

# CLEARING THE HAZE SURROUNDING STATE MEDICAL MARIJUANA LAWS: A PREEMPTION ANALYSIS AND PROPOSED SOLUTIONS

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## I. INTRODUCTION

Medical marijuana has been one of the most controversial topics in both the political and judicial realms over the last decade. The courts have provided relatively little guidance on this topic and specifically have put little emphasis on field preemption. The Food

and Drug Administration (“FDA”) has regulated the generic drug Dronabinol, originally marketed under the brand name “Marinol,” for approximately 25 years.<sup>1</sup> The FDA knew that marijuana existed in plant form that users ingest through smoke inhalation, but it denied legalization of the plant when it classified Marinol as a schedule II drug in 1986,<sup>2</sup> and later as a schedule III drug in 1999.<sup>3</sup>

Field preemption is a judicially created concept that prohibits states from enacting laws that are within an area already governed by the federal government.<sup>4</sup> Since the FDA is a division of the Department of Health and Human Services, an agency of the executive branch of the United States government, its actions reflect those of the federal government.<sup>5</sup> The FDA has regulated the sale of medicinal marijuana through Marinol capsules, thereby entering the field of medical marijuana and preempting the states from passing laws that allow medical marijuana use. Nineteen states and Washington D.C. have enacted laws allowing certain persons with medical conditions to obtain and use medicinal marijuana as opposed to limiting them to utilizing the federally regulated Marinol.<sup>6</sup>

In order to solve the negative implications of states enacting the legalization of medical marijuana laws, Congress needs to act. This comment suggests that it takes one of two approaches: 1) utilize its spending power in order to strongly encourage states that have adopted legalized marijuana laws to abandon enacted statutes, or 2) reschedule marijuana as a Schedule II drug thereby legalizing it on

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<sup>1</sup> See Gregg A. Bilz, *The Medical Use of Marijuana: The Politics of Medicine*, 13 HAMLINE J. PUB. L. & POL'Y 117, 125 (1992).

<sup>2</sup> *Id.*

<sup>3</sup> Schedules of Controlled Substances: Rescheduling of the Food and Drug Administration Approved Product Containing Synthetic Dronabinol [(-)-Δ-(trans)-Tetrahydrocannabinol] in Sesame Oil and Encapsulated in Soft Gelatin Capsules From Schedule II to Schedule III, 64 Fed. Reg. 35,928-30 (June 8, 1999) (to be codified at 21 C.F.R. pts. 1308, 1312) [hereinafter *Schedules of Controlled Substances*].

<sup>4</sup> *Altria Group, Inc. v. Good*, 555 U.S. 70, 77 (2008).

<sup>5</sup> See *About HHS*, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, [www.hhs.gov/about/foa/index.html](http://www.hhs.gov/about/foa/index.html) (last visited Nov. 15, 2013).

<sup>6</sup> *State Medical Marijuana Laws*, NATIONAL CONFERENCE OF STATE LEGISLATURES, [www.ncsl.org/issues-research/health/state-medical-marijuana-laws.aspx](http://www.ncsl.org/issues-research/health/state-medical-marijuana-laws.aspx) (last updated Aug. 2013).

the federal level for medical use, but allowing Congress to exert uniform control over the distribution in pharmacies.

Part II of this comment will address the history of Marijuana and Marinol in the United States as well as provide a brief comparison on the effects of smoking marijuana and ingesting Marinol in patients that can benefit from these drugs. Part III will examine whether federal law preempts state laws legalizing medicinal marijuana. Part IV proposes two suggested approaches that Congress could perform in order to avoid the preemption problem as well as the potential undesirable results of existing state laws. Finally, Part V anticipates two negative consequences of states legalizing medical marijuana and demonstrates the necessity of implementing one of the proposed congressional actions, which both have the ability to solve these issues.

States that have enacted medical marijuana legalization laws will run into administrative problems while attempting to regulate and control the sales of medicinal marijuana to those that are actually qualified for its consumption. Those persons who simply desire to utilize marijuana for recreational purposes have easier access to the illegal substance and defy the purpose of the state laws. Additionally, most dispensary workers are not licensed pharmacists,<sup>7</sup> creating potential risks because of their inability to notify users of harmful drug interactions. Therefore, Congress must take action.

## II. HISTORY OF MARIJUANA AND DRONABINOL IN THE UNITED STATES

### A. History of Marijuana

Marijuana usage within the United States dates back as early as the settlers of Jamestown, who utilized the drug for its hemp fibers.<sup>8</sup> George Washington, one of America's founding fathers and its first

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<sup>7</sup> Matthew J. Seamon, *The Legal Status of Medical Marijuana*, 40 ANN. PHARMACOTHERAPY 2211, 2212 (2006) (declaring that states where medical marijuana is legal "do not provide a source of marijuana," suggesting that medical marijuana is not sold by state registered pharmacists).

<sup>8</sup> BERNARD SEGAL, PERSPECTIVES ON DRUG USE IN THE UNITED STATES 14 (1986).

President, even grew hemp to accumulate wealth.<sup>9</sup>

As time went by, the medical community in the United States began recognizing marijuana's potential as a medicine, and early American medical journals included information pertaining to the treatment of "inflamed skin, incontinence and venereal disease" through the use of hemp seeds.<sup>10</sup>

At the end of the 19<sup>th</sup> century, a relatively significant number of Americans had unknowingly become addicted to morphine.<sup>11</sup> Therefore, the US government passed the Pure Food and Drug Act of 1906, which created the Food and Drug Administration ("FDA").<sup>12</sup> Due to the limited knowledge that existed at the time on most chemical substances, the Act placed the heavy burden of proving that a drug was unsafe on the FDA.<sup>13</sup> This made it difficult to regulate nearly all medications.<sup>14</sup> As a result, marijuana was not under the control of the FDA at the passage of this act.<sup>15</sup>

The Harrison Act was enacted in 1914 in order to respond to the high levels of drug users in the United States.<sup>16</sup> The original Act posed several problems, including holding physicians prescribing narcotics liable for illegal distribution, and therefore, the Act was amended in 1922.<sup>17</sup> Marijuana was never officially addressed within the Federal Government's early attempts at drug reform until the

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<sup>9</sup> ROBERT DEITCH, HEMP – AMERICAN HISTORY REVISITED, VITAL RESOURCE TO CONTENTIOUS WEED 19 (2003).

<sup>10</sup> Patrick Stack & Claire Suddath, *A Brief History of Medical Marijuana*, TIME HEALTH & FAMILY (Oct. 21, 2009), <http://www.time.com/time/health/article/0,8599,1931247,00.html>.

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*

<sup>13</sup> Katharine A. Van Tassel, *Slaying the Hydra: The History of Quack Medicine, the Obesity Epidemic and the FDA's Battle to*

*Regulate Dietary Supplements Marketed as Weight Loss Aids*, 6 IND. HEALTH L. REV. 203, 220-221 (2009).

<sup>14</sup> *Id.*

<sup>15</sup> Stack & Suddath, *supra* note 10.

<sup>16</sup> *Regulation of Narcotics and Controlled Substances*, 21 ILL. PRAC., THE LAW OF MEDICAL PRACTICE IN ILLINOIS § 15:74 (3d ed. 2011).

<sup>17</sup> *Id.*

Marihuana Tax Act of 1937 was passed.<sup>18</sup> This provision, however, still allowed marijuana to be sold and prescribed medically so long as the requisite tax was paid.<sup>19</sup>

All marijuana use eventually became criminalized and harsh sentences for marijuana possessors and distributors were enacted through the Boggs Act in 1951.<sup>20</sup> In 1970, Congress passed the Controlled Substances Act (“CSA”), which classified marijuana as a Schedule I substance, the highest classification for narcotics due to its “high potential for abuse.”<sup>21</sup> Therefore, marijuana was illegal to possess and use for any purpose whatsoever as it had no accepted medical value according to federal law.<sup>22</sup> Over time, many advocates of marijuana use attempted to “reschedule” the drug as Schedule II, which would allow physicians to prescribe it as medicine, but all results to date have been unsuccessful.<sup>23</sup> The only legal form of marijuana use was through the Investigation New Drug Compassionate Use Medical Marijuana Program established in 1976; where the government provided marijuana to those exhibiting certain medical conditions.<sup>24</sup>

In the late 1970s and early 1980s, the states began to develop their own theories as to how marijuana was medically valuable. In 1978, New Mexico passed a law that allowed marijuana to be used as a medicine for research in cancer patients, creating the Lynn Pierson Therapeutic Research Program.<sup>25</sup> Shortly after New Mexico’s law

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<sup>18</sup> *Id.*

<sup>19</sup> David Solomon, *The Marihuana Tax Act of 1937*, SCHAFFER LIBRARY OF DRUG POLICY, <http://www.druglibrary.org/schaffer/hemp/taxact/mjtaxact.htm> (last visited Feb. 7, 2014).

<sup>20</sup> See Stack & Suddath, *supra* note 10.

<sup>21</sup> U.S. DEP’T OF JUSTICE & DRUG ENFORCEMENT ADMIN., DRUGS OF ABUSE 13, 69 (2011).

<sup>22</sup> 21 U.S.C. § 812 (2006); 21 U.S.C. §§ 841, 844 (2006 & Supp. 2011).

<sup>23</sup> See Rosalie Liccardo Pacula et al., *State Medical Marijuana Laws: Understanding the Laws and their Limitations*, 23 J. PUB. HEALTH POL’Y 413, 416 (2002).

<sup>24</sup> MARK EDDY, CONG. RESEARCH SERV., RL33211, MEDICAL MARIJUANA: REVIEW AND ANALYSIS OF FEDERAL AND STATE POLICIES 8 (2010).

<sup>25</sup> BEHAVIORAL HEALTH SERVS. DIV. HEALTH & ENV’T DEP’T, THE LYNN PIERSON THERAPEUTIC RESEARCH PROGRAM: A REPORT ON PROGRESS TO DATE 1, 1 (1983).

passed, 30 other states passed similar laws.<sup>26</sup>

Despite numerous state studies being performed to determine the benefits of medical marijuana, the drug remained illegal. In 1991, a Florida Court of Appeals allowed a medicinal marijuana user to utilize the necessity defense for his charge of cultivating and possessing the narcotic in *Jenks v. State*.<sup>27</sup> However, the court limited its decision to situations where: 1) the defendant did not intentionally bring about the conditions causing the illegal acts; 2) the defendant had no other less offensive alternatives; and 3) the harm avoided by the defendant's unlawful act was more significant than the harm of the unlawful act taken.<sup>28</sup>

Only a few days after the decision in *Jenks*, the Federal Government "phased out" the Compassionate Use Medical Marijuana Program that had been providing free marijuana to the seriously ill since 1976, the only legalized marijuana existing at the time.<sup>29</sup> As a result of this decision, states and municipalities began to take action by passing laws permitting the use of marijuana for medical purposes. San Francisco was the first to pass an ordinance in November of 1991 legalizing marijuana and leading the way for the entire state of California.<sup>30</sup>

Sure enough, in 1996, California became the first state to legalize marijuana for medicinal purposes by passing Proposition 215.<sup>31</sup> The provision, known as the Compassionate Use Act of 1996, allowed marijuana to be prescribed by a physician to patients for treatment of "cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief."<sup>32</sup>

Since California passed Proposition 215 in 1996, 18 other states as well as the District of Columbia have legalized marijuana for medical

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<sup>26</sup> Elsa Scott, *Marinol: The Little Synthetic That Couldn't*, HIGH TIMES, July 1994, at 18, 20.

<sup>27</sup> *Jenks v. State*, 582 So.2d 676, 679 (Fla. Dist. Ct. App. 1991).

<sup>28</sup> *Id.*

<sup>29</sup> Michael Isikoff, *HHS to Phase Out Marijuana Program: Officials Fear Sending 'Bad Signal' by Giving Drug to Seriously Ill*, THE WASHINGTON POST, June 22, 1991, at A14.

<sup>30</sup> RICHARD GLEN BOIRE & KEVIN FEENEY, MEDICAL MARIJUANA LAW 26-27 (2006).

<sup>31</sup> CAL. HEALTH & SAFETY CODE § 11362.5 (West 2007); Stack & Suddath, *supra* note 10.

<sup>32</sup> CAL. HEALTH & SAFETY CODE § 11362.5(b)(1)(A) (West 2007).

purposes.<sup>33</sup> This poses a significant legal question regarding the validity of such measures due to the fact that marijuana remains a Schedule I drug under the CSA.<sup>34</sup>

In order to avoid liability under the federal law, physicians in states that have enacted medical marijuana laws recommend the drug to qualifying patients, rather than provide patients with a prescription.<sup>35</sup> Upon obtaining the “recommendation” for medicinal marijuana, the patient can obtain the narcotic in one of three ways: 1) they can simply grow the marijuana plant themselves; 2) they can obtain it through their caregiver; or 3) they can purchase it from local dispensaries.<sup>36</sup>

According to a San Francisco ordinance, a medical marijuana dispensary is “a cooperative or collective of ten or more qualified patients or primary caregivers that facilitates the lawful cultivation and distribution of cannabis for medical purposes and operates not for profit.”<sup>37</sup> The states that allow medical marijuana have enacted regulations pertaining to dispensaries, which include: 1) zoning ordinances that limit how close a dispensary can be located to an educational facility; 2) restrictions on how much marijuana can be sold; and 3) constraints on profits that the owners can generate.<sup>38</sup> Despite the regulations that have been put into place by state governments to regulate and control dispensaries, some argue that recreational users can gain access to marijuana more easily because the provisions are vague and difficult to apply.<sup>39</sup> As a result, state

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<sup>33</sup> *State Medical Marijuana Laws*, *supra* note 6.

<sup>34</sup> *Id.*

<sup>35</sup> See EDDY, *supra* note 24, at 19.

<sup>36</sup> *Id.*

<sup>37</sup> S.F., CAL., S.F. HEALTH CODE art. 33, § 3301(f) (2008).

<sup>38</sup> See, e.g., S.F., CAL., S.F. HEALTH CODE art. 33, § 3308(c), (f) (2008) (limiting dispensaries to selling one ounce of dried marijuana per patient per visit, limiting the dispensary to operating as not-for-profit, and restricting profits to only reasonable compensation for services to patients); see also CAL. HEALTH & SAFETY CODE § 11362.768(b) (West 2011) (specifying that dispensaries must not be within a 600 foot radius of any school); ARIZ. REV. STAT. ANN. § 36-2804 (2010) (restricting dispensaries from being within 500 feet of a public or private school).

<sup>39</sup> See, e.g., Norimitsu Onishi, *Marijuana Only for the Sick? A Farce, Some Angelenos Say*, N.Y. TIMES (Oct. 7, 2012), <http://www.nytimes.com/2012/10/08/us/california-fight-to-ensure->

medical marijuana laws have generated a heated debate among politicians and lawmakers.<sup>40</sup>

Marijuana has been utilized to treat a variety of diseases and ailments throughout its long history.<sup>41</sup> Among the most common include: nausea and vomiting resulting from chemotherapy treatment in cancer patients, weight loss or decreased appetite in AIDS and cancer patients, muscle spasticity arising from neurological diseases like multiple sclerosis, severe pain, and glaucoma.<sup>42</sup> Marijuana's anti-inflammatory characteristics open its usage to virtually any illness or disease involving significant amounts of pain.<sup>43</sup>

Due to the popularity of marijuana as a medication, drug companies pushed to develop similar alternatives in the attempt to generate large amounts of profit.<sup>44</sup>

## B. History of Dronabinol (Brand Name Marinol)

In 1980, The National Cancer Institute experimented with an oral pill form of Tetrahydrocannabinol ("THC"), the primary active ingredient in the marijuana plant that causes psychoactive side effects.<sup>45</sup> The pill form of THC was first marketed by Unimed under the brand name Marinol, but possesses the generic name of Dronabinol.<sup>46</sup> For simplicity, the synthetically produced pill form of THC will be referred to as Marinol throughout the rest of this comment.

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marijuana-goes-only-to-sick.html?emc=eta1.

<sup>40</sup> *Id.*

<sup>41</sup> Matthew J. Seamon et al., *Medical Marijuana and the Developing Role of the Pharmacist*, 64 AM. J. HEALTH-SYST. PHARM. 1037, 1040 (2007).

<sup>42</sup> *Id.*

<sup>43</sup> *Id.*

<sup>44</sup> See generally, David Dias, *Just Don't Call it Pot*, NATIONAL POST (Oct. 7, 2008), <http://www.nationalpost.com/related/topics/Just+call/850924/story.html>.

<sup>45</sup> See, e.g., Kambiz Akhavan, *Marinol vs. Marijuana: Politics, Science, and Popular Culture*, DRUGTEXT.ORG 4-5 (2001), <http://www.drugtext.org/pdf/Cannabis-marijuana-hashisch/marinol-vs-marijuana-politics-science-and-popular-culture.pdf>; LAURENCE BRUNTON ET AL., GOODMAN & GILMAN'S MANUAL OF PHARMACOLOGY AND THERAPEUTICS 396 (2008).

<sup>46</sup> EDDY, *supra* note 24, at 8.



Marinol was originally labeled as a Schedule II drug available only to cancer patients who suffered from nausea and vomiting while undergoing chemotherapy treatment.<sup>47</sup> In 1992, Marinol was approved for use by patients suffering from anorexia and AIDS, and by 1999, the lack of abuse exercised by its users led to the lowering of the drug's classification to Schedule III, thus making it more accessible.<sup>48</sup> Marinol is available through prescription primarily to treat loss of appetite and anorexia in AIDS patients as well as nausea and vomiting associated with chemotherapy.<sup>49</sup> In other words, Marinol is being sold to patients to treat the same illnesses and side effects that medicinal marijuana is utilized to treat.<sup>50</sup>

### C. Smoking Marijuana Compared with Ingesting Marinol

Although Marinol and marijuana contain the same primary psychoactive component, or substance that affects the mental processes of the user, critics of Marinol argue that it is not as effective as inhaling marijuana smoke—Marinol does not produce results as quickly since it must be processed through the digestive system before entering the bloodstream.<sup>51</sup> Critics also argue that because Marinol only includes the primary ingredient of medical marijuana, the medication is less effective because all of marijuana's active ingredients collectively produce the beneficial treatment.<sup>52</sup> Additionally, Marinol can be difficult to administer or swallow for patients suffering from nausea and vomiting, and these are some of the patients who need it most.<sup>53</sup> Therefore, many proponents of statewide-legalized medical marijuana argue that Marinol simply does not function the same as marijuana.<sup>54</sup>

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<sup>47</sup> *Id.*

<sup>48</sup> *Id.* at 8-9.

<sup>49</sup> *Dronabinol*, DRUG FACTS AND COMPARISONS 874, 874 (Nov. 2008).

<sup>50</sup> See Leonard I. Frieling, *Overview of Medical Marijuana in Colorado*, 40 COLO. LAW. 37, 40 (2011).

<sup>51</sup> Mitch Earleywine, *Medical Marijuana Benefits*, CBS NEWS (Nov. 13, 2010, 7:56 AM), [http://www.cbsnews.com/2100-503823\\_162-4844665.html](http://www.cbsnews.com/2100-503823_162-4844665.html).

<sup>52</sup> *Id.*

<sup>53</sup> *Id.*

<sup>54</sup> See Peter A. Clark, *The Ethics of Medical Marijuana: Government Restrictions vs. Medical*

However, studies have tested the results and effectiveness of the two drugs. One such study tested the effects of Marinol and marijuana on patients who were HIV-positive and smoked marijuana.<sup>55</sup> HIV-positive patients were tested because HIV-positive patients are the largest group of persons that utilize marijuana for medicinal purposes.<sup>56</sup> The study concluded that, "for HIV-positive marijuana smokers, [Marinol] and marijuana produce comparable increases in food intake and improve mood without producing disruptions in psychomotor functioning."<sup>57</sup> However, the study noted that marijuana also produces the added benefit of improving the patient's sleep.<sup>58</sup> This bonus advantage does not make Marinol more or less effective than marijuana because it does not pertain to easing pain or nausea, the typical desired effects of medical marijuana.<sup>59</sup>

Even though medical marijuana may produce faster results, the health risks of inhaling the smoke are numerous.<sup>60</sup> In fact, some physicians argue that the negative health effects resulting from inhaling the smoke outweigh the benefits derived from medical marijuana.<sup>61</sup> However, marijuana can be ingested through foods, or the psychoactive ingredients can be vaporized and inhaled as vapor rather than smoke.<sup>62</sup> Ingesting marijuana in food causes the results to take just as long as Marinol, and vaporizers are relatively uncommon due to complications arising from drug paraphernalia regulation by the federal government.<sup>63</sup>

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*Necessity*, 21 J. PUB. HEALTH POL'Y 40, 43-44 (2000); George J. Annas, *Reefer Madness – The Federal Response to California's Medical-Marijuana Law*, 337 NEW ENG. J. MED. 435, 438 (1997).

<sup>55</sup> Margaret Haney et al., *Dronabinol and Marijuana in HIV-Positive Marijuana Smokers*, 45 J. ACQUIRED IMMUNE DEFICIENCY SYNDROME 545, 546 (2007).

<sup>56</sup> *Id.* at 545.

<sup>57</sup> *Id.* at 552.

<sup>58</sup> *Id.*

<sup>59</sup> See Seamon, *supra* note 41, at 1040.

<sup>60</sup> EDDY, *supra* note 24, at 29-31.

<sup>61</sup> *Id.* at 29-30 ("Smoked marijuana is unlikely to be a safe medication for any chronic medical condition." (quoting an Institute of Medicine Report)).

<sup>62</sup> *Id.* at 30.

<sup>63</sup> *Id.* at 31. Despite the potential benefits of vaporizers, legalizing marijuana ingestion only through vaporizers could cause regulatory problems since it would be nearly impossible for authorities to control the specific means of a consumer's ingestion.

Therefore, marijuana may be more harmful to the human body than it is helpful. The medicinal benefits the drug creates are outweighed by the health risks associated with inhaling smoke, making cannabis more comparable to Marinol. Medicinal marijuana and Marinol both have their downfalls, yet both drugs perform the same function and treat the same diseases with similar results.<sup>64</sup>

### III. MEDICAL MARIJUANA LAWS ARE PREEMPTED BY FDA REGULATION OF MARINOL

Preemption refers to circumstances where the laws of a state and the laws of the federal government contradict one another.<sup>65</sup> The preemption doctrine arises out of The United States Constitution, article VI, clause 2, which states that “the Laws of the United States . . . shall be the supreme Law of the Land . . . any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.”<sup>66</sup>

There are two types of preemption: express and implied preemption.<sup>67</sup> Express preemption occurs when a federal statute explicitly states that it is to control a certain field of law over any state law.<sup>68</sup> Implied preemption can occur 1) when an inference can be made as to Congress’ intent to control that field of law, or 2) when state and federal law conflict with one another such that a person could not possibly comply with both laws at the same time.<sup>69</sup>

In preemption cases, courts begin by assuming that Congress did not intend to supersede the states’ police powers unless doing so was Congress’ clear intent, especially when the law applies in a “field traditionally occupied by the States.”<sup>70</sup> Therefore, when the law can reasonably be read in more than one way, the courts generally accept

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<sup>64</sup> Haney, *supra* note 55.

<sup>65</sup> See, e.g., *Altria Grp., Inc. v. Good*, 555 U.S. 70, 76 (2008) (holding that the Maine Unfair Trade Practices Act was not preempted expressly or implicitly).

<sup>66</sup> U.S. CONST. art. VI, cl. 2.

<sup>67</sup> *Altria*, 555 U.S. at 76-77.

<sup>68</sup> *Id.*

<sup>69</sup> *Id.*

<sup>70</sup> *Id.* at 77.

the interpretation that “disfavors preemption.”<sup>71</sup> Since states have traditionally governed in the field of safety and welfare of its citizens, and there is no express language in the federal laws that demonstrate Congress’ intent to control all drug sales, it is unlikely that express preemption would apply to state laws that legalize medical marijuana.<sup>72</sup>

Nevertheless, in the medicinal marijuana context, there appears to be a noticeable conflict between state and federal law such that implied preemption may render the state laws unenforceable.<sup>73</sup> Marijuana is classified as a Schedule I narcotic under federal law, making the drug illegal to possess, use, or distribute for any reason whatsoever.<sup>74</sup> Conversely, the drug Marinol is classified as a Schedule III narcotic, making it available for medicinal purposes.<sup>75</sup> However, the United States Code classifies marijuana as a Schedule I narcotic, which prohibits all uses, including medicinal.<sup>76</sup> Therefore, the state laws that allow marijuana for medicinal use directly conflict with the United States Code. Although states have traditionally occupied the field of health and safety, Congress has been involved in drug regulation for well over a century.<sup>77</sup> This history establishes Congress’ intent to control this field and rebuts the presumption that Congress did not intend to supersede state powers.<sup>78</sup>

A recent Supreme Court case that resulted in a federal law preempting a state law was *U.S. v. Arizona*.<sup>79</sup> In that case, Arizona

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<sup>71</sup> *Id.*

<sup>72</sup> See Todd Garvey, *Medical Marijuana: The Supremacy Clause, Federalism, and the Interplay Between State and Federal Laws* 7-14, CONG. RESEARCH SERV., R42398 (2012); *Martinez-Hernandez v. Butterball, LLC*, 578 F.Supp.2d 816, 818-819 (E.D.N.C. 2008).

<sup>73</sup> See *id.* at 14.

<sup>74</sup> 21 U.S.C.A. § 841 (West 2006); 21 U.S.C.A. § 812 (West 2006).

<sup>75</sup> *Schedules of Controlled Substances*, *supra* note 3.

<sup>76</sup> Compare, e.g., 21 U.S.C.A. § 812 (West 2012), with Cal. Health & Safety § 11362.5 (West 2003)(allowing use of marijuana for medical purposes); see also *Altria*, 555 U.S. at 77 (performing both the implied and express preemption analysis).

<sup>77</sup> *Butterball*, 578 F. Supp. 2d at 818-819.

<sup>78</sup> *Wyeth v. Levine*, 555 U.S. 555, 566 (2009); *Vitaoe v. Mylan Pharm., Inc.*, 696 F. Supp. 2d 599, 612 (N.D. Va. 2010).

<sup>79</sup> *U.S. v. Arizona*, 132 S. Ct. 2492 (2012).

had enacted a strict immigration law in order to address issues with the increase in illegal aliens residing within the state.<sup>80</sup> The new law imposed misdemeanor culpability upon aliens that failed to comply with federal registration requirements or sought work without authorization. Additionally, it allowed police officers to arrest persons for these offenses if they had probable cause. These arrests could result in deportation.<sup>81</sup> Further, the law required officers to check every detainee's immigration status upon arrest.<sup>82</sup> The federal government has traditionally exercised broad and unilateral power over the field of immigration law and alien status, and this power results directly from the Constitution.<sup>83</sup> The Supreme Court found that Congress left no room for the states to govern in the field of immigration law because of the government's strict control. The Supreme Court struck down the argument that Arizona's laws were valid because they sought to achieve the same objective as the federal government's regulations.<sup>84</sup>

Similar to the *Arizona* case, state laws legalizing medical marijuana use are preempted through the federal government's regulation of drugs, but specifically of Marinol. The federal government has classified Marinol as a Schedule III narcotic, making it available to patients for medical use upon prescription.<sup>85</sup> The FDA is an agency of the U.S. Department of Health and Human Services, a department of the executive branch of the federal government, similar to the Department of Homeland Security that regulated immigration law and played an important role in *U.S. v. Arizona*.<sup>86</sup> The FDA regulates and controls the sale of controlled substances in interstate commerce in the United States, including Marinol and

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<sup>80</sup> *Id.* at 2497.

<sup>81</sup> *Id.* at 2494.

<sup>82</sup> *Id.*

<sup>83</sup> *Id.* at 2498.

<sup>84</sup> *Id.* at 2501-03.

<sup>85</sup> *Schedules of Controlled Substances, supra* note 3.

<sup>86</sup> *FDA Fundamentals, U.S. FOOD AND DRUG ADMIN.*, <http://www.fda.gov/AboutFDA/transparency/Basics/ucm192695.htm>. (last updated May, 6, 2013); *Arizona v. U.S.*, 132 U.S. 2492, 2499 (2012)(discussing preemption and the role of the ICE).

marijuana.<sup>87</sup> Congress has been controlling the sale of Marinol since 1985.<sup>88</sup> Marinol and marijuana serve essentially the same medical purpose.<sup>89</sup> Furthermore, marijuana is classified under the United States Code as a Schedule I narcotic.<sup>90</sup> Therefore, Congress clearly intended to regulate, and has regulated, the sale of marijuana in the United States. Therefore, under the principle of preemption, the laws enacted by the states that legalize the sale of marijuana for medicinal purposes are ineffective.

Alternatively, federal law expresses that, "No person shall introduce or deliver for introduction into interstate commerce any new drug, unless an approval for application filed pursuant to . . . this section is effective with respect to such drug."<sup>91</sup> Through the Food and Drug section of the United States Code, Congress has displayed its full intent to control all drugs sold within interstate commerce.<sup>92</sup> Therefore, so long as the medical marijuana sold in states where it has been legalized is classified as an "interstate" good, then the United States Code preempts the state provisions.

In *Gonzales v. Raich*, the Supreme Court held that the "intrastate" growing or cultivation of medical marijuana was prohibited by federal law under the CSA through Congress' power under the Commerce Clause.<sup>93</sup> The Court extended the Commerce Clause to apply to purely intrastate activities that have a substantial effect on interstate commerce.<sup>94</sup> Also, the Court deemed the cultivation of medical marijuana as having a substantial impact on interstate commerce because the drug was being created for home use, which

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<sup>87</sup> See *Legislation*, U.S. FOOD AND DRUG ADMIN., <http://www.fda.gov/RegulatoryInformation/Legislation/default.htm> (last updated July 9, 2012).

<sup>88</sup> Akhavan, *supra* note 45.

<sup>89</sup> Haney, *supra* note 55, at 552.

<sup>90</sup> 21 U.S.C. § 812(c) (2012).

<sup>91</sup> 21 U.S.C. § 355(a) (2012).

<sup>92</sup> *Wyeth v. Levine*, 555 U.S. 555, 566 (2009); *Vitaoe v. Mylan Pharm., Inc.*, 696 F. Supp. 2d 599, 612 (N.D. W. Va. 2010).

<sup>93</sup> *Gonzales v. Raich*, 545 U.S. 1 (2005); EDDY, *supra* note 24, at 16-17. Homegrown medical marijuana was at issue in *Raich*, and not medical marijuana sold at dispensaries.

<sup>94</sup> EDDY, *supra* note 24, at 16.

would substantially affect interstate commerce when assessed in the aggregate.<sup>95</sup> Therefore, the Court determined that Congress, via the Commerce Clause, could regulate home cultivation of medical marijuana, but the Court failed to issue a ruling regarding whether federal law preempted California's state law legalizing medical marijuana.<sup>96</sup>

By applying the same reasoning the Court utilized in *Raich*, all medicinal marijuana being sold within states that have legalized the drug are considered an interstate good. The intrastate medicinal marijuana that was cultivated in *Raich* was still governed by the CSA through Congress' Commerce Clause power because if everyone were to grow his or her own marijuana, the interstate market would be heavily impacted.<sup>97</sup> Similarly, the medicinal marijuana being sold in certain states is drastically impacting the interstate market in much the same way as the homegrown marijuana because only a minority of states have enacted laws to legalize the narcotic.<sup>98</sup> Medicinal marijuana being sold in states where it has been legalized undoubtedly affects the interstate market for medicinal marijuana, an illegal market, as seen by simple economics.

Economically, when a state legalizes the use of medicinal marijuana, the demand for it increases. The increased demand stems from the fact that more people are now willing to purchase something that was once illegal as a result of the decreased chance of risking negative legal consequences. When demand for a product increases, the price of that product subsequently increases.<sup>99</sup>

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<sup>95</sup> See *Gonzales*, 545 U.S. at 17-19. The basic principle of this reasoning by the Court is that it looks to a single person's actions and asks what the effect would be if everyone were to perform those same actions. In other words, if every medical marijuana user were to grow his or her own crop, the interstate market for medicinal marijuana would be significantly impacted. The Court found that this provided Congress with the ability to apply the Controlled Substances Act to intrastate medical marijuana despite the fact that this was an illegal market outside of California.

<sup>96</sup> Stephen Gardbaum, *Congress's Power to Preempt the States*, 33 PEPP. L. REV. 39, 42 (2006).

<sup>97</sup> *Gonzales*, 545 U.S. at 17-19.

<sup>98</sup> State Medical Marijuana Laws, NATIONAL CONFERENCE OF STATE LEGISLATURES, [www.ncsl.org/issues-research/health/state-medical-marijuana-laws.aspx](http://www.ncsl.org/issues-research/health/state-medical-marijuana-laws.aspx) (last updated Sept. 2013).

<sup>99</sup> MICHAEL R. BAYE, *Managerial Economics and Business Strategy* 37-38 (7th ed. 2010).

Therefore, the increased demand caused by a state legalizing medical marijuana will significantly impact the entire interstate market of that commodity. Thus, intrastate medicinal marijuana sales at dispensaries affect interstate commerce such that those sales are governed by Chapter 9 of Title 21 of the United States Code, the Federal Food, Drug, and Cosmetic Act, and thereby preempt any state laws that legalize cannabis for medical purposes.<sup>100</sup>

Marinol and marijuana are significantly similar such that Congress' control over the sale and distribution of Marinol signifies its intent to control the sale of marijuana. Marinol is a synthetically produced medication that requires significant amounts of time and funds during production to mimic the effects of marijuana through a single pill, whereas marijuana is a naturally grown plant that is highly inexpensive when compared to the manufacture of Marinol.<sup>101</sup> Therefore, supporters of medicinal marijuana argue that the plant form is sufficiently distinct from Marinol in such a way that no preemption can exist from Congress's regulation of the sale of the legalized pill form of the medication.<sup>102</sup>

However, the anti-preemption argument does not take into account the studies performed comparing the effects of marijuana to those of Marinol. Despite the fact that the two substances arise from completely different origins (one is man-made, while the other is naturally occurring), the two drugs perform comparable functions such as increased food intake.<sup>103</sup> Therefore, marijuana and Marinol may not be the exact same substance with the exact same components, but they both are used for the same primary medicinal purposes of increasing the appetite of AIDS and anorexia patients and alleviating the nausea of cancer patients enduring chemotherapy treatment.<sup>104</sup>

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<sup>100</sup> 21 U.S.C. § 301 (West 2012); *Gonzales*, 545 U.S. at 17-19.

<sup>101</sup> Akhavan, *supra* note 45.

<sup>102</sup> Peter J. Cohen, *Medical Marijuana: The Conflict Between Scientific Evidence and Political Ideology*, UTAH L. REV. 35, 95-96 (2009).

<sup>103</sup> Haney, *supra* note 55 (reporting that Marinol and smoked marijuana were "similarly effective at increasing food intake, with minimal negative drug ratings or decrements in cognitive performance.").

<sup>104</sup> *Id.*



Additionally, the anti-preemption viewpoint tends to ignore the fact that the CSA still prohibits the use of marijuana for any reason whatsoever, including medicinal purposes because the narcotic is classified as a Schedule I drug.<sup>105</sup> Therefore, despite the differences between Marinol and marijuana, federal laws still speak to the issue of the legality and sales of medical marijuana.

#### **IV. PROPOSED REGULATIONS**

In order to solve the growing problem surrounding medical marijuana and the negative policy issues that it has created, Congress could potentially implement one of two possible and relatively simple solutions. First, Congress could utilize its spending power to strongly encourage states that have legalized medical cannabis to revoke such provisions. The second solution still requires that Congress establish its control over medicinal marijuana, but creates a drastically different result: since Congress possesses the power to alter or change the Schedule classification of marijuana, it could establish outright control over the substance by lowering marijuana to a Schedule II drug. The second option would be to make medicinal marijuana legal on a federal level thereby still allowing qualified persons access to the medication, but it would also allow marijuana to be placed within the control of doctors and pharmacists.

##### **A. Congressional Spending Power**

The first proposed action that Congress could take in order to end the preemption debate is an effective option, but would completely eliminate marijuana as a treatment altogether. This comment argues that the state laws legalizing marijuana are preempted by Congress's prior control over drug regulation, and specifically through its regulation of the sale of Marinol, the pill form of THC and the closest legal alternative to smoking the plant form of marijuana. However, no court has gone so far as to make the conclusion that federal law actually preempts state laws legalizing medical marijuana, and thus the state laws remain in effect.

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<sup>105</sup> 21 U.S.C. § 812 (West 2012).

The first proposed action for Congress would be to enact a statute that would encourage the states that have legalized medical marijuana to abandon those laws in order to ensure that consistency will reemerge among the states regarding this controversial topic. In *South Dakota v. Dole*, the Supreme Court dealt with an issue regarding the constitutionality of a statute enacted by Congress that encouraged states to establish the minimum drinking age at 21.<sup>106</sup> Congress effectively set a national drinking age by enacting the provision because it threatened to withhold highway funds from the states if the drinking age were less than 21 years old.<sup>107</sup> The Supreme Court upheld Congress' provision as valid under the United States Constitution because it held that Congress was exercising its spending power expressed in Article I, Section 8, Clause 1 of the Constitution.<sup>108</sup> The Court determined that in order for Congress' statute to be a valid employment of the spending power, the statute must further the general welfare as well as unambiguously allow the states to make their own decisions.<sup>109</sup> In other words, Congress cannot simply withhold necessary funds from states in order to achieve a desired result, effectively giving the states no choice in the matter.

The first proposed action for Congress to take in order to solve the muddled issue of medical marijuana legalization would be to enact a similar statute that would strongly persuade states to adhere to a nationwide ban on medicinal marijuana. In order to reach the desired result, Congress would need to utilize the spending power as it did in *South Dakota v. Dole*. Therefore, Congress would have to identify funds that it provides to the states that are sufficiently important, such that the states that have enacted medical marijuana legalization laws would be strongly encouraged to revoke the legalization provisions if the identified funds were withdrawn. For example, Congress could decrease the amount of Medicaid funds provided to the states by 10% if states continued to uphold legalized

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<sup>106</sup> *South Dakota v. Dole*, 483 U.S. 203, 205 (1987).

<sup>107</sup> *Id.*

<sup>108</sup> *Id.* at 205-06

<sup>109</sup> *Id.* at 206.

medical marijuana laws.<sup>110</sup>

Congress would meet the two requirements laid out in *South Dakota v. Dole* through such a provision. Congress could argue that state laws legalizing marijuana have negative health effects on those that smoke the drug and that eliminating those state laws would benefit the general welfare.<sup>111</sup> Congress could easily conduct studies and present opinions that show how the health risks of medicinal marijuana significantly outweigh the potential medical benefits that it creates. Through these studies, Congress could thereby defeat any argument that medicinal marijuana actually benefits the general welfare of the United States.

Secondly, Congress would have to demonstrate that the states have a legitimate choice in deciding whether to abandon the legalized medical marijuana laws or bear the burden of receiving fewer funds. Congress could prove that the states have autonomy in the matter by presenting evidence that a 10% cut in Medicaid funding is affordable for all states with legalized medical marijuana laws. Congress would need to show that such states could continue to function with the decreased resources.

Congress could successfully utilize its spending power to enact a law that would strongly encourage states that have legalized medical marijuana to abandon those laws. Congress could thereby reestablish uniformity among the states and essentially end the argument over whether states can enact medical marijuana legalization laws.

## **B. Reschedule Marijuana to Schedule II**

The first proposed method for potentially solving the medical marijuana debate does not create optimal results, as the drug would be completely unavailable for all purposes, including the medical uses known to be effective. Therefore, the second proposed action that Congress could take in order to solve the problematic laws of

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<sup>110</sup> The 10% decrease in Medicaid funds was chosen because it is reasonable to assume that it is not significant enough to constitute “coercing” the states, yet it is not so insignificant that states would completely disregard the Congressional act and likely cause them to eliminate the medical marijuana laws.

<sup>111</sup> EDDY, *supra* note 24, at 29.

medicinal marijuana legalization among the states would be to reschedule marijuana as a Schedule II drug. Congress could thereby place regulatory control over the distribution of the drug within its power and in the hands of pharmacists. This proposed action would still allow marijuana to be utilized by those who actually benefit from its medicinal effects, but would create a more uniform and efficient system for regulating distribution.

Currently, medical marijuana is being distributed through dispensaries or through homegrown operations for those who receive a recommendation from a physician.<sup>112</sup> These methods of obtaining marijuana cause numerous problems in terms of regulation. Despite the states' efforts to enact regulations and statutes, marijuana distribution remains difficult to monitor and states cannot ensure whether the drug is ending up in the hands of those persons that actually need it.<sup>113</sup>

As mentioned previously, marijuana is currently codified as a Schedule I narcotic under the federal laws of the United States.<sup>114</sup> The current classification system places substances into five different categories, or "schedules."<sup>115</sup> Congress evaluates three different factors in order to make the classification of a substance: 1) the potential for users of the drug to abuse it; 2) whether the drug has a currently accepted medical use; and 3) the level of physical or psychological dependency caused by abuse of the drug despite being administered under the control of medical professionals.<sup>116</sup> Schedule I drugs are what Congress considers the most dangerous substances, whereas Schedule V drugs pose the smallest threat to the user.<sup>117</sup>

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<sup>112</sup> See Dan Ring, *Backers of Medical Marijuana Protest State Rule to Control Home Growing of Pot*, MASS LIVE (Aug. 1, 2013), [http://www.masslive.com/politics/index.ssf/2013/08/backers\\_of\\_medical\\_marijuana\\_p.html](http://www.masslive.com/politics/index.ssf/2013/08/backers_of_medical_marijuana_p.html).

<sup>113</sup> See Noelle Crombie, *Medical Marijuana: A Few High-Volume Doctors Approve Most Patients*, OREGON LIVE (Dec. 29, 2012), [http://www.oregonlive.com/health/index.ssf/2012/12/medical\\_marijuana\\_a\\_few\\_high-v.html](http://www.oregonlive.com/health/index.ssf/2012/12/medical_marijuana_a_few_high-v.html).

<sup>114</sup> See 21 U.S.C. § 812 (West 2012); 21 U.S.C. § 841 (West 2010).

<sup>115</sup> 21 U.S.C. § 812(a) (West 2012).

<sup>116</sup> See generally 21 U.S.C. § 812 (noting the level of each finding that satisfies a given schedule).

<sup>117</sup> *Id.*

Congress then compiles a list of all drugs under each of the five schedules and updates this list annually.<sup>118</sup> The schedule of marijuana could be changed either administratively by the Department of Health and Human Services, or it could be performed directly through an act of Congress.<sup>119</sup>

Congress should take action and reschedule marijuana to Schedule II, and thus legalize the drug for medical purposes. Schedule II drugs still have a relatively high potential for abuse and the creation of physical and psychological dependencies; however, the drug possesses a currently accepted medical use.<sup>120</sup> Other medications that are currently used for medicinal treatment in the United States and are classified as Schedule II drugs include narcotics such as cocaine and morphine.<sup>121</sup>

However, rescheduling marijuana to a Schedule II drug could create unintended consequences. For example, marijuana is a “crude herbal substance,” which means that a variety of different marijuana plants exist and they do not all contain the exact chemical makeup.<sup>122</sup> Therefore, problems could arise when the government allows marijuana to be dispensed in pharmacies because the “chemistry of the drug must be known and reproducible.”<sup>123</sup> Since the chemistry is not consistent throughout each plant, potential problems could arise for the FDA when attempting to reschedule marijuana to Schedule II.<sup>124</sup> As a result, persons that seek to manufacture medicinal marijuana would have to incorporate the plant into an FDA-approved product.<sup>125</sup>

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<sup>118</sup> *Id.* at § 812(a).

<sup>119</sup> EDDY, *supra* note 24, at 31.

<sup>120</sup> 21 U.S.C. § 812(b)(2) (West 2012).

<sup>121</sup> EDDY, *supra* note 24, at 32.

<sup>122</sup> Andrea G. Barthwell, *Marijuana Dispensaries and the Federal Government: Recommendations to the Obama Administration 2009: Part 1*, J. GLOBAL DRUG POL'Y & PRAC., (2010), <http://ibhinc.org/pdfs/MarijuanaDispensariesRecommendationsBarthwellBarnes2009Part1.pdf>.

<sup>123</sup> *Id.*

<sup>124</sup> *Id.*

<sup>125</sup> Kevin A. Sabet, *Commentary: Clearing The Smoke on Medical Marijuana, Part I, THE PARTNERSHIP AT DRUGFREE.ORG* (February 14, 2012), <http://www.drugfree.org/uncategorized/clearing-the-smoke-on-medical-marijuana-part-i>.

Even upon classifying marijuana as a Schedule II drug, in order to dispense the drug in pharmacies, a manufacturer would first have to incorporate marijuana into a digestible medication and then go through the 12-step approval process regulated by the FDA.<sup>126</sup> Therefore, a significant delay could potentially occur, first in making marijuana a Schedule II drug, and second in allowing patients access to the medication.

Regardless, rescheduling marijuana to a Schedule II substance provides a viable solution because it would legalize marijuana for medicinal purposes at the federal level, which would allow doctors and physicians to prescribe the drug to patients and thereby dispense it through pharmacists.<sup>127</sup>

## V. NEGATIVE POLICY IMPLICATIONS ARISING FROM STATE LEGALIZATION OF MEDICINAL MARIJUANA

There are numerous negative consequences that result from permitting state legalization of medicinal marijuana that could be resolved by either of the proposed actions described above. This comment focuses on two of these issues created by legalized medical marijuana at the state level that affect the entire nation. First, medical marijuana dispensaries create easier access to the drug for recreational users.<sup>128</sup> Second, allowing non-licensed pharmacists to distribute medical marijuana creates the threat that patients will not receive the necessary information regarding the health risks involved with smoking the drug.<sup>129</sup> Examples of information that a pharmacist is generally required to disclose to patients include: drug-to-drug interactions, the possibility of aggravated symptoms of other diseases, and long term health issues that could arise from prolonged

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<sup>126</sup> See *THE FDA'S DRUG REVIEW PROCESS: ENSURING DRUGS ARE SAFE AND EFFECTIVE*, U.S. FOOD AND DRUG ADMIN. <http://www.fda.gov/drugs/resourcesforyou/consumers/ucm143534.htm> (last updated May 1, 2012).

<sup>127</sup> 21 U.S.C. § 829(a) (2009).

<sup>128</sup> See Crombie, *supra* note 113; Onishi, *supra* note 39.

<sup>129</sup> See generally Seamon, *supra* note 41.

use.<sup>130</sup>

### A. Ease of Access to Recreational Users

States that have legalized medical marijuana have regulated dispensaries in order to attempt to control the distribution of marijuana.<sup>131</sup> However, these rules and restrictions have been criticized for being vague and unclear, as well as difficult to enforce, thereby increasing the risk that recreational users will have easier access to the drug.<sup>132</sup>

Dispensaries provide medicinal marijuana to those persons that present a valid authorization from a physician.<sup>133</sup> However, the physicians who recommend marijuana to patients use their own subjective judgment in order to determine whether the patient qualifies for the drug, which can produce highly inconsistent or inaccurate results and allow persons with no ailment access to the medication.<sup>134</sup> A pharmacy requires a valid doctor's prescription, as opposed to a mere recommendation, before it can provide Schedule II drugs to patients.<sup>135</sup> In other words, rescheduling marijuana would make distribution of medicinal marijuana more consistent because pharmacies have procedures in place to ensure that drugs go into the hands of patients that truly need it.<sup>136</sup>

Additionally, the fact that the drug has become legal for medicinal purposes has caused the public to become more willing to accept the drug and perceive it as less dangerous than in the past.<sup>137</sup> It is likely that this shift in views has occurred because there is less risk of legal consequences for possessing and smoking the drug. During the 2012 elections, Colorado and Washington legalized marijuana for

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<sup>130</sup> *Id.* at 1042.

<sup>131</sup> *See, supra* note 38.

<sup>132</sup> *See* Crombie, *supra* note 113; Onishi, *supra* note 39.

<sup>133</sup> Susan Okie, *Medical Marijuana and the Supreme Court*, 353 (7) *NEW ENG. J. MED.* 648, 649 (2005).

<sup>134</sup> *See* Crombie, *supra* note 113.

<sup>135</sup> 21 U.S.C. § 829(a) (2006).

<sup>136</sup> *See id.*

<sup>137</sup> EDDY, *supra* note 24, at 32.

recreational use at the state level.<sup>138</sup> The fact that the citizens of these states voted to legalize the drug for all purposes demonstrates a growing acceptance of marijuana in the United States.<sup>139</sup>

As a result of the validation for marijuana among the citizens in Colorado and Washington, people in other States are willing to seek out the drug regardless of whether they exhibit true symptoms of an illness that the drug treats effectively.<sup>140</sup> In other words, the increase in public acceptance of marijuana, coupled with the fact that people understand the relative ease associated with obtaining a recommendation from a physician for marijuana, could potentially cause an increase in the amount of recreational marijuana smokers in all states where medical marijuana is legal.<sup>141</sup> Therefore, state laws that legalize medical marijuana are actually counterproductive by allowing easier access to the drug to those without medical problems, which essentially forces the benefits of providing treatment to those who need it to be eliminated.

State regulations of dispensaries and the qualifications that a patient must possess in order to purchase the medical marijuana do not sufficiently protect against risk of recreational users gaining access to the narcotic. Businesses have developed that solely provide the service of performing evaluations for medical marijuana, and some only charge customers upon issuance of the recommendation for medical marijuana.<sup>142</sup> Furthermore the physicians "recommending" marijuana to patients are not only relying on the patient's word that he or she is suffering from a qualifying illness, but also only generate profits upon issuing the marijuana card.<sup>143</sup> Therefore, physicians have the incentive to issue recommendations to

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<sup>138</sup> See COLO. CONST. art. XVIII, § 16 (West, Westlaw through Dec. 2012 amendments); I.M. 502, 63d Leg., Reg. Sess. (Wash. 2012).

<sup>139</sup> David Knowles, *On 4/20 Day, Marijuana Activists Cite Growing Acceptance of the Drug and Set Sights on Legalization in More States*, N.Y. DAILY NEWS (April 19, 2013), available at <http://www.nydailynews.com/news/national/activists-tout-marijuana-acceptance-4-20-day-article-1.1322515>.

<sup>140</sup> Crombie, *supra* note 113.

<sup>141</sup> EDDY, *supra* note 24, at 32-33.

<sup>142</sup> BEST PRICE EVALUATIONS (2012), <http://www.bestpriceevaluations.com> (Evaluation is free if you are not approved).

<sup>143</sup> Crombie, *supra* note 113.



almost anyone that comes in and requests their services.<sup>144</sup> More recreational users are likely obtaining authorization to access medicinal marijuana, and the state legalization laws are essentially facilitating an illegal activity. Thus, medicinal marijuana needs to be where it can be controlled with certainty and consistency, a pharmacy.

## **B. Risks of Non-Licensed Pharmacists Dispensing Medical Marijuana**

The second major policy implication of allowing states to enact medical marijuana legalization laws is that the distributors of the drug are not licensed pharmacists, and therefore cannot provide the drug's end user with appropriate information pertaining to drug interactions.<sup>145</sup> The fact that patients are not being properly informed of potential drug interactions can create substantial health risks because the patient is unaware of the hazards involved with smoking marijuana while ingesting other medications.

Since medical marijuana dispensary workers generally are not licensed pharmacists, they are unlikely to be aware of the different potential risks involved with smoking marijuana while also utilizing one of the medications capable of negatively interacting with marijuana.<sup>146</sup> Additionally, dispensary workers are unlikely to inquire as to the other medications a patient is currently taking because of their inadequate understanding of the risk of potential harmful interactions due to their lack of medical training.<sup>147</sup>

Marijuana's drug interactions have been determined through extrapolation of cannabinoids, and it can potentially react with "[O]pioids, barbiturates, CNS depressants, protease inhibitors, selective serotonin-reuptake inhibitors, sildenafil, theophylline, tricyclic antidepressants, anticholinergics, sympathomimetics,  $\alpha$ -agonists, naltrexone, disulfiram, lithium, neuroleptic antipsychotics,

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<sup>144</sup> *Id.*

<sup>145</sup> See generally Matthew J. Seamon et al., *Medical Marijuana and the Developing Role of the Pharmacist*, 64 AM. J. HEALTH-SYST. PHARM. 1037 (2007).

<sup>146</sup> See *id.* at 1037.

<sup>147</sup> See *id.* at 1042.

and anesthetic agents.”<sup>148</sup> Marijuana has the potential to interact negatively with a significant amount of substances that could cause numerous harmful side effects to the end user.

In addition to there being other medications that negatively interact with marijuana, there are also several diseases and conditions that marijuana usage could potentially adversely affect.<sup>149</sup> Those conditions include: immunosuppression, psychiatric disturbances, cardiac disease, respiratory disease, vertigo, cancer, pregnancy, and obesity.<sup>150</sup> Patients who suffer from any of these illnesses or conditions may experience additional difficulties or aggravated side effects through the use of marijuana.<sup>151</sup>

Finally, although an overdose of marijuana resulting in death is nearly impossible, heavy use of the drug can cause significant health issues.<sup>152</sup> Prolonged use of medical marijuana can lead to lung cancer, as marijuana smoke contains approximately 50-70% more carcinogens than cigarette smoke.<sup>153</sup> Additionally, psychological disorders can result that affect the user's memory and ability to focus.<sup>154</sup>

Smoking marijuana poses the same risks as ingesting other forms of medication as the potential for drug-to-drug interactions and harmful side effects on the body do exist.<sup>155</sup> It is imperative that patients that choose to smoke marijuana for medicinal reasons be properly informed about the potential side effects that can result from other medications that are being taken, other illnesses that may react poorly to the drug's effects, or prolonged exposure to the inhalation of the smoke. The persons distributing marijuana in

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<sup>148</sup> *Id.* at 1041 (footnotes omitted).

<sup>149</sup> *Id.*

<sup>150</sup> *Id.*

<sup>151</sup> See Matthew J. Seamon et al., *Medical Marijuana and the Developing Role of the Pharmacist*, 64 AM. J. HEALTH-SYST. PHARM. 1037, 1042 (2007).

<sup>152</sup> MITCH EARLEYWINE, UNDERSTANDING MARIJUANA: A NEW LOOK AT THE SCIENTIFIC EVIDENCE 4 (2002) (noting that no one has died of a marijuana overdose); see Seamon, *supra* note 41, at 1041.

<sup>153</sup> Seamon, *supra* note 41, at 1040.

<sup>154</sup> Seamon, *supra* note 41, at 1041.

<sup>155</sup> See Seamon, *supra* note 41, at 1041.

dispensaries lack the formal education and training of a licensed pharmacist that would allow them to inform patients about the precautions that must be taken when administering the drug.<sup>156</sup>

Supporters of medicinal marijuana argue that the health risks of smoking marijuana are relatively low.<sup>157</sup> However, studies indicate that smoking marijuana can cause negative health risks.<sup>158</sup>

It is unlikely that dispensary workers could obtain the knowledge needed to inform patients of potential harmful side effects through experience, as pharmacists must undergo years of training in order to receive a license to dispense drugs.<sup>159</sup> The pharmaceutical industry is advancing at a rapid pace in today's society.<sup>160</sup> New drugs are constantly being developed and introduced into the market, especially those attempting to treat the illnesses that marijuana targets, such as AIDS and cancer, which have no cure.<sup>161</sup> Dispensary workers need to be consistently undergoing research in the field as well as acquiring knowledge of relatively complex chemistry in order to understand all of the risks involved with drug-to-drug interactions. Thus, marijuana poses significant risks to

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<sup>156</sup> See generally Seamon, *supra* note 41.

<sup>157</sup> Paul Armentano, *JAMA: Long-Term Exposure to Cannabis Smoke is Not Associated with Adverse Effects on Pulmonary Function*, NORML (Jan. 10, 2012), <http://blog.norml.org/2012/01/10/jama-long-term-exposure-to-cannabis-smoke-is-not-associated-with-adverse-effects-on-pulmonary-function/>.

<sup>158</sup> See Zuo-Feng Zhang et al., *Marijuana Use and Increased Risk of Squamous Cell Carcinoma of the Head and Neck*, 8 *CANCER EPIDEMIOLOGY, BIOMARKERS & PREVENTION* 1071, 1071 (1999) (concluding that smoking marijuana can increase the risk of head and neck cancer); see also Donald P. Tashkin, MD, *Is Frequent Marijuana Smoking Harmful to Health*, 158(6) *THE WESTERN J MED.* 635, 635 (1993) (documenting the negative effects on the lungs that smoking marijuana creates).

<sup>159</sup> See *State CE Requirements for Pharmacists*, MEDSCAPE EDUCATION (May 31, 2011), <http://www.medscape.org/public/pharmcestaterequirements>.

<sup>160</sup> See *US Pharmaceutical Market to Grow at a 3.5% CAGR Says New Market Research Report at ReportsnReports.com*, PRWEB (May 28, 2013), <http://www.prweb.com/releases/us-pharmaceutical/medical-devices-market/prweb10773806.htm> (predicting the United State's pharmaceutical market value will climb from \$359 billion in 2012 to \$476 billion in 2020).

<sup>161</sup> See Tara Parker-Pope, *Cancer Funding: Does It Add Up?*, *NEW YORK TIMES* (March 6, 2008), <http://well.blogs.nytimes.com/2008/03/06/cancer-funding-does-it-add-up/> (noting that the National Cancer Institute's proposed budget for cancer research in 2008 was \$6 billion); see also *Funding for HIV and AIDS*, AVERT, <http://www.avert.org/aids-funding.htm> (last visited Sep. 6, 2013) (noting that total funding for HIV and AIDS was \$6.9 billion).

patients that utilize it, and in order to provide the proper information to patients that would sufficiently protect them, pharmacists must be the ones to disperse the medication.

Making marijuana a Schedule II drug, and thereby allowing pharmacists to distribute the substance via prescriptions from doctors, would eliminate these problems. This is the preferred solution of the two proposed actions described above. First, patients that obtain medical marijuana do not receive actual prescriptions from a doctor, but rather only a medical opinion or recommendation in order to get around the federal laws prohibiting physician prescriptions of the drug.<sup>162</sup> By allowing physicians to merely "recommend" marijuana to certain patients, the states have provided little incentive for doctors and physicians to provide a thorough and correct analysis because they will not be held accountable if the patient does not actually demonstrate the medical issues that he or she claims. In other words, in the states where marijuana has been legalized, the State Boards of Medicine do not have strict provisions that hold doctors accountable for misdiagnosing a patient upon recommendation for marijuana.<sup>163</sup>

Therefore, by rescheduling marijuana to Schedule II, patients will be required to obtain marijuana through prescription, and the physicians that provide the authorization will be scrutinized and held accountable for malpractice upon negligently prescribing the medication.<sup>164</sup> As a result, doctors and physicians will be less likely to liberally authorize a patient for medical marijuana use due to the potential for negative consequences to his or her career.

Additionally, rescheduling marijuana to a Schedule II drug will allow pharmacists, not dispensary workers, to distribute the drug through valid prescriptions. Pharmacists undergo years of schooling that include heavy training in chemistry so that they can understand how various medications work and the potential for chemical

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<sup>162</sup> *Dominica Minore Bassett, Medical Use and Prescription of Schedule I Drugs in Arizona: Is the Battle Moot?*, 30 ARIZ. ST. L. J. 441, 452 (1998).

<sup>163</sup> *See CAL. MED. ASS'N, PHYSICIAN RECOMMENDATION OF MEDICAL CANNABIS: GUIDELINES OF THE COUNCIL ON SCIENTIFIC AFFAIRS SUBCOMMITTEE ON MEDICAL MARIJUANA PRACTICE ADVISORY*, 5 (2011).

<sup>164</sup> *See Joseph H. King, Jr., Causation, Valuation, and Chance in Personal Injury Torts Involving Preexisting Conditions and Future Consequences*, 90 YALE L. J. 1353, 1357 (1981).

interactions between drugs taken simultaneously.<sup>165</sup> They are also required to complete yearly continuing education to ensure they are up to date on new medications.<sup>166</sup> These persons are qualified to distribute controlled substances because they are able to provide accurate information to the patients regarding any risks involved with taking the drug.

Rescheduling marijuana will undoubtedly put uniform laws in place among the states by allowing the federal government to regulate the sale of medical marijuana through pharmacies. This potential act would solve some of the main negative consequences of state legalized medical marijuana laws, while still allowing those persons who need the drug to obtain access to it.

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<sup>165</sup> *The Pharmacy Profession*, AMERICAN PHARMACISTS ASSOCIATION (2013), <http://www.pharmacist.com/pharmacy-profession>.

<sup>166</sup> See *State CE Requirements for Pharmacists*, MEDSCAPE EDUCATION (May 31, 2011), <http://www.medscape.org/public/pharmcestaterequirements>.