Irrational Basis The Legal Status of Medical Marijuana

Rebecca Dresser

Hastings Center Report, Volume 39, Number 6, November-December 2009, pp. 7-8 (Article)

Published by The Hastings Center

DOI: 10.1353/hcr.0.0207

For additional information about this article

http://muse.jhu.edu/journals/hcr/summary/v039/39.6.dresser.html
Irrational Basis: The Legal Status of Medical Marijuana

by Rebecca Dresser

In a growing number of states, medical marijuana occupies a dual legal status. The federal Controlled Substances Act (CSA) classifies marijuana as a Schedule I drug, signifying that it has both a high potential for abuse and no acceptable medical use. Patients and physicians are thus subject to the same federal criminal penalties as any other individuals who produce, distribute, or possess marijuana. By mid-2009, however, fourteen states had decided to permit medical marijuana under certain circumstances. Through voter initiatives or legislation, these states have exempted patients and physicians from prosecution for violating state laws governing the use, possession, or cultivation of marijuana.

The disparate legal regimes have generated much litigation, including two cases that reached the U.S. Supreme Court. Both cases rejected challenges to federal enforcement of the CSA in California, the state with the most liberal provisions on medical marijuana. Under the Court decisions, federal authorities could continue to take action against patients, physicians, and others who were protected under state medical marijuana laws.

Two recent legal developments are more favorable to states seeking to permit medical marijuana, however. First, U.S. Attorney General Eric Holder announced that the federal Drug Enforcement Agency would limit future raids and other enforcement activity to individuals violating both federal and state criminal law. This means that people complying with state medical marijuana laws will no longer be targeted by federal law enforcement officials. Holder said that under his leadership, the agency would focus its efforts on large-scale commercial marijuana operations.

In a second development with implications for state marijuana laws, the U.S. Supreme Court declined to review a court decision upholding legislation implementing California’s medical marijuana law. In 1996, California voters approved Proposition 215, designed to “ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician.” Seven years later, the California legislature enacted the Medical Marijuana Program Act to supplement the earlier law. The 2003 law requires counties to participate in a system that enables patients and caregivers to register and obtain identification cards protecting them from arrest for violating state marijuana prohibitions.

County versus State versus Federal Authority

California officials unhappy with the state’s permissive stance on medical marijuana balked at the mandate to create the identification system. San Diego and San Bernardino counties brought a lawsuit seeking a judicial declaration that they were not required to comply with the state’s mandate. According to the plaintiffs, the California law was preempted by the CSA, which fails to exempt medical marijuana from the usual criminal penalties.

The U.S. Constitution gives Congress the power to supercede state law. Over the years, courts have developed principles for determining when federal law preempts state law. Congressional purpose is the central consideration in resolving preemption claims. The easiest case arises when Congress includes in the legislative text an explicit provision on whether the law is intended to preempt state rules. In other cases, courts consider factors such as whether the state law under challenge presents an obstacle to achieving Congress’s objectives in enacting the pertinent federal law.

In 2008, a California appellate court ruled against the counties, holding that preemption failed to bar implementation of the California identification card program. As the court noted, the CSA itself states that it is not intended to preempt state laws “unless there is a positive conflict between [the CSA and state law] so that the two cannot consistently stand together.” Moreover, the court observed, the states’ historical authority over medical practice and state criminal law creates a presumption against federal preemption in these areas.

The California court said that county officials could not use preemption as a basis for rejecting their obligations under the state identification law. According to the court, officials could meet their state law obligations without violating any CSA provision. And the identification law failed to present a significant obstacle to Congress’s objective in classifying marijuana as a Schedule I drug because that classification was designed to discourage recreational use, not to control state medical practice. The court conceded that California’s broader decision to create a medical use exemption from state marijuana prohibitions “arguably undermines the goals of or is inconsistent with the CSA.” But county officials lacked standing to challenge California’s general provisions on medical marijuana because those provisions “neither impose obligations on nor inflict direct injury to Counties.”
The U.S. Supreme Court’s refusal to review the state court decision means that the federal preemption threat has been removed, at least for the time being. And Holder’s decision means that people complying with state medical marijuana statutes face no immediate threat of federal prosecution. But the overall legal situation leaves much to be desired, for at least two reasons.

First, neither the state medical marijuana laws nor CSA’s marijuana classification rests on solid scientific evidence. Few good studies have evaluated the risks and benefits of smoked marijuana. State medical marijuana laws were passed in reliance on anecdotal and other weak evidence of marijuana’s medical benefits. Similarly, the federal judgment that marijuana has no acceptable medical use lacks solid support. The CSA permits marijuana use in research approved by the Food and Drug Administration, but the Drug Enforcement Agency and National Institutes of Health have made it difficult for investigators to obtain the marijuana they need to conduct this research. The agencies have resisted research efforts in the face of reports from groups like the Institute of Medicine and American College of Physicians calling for systematic evaluation of marijuana’s risks and potential therapeutic effects. Meanwhile, the FDA has criticized state medical marijuana laws as “inconsistent with efforts to ensure that medications undergo the rigorous scientific scrutiny of the FDA approval process.”

Medical versus Recreational Use

A second problem with the current situation concerns how state and federal officials have responded to the risk that medical marijuana will be diverted to recreational use. California’s expansive medical marijuana law permits physicians to recommend marijuana for “any . . . illness for which marijuana provides relief.” The law also allows individuals to designate as a legally protected “primary caregiver” anyone “who has consistently assumed responsibility for the housing, health, or safety of the individual.”

Journalists report that California’s broad approach to decriminalizing medical marijuana has gone a long way toward decriminalizing recreational use, as well. In 2008, the New Yorker published a vivid account of how this has happened, featuring physicians who recommend marijuana for problems like anxiety and attention-deficit disorder and marijuana brokers and growers who make a living serving as patients’ primary caregivers. Last July, two Associated Press reporters wrote about the broad economic impact medical decriminalization has had in California, producing “chains of for-profit clinics with doctors who specialize in medical marijuana recommendations” and couriers delivering marijuana products for allergies and insomnia “with the practiced efficiency of a home-delivered pizza—and with just about as much legal scrutiny.”

In 2008, California’s attorney general sought to rein in some of these practices by issuing “Guidelines for the Security and Non-Diversion of Marijuana Grown for Medical Use,” but it remains to be seen whether the guidelines will have any real impact. Meanwhile, in the absence of direct debate over whether to decriminalize recreational use of marijuana, communities are grappling with the social and environmental impact of what has become a significant business in California.

Things are no better on the federal side, where officials’ concern over potential diversion of medical marijuana seems to account for their lack of cooperation with efforts to study the drug. Many controlled substances approved for medical use can be diverted to illegitimate uses. Indeed, the FDA is attempting to develop better control programs to address widespread and harmful prescription drug abuse. In light of this situation, concern about potential marijuana abuse is an inadequate basis for obstructing research to determine whether marijuana is a safe and effective drug for certain medical conditions.

A better approach would be to treat marijuana as we do other potentially therapeutic agents, subjecting it to rigorous scientific evaluation. State voters and legislators should be more skeptical of claims about marijuana’s medical benefits, and federal officials less hostile to efforts to test those claims. If research were to establish that marijuana is a safe and effective intervention for certain conditions, distribution restrictions could be imposed to prevent misuse. Decriminalization of recreational marijuana use should be addressed directly rather than through loose medical marijuana laws like California’s. Neither a libertarian nor a “War on Drugs” mentality is a rational basis for the legal status of medical marijuana.