

Clearing the air: What the latest Supreme Court decision regarding medical marijuana really means

Sunil Aggarwal, BS, BA
Gregory T. Carter, MD
Jeffrey J. Steinborn, LLb

In June, the US Supreme Court handed down its 6-3 decision against Angel Raich and Diane Monson.¹ The Court ruled that the federal government can prohibit even intrastate and noncommercial marijuana possession and cultivation under the rubric of “interstate commerce.” In the prior Supreme Court ruling, *United States vs. the Oakland Cannabis Buyers’ Cooperative*,² the Court ruled that “medical necessity” is not a legal defense for the possession, manufacture, or distribution of marijuana, and

that the federal law classifying marijuana as illegal has no exemption for ill patients. Although the latest decision did not address medical necessity or due process arguments, Justice Stevens, who wrote the majority opinion, did add at the end of Section I, “The case is made difficult by respondents’ strong arguments that they will suffer irreparable harm because, despite a congressional finding to the contrary, marijuana does have valid therapeutic purposes.”³

One week after the Supreme Court ruling, the US House of Representatives rejected an amendment prohibiting the federal government from undermining state medical marijuana laws. However, the bill received 13 more votes than last year, indicating growing support for patients. The Supreme Court ruling and the subsequent defeat in Congress brought

much angst to many ill people currently using medical marijuana. Fortunately, for those living in states that allow the use of medical marijuana, this ruling does not overturn state law.

Nearly all of the roughly 750,000 annual marijuana arrests in the United States are made by state and local officials. States are not required to have laws that are identical to federal law nor are they required to enforce federal laws. California Attorney General Bill Lockyer plainly stated this in a recent statement from his office: “The federal government cannot force state officials to enforce federal laws.”⁴ Although federal authorities retain the power to target patients and providers, state lawmakers should redouble their efforts to move forward with legislation to protect patients from arrest and jail. In addition, states without medical marijuana laws are still free to enact them. Following the

Sunil Aggarwal, BS, BA, University of Washington, Department of Medicine and Department of Geography, Seattle, Washington.

Gregory T. Carter, MD, Clinical Professor of Rehabilitation Medicine, University of Washington, School of Medicine, Seattle, Washington.

Jeffrey J. Steinborn, LLb, Law Offices of Jeffrey Steinborn, Seattle, Washington.

Raich decision, for example, Rhode Island's state legislature passed a law allowing the use of medical marijuana, although it was immediately vetoed by the Governor. The veto was then overturned by the Rhode Island Senate, and a House vote is pending.

We certainly acknowledge that marijuana is neither a miracle compound nor the answer to everyone's ills. Yet it does not deserve the tremendous legal and societal commotion that has occurred over it. Over the past 30 years, the United States has spent over a trillion dollars in an effort to stem the use of illicit drugs,⁵ including marijuana, with limited success. Some very ill people have had to fight long court battles to defend themselves for the use of a compound that has effectively treated a medical condition and alleviated suffering for them.

There is no evidence that nonmedically sanctioned marijuana use has increased in states that have allowed for its medicinal use. Moreover, prohibition strategies have never proven effective at limiting the use of a substance for any reason, whether alcohol or other compounds. The US Drug Enforcement Administration (DEA) frequently mentions that more people are "seeking" treatment for marijuana addiction but fails to mention that this is court-mandated and can be coercively forced on individuals after a first offense in some states.⁶ The DEA also likes to proclaim that marijuana is stronger today than it was during the "summer of love" (circa 1967). However, it fails to mention that doctors can prescribe dronabinol (Marinol), a 100 percent pure synthetic delta nine-tetrahydrocannabinol (THC). Most patients find dronabinol too sedating. It is the most psychoactive form of cannabinoid, yet the DEA categorizes it as a schedule III drug, meaning physicians can phone in a prescription. Despite its strength, dronabinol has never caused a death or even a life-threatening side effect. The DEA's own administrative law judge, the Honorable Francis Young, stated in 1988, "Marijuana is the safest

therapeutically active substance known to man The evidence clearly shows that marijuana is capable of relieving the distress of great numbers of very ill people, and doing so with safety under medical supervision, it would be unreasonable, arbitrary, and capricious for the DEA to continue to stand between those sufferers and the benefits of this substance" (pp. 67-68).⁷ Regardless of these conclusions, over a decade and a half later, the DEA and the rest of the federal government persist in their policy of total prohibition.

Marijuana is still federally classified as a Schedule I substance having "no currently accepted medical use in treatment in the United States." But given the wide medical and legal support for marijuana in many countries, in 11 states, and by many US public health and medical groups; and given the results of several recent national polls conducted by *Time*, Zogby International, and others showing that 68-80 percent of the American public supports medical marijuana,^{8,9} the question is this: By whose criteria is marijuana not an "accepted medical treatment?"

The purpose of this editorial is not to debate the pros and cons of medical versus nonmedically sanctioned marijuana use. That is a separate and altogether different topic. In our opinion, the medical marijuana user should not be considered a criminal in any state. Rational minds need to drive drug policy, separating myth from fact, right from wrong, and responsible medicinal use from other uses. Despite overwhelming scientific evidence of medical benefit, Drug Czar John Walters commented after the Supreme Court ruling, "I don't doubt that some people feel better when they use marijuana, but that's not modern science. That's snake oil."¹⁰ But isn't the very definition of palliative care the abatement of suffering—i.e., making patients "feel better"?

The Office of National Drug Control Policy continues to scour the medical literature for evidence of an untoward

effect of cannabis, recently pointing to a study linking marijuana use and schizophrenic symptoms.¹¹ That study was flawed, however, as none of the subjects were randomly assigned to smoke cannabis. Thus, pre-existing conditions may have led people towards cannabis use, which is the likely explanation for the findings. In addition, most studies purporting to show a link between marijuana and psychosis assess symptoms, not the disorder. Symptom checklists and questionnaires include items that might fit the features of cannabis-induced altered states of consciousness in a setting of legal prohibition (paranoia, deviant thoughts, etc.), but the researchers often fail to state that people should not include any drugged experiences when responding to questions. The questions also often include items that anyone who engages in a deviant behavior like cannabis use would have to endorse even if they had no psychotic symptoms. As Mirken and Earleywine¹² state in their letter in response to this study, "Someone using a substance that is both illegal and socially frowned upon almost by definition has 'ideas or beliefs that others do not share.' This is not a sign of mental illness, but rather an indication of a rational, thinking person realistically assessing his or her situation. Considering the widespread use of undercover officers in drug stings, the same can be said for 'feeling other people cannot be trusted.'"

Even the oft-trumpeted evidence that cannabis smoke causes precancerous lesions in the upper respiratory tract has been refuted by a team that included the investigators who originally reported these findings.¹³ Cannabis smoke can be avoided altogether with the highly effective delivery method of vaporization, in which the traditional combustion approach is substituted for a stream of hot air that delivers the active chemicals in a fine vapor mist.

We now know that cannabinoid receptors exist in many areas of the body and endogenous cannabinoids appear to

regulate many systems in the body, including analgesia, muscle relaxation, bronchodilation, appetite stimulation, and sleep induction, among others. The scientific community continues to evaluate the therapeutic effects of marijuana through ongoing research and assessment of available data. With regard to the medicinal use of marijuana, our legal system should take a similar approach, using science and logic as the basis of policy rather than political views and societal trends that are more reflective of the ongoing debate over potential harmful effects of marijuana outside of the doctor-patient relationship. Marijuana has remarkably low toxicity, and lethal doses in humans have not been described. This is in stark contrast to a number of other commonly prescribed medications used for similar purposes, including opiates, antiemetics, antidepressants, and muscle relaxants, not to mention widely used legal substances such as tobacco and alcohol, whose lethality potential with misuse is routinely documented in autopsy reports and death certificates.

A final word of caution: Given the current administration's track record of aggressive political stands, it would not be unrealistic to predict that someone using or providing marijuana for medicinal purposes will be arrested somewhere along the line to send a strong message, both to patients and states, that the Supreme Court ruling should be taken seriously. Justice Department spokesman John Nowacki would not say whether prosecutors would pursue cases against individual users, but on the day of the Supreme Court ruling, DEA Chief Karen Tandy was quoted as saying, "We don't target sick and dying people."¹⁴ For the present, physicians should take great care when discussing medical marijuana with their patients and be sure they understand the state and local laws governing what they can safely say and what patients can legally possess and use. The First Amendment right to free speech and the privacy of

the doctor-patient relationship still protect physicians who recommend medical marijuana use to their patients, as the Ninth Circuit Federal Court ruled in *Conant v. Walters*¹⁵ and which the Supreme Court let stand.

As with any medication, proper documentation of the risks and benefits and any other requirements mandated by local laws must be clearly noted in the medical record. Physicians must be careful not to let their enthusiasm, frustration, and concern for suffering cause them to be careless when taking advantage of any law allowing their patients to use medical marijuana. Physicians who frequently authorize the therapeutic use of marijuana could potentially be investigated by federal authorities for compliance, even in the form of an undercover agent disguised as a patient. It is worth noting that no physician has yet lost his or her license to prescribe medications or has been prosecuted federally for authorizing the medicinal use of marijuana. At the state level, compliance with the terms of the local law allowing medicinal use of marijuana continues to protect physicians who authorize such uses to alleviate suffering. When it comes to sensitive patient care, healthcare providers who recommend marijuana and care for these patients should be especially mindful of the overall environment of stress and anxiety that patients face outside the clinic due to the conflicting legal status of medical marijuana.

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