

NEW YORK CITY BAR

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A.4867

M. of A. Gottfried

AN ACT to amend the public health law and the general business law, in relation to medical use of marihuana; and providing for the repeal of certain provisions upon expiration thereof

THIS BILL IS APPROVED

The Committee on Drugs and the Law (the "Committee") of the Association of the Bar of the City of New York supports Assembly Bill A04867 (the "Bill"). The Bill would permit the manufacture, delivery, possession, and use of marihuana for medical purposes. Enactment of the Bill would allow critically ill medical patients in the State of New York to use marihuana as recommended by their physicians when it would be medically beneficial. Enactment of this bill provides legal recognition of the reality that tens of thousands of Americans are using marihuana exclusively for medical purposes under medical supervision, and removes the most substantial legal liability they currently face, which is the threat of a state criminal action.

The Bill is a very modest measure, much more limited than the laws enacted in twelve other states permitting the use of marihuana for medical purposes. The Committee hopes that enactment of the Bill will increase the likelihood that federal law will be amended, either by regulatory action or by Act of Congress, to protect bona fide medical use of marihuana.

The Bill would permit patients to possess and use marihuana to treat their medical condition if the medical condition or its treatment is "life-threatening," and other drugs or treatments are not or would not be effective.

Patients must have the written certification of a person licensed in New York to prescribe controlled substances (typically a licensed physician).

The state Department of Health shall issue an identification card to the patient who applies for such a card, or to a patient's caregiver.

Holders of such cards can grow marihuana, deliver it to a patient, and possess it as long as the quantity does not exceed 2.5 ounces of marihuana or twelve plants.

In 1997, the Committee issued a detailed statement a copy of which is annexed, supporting then-pending medical marihuana legislation. Referring to research into marihuana's therapeutic uses, the Committee said then, "[r]esearch into marihuana should continue with the active involvement of the Federal government." Unfortunately, there is no indication that the federal government has taken any step to support or even to facilitate research that would evaluate marihuana's medical utility. To the contrary, as reflected in the recent ruling by DEA Administrative Law Judge Mary Ellen Bittner on an application by Professor Lyle Craker for permission to grow marihuana for use in research, federal agencies have obstructed attempts to

conduct precisely the sort of research into marihuana that the federal government says is lacking. Accordingly, at this late date, any objection to the Bill on the ground that patients should await the results of clinical research in deference to the federal prohibition of marihuana for medical purposes should be discounted.

The Bill does not authorize any use of marihuana outside the limited medical use outlined in the Bill.

The Committee recognizes that the Bill is seriously inadequate. Many valid medical uses of marihuana will not be permitted under the Bill, i.e. in circumstances that are not life threatening. Nevertheless, this Bill is a reasonable first step.

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MARIJUANA SHOULD BE MEDICALLY AVAILABLE

The recent passage in California and Arizona of propositions permitting physicians to prescribe marijuana (cannabis) and creating a defense to criminal charges for possession of marijuana if prescribed by a doctor, has engendered much public debate on a subject of significant legal and medical interest. The issue, as viewed by the Committee on Drugs and the Law of the Association of the Bar of the City of New York, is not the wholesale legalization of marijuana. Rather, it is whether marijuana should be made available, by prescription and under medical supervision, for the treatment of a number of serious diseases and their symptoms.

Marijuana has a long history of medicinal use going back 5,000 years. Between 1840 and 1900 more than one hundred articles were published in medical journals on its pharmacological usefulness. In this century, it has been found beneficial as an antiemetic during chemotherapy, for pain in treating cancer, in the treatment of glaucoma, to counteract wasting syndrome in AIDS, to partially alleviate the symptoms of multiple sclerosis and epilepsy and to control muscle spasms in paraplegics and quadriplegics.¹ Indeed, throughout the 1970's and 1980's limited research studies relating to the clinical pharmacology of marijuana were conducted under the auspices of many states in coordination with the Federal government.² Funding for these studies diminished in the mid-1980's, and the studies came to an abrupt end in 1992, while in their final phases. Nonetheless, these studies have yielded some valuable results pointing to the beneficial effects of marijuana. As a result of these studies, in 1985 THC (tetrahydrocannabinol), a constituent of marijuana, was approved for medical use in pill form. However, it is still illegal to smoke marijuana even though

¹ Grinspoon, L. and Bakalar, J., "Marijuana as Medicine - A Plea for Reconsideration," *Journal of the American Medical Association* at pp 1875 - 1876 (1995); See generally, Grinspoon, L. and Bakalar J., Marijuana: The Forbidden Medicine (Yale Univ. Press 1993).

² Peter Gwynne, "Trials of Marijuana's Medical Potential Languish as Government Just Says No," *The Scientist*, Vol. 9, No. 23, p. 2; Zeese, K., "Medical Marijuana: Effectiveness is Proven By Research" (1997).

smoked marijuana has been demonstrated to be far more effective and its dosage easier to control.³

The inability to use inhalation marijuana for medicinal purposes stems from its classification under the Controlled Substances Act. 21 U.S.C. § 801 *et seq* (1970). The statute places drugs in five schedules, classifying them by their potential for abuse, their medical usefulness and their safety. Marijuana was classified as a Schedule I drug, having a high potential for abuse, having no acceptable medical purpose, and being unsafe for use even under medical supervision. Unlike inhalation marijuana, cocaine, codeine, morphine, Demerol and THC are Schedule II drugs, drugs which may be prescribed by a physician because they are recognized to have an accepted medical use.⁴

In enacting the Controlled Substances Act, Congress found and declared that:

[M]any of the drugs included within this subchapter have a useful and legitimate medicinal purpose and are necessary to maintain the health and general welfare of the American people.⁵

Moreover, the Act contemplated further research as to the pharmacological usefulness of the various drugs, their potential for abuse and their risk to public health. The Act, therefore, contains a mechanism for substances to be transferred from one Schedule to another or to be added or deleted from the Schedules.

In keeping with the legislative intent and in light of the evidence demonstrating the beneficial medicinal uses of marijuana, attempts were made to move marijuana from a Schedule I drug to a Schedule II drug. Hearings on the issue were held by the Department of Justice Drug Enforcement Administration ("DEA") in 1986. At the close of those hearings in 1988, the presiding DEA administrative law judge, Judge Francis Young, recommended that marijuana be rescheduled as a Schedule II drug. He observed that marijuana has been accepted as capable of safely relieving the distress of many ill people under medical supervision and specifically found:

³ Zeese, *supra* at 10-11; Vinciguerra, V. Moore-Terry and Brennan, "Inhalation Marijuana as an Antiemetic for Cancer Chemotherapy," 88 N.Y.S. Journal of Medicine (1988) pp 525-527; Doblin and Kleiman, "Marijuana an Antiemetic Medicine: A Survey Of Oncologists' Experiences And Attitudes," Journal of Clinical Oncology Vo. 9 (July 1991) at pp 1314-1319. Grinspoon and Bakalar, Marijuana: The Forbidden Medicine at p 14.

⁴ 21 U.S.C. § 812.

⁵ 21 U.S.C. § 801(1).

It would be unreasonable, arbitrary, and capricious for the DEA to continue to stand between those sufferers and the benefits of this substance in light of the evidence in this record.⁶

Despite the findings of Judge Young, the DEA did not reschedule marijuana, and in 1992 issued a final rejection of its reclassification, stating that marijuana has no currently acceptable medical use.

Those against reclassification of medical marijuana argue that: (1) the medical benefits of marijuana have not been proven in sound scientific studies; (2) marijuana is an addictive and dangerous drug; and (3) other drugs, including synthetic THC, are as effective or more effective than smoked marijuana. These countervailing arguments are weak.

A cogent response to the anti-medicalization position was recently published as an editorial in *The New England Journal of Medicine*. Seriously ill patients and their families are described as "willing to risk a jail term to obtain or grow" marijuana. Patients "whose treatments are often accompanied by intractable nausea, vomiting, or pain" have reported obtaining "striking relief from these devastating symptoms by smoking marijuana." The editorial continues:

Marijuana may have long-term adverse effects and its use may presage serious addictions, but neither long-term side effects nor addiction is a relevant issue in such patients. It is also hypocritical to forbid physicians to prescribe marijuana while permitting them to use morphine and meperidine to relieve extreme dyspnea and pain. With both these drugs the difference between the dose that relieves symptoms and the dose that hastens death is very narrow; by contrast, there is no risk of death from smoking marijuana. To demand evidence of therapeutic efficacy is equally hypocritical. The noxious sensations that patients experience are extremely difficult to quantify in controlled experiments. What really counts for a therapy with this kind of safety margin is whether a seriously ill patient feels relief as a result of the intervention, not whether a controlled trial "proves" its efficacy.

Paradoxically, dronabinol, a drug that contains one of the active ingredients in marijuana (tetrahydrocannabinol), has been available by prescription for more than a decade. But it is difficult to titrate the therapeutic dose of this drug, and it is not widely prescribed. By contrast, smoking marijuana produces a rapid increase in the blood level of the active ingredients and is thus more likely to be therapeutic.⁷

⁶ Young, F., *Opinion and Recommended Ruling, Marijuana Rescheduling Petition*, Dept. of Justice, Drug Enforcement Admn., Docket 86-22 (Sep. 6, 1988).

⁷ Kassirer, J.P., "Federal Foolishness and Marijuana" 336 *New England Journal of Medicine and Surgery* at pp. 366-367.

From the array of evidence and opinion currently available there is now an accepted medical purpose for marijuana. Considering the non-toxic effect and necessity of physician's prescription, marijuana belongs on Schedule II. Research into marijuana should continue with the active involvement of the Federal government.

Until such rescheduling or other steps are taken toward decriminalization of medical marijuana, the Association believes that state legislative initiatives and court challenges should be pursued.

The government can effectively differentiate medical marijuana and recreational marijuana, as it has done with cocaine. The image of the Federal authorities suppressing a valuable medicine to maintain the rationale of the war on drugs only serves to discredit the government's effort.

Committee on Drugs and the Law

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Dated: February 19, 1997