

***In the Interest of Patient Care:
The Need to Reject Illinois House Bill 30 on the Use of Medical Cannabis***

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Part I. Introduction

On May 5, 2011, the Illinois House of Representatives narrowly rejected a bill known as House Bill 30, which, if passed, would have permitted the doctor-advised medical use of cannabis by patients with select medical conditions.¹ Though the bill failed to garner the necessary votes from members of the House, the measure did gain enough support to be placed on “postponed consideration,” and will likely resurface for vote again in the near future.² Illinois residents will then be left to wonder if House Bill 30 is a rational and effective bill that the Illinois legislature should support.

If approved, House Bill 30 would create the “Compassionate Use of Medical Cannabis Pilot Program Act,” a program designed to allow patients diagnosed with a “debilitating medical condition” (including cancer, glaucoma, AIDS, hepatitis C, Alzheimer-associated agitation, Parkinson’s, multiple sclerosis, and numerous other conditions) to possess a certain quantity of marijuana with a physician’s written permission.³ Under the proposed three-year pilot project, the Illinois Department of Public Health would administer registry identification cards to qualifying patients and their primary care givers.⁴ These cards would allow patients and their caregivers to purchase up to 2.5 ounces of medical marijuana every two weeks at approved “non-profit medical cannabis organizations” (MCO’s).⁵ Notably, the medical use of marijuana includes “paraphernalia” to administer the drug.⁶

¹ Dave McKinney, *Illinois Medical Marijuana Bill Snuffed Out*, THE CHICAGO SUN-TIMES (May 5, 2011, 2:12 PM), <http://www.suntimes.com/5205098-417/illinois-medical-marijuana-bill-snuffed-out.html>.

² *Id.*

³ H.R. 30, 97th Leg., 1st Spec. Sess. (Ill. 2011).

⁴ H.R. 30; Todd Wilson, *Medical Marijuana Could Become Legal in Illinois*, THE CHICAGO TRIBUNE (April 27, 2011), http://articles.chicagotribune.com/2011-04-27/health/ct-met-illinois-medical-marijuana-20110427_1_medical-marijuana-multiple-sclerosis-medical-research.

⁵ Wilson, http://articles.chicagotribune.com/2011-04-27/health/ct-met-illinois-medical-marijuana-20110427_1_medical-marijuana-multiple-sclerosis-medical-research.

⁶ McKinney, *supra* note 1.

There are two main objectives of House Bill 30. The first is that marijuana would be treated similar to other medicines which are subject to regulatory oversight and quality controls.⁷ In this regard, the bill stipulates that the drug is only approved for select conditions, that there is controlled access to the drug (i.e., it can not be cultivated by patients), that there will be regulatory inspections of the MCO's, and, as with currently approved pharmaceuticals, the drug would come with warnings (e.g., prohibition against driving while under the influence of cannabis).⁸ The second principle is that patients and their physicians would be protected from criminal and civil penalties.⁹

Apart from the medical exceptions proposed by House Bill 30, Illinois' penalties for marijuana use would remain as outlined in the Illinois Cannabis Control Act: for example, possession of 10 to 30 grams of cannabis is a Class A misdemeanor (with a possible sentence under state law of up to one year in jail and a fine of \$2,500),¹⁰ while possession of any drug paraphernalia is a criminal offense under the Illinois Drug Paraphernalia Act.¹¹

This article will argue that neither of these objectives is achieved by Illinois House Bill 30, in spite of the obvious care that went into crafting this proposal, and that patients would be far better served by rejecting this bill and repealing similar acts that exist in other states (medical marijuana is currently approved in 15 states and the District of Columbia).¹² Part II examines the widely divergent views about medical marijuana; Part III explores some of the downsides of the current reality; and Part IV presents a solution, which is that proposed or existing state laws

⁷ See H.R. 30, 97th Leg., 1st Spec. Sess. (Ill. 2011).

⁸ H.R. 30.

⁹ H.R. 30.

¹⁰ 720 ILL. COMP. STAT. ANN. § 550/4 (LexisNexis 2011).

¹¹ *Id.*; 720 ILL. COMP. STAT. ANN. 600/3 (LexisNexis 2011).

¹² Mark Eddy, CONG. RESEARCH SERV., RL 33211, Medical Marijuana: Review and Analysis of Federal and State Policies 17 (2010).

which allow the smoking of marijuana for medicinal purposes should be rejected, and that, for the sake of patients in need, marijuana should, indeed, be treated like other medicines.

Part II. Intensely Polarizing Views Regarding Medical Marijuana

A. Views of Medical Marijuana Advocates

Those in favor of state laws which permit the cultivation and smoking of marijuana for medical purposes use a number of arguments. First of all, they believe governmental fears are unsubstantiated. For some of their arguments, they have the support of the prestigious Institute of Medicine (IOM), which was commissioned in 1997 to review the science behind medical marijuana.¹³ IOM's 257-page report refuted claims that marijuana was a "gateway" drug, and did not find evidence that medical marijuana would increase drug use in the general population if it was "regulated like other medications."¹⁴ Concerning the allegation that allowing medical marijuana "sends the wrong message," a *Boston Globe* columnist sarcastically asked, "[w]hat is the infamous signal being sent . . . If you hurry up and get cancer, you, too, can get high?"¹⁵

The most powerful arguments made by advocates have to do with patient care. Smoked marijuana, they argue, has been shown to be effective in patients who can not find adequate relief with traditional medication.¹⁶ Regarding the controversial aspect of smoking, advocates note that "many . . . physicians prefer crude [smoked] marijuana because the dosage and duration of effects are easier to control,"¹⁷ and that synthetic cannabinoids are "poor substitutes" for the

¹³ *Id.* at 10.

¹⁴ Ryan Conboy, *Smoke Screen: America's Drug Policy and Medical Marijuana*, 55 FOOD AND DRUG L.J. 601, 615 n. 128 (2000).

¹⁵ *Id.* at 617.

¹⁶ Mark Eddy, CONG. RESEARCH SERV., RL 33211, *Medical Marijuana: Review and Analysis of Federal and State Policies* 30 (2010).

¹⁷ *Id.* at 613; *See id.* at 613 n. 111.

whole plant.¹⁸ Advocates are also bolstered by numerous public opinion polls indicating “overwhelming support for the medical use of marijuana.”¹⁹ Finally, those in favor, backed by a former editor of the *New England Journal of Medicine*, call for marijuana to be classified as a schedule II narcotic,²⁰ and also call for relief from the “numerous impediments” to marijuana research which currently exist.²¹ One writer emphasizing this final point has charged that the government “has all but shut down marijuana clinical trials for reasons based on politics and ideology rather than science.”²²

B. Views of Medical Marijuana Opponents

The opposing side’s arguments are just as fervently held. Regarding marijuana’s role as a “gateway” drug, opponents of medical marijuana are concerned that permitting its use “affords the drug a legitimacy it does not deserve,”²³ and that making the drug more available will lead to increased use and experimentation with other drugs. They note that marijuana use among adolescents has climbed, accompanied by a softening of youth attitudes about its risks.²⁴ They are also worried that the marijuana of today, “with over 360 chemicals affecting the brain,” is more addictive than decades ago.²⁵

¹⁸ Mark Eddy, CONG. RESEARCH SERV., RL 33211, *Medical Marijuana: Review and Analysis of Federal and State Policies* 28 (2010).

¹⁹ Andrew J. LeVaj, *Urgent Compassion: Medical Marijuana, Prosecutorial Discretion and the Medical Necessity Defense*, 41 B.C. L. Rev. 699, 705 (2000); *See id.* 722 n. 64 (discussing a CNN Interactive Poll from April 1999 in which 96% of respondents supported the use of medical marijuana).

²⁰ Conboy, *supra* note 14, at 610. For further understanding, see Jerome P. Kassirer, *Federal Foolishness and Marijuana*, 336(5) *New Eng. J. Med.*, www.nejm.org/content/1997/0336/0005/0366.asp.

²¹ LeVaj, *supra* note 19, 702; W.T. BEAVER, ET. AL., *Medical Use of Marijuana: Policy, Regulatory and Legal Issues* 13 (Tatiana Shohov, 2003).

²² Mark Eddy, CONG. RESEARCH SERV., RL 33211, *Medical Marijuana: Review and Analysis of Federal and State Policies* 44 (2010).

²³ *Id.* at 35.

²⁴ Conboy, *supra* note 14, at 605; Office of Nat’l Drug Control Policy, Executive Office of the President, *Marijuana Legalization* (Oct. 2010) (alluding to the escalating addiction problem with oxycontin and suggesting that legalization of drugs can be associated with widespread abuse, regardless of the regulatory controls in place).

²⁵ Conboy, *supra* note 14, at 605.

Opponents have a litany of other serious concerns. To them, the legalization of medical marijuana leads to “diversion to the streets and black market trade,”²⁶ and undermines the war on drugs by causing state and local priorities to diverge from federal ones, and making it difficult for police to distinguish legal from illegal users.²⁷ Opponents present images of providers engaged in “nothing more than high-stakes drug dealing, complete with the same high-rolling lifestyles.”²⁸ Overall, opponents view the condoning of medical marijuana as inconsistent with public health and safety.²⁹ They also remain suspicious of the other side’s agenda, viewing the medical marijuana concept as a “Trojan Horse tactic toward the goal of legalization.”³⁰

Opponents also focus on patient care issues. They point to a lack of clinical studies demonstrating that smoked marijuana is more effective than other drugs for any condition,³¹ and highlight its harmful effects, including organ system damage, its carcinogenic potential, and its adverse effects on cognitive ability and memory.³² Unregulated, home-grown, poorly studied medical marijuana is viewed, with perhaps some justification, as “a step backward to the times of potions and herbal remedies.”³³

C. A Debate Going Nowhere

Like with the pundits of left- and right-wing talk shows, the opposing arguments, as outlined above, are frequently shrill and accusatory, flamed by mutual suspicion, with little hope

²⁶ *Id.*

²⁷ Mark Eddy, CONG. RESEARCH SERV., RL 33211, *Medical Marijuana: Review and Analysis of Federal and State Policies* 37 (2010).

²⁸ *Id.* at 13.

²⁹ Office of Nat’l Drug Control Policy, Executive Office of the President, *Marijuana Legalization* (Oct. 2010).

³⁰ Mark Eddy, CONG. RESEARCH SERV., RL 33211, *Medical Marijuana: Review and Analysis of Federal and State Policies* 45 (2010).

³¹ Conboy, *supra* note 14, at 603.

³² *Id.* at 604. *See also* Nat’l Inst. on Drug Abuse, *How Does Marijuana Use Affect Your Brain and Body?*, MARIJUANA ABUSE, <http://www.nida.nih.gov/researchreports/marijuana/marijuana3.html>. (outlining the health effects of marijuana).

³³ Mark Eddy, CONG. RESEARCH SERV., RL 33211, *Medical Marijuana: Review and Analysis of Federal and State Policies* 26 (2010).

of the two sides meeting somewhere in the middle. In the meantime, positions become more intransigent and rational solutions are not pursued or achieved. Part III will look briefly at the current unsatisfactory reality.

Part III. The Current Reality

The stalemate brought about by the deeply polarized views outlined above has significant consequences. The first, and most obvious, is that states and the federal government are currently at odds. State legislators and voters have supported medical marijuana use, while federal agencies have not. For example, Health and Human Services (HHS) concluded that there were “no sound scientific studies supporting the medical use of marijuana,” an entrenched view which ignores the findings of the IOM report.³⁴ Proponents of medical marijuana, on the other hand, have hoped that it might be moved from schedule 1 to schedule 2,³⁵ but there are no signs that it will be rescheduled “any time soon.”³⁶ Two recent bills addressing rescheduling and the use of an affirmative defense in federal court are also unlikely to pass.³⁷ The medical necessity defense, which would also allow a more compassionate approach to patients using medical marijuana, is likewise not currently supported by the Department of Justice (DOJ).³⁸

States with medical marijuana laws and the federal government also work at cross-purposes in how they view the legality of medical marijuana use. An underlying principle of many medical marijuana acts from various U.S. states was to protect patients and physicians from criminal and civil penalties, but that is not what was achieved. Although federal actions

³⁴ *Id.* at 11.

³⁵ Conboy, *supra* note 14, at 610 n. 11 (2000) (discussing the definition of Schedule I, defined as drugs with no therapeutic value which are unsafe and have a high abuse potential).

³⁶ Mark Eddy, CONG. RESEARCH SERV., RL 33211, Medical Marijuana: Review and Analysis of Federal and State Policies 31 (2010).

³⁷ *Id.* at 7.

³⁸ *Id.* at ii; LeVaj, *supra* at 19, at 713 (noting that the DOJ decision is on the basis of marijuana having no legitimate medical use).

against medical marijuana growers have been halted under the Obama administration, the DOJ has recently emphasized that the agency does not feel precluded from investigation or prosecution “even when there is . . . unambiguous compliance with existing state law”³⁹ A recent court case, *Gonzalez v. Raich* (2005), permits the Drug Enforcement Agency (DEA) to continue going after medical marijuana patients and their caregivers.⁴⁰

In California, a recent bill makes possession of up to one ounce of marijuana on par with getting a speeding ticket,⁴¹ further polarizing this issue. In Oregon, meanwhile, recent reactions to the ongoing controversy have been mixed. In 2007, *Arison v. Allen* highlighted that medical marijuana, a drug without the safeguards of traditional pharmaceuticals, can cause motor vehicle crashes by impairing decision-making,⁴² while *Oregon v. Williamson* presented the disturbing picture of a medical marijuana user helping her boyfriend expand his marijuana garden.⁴³ Oregon lawmakers, concerned that too many people were “scamming the law,” have sought to restrict which patients can qualify.⁴⁴ Voters in Oregon have recently rejected a measure to set up state-regulated marijuana dispensaries, suggesting discomfort with expanding the state’s program.⁴⁵ In Michigan, meanwhile, the 2008 Michigan Medical Marijuana Act has created confusion over the circumstances under which patients can be protected from criminal prosecution.⁴⁶ As noted in

³⁹ Memorandum from the David W. Ogden, Deputy Attorney Gen., Office of the Deputy of the Attorney General, to U.S. Attorneys (Oct., 19, 2009) (on file with the U.S. Department of Justice).

⁴⁰ Mark Eddy, CONG. RESEARCH SERV., RL 33211, *Medical Marijuana: Review and Analysis of Federal and State Policies* 11 (2010).

⁴¹ Tove Tupper, *California Police: Marijuana possession bill could create complications for law enforcement* (October 8, 2010), <http://kdrv.com/page/191398>.

⁴² *Arison v. Allen*, 2007 WL 4798438 (Or. Cir.).

⁴³ *State v. Williamson*, 164 P.3d 315, 317-18 (Or. Ct. App. 2007).

⁴⁴ Harry Esteve, *Proposal to Restrict Oregon Medical Marijuana Use Gets Trashed in Hearing*, THE OREGONIAN (March 17, 2011, 6:31 AM), http://www.oregonlive.com/politics/index.ssf/2011/03/proposal_to_restrict_oregon_me.html.

⁴⁵ Mark Eddy, CONG. RESEARCH SERV., RL 33211, *Medical Marijuana: Review and Analysis of Federal and State Policies* 20 (2010).

⁴⁶ *Id.* at 34.

People v. Radden, when terms are used in a law that invite conflicting interpretations, such as “bona-fide patient relationship,” or “debilitating medical condition,” it transforms a law from one that was intended to provide an avenue for improving the health of those afflicted with debilitating medical conditions into one that is open to abuse from those wishing to use marijuana only for recreational purposes.⁴⁷

Court opinions and criminal statutes in Illinois are also polarizing. The Illinois Supreme Court in *People v. McCabe* refused to characterize marijuana as a drug comparable to other “hard drugs” as classified under the Narcotics Act, and suggested instead that the drug should be treated and penalized like legal, controlled substances such as barbiturates and amphetamines.⁴⁸ Other courts in Illinois, however, such as the court in *People v. Kratovil*, have been swayed by the lack of medical research on the palliative effects of marijuana, and have issued rulings against physically ill defendants who used marijuana to lessen intractable pain from debilitating medical conditions such as glaucoma.⁴⁹

This is clearly a controversy going nowhere, with patients unfortunately caught in the middle. There is, however, a way out – which is to return to principles of acceptable medical care, since this is, after all, a medical issue but one that has become hopelessly muddled by being caught in a heated debate about the legalization of illicit drugs.

Part IV. A Solution

The solution is found in one of the objectives underlying Illinois House Bill 30, that marijuana should be treated like other medicines.⁵⁰ Although some of the provisions of Illinois House Bill 30 are more stringent than the medical marijuana laws existing in other states, it still

⁴⁷ *People v. Redden*, 2010 WL 3611716 (Mich. App. Sept., 14, 2010).

⁴⁸ *People v. McCabe*, Ill.2d 338, 275 N.E.2d 407, 408-17 Ill. 1971.

⁴⁹ *People v. Kratovil*, Ill.App.3d 1023, 815 N.E.2d 78, 82-92 Ill.App. 2 Dist., 2004.

⁵⁰ See H.R. 30, 97th Leg., 1st Spec. Sess. (Ill. 2011).

allows patients and their caregivers to administer a drug by smoking via the use of “paraphernalia,” without adequate regulatory oversight or quality control, and as such is not in line with basic tenets of modern U.S. medicine. In this regard, some of the views of opponents of state-sanctioned medical marijuana programs seem correct. They note, for example, the need to have “science prevail over ideology;” that U.S. citizens need to be protected from “snake oils . . . unproven substances, and ineffective treatments;” and that no drug should be exempt.⁵¹ They warn that efforts to gain legal status for medical marijuana through ballot initiatives “seriously threaten the Federal Drug Administration’s (FDA’s) statutorily authorized process of proving medication safety and efficacy,” and that such initiatives create an atmosphere of medicine by “popular vote,” rather than by the rigorous scientific process that pharmaceuticals should undergo.⁵² They also point out the unusual nature of botanical marijuana: an herb with an inadequately described, highly variable chemical composition “that can not substitute for a legitimate pharmaceutical.”⁵³

There are the equally troubling aspects of permitting a poorly controlled, quasi-pharmaceutical agent to be smoked. The IOM notes that smoked marijuana is unlikely to be safe for any chronic medical condition and finds “more promise in synthetic cannabinoid drugs.”⁵⁴ Highly respected national organizations, such as the American Medical Association and the American Cancer Society, do not support the smoking of any drug.⁵⁵ A DEA administrator writes, “Smoked marijuana is a health danger not a cure . . . the FDA has approved no

⁵¹ Conboy, *supra* note 14, at 611.

⁵² Mark Eddy, CONG. RESEARCH SERV., RL 33211, *Medical Marijuana: Review and Analysis of Federal and State Policies* 41-2 (2010).

⁵³ *Id.* at 26.

⁵⁴ *Id.* at 11.

⁵⁵ Conboy, *supra* note 14, at 604.

medications that are smoked,⁵⁶ while an IOM scientist notes simply, “Marijuana’s future medical use does not involve smoking.”⁵⁷ Why then are we permitting patients to be treated outside recognized standards of medical care?

It is striking that the heat of the debate seems so disproportionate to the value of the drug in question. The IOM report notes several facts: most uses of medical marijuana have been poorly studied, the drug’s role is limited to the relief of symptoms, the effect on symptoms is modest, and most of the symptoms are more effectively treated by other agents.⁵⁸ Clearly, there are many extraneous factors influencing this debate, with best medical practice, thus far, taking a back seat.

The solution to all of the above is, indeed, to treat marijuana like other medicines, which means to reject state laws condoning the smoking of botanical marijuana and to begin treating this drug with the rigorous oversight provided for other pharmaceutical agents. Fortunately, the main pharmaceutical agent (and principal psychoactive compound) from the marijuana plant has already gone through the FDA process. Dronabinol, a synthetic form of tetrahydrocannabinol, was approved in 1985 for chemotherapy-associated nausea and vomiting and for AIDS-related wasting, and in 1999 was moved to Schedule 3,⁵⁹ placing it alongside such widely accepted drugs as vicodin and tylenol with codeine. Accepting dronabinol as the true medical marijuana has many advantages: FDA oversight to ensure safety and efficacy, quality control in the production of the drug, use according to approved indications, above-board prescribing by

⁵⁶ Mark Eddy, CONG. RESEARCH SERV., RL 33211, *Medical Marijuana: Review and Analysis of Federal and State Policies* 29 (2010).

⁵⁷ Conboy, *supra* note 14, at 614

⁵⁸ *Id.* at 613; Mark Eddy, CONG. RESEARCH SERV., RL 33211, *Medical Marijuana: Review and Analysis of Federal and State Policies* 27 (2010).

⁵⁹ Mark Eddy, CONG. RESEARCH SERV., RL 33211, *Medical Marijuana: Review and Analysis of Federal and State Policies* 8, 9 (2010). Importantly, HHS has found little evidence that Dronabinol is abused.

physicians, education of patients regarding adverse effects, as well as opening the door to research regarding this agent and related compounds.

Part V. Conclusion

Marijuana should be treated like other medicines and patients and their physicians protected from liability. Those objectives, however, will not be met with the passage of Illinois House Bill 30 or any other state laws legalizing medical marijuana, but by returning this issue to where it belongs – within well-established principles of medical care.

It should be noted, however, that compared with other state laws, House Bill 30 is a relatively enlightened approach. Similar to other state laws, it is well-intentioned, with the goal of helping patients who are suffering from inadequately treated symptoms associated with such debilitating conditions as cancer, neurological disorders, and auto-immune diseases. But, unlike many existing laws, it requires that patients must obtain a recommendation from a physician with whom the patient has a “bona fide physician-patient relationship,” which would help prevent doctors from specializing exclusively in providing recommendations for medical marijuana, as has happened in other states.⁶⁰ In addition, unlike medical marijuana legislation in states such as Oregon, where patients (and their caregivers) are now able to grow up to 24 marijuana plants if approved by a physician,⁶¹ House Bill 30 would not permit patients or caregivers to cultivate marijuana.⁶² Instead, all medical marijuana would be cultivated and purchased at state-regulated MCO’s.

Yet despite these provisions, the bill remains flawed. For instance, some Illinois state representatives have noted that the bill’s allowance of up to 2.5 ounces of cannabis every two

⁶⁰ H.R. 30, 97th Leg., 1st Spec. Sess. (Ill. 2011).

⁶¹ OR. REV. STAT. ANN § 475.302 (WEST 2011); Mark Eddy, Cong. Research Serv., RL 33211 Medical Marijuana: Review and Analysis of Federal and State Policies 20 (2010).

⁶² H.R. 30.

weeks for qualifying patients adds up to about 10 to 13 “joints” per day.⁶³ Allowing this much marijuana to be legally possessed may lead to increased recreational use of the drug. In addition, House Bill 30 suffers from overly broad indications for use; for example, qualifying conditions include severe fibromyalgia and post-concussion syndrome, poorly characterized medical diagnoses where the benefit of marijuana is unproven and with potential for facilitating abuse of the drug.⁶⁴

Most importantly, regardless of what provisions they might contain, state laws allowing the smoking of marijuana are not in accord with acceptable medical practice and do not serve the needs of patients. If we accept that marijuana has safe and effective medical uses, it is imperative that the drug be treated and regulated like every other approved pharmaceutical agent. The solution to this ongoing and contentious debate is to accept that there already is a safe, FDA-approved medical marijuana, dronabinol, which can provide symptom relief for those in need. For the patients’ sake, “it is time for a cease-fire,”⁶⁵ and time to get this issue out of the hands of those concerned about illicit drug use and back in the hands of those focused on safe pharmaceutical and medical practice.

⁶³ McKinney, *supra* note 1.

⁶⁴ H.R. 30.

⁶⁵ Conboy, *supra* note 14, at 617.