Legal case of medicinal cannabis

The political and social views in the U. S. regarding medicinal cannabis have transmuted over the years and have created an execution dilemma for the healthcare executive. We must review the historical framework to fully understand the current legal context as they are intricately woven together. The medical uses of the cannabis sativa plant were listed in the 1851 U. S. Pharmacopeia (Rubens, 2014). The perception of the application and effectiveness of marijuana changed in part to economics, racism, xenophobia, and the conflation of three different plants into a single plant resulting in the Marihuana Tax Act of 1937 (Thompson, 2013). However, the American Medical Association (AMA) disagreed with medicinal cannabis being included in the Marihuana Tax Act of 1937 and noted there were no cases of addition of medicinal cannabis, inclusion in the tax act would deprive the public of the therapeutic benefits and should be professionally regulated like coca leaves and opium under the Harrison Narcotics Act (Woodward, 1937).

The Marihuana Tax Act of 1937 was ultimately overturned in 1968 by the U. S. Supreme Court in Leary v. United States. The reversal did not address the medicinal value of cannabis but rather the violation of the protections against self-incrimination (Harlan II, J. M. & Supreme Court of the United States, 1968). Subsequently, Congress repealed the Marihuana Tax Act of 1937 while concurrently passing the Comprehensive Drug Abuse Prevention and Control Act of 1970, which contained the Controlled Substances Act (CSA) Title II (Revell, 2018). The CSA is essentially the U. S. federal drug policy regarding the manufacture, possession, importation, use, and distribution of certain medications and substances. Further, the medicines

and substances are stratified into five levels based on the potential for abuse, accepted medical applications in the U. S., and the safety and potential for abuse. Currently, cannabis is designated as a schedule I drug, which indicates it has a high potential for abuse, no medically acceptable use in the U. S., and lack of safety in a medically supervised situation (Anderson, 2018).

Despite this long history and fluctuation of acceptance of cannabis as a medicinal therapeutic strategy, as of May 24, 2019, two-thirds of the states within the United States had laws allowing for the use of medicinal marijuana (ProCon. org, 2019). The growing ideological dichotomy between the position of the U. S. federal government and individual states regarding the status of medicinal cannabis is creating several dilemmas. The ideological schism was widened further with the passage of the 1996 California Proposition 215, which not only decriminalized the possession or growing marijuana for medicinal purposes but also protected the primary care provider from state prosecution for recommending medicinal marijuana (Conboy, 2000). In response states beginning to legalize medicinal marijuana, the Department of Justice (DOJ) indicated their policy and position that a clinician “ recommending or prescribing Schedule I controlled substances is not consistent with the public interest.“ Further, the act of endorsing the use of a Schedule I substance would eventually result in the “ revocation of a physician’s Drug Enforcement Administration (DEA) registration to authorize prescriptions” (The Canna Law Group, 2016, para. 2)

Dr. Marcus Conant and a consortium of interested parties including other physicians, patients, and advocacy coalitions sued the federal government related to the DOJ policy which would inhibit physicians from discussing all options available with their patients is essentially violating the physician's First Amendment rights. Further, the plaintiffs claimed the DOJ policy impeded the patient-physician relationship (Conboy, 2000).

The defendants were Barry McCaffrey, Director of the Office of National Drug Control Policy; Donna Shalala, Secretary of Health and Human Services; Thomas Constantine, Administrator, U. S. DEA; and Janet Reno, Attorney General of the United States. The District Court provided a decision in Conant v. McCaffrey, 172 F. R. D. 681 (N. D. Cal. 1997) which carefully threaded the eye of the needle. The court affirmed the DOJ could " only prosecute physicians who recommend marijuana to their patients if the physicians are liable aiding and abetting or conspiracy." Also, the courts advised the government could not seek administrative sanctions against physicians for recommending medicinal marijuana unless there is good faith substantial evidence of aiding and abetting or a conspiracy (U. S. District Court, Northern District of California, 1997, para. 29).

The case was appealed, and the defendants were updated to reflect those currently in office. The defendants were now John P. Walters, Director of the White House Office of National Drug Control Policy; Asa Hutchinson, Administrator, U. S. DEA; John Ashcroft, Attorney General of the United States; and Tommy G. Thompson, Secretary of the Department of Health and Human Services to block enforcement of the DOJ policy (United States Court of Appeals, 2002). In Conant v. Walters, 309 F. 3d 629 (9th Cir 2002) the

court reaffirmed the First Amendment rights of physicians includes discussions and recommendations for medicinal marijuana as well as the sovereignty of states. Circuit Judge Kozinski presented a concurring opinion, which focused on the therapeutic value of the marijuana which had been under review by several agencies including the National Institute of Medicine, Health Canada, and the British government. Further, the Honorable Kozinski noted, " the harm to patients from being denied the right to receive candid medical advice is far greater than the harm to doctors from being unable to deliver such advice." (United States Court of Appeals, 2002, para. 53).

The United States Congress enacted into law the CSA as Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970. The function of the CSA is to provide the foundation for the government's fight against drugs of abuse. The CSA also centralizes several laws, which regulated the manufacture and distribution of certain medications and substances. Another significant purpose of the CSA was U. S. compliance with the requirements of the 1961 Single Convention on Narcotic Drugs and the 1971 Convention on Psychotropic Substances. These treaties instituted a " system for classifying controlled substances in several schedules in accordance with binding scientific and medical findings of a public health authority." In the U. S., the public health authority is the Secretary of Health and Human Services (HHS) (Van Dusen & Spies, 2007, paras. 4–5).

At first blush, Conant v. Walker may not seem directly applicable to the Comprehensive Drug Abuse Prevention and Control Act of 1970 as the CSA does not explicitly preclude physicians from discussing medicinal marijuana

with patients. Instead, it controls the manufacture, possession, importation, use, and distribution of certain medications and substances (Revell, 2018). However, as states have enacted propositions and laws decriminalizing the medicinal use of marijuana, the federal government has reacted with a concerted effort to reiterate their power by proclaiming marijuana should remain a schedule I substance and if a physician discusses or recommends it to patients, the physicians will risk sanctions including the loss of their DEA certifications.

The very act of multiple states enacting laws decriminalization the use of medicinal marijuana calls into question the codified notion of the lack of therapeutic value. Additionally, the attempt to place a gag order on physicians could be construed as an attempt to restrict the free flow of information including examples of medicinal value as determined by the National IOM and Health Canada, which would also strike at the very notion of CSA marijuana classification. Additionally, the healthcare executive must keep abreast of the narrow ridge of compliance the providers as determined by Conant v. Walters, lest the organization face federal scrutiny, fines, and sanctions. Also, the healthcare executive could face criminal charges when trying to comply with the state and federal regulations, loss of facility licensure resulting in the closure of the facility, federal health care dollars, and loss of DEA licenses (Marcoux, Larrat, & Vogenberg, 2013). Thus, the outcome of Conant v. Walker is highly relevant to the CSA, clinicians, and healthcare executives.

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