

AMERICAN MEDICAL ASSOCIATION
MEDICAL STUDENT SECTION

Resolution 2
(A-08)

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Subject: Marijuana: Medical Use and Research

Referred to: MSS Reference Committee
(Despina Siolas, Chair)

1 Whereas, The federal Controlled Substances Act of 1970 categorized marijuana as a Schedule I substance
2 not permitted for prescription use¹, yet 12 states (AK, CA, CO, HI, ME, MT, NV, NM, OR, RI, VT,
3 WA)² have laws that permit the use of marijuana when recommended by a physician; and
4

5 Whereas, A ruling by the Ninth U.S. Circuit Court of Appeals reaffirmed and the Supreme Court let stand
6 the right of physicians and patients to discuss the therapeutic potential of marijuana, but patients who
7 follow their physicians' advice are put at risk for up to one year in federal prison for possession of
8 marijuana, and up to five years in federal prison for growing one marijuana plant, as federal law does not
9 make a distinction between medicinal and other marijuana use³; and
10

11 Whereas, Legal access to marijuana for specific medical purposes has been supported by numerous
12 national and state medical organizations, including the National Academy of Sciences' Institute of
13 Medicine, American College of Physicians, American Psychiatric Association's Assembly, American
14 Academy of Addiction Psychiatry, American Academy of Family Physicians, California Medical
15 Association, Medical Society of the State of New York, Rhode Island Medical Society, American
16 Academy of HIV Medicine, HIV Medicine Association, Canadian Medical Association, British Medical
17 Association, and the Leukemia & Lymphoma Society⁴; and
18

19 Whereas, The Institute of Medicine concluded after reviewing relevant scientific literature – including
20 dozens of works documenting marijuana's therapeutic value – that “nausea, appetite loss, pain, and
21 anxiety are all afflictions of wasting, and all can be mitigated by marijuana”⁵; and
22

23 Whereas, Subsequent studies since the 1999 Institute of Medicine report, including randomized, double
24 blind, placebo-controlled ones, continue to show the therapeutic value of marijuana in treating a wide
25 array of debilitating medical conditions, including relieving medication side effects and thus improving
26 the likelihood that patients will adhere to life-prolonging treatments for HIV/AIDS and Hepatitis C and
27 alleviating HIV/AIDS neuropathy, a painful condition for which there are no FDA-approved treatments⁶;
28 and
29

30 Whereas, “Given marijuana's proven efficacy at treating certain symptoms and its relatively low toxicity,
31 reclassification would reduce barriers to research and increase availability of cannabinoid drugs to
32 patients who have failed to respond to other treatments”⁷; and

33 Whereas, “Only two cannabinoid drugs are currently licensed for sale in the U.S. (dronabinol [Marinol®]
34 and nabilone [Cesamet®]), and both are only available in oral form” and while “useful for some, these
35 drugs have serious limitations”⁸; and
36

37 Whereas, Reclassifying marijuana as medically useful should draw from medical experience with opiates,
38 which indicates that “opiates are highly addictive yet medically effective substances and are classified as
39 Schedule II substances,” but “there is no evidence to suggest that medical use of opiates has increased
40 perception that their illicit use is safe or acceptable”⁹; and
41

42 Whereas, “Preclinical, clinical, and anecdotal reports suggest numerous potential medical uses for
43 marijuana . . . unfortunately, research expansion has been hindered by a complicated federal approval
44 process, limited availability of research-grade marijuana, and the debate over legalization”¹⁰; and
45

46 Whereas, the National Institute on Drug Abuse (NIDA) generally supplies marijuana for the research of
47 harms and does not automatically provide marijuana to researchers who hold an FDA Investigational New
48 Drug (IND) and a Drug Enforcement Administration (DEA) Schedule I researcher’s registration for
49 marijuana¹¹; and
50

51 Whereas, The federal government has obstructed privately funded research through NIDA’s monopoly
52 over the production of marijuana for research, as well as through the DEA’s refusal to license any
53 privately funded marijuana production facilities, even though DEA-licensed, private facilities produce
54 LSD, MDMA, psilocybin, mescaline, and other Schedule I drugs; and
55

56 Whereas, Despite these obstructions, the accumulated scientific data regarding marijuana’s safety and
57 efficacy in certain clinical conditions and its increasingly accepted medical use in treatment can no longer
58 be ignored¹²; therefore be it
59

60 RESOLVED, That our AMA support review of marijuana’s status as a Schedule I controlled substance,
61 its reclassification into a more appropriate schedule, and revision of the current protocol for obtaining
62 research-grade marijuana so that it conforms to the same standards established for obtaining every other
63 scheduled drug for legitimate research purposes; and be it further
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65 RESOLVED, That our AMA strongly support exemption from federal criminal prosecution, civil
66 liability, and professional sanctioning for physicians who recommend medical marijuana in accordance
67 with state law, as well as full legal protections for patients who use medical marijuana under these
68 circumstances; and be it further
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70 RESOLVED, That this resolution be promptly forwarded to the House of Delegates at A-08 for national
71 action.

Fiscal note: TBD

Date received: 4/10/08

References:

1. Drug Enforcement Administration (DEA) drug scheduling. Available at <http://www.dea.gov/pubs/scheduling.html>.
2. USA Today. “Medical marijuana laws vary among states.” (2007) Available at http://www.usatoday.com/money/workplace/2007-04-16-marijuana-chart_N.htm.
3. DEA federal penalties for marijuana. Available at <http://www.dea.gov/agency/penalties.htm>.
4. Endorsements document. Available at <http://www.mediafire.com/?0ojtfmxwgdi>.
5. Joy, J., Watson, S., and Benson, J. *Marijuana and Medicine: Assessing the Science Base*. National Academy Press, 1999.

6. deJong B.C., et al, "Marijuana Use and its Association With Adherence to Antiretroviral Therapy Among HIV-Infected Persons With Moderate to Severe Nausea," *Journal of Acquired Immune Deficiency Syndromes*, January 1, 2005; Sylvestre D.L., Clements B.J., and Malibu Y., "Cannabis Use Improves Retention and Virological Outcomes in Patients Treated for Hepatitis C," *European Journal of Gastroenterology and Hepatology*, September 2006; Abrams D., et al, "Cannabis in Painful HIV-Associated Sensory Neuropathy," *Neurology*, February 13, 2007.
7. American College of Physicians, "Supporting Research into the Therapeutic Role of Marijuana," January 2008: 10. Available at http://www.acponline.org/advocacy/where_we_stand/other_issues/medmarijuana.pdf.
8. *Ibid*, p 8.
9. *Ibid*, p 10.
10. *Ibid*, p 3.
11. National Institutes of Health. (1999) Announcement of the Department of Health and Human Services' Guidance on Procedures for the Provision of Marijuana for Medical Research. Available at <http://grants.nih.gov/grants/guide/notice-files/not99-091.html>.
12. E Lawrence O. Gostin, JD, LLD (Hon), Georgetown Law Professor, "Medical Marijuana, American Federalism, and the Supreme Court." *JAMA*. 2005;294:842-844.

Relevant AMA and MSS Policy:

H-95.952 Medical Marijuana

(1) Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease. (2) Our AMA recommends that marijuana be retained in Schedule I of the Controlled Substances Act pending the outcome of such studies. (3) Our AMA urges the National Institutes of Health (NIH) to implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research into the medical utility of marijuana. This effort should include: a) disseminating specific information for researchers on the development of safeguards for marijuana clinical research protocols and the development of a model informed consent on marijuana for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of marijuana for clinical research purposes; c) confirming that marijuana of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the Drug Enforcement Agency who are conducting bona fide clinical research studies that receive Food and Drug Administration approval, regardless of whether or not the NIH is the primary source of grant support. (4) Our AMA believes that the NIH should use its resources and influence to support the development of a smoke-free inhaled delivery system for marijuana or delta-9-tetrahydrocannabinol (THC) to reduce the health hazards associated with the combustion and inhalation of marijuana. (5) Our AMA believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions. (CSA Rep. 10, I-97; Modified: CSA Rep. 6, A-01)

100.006 MSS Reclassification of Heroin for Therapeutic Use

AMA-MSS will ask the AMA to: (1) strongly support research into the therapeutic use of heroin as a Schedule I drug in the context of addiction treatment, for those patients for whom other standard methods have been tried and have failed; and (2) urge the Drug Enforcement Administration, Department of Health and Human Services, and National Institute of Drug Abuse to allow such research with appropriate oversight and safeguards. (MSS Sub Res 20, A-98) (AMA Res 504, I-98, Not Adopted) (Reaffirmed: MSS Rep E, I-03)

H-95.995 Health Aspects of Marijuana

Our AMA: 1. discourages marijuana use, especially by persons vulnerable to the drug's effects and in high-risk situations; 2. supports the determination of the consequences of long-term marijuana use through concentrated research; and 3. supports the modification of state law to reduce the severity of penalties for possession of marijuana. (CSA Rep. D, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

H-95.997 Marijuana

Our AMA:

1. recommends personal possession of insignificant amounts of that substance be considered a misdemeanor with commensurate penalties applied; 2. believes a plea of marijuana intoxication not be a defense in any criminal proceedings; and 3. urges that educational efforts be expanded to all segments of the population. (BOT Rep. J, A-72; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)