe it. The Judge's findings and recommendation were soon rejected by the DEA Administrator because "marijuana has not been demonstrated as suitable for use as a medicine."

NIH-Sponsored Workshop (1997). NIH convened a scientific panel on medical marijuana composed of eight nonfederal experts in fields such as cancer treatment, infectious diseases, neurology, and ophthalmology.

Over a two-day period they analyzed available scientific information on the medical uses of marijuana and concluded that "in order to evaluate various hypotheses concerning the potential utility of marijuana in various therapeutic areas, more and better studies would be needed."

Research would be justified, according to the panel, into certain conditions or diseases such as pain, neurological and movement disorders, nausea of patients undergoing chemotherapy for cancer, loss of appetite and weight related to AIDS, and glaucoma.

Institute of Medicine Report (1999). In January 1997, shortly after passage of the California and Arizona medical marijuana initiatives, the Director of the Office of National Drug Control Policy (the federal drug czar) commissioned the Institute of Medicine (IOM) of the National Academy of Sciences to review the scientific evidence on the potential health benefits and risks of marijuana and its constituent cannabinoids.

Begun in August 1997, IOM's 257-page report, *Marijuana and Medicine: Assessing the Science Base,* was released in March 1999. A meta-analysis of all existing studies of the therapeutic value of cannabis, the IOM Report was also based on public hearings and consultations held around the country with biomedical and social scientists and concerned citizens. For the most part, the IOM Report straddled the fence and provided sound bites for both sides of the medical marijuana debate.

In general, the report emphasized the need for well-formulated, scientific research into the therapeutic effects of marijuana and its cannabinoid components on patients with specific disease conditions. To this end, the report recommended that clinical trials be conducted with the goal of developing safe delivery systems.

DEA Enforcement Actions against Cannabis Buyers' Clubs. Most arrests in the United States for marijuana possession are made by state and local police, not the DEA.

Federal agents do, however, move against medical cannabis growers and distributors in states with medical marijuana programs. In recent years, more than 20 large-scale raids of cannabis buyers' clubs have occurred in California, and a handful of raids have taken place in other states. DEA's actions to shut down medical marijuana growing and distribution operations have provoked lawsuits and other responses.

Medical Cannabis in the Courts: Major Cases

U.S. v. *Oakland Cannabis Buyers' Cooperative* (2001). The U.S. Department of Justice filed a civil suit in January 1998 to close six medical marijuana distribution centers in northern California. A U.S. district court judge issued a temporary injunction to close the centers, pending the outcome of the case.

The Oakland Cannabis Buyers' Cooperative fought the injunction but was eventually forced to cease operations and appealed to the Ninth Circuit Court of Appeals. At issue was whether a medical marijuana distributor can use a medical necessity defense against federal marijuana distribution charges.

The Ninth Circuit's decision found in September 1999 that "medical necessity" is a valid defense against federal marijuana trafficking charges if a trial court finds that the patients to whom the marijuana was distributed are seriously ill, face imminent harm without marijuana, and have no effective legal alternatives.

The Justice Department appealed to the Supreme Court. The Supreme Court held, 8-0, that "a medical necessity exception for marijuana is at odds with the terms of the Controlled Substances Act" because "its provisions leave no doubt that the defense is unavailable."

This decision had no effect on state medical marijuana laws, which continued to protect patients and primary caregivers from arrest by state and local law enforcement agents in the states with medical marijuana programs.

Conant v. *Walters* (2002). After the 1996 passage of California's medical marijuana initiative, the Clinton Administration threatened to investigate doctors and revoke their licenses to prescribe controlled substances and participate in Medicaid and Medicare if they recommended medical marijuana to patients under the new state law.

A group of California physicians and patients filed suit in federal court, early in 1997, claiming a constitutional free-speech right, in the context of the doctor-patient relationship, to discuss the potential risks and benefits of the medical use of cannabis.

A preliminary injunction, issued in April 1997, prohibited federal officials from threatening or punishing physicians for recommending marijuana to patients suffering from HIV/AIDS, cancer, glaucoma, or seizures or muscle spasms associated with a chronic, debilitating condition.

The court subsequently made the injunction permanent in an unpublished opinion. On appeal, the Ninth Circuit affirmed the district court's order entering a permanent injunction.

The federal government, the opinion states, "may not initiate an investigation of a physician solely on the basis of a recommendation of marijuana within a bona fide doctor-patient relationship, unless the government in good faith believes that it has substantial evidence of criminal conduct."

The first Bush Administration appealed, but the Supreme Court refused to take the case.

Gonzalez v. *Raich* (2005). In response to DEA agents' destruction of their medical marijuana plants, two patients and two caregivers in California brought suit. They argued that applying the Controlled Substances Act to a situation in which medical marijuana was being grown locally for no remuneration in accordance with state law exceeded Congress's authority under the Commerce Clause.

In December 2003, the Ninth Circuit Court of Appeals in San Francisco agreed, ruling that states are free to adopt medical marijuana laws so long as the marijuana is not sold, transported across state lines, or used for non-medical purposes.

Federal appeal sent the case to the Supreme Court. The issue before the Supreme Court was whether the Controlled Substances Act, when applied to the *intra*state cultivation and possession of marijuana for personal use under state law, exceeds Congress's power under the Commerce Clause.

The Supreme Court, in June 2005, reversed the Ninth Circuit's decision and held, in a 6-3 decision, that Congress's power to regulate commerce extends to purely local activities that are "part of an economic class of activities that have a substantial effect on interstate commerce." *Raich* does not invalidate state medical marijuana laws.

Although *Raich* was not about the efficacy of medical marijuana or its listing in Schedule I, the majority opinion stated in a footnote: "We acknowledge evidence proffered by respondents in this case regarding the effective medical uses for marijuana, if found credible after trial, would cast serious doubt on the accuracy of the findings that require marijuana to be listed in Schedule I."

The majority opinion, in closing, notes that in the absence of judicial relief for medical marijuana users there remains "the democratic process, in which the voices of voters allied with these respondents may one day be heard in the halls of Congress."

Thus, the Supreme Court reminds that Congress has the power to reschedule marijuana, thereby making it available to patients. Congress, however, does not appear likely to do so. In the meantime, actions taken by state and local governments continue to raise the issue.