Descriptive Abstract:

The issue of medical marijuana in the United States has been a hotly debated topic for years. Throughout America's history marijuana has been at one point or another legal, illegal, deemed to have medicinal benefit or has been seen as having no medicinal value. The current public policy in the United States regarding medical marijuana is confusing. At the federal level, marijuana is classified as a schedule one substance which means it is illegal to possess or to be prescribed to patients by a licensed physician. However, 23 states and Washington D.C. have legalized some form of medical marijuana. Four states and Washington D.C. have also legalized the recreational use of marijuana which confuses the issue even more. Currently, the federal government has not been actively prosecuting state medical marijuana programs but it has in the past. Individual agencies and agents have, on occasion, not followed the directives issued by the Department of Justice. This paper will offer alternatives and recommendations in order to alleviate the problems of medical marijuana policy in the United States.
Medical Marijuana Policy

Introduction:

Medical marijuana is legal in 23 states and the District of Columbia (23 Legal) and it is legal for recreational use in four more states as well as the District of Columbia (Huff). However, marijuana is illegal at the federal level. This means that even though 23 states and the District of Columbia have passed laws to legalize medicinal marijuana, patients, doctors, caregivers and medical marijuana dispensaries can still be prosecuted by federal agencies. This can be a huge problem for both the state and federal governments. State governments believe they have the right to legalize substances at the state level but the federal government is able to trump those state laws due to the concept of national supremacy. This difference between state laws and federal law has caused tensions between the state governments and the federal government. The issue of medical marijuana needs to be addressed on a nationwide scale.

World History of Marijuana:

Marijuana may have been the world’s first agricultural crop. This was hypothesized by Carl Sagan in his book, *Dragons of Eden: Speculations on the Evolution of Human Intelligence*. Sagan hypothesizes this while he was staying with a tribe in Central Africa called the Pygmies. The Pygmies are an isolated tribe which means they have had no contact with the rest of the developed world and as such have been living in the same manner for thousands of years. Sagan discusses this hypothesis when it is discovered that the Pygmies use marijuana in order to prepare for hunting and fishing. The manner in which the Pygmies hunt and fish is extremely time consuming and tedious. Marijuana is used in order to pass the time quickly and to ward off boredom. Sagan also points out that marijuana is the only agricultural plant that the pygmies
have and from this he extrapolates that marijuana may have potentially been the first agricultural product.

While Carl Sagan proposed that marijuana was the first agricultural crop, hemp, which is a member of the cannabis family, was first discovered to have been cultivated almost 10,000 years ago in Taiwan (US Marijuana Timeline). Hemp is not the same plant as marijuana. Agriculture is thought to have only been invented about 12,000 years ago (Barker). This would put hemp as one of the first agricultural products. Hemp is high-growing, while marijuana is a low growing plant. Hemp contains Tetrahydrocannabinol (THC), the main chemical that gets a marijuana user high, it is so low that hemp cannot effectively get an individual high. Hemp also has thousands of uses, everything from making paper to clothes to dynamite (The Union).

The first recorded use of marijuana being used as a medicine was in the year 2737 BCE by Emperor Shen Nung of China. According to Chinese tradition, Emperor Shen Nung wrote a medical textbook at this time titled The Herbal which extolled the benefits of a marijuana infused tea (History of Cannabis). This means that marijuana has been used by humans for almost 5000 years as a medicine. The majority of ancient, herbal traditions of medicine have fallen out of favor in Western culture, but marijuana has managed to stand the test of time and science.

The first recorded instance of marijuana being used as a medicine outside of China was in India in an ancient Hindu text around the year 700 BCE (US Marijuana Timeline). In this text, marijuana is referred to as “bhang” which is dried cannabis leaves, stems and seeds. In English, “bhang” is translated as the “good narcotic” (US Marijuana Timeline). It can be inferred from
this translation and the context of the word being used in this text that the ancient Hindus used marijuana to treat certain ailments.

Cannabis or a cannabis related product was discovered to have been used in the Western world for the first time in Greece in the year 200 BCE (US Marijuana Timeline). Hemp rope was discovered to have been used in Greece around that time. Roughly 300 years later in 100 CE, imported hemp rope was discovered in England (US Marijuana Timeline). In roughly 2800 years, cannabis spread across the entire Eurasian continent without the aid of any modern transportation or communication devices.

One of the first instances in which marijuana is used as a medicine is in France in the early 1500s. Gargantua and Pantagruel is a text written by a French physician, Francois Rabelais, in which the medicinal benefits of marijuana are discussed (US Marijuana Timeline). The first law in the Western world to be passed regarding any type of cannabis was an edict proclaimed by King Henry VIII in 1533 that forced peasant farmers to grow hemp or they would face a fine (US Marijuana Timeline). Between this early 1600s and the mid-1800s, many European journals and medical texts published research that discussed the medicinal benefits of marijuana. One particular text, Anatomy of Melancholy, written by Robert Burton discusses the potential treatment of depression with marijuana.

United States History of Marijuana:

The history of marijuana in the United States began as early as the Jamestown Colony. The Jamestown Colony was established in 1607 by England in what later became known as Jamestown, Virginia (History of Jamestown). By the year 1619, a law had been passed by the Virginia Assembly forcing every farmer to grow a certain amount of hemp (US Marijuana
Timeline). This is very similar to the laws passed in England forcing peasant farmers to grow hemp. Throughout the early years of American history, hemp was encouraged to be grown by the state governments.

Recreational marijuana was not prevalent throughout the United States during its formative years but there were instances of Americans smoking hashish which had been brought over by French soldiers and French immigrants (US Marijuana Timeline). On the other hand, marijuana was prevalent throughout early American medicine as many medicines sold in pharmacies contained marijuana derivatives. There were no laws on the books prohibiting marijuana until the early 1900s. In fact, there were no laws even regarding marijuana, medicinal or otherwise, until the federal government passed the Pure Food and Drug Act in 1906 (US Marijuana Timeline). This law didn’t outlaw or restrict the use of marijuana as a medicine but rather forced companies to label whether or not their product contained marijuana for any over the counter products.

Recreational marijuana arrived in force in the United States in the early 1920s. During this time period smoking marijuana for pleasure was present throughout Mexican society. In the early 1900s, there was a flood of Mexican immigrants into the United States and they brought their preferred past time of smoking marijuana with them (Schmal). As Mexican immigrants spread throughout the country, so did the smoking of marijuana.

It was at this time that marijuana use became associated with minorities. As non-English speaking immigrants, mainly Mexican and other Latin American immigrants, spread throughout the United States, racist fears took hold (Schmal). The United States, as a whole, had already had experience with racism with regards to African Americans, so the racism toward Hispanic-
Americans fit right in. As more and more minorities, both African-Americans and Hispanic-Americans, were prosecuted for crimes, marijuana began to be seen as a leading culprit. It was at this time that “Reefer Madness” began to take hold of the country.

“Reefer Madness” was the prevailing thought during the 1930s and it was the idea that individuals smoked marijuana and then went on to commit heinous crimes. This idea had really taken hold of the country when a movie of the same name, *Reefer Madness*, originally titled *Tell Your Children*, debuted in theaters in the 1930s. This movie centered on the idea that marijuana “pushers” would force high school students to smoke marijuana and these students would then get addicted to marijuana. During the course of their addiction, these teenagers would go on to commit crimes while under the influence of marijuana. These crimes included a hit and run accident, manslaughter, attempted rape and eventually culminated in the descent of the addicts into madness caused by marijuana use (Reefer Madness). This movie was originally marketed toward parents who wanted to show the moral implications of marijuana use to their children. However, soon after it was released, it was purchased by producer Dwain Esper and distributed across the country to raise support for the prohibition of marijuana (Murphy, Studney).

*Reefer Madness* went from a poorly made film to a full blown pandemic throughout the United States. Soon after the film was released and viewed by the American public, yellow journalism took hold of the idea that marijuana causes violence (The Union). Yellow journalism was a type of writing popularized around the time of the Spanish-American War. Newspaper journalists would sensationalize and sometimes even manufacture suspenseful events in order to sell copies of a particular newspaper. These journalists would use “melodrama, romance and hyperbole” in order to write a compelling story. (Yellow Journalism). The media then made the connection between minorities committing crime and the use of marijuana. Previously held racist
views allowed the misconception to develop that racial minorities would smoke marijuana and then go on to commit violent crimes. This idea was prevalent throughout the United States and led to many public service announcements denouncing the evils of marijuana and the minorities that smoked it (The Union).

“Reefer Madness” and the accompanying racism eventually culminated in the Marijuana Tax Act of 1937. This Act did not prohibit marijuana nor hemp but rather levied a significant tax on the growing of marijuana and associated marijuana products. Farmers could only grow marijuana for medicinal and industrial purposes (Marihuana Tax Act of 1937). These same farmers could only grow marijuana if they purchased a tax stamp from the federal government allowing them to do so. The only problem with this was that the federal government wasn’t allowing very many tax stamps to be sold and thus this act effectively began the prohibition of marijuana (The Union).

Even though the federal government effectively outlawed marijuana in the late 1930s, Congress changed its mind regarding the usefulness of marijuana and hemp during World War II. The beginning of the war saw Congress put into place a program called “Hemp for Victory” (The Union). This program encouraged farmers to grow hemp in order to help fund the war effort. Congress didn’t change any of the existing laws but rather the federal government just began to hand out more tax stamps in order to allow farmers to grow hemp for industrial purposes. This period of leniency didn’t last very long. As soon as the war ended, Congress decided, again, that marijuana was a dangerous substance and it, along with any marijuana associated products should not be grown.
During the 1950s, the federal government began to implement more serious punishments for the possession of marijuana. Stricter sentencing guidelines were issued to federal judges and mandatory minimums were established to deal with marijuana offenses. The Boggs Act of 1952 and the Narcotics Controls Act of 1956 established that a first time marijuana possession offense would include a minimum of two years of jail time and a $20,000 fine (Shafer). Federal guidelines regarding sentencing are important to note because state lawmakers typically tend to follow the guidelines of the federal government, especially when it comes to sentencing guidelines for drug offenses. This problem of mandatory minimum sentencing came to the forefront of American society in 1969 when a Virginia Court sentenced a woman to 20 years imprisonment for the possession of a small amount of marijuana (Bonnie).

In 1970, the federal government repealed the laws requiring mandatory minimum sentencing of marijuana possession. Also in 1970, the Controlled Substances Act was passed (US Marijuana Timeline). This act created several categories for drugs and other addictive substances. There are five categories in total. These categories range from the most restrictive category (schedule I) to the least restrictive (schedule V). A schedule I substance is said to have a high potential for abuse, no currently accepted medical use in the United States and a lack of accepted safety guidelines for the use of the drug or other substance under medical supervision (Controlled Substances Act). Placing a substance in schedule I of the Controlled Substances Act renders it illegal in the United States and the substance cannot be produced, sold or possessed under penalty of law. A schedule V substance is said to have a low potential for abuse relative to other substances in schedule IV, the substance has a currently accepted medical use in the United States and the substance may lead to physical or psychological dependence relative to other substances in schedule IV (Controlled Substances Act). At this point in time, marijuana is still a
schedule I substance. As a side note, at the time the Controlled Substances Act was passed, a majority of the states had already made marijuana illegal under state poison laws.

During this same time period, Richard Nixon created a commission to investigate the effects of marijuana. This commission was created in order to determine whether or not marijuana had been placed into the correct schedule at the creation of the Controlled Substances Act. This report was the first comprehensive report done in order to assess the proper place of marijuana in American society. At the conclusion of the report, the Commission stated that due to “the absence of adequate understanding of the effects of the drug” marijuana should not have been placed in schedule I. That combined with, “lurid accounts of [largely unsubstantiated] ‘marijuana atrocities’” led to false public conceptions of marijuana (Shafer). The commission also found that marijuana, pacified the user, “…and generally produc[ed] states of drowsiness, lethargy, timidity and passivity.” (Shafer). This was in stark contrast as to the reasons why marijuana was made illegal in the first place. The Shafer commission produced scientific evidence that marijuana, in fact, did not cause users to become violent or to commit crimes. Rather it produced the opposite effect and made the user more docile and prone to fits of laziness, not fits of violence (Shafer).

The Shafer Commission directly condemned the thinking behind prior marijuana prohibition. The members of this commission found that former Congresses relied on outdated and wrong information in order to prohibit marijuana. Marijuana prohibition had been built upon the idea that marijuana was dangerous, caused users to commit violent acts and crimes. The Shafer Commission directly refuted this. The final recommendation of the committee was that marijuana be decriminalized. However, the Nixon administration, which had commissioned the report in the first place, chose to ignore the findings of the report. President Nixon did not expect
that the commission would make this recommendation. In fact, when it started to become clear
that the commission was not going to rule in the direction his administration wanted it to go,
Nixon attempted to influence the Chairman of the Commission, Raymond P. Shafer. In one of
the infamous Nixon tapes, Nixon says to Shafer, "You're enough of a pro to know that for you to
come out with something that would run counter to what the Congress feels and what the country
feels, and what we're planning to do, would make your commission just look bad as hell." (Oval
Office Tapes).

This was the beginning of the “War on Drugs”. Richard Nixon began the “War” early in
his presidency and the eradication of the drug culture prevalent in American society was a big
aim of his domestic policy. The War on Drugs continued in the 1980s when Ronald Reagan
signed the Anti-Drug Abuse Act into law. This law, again, instituted mandatory minimum
sentences for specific drug offenses including marijuana. Many of the problems currently facing
the legalization of medical marijuana can be traced back to different proponents of the War on
Drugs and the stigma that has been associated with those who smoke marijuana.

Policy Problem:

The biggest problem currently facing medical marijuana is the fact that marijuana is
illegal at the federal level. This means that no matter what state laws are passed, either legalizing
medicinal marijuana, legalizing recreational marijuana or even just decriminalizing the
possession of marijuana, federal prohibition trumps those laws. This is because of the National
Supremacy Clause of the constitution. This clause states that all federal laws are superior to state
laws and no state law can contradict a federal law. This is such a problem because even though a
state law can stop state officers from prosecuting medicinal marijuana patients, a federal agent
can enforce federal law throughout the entire United States and prosecute that same medicinal marijuana patient.

This problem is evident not just in medicinal marijuana enforcement but whether or not a marijuana offender is caught by a federal agent or a state officer. The differences in penalties at the state and federal level are stark. Possession of marijuana at the federal level has serious penalties attached to it. A first time offense is considered a misdemeanor and can entail up to a year in prison and a $1,000 fine (NORML Federal). A second and third offense is also considered a misdemeanor and can net anywhere from 90 days to three years in prison and a $2,500 to $5,000 fine (NORML Federal). The penalties for the sale of marijuana are even stricter. The sale of less than 50 kilograms can have a sentence of up to five years in prison and a $250,000 fine. The sale of marijuana between 50-999 kilograms can send an individual to prison for anywhere from five to 40 years and a fine of up to a million dollars fine (NORML Federal). A large scale operation, anything larger than 1000 kilograms, if convicted, can range from a minimum of 10 years in prison to a life sentence along with a $1,000,000 fine (NORML Federal).

The cultivation of marijuana receives very similar penalties to the sale of marijuana at the federal level. Growing less than 50 plants can result in five years of prison time and a $250,000 fine. Cultivating anywhere from 50-1000 plants guarantees a minimum of five years in prison and a maximum of 40 years in prison (NORML Federal). There is also a minimum fine of $500,000 and a maximum fine of $1,000,000 fine (NORML Federal). For a large scale operation, consisting of a 1,000 plants or more, the penalty is a minimum of 10 years in prison to a maximum of life imprisonment to go along with a $1,000,000 fine (NORML Federal). Also, all sale and cultivation related offenses are considered felonies and have the same penalties.
associated with being labeled a felon. These penalties include disenfranchisement, losing the right to certain licenses, the right to own a firearm, right to serve on a jury, ineligibility to receive government assistance or welfare and being barred from living in federally funded housing (Sentencing Classification of Offenses).

The federal government imposes very strict penalties for a non-violent, and what some would argue, a victimless crime. The federal penalties for marijuana possession, sale and cultivation are much, much stricter than even the penalties imposed by the Commonwealth of Pennsylvania which has some of the stricter marijuana laws in the country. In Pennsylvania, possession of less than 30 grams of marijuana is a misdemeanor that carries with it a maximum of 30 days of prison time and a $1,500 fine (NORML Pennsylvania). Possession of more than 30 grams is also a misdemeanor and results in up to one year in prison and a $15,000 fine (NORML Pennsylvania). The sale of marijuana is more a bit more severe than possession but it pales in comparison to the federal penalties. The sale of two to ten pounds of marijuana can results in a maximum of one year in prison and a $5,000 fine. Selling 10-1,000 pounds of marijuana can result in the offender receiving a maximum sentence of three years in prison and up to a $250,000 fine (NORML Pennsylvania). A large operation with more than 1,000 pounds can result in up to 10 years of prison time and a $250,000 fine (NORML Pennsylvania).

In Pennsylvania, a small operation, anywhere from 10-21 plants, if convicted, nets the offender up to one year in prison and a $5,000 fine. A larger operation, 22-51 plants, can result in up to three years of prison time and a $15,000 fine (NORML Pennsylvania). While these penalties are still pretty stiff compared to states that have either decriminalized marijuana, such as New York and Colorado which has legalized it all together, they are much less strict than the federal penalties. The stark contrast between these sets of laws is such a problem because the
penalty is dependent upon who the offender gets caught by. A marijuana offender can be doing nothing but growing a few plants for himself for medical use in Pennsylvania and if the individual gets caught by the federal government, it can be up to five years in prison but if that same individual gets caught by the state police of Pennsylvania, there is only the potential for one year of prison time.

The real problem is not the differences between federal and state laws regarding recreational marijuana users but rather the way the federal government prosecutes medical dispensaries in states that have legalized marijuana for medical use. Since marijuana is illegal at the federal level, federal agencies such as the Federal Bureau of Investigation and more importantly, the Drug Enforcement Agency (DEA), can investigate, raid and then prosecute medical marijuana dispensaries that are legal at the state level. This is able to occur because of the Supremacy Clause of the Constitution that was mentioned earlier. This is such a huge problem because a medical marijuana dispensary that follows all state level regulations, pays taxes, only sells to patients that are registered in that state, doesn’t sell to minors and keeps impeccable documentation can be raided by the DEA. The owners and operators of the dispensary can then be arrested and fined. All of the assets of the dispensary can be seized and the individuals who own that particular dispensary are left either in jail or penniless.

During the beginning of the legalization phase, the early and mid-2000s, this was a much bigger problem than it is in 2014. In 2007, the DEA raided over 10 medical marijuana dispensaries in West Hollywood and Los Angeles. These raids happened at the request of West Hollywood officials who had implemented new guidelines regarding medical marijuana dispensaries. Several of these dispensaries had been poorly run and were violating state laws regulating where patients can medicate, how they were obtaining their medicine and selling to
patients with forged documents (Klausner). However, one dispensary that was also raided was a dispensary called the “Farmacy”. The Farmacy is noted as being one of the best run dispensaries not only in Los Angeles but the entire state of California. It had also not been on the list of dispensaries that the West Hollywood officials had asked to be raided (Klausner). The Farmacy imposes additional regulations upon its members such as only allowing patients to possess one ounce at a time even though the law allows eight (Klausner). The Farmacy also doesn’t allow patients to medicate on their premises and even detains “patients” who attempt to purchase medicine with false documents until the proper authorities show up. The Farmacy has been an industry leader in the education of its patients. Employees who work at the dispensary routinely explain the different strains of marijuana and which strains are better suited to treat different symptoms of different diseases (Klausner). The Farmacy even offers additional products such as edibles (foods infused with THC) and oils infused with THC in order to cater to the patient who either doesn’t want to smoke marijuana or can’t smoke.

The problem of federal agencies prosecuting state legal dispensaries was supposed to have been solved with the issuing of a Department of Justice memo known as the “Cole Memo”. This memo was issued by US Deputy Attorney General James M. Cole on August 29, 2013. The memo basically states that federal agencies will no longer persecute dispensaries and grow operations so long as they are in compliance with all state regulations (United States). The memo also states that the Department of Justice will continue to investigate and prosecute businesses in order to ensure that certain practices do not occur. These practices include,

“Preventing the distribution to minors; Preventing revenue from the sale of marijuana from going to criminal enterprises, gangs and cartels; Preventing the diversion of marijuana from states where it is legal under state laws in some form to other states; Preventing state authorized marijuana activity from being used as a cover or pretext for trafficking of other illegal drugs or illegal activity; Preventing violence and the use of
firearms in the cultivation and distribution of marijuana; Preventing the growing of marijuana on public lands and the attendant public safety, and environmental dangers posed by marijuana cultivation on public lands; and Preventing marijuana possession or use on federal property.” (United States).

Even though this memo sets out specific guidelines on when to enforce federal law, it does nothing to change the specific laws themselves. It is still up to individual agencies and individual agents on whether or not to pursue a marijuana conviction in a state where medicinal marijuana is legal.

This memo was seen as the federal government finally acquiescing and allowing the states to govern themselves when it came to the issue of medical marijuana. This was not the case. Recently, two medical marijuana dispensaries were raided by DEA agents in Los Angeles. Both dispensaries were owned and operated by a company called the Farmacy (Ferner). The same dispensary that was raided in 2007. As of right now, it is still not clear as to why these two branches of the Farmacy were raided as the warrant was under seal and the Department of Justice refused to comment on an ongoing investigation (Ferner). The lawyer for the Farmacy is quoted as saying that, “I represent a lot of medical marijuana clubs in LA and The Farmacy is the most compliant club in Los Angeles -- they pay their taxes, go to all the city council meetings, they even helped put together the ordinance for the city of West Hollywood” (Ferner). The manager for the West Hollywood dispensary has also gone on the record as saying, “We are completely in the dark as to why this happened. We have been around for close to 10 years in Los Angeles and are completely 100 percent state-compliant and we pay our taxes.” (Ferner). The DEA seized all of the product that the two locations had in their inventory at the time and this will leave many patients without their medicine for several days. This example of the DEA raiding a state compliant dispensary, after the issuing of the Cole Memo, is one of the biggest problems with the current policy surrounding medical marijuana.
This past December, Congress passed an appropriations bill for the fiscal year 2015 which included an important amendment that reinforces the ideas laid out in the Cole Memo. The amendment that was added to this “omnibus” bill does not allow any of the funds appropriated by the federal government to be used by the Department of Justice, which includes the DEA, to prosecute federal marijuana offenses in any state that currently allows medical marijuana to be recommended to patients (Consolidated and Further Continuing Appropriations Act). Section 538 of the spending bill states

“SEC. 538. None of the funds made available in this Act to the Department of Justice may be used, with respect to the States of Alabama, Alaska, Arizona, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Illinois, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Oregon, Rhode Island, South Carolina, Tennessee, Utah, Vermont, Washington, and Wisconsin, to prevent such States from implementing their own State laws that authorize the use, distribution, possession, or cultivation of medical marijuana.” (Consolidated and Further Continuing Appropriations Act).

This bill guarantees that the DEA and the Department of Justice as a whole will not be able to prosecute state legal medical marijuana dispensaries at least for all of 2015.

**Medicinal Benefits and Concerns:**

There is a significant amount of misinformation that has been perpetuated regarding the medicinal use of marijuana. This misinformation ranges from claims to supposed harms caused by inhaling marijuana to scientific studies that have stated there is no place in medicine for marijuana. Different myths and stereotypes have been perpetrated by groups whose main goal is marijuana prohibition. One of the first groups were the creators of *Reefer Madness* and continued with the Nixon administration when the findings of the Shafer Commission were ignored. All of this misinformation has led to lawmakers and a portion of the public becoming wary of the medicinal benefits of marijuana.
One of the biggest, if not the biggest, concern regarding the use of marijuana is the idea that smoking marijuana kills brain cells. However, this is not necessarily true. The study that is most often cited to prove this fact is an experiment called the Heath-Tulane Study which was conducted in the early 1970s. The scientists who conducted this study stated they had administered 30 joints to monkeys every day for a year (The Union). After the year had elapsed the monkeys’ brains were examined and it was found that a significant number of brain cells had died.

Years after this study was published it was discovered that the scientists had not followed the method they said they had. In fact the methods used during this study were nothing similar to the original methods described (The Union). What actually occurred was that gas masks were attached to the same monkeys’ and then pure marijuana smoke was pumped into the masks for five minutes at a time, the equivalent of 63 marijuana joints. During these five minutes, no additional oxygen was given to the monkeys (The Union). On average, four minutes without oxygen is enough to cause brain damage. These monkeys were submitted to this daily regimen for at least a month. Basically these monkeys were suffocated and the scientists used that information to “prove” marijuana kills brain cells.

There is also a fear that the use of marijuana will lead to an increased risk of lung cancer and a decrease in lung function. Marijuana has never been shown to have caused a case of lung cancer (Does Smoking Cannabis). Studies in the mid-2000s performed in the United Kingdom explored this very fact and cannabis smoke was not linked to any increase in risk of lung cancer. Similar studies performed in the United Kingdom also studied whether smoking cannabis led to an increased risk for other types of cancer but no significant links were established (Does Smoking Cannabis). This could have been for several reasons as the majority of the studies were
limited in some way. According to the National Cancer Institute in the United States after a study of 5,000 men and women found that occasional or low use of marijuana did not cause any decrease in lung function (Cannabis and Cannabinoid).

Several studies have also disputed the idea that marijuana is a gateway drug. The gateway drug theory is the idea that individuals, typically minors or young adults, will begin to start smoking marijuana and eventually will move onto harder drugs such as cocaine or heroin. A study published in 2006 showed that out of every 104 marijuana users, there was only one cocaine user and less than one heroin user (The Union). A recent study published in 2012 refutes the idea that increased legalization of medicinal marijuana will increase the recreational use of marijuana (Igor). However, after controlling for certain variables, the researchers of this study discovered that marijuana use did not increase in any significant amount in any state that had legalized medicinal marijuana.

Over the last several years a significant amount of research has been performed that has shown the many medicinal benefits of marijuana. One area that has been extensively studied is the administration of cannabis to patients suffering from neuropathic pain disorders. Neuropathic pain is a pain that is associated with the nervous system. Normally non-painful stimuli begin to cause pain as the nervous system has been compromised by either a traumatic event or some type of diseases (Torrance). A stroke or a spinal cord injury can trigger such pain as well as complications from HIV.

Increasingly an alternative for conventional opioids are being sought because of the high risk of addiction and other side effects from long-term opioid use (Nelson). A study performed by the University of California in 2008 attempted to determine whether marijuana would be able
to relieve the neuropathic pain associated with HIV (Ellis). The researchers administered marijuana to patients in conjunction with the regimen of conventional medications that had already been prescribed by each individual’s doctor. This study found that patients who smoked marijuana described a decrease in pain as well as an increase in quality of life and the ability to function more independently. One half of all patients reported at least a 30 percent decrease in pain (Ellis).

A very recent study published in early 2015 took a look at a large amount of literature on the topic of marijuana and its uses in the medical world (Nelson). The first area that this study focused on is the idea that even though cannabinoids may be less effective in treating certain pain disorders than conventional opioids, there are significantly less risks associated with the prescription of cannabis over opioids. This same study also took a look at the opinions of physician’s across the world on the subject of medical marijuana. Physicians in 42 countries were surveyed and it was discovered that 76 percent approved of the use of medical marijuana (Nelson).

**Bioethics of Medical Marijuana:**

Every time a new medical procedure is discovered or when a new drug is created there are ethical questions concerning the implementation of that procedure or the prescription of that drug. These questions can arise from whether there are moral questions regarding the actual procedure itself such as in the case of abortion. The same questions can be asked when it comes to how certain drugs are developed. In the case of medical marijuana, the drug itself is not in question but rather the methods used to develop that drug are being questioned for their morality as well as its practical application. There is not a significant amount of literature regarding any
ethical questions surrounding the medicinal use of marijuana. The only ethical question that has been raised is whether it is moral for a cancer patient to break the law in order to relieve the suffering that is associated with the cancer itself or the side effects of chemotherapy. However, the Catholic Church has extensive direction regarding the ethics of medicine and many of these teachings can be applied to medicinal marijuana.

When it comes to the Catholic Church’s teachings on the ethics of medicine the first thing that must be considered is the idea of Christian Humanism. Christian Humanism emphasizes Jesus’s humanity especially the principle of universal human dignity (Drake). The meaning of human dignity has been debated throughout the world. In 2008, “The President’s Council on Bioethics” failed to determine the definition of human dignity when it came to applying it to medicine (Beyleveld). However, in Sweden human dignity is defined as the “integrity of the individual” (Peil). This definition most closely fits the Catholic definition of human dignity. Catholicism believes that every human was created in the image of God and as such human dignity must be preserved in order to preserve that likeness. This means that human dignity is the ability to preserve one’s ability to follow the teachings of Jesus. The question must then be asked “Does medical marijuana contribute to the advancement of human dignity or the degradation of that concept?”

According to the United States Council of Catholic Bishops the first thing that must be considered when discussing any new medicine is whether that medicine reaffirms ethical standards and if it preserves human dignity (Ethical and Religious). The next directive that this council provides is that any new medicine must follow natural law (Ethical and Religious). Natural law is the concept that there is a system of laws that are determined by nature and thus universal across all cultures and areas of the world. Often natural law is thought to have been
derived from a divine being and in the case of Christianity that being would be God. One last

guiding factor in determine if a medicine follows Christian values is whether it allows physicians
to follow Jesus’s teachings regarding the concern for the sick (Ethical and Religious). According
to the United States Council of Catholic Bishops so long as it meets the prior directives, more
often than not, the medicine itself should be implemented into modern medicine.

These directives can be applied to medical marijuana. When it comes to the actual use of
marijuana as a medicine there are no ethical boundaries that are being crossed. The only gray
area is whether the use of this medicine, as it is currently not allowed at the federal law, violates
the moral responsibility to follow the law. However if were to be made legal it would no longer
have to face that ambiguity. It seems that the use of medical marijuana would in fact preserve
human dignity. Medical marijuana has the ability to ease the suffering of a significant number of
Americans. According to the Swedish definition of human dignity, this would qualify as
preserving the integrity of the human person. Instructions Dignitas Personae on Certain
Bioethical Questions addresses this exact issue. According to this document the dignity of the
human person must be considered above all else when it comes to any medical decision. Dignity
cannot be maintained if there is a tremendous amount of suffering. Medical marijuana may have
the potential to ease this pain and allow those suffering from debilitating diseases to lead a
normal or a more normal life than would otherwise be possible.

The United States Council of Catholic Bishops also discusses the biblical mandate to care
for the poor. This directive coincides directly with both of the public policy alternatives
discussed in this paper. In order to effectively care for the poor in this situation, medical
marijuana must be made available at a low enough cost that anyone who needs it can afford to
have it. There are no directives on how to implement this but a government subsidy or the ability for insurance companies to cover medical marijuana would be two important first steps.

Pope Pius XII in “An Address to the First International Congress on the Histopathology of the Nervous System” discusses three guidelines that must be followed in order to justify the morality of new procedures and methods of research. These guidelines address the interest of medical science, the interest of the individual to be treated and the interest of the community as a whole. Scientific research has its own set of values that must be followed. However science just for the pursuit of knowledge is not enough. There are a set of moral rules that must be followed in the pursuit of knowledge. If the research crosses a moral line, the research is no longer useful but rather hurtful (Pius). This moral line is crossed when an individual or that individual’s rights are compromised. All scientific research must maintain the universal human dignity of the person. The scientific method makes no moral guarantees even if the end results better humanity (Pius).

Pope Pius XII also discusses the interests of the patient. In this matter, the interest of the patient do not guarantee a moral right of the doctor’s conduct. A certain procedure may be in the interest of the patient but that does make it a morally right action. On the other hand, just because a doctor performs a morally questionable procedure on a patient that has the need for that procedure does not guarantee that the doctor has been true to his own moral of preserving the integrity of the patient. The patient is also not the absolute master of himself and cannot decide if a specific procedure is morally right. The only one who can decide is God. The interest of the common good must also be considered when discussing new medical advancements. During this address Pope Pius XII speaks on whether there is a moral limit to the medical interests of the community. He also discusses if a public authority can give doctors the right to perform
experiments. This is discussed in the context of whether an experiment should be performed if it will better the community but harm the individual who is participating in the study. The end conclusion is that these actions cannot be performed as the individual does not exist for the community but rather for the entirety of mankind.

This address was not directed at any specific research methods or any specific medical procedure but all three guidelines can be applied to medicinal marijuana. So far, the research methods that have been implemented to study the benefits of marijuana have not seemed to cross any moral boundary. Studies that have focused on the medicinal benefits of marijuana have involved administering marijuana to patients who have no other options. In the majority of these cases, administering of marijuana may actually be preserving human dignity in ways that conventional medicine has failed. In this respect, medical marijuana would follow the criteria set out by Pope Pius XII when it comes to the moral values of scientific research.

It would seem that when medical marijuana and the interests of the patient are being discussed that there is no moral wrong being pursued. In this specific case, as discussed earlier, prescribing a patient medical marijuana may be preserving the integrity of the person. The doctor would be committing no moral wrong, if medical marijuana was legal, by prescribing it to the patient. Human dignity would be maintained as the patient would be able to more fully enjoy life. The interest of the common good would also be met. The consequences that Pope Pius XII discusses would not materialize when it comes to medical marijuana. The individual is not being harmed, in fact that individual is actually being helped throughout the course of these studies.

There currently is not a lot of debate regarding the ethics of medicinal marijuana. However, as medical marijuana becomes more widespread this issue will begin to be put into the
spotlight. The Catholic Church has also not established any guidelines on this subject other than respecting federal authority. This will also change if the federal status of marijuana changes. If this happens an organization such as the United States Council of Catholic Bishops will issue an official declaration on the use of medical marijuana.

**Policy Alternative #1:**

The current policy regarding medical marijuana in the United States does not reflect the attitudes of the American people. When discussing the issue of legalizing marijuana, for recreational and medicinal purposes, there has recently been a shift in favor of legalization. In a poll conducted in 2010 by the Pew Research Center stated that 41% of Americans supported the legalization of marijuana for recreational purposes (Section 2). A more recent study, conducted in 2014, by the same organization, showed that 52% of Americans supported the legalization of marijuana for recreational use (Section 2). When the issue of medicinal marijuana is polled nationally, a study done by the Fox News Poll, in 2013, showed that 85% of registered voters were in favor of legalizing medicinal marijuana (Section 2).

The first possible alternative to the current policy regarding medicinal marijuana is to continue the legalization process at the state level but with several important changes. Currently, medical marijuana law in the United States is different in every state that has legalized marijuana for medicinal use. Each state differs in the standard of care regarding medicinal marijuana, different methods associated with registering to obtain medicinal marijuana, different prices of the marijuana itself, different amounts that are allowed to be possessed, different types of marijuana that can be bought, different ways to acquire marijuana and most importantly, each state has different conditions that are legally allowed to be treated with marijuana. The three
major issues are the standard of care, how to obtain the medicine and what conditions are allowed to be treated by marijuana. These problems are made evident by looking at the marijuana laws in one West Coast state, California and one East Coast state, New York.

California and New York have two very different set of laws regarding medicinal marijuana. Marijuana was legalized in New York in 2014 when Governor Cuomo signed the new law into effect. Even though this law legalizes medicinal marijuana, it puts severe restrictions on what can be possessed and what conditions can be treated by marijuana. In New York State, the only conditions that can be treated by marijuana are cancer, epilepsy, HIV/AIDS, Huntington's disease, inflammatory bowel disease, Lou Gehrig's disease, Parkinson's disease, multiple sclerosis, neuropathies and spinal cord damage (NORML New York). This is a very short list of diseases compared to a state such as California and there has been research that shows marijuana is useful in treating many serious pain disorders which this law does not allow marijuana to be recommended for. Medicinal marijuana is also not allowed to be smoked in New York (NORML New York). This means that marijuana must be consumed in a different manner either through oils, extracts or pills and this severely limits the way marijuana can be used to treat patients. New York also only allows a patient to possess a 30 day supply of medicine as determined by the patient's physician (Lawful Medical Use). Medical marijuana patients are also required to register with the Department of Health and received a registration card in order to ensure that only qualified patients are able to purchase medical marijuana (NORML New York). The last part of this law places a seven percent tax on medicinal marijuana and it also places a sunset provision on the law (Lawful Medical Use). This means that the law will expire in seven years and must be renewed at that point in time.
California’s medical marijuana laws could not be any different than the laws put in place in New York. Proposition 215, as the medical marijuana law is titled in California, was passed in 1996 by a ballot initiative with a 56% approval rating. This law allows physicians to recommend the use of marijuana to patients for a variety of medical conditions. These conditions include “anorexia, arthritis, cachexia, cancer, chronic pain, glaucoma, migraine, persistent muscle spasms, including, but not limited to, spasms associated with multiple sclerosis, seizures, including, but not limited to, seizures associated with epilepsy, severe nausea.” (Definitions).

California also includes,

“All other chronic or persistent medical symptom that either:

(A) Substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990 (Public Law 101-336).

(B) If not alleviated, may cause serious harm to the patient’s safety or physical or mental health.” (Definitions).

This is a very important part of the California law as it allows physicians to recommend marijuana to any patient that they deem it would benefit. This allows physicians to stay up to date with current medical marijuana research and recommend marijuana to patients that it would benefit without having to wait for the bureaucratic system to decide that marijuana is a possible treatment option.

In California, qualified patients are allowed to possess up to eight ounces of medicine or six mature plants (Definitions). Patients are also allowed to possess greater amounts than that if a physician deems it necessary for that patient’s particular condition (Definitions). California patients are able to obtain their medicine through several different methods. The first method is for a patient to cultivate his or her own medicine. A second method is for a patient to obtain a caregiver, usually a relative or close friend, to cultivate marijuana for them (Boire, Feeney). The
caregiver has to register with the state and is issued their own registry card, same as the actual patient. The caregiver is then, legally allowed to, grow marijuana and assist the patient with any needs surrounding the administering of marijuana (Boire, Feeney). Lastly, patients can obtain marijuana at one of the many medical marijuana dispensaries that operate throughout the entirety of California. These dispensaries are basically pharmacies that only sell marijuana.

In order to solve the problem of different state regulations, the Uniform Law Commission or ULC (About the ULC) could be tasked with drafting a model medical marijuana law that could be adopted by any state willing to legalize medicinal marijuana. The ULC, “established in 1892, provides states with non-partisan, well-conceived and well-drafted legislation that brings clarity and stability to critical areas of state statutory law” (About the ULC). This basically means that the ULC drafts model laws regarding different areas of law that can then be proposed by state representatives to their respective state law making bodies. The purpose of this organization and these model laws is to work toward uniform state laws regarding specific issues. These model laws can be amended by the state legislatures if they deem it necessary in order to fit their state’s specific circumstances.

The law drafted by the ULC could be very similar to the laws already in place in California. The law would allow physicians to recommend marijuana to patients for a specified set of qualifying conditions. These conditions would be the exact same as the conditions listed in California’s Proposition 215 including the last statement allowing physicians to recommend marijuana for, “Any other chronic or persistent medical symptom”. The Department of Health for each state would also be able to add specific conditions to the list of qualifying conditions as new research in the area of medical marijuana is published.
This alternative would also force each patient and their caregivers to register with the state and receive a registry card. There would also be guidelines on the standard of care that each physician must provide to every patient that is recommended marijuana. In order for a patient to receive a registry card, the attending physician must be able to prove that there was a thorough initial examination and subsequent follow-up visits in order to ascertain whether or not the marijuana is making a difference in the patient’s standard of living. The possession limits would be limited to two ounces and 6 mature plants per patient but the patient’s physician, if it is deemed necessary, can increase that possession limit. In this medical marijuana system, the physician would have a greater role as a gate-keeper, insuring that patients aren’t lying about symptoms and determining how much medicine each individual should be consuming and possessing.

Medical marijuana would have a similar tax to the tax imposed by New York State. The level of the tax would be decided by each state according to their specific circumstances. Also, this tax would go on to fund subsidies to patients who would not otherwise be able to afford their medicine and also fund potential educational reforms in each state. Patients would be able to obtain their medicine in the same way as patients in California currently obtain their medicine. Patients could either grow it themselves, have a caregiver grow it for them or obtain it at a state licensed dispensary. One of the last provisions of this law would force every state that implements these laws to accept other states registry cards. This is very important because, in this alternative, marijuana is still illegal at the federal level. This means that patients cannot travel across state lines with marijuana. In this scenario, patients would be able to travel freely between medical marijuana states and not have to fear being without their medicine for an extended period of time.
While this policy would solve many of the current problems facing medicinal marijuana, there are still several problems that it would not address. The first and foremost problem it doesn’t address is universal access to medicinal marijuana. Since this policy leaves it up to the states to decide if legalization is the right policy, some states would still not legalize medicinal marijuana. This could potentially leave millions of patients without access to medicine. Currently, the majority of insurance companies do not pay for medicinal marijuana as a part of their insurance plans (Boire, Feeney). This is because most insurance companies fear the possibility of federal backlash. However, this problem would be minimal because of the state subsidies that would be provided in order to help pay for a medical marijuana patient’s medicine. This policy also leaves open the possibility for federal interference. As evidenced earlier, just because the federal government states it will not interfere in state legal dispensaries, there is no incentive or penalty for following through on that statement.

This policy would solve some of the most pressing issues surrounding medical marijuana, different standards of care, different qualifying conditions and different methods of obtaining marijuana all while minimizing federal involvement. This policy would also provide a boost to the economy while maintaining a high degree of political viability. The tax on medicinal marijuana could go to fund educational reform as well as medical marijuana subsidies. The economy of states that legalize medicinal marijuana would also see a boost as a large number of jobs would be created. These jobs would include jobs at grow houses, medical marijuana dispensaries and an industry centered on teaching people how to grow their own medicine. This policy would be the most politically viable option for several reasons. The first reason is that, as of right now, 85% of registered voters approve of the legalization of medical marijuana (Section
Policy Alternative #2:

A second alternative to the current policy regarding medical marijuana would begin at the federal level. This policy would start with the rescheduling of marijuana under the Controlled Substances Act. As noted before, marijuana is a schedule I substance and as such is illegal throughout the United States. In order to make medical marijuana accessible to patients throughout the country, it could be rescheduled to a schedule III or a schedule IV substance dependent upon a further government study. According to the Controlled Substances Act, a schedule III substance has,

“A) The drug or other substance has a potential for abuse less than the drugs or other substances in schedules I and II. B) The drug or other substance has a currently accepted medical use in treatment in the United States. C) Abuse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence.” (Controlled Substances Act).

Marinol, a pill containing synthetic THC, is already classified as a schedule III substance so rescheduling marijuana into this schedule would be the most politically viable and potentially make the most sense scientifically. The decision to classify marijuana as a schedule III substance as opposed to classifying it as a schedule IV or V substance is based primarily on the political viability of the situation. Since Marinol is already classified as a schedule III substance, the easiest and most winnable route would be to classify non-synthetic THC in the same category as synthetic THC.

There are two routes that can be taken in order to reschedule marijuana as a schedule III substance. The first route, and the most common, is to petition the DEA to reschedule marijuana.
After the DEA has received the petition, a joint investigation takes place with the Department of Health and Human Services. This investigation generates a report on all aspects of the substance in question; any medical uses, potential for abuse, whether it can be regulated efficiently etc. The report is then presented to the DEA by the Director of the Department of Health and Human Services and the Director then gives a recommendation on whether the substance should be rescheduled (Controlled Substances Act). The DEA is bound by the Director’s recommendation.

The second route, much less commonly used, is to have Congress pass a law rescheduling a particular substance, such as marijuana in this case.

Assuming the rescheduling of marijuana has occurred, Congress would need to draft and pass a comprehensive bill regarding medical marijuana. This part of the policy may seem a little unnecessary as the rescheduling of marijuana would allow physicians to prescribe marijuana to any patient as easily as Marinol and other schedule III drugs are prescribed. The problem with this is that marijuana is so widespread, so many American smoke marijuana and the black market is so pervasive, the medical marijuana industry would have to be very tightly regulated.

Richard Glen Boire and Kevin Feeney, the authors of a book titled Medical Marijuana Law, propose a model medical marijuana bill that they believe could be adopted by individual states. However, this same bill, with a few changes, could be implemented at the federal level. The bill has several sections to it, definitions and medical findings, patient protections, creation of a department that would oversee the implementation of this industry and an optional section on dispensaries (Boire, Feeney).

The bill would begin by stating the current medical findings regarding medicinal marijuana. Then it would go on to state the difference between a medical marijuana patient and a
recreational user. This bill would provide legal protections to those who have legally been prescribed marijuana and the recreational user would receive no legal protections. Marijuana would only be allowed to be prescribed to patients over the age of 18. This section would also discuss what conditions physicians would be allowed to prescribe marijuana for. These conditions would be the same as the conditions listed in the California law (Boire, Feeney). This section would also allow the Department of Health to add additional conditions to this list as further research is done. One change that would be made to this bill would be to add a section similar to California that would allow physicians to prescribe marijuana for any condition in which consuming marijuana would benefit the patient.

The next part of the bill goes on to describe the legal protections that the law would provide to the medical marijuana patient and their caregivers. A patient must register with a newly created state level department and receive a registry card. Anyone willing to become a caregiver must also register with the same department. This registry card allows the patient to possess up to two and a half ounces of marijuana and up to twelve mature plants. The caregiver is allowed to possess the same amount so long as all marijuana is being administered to the patient. In select cases, physicians may recommend that patients possess more than that amount and it will be noted on their registry card. Registry cards would also be accepted in every state in the country regardless of which state issued it. Another addition to the bill Boire and Feeney described would be guidelines regarding universal standard of care. Each physician must be able to prove that a certain minimum standard of care had been provided. This standard of care would be developed by the new department created to oversee the implementation of this law. The most important legal protection, next to being allowed to actually possess marijuana, is the portion of the bill that states, “No school, employer, or landlord may refuse to enroll, employ, lease to, or
otherwise penalize a medical marijuana user” (Boire, Feeney). This is extremely important because right now a medical marijuana patient can be fired for failing a company or federally mandated drug test even though they aren’t smoking marijuana for recreational reasons but rather just to maintain a certain level of comfort.

This bill would also outlaw patients from performing activities that constitute negligence or professional malpractice while under the influence of marijuana. Marijuana could not be smoked in school or on school grounds, in correctional facilities, on a school bus or other forms of public transportation and in any public place (Boire, Feeney). A patient would not be allowed to operate a motor vehicle, aircraft or motorboat under the influence (Boire, Feeney). Physicians would have to demonstrate the same standard of care as described in the first policy alternative. States would also be able to institute a tax on medical marijuana, much like New York currently does. This tax could then go on to fund education reform or drug addiction programs. The final section of this bill is an optional section on dispensaries. This part of the bill would be left up to the individual state to decide how patients would be able to obtain their medicine.

This alternative would solve almost every problem currently facing medical marijuana. The biggest problems such as access, differing standards of care, how and where to obtain marijuana would be solved. Insurance companies would also begin to include marijuana as part of their regular medical coverage. They would be able to do this because there would no longer be a fear of federal backlash as marijuana would be legal at both the state and federal level. Medicare and Medicaid would also be able to provide coverage for medical marijuana patients and the amount of people who could be helped by this substance would be even greater. One of the most important problems that would be solved is there would no longer be a contradiction
between state and federal law. A legal medical marijuana dispensary would no longer have to fear being raided by the DEA.

There are other, slightly less obvious, benefits of this policy alternative. The first of which, is that crime rates could decrease. There are two reasons for this. The first of which is that no longer would normally, law-abiding citizens, break the law in order to obtain their medicine. Also, federal agencies would no longer be able to prosecute state legal dispensaries and in turn they would be able to take the resources normally dedicated to those endeavors and dedicate them to other, more pressing issues. The black market centered on marijuana would also begin to decrease as patients in every state would be able to obtain their medicine without having to resort to breaking the law. One of the last benefits would be an economic benefit. The creation of a large medical marijuana industry, everything from grow houses to dispensaries to security guards at both of those operations would create thousands of jobs across the United States.

While there aren’t many cons associated with this policy, there are a few. The first of which is that the policy wouldn’t be supported by one hundred percent of the American public. While 85% of voters polled approved of the legalization of medical marijuana, which still leaves 15% who do not approve of this issue (Section 2). This could potentially lead to protests regarding the legalization of medical marijuana. There is also the possibility of individuals attempting to scam the system for “legal” marijuana. This problem would be diminished by physicians acting in the role of a gate-keeper and insuring that patients are actually suffering from the conditions they say they are suffering from. One last con that is associated with this policy is that if marijuana is more readily accessible to patients who need it, there is the potential for some of that marijuana to fall into the hands of minors.
**Recommendation:**

The policy regarding medicinal marijuana that should be implemented is policy suggestion number two. This policy would solve all of the major problems currently facing medicinal marijuana in the United States. The two biggest issues involving medicinal marijuana, differing standards of care as well as universal access would be solved by this policy suggestion. Since marijuana would be legal to be prescribed at the federal level doctors would be able to prescribe marijuana to patients in the same manner as Vicodin or any other controlled substances. The differing standards of care would be solved by the framework of the federal bill that would be passed by congress. This bill would require physicians to follow certain guidelines regarding the prescription of marijuana. There would no longer be a haphazard set of rules that differ from state to state regarding how physicians follow-up with their medical marijuana patients or even what conditions marijuana would be allowed to be prescribed for.

Patients would now be able to easily obtain their medicine in the same manner any other prescription would be filled. There would be no need to jump through any hoops in order to obtain medicinal marijuana as it would be prescribed just as any other medicine. Another important issue that would be solved is the one of cost. Many patients would have few, if any, direct costs as insurance companies would begin to incorporate medical marijuana prescriptions into their coverage plans much the same as other drug prescriptions are covered. One of the last obvious benefits is that there would no longer be a difference between state and federal laws on the topic of marijuana.

This policy would also have other benefits not directed at patients, physicians or caregivers. The biggest benefit would be to the economy. A large number of jobs would be
created in both the dispensary industry as well as the actual growing of marijuana. States that decided to tax medicinal marijuana would also see an increase in tax revenue as they would be collecting money that normally would not have been collected. This could potentially be a huge help to states struggling with debt. In 2014, Colorado collected 44 million dollars from its tax on recreational marijuana (Wyatt). Now this tax was on recreational marijuana and this policy only discusses medicinal marijuana so the numbers for Colorado’s tax revenue would be significantly higher. However states that adopted a tax on medicinal marijuana would still see an increase in tax revenue as a new source of tax revenue would be created.

The second policy suggestion, legalizing marijuana for medical use at the federal level, should also be implemented because recent polls have suggested that an overwhelming majority of Americans support reform in this area. This would indicate that the political climate is sufficiently pro-legalization that current members of Congress need not fear retribution from constituents if they vote for the legalization of medicinal marijuana and a subsequent bill regulating the industry. The second policy alternative would also be politically viable as a bipartisan group of Senators have recently introduced a bill that would reschedule marijuana as a schedule II substance and thus allow physicians to prescribe marijuana as a legal medicine (Ciaramella). Legalizing medicinal marijuana at the federal level would solve most, if not all, of the problems currently facing medical marijuana while minimizing any potential costs.

**Conclusion:**

The problem of the policy surrounding medical marijuana in the United States is a widespread one. The problems begin at the federal level with the classification of marijuana as a schedule I substance. There has been significant research in the potential of marijuana as a
medicine. This information had led such pro-legalization groups and individuals to believe that marijuana has been misclassified. This was evident in reports commissioned by President Nixon during the 1970s and the evidence has only grown since then. The problem is further confounded by the fact that many state governments have legalized the use of marijuana as a medicine in their particular state. This contradiction between state and federal law creates a tension between federal law enforcement agencies and state medical marijuana dispensaries as well as physicians who recommend marijuana and their patients. There is even a problem between the states that legalize marijuana for medical use. These problems include, differing standards of care, different methods of obtaining marijuana, different conditions that can be treated by marijuana and the fact that most states do not accept registry cards from other states.

All of these problems, at both the state and federal level, could be solved by implementing the second policy alternative as described above. As stated earlier, this policy begins with rescheduling marijuana to, minimally, a schedule III substance. Next, a comprehensive medical marijuana bill would have to be drafted and passed by Congress. Lastly, this policy would involve the implementation of the bill over the next few years while leaving open the possibility to amending the bill in order to solve unforeseen problems.
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