Medical Marijuana: Change in the Air?

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Controversy has swirled around the topic of medical marijuana, or medicinal cannabis, for decades.¹ Current federal and (some) state efforts to curtail or prevent use of marijuana for either personal medical or recreational purposes must contend with the widespread use of the substance and the fact that the pot industry really is just that – an industry - in states such as California.² In fact, marijuana is a major cash crop on the West coast of the U.S. as well as the fulcrum of a sub-culture which has roots on both coasts, Texas,³ and the Caribbean. The use of marijuana for medicinal as opposed to purely recreational purposes, however, is a more recent phenomenon. Recently publicized proposals range from conducting more clinical research into potential uses to outright legalization of marijuana without any restrictions.

State and Federal Approaches May Differ

Marijuana for personal recreational or medical use remains illegal under federal law. Marijuana is not currently an approved prescription or over-the-counter drug in the U.S., and is classified as a Schedule I substance⁴ by the U.S. Drug Enforcement Agency (DEA) as well as by the individual states. Drugs in this Schedule are those that have no accepted medical use in the U.S., lack accepted safety for use in treatment under medical supervision, and have a high abuse potential. However, as with some Schedule I substances such as LSD, these drugs may be available to physicians for investigational purposes if they are going to be used in carefully-controlled, federally-approved clinical research trials.

The classification of drugs into the different schedules used by the DEA is somewhat arbitrary. For example, alcoholic beverages account for thousands of deaths directly from alcohol-related liver disease from consumption of hard liquor, yet alcohol (a substance which is clearly a drug) does not appear in any of the five Schedules for classification of drugs. And cigarettes, which are nothing more than a medical device for delivering the addictive drug substance nicotine,⁵ annually result in more women in the U.S. developing lung cancer than breast cancer and can be purchased from a vending machine by anyone in a bar. Yet both of these drugs are legal, potentially lethal, and are regulated by the same federal agency which regulates firearms.

² David Samuels, Dr. Kush. How medical marijuana is transforming the pot industry, THE NEW YORKER, July 28, 2008.
³ Texas cultural icons such as Willie Nelson have made no secret of the fact that they are frequent users of marijuana for recreational purposes.
⁴ TEXAS HEALTH & SAFETY CODE § 481.031-481.038.
Individual states may embrace the entire federal regulatory matrix used for classification of all controlled substances, or alternatively may treat some substances such as marijuana differently. As of 2008 eleven states had legalized medicinal use of marijuana even though the DEA and the Director of National Drug Control Policy John P. Walters opposed those laws. This difference in drug laws is a classic confrontation between states’ rights (efforts to regulate public health under state police power) and federal supremacy, and has resulted in notable clashes in federal court as well as several substantive legal reviews on the subject.

Previous efforts by California physicians to circumvent federal laws proscribing non-investigational use of marijuana for medical reasons were defeated in *Gonzales v. Raich*, in which the Supreme Court held that the dispensing of new, unapproved drugs (in this case Cannabis) had to await federal approval even when both the physicians and an individual state approved their use for medical purposes. Specifically, the Court held that the plaintiffs did not have a fundamental right to use medical marijuana as a form of medical treatment.

**Federal Law: Shifting From Strict Enforcement to Enforcement Discretion**

Federal legislative regulation of marijuana has varied over the years, depending on the political and social winds blowing at the time. Under the George W. Bush administration, “federal authorities maintained that federal marijuana laws took precedence over state law, even in states that had approved therapeutic cannabis.” The difference between current federal and some state laws on the legal status of marijuana has created a split in the enforcement of federal law in a uniform manner in the U.S. More relaxed state laws in states such as California have placed DEA officers in the unenviable position of using federal law to close down “smoke shops” in communities and states where medical marijuana is sold by prescription and local law officials would prefer to look away.

The disconnect between the way individual states and the federal government approach the issue of medical marijuana is also seen at the executive as well as the judicial and legislative levels. Pot politics during the past decade managed to inject the U.S. Food and Drug Administration into the fierce political fight surrounding medical marijuana when FDA issued a statement in 2006 that “no sound scientific studies” supported the

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8 *Gonzales v. Raich*, 545 U.S. 1 (2005).
9 Id.
12 Harris, *supra* note 6.
medical use of marijuana despite the existence of a 1999 review by a panel of highly regarded scientists which reached exactly the opposite conclusion.¹⁴

During the Presidential campaign, then-Senator Obama indicated that he supported the controlled use of marijuana for medical purposes, stating that he saw no difference between marijuana and other drugs used to control pain as well as other symptoms.¹⁵ It would appear that President Obama is going to keep his word on this issue. In a sign that the political winds on marijuana use are going to shift once again, at least as far as medicinal use of marijuana is concerned, the Obama administration has indicated that its new DEA chief will be shifting federal medical marijuana enforcement policy to bring them more in line with state laws.¹⁶ There already signs that the commercial market for medical marijuana has seen a significant increase in volume since Obama took office.¹⁷

The net effect of this will be to minimize the clash between state and federal law over the legal status of marijuana, permit more medical marijuana prescribing and more clinical investigation. It will also allow scarce enforcement resources to combat more serious illegal drug problems such as heroin and cocaine. In short, the U.S. will move closer to the Canadian approach to medical marijuana than it has for the past several decades. There will likely be some spillover into enforcement actions on recreational use of the drug as well, or at least respect for local and state laws downgrading possession of small amounts of the drug for personal use to misdemeanor status.¹⁸

Evidence to Support Evolution of Medical Marijuana Policy

Widespread publicity about the potential medical benefits of medical marijuana notwithstanding, the data in the established, peer-review medical literature which conclusively establishes the benefits of cannabis or its main component, THC, for treatment of recognized medical conditions such as glaucoma, intractable migraines, or nausea and vomiting associated with chemotherapy is robust.¹⁹ By consensus (though not unanimous), marijuana appears to demonstrate some definite benefit for some patients who fail conventional drug therapies.²⁰ And, contrary to conventional wisdom that chronic marijuana use is without deleterious side effects, medical evidence has accumulated over the past several years indicating that marijuana, like cigarettes, may raise the risk of the individual user for some cancers.²¹

¹⁵ Alexander, supra note 10.
¹⁶ Devlin Barrett, Change in air for medical marijuana use. Obama’s new DEA chief expected to shift policies to meet state laws, THE HOUSTON CHRONICLE, February 8, 2009 at A16.
¹⁷ Alexander, supra note 10.
¹⁸ U.S. GOVERNMENT ACCOUNTING OFFICE (GAO), MARIJUANA: EARLY EXPERIENCES WITH FOUR STATES’ LAWS THAT ALLOW USE FOR MEDICAL PURPOSES, GA)-03-189, NOVEMBER 1, 2002.
²⁰ Id.
Federal government policy towards medical marijuana may take one of three possible paths: (1) a prohibitionist position which essentially adheres to the theory that marijuana has no generally accepted medical benefits; (2) withholding federal approval until a consensus is reached in both the medical and political communities about the benefits of medicinal marijuana; or (3) a more proactive approach which de facto acknowledges that medical marijuana has some defined benefits and acknowledges some degree of legal rights of seriously ill individuals to use marijuana as a legitimate form of medical treatment. The recent Bush administration clearly took the first approach which resulted in some individual states taking matters into their own hands. The Obama administration appears to be leaning toward the second approach.

The Canadian government has moved towards the third approach for the past decade. The impetus for the shift in position by the Canadian government was a concerted push by patients seeking legal access to marijuana for medicinal uses in the Canadian courts. Canadian courts looked favorably upon the notion of a medical exception to blanket federal prohibition against the use of marijuana, and in a series of cases threatened to strike down the prohibition against marijuana altogether if the government did not comply. The end result of the dialogue among patients, physicians, Province courts, and the central government was a recognized due process right of severely ill patients to use medical marijuana for certain medical conditions as well as a legal means to purchase the drug from a limited number of government-approved central suppliers.

The U.S. government may not quite be at the point where there will be a push to legalize medical marijuana and mimic the Canadian government’s approach; in the current political climate merely changing the level of DEA enforcement discretion may be the best compromise, and the most medical marijuana advocates can hope for. U.S. federal courts have a long history of preferring federal regulation of unapproved drugs over local state regulations, and the recent en banc 2nd Circuit Court of Appeals decision in Abigail Alliance v. von Eschenbach again reaffirmed the notion that terminally ill patients do not have a fundamental Constitutional right to obtain access to unapproved drugs. Federal courts in the U.S. have generally been less receptive to arguments by consumer advocates on access to experimental and unapproved drug therapy than their colleagues across our northern border, and there is no sign that this difference is likely change for the foreseeable future.


24 Gonzales v. Raich, supra note 8.