VETERANS ACTION COUNCIL

UNITED STATES OF AMERICA

Sponsoring Offices:
United States Senate;
RE: Cannabis Administration and Opportunity Act
Discussion draft, input from United States military
Veterans collated by the Veterans Action Council
Cannabis_Reform@finance.senate.gov

The Veterans Action Council (VAC) is an all-volunteer group of Veterans and venerated professionals in our respective fields. We organized to promote and coordinate efforts on issues concerning Veteran access to alternative treatments and therapies, thereby promoting the physical health and mental well-being of our community. We look forward to working with the sponsoring offices on this complex issue.

We are writing to express our gratitude for your proposing legislation to protect the health and safety of Americans by de-scheduling cannabis. As veterans, we urge you to expand the federal Compassionate Investigational New Drug Program (IND) through the Veterans Health Administration. This will ensure cannabis and other adjunct treatments are available options for Veterans' healthcare in all 50 U.S. States and Territories.

As per your public call for feedback we are providing the following for your consideration, specifically, as it relates to the veteran and medical cannabis components of the Cannabis Administration and Opportunity Act.

Veterans require federal legislation which:

- Compels the VHA to release to the public data collected per VHA DIRECTIVE 1315 and its predecessors since 2010 on Veterans' use of Cannabis under State-run access programs.
- Expands the federal Compassionate Investigational New Drug Program (IND) through the VHA.
- Provides for VHA to grow Cannabis for Veterans participating in the expanded IND program and occupational therapy programs.
- Promotes and supports home cultivation and medicinal access to a broad variety of plant material and Cannabis products, especially those grown by small farmers for use in traditional and complementary medicine.
- Provides for a Cannabis voucher system for Veterans to access Cannabis under State-run medicinal access programs, patterned after the VA Disabled Veterans Clothing Allowance program.
- Provides an identifier on VHA patient data cards identifying Veterans as federal Cannabis patients; eliminating the threat of prosecution/incarceration for possessing Cannabis while traveling in the U.S. or on federal property.
- Provides for training and continuing education at the VISN level including, but not limited to the history of Cannabis medicine; the function of the endocannabinoid system; new discoveries as research is conducted; and federal/state policy in order to best integrate treatment into patient care.

VETERANS ACTION COUNCIL

UNITED STATES OF AMERICA

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Veterans Action Council has created this document as a team effort created by a consensus process amongst military veterans working as equals towards a shared vision of an equitable and sustainable world dedicated to the reduction of suffering and maximization of bliss. We share this work with the world in the hope of achieving these ends.

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Executive Summary

The Veterans Action Council (VAC) is an all-volunteer group of Veterans, and venerated professionals in our respective fields. We came together to promote and coordinate efforts on issues concerning Veteran access to alternative treatments and therapies, thereby promoting the physical health and mental well-being of Veterans and their families. We are submitting this "*Green Paper*" to the "Sponsoring Offices", in response to their request for input from the public regarding their draft legislation entitled "Cannabis Administration and Opportunity Act".

Our *Green Paper* outlines significant concerns within the medical cannabis community, and what we feel are some potential remedies. As Veterans of the United States (U.S.) Armed Forces, we call on lawmakers and the Veterans Health Administration (VHA) to fully recognize Cannabis as a viable treatment option for U.S. Veterans. Leaders are increasingly aware of the devastation to former military members and their families caused by inappropriate prescription of opiates, SSRIs, benzodiazepines, and other pharmaceuticals. Multiple attempts have been made to resolve the inability of Veterans to incorporate Cannabis into their official treatment plans. Every attempt made to address our concerns has been sabotaged at the federal level. The VHA must take action on this issue. Federal leadership in the executive and legislative branches of our government must understand the enormity of this situation.

The fact is, Veterans are self-medicating with cannabis and other substances. Veterans report turning to cannabis after pharmaceutical options provided by the VHA -- some of which include warnings of suicidal ideation -- exacerbate their symptoms. We have an opportunity to expand the conversation into areas such as MST, TBI, CTE, and other issues Veterans face beyond post-traumatic stress (PTS). Veterans farming cannabis should be supported by the Department of Agriculture, with programs sponsored by the VHA. Veterans are being forced, sometimes into criminal behavior, to heal themselves using alternative substances not currently recognized by the VHA. The experienced cultivators and medical healthcare and research providers in our network are capable of providing reliable information regarding the benefits of using "real world" cannabis, as opposed to the currently mandated NIDA product. These professionals can break down the many data points of cannabis being used by Veterans across the country.

Finally, given the VHA is a federal program, operating in all fifty states, Veterans receiving care from the VHA are federal patients who require equal medical treatment, regardless of state laws. The current situation is untenable and an expansion of existing federal policy is in order. Service members are losing their benefits before entering into Veteran status, and they are experiencing undiagnosed issues stemming from their service. This leaves Veterans with debilitating health concerns that often result in them fending for themselves. We are urging our representatives to protect the health and safety of Veterans by de-scheduling cannabis and re-opening the federal Compassionate Investigational New Drug Program (IND) through the VHA. This will ensure cannabis and other adjunct treatments are available options for Veterans' healthcare in all 50 States and Territories of the U.S.

Key issues within the Veteran community regarding medical cannabis laws.

- **To date, 36 states and 4 territories of the United States have legalized the use of medical cannabis**.

Citizens across our country have acknowledged the therapeutic potential of cannabis, as witnessed by their voter initiatives, and state legislation addressing the disparity between law and reality. Even still, not all state medical programs are created equal. In one state, a Veteran may have access to a wide array of cannabis products, whereas in others the options are significantly limited in product and methods of administration. What's more, due to "local control" ordinances in "legal" counties, Veterans can still be denied access to their medication despite their compliance with state laws.

- **The Patient/Doctor Relationship.**

VHA Directive 1315, as of December 8, 2017, is in effect and addresses State-approved marijuana programs. Tens of thousands of Veterans have voluntarily self-identified as cannabis users after recommendations are received outside of the VHA, and the requirements of their State or Territory of residence are met. The directive outlines the responsibility of the VHA Medical Facility Director to ensure cannabis use reported to clinical staff is charted in a separate section of the Veteran's electronic health record. Further in the directive, it is noted that *if* the provider discusses medical cannabis, "relevant information" must be documented in the progress notes.

Since the inception of state-run Cannabis programs, there has been a disconnect between VHA healthcare providers and their patients. Veterans require the unobstructed ability to engage in open and honest dialogue with their VHA Primary Care Teams about their use of cannabis; where they can then develop proper treatment plans, document their experiences, and utilize the healthcare system designed for them. The Veterans Action Council is requesting the VHA provide to this organization the results of evaluating patients using cannabis therapeutically for the last decade, preferably in an Executive Summary format with all data relevant to this treatment appreciated.

- **The added burden to Veterans and their families**.

Veterans are being forced to pay out of pocket to access state medical cannabis programs across the country. The cost of these programs varies from state to state for credentials that have to be renewed on an annual or bi-annual basis. The cost of cannabis itself varies greatly from store to store, county to county, and state to state. It is not cheap, especially for Veterans on fixed incomes choosing between their bills or cannabis. Recommendations for cannabis from our VHA primary care physicians should be the agreed-upon treatment plan, rather than going to a state-authorized entity. These recommendations can be converted into vouchers to be filled at local dispensaries, as the Canadian medical cannabis program demonstrates.

- **Criminal or Patient? That depends on which state Veterans call their home.**

Veterans will violate the law to heal themselves, and the authorities have no trouble enforcing those laws. Idaho for instance, possession of *any* amount of cannabis is a crime -- punishable by up to one year in jail, and/or a $1,000 maximum fine. Veterans are being victimized by the criminal justice system, simply for attempting to find relief. Our Heroes deserve treatment options that transcend state lines. No matter what state a Veteran may call their home, despite being a qualified cannabis patient under a state program, all possession or use of cannabis on VHA property is federally restricted. This means that a Veteran can be charged with a federal crime for medicating themselves at their VHA hospital, nursing home, Fisher House, or federal housing.

- **Cannabis Use Disorder (CUD).**

CUD has become a staple of VHA medical records for Veterans choosing to have honest discussions with their primary care teams regarding their cannabis use. Under a diagnosis of PTS, substance abuse is an attributed factor in the further diagnosis of CUD. Through word of mouth, Veterans have come to learn that cannabis helps alleviate a majority of symptoms attributed to PTS. They end up with a CUD diagnosis with no contributing factors other than their use of cannabis and a diagnosis of PTS, along with an unwarranted stigma to overcome. To see the blatant bias at play, one need only to look at the budget request from the Department of Veterans Affairs to the ONDCP for FY 2022. The VHA would rather spend a billion dollars on substance use disorder, than research the medical utility of cannabis. Any funding provided to the VHA from the ONDCP should contain provisions mandating research into the efficacy of cannabis when used to treat PTS, TBI, chronic pain, etc.

- **Proliferation of opioid prescriptions since the start of the Global War On Terror (G.W.O.T.).**

Within the VHA, pharmaceutical narcotics are being prescribed in staggering numbers, putting Veterans at the forefront of the opioid epidemic that has swept the country. Many individuals are entering military service in top physical and mental health, only to be thrust into an overwhelmed system relying too heavily on a pharmaceutical approach to healthcare. The VHA has recently taken minor steps to include a more holistic approach to Veteran healthcare but has continually denied the inclusion of cannabis regardless of the science. Studies show opioid use/abuse is reduced in states that have legalized medical cannabis, and it is time for VHA primary care teams to act upon this information.

- **Suicide rate increased since the start of the G.W.O.T.**

In addition to being inundated with pharmaceutical narcotics, the Veteran community is struggling with alcohol. For individuals who have lost their identities, careers, professions, and oftentimes spouses, children, and friends, these potentially destructive substances are too easy to abuse. We have lost more troops to suicide than to combat, many more. Death is an ever-present reality in combat environments. Through training, repetition, teamwork, and accountability, the warfighter hardens themselves against this fact. To protect what they love, they knowingly enter into the fight. Nobody was ready for the suicide epidemic. There was no preparation, and it is getting worse. Over the years leaders have stated "nothing is off the table" when it comes to curbing the suicide rate within the military community, it is time for them to prove it. The status quo further aggravates hardships for America's Veterans.

- **Veterans learning about their medicine is empowering, therapeutic, and is why you're reading this**.

All across the country, there are programs geared toward Veterans interested in agriculture. Cannabis farming should be no different. There are many benefits to farming, gardening, and generally getting out in nature on a regular basis. The routine of planting, tending to a crop, harvesting, and preparing for the next season is a structure that fits right in line with the military mentality. Farming brings with it a sense of hope, opportunity, and accomplishment. Bringing in any successful crop is an achievement. It keeps the mind and body occupied, focused, and engaged in a productive manner. Self-sustainability is a key component to a happy, healthy lifestyle.

Veterans should have the opportunity to learn more about cannabis, or other medicinal herbs if they are at all interested. Cannabis Centers of Excellence at specified VHA healthcare facilities designed to teach Veterans about their medication, how to grow it, and to supply regional VHA facilities are called for. Top-performing VHA facilities, along with consideration of state cannabis laws should be identified as the initial qualifications for implementation of this proof of concept. Cannabis cultivation facilities do not have to be on the VHA campus but can utilize land grant university space, and/or vacant Department of Defense property, in partnership with various community programs. This scenario fosters further community engagement.

- **The NIDA/University of Mississippi monopoly must be busted up.**

Research into the medicinal properties of cannabis needs to be fast-tracked. Over-reliance on research conducted by the National Institute on Drug Abuse has hindered our overall understanding of the cannabis plant; its safety, efficacy, and potential medical utility. Monopolizing patents, obstructing objective research, and working to subvert patients' access to the healing properties of cannabis, are all federal themes played out time and again. This is not hyperbole. It is documented in myriad court cases spanning decades, leading right into the present moment.

- **Research from allied nations sponsored by the NIH needs to be acknowledged and acted upon.**

Since the early 1960s, the National Institutes of Health have been providing scientists in the state of Israel with grants to research the cannabis plant, its compounds, and its potential for medicinal use. United States taxpayers have paid for research which has led to the state of Israel becoming the world leader in cannabis science. Additionally, due to compulsory service requirements for their citizens, barring medical or other disqualifications, the majority of Israeli citizens are Veterans.

Scientific breakthroughs have led to cannabis being introduced as a viable treatment for use within the Israeli healthcare system. Tens of thousands of Israeli Veterans use cannabis on a regular basis which is supplied to them by their government. It is time for the United States to treat its Veterans with the same respect and compassion.

- **Research investigating what Veterans are using in real-world scenarios is required.**

Because of federal obstruction, Veterans are forced to conduct their own research. "For Purpose" organizations like the Helmand Valley Growers Company -- a Veteran owned entity -- are working toward identifying answers to questions being ignored by the United States government. Veterans want to participate in objective cannabis research programs. This research will further assist in understanding medical cannabis, and how to best introduce it into treatment regimens.

The Veterans Action Council is including the following document "*Marijuana as Medicine"* from 1993, for comparison regarding cannabis policy then, and now. The news articles, political discussion, controversy, injustice, and misery of it all are outrageously similar. **Emphasis has been added where we feel the information is particularly striking**. When you read about states taking individual action -- **pressure campaigns led by sick, disabled, and dying patients** -- remember that now, in 2021, we are looking at over a dozen states with *recreational* cannabis laws. The movement founded by Mr. and Mrs. Randall for access to *medical* cannabis is to this day being ignored by our federal government, and so-called representatives.

The *Green Paper* is a testament to the Truth announced so long ago, and a proclamation that we will no longer accept the prohibition of cannabis. Decades spent attempting to get through to our elected officials that we know the truth about cannabis, engaging in constant struggle with out-of-control federal agencies, have left us with a significant gap in our healthcare and knowledge base.

In the two decades since the G.W.O.T. began, that gap has consumed over one hundred thousand Veteran lives, if we are just accounting for those who have committed suicide.

The time to act on this was yesterday.

Marijuana As Medicine

Initial Steps

Recommendations for the Clinton Administration

Robert C. Randall & Alice O'Leary

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VETERANS ACTION COUNCIL

UNITED STATES OF AMERICA

Dedication

Carl E. Randall & James C. O'Leary

Who gave us good minds,
The courage to use them,
And who taught us to tell the Truth.

Acknowledgment

Funded by:
Richard J. Dennis
Chicago, Illinois.

Preface

“The evidence in this record clearly shows that marijuana has been accepted as 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 DEA to continue to stand between those sufferers and the benefit of this substance in light of the evidence in this record.”

In the Matter of Marijuana Rescheduling
Francis L. Young, Chief Administrative Law Judge
Drug Enforcement Administration (DEA)
September 6, 1988

Judge Young’s decision followed two years of court-ordered public hearings. The record, In the Matter of Marijuana Rescheduling, constitutes the most complete review of marijuana’s therapeutic properties in the 20th century.

Purpose

Marijuana's medical value is incontrovertible. This simple fact was true 5,000 years ago. It's true today.

Marijuana's therapeutic value is not at issue. What is at issue are irrationally prohibitory federal policies which prevent marijuana's legal, medical availability. This is not an insignificant problem. Today, many thousands of seriously ill Americans must break the law to meet their urgent medical needs. Governmental attempts to criminalize the sick for securing needed medical care are intolerable in a civilized, democratic society.

Much has been written about marijuana's medical use. Those seeking detailed factual information on the plant's long medical history, complex chemistry, therapeutic actions or current legal status can easily find such information elsewhere.

This publication speaks to the present moment -- our national government is in transition, the medical prohibition of marijuana is in crisis, and people are suffering. One year ago, in March 1992, the Bush Administration killed the nation's fourteen-year-old marijuana-as-medicine program, slamming the door on seriously ill Americans who dared to petition their government for legal access to medically needed marijuana. Today, seriously ill Americans are dying, going blind, and being crippled by this cruel policy.

On January 20, 1993, President Bill Clinton inherits the problem of medical marijuana. **This publication is designed to provide interested parties with an overview of the problem and a review of those events which led the Bush Administration to kill the nation's Compassionate IND program**. It also explores the political dynamics of medical marijuana. The American people strongly favor marijuana's medical availability and they will no longer tolerate bureaucratic efforts to legally prevent such use.

Finally, this publication outlines pragmatic actions President Clinton can take to resolve this problem. These recommendations are not designed to satisfy drug warriors, left or right. Instead, they are crafted to meet the legitimate treatment needs of those who are currently ill, while encouraging aggressive research and exploring legally appropriate ways to make marijuana medically available for therapeutic use in the treatment of life-and sense-threatening diseases.

Ending the five decades of irrational federal policy is not a simple undertaking. But failure to confront the bureaucracy and rationally resolve this problem will condemn many seriously ill Americans to unnecessary suffering and many others to unwarranted criminality. **Of all the problems facing the new administration, resolving the question of marijuana's medical availability is easy. All it takes is courage, compassion, and common sense**.

Robert C. Randall & Alice O'Leary
January 1993

VETERANS ACTION COUNCIL

UNITED STATES OF AMERICA

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Executive Summary

Among the problems President Clinton will inherit from the Bush Administration is the matter of marijuana's legal availability for legitimate medical purposes.

This document outlines the existing situation, provides critical background information, and recommends the pragmatic steps the Clinton Administration can take to resolve the problem of marijuana's legal availability for medical use.

Marijuana has NO political complexion. This is NOT a liberal issue with well-defined conservative opposition. Indeed, conservatives believe doctors, not bureaucrats, should be in charge of medical care. The bipartisan character of public support is so broad that political efforts to characterize the following recommendations as liberal or radical will lack credibility and further isolate such critics from the emerging social mainstream.

The following actions are recommended to the Clinton Administration:

- Immediately and fully restore the FDA's Compassionate IND program for medical marijuana,
- Encourage aggressive medical research by rescheduling marijuana from Schedule I to Schedule II of the Controlled Substances Act, and
- Appoint a Presidential Task Force to fully explore appropriate ways to make marijuana available for therapeutic applications.

These moderate initial actions -- restore, encourage, explore -- enjoy broad public support. The American people know marijuana has legitimate medical uses, and they deeply resent bureaucratic efforts to block marijuana's medical availability.

By adopting the above recommendations President Clinton will be credited for taking decisive action to ease human suffering by ending decades of ideologically institutionalized gridlock. The hallmarks of the recommended actions are courage, compassion, and common sense. A broad coalition of groups will support these moderate moves and individuals - including many seriously ill Americans - will publicly offer their testimony of thanks and congratulations.

"**If we think we are going to accomplish much by subterfuge, somehow hiding the fact that marijuana … may be of benefit for some purpose, I would disagree. I think sooner or later the public will find out, and it will become one more reason not to trust the Federal Government on anything it says**…."

Rep. Stephen L. Neal
Chairman, Task Force on Marihuana,
Select Committee on Narcotics Abuse and Control Hearings, May 20, 1980.

WHY PRESIDENT CLINTON MUST RESOLVE THIS PROBLEM

The Clinton Administration should resolve this problem because:

- Seriously ill Americans are suffering as a result of irrationally prohibitory federal policies,
- The American people reject the medical prohibition and view bureaucratic efforts to block marijuana's medical use as a regulatory fraud, and
- By failing to act President Clinton will inherit, and be forced to defend, the Bush Administration's extremely unpopular War on Drugs approaches to marijuana's medical use.

The Problem

People are suffering.

Marijuana has unique therapeutic properties in the treatment of several life-and sense-threatening diseases including glaucoma, cancer, AIDS, and neurologic disorders resulting in muscle spasms and chronic pain. Federal law, however, forbids marijuana's medical use. Licensed physicians who routinely prescribe far more dangerous drugs are legally forbidden to provide people who are dying, going blind or being crippled with licit, therapeutic access to marijuana.[1] This stark conflict between urgent medical needs and prohibitory federal policies has created a perverse situation in which physicians must send desperately ill Americans into the streets -- and criminality -- to meet their legitimate medical needs. Modern studies have reconfirmed marijuana's historically recognized therapeutic value. This document only concerns itself with marijuana's medical use in the treatment of several life- and sense-threatening disorders.

Glaucoma: Glaucoma is the leading cause of blindness in the United States. In the 1970's researchers discovered marijuana significantly lowers the elevated eye pressures associated with glaucoma.[2] Between 2 and 4 million Americans are afflicted with glaucoma and nearly 10,000 are blinded by the disease each year.[3] This statistic indicates that standard treatments and surgery are often ineffective. It is clear that, for some glaucoma patients, the addition of marijuana can make a critically important difference in prolonging sight.

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[1] "Marijuana, in its natural form, is one of the safest therapeutically active substances known to man. By any measure of rational analysis marijuana can be safely used within a supervised routine of medical care." Ruling of Drug Enforcement Administration Administrative Law Judge Francis L. Young, "In the Matter of Marijuana Rescheduling," *See Marijuana, Medicine & The Law, Volume II*, R.C. Randall, ed., (Galen Press: Washington, D.C.?, 1989, p.440.
[2] Robert S. Hepler, M.D. and Ira Frank, "Marijuana Smoking and Intraocular Pressure," *JAMA*. 217 (September 6, 1971) p. 1392.
[3] "Fact Sheet: Marijuana & Glaucoma," Statement from the National Eye Institute, August 16, 1978.

Cancer: One million Americans are diagnosed with cancer each year. Many suffer from intractable nausea and vomiting caused by highly toxic anti-cancer drugs.[4] The debilitating effect of chemotherapeutic agents cause many patients to discontinue potentially life-saving treatment. Medical studies consistently show marijuana is one of the safest, most effective anti-nausea drugs known to man.[5] In the mid-1970s cancer patients began smoking marijuana to control nausea and vomiting, and stimulate appetite. Subsequent studies found marijuana helps up to 90% of these patients control nausea and vomiting.[6]

AIDS: HIV-positive (HIV+) people smoke marijuana for many of the same reasons as cancer patients. Marijuana effectively reduces the intense nausea, vomiting and rapid weight loss caused by advanced HIV-infection and the highly toxic drugs used to treat AIDS. While it has only recently come to public attention the medical use of marijuana, even though illegal, is already widespread among HIV+ people. AIDS is now the nation's most rapidly increasing cause of death. More than 242,000 Americans have AIDS and more than 1 million Americans are now infected by the deadly virus.[7]

Muscle Spasm: More than a million Americans suffer from neurologic conditions like multiple sclerosis (MS), muscular dystrophy, spinal injury and arthritis which cause severe muscle spasms and chronic pain. These conditions are not well treated with conventional medications. Marijuana's illegality makes it impossible to accurately estimate how widespread marijuana's medical use is among neurologically-impaired Americans. It is clear marijuana's medical use among paralyzed Americans is now widespread. As one neurologist testified during the recent DEA hearings, "**You cannot walk down a neurology ward in a V.A. hospital without smelling marijuana.**"[8]

Marijuana does not cure any of these conditions. But rationally employed, under medical supervision, marijuana can prolong sight in glaucoma, ease nausea and vomiting caused by anti-cancer and AIDS therapies while helping patients maintain body weight, reduce the crippling spasms common to neurologic disorders like multiple sclerosis, muscular dystrophy and paralysis, and ease chronic pain.

Political Analysis

The Medical Prohibition Has No Public Support.

It is difficult to find any other question which unites so many of the American people in opposition to an existing federal policy.

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[4] Malin Dollinger, M.D., Ernest H. Rosendbaum, M.D., and Greg Cable. *Everyone's Guide to Cancer Therapy*. (Andrews and McMeel: New York), 1991, pp. 119-121.
[5] Decision of Judge Francis L. Young, *See Marijuana, Medicine & The Law, Vol. II*, pp. 413-421.
[6] Decision of Judge Francis L. Young, *See Marijuana, Medicine & The Law, Vol. II*, pp 416 at 21.
[7] Center for Disease Control, *AIDS Quarterly Surveillance Report*, December 31, 1992.
[8] Decision of Judge Francis L Young, *See Marijuana, Medicine & The Law, Vol II*, p. 437 at 44.

Federal laws which prohibit marijuana's therapeutic availability are not politically, socially, or legally tenable. Federal agencies enforcing the medical prohibition long ago lost the public debate for hearts and minds.

While few people would identify medical marijuana as a "front-burner" issue, there are emblematic aspects to the problem which can directly affect public perceptions of an administration's candor, honesty, and compassion.

All available evidence suggests the medical prohibition of marijuana has no support among the American people. Indeed, public repudiation of the medical prohibition is now nearly universal. Despite two decades of bureaucratic disinformation, the American people view the medical prohibition as an irrational outgrowth of misdirected War on Drugs zealotry.[9]

Public rejection of the medical prohibition is evident in political actions, available polling data, and recent election returns.

Political Actions

In 1978, a young cancer patient, Lynn Pierson, brought marijuana's medical value to the attention of the New Mexico Legislature. After public hearings in which cancer and glaucoma patients and their physicians strongly endorsed marijuana's medical availability, the legislature overwhelmingly enacted the nation's first law recognizing marijuana's medical value.[10]

Patients in other states quickly followed Lynn Pierson's lead and petitioned their legislatures for similar laws. The result was an explosion of state legislation which has continued into this decade.

On December 31, 1991, Massachusetts Governor William Weld signed the nation's thirty-fifth state law recognizing marijuana's medical value. In every instance these state laws gained broad bipartisan support and were enacted by tremendous legislative margins.

State efforts to end the medical prohibition failed, however, because of entrenched opposition from federal drug agencies.[11] This bureaucratic opposition had very real human consequences. In New Mexico nine patients, including Lynn Pierson, **died "while waiting for promised supplies of federal marijuana which never arrived**."[12]

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[9] "Out of Joint: The Case for Medical Marijuana," by Brian Hecht, *The New Republic* (July 15 & 22, 1991), pp 8-9. "Voices from Across the USA, Question: Should The Use of Marijuana For Medical Purposes Be Permitted?," *USA Today*, (March 12, 1992).
[10] H.B. 329, later renamed *The Lynn Pierson Marijuana Treatment & Research Act*, was enacted by a vote of 53-9 in the New Mexico House and 33-1 in the Senate. The bill was signed by Governor Jerry Apodaca in February 1978.
[11] "[W]e encountered severe difficulties with FDA, the Drug Enforcement Administration (DEA), and the National Institute on Drug Abuse (NIDA). To say that these federal agencies were uncooperative would be an understatement." Direct testimony of George Goldstein, Ph.D., former Secretary of Health for the State of New Mexico. *See Marijuana, Medicine & The Law, Volume I*, R.C. Randall, ed., (Galen Press: Washington, D.C.) 1989, p. 118, at 28.
[12] *Ibid*., p.120 at 42.

Despite bureaucratic hostility, six states finally managed to satisfy federal regulatory demands to establish programs of patients' access to medical marijuana.[13]

Angered by federal efforts to destroy the intent of their marijuana-as-medicine statutes, the legislatures of New Mexico, Michigan and New Hampshire enacted Resolutions to the U.S. Congress condemning federal efforts to block marijuana's medical use. The Michigan Resolution bluntly states:

"Federal agencies have failed to meet this good faith effort, and have instead, through regulatory ploys and obscure bureaucratic devices, **resisted and obstructed** the intent of the Michigan legislature."[14]

- Many of these state legislative actions were authored by conservatives. **The first four states to recognize marijuana's medical value -- New Mexico, Florida, Illinois, and Louisiana -- could hardly be characterized as "liberal.**"

- State laws recognizing marijuana's medical value consistently received exceptionally broad bipartisan support. A cumulative 87% of the state legislators voting on this question voted in favor of making marijuana medically available.

- These legislative actions were endorsed by the major media in these states and received broad public support. Physicians, nurses, and patients appeared at legislative hearings to express their support for marijuana's medical availability.

- Opposition to such legislation was muted, ill-organized and often dismissed as hysterical.

- Finally, **the profoundly bipartisan nature of these political actions indicates medical marijuana is not a politically or culturally sensitive issue**. Significantly, no legislator who sponsored or supported marijuana-as-medicine legislation ever lost an election because of such support.

[13] New Mexico, New York, Michigan, Georgia, Tennessee, and California established programs of medical access in the 1980s. Only one state, New York, formally published the results of their study. See "Inhalation Marijuana as an Antiemetic of Cancer Chemotherapy," *New York State Journal of Medicine*, Vincent Vinciguerra, M.D., (October 1988), pp. 525-527. Data from the other state studies was routinely submitted to FDA and various state agencies. This data is summarized in the A.C.T. Brief in Support of Findings of Fact and Conclusions of Law, *See Marijuana, Medicine & The Law, Vol. II*, pp. 33-63.

[14] Senate Concurrent Resolution 473, Michigan Legislature, 1983.

97th Congress
2D Session H.R. 4498

To provide for the therapeutic use of marihuana in situations involving life-threatening or sense threatening illnesses and to provide adequate supplies of marihuana for such use.

IN THE HOUSE OF REPRESENTATIVES

September 16, 1981
Mr. McKinney (for himself, Mr. Gingrich, Mr. Fish, and Mrs. Fenwick) introduced the following bill; which was referred to the Committee on Energy and Commerce

March 3, 1982
Additional sponsors:
Mr. Kastenmeier, Mr. Forsythe, Mr. Ottinger, Mr. Beilenson, Mr. O'brien, Mr. Fazio, Mr. Neal, Mr. Edgar, Mr. Minish, Mr. Whitehurst, Mr. Jeffords, Mr. Frenzel, Mr. DeNardis, Mr. Miller of California, Mr. Stokes, Mr. Porter, Mr. Stark, Mr. Applegate, Mr. Ginn, Mr. D'Amours, Mr. Lehman,
Mr. Bonoir of Michigan, Mr. Morrison, Mr. Erdahl, Mr. Synar, Mr. Dannemeyer, Mr. Addabbo,
Mr. Bevill, Mr. Marlenee, Mr. Zeferetti, Mr. Guarini, Mr. Harkin, Mr. Richmond, Mr. Rahall,
Mr. McGrath, Mr. Seiberling, Mr. Dellums, Mr. Weiss, Mr. Siljander, Mr. LaFalce, Mrs. Collins of Illinois, Mr. Bingham, Mr. Gibbons, Mr. Chappell, Mr. Frank, Mr. Oberstar, Mr. Rinaldo, Mr. Daniel B. Crane, Mr. Garcia, Mr. Pritchard, Mr. Molinari, Mr. Mineta, Mr. Derwinski, Mr. Gradison, Mr. Ford of Tennessee, Mr. Hughes, Mr. James K. Coyne, Mrs. Snowe, Mr. Simon, Mr. McCollum, Mr. Conyers,
Mr. Brown of California, Mrs. Martin of Illinois, Mr. Marks, Mr. Green, and Mr. Pickle.

Federal Legislation

This same pattern of bipartisan political support was also evident in federal legislative efforts. In September 1981, four Republican Congressmen - Stewart McKinney (CT), Millicent Fenwick (NJ), Hamilton Fish (NY), and Newt Gingrich (GA) - introduced a federal marijuana-as-medicine bill. This legislation, re-introduced in 1983 and 1985, received broad bipartisan support in the House, attracting more than 110 co-sponsors. It is difficult to find another legislative matter which could unite far-right conservatives Gingrich, Fish, William Dannemeyer, and Mickey Edwards with moderates McKinney, Fenwick and William B. Hughes, and liberals Richard Gephardt and Barney Frank.[15]

[15] Under intense pressure from War on Drugs hard-liners in the Reagan Administration, Gingrich withdrew his sponsorship in late 1982. Other conservatives, however, did not follow Gingrich's example.

Despite the wide-range of political support for meaningful federal legislation, Representative Henry Waxman (CA) failed to hold public hearings on this Republican sponsored marijuana-as-medicine measure.

In early 1987, Representative McKinney became the first Member of Congress to die of AIDS. No federal marijuana-as-medicine bill has been introduced in Congress since his untimely death.

Opinion Samplings

Polling data of public attitudes on this question mirrors the actions of the state legislatures and consistently indicate a vast majority of the American people believe marijuana has medical value and should be legally available, by prescription.

There is a generalized public anger over increasingly intrusive bureaucratic controls on the delivery of medical care. A recent poll conducted by The Wirthlin Group found 80% of Americans believe patients should have a legal right to use promising, but not yet approved, therapies for terminal illnesses such as AIDS or cancer.

Even in non-fatal diseases, 78-84% of the American people felt control over the choice of medical treatment should be decided by patients and their physicians, not remote bureaucrats or policemen.[16]

This deep-seated public concern over who controls basic medical decisions is starkly evident in the polling data available on the question of marijuana's medical availability.

Polls & Surveys

The first reliable polling information on this question appeared in the late 1970's from surveys conducted in Pennsylvania[17] and Nebraska. Both polls disclosed more than 80% of those randomly questioned favored marijuana's prescriptive medical availability. A very sizable majority of all those questioned -- whether segmented by age, party identification, religion, education or income -- supported marijuana's medical use. Both polls, conducted by different polling organizations, found opposition to marijuana's medical use was limited to a scant 12% of the population.

A telephone poll conducted by the Detroit Free Press on October 13, 1978, revealed 85.4% of those calling favored prescriptive access to marijuana.

In Washington, the State Medical Association conducted a poll in which 80% of the doctors favored the controlled medical availability of marijuana.

[16] "Poll: Unapproved Drugs Should Be Available," by David E. Anderson, UPI Newswire, September 24, 1991.
[17] Survey conducted by the National Center for Telephone Research, Princeton, NJ, December 1978.

A more recent polling of physicians was conducted in 1991 by Harvard University's J.F.K. School of Public Policy. More than 2,000 career specialists were surveyed about their attitudes towards marijuana's medical utility. An astonishing 89% of those physicians with an opinion said marijuana is an effective antiemetic treatment.[18]

Unscientific radio-talk show and newspaper samplings of public opinion consistently register a similarly high range -- 75-85% -- of public support for medical marijuana.

For example, a December 22, 1992 radio-talk poll conducted by Roanoke, Virginia station *WFIR* is typical. The station reports that 96% of the listeners who phoned the station vote-line endorsed marijuana's medical availability.[19]

The most recent scientific poll on this question was conducted for the Drug Policy Foundation. In response to the one question relating to marijuana's medical use 69% of those questioned favored prescriptive access to marijuana for the treatment of glaucoma.[20]

Public Elections

While polls provide a "snapshot" of social attitudes, there is no more powerful, exacting or legitimate expression of the electorate's mind than that afforded by an election.

There have been two recent public elections on the question of marijuana's medical availability.

In November 1991, "liberal" San Francisco became the first political jurisdiction in the United States to put this question on the ballot. An astonishing 79.5% of the electorate rejected the federal prohibition to vote in favor of marijuana's medical availability.

In November 1992, the voters in "conservative" Santa Cruz County, south of San Francisco, voted to end the medical prohibition by an equally astonishing 77.1%.

Significantly, Proposition P in San Francisco and Measure A in Santa Cruz County won by larger electoral margins than any national candidate on the 1992 ballot or any previous voter initiatives in California history.

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[18] "Marijuana as Antiemetic Medicine: A Survey of Oncologists Experiences and Attitudes," by Richard E. Doblin and Mark A.R. Kleiman, *Journal of Clinical Oncology*, Vol. 9, No. 7 (July 1991), p. 1316.
[19] Charlene Cochran, program host WFIR, January 4, 1993.
[20] "The American People Talk About Drugs: A Nationwide Survey," conducted by Targeting Systems, Arlington, Virginia. April 1990. Distributed by the Drug Policy Foundation, Washington, D.C.

A Remarkable Consensus

There is no other issue which unites so many of the American people in opposition to an existing federal policy.

The American people know marijuana has medical value, and they are clearly fed up with bureaucratic efforts to block marijuana's therapeutic availability. As noted above:

- 87% of the legislators in thirty-five states voted to end the medical prohibition.
- 82% of the American people, when polled, reject the medical prohibition.
- 79.5% and 77.1% of the voters in two public elections voted to end the medical prohibition.

The scale of the electoral victories in California reflects the bipartisan consensus so evident in the state legislatures, in the range of co-sponsors attracted to Representative McKinney's federal marijuana-as-medicine bill, and in the available polling data.

The most remarkable aspect of this vast public consensus is its constancy over time and its reach beyond mere party or ideological identifications. In the purest political terms, the net difference between multi-ethnic urban liberal voters in San Francisco and predominately white, conservative voters in Santa Cruz County rejected the medical prohibition to vote in favor of a more rational and humane policy directed at meeting legitimate medical needs.

INHERITING BAD POLICY

Current Federal Policy

Richard Nixon was president when marijuana was made a Schedule I drug under the federal Controlled Substances Act. As such marijuana is defined in law as a drug "with no accepted medical use in treatment in the U.S."

For twenty-two years FDA, by erecting regulatory barriers to cogent scientific and medical evaluations, has assisted DEA in maintaining the medical prohibition. For example, the FDA officially classifies marijuana, a natural plant with an ancient medical heritage, as a New Drug.[21]

[21] DEA Judge Francis L. Young ridiculed FDA's definition of marijuana as a New Drug. "The marijuana plant is anything but a new drug. Uncontroverted evidence in this record indicates that marijuana was being therapeutically used by mankind 2000 years before the Birth of Christ." Decision of Judge Francis L. Young. *See Marijuana, Medicine & The Law, Vol. II*, p. 426.

Gerald Ford was president when a federal court ruled a glaucoma patient's use of marijuana was not criminal, but an act of "medical necessity." In part, federal Judge James Washington ruled, "**It is unlikely that [marijuana's] slight, speculative and undemonstrable harm could be considered more important than defendant's right to sight.**"[22] Concurrent with the court's verdict, this man also became the first American to secure legal, medical access to FDA-approved supplies of pre-rolled marijuana cigarettes.

Jimmy Carter was president when FDA, in the wake of a lawsuit by this glaucoma patient, created the Compassionate IND system for medical marijuana.[23]

Demands for Change

For twenty years the medical prohibition has been under sustained scientific, medical, legal, social and political challenge. In the course of this protracted debate the courts, a majority of the state legislatures, the press and the American people have rejected the medical prohibition.[24]

Eroding societal support for the medical prohibition reached its zenith in 1988 when DEA's chief administrative law Judge Francis L. Young condemned the federal prohibition as "unreasonable, arbitrary and capricious." After two years of court-ordered public hearings, Judge Young ruled DEA should immediately reschedule marijuana to Schedule II, and recommended marijuana be made prescriptively available for the medical treatment of persons afflicted by life-or sense-threatening disorders.

Anticipating the bureaucratic response, Judge Young noted:

"There are those who, in all sincerity, argue that the transfer of marijuana to Schedule II will 'send a signal' that marijuana is 'OK' generally for recreational use. This argument is not specious… **The fear of sending such a signal cannot be permitted to override the legitimate need … of countless sufferers for the relief marijuana can provide when prescribed by a physician**…."[25]

[22] U.S. v Randall, D.C. Superior Court, D.C. Crim. No. 65923-75, "Criminal Law & Procedure: Medical Necessity," *The Daily Washington Law Reporter*, Vol. 104, No. 250, (December 28, 1976), p. 2253. See "Significant Legal Cases," Appendix.
[23] *Randall v U.S.*, 1978. See "Significant Legal Cases," Appendix.
[24] See "Political Analysis" above.
[25] Decision of Judge Francis L. Young, *See Marijuana, Medicine & The Law, Vol. II*, p. 445.

Medical Prohibition Under Pressure

Judge Young's historic verdict fractured the bureaucratic facade of unqualified resistance and greatly accelerated patient demands for access to care. These demands took on even greater urgency in the early 1990s when **FDA was compelled to expand the nation's Compassionate IND program for medical marijuana to include HIV+ people and Americans afflicted by neurologic disorders like paralysis, multiple sclerosis, and muscular dystrophy.**[26]

Federal drug agencies were whipsawed by these accelerating demands for care. **DEA steadfastly maintained marijuana has no medical value even as FDA authorized marijuana's compassionate medical use for the treatment of an expanding number of life-and sense-threatening diseases**. By April 1991, this profound contradiction in federal policy brought the medical prohibition into crisis.

The Collapse of Compassion

This crisis in policy reached critical mass in April 1991, when the U.S. Court of Appeals rejected DEA's standards for scheduling marijuana.[27] In so ruling the Court focused on the central contradiction in federal policy: **how could DEA argue marijuana is medically useless if FDA routinely authorized marijuana's therapeutic availability in compassionate programs of medical care?**

Bush Blunders

The Bush Administration foolishly sharpened public awareness of this long unresolved problem in June 1991, when PHS Chief James O. Mason abruptly and arbitrarily terminated the nation's fourteen year old Compassionate IND program for medical marijuana.

Confronted by a rising tide of demands for licit access to medical marijuana, alarmed by DEA's rapidly eroding legal position, and under escalating bureaucratic pressure to "do something," the Bush Administration panicked. **PHS Chief Mason initially cited the "surge in new applications" as his reason for terminating the long-standing program.**[28]

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[26] "Couple Urges Medicinal Use of Marijuana," *Chicago Sun-Times*, March 1, 1991. "Marijuana Helps Soothe MS Victims," *Cape Cod Times*, March 19, 1991. "Paraplegic Lauds Marijuana's Benefits," *The Tampa Tribune*, April 20, 1991.
[27] A.C.T. v DEA, U.S. Court of Appeals (D.C. Circuit). April 26, 1991, No. 90-1019. See also "DEA Told to Reevaluate Marijuana's Medical Value," *The Washington Post*, April 27, 1991.
[28] "H.H.S. to Phase Out Marijuana Program," by Michael Isikoff, *The Washington Post*, June 22, 1991.

“**It is more than being cruel. It’s uncivilized.**”
Ron Shaw
Chronic pain patient
Florida Today, March 4th, 1992

“They’re giving me a death sentence.”
Tim Braun
AIDS patient
AP, March 12, 1992

“**Why won’t they believe us?**”
John Skidmore
AIDS patient
CNN, March 13, 1992

Mason’s announcement caught policy-makers in the White House off-guard. It also triggered intense, universally negative editorial reaction. People with glaucoma, AIDS and other serious illnesses besieged the White House, Congress and the bureaucracy. This fierce, sustained public reaction stunned the Bush White House.[29]

For the next nine months, while desperately ill Americans suffered, the Bush Administration was torn by protracted inter-bureaucratic debate.

Events in the real world only deepened the Bush Administration’s confusion.

- October 8, 1991: The Florida Supreme Court ruled marijuana can be a drug of “medical necessity” in the treatment of AIDS.[30]

[29] “Medical Quandary Pushing Husband On Illegal Path”, by Cory Farley, *Reno Gazette-Journal*, (Reno, Nevada), June 18, 1991; “Feds Withhold AIDS Couple’s Marijuana,” by Phil Davis, *News Herald* (Panama City, Florida), June 21, 1991; “US Curbs Marijuana Distribution for Ill,” *Chicago Tribune*, June 23, 1991; “Pot Better For Chemotherapy,” *Tampa Tribune*, June 27, 1991; “Patients Blast Decision To Ax Marijuana Medicine Program,” *Sioux City Journal* (Sioux City, Iowa), June 28, 1991; “Woman Pleads For Marijuana To Ease Glaucoma,” *Fremont Tribune* (Fremont, Nebraska), June 29, 1991; “Stoned Cold Justice,” *Boston Globe*, July 7, 1991; “Medical Marijuana,” *Orange County Register*, September 11, 1991; “Paralyzed Push For The Right To Medical Marijuana,” St. Petersburg Times, October 2, 1991; “Forbidden Relief,” *Dallas Morning News*, November 10, 1991.
[30] *State of Florida v Kenneth & Barbara Jenks* See “Significant Legal Cases,” Appendix.

- November 6, 1991: Nearly 80% of the voters in San Francisco rejected the medical prohibition. By some estimates, more than 65% of the city's conservative voters favored marijuana's medical availability.
- December 1, 1991: The popular CBS News magazine program *Sixty Minutes* highlights the question of marijuana's medical availability in a segment titled "Smoking to Live."
- February 1992: The National Association of People With AIDS (NAPWA) endorsed marijuana's medical availability in AIDS care and called on the White House to maintain the Compassionate IND program.
- February 1992: **The nation's ten legal marijuana smokers blasted the Bush Administration for "turning the promise of compassionate care into a cruel bureaucratic con game played against desperately ill Americans."** The patients accused PHS Chief James O. Mason of **"medical terrorism."**[31]

Administration officials, traumatized by these external events, wandered through indecisive policy debates marked by months of private meetings attended only by bureaucrats and political appointees. **The obvious chaos solidified public impressions that federal drug policy was being driven by ideology and not by concern for the needs of seriously ill Americans.**

What the Press Says . . .

[31] "Medical Marijuana Chief Should Resign, Patients Say," *Saint Pioneer Press* (St. Paul, Minnesota), February, 5, 1992. "Official Accused of Medical Terrorism," *Orlando Sentinal* (Orlando, Florida), February 5, 1992.

Let Sick People Have Medicinal Marijuana

"Sick people should not have to become outlaws to relieve their suffering."
USA Today,
November 24, 1992

Kinder, Gentler Marijuana Policy

"When the medical history and testimony of patients…. Are juxtaposed against the policy dictates of the Bush Administration and the impact they have on individuals, the meanness of the federal bureaucracy is inescapable. [We] can and must be more humane."
The Boston Globe,
June 5, 1992

The Drug War Claims More Innocent Victims

"The Public Health Service's message to [patients who medically need marijuana] is: Drop dead. The bureaucrats … don't deny that marijuana helps. But if some people with AIDS will die sooner rather than later because they can't get pot, the people at PHS are bravely resolved to accept that sacrifice . . . . Plenty of Americans can see the difference between legalizing marijuana for recreation and legalizing for medical treatment. Why can't the drug warriors in Washington?"
Stephen Chapman,
The Chicago Tribune
March 12, 1992

Medical Use of Marijuana; Let Doctors Decide

"[T]he Public Health Service recommendations evidence a prejudice against study of this natural drug's medical effectiveness. Such prejudice is especially unfortunate because of marijuana's low toxicity, far lower than aspirin… Such hypocrisy is not harmless; it can turn medically needy citizens into criminals."

The Star Tribune,
Minneapolis, Minnesota
March 23, 1992

War on Drugs Heaps Suffering on Sufferers

"It's a shameful decision…. [T]o ban the use of marijuana as a medicine has nothing whatsoever to do with the physical effects of the drug on its users; the decision is based solely on the political effects of the drug on Bush's ill-advised war on drugs."
The News-Herald,
Panama City, Florida
March 13, 1992

Why Not Let Suffering People Use Pot?

"It's obvious that the government hasn't made or sponsored the studies necessary to find out for sure whether marijuana can be beneficial …. Why in the world not, given the accumulation of reports from patients who say pot has helped them when nothing else has? It's inexcusable that the necessary answers aren't available to sick and suffering people who need them."
From the *Chicago Tribune*,
as published in "Other Voices,"
The Tampa Tribune
March 25, 1992

The Last Smoke

"Some sick people who would benefit from marijuana will be deterred by the ban; others, desperate, will smoke it anyway. So far, 35 states have endorsed medical marijuana. In San Francisco police have agreed to turn a blind eye to it. Unless the government does something similar, smoking marijuana to relieve intolerable discomfort will remain, incredibly, a crime.
The Economist,
March 28, 1992

The Government's Tunnel Vision Denies Pot's Useful Potential

"It seems the Public Health Services and corollary agencies such as the National Institutes of Health are doing everything in their power to deny the obvious -- that marijuana deserves consideration as a prescription drug. This tunnel vision brought on by a single-minded drug war and election-year politics is not only unscientific, it's cynical and cruel."
The Mining Journal,
Marquette Michigan
March 29, 1992

In a futile attempt to escape this public censure the White House Office of National Drug Control Policy actually joined the chorus of outrage. In January 1992, **White House officials called PHS Chief Mason's actions "unconscionable" and bluntly told PHS "people are suffering" because of bureaucratic delays in the delivery of FDA-promised supplies of medical marijuana**. The White House promptly leaked this scathing letter.[32]

Bush Blunders II

It was too late. In March 1992, War on Drugs hardliners in the bureaucracy won. Bush killed the FDA's Compassionate IND program for medical marijuana.[33] **FDA dumped hundreds of Compassionate IND applications into the trash and scores of patients were arbitrarily denied promised access to medical care.** Only a handful of patients -- those already receiving medical marijuana -- were spared.

Editorial and news reaction to the March 1992 announcement was even harsher and more sustained than in June - September 1991.[34] PHS efforts to justify the policy shift were subjected to outright ridicule. To make matters worse, high officials in PHS, FDA, NIDA and the White House - in off-the-record comments - routinely told reporters they strongly opposed the Bush Administration's decision to terminate the Compassionate IND program for medical marijuana.

The most scathing comments, however, came from the seriously ill. One Minneapolis AIDS patient, Tim Braun, captured the public mood when he told the *Associated Press*, "I think it's a decision … made by some bozos that don't get their fat duffs out of the office and ask the doctors who work with patients like this, talk to the patients who are using it, talk to the families and the friends that see the difference."[35]

Braun received the FDA approval for marijuana therapy in December 1990. For nearly eighteen months, while bureaucrats bickered, Tim Braun waited for his FDA-promised marijuana. Often he could not obtain enough marijuana off the streets to meet his needs. During these times Braun always lost weight. At one point he lost 60 pounds.

When an *AP* reporter told Tim Braun about the PHS decision to kill the Compassionate IND program Tim prophetically said, **"They're giving me a death sentence."**[36] Tim Braun, 44, died two months later without ever receiving the compassionate care his government had promised to provide.

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[32] "Delay in Lifting Ban on Pot for Ill Is Assailed," by Ronald J. Ostrow, *Los Angeles Times*, January 31, 1992; "Drug Office Blasts Delay on Medical," *San Francisco Chronicle*, January 31, 1992.
[33] "The Last Smoke," *The Economist*, March 28, 1992. "Marijuana Still A Drug, Not a Medicine," by Katherine Bishop, *The New York Times*, March 22, 1992.
[34] See "What the Press Says."
[35] "Government Limits Marijuana Medical Use," *Houston Chronicle*, March 11, 1992, p. 6A.
[36] Ibid.

Critics charge **Bush killed the program in a craven attempt to appease War on Drugs hardliners and homophobic elements of the religious right.**[37] Destroying the nation’s marijuana-as-medicine program may have appealed to a few cultural zealots in Bush’s narrow base, but **“killing compassion”** fueled the already wide-spread public perception Bush was **“out of touch,” “uncaring,”** and **“too ideological”** to remain in office.[38]

Aftermath

Bush’s politically maladroit move to kill the Compassionate IND program has galvanized patients, physicians and drug reform advocates. As a result, the incoming administration faces an active, aggressive and broad-based coalition ready to amplify deep-seated public demands for an end to the medical prohibition.

By far the most legitimate and powerful voices in this emerging coalition belong to seriously ill Americans who command media attention. A review of media from June 1991 through June 1992 underscores just how decisively **a few well-spoken patients “won” the public debate** against George Bush. Significantly, editorial and press reaction to Bush’s medical prohibition was universally negative, often hostile.[39]

“**Essentially, we’re victims but they’re making us criminals**”

Ladd Huffman
MS patient
Des Moines Sunday Register, March 22, 1992

“**Closing our eyes to what’s happening is not helping; it is the real blindness.**”

Elvy Musikka
Glaucoma Patient
Oregon Daily Courier, October 1992

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[37] “The Sick Who Need Pot Say Anti-Drug Era Hurts,” by Cory Jo Lancaster, *Orlando Sentinel*, March 4, 1992.
[38] “Pot as Medicine: Unfair Decision,” *The Ann Arbor News*, as reprinted in The Bay City Times, March 23, 1992. “Medicinal Use of Marijuana Inconsistent,” by Ken Fuson, *Des Moines Sunday Register*, March 22, 1992. “Marijuana Ban Sparks Outrage,” by Alfredo Azula, *The Phoenix Gazette*, March 16, 1992.
[39] “The Drug War Claims More Innocent Victims,” by Stephen Chapman, *Chicago Tribune*, March 12, 1992, p. 29. “War on Drugs Heaps Suffering on Sufferers,” *The News Herald* (Panama City, Florida), March 13, 1992. “Medical Use of Marijuana: Let Doctors Decide,” *The Star Tribune* (Minneapolis), March 23, 1992.

SYNTHETIC SOLUTIONS

Rather than respond to public and political demands for marijuana's medical availability, federal drug agencies are instead promoting bureaucratically sanctioned alternatives that are synthetic, expensive, and often ineffective. It is ironic that after decades of pretending marijuana is medically useless, federal drug agencies are now aggressively pushing synthetic Marinol, the so-called "pot pill," by arguing it is as safe and effective as marijuana.[40]

Patients familiar with the synthetic "pot pill" have strongly condemned the bureaucrats for "pushing" an inferior substitute. One AIDS patient recently told a reporter,

> "I tried [Marinol]. I went through five pills before I was able to keep one down… When I did manage to keep one down it took a long while to take effect, and only worked about half a day. Two or three tokes on a joint helps me immediately."[41]

Let'em Eat THC

Delta-9-Tetrahydrocannabinol (THC) is the most powerful *psycho*-active chemical in marijuana. Synthetic THC was developed for drug abuse research on rats and other animal subjects. **The synthetic "pot pill" was never intended for human use in a routine of medical care**. In the early 1980s, however, federal agencies were overwhelmed by demands for legal access to government supplies of marijuana cigarettes for use in legislatively authorized, state programs of patient care. **FDA and DEA, unable to meet these state requests for natural marijuana, began promoting synthetic THC pills as a therapeutic substitute for marijuana**.

In September 1980, federal agencies released THC through the National Cancer Institute's Group C Treatment Program. Then federal agencies frantically searched for a private-sector pharmaceutical company to sponsor a New Drug Application (NDA) for the federally-developed THC pill. In exchange, federal agencies promised the company exclusive control over the medical market for synthetic THC.

This promotion of synthetic THC was not designed to meet legitimate human needs. **It had only one objective: to maintain the medical prohibition against marijuana**.
The public was told "Pot Pill Approved." Federal drug agencies assisted in a disinformation campaign by saying marijuana was no longer medically needed because the modern, synthetic "pot pill" had arrived. **Federal agencies knew this was a lie**.

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[40] "One alternative is the use of the oral dosage form of the major active ingredient in marijuana, delta-9 THC….. Its trade name is Marinol…. Marinol may be as effective and even less likely to cause adverse effects than smoking marijuana cigarettes in controlling your patient's symptoms." *Information for the Physician on the Use of Marijuana Cigarettes Provided by the National Institutes on Drug Abuse*, Fact Sheet prepared by NIDA, August 1991.
[41] "They Smoke Pot, But Not to Get High," by Sylvia Rubin, *San Francisco Chronicle*, March 13, 1992.

What Patients Say . . .

"**Overall I was very disappointed with Marinol. Never did it seem to relieve my nausea …. It didn't help my appetite, much less ease my headaches. Compared with marijuana, Marinol is a joke**."

Jim Barnes
Michigan AIDS patient

"**While synthetic THC helped to control my spasms, I noticed that the drug appeared to become less effective with repeated use. I also noticed that, unlike marijuana, THC had a powerful mind-altering effect**…"

David Bransetter
Missouri quadriplegic

"**The difference was like night and day. When I used marijuana it was much more helpful.**"

Ron Jochim
Maryland cancer patient

"**I've been taking Marinol for more than a year. But it's very hard to regulate. It doesn't stimulate my appetite. Marijuana stimulates my appetite [and] is a lot easier to control than the Marinol pill.**"

Daniel Parsons
New Hampshire AIDS patient

"**We expected [Marinol] would work as well as marijuana. We were wrong.**"

John J. Dunsmore, Jr.
Colorado father of cancer patient

"**There was a really big difference between how I feel after smoking marijuana and how I feel after Marinol. Marijuana makes me feel relaxed. I can think clearly.**"

Barbra Jenks
Florida AIDS patient

"**Based on our findings in New Mexico, marijuana has distinct therapeutic advantages over synthetic THC.**"

Katy Brazis, R.N.
New Mexico oncologic nurse

"**Marinol is ok sometimes. And sometimes Marinol fails to work and I feel nauseated. Marijuana always works.**"

Rocky Lane
California AIDS patient

"**If Sheila has marijuana to smoke she doesn't get real sick.**"
Rosalie Pluskis
Wisconsin mother of cancer patient

Marinol Isn't Marijuana

The problem with this synthetic strategy was most quickly evident to patients. Marinol isn't marijuana. The synthetic solution failed because Marinol is only marginally effective.

The difference between marijuana and THC was apparent from the outset. Cancer patients quickly discovered smoking marijuana is far more effective than swallowing oral THC pills.[42] During the DEA hearings before Judge Young, one researcher, Norman Zinberg, M.D., testified that during his 1974 research nearly **half the patients quit his legal, THC-based study in order to obtain illegal, but more effective, marijuana.**[43]

Zinberg's observations were amplified in an internal National Cancer Institute (NCI) memo from mid-1978. **Synthetic THC is described as "erratic," "unpredictable," and finally dismissed as "unfit" for human use.** Marijuana cigarettes, by contrast, are described as "reliable" and "highly predictable." After reviewing the available evidence the cancer specialists at NCI concluded, **"All in all the [marijuana] cigarette may be the best means of delivering the drug."**[44]

After reviewing the available evidence DEA Judge Francis L. Young concluded Marinol is not an adequate substitute for marijuana.[45]

Some will argue these are "old" conclusions. Yet as recently as 1992, Dr. Robert Gorter, a primary researcher of synthetic Marinol's use in AIDS therapy, echoed Zinberg's testimony:

"Again and again patients have testified that they prefer marijuana above dronabinol [Marinol] for its appetite stimulating effect. Therefore, it is hoped that marijuana will stay an option for the medical treatment of [wasting syndrome] in AIDS patients."[46]

Why is inhaled marijuana superior to synthetic THC?

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[42] "Theoretically, smoking might be the preferable route since it results in less variability of absorption through the gastro-intestinal route. Moreover, smoking provides greater opportunity for individual patient control by permitting the patient to regulate and maintain the 'high'." S. Sallan M.D., &E.I. Frei III, M.D. "Antiemetic Effect of Delta-9-Tetrahydrocannabinol in Patients Receiving Cancer Chemotherapy," *New England Journal of Medicine*, Vol 293, No. 16, (October 15, 1975), pp. 795-797.

[43] Direct Testimony of Norman Zinberg, M.D., *Marijuana, Medicine & The Law, Vol. I*, p. 416.

[44] National Cancer Institute, internal memo dated May 15, 1978. Minutes of a May 9, 1978 meeting, pages 1 & 4.

[45] "Marijuana cigarettes in many cases are superior to synthetic THC capsules in reducing chemotherapy-induced nausea and vomiting. Marijuana has an important, clear advantage over synthetic THC capsules in that natural marijuana is inhaled and generally takes effect more quickly than the synthetic capsule which is ingested and must be processed through the digestive system before it takes effect." Decision of Judge Francis L. Young, *Marijuana, Medicine & The Law, Vol. II*, p. 413 at 3.

[46] Robert Gorter, M.D. "Management of Anorexia-Cachexia in Advanced HIV Disease," *PAACNOTES*, Vol 3, No. 5, 1992.

Speed of delivery: When inhaled, marijuana reduces nausea and vomiting in five to ten minutes.[47] Marinol, when ingested, takes 1 to 4 hours to start working. This gives patients plenty of time to throw up the pill.

Control of Dose: Marijuana, when inhaled, **works so quickly patients can exercise very fine control over their dose**. Once relief is achieved they simply stop smoking. Inversely, a patient exercises NO control over an oral dose; once the pill is swallowed all further control is lost. Moreover, because oral THC takes so long to work, and works so erratically and unpredictably, patients may take a second oral dose. **Little wonder adverse psychological effects are far more common among people employing oral Marinol than among those smoking marijuana.**

Chemical Composition: Marijuana, like all naturally occurring substances, is chemically complex. **Marijuana has more than 400 chemical ingredients**. Little is known about which chemical ingredients -- or what combination of ingredients -- are responsible for the plant's multiple therapeutic actions. Federal agencies did not approve Marinol because of evidence indicating delta-9-THC is marijuana's most *therapeutically*-active ingredient. Delta-9-THC was synthesized to facilitate drug abuse research on marijuana's psychoactive effects. **Trapped by their legal fixation on psychoactive effects, federal agencies simply assumed, despite ample evidence to the contrary, that what gets you "high" makes you well.** The irony, of course, is that to avoid making marijuana medically available, **federal agencies are now aggressively promoting a synthetic alternative which contains pure THC which is profoundly more psycho-active than marijuana in its natural form.**[48]

Pills are medically familiar. Smoking is not. Opponents of marijuana's medical use often argue inhalation is not compatible with modern medical practice. In the name of science such opponents would deprive those who are now ill of care while researchers endeavor to create a perfect "marijuana-like pill." **Advocates of marijuana's medical availability do not contend marijuana is "perfect" or object to research into synthetic alternatives.** Such research must continue and, in some cases, begin.[49] But **it is medically unethical to use an elusive search for pharmaceutical perfection as an excuse to deprive millions of currently ill Americans of therapeutic access to an effective, albeit imperfect, treatment.** This is particularly true when one considers the long and distinguished history of marijuana's medical use. **To put it simply; how can the government criminalize seriously ill citizens who choose to medically use a God-given plant?**

[47] "Marijuana cigarettes have been used to treat chemotherapy-induced nausea and vomiting and research has shown that the active ingredient THC is more readily and quickly absorbed from marijuana smoke thgan from an oral preparation of the substance." From *Marijuana For Chemotherapy-Induced Nausea and Vomiting*, Fact Sheet Prepared by the National Cancer Institute, February 12, 1992.
[48] According to a Harvard University survey of oncologists, 44% of cancer specialists believe marijuana more effective than Marinol and 47% stated Marinol caused negative side effects. "Marijuana as Antiemetic Medicine: A Survey of Oncologists Experiences and Attitudes," *Journal of Clinical Oncology*, (July 1991), p. 1316.
[49] "Many of the therapeutic properties of cannabis have been verified with pure natural or synthetic cannabinoids. In several fields, however, no modern work exists. The most blatant examples are the anthelmintic, antimigraine, and oxytocic effects. Are we missing something?" Raphael Mechoulam, Ph.D., *Cannabinoids as Therapeutic Agents*, (Boca Raton, Florida: CRC Press, Inc.) 1986, p.16.

The Great White Drug

When bureaucratic attempts to push synthetic Marinol as a substitute for marijuana fail, federal drug agencies fall back on another old standard: there are "new" drugs which make marijuana medically unnecessary.

In the early 1980s, for example, federal agencies promoted Torecan (Reglan) as an antiemetic substitute for marijuana. Health care workers like Torecan because patients are well-controlled. Indeed, Torecan **renders patients nearly comatose.** Many still vomit, but **they are not conscious enough to care**.

Michigan tested the Torecan alternative in their state-authorized marijuana program. Researchers allowed patients to begin on Torecan or marijuana. Patients could, at any time, elect to switch to the alternative drug. Significantly, **90% of the patients who started on marijuana stayed on marijuana.** Even more significantly, 90% of the patients who received Torecan elected to switch to marijuana.[50]

The most recent "new" drug receiving bureaucratic praise as a marijuana alternative is Zofran which **costs $600 *per dose* and requires hospitalization at a cost of $500 - $1,500 *per day***. Zofran is said to be effective 75% of the time in helping patients vomit six times or less per chemotherapy treatment.

By contrast, **marijuana costs a penny per dose, patients can safely use it at home, and marijuana helps 90% of cancer patients unable to obtain relief using prescriptive antiemetic agents.**[51]

There is a final important difference. Zofran is not an appetite stimulant. Marijuana is.
A patient employing marijuana at home can sit down to eat dinner with the family. This is not a matter of insignificant benefit.[52]

As Kenny Jenks, Chairman of the *Marijuana*/AIDS *Research Service* (MARS) has noted, "To the unintentionally anorexic the munchies can be a life-saver."[53]

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[50] *Marijuana Therapeutic Research Project*: Trial A 1980-1981," Department of Social Oncology - Evaluations Unit, Michigan Cancer Society, March 18, 1992, Table 9 at pg 10. See *Marijuana, Medicine & The Law, Vol II*, p. 45.
[51] Ibid. See Chang/NCI & New Mexico studies, *Marijuana, Medicine & The Law, Vol. II*, pp. 34-38.
[52] Mae Nutt testified that when her son Keith, a cancer patient, had access to marijuana, "He would join the family for dinner, where he would eat more than his share. He became outgoing and talkative. Keith became part of our family again because [of] marijuana…." *Marijuana, Medicine & The Law, Vol. I*, p. 91 at 42.
[53] Press Conference to announce creation of the *MARS Project*, February 28, 1991, Chicago, Ill.

Let The Market Decide.

No one is advocating that all patients with marijuana-responsive disorders be forced to use marijuana. **Ultimately the decision to employ any medication is a profoundly personal decision which is best left to the patient and physician.** In a more rational world natural marijuana and synthetic Marinol would both be medically available and patients and physicians would determine which drug was most appropriate for a particular treatment need. The market would decide.

For nearly two decades, federal agencies have used the medical prohibition to prevent such a market-based determination. They have compounded this error by granting an exclusive monopoly to the manufacturer of Marinol. In doing so FDA has ensured that the American people will be forced to pay exorbitant prices to obtain a demonstrably inferior synthetic substitute developed and researched almost exclusively at tax-payers' expense.

Surely if physicians
can be trusted to prescribe morphine,
they can be trusted
to employ marijuana in a safe,
medically appropriate
manner.

INITIAL STEPS

WHAT CAN PRESIDENT CLINTON DO?

One thing is certain, inaction is not an option. The Clinton Administration will be publicly compelled, early on, to take steps to resolve this problem. Fierce bureaucratic resistance is likely.

Presidents Come & Go

Federal drug agencies will conspire to enmesh President Clinton in a foolhardy defense of their publicly unpopular medical prohibition. **The bureaucrats will use pending legal actions against DEA to draw the new administration into the issue on their side.**[54] It is also possible federal agencies could initiate actions designed to embarrass the new administration.[55] These bureaucratic pressures can be considerable. The nine months of policy chaos triggered by PHS Chief Mason's impromptu attempt to kill the Compassionate IND program in June 1991 was **an outgrowth of the deeper struggle between ideologues in the bureaucracy and political realists** in the Bush White House.

By January 1992, White House realists, alarmed by the corrosive political effects of the medical prohibition, publicly called bureaucratic efforts to kill the Compassionate IND program "unconscionable." Yet, in March 1992, War on Drugs ideologues won. The program was terminated. **FDA dumped hundreds of Compassionate IND applications into the trash and scores of patients were arbitrarily denied promised access to medical care.** Only a handful of patients - those already receiving medical marijuana - were spared.

In the end, the bureaucrats got their (nearly) absolute prohibition. But at what price? President Bush was subjected to months of negative news stories and scathing editorial comment which reinforced the already widespread public apprehension that **zealots had taken over his administration** - as indeed they had. Bureaucratic resistance to marijuana's medical use is deeply ingrained. **Entrenched and terrified of change, federal drug bureaucrats do not have to live with the political consequences of their publicly discredited prohibition**. Politicians, as Mr. Bush recently learned, are not so easily forgiven.

On The Other Hand

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[54] The Alliance for cannabis Therapeutics, joined by the Physicians Association for AIDS and The Lymphoma Foundation of America, has appealed DEA's March 1992 rejection of Judge Young's 1988 ruling that marijuana should be rescheduled. *A.C.T. v DEA*, U.S. Court of Appeals (D.C. Circuit Case No. 92-1168).

[55] Federal agencies could sabotage scheduled shipments of medical marijuana to the ten seriously ill Americans still receiving Compassionate IND care. War on Drugs hardliners in the bureaucracy would exploit such supply disruptions to provoke a confrontation which publicly pits the incoming Clinton appointees against these seriously ill Americans. The bureaucracy would, of course, use the resulting confusion to solidify control over future drug policy.

If President Clinton fails to decisively address this problem, seriously ill Americans, backed by an articulate, broad-based coalition of drug law reform, legal, libertarian, medical, and patient-advocacy groups will focus this same powerfully corrosive media energy on the incoming administration.

Seriously ill Americans who medically need marijuana are increasingly well-organized and have ample access to national media. Events from June 1991 through June 1992 suggest the tremendous influence such patients can exercise. A review of the media during this period shows just how decisively these patients thrashed Bush and the bureaucrats who sought to block marijuana's medical availability.

If President Clinton takes no action **these demands for reform will intensify**. Some **elements within this broad coalition may cynically exploit seriously ill Americans in a misguided attempt to promote reforms which have nothing to do with marijuana's medical availability**. The notion that ending the medical prohibition will automatically lead to the backyard cultivation of marijuana may appeal to romantics in "the movement." But **such antic aspirations do not seriously address the legitimate treatment needs of the ill**.

The American people -- in particular those who are seriously ill -- will not be well served by a Punch 'n Judy culture clash between ultra-prohibitionists on the far right and utopian reformers on the far left. The Clinton Administration cannot meet the needs of seriously ill Americans by responding to pressure from "ideologues" and "activists" operating on the political margin; left or right.

Beyond Cultural Warfare

By advancing a decisive, yet moderate plan to resolve the problem of marijuana's medical availability the Clinton Administration can:

- Avoid public identification with extremely unpopular Bush policy,
- Seize the initiative in crafting a credible solution, and
- **Effectively demonstrate a willingness to cut through the decades of ideological crap and bureaucratic stonewalling to deliver the kind of "change" the American people expect**.

The nation is ready to resolve this problem as two recent editorialists illustrate.

On January 4, 1993, the *Albany Times Union*, noted: "**We are somewhat incredulous… that the federal law of the land still bars marijuana for any medical use**…" In keeping with public opinion, the editors in Albany conclude, "**There's no good reason to forbid such use.**"[56]

[56] "Let Doctors Prescribe Pot," *Albany Times Union*, editorial, January 4, 1993.

The following day, a continent away, the *Oakland Tribune* echoed the comments of the *Albany Times Union* when it observed that the medical prohibition is "wrong-headed because it **denies reality**." The *Tribune* noted that morphine and cocaine, "highly addictive drugs, are available for doctors to prescribe. Their use is successfully controlled through extra-stringent prescriptions."

The paper concluded with **a call for "clear-headed and compassionate policy that allows the medical use of marijuana."**[57]

The recommendations outlined in this document will not satisfy libertarians and those on the left who advocate sweeping changes in the U.S. drug law. Nor will these recommendations appeal to the ultra-prohibitionists in the bureaucracy and on the right. In short, the recommendations advanced here are not designed to satisfy those with a merely political agenda.

These recommendations instead appeal to the broad American middle. They focus on three simple objectives: 1) meeting the legitimate treatment needs of those who are currently ill, 2) increasing marijuana's availability for research, and 3) exploring pragmatic ways to resolve the regulatory problems created by five decades of irrational federal policy.

The American people know marijuana has important medical benefits. What is now needed is a rational plan to make marijuana legally available, under medical supervision, to those with legitimate medical needs.

RECOMMENDED ACTIONS

Step I - Restore the Compassionate IND program for medical marijuana

It is imperative the government meet the legitimate medical needs of currently ill Americans by restoring the Compassionate IND program for medical marijuana.

This is the minimum action the Clinton Administration should take.

The Compassionate IND program, created in 1978 during the Carter Administration, was arbitrarily terminated by the Bush Administration in March 1992.[58]

President Clinton should reverse PHS Chief Mason's publicly unpopular and arbitrary action by fully restoring the nation's Compassionate IND program for medical marijuana.

[57] "Marijuana Therapy Should Be Approved," *The Oakland Tribune*, January 5, 1993.
[58] PHS Chief Mason's order terminating the Compassionate IND program for medical marijuana, March 4, 1992. From F.O.I.A. materials obtained by the Drug Policy Foundation, Washington, D.C.

Prior to March 1992, FDA had authorized marijuana's compassionate, therapeutic availability to persons afflicted by glaucoma, cancer, AIDS, multiple sclerosis, muscular dystrophy, paralysis, and chronic pain.

Of the highest priority: all persons who received FDA approval under the Compassionate IND program prior to March 1992 should receive the licit treatment access to marijuana they were promised. **FDA should be firmly instructed to handle all future Compassionate IND applications for marijuana in a timely, legally appropriate manner.**

IMPLEMENTATION

Step I can be implemented by Executive Order of the President. Restoration of the nation's marijuana-as-medicine program can also be accomplished by the Commissioner of FDA, the Chief of Public Health Service, the Assistant Secretary for Health or the Secretary, Health and Human Resources.

FDA and DEA will seek to block restoration of this program. At some point, they will simply assert there is not enough "legal" marijuana in federal stockpiles to meet the anticipated needs of Compassionate IND applicants. The most obvious response, of course, is to instruct the bureaucrats to **grow more marijuana**.

In addition to meeting the legitimate treatment needs of those who are currently ill, **a properly administered Compassionate, single-patient IND program could quickly provide a wealth of information on the full range of marijuana's therapeutic actions.** Treatment and research would advance hand-in-hand.

Step II - Encourage aggressive medical research by rescheduling marijuana from Schedule I to Schedule II of the CSA

The medical prohibition is rooted in ideological, not medical concerns. This ideological view is most evident in DEA's discredited definition of marijuana as a medically useless Schedule I drug. **This irrational classification is not legally tenable.**[59]

DEA has used marijuana's highly restrictive Schedule I status to impede legitimate research efforts and intimidate physicians seeking Compassionate IND approval.[60]

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[59] "The Administrative law judge recommends … the marijuana plant considered as a whole has a currently accepted medical use in the treatment in the United States, that there is no lack of accepted safety for use of it under medical supervision and that it may lawfully be transferred from Schedule I to Schedule II." Decision of Judge Francis L. Young, See *Marijuana, Medicine & The Law, Vol. II*. pp. 445-446.

[60] DEA agents have routinely conducted extensive face-to-face interviews with physicians who requested Compassionate IND access to medical marijuana. During such encounters law enforcement officers demand that licensed physicians justify treatment decisions. The intent of these interviews is to harass, coerce, and intimidate the physician.

DEA's Schedule I classification of marijuana has already been declared "unreasonable, arbitrary and capricious" by the agency's chief administrative law judge, and the U.S. Court of Appeals (D.C. Circuit). This matter is still being litigated in the pending case of ACT v DEA.

If President Clinton fails to alter the DEA's misclassification of marijuana his DEA Administrator and his Attorney General will soon have to appear before the U.S. Court of Appeals to defend DEA's publicly unpopular medical prohibition. Altering marijuana's classification to Schedule II would dramatically reduce regulatory barriers to cogent medical research while maintaining strict security requirements and severe criminal penalties for misuse of the drug.

For example, most physicians have a DEA registration to prescribe Schedule II substances. Placing marijuana on Schedule II would eliminate the need for physicians to seek special, Control I clearance from the DEA. It would also reduce often duplicative state reporting requirements. Many states require physicians engaged in Schedule I research to register with the state health and/or law enforcement agencies. No such special registration and reporting requirements exist for physicians engaged in the routine prescriptive use of Schedule II substances. **Surely, if physicians can be trusted to prescribe morphine (Schedule II), they can be trusted to employ marijuana in a safe, medically appropriate manner.**

Placing marijuana on Schedule II - **as many states have already done** - effectively removes DEA from direct involvement with physicians engaged in FDA-authorized studies. Rescheduling would in no way diminish FDA control over marijuana's therapeutic availability.

IMPLEMENTATION

Step II can be accomplished by Executive Order of the President, by action of the Attorney General, or the DEA Administrator. Since DEA's chief administrative law judge has already issued a detailed ruling recommending marijuana's immediate reclassification to Schedule II no additional hearings on this matter are required.

Step III - Appoint a Presidential Task Force to Explore Marijuana's Legal Availability for Medical Applications

Steps I and II are designed to address the urgent medical needs of the currently ill and permit physicians to aggressively explore marijuana's therapeutic uses. But steps I and II do not resolve the primary problem.

The medical prohibition of marijuana has been in place for more than five decades. In this time federal agencies have evolved rococo regulatory controls which have transformed the medical prohibition into a Gordian knot of Catch-22 provisions and contradictory bureaucratic demands. **This awkward regulatory structure is designed to thwart rational study and reform.** The Clinton Administration must cut through this Gordian knot of regulatory nonsense.

On the surface making marijuana legally available for medical purposes seems simple. As a natural substance, however, marijuana is not a "new drug." Nor does it have a private pharmaceutical sponsor. Creating a rational system of prescriptive medical access encompasses complex regulatory and legal issues. There are also concrete concerns of appropriate governmental control over, and involvement in, programs of research, cultivation, manufacturing, and distribution. These questions require careful, public consideration.

A Presidential Task Force should be created to isolate and evaluate such questions. **This Task Force should not be chartered to "decide" if marijuana is therapeutically useful. Patients and physicians, courts and legislatures, researchers, and history have already resolved this question.** Marijuana clearly has medical value. **The Task Force should be charged with determining how the nation can best acknowledge this fact in order to address the legitimate treatment needs of seriously ill Americans.**

This Task Force, in short, should provide President Clinton and his Administration with a cogent, humane plan for ending the medical prohibition by **creating a rational system of prescriptive access to marijuana.**

This Presidential Task Force should be chaired by the Surgeon General. But **this effort will lack credibility if the bureaucrats who created this problem are put in charge of defining a solution.** Public participation is critical to a successful outcome. **Members of this Task Force should be drawn from patients affected by the prohibition, researchers and physicians from various medical specialties, state and/or federal legislators familiar with health-related issues, representatives from disease-specific advocacy groups, experts in drug policy and law enforcement.**

Such a Task Force will require a small budget and staff and should have the power to call on federal officials and others to testify and provide guidance. Since people are suffering **the Task Force should move with dispatch and issue recommendations on needed regulatory and/or legislative actions** by late 1993.

CONCLUSION

Seriously ill Americans are suffering because of federal policies which prohibit marijuana's prescriptive medical use. To maintain this irrational prohibition, federal drug agencies have ignored the will of the people and the needs of seriously ill Americans, retarded research, obstructed the intent of state legislatures and refused to abide by administrative and judicial rulings. In March 1992, President Bush, under pressure from War on Drugs ideologues in the bureaucracy, arbitrarily terminated the nation's long-standing marijuana-as-medicine program. People are dying, going blind, and being crippled by this cynical policy.

Based on polling data, election returns, and the actions of their elected political representatives, **the American people do not support the medical prohibition**. Indeed, it is difficult to find any other question which unites so many of the American people in opposition to an existing federal policy. **A vast majority of Americans view the medical prohibition as a regulatory fraud**; an irrational outgrowth of War on Drugs zealotry.

President Clinton has two options. He can commit his political credibility to a foolhardy defense of the medical prohibition or he can move to end that prohibition. By taking moderate steps to meet the medical needs of seriously ill Americans, President Clinton can win broad public and political support for a rational system of prescriptive access to marijuana. Failure to resolve this problem will leave the new President exposed to attacks from ultra-prohibitionists on the right and utopian reformers on the left. These attacks will have a very corrosive effect on President Clinton's evolving relationship with the American people.

Federal drug agencies will, of course, strongly resist efforts to end the medical prohibition. It is likely these agencies will agitate their clients in politics, law enforcement, and the pharmaceutical sector to oppose such action. It is less likely, but possible, that medical marijuana could be exploited by some as a cultural "wedge" issue. However, **there is precious little political profit to be gained opposing compassion**. All available data indicate such arguments have very limited public appeal. Moreover, true conservatives are strongly opposed to bureaucratic interference in personal medical decisions. Conservatives supported state legislation recognizing marijuana's medical value. In Congress, many conservatives sponsored a federal marijuana-as-medicine measure.

The American people know marijuana has medical value, they are fed up with bureaucratic efforts to block marijuana's medical use, and they are wary of being victimized by those on the political margins - left and right - who advocate the cult of cultural warfare. The American people did not elect President Clinton merely hoping for change. They voted for Mr. Clinton to **initiate change**. We hope the pragmatic and moderate recommendations advanced in this document help those in the new Administration to secure such change **for the benefit of all Americans**.

***2021 Update: Nothing has changed.**

Shame.

APPENDIX

SUMMARY OF SUPPORT

Thirty-five states have legislatively recognized marijuana's medical value.

State courts in the District of Columbia, Idaho, Washington, and Florida have recognized marijuana can be a drug of "medical necessity." In 1988, DEA's Chief Administrative Law Judge ruled current **federal policies prohibiting marijuana's medical use are "unreasonable, arbitrary and capricious."**

The American Bar Association, the National Association of Criminal Defense Attorneys, the American Civil Liberties Union, the National Association of Attorneys General, the Conference of Episcopal Bishops, the National Association of People with AIDS, Mothers Against Misuse and Abuse, have called for a repeal of the medical prohibition of marijuana.

Polling data, available from a variety of sources over a period of more than a decade, consistently indicates between 70% to 80% of the American people believe marijuana should be legally available, by prescription, for the treatment of life-and sense-threatening diseases.

A 1991 Harvard survey of the nation's leading oncologists found that 44% of the cancer specialists had recommended patients break the law to obtain the marijuana they medically required. An astonishing 89% of those expressing an opinion felt marijuana should be legally available, by prescription.

In 1991, San Francisco became the first political jurisdiction in the U.S. to put the question of marijuana's medical availability on the ballot. Eighty percent of the electorate voted in favor of making marijuana legally available for medical purposes.

In 1992, a similar ballot measure in conservative Santa Cruz County received support from 77% of the voters.

In April 1992, the Physicians Association for AIDS Care (PAAC), the nation's largest organization of doctors involved in the treatment of H.I.V.-infection, and the National Lymphoma Foundation joined in suing the DEA for refusing to recognize marijuana's medical value.

Significant Legal Cases

While federal agencies adamantly maintain marijuana has "no accepted medical use in treatment in the United States," **the medical prohibition has come under strong legal challenge from seriously ill Americans who have been arrested on marijuana-related charges**.

U.S. v. Randall

In 1976, a Washington D.C. man afflicted by glaucoma employed the little-used Common Law doctrine of necessity to defend himself against criminal charges of marijuana cultivation. On November 24, 1976, federal Judge James Washington ruled Randall's use of marijuana constituted "medical necessity."

In part, Judge Washington ruled: "While blindness was shown by competent medical testimony to be the otherwise inevitable result of the defendant's disease, no adverse effects from the smoking of marijuana have been demonstrated… **Medical evidence suggests that the medical prohibition is not well-founded.**"[61]

Judge Washington dismissed criminal charges against Randall. **Concurrent with this judicial determination, federal agencies responding to a May, 1976 petition filed by Randall, began providing this patient with licit, FDA-approved access to government supplies of medical marijuana. Randall was the first American to receive marijuana for the treatment of a medical disorder.**

Randall v. U.S.

In 1978 federal agencies, disquieted by Randall's outspoken opposition to the medical prohibition, sought to silence him by disrupting his legal access to marijuana.[62] In response, Randall, represented pro bono publico by the law firm of Steptoe & Johnson, brought suit against FDA, DEA, the National Institute on Drug Abuse, the Department of Justice and the Department of Health, Education & Welfare.

Twenty-four hours after the suit was filed, federal agencies requested an out-of-court settlement. The resulting settlement provided Randall with prescriptive access to marijuana through a federal pharmacy located near his home. The settlement in Randall v U.S. became the legal basis for the FDA's Compassionate IND program.

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[61] U.S. v Randall, D.C. Superior Court, D.C. Crim. No. 65923-75, "Criminal Law & Procedure: Medical Necessity," *The Daily Washington Law Reporter*, Vol. 104. No. 250, (December 28, 1976), p. 2253.

[62] President Carter's drug advisor, Peter Bourne went so far as to threaten Randall. In a June 6, 1977 letter Bourne told Randall, "Publicity in this case has forced consideration of tightening up the dispensing of your supplies." Direct Testimony of Robert Randall, *Marijuana, Medicine & The Law, Vol. I*, p. 36 at 104.

Initially, this program was limited to patients afflicted by marijuana-responsive disorders and some orphan drugs. In the mid-1980's however, the Compassionate IND concept was expanded to include HIV-positive people seeking legal access to drugs which had not yet received final FDA marketing approval.

In the Matter of Craig Reichart

In response to pleas from the parents of a young man afflicted with terminal cancer, Imperial County Superior Court Judge Don Work issued three orders to facilitate the legal availability of marijuana to treat the symptoms of nausea, vomiting, and weight loss. Judge Work ordered the Sheriff of Imperial Court to provide the young man's physician with contraband supplies of marijuana; immunized the patient from criminal liability for possessing the marijuana provided to him by his treating physician.

State of Washington v. Diana

A man afflicted by multiple sclerosis (MS) was arrested and charged with possession of marijuana. At trial, Sam Diana argued his use of marijuana was a "medical necessity." The court refused to hear medical evidence and convicted Diana. The Washington Court of Appeals overturned the verdict and returned the case to the lower court for retrial. The appeals Court ruled that "medical necessity" was a valid defense and instructed the lower court to consider evidence of Diana's medical need.[63] On retrial Diana presented testimony from numerous medical experts, his treating physicians, his family and other multiple sclerosis patients who endorsed marijuana's medical value in relieving severe muscle spasms. The Court concluded that Diana was **"not guilty by reason of medical necessity."**

[63] *Washington v Diana*, Superior Court, Spokane Washington, March 4, 1981.

State of Florida v. Musikka

A middle-aged woman afflicted with glaucoma was arrested for growing six marijuana plants. At trial, Musikka, who had already lost sight in one eye as a result of failed surgical interventions, argued her use of marijuana was a "medical necessity." Musikka's treating physician, a noted ophthalmic researcher at Miami's famous Bascom-Palmer Eye Institute testified that "if marijuana were legal I would have prescribed it for Elvy Musikka's medical use in the treatment of glaucoma."

He further testified that, without marijuana, Musikka would go blind. The Court, after hearing from other medical experts, concluded Musikka's use of marijuana was protected by the Common Law defense of "medical necessity" and found Ms. Musikka not guilty. In reaching this verdict, Judge Mark E. Pollin wrote: **"This is an intolerable, untenable legal situation. Unless legislators and regulators heed urgent human needs and rapidly move to correct the anomaly arising from the absolute prohibition of marijuana which forces law-abiding citizens into the streets - and criminality - to meet their legitimate medical needs, cases of this type will become increasingly common in coming years.**

There is a pressing need for a more compassionate, humane law which clearly discriminates between the criminal conduct of those who socially abuse chemicals and the legitimate medical needs of seriously ill patients whose welfare and very lives may depend on the prudent therapeutic use of those very same chemical substances."[64]

U.S. v. Burton

Mr. Burton, a glaucoma patient, argued his use of marijuana was a "medical necessity." Testimony was received from Burton's personal physician, an ophthalmic physician who had researched marijuana's use in glaucoma therapy, from his uncle who was blinded by glaucoma, and relatives and others who testified to Burton's good character and work habits. The jury refused to convict Burton on the felony charge of marijuana cultivation with intent to distribute, but found him guilty of simple misdemeanor possession. **A Reagan-appointed federal judge, however, sentenced Burton, a Vietnam Veteran with no prior criminal record, to serve one year in federal prison**. **Federal drug agencies seized Burton's home, truck and farmland.** After serving his criminal sentence, **Burton and his wife fled the United States.** The couple now live in Holland, where Burton can legally obtain the marijuana he medically requires.

[64] *Florida v. Musikka*, 17th Judicial Circuit, Broward County Florida, Case No. 68 4395 CFA 10, *The Florida Law Weekly*, 14 FL W 1 (January 27, 1989).

State of Minnesota v. Gordon Hanson

A man suffering from epilepsy was arrested for growing marijuana. At trial, he argued his use of marijuana was “medically necessary” to control the debilitating seizures. Research neurologists from New York and Washington D.C. testified that Hanson’s use of marijuana was medically appropriate. The local court dismissed this medical testimony and found Hanson guilty. On appeal, the Minnesota Supreme Court ruled that “medical necessity” could not be used as a defense against criminalization for marijuana cultivation. The ruling drew sharp editorial criticism from many local newspapers. **Hanson served nearly one year in prison. During that time he had numerous gran mal and petit mal seizures.**

State of Florida v. Kenneth & Barbra Jenks

Kenny Jenks, a hemophilic, and his wife, Barbra, were arrested in March 1990 for growing two marijuana plants. They were charged with three felony counts. At trial, however, the young couple revealed they both were infected by the deadly AIDS virus, and argued that their use of marijuana was “medically necessary” to control nausea, vomiting, and rapid weight loss caused by advanced HIV infection. The local court refused to heed medical testimony from their treating physician and other experts and they were convicted on all three felony charges.

In April 1991, the Florida Court of Appeals reversed the lower court, overturned the young couple’s criminal conviction, and ruled their use of marijuana was a “medical necessity” in the treatment of AIDS In October 1991 the Florida Supreme Court upheld the Appeals Court’s verdict and ordered the prosecutor to file no further appeals in the landmark case.

State of Idaho v. Hastings

A woman afflicted by crippling arthritis was arrested for growing a few marijuana plants. At trial, she argued her use of marijuana was “medically necessary” to control the debilitating pain caused by her arthritis. Her treating physician, other patients afflicted by chronic pain and muscle spasm, testified in her defense. The local court refused to consider the medical evidence but withheld judgment. On appeal, the Idaho Supreme Court ruled the defendant did have the right to “introduce evidence relating to the common law defense of necessity.” The Court ordered the lower court to consider all evidence of Ms. Hasting’s medical needs. At this juncture, the prosecutor dropped all criminal charges against Ms. Hastings.

About the Authors (1993)

Robert Randall is president of the Alliance for Cannabis Therapeutics (ACT), a Washington-based patient rights group. A glaucoma patient, Mr. Randall was the first American to secure legal, medical access to marijuana and is the nation's leading advocate for marijuana's medical availability. He has authored numerous articles, books, and is a frequent lecturer on the topic of marijuana's medical uses.

Alice O'Leary is the publisher at Galen Press. Ms. O'Leary formerly worked for the Marijuana Reclassification Project, the National Women's Health Network, and for nearly a decade as the administrative officer of the Society for Scholarly Publishing. She is secretary-treasurer for Alliance for Cannabis Therapeutics. Her publishing company, Galen Press, is the nation's leading source of information on marijuana's medical uses.

- ***Alice O'Leary Randall*** *is a senior spokesperson for the medical marijuana movement, co-founded in 1976 with her late husband, Robert C. Randall, the first person in the U.S. to legally receive medical marijuana. Following her husband's untimely death in 2001, Alice took a well-earned break from the frontlines of the medical marijuana movement and embarked on a nursing career. Following her retirement in 2012, Alice has returned to the medical cannabis issue to educate and celebrate the contributions of many brave individuals who courageously fought for medical access to cannabis.*

Once called "First Lady of the medical marijuana movement," Alice O'Leary-Randall communicates her singular perspective on the emotional and long-running movement to legalize marijuana as medicine. She was literally there at the start. For two decades, she and her husband, Robert C. Randall, were advocates for medical access to marijuana. Robert, who had advanced glaucoma at a young age, discovered that he actually saw better after smoking pot. In 1976 he became the first U.S. citizen to have marijuana prescribed for a medical condition. Their personal battle is chronicled in their memoir, the highly respected Marijuana RX: The Patients' Fight for Medicinal Pot. In the late 1970s, Alice and Robert helped enact 35 state laws that recognized marijuana's medical value and attempted to establish state-sponsored research programs (the federal government thwarted these efforts).

In 1980 they founded the Alliance for Cannabis Therapeutics (ACT), the first non-profit organization dedicated solely to resolving the medical marijuana issue, and drafted national legislation that was introduced in the U.S. House of Representatives and had 110 co-sponsors. ACT served as the primary plaintiff in the historic DEA hearing on marijuana's medical utility in the mid-1980s. In the '90s, Alice and Robert secured funding from a Chicago-based backer and took the medical marijuana movement to new heights, paving the way for state ballot initiatives that have secured legal medical access to marijuana for citizens of seventeen states.

Hospice and nursing: From 2006 to 2012 O'Leary-Randall worked as a grief specialist and nurse for Tidewell Hospice, She also worked in oncology and emergency rooms in Southwest Florida. Additionally, she utilized her nursing skills on medical missions to Haiti, Peru, Uganda, and India where she was able to assist just one month after the tragic tsunami of 2004.

Association management: Alliance for Cannabis Therapeutics, Director, 1980-1995; Society for Scholarly Publishing, Administrative Officer, 1981-1989; National Organization for the Reform of Marijuana Laws (NORML), Coordinator Medical Reclassification Project, 1978-1980; and National Woman's Health Network, Membership Coordinator 1976-1977.

Publishing Company: Founded Galen Press that compiled and released five massive volumes of information collected between 1986-1987 during marijuana rescheduling hearings conducted by the Drug Enforcement Administration (DEA). These court-ordered hearings, spearheaded by ACT, constituted the most complete investigation of marijuana's medical utility in the 20th century. Galen Press has a second imprint, Looking Glass Publications, for non-marijuana-related titles.

International Considerations

In addition to the domestic hurdles outlined above, one issue has consistently been identified as a significant obstacle, the drug control treaty system / Single Convention on Narcotic Drugs. This is not just a problem for the United States. **The *War on Drugs* is a global failure**. The United Nations 1961 Single Convention on Narcotic Drugs has been looming over U.S. drug reform for decades. As of December 2, 2020, Cannabis has been removed from the most dangerous drugs category of the international treaty. Much is involved at the world stage, there are many moving parts, and we will need to dedicate considerable attention to this evolving situation.

- Commission on Narcotic Drugs Reconvened sixty-third session Vienna, 2–4 December 2020. Item 5 of the provisional agenda* Implementation of the international drug control treaties.
- United Nations 64th meeting of the Commission on Narcotic Drugs.
- The World Intellectual Property Organization: Importance of considering the Convention on Biological Diversity, associated trade rules and regulations needed to reduce the rate of deforestation associated with cannabis cultivation.
- This article from the Cannabis Business Times best captures some of the main points on how the Convention on Biological Diversity as codified in the Nagoya Protocol will need to be embedded into all national/international cannabis policy if the policy is to be equitable, earth-friendly, and sustainable.
- Voluntary contribution to INCB Cannabis Guidelines.
- The Importance of Appellations of Origin to the Successful Therapeutic Model of Whole Plant Cannabis.
- Food and Agricultural Organization: In the future, this is going to be an important entity to have on your radar. Cannabis must be viewed as an agricultural crop, regardless of THC content, and then taxed/regulated as such. UNODC Resolution, 1955.

Beyond Cannabis: Welcome to Today

Due in large part to the war on drugs, and cannabis specifically, we have been neglecting another potential series of breakthroughs. Psychedelic treatment for Veterans experiencing treatment-resistant PTS is currently underway. Cannabis may indeed prove to be a "gateway." A gateway to a more productive, healthy lifestyle. What is beyond that entrance, for long-term impact, are psychedelics.

Which ones specifically, show promise?

- **MDMA**
- **Psilocybin**
- **DMT**
- **5 MEO-DMT**
- **Ayahuasca**
- **Ketamine**
- **LSD**
- **Ibogaine**
- **Kratom**

Who is *working in this field*?

- **MAPS**
- **Scottsdale Research Institute**
- **Johns Hopkins**

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Veterans Action Council has created this document as a team effort created by a consensus process amongst military veterans working as equals towards a shared vision of an equitable and sustainable world dedicated to the reduction of suffering and maximization of bliss. We share this work with the world in the hope of achieving these ends.

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