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Medical Marijuana and the Law

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The U.S. legal landscape surrounding "medical marijuana" is complex and rapidly changing. Fourteen states — California, Alaska, Oregon, Washington, Maine, Hawaii, Colorado, Nevada, Vermont, Montana, Rhode Island, New Mexico, Michigan, and most recently, New Jersey — have passed laws eliminating criminal penalties for using marijuana for medical purposes, and at least a dozen others are considering such legislation.[1] Medical experts have also taken a fresh look at the evidence regarding the therapeutic use of marijuana,[2,3] and the American Medical Association (AMA) recently adopted a resolution urging review of marijuana as a Schedule I controlled substance, noting it would support rescheduling if doing so would facilitate research and development of cannabinoid-based medicine. Criticizing the patchwork of state laws as inadequate to establish clinical standards for marijuana use, the AMA has joined the Institute of Medicine, the American College of Physicians, and patient advocates in calling for changes in federal drug-enforcement policies to establish evidence-based practices in this area.

States have led the medical marijuana movement largely because federal policymakers have consistently rejected petitions to authorize the prescription of marijuana as a Schedule II controlled substance that has both a risk of abuse and accepted medical uses. Restrictive federal law and, until recently, aggressive federal law enforcement have hamstrung research and medical practice involving marijuana. The federal Controlled Substances Act (CSA) classifies marijuana as a Schedule I drug — one with a high potential for abuse and "no currently accepted medical use" — and criminalizes the acts of prescribing, dispensing, and possessing marijuana for any purpose. Although physicians may recommend its use under First Amendment protections of physician–patient communications, as set forth in the 2002 federal appeals court decision *Conant v. Walters*, they violate federal law if they prescribe or dispense marijuana and may be charged with "aiding and abetting" violation of the federal law if they advise patients about obtaining it. A 2005 Supreme Court decision (*Gonzales v. Raich*) made clear that regardless of state laws, federal law enforcement has the authority under the CSA to arrest and prosecute physicians who prescribe or dispense marijuana and patients who possess or cultivate it.

Nevertheless, in October 2009, the Department of Justice issued a memorandum to U.S. Attorneys stating that federal resources should not be used to prosecute persons whose

actions comply with their states' laws permitting medical use of marijuana. This change in the Justice Department's prosecutorial stance paved the way for states to implement new medical-marijuana laws, and states are now attempting to design laws that balance concerns about providing access for patients who can benefit from the drug with concerns about its abuse and diversion. Although the current state laws facilitate access, they do little to advance the development of standards that address the potency, quality, purity, dosing, packaging, and labeling of marijuana.

All the state laws allow patients to use and possess small quantities of marijuana for medical purposes without being subject to state criminal penalties. They also allow a patient's "caregiver" — an adult who agrees to assist with a patient's medical use of marijuana — to possess, but not use, marijuana. Most laws protect "qualifying" patients, who are variously defined as those who have received a diagnosis of a debilitating medical condition and have written documentation (or, in one case, an oral recommendation) from their physician indicating that they might or would "benefit from the medical use of marijuana" or that the "potential benefits of medical use of marijuana would likely outweigh the health risks." Definitions of "debilitating medical condition" vary by state (see Table 1) but typically include HIV–AIDS, cachexia, cancer, glaucoma, epilepsy and other seizure disorders, severe nausea, severe and chronic pain, muscle spasms from multiple sclerosis or Crohn's disease, and other conditions. All but two states allow additions to this list if approved by the state health department.

Table 1. Diseases and Conditions for Which Medical Marijuana Use Is Permitted According to State Laws.

State laws do not regulate marijuana's quality or potency, and most don't address ways of obtaining the drug. Virtually all permit patients or caregivers to cultivate marijuana. New Jersey's new law prohibits such cultivation but provides for the establishment of alternative treatment centers that will "fill" a physician's written instruction for a certain quantity of marijuana. Most laws are silent on whether patients or their caregivers may buy or sell marijuana or whether dispensaries are permitted (see Table 2). California permits dispensing through cooperatives or collectives, but until recently most other states did not — a situation that is changing with the enactment of some recent laws and amendments.

Table 2. Variation among State Medical Marijuana Laws.

Most of the statutes also limit the amount of marijuana that patients or caretakers can possess or cultivate, although the quantities allowed are not derived from clinical trials or pegged to a medical condition (see Table 2). The amounts range from 1 oz and 6 plants in Alaska to 24 oz and 15 plants in Washington, an amount that Washington considers to be a "60-day supply." California's original medical-marijuana ballot initiative did not specify an allowed quantity, instead permitting an amount reasonably related to the patient's medical needs. Subsequent legislation set limits, which apply to individuals who register and thereby gain protection from arrest, but the California Supreme Court recently struck

down the limits as they apply to unregistered patients who possess amounts of marijuana acceptable under the original ballot initiative. Such patients can be arrested, but if prosecuted can assert that the quantity they possess is reasonably related to their needs. Under the New Jersey law, physicians must provide patients with written instructions specifying the amount of marijuana to be dispensed by legally sanctioned treatment centers, but the maximum amount for a 30-day period is 2 oz — making a "60-day supply" in New Jersey just 4 oz, one sixth of that in Washington, a disparity that underscores the absence of standards.

The laws also vary in terms of whether they establish a registry and issue identification cards for qualifying patients. Eleven of the 14 states have a registry, and Maine and New Jersey will soon. In most states where patients have identification cards, they are protected from arrest and prosecution. In some states, however, registered patients with identification cards may be arrested but can use the defense that they have a demonstrated medical need for marijuana. And in a few states, unregistered but "qualifying" patients who meet other requirements of the law may also use this defense.

Missing from many state laws is a requirement that physicians recommending medical marijuana to adult patients provide the rudimentary disclosure of risks and benefits necessary for informed consent, although such disclosure is generally required for patients who are minors. In Canada, the first country to decriminalize medical marijuana, regulations require that physicians discuss the risks with their patients, yet the lack of relevant clinical trials of smoked cannabis makes it difficult for physicians to comply with the law.[4]

In states debating new legislation, policymakers are grappling with questions that only scientific research can answer: For what conditions does marijuana provide medicinal benefits? Are there equally effective alternatives? What are the appropriate doses for various conditions? How can states ensure quality and purity?

Although state laws represent a political response to patients seeking relief from debilitating symptoms, they are inadequate to advance effective treatment. Medical experts emphasize the need to reclassify marijuana as a Schedule II drug to facilitate rigorous scientific evaluation of the potential therapeutic benefits of cannabinoids and to determine the optimal dose and delivery route for conditions in which efficacy is established.[2] This research could provide the basis for regulation by the Food and Drug Administration. Current roadblocks to conducting clinical trials, however, make this more rational route of approval unlikely and perpetuate the development of state laws that lack consistency or consensus on basic features of an evidence-based therapeutic program.

Reliance on state laws as the basis for access to medical marijuana also leaves patients and physicians in a precarious legal position. Although the current Justice Department may not prosecute patients if they use marijuana in a manner consistent with their states' laws, the federal law remains unchanged, and future administrations could return to previous enforcement practices.

Disclosure forms provided by the authors are available with the full text of this article at NEJM.org.

Source Information

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