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Testimony of the ACLU of Iowa
presented to the Iowa Board of Pharmacy
regarding Medical Use of Cannabis
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I. Introduction: How we got to where we are

Authorizing the medical use of cannabis is not an easy decision but it is an important one. By now the Board has received a great wealth of information both scientific, regulatory and anecdotal. The ACLU of Iowa cannot hope to do anything at this point except to suggest clarification of the debate and decision-making process.

First, the proposal to permit medical use of cannabis is not the first step of a process that is likely to lead toward "legalization of marijuana." If medical use of cannabis is authorized, it will almost certainly continue to be listed as a schedule II substance. Schedule II contains a long list of very dangerous drugs and substances that are authorized for use in medical treatment, and none of them are even close to being legalized despite having been on schedule II for years.

Second, we all need to realize that decision-making concerning the medical use and classification of cannabis has never been "science based" even though it should be.

Harry Anslinger, our nations first "drug czar," testified before Congress that marijuana "led to murders and sex crimes, making marijuana use a law enforcement problem" and that "most marijuana smokers are Negroes, Hispanics, jazz musicians, and entertainers. Their satanic music

is driven by marijuana."[1] He also had the gall to say that marijuana led white women to have sex with black men.[2] He said all of the above without scientific evidence, or any evidence at all.

Thus began the beginning of the federal prohibition of marijuana in 1937, which was not the result of science, but of political grandstanding and power grabbing by federal officials.

One of the first states to statutorily prohibit marijuana, Iowa's ban was enacted in 1923. California was the first, followed by Wyoming (1915), Texas (1919), and then Iowa (1923), Nevada (1923), Oregon (1923), Washington (1923), Arkansas (1923), and Nebraska (1927). "These laws tended to be specifically targeted against the Mexican-American population as marijuana was introduced into the U. S. by people coming from Mexico."[3]

"Prior to 1937, at least 27 medicines containing marijuana were legally available in the United States. Many were made by well-known pharmaceutical firms that still exist today, such as Squibb (now Bristol-Myers Squibb) and Eli Lilly. The Marijuana Tax Act of 1937 federally prohibited marijuana. Dr. William C. Woodward of the American Medical Association opposed the Act, testifying that prohibition would ultimately prevent the medicinal uses of marijuana."[4]

"Despite the AMA's opposition, the federal Marihuana Tax Act was approved, causing all medicinal products containing cannabis to be withdrawn from the market and leading to marijuana's removal in 1941 from *The National Formulary* and the *United States Pharmacopoeia*, in which it had been listed for almost a century."[5]

"In 1944, the New York Academy of Medicine released a study demonstrating that marijuana did not cause violence and had positive medical benefits, contradicting Anslinger's propaganda. As a result, the Federal Bureau of Narcotics banned all marijuana research in the United States."[6] When the federal Controlled Substances Act was established, it was a Congressional decision and not scientific analysis that resulted in cannabis being placed in Schedule I rather than in schedule II where substances having medical utility are placed. When Iowa adopted its own Uniform Controlled Substances Act it simply adopted the federal scheduling decision.

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[1] Marijuana; Opposing Viewpoints. Ed. Jamuna Carroll. Detroit: Thomson Gale, 2006. P. 13.

[2] Knapp, Alex. "*Harry Anslinger: The Original Drug Warrior*." http://www.hereticalideas.com/2009/02/harry-anslinger-the-original-drug-warrior/ Feb. 25, 2009.

[3] Edwards, C.E., **HISTORICAL PERSPECTIVE ON MARIJUANA-USE PUBLIC POLICY,** March 2006,footnote #4, p.2.; Also, Guither, Pete. "DrugWarRant: Why is Marijuana Illegal?" http://www.drugwarrant.com/articles/why-is-marijuana-illegal/ © 2009.

[4] Marijuana; Opposing Viewpoints. Ed. Jamuna Carroll. Detroit: Thomson Gale, 2006. P. 148.

[5] Eddy, Mark. *Medical Marijuana: Review and Analysis of Federal And State Policies, Congressional Research Service*, March 31, 2009, p.3.

[6] Knapp, Alex. *Harry Anslinger: The Original Drug Warrior*, Heretical Ideas; February 25, 2009. http://www.hereticalideas.com/2009/02/harry-anslinger-the-original-drug-warrior/

In 1978 in response to mounting pressure to investigate the medical utility of cannabis Congress authorized limited research and investigation through the "Investigational New Drug and Compassionate Access" program administered by the FDA. However, in 1992, when it became apparent that cannabis was very effective in countering the loss of appetite and nausea experienced by AIDS patients, President George H.W. Bush closed the program, fearing that large numbers of patients using cannabis would have politically unfavorable consequences. The program has never been reopened.[7]

In sum, though opponents of the authorization of cannabis are often very vocal in demanding a scientific approach to the question, they historically have been the most active in ignoring and suppressing scientific investigation.

The Iowa legislature has expressed interest in having the Board of Pharmacy examine and regulate the medical use of cannabis, but until now the Board has not risen to this challenge. See State v. Bonjour, 694 N.W.2d 511, 515 (2005) *dissenting op.*, Wiggins. As a result, cannabis, in Iowa, is very conspicuously and inconsistently listed on both Schedule I and Schedule II. The only difference between these schedules is whether a drug or substance has medical usefulness so it is illogical to list "marijuana" on both schedules.

II. Medical Utility

Personal testimony given to this Board by a number of courageous[8] individuals with chronic and acute health problems establishes that cannabis does have strong therapeutic and ameliorative effects which positively affect the health and quality of life of some medically afflicted individuals in ways that legally prescribed medications and treatments have been unable to achieve. Practical reasons for using marijuana to address or alleviate the effects of medical conditions include its apparent effectiveness, its low cost and accessibility, more acceptable side effects and its safety. Medical users often cite these advantages in contrast to other prescribable drugs or treatments that have been ineffective, too expensive[9] or accompanied by unacceptable side effects.

This anecdotal evidence is consistent with the long historical record of recognition of the medical value of cannabis spanning several centuries and emerging scientific studies.

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[7] Eddy, CSR Report for Congress,Medical Marijuana: Review and Analysis of Federal and State Policies, May 15, 2007, Order Code RL33211, page 8

[8] These individuals testified sincerely despite the risk of personal identification and subsequent prosecution.

[9] For example, a years supply of Nabilone which is a syntheticly produced cannabinoid that mimics some of cannabis's medical effects can cost $4000 per year. *See* http://en.wikipedia.org/wiki/Medical_cannabis

> On October 7, 2003 a patent entitled "Cannabinoids as Antioxidants and Neuroprotectants" (#6,630,507) was awarded to the United States Department of Health and Human Services, based on research done at the National Institute of Mental Health (NIMH), and the National Institute of Neurological Disorders and Stroke (NINDS). This patent claims that cannabinoids are "useful in the treatment and prophylaxis of wide variety of oxidation associated diseases, such as ischemic, age-related, inflammatory and autoimmune diseases. The cannabinoids are found to have particular application as neuroprotectants, for example in limiting neurological damage following ischemic insults, such as stroke and trauma, or in the treatment of neurodegenerative diseases, such as Alzheimer's disease, Parkinson's disease and HIV dementia."[10]

The medical value of cannabis results from many of the compounds (over 300) and the 60 cannabinoids that it is known to contain. The chemistry and utility of all of these cannabinoids have not been fully defined. Science has not learned how to optimally replicate the combined effects of these components with drugs that can provide comparable safety, effectiveness and accessibility. Not all of these cannabinoids have psycho-active effects. It is therefore ironic, that drugs like Marinol which are synthetic forms of THC which is known for its psychoactive qualities are legally available for treatment while cannabis which is less dependent on THC for its overall effects is not.

Research has suggested dozens of uses for cannabis including treatment of certain cancers, spasms, pain management, opioid dependence, glaucoma, nausea, anxiety, and anorexia. While cannabis may not be optimal for treatment of all of these conditions it has proved very important in some cases and medical science needs legal breathing space to pursue investigation of its full potential. Eventually, this may lead to more effective and inexpensive drug therapies.

III. Safety

That cannabis does have strong and valuable medical effects is beyond debate. Instead, opponents, largely from the law enforcement community have focused on issues of safety and abuse. Most of these critique focus on the known side effects of marijuana when it is used in non-therapeutic environments and fail to compare these effects with the known side effects of alternative medications which in some cases can be quite severe when compared to cannabis.

Overall, cannabis is highly safe. Although in inhaled form, dosage may defy rigid controls, it is not unknown for other drugs to be prescribed within safe limits on an "as needed" basis. In fact,

[10] *Id*.

when sufferers of nausea or other symptoms resort to cannabis, they appear to demonstrate ability to self regulate their dosage to achieve an optimal level between unwanted side effects and symptomatic relief. In similar ways, we trust diabetics to and asthmatics to self regulate some aspects of their medications and treatment.

In this regard, it is important to note that deaths or disabilities from excessive use of cannabis are virtually unrecorded in medical literature. Even when examining figures for millions of people who use the substance without medical oversight for the very purpose of "getting high," deaths from the drug itself have not been reported.

Even serious side effects are not a bar to many legal medications. To the extent that side effects are a concern, that is an argument for why medical use of cannabis actually should be legalized so that it can be placed "**under medical supervision.**" As the hearings have shown many individuals will continue to use cannabis for cogent therapeutic reasons without the benefit of oversight from a doctor or pharmacist. Moreover, many current users of cannabis for medical reasons indicate they are using that substance for the very purpose of avoiding intolerable side effects associated with other drug therapies.

In 1988, after 16 years of debate, hearings, and court proceedings, the chief administrative law judge for the DEA, Francis L. Young, ruled on a petition to reschedule cannabis and make it available by prescription. Judge Young stated that "[m]arijuana, in its natural form, is one of the safest therapeutically active substances known to man." He went on to rule that evidence in the record "shows that marijuana has been accepted as capable of relieving the distress of great numbers of very ill people, and doing so with safety under medical supervision. It would be arbitrary and capricious for DEA to continue to stand between those sufferers and the benefits of this substance in light of the evidence in this record."[11]

Judge Young recommended that "the marijuana plant considered as a whole has a currently accepted medical use in treatment in the United States, that there is no lack of accepted safety for use of it under medical supervision and that it may lawfully be transferred from Schedule I to Schedule II." He recommended "that the Administrator transfer marijuana from Schedule I to Schedule II."[12] Although Judge Young's decision was later rejected on legal grounds his factual findings have importance for the continued debate, especially in regard to safety.

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[11] Eddy, Mark. Medical Marijuana: Review and Analysis of Federal And State Policies, Congressional Research Service, March 31, 2009, p.9

[12] Young, Francis (Administrative Law Judge) UNITED STATES DEPARTMENT OF JUSTICE Drug Enforcement Administration In The Matter Of MARIJUANA RESCHEDULING PETITION Docket No. 86-22 OPINION AND RECOMMENDED RULING, FINDINGS OF FACT, CONCLUSIONS OF LAW AND DECISION OF ADMINISTRATIVE LAW JUDGE. http://www.druglibrary.org/schaffer/Library/studies/YOUNG/index.html Sept. 6, 1988. P. 68

IV. Potential for Abuse and Distribution

A. Potential for Abuse

The use of cannabis can have pleasing psycho-active effects, particularly when used on an intermittent basis for "recreation." Accordingly, it is subject to abuse. Although, the overall dangerousness of this drug in terms of side effects and mortality appears to be low, current social norms require strict control of this substance. Its potential for abuse has to be acknowledged and become part of the Board's decision-making.

Again, the mere fact that a substance can be abused is no argument against its medical use. Many of medicine's most important drugs are subject to the same vulnerability. Authorizing cannabis for medical use is not the same thing as permitting its general distribution and consumption.

Recently, the Obama administration announced that it was no longer seeking to arrest and prosecute persons who use or distribute cannabis legally for medical purposes in accordance with the laws of their own state. In the apparent judgment of the administration, the cause of controlling abuse of cannabis cannot be advanced by continuing to prosecute cancer patients. The wisdom of this decision should guide the Board's own analysis. Making martyrs out of those who resort to marijuana out of desperation in dealing with extreme medical conditions does not improve the public's respect for laws denying access to cannabis, and it focuses on the wrong targets if the concern is to impact those who use the substance recreationally.

As with other drugs, the public is quite capable of understanding and respecting the difference between prescribed treatment and illegal use. Moreover, continuing to prosecute medical users will not diminish recreational use. If anything, it pulls resources away from that fight.

B. Distribution

The most frequently mentioned model for cannabis distribution is the rather *ad hoc* system that has grown up in California. The criticisms of California in the press may be justified. In any case, they do not fit with Iowa's standards.

With over 13 states now authorizing the medical use of cannabis there are other models to follow. The ACLU's national Drug Reform Project has been working on a position regarding distribution systems for medical cannabis, but it has not at this point released any papers.

In the meantime, the Board does have some options. It need not solve the distribution issues overnight. Although in the end the public should have a safe, reliable and well controlled means to acquire cannabis for medicinal use under the direction of a physician, reform could start with a measure as simple as removing marijuana from Schedule I and adopting regulations for identifying when marijuana may be used medically under a physician's supervision.

The ACLU of Iowa does not recommend a system that requires physicians to actually "prescribe" cannabis at this time. The experience in Arizona after the law was changed there shows that physicians will be legally unable to "prescribe" cannabis until federal law is changed. Instead, the Board should look at regulations that would currently permit physicians to "recommend" or "suggest" or "permit" their patients to use cannabis under medical supervision in a way that can be verified for legal purposes.

Conclusion

The ACLU of Iowa would like to thank the Board of Pharmacy for tackling this grave issue. We appreciate that the decision making is not always simple and that the Board will want to proceed cautiously. We think, however that the importance of the issue deserves intellectual honesty and action to remedy the misguided policies of the past. At present, and for the foreseeable future, cannabis will be used medically by certain patients in grave need with good results. We should support their efforts with a regulatory scheme that legitimizes appropriate medical uses of cannabis while continuing to distinguish abuse. It is time for the Board to treat medical use of cannabis as a medical issue rather than as a law enforcement problem.

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