Addiction Medicine Perspective on the Medicalization of Marijuana

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Abstract—Many medical, ethical, legal and political issues have been raised by legislation in California removing criminal penalties for the medical use of marijuana. The California Society of Addiction Medicine (CSAM) has taken an addiction medicine perspective on the use of marijuana as medicine in an effort to create a neutral framework for dealing with these issues. As part of this perspective, CSAM has called for marijuana to be rescheduled beneath its current Schedule I status. Guidelines for safely integrating cannabis into accepted medical practices are suggested.

Keywords—addiction medicine, dependence, medical marijuana, psychopharmacology, public policy

On November 5, 1996, California and Arizona voted for initiatives to legalize marijuana for medical purposes. California’s Proposition 215, now installed in the Health and Safety Code as the Compassionate Use Act of 1996, permits individuals to use marijuana if “. . . recommended by a physician who has determined the person’s health would benefit,” or relief from illness would be provided. Statewide, 55% of the voters approved the measure.

Whatever mixture of motives underlay the public’s support for the medicalization of marijuana, substantial medical opinion exists for reconsidering the current Drug Enforcement Agency (DEA) classification of cannabis as a Schedule I drug, defined as having no accepted medical use and a high abuse potential. Jerome Kassirer (1997), editor-in-chief of the New England Journal of Medicine, editorialized: “Thousands of patients with cancer, AIDS, and other diseases report they have obtained striking relief from these devastating symptoms by smoking marijuana.” He believes “. . . that a federal policy that prohibits physicians from alleviating suffering by prescribing marijuana for seriously ill patients is misguided, heavy-handed, and inhumane.” An earlier commentary (Grinspoon & Bakalar 1995) in the Journal of the American Medical Association stated clearly that “It is time for physicians to acknowledge more openly that the present classification (of marijuana) is scientifically, legally, and morally wrong.”

The federal government has not welcomed Proposition 215, nor has it seemed prone to reconsider its position regarding marijuana’s absolute lack of medical utility and high abuse potential. Gen. Barry R. McCaffrey, chief of the White House drug policy office, threatened doctors who prescribe marijuana with loss of their DEA licenses to prescribe Schedule II drugs and possible prosecution. A lawsuit to protect the First Amendment rights of physicians and patients to talk freely and confidentially was brought against McCaffrey and others in the federal government by several California physicians. After unsuccessful efforts to settle the suit, U.S. District Court Judge Fern Smith issued a preliminary injunction on April 30, 1997, prohibiting federal prosecution or withdrawal of DEA licenses of physicians recommending marijuana. Most recently, state and federal prosecution of cannabis distribution centers has begun closing the centers under existing federal drug laws.

It is clear that the passage of Proposition 215 forces society to struggle with many complex, significant and emotional issues, including the age-old tension between state and federal governments. The current situation

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parallels the Whiskey Rebellion of 1794, during which grain farmers in western Pennsylvania considered the federal government’s excise tax as an attack on their freedom and economic well-being. Since the first test of our federal government’s law enforcement power involved a mood altering drug with addictive potential, it is not surprising that similar issues cloud the debate regarding medicalizing marijuana.

Even more germane are issues arising from the War on Drugs waged by the federal government for a variety of largely political reasons. There are abundant indications that the public is ahead of its political leaders in rejecting current punitive practices directed toward drug users. Even those who had previously wished that the “War” would be part of the answer to drug abuse have begun acknowledging that the consequences of imprisoning vast portions of the population are no longer acceptable, and not contributing substantially to diminishing drug use (Baum 1996).

Our country needs a mutually acceptable framework to foster true debate about the potential medical uses of marijuana and the failure of America’s War on Drugs; that framework should be implemented before any federal officials are tarred and feathered out west or the militia is sent out from Washington again. Addiction medicine is in a position to provide such a perspective, as it could be substantially the same as the perspective it currently takes toward opiates, benzodiazepines, and other medically useful drugs with abuse potential. This article outlines how the addiction medicine perspective can serve as a template for a more rational approach to the question of medical use of marijuana.

CSAM MEDICAL MARIJUANA TASK FORCE

The California Society of Addiction Medicine (CSAM) abstained from taking a position on Proposition 215 prior to its passage. Following its passage, however, I was asked to lead a task force in crafting a response to the medicalization of marijuana which the bulk of our membership could support. The task force strove throughout its work to embody CSAM’s central purpose, which is to advance the understanding of addiction medicine. In other words, CSAM strives to assume responsibility for clarifying and promulgating the unique and critically important perspectives which addiction medicine has to offer regarding the medicalization of marijuana in California.

All California physicians are faced with a host of important questions, such as whether marijuana possesses therapeutic efficacy and what rights all physicians have to discuss patient care in confidentiality without intrusions by the federal government. The members of CSAM are no more qualified to answer these questions than most physicians. We chose instead to concentrate primarily on issues directly related to our specific specialty-addiction medicine.

To begin with, CSAM felt a responsibility to assert that the passage of Proposition 215 into law as Section 11362.5 of the California Health and Safety Code does not negate the fact that marijuana is a psychoactive substance with significant potential for physiological and psychological dependence. However, we also felt that the potential for marijuana to be addictive and/or to serve as a gateway substance for more destructive psychoactive substances should not exclude it from medical use. The known hazards of marijuana require that thoughtful safeguards be considered and implemented in order to minimize potential negative effects on individuals for whom medical use is justified, as well as for public health considerations.

CSAM’s Medical Marijuana Task Force then took the responsibility both to document the addictive qualities of cannabis to the rest of California’s physicians and to state and federal officials, and also to help everyone keep the potential for addiction in proper perspective by answering exaggerated claims of harmfulness with the scientific and clinical facts. The task force sensed an opportunity-and challenge-to provide substantive, constructive input first to clarify the physician’s role in implementing California Health and Safety Code 11362.5, and then to interpret its wider implications for our country’s approach to all psychoactive chemicals.

BASIC ASSUMPTIONS

The task force’s deliberations regarding the medical use of marijuana began with three core beliefs
Marijuana is a mood-altering drug capable of producing dependency. This basic assertion, which
begins the American Society of Addiction Medicine’s 1987 Public Policy Statement on Marijuana, was
not altered by passage of the Compassionate Use Act of 1996.

2. “Compassionate Use” of marijuana is accepted by a majority of the voting segment of California’s
population. Physician support for the concept of compassionate use of cannabis and physician opposition
to the unwarranted intrusion of governmental control into the practice of medicine and the doctor-patient
relationship are both strong, as reflected in a quote from the JAMA Commentary published June 21, 1995:
“It is time for physicians to acknowledge more openly that the present (Schedule I) classification (of
marijuana) is scientifically, legally, and morally wrong.”

3. Health and Safety Code 11362.5 is poorly written and unimplementable without further enabling and
clarifying legislation. Implementing legislation and regulatory changes creating appropriate safeguards
(both for physicians and patients) are required on both the state and federal levels.

4. The use of marijuana, as opposed to the therapeutic value of the cannabinoids it contains, is likely
to be a time-limited issue. Two quotes illustrate this prediction:

A. “While there may be some merit in legalization arguments (for medical purposes), the development
of a potent and selective cannabinoid possessing greater efficacy than current drugs (and
disconnecting the medically valuable effects from psychoactive effects) would, of course, end
the ongoing debate.”-Adams, Irma and Martin, Billy, “Cannabis: pharmacology and toxicology in
animals and humans, Addiction (1996) 91(11), 1585-1614.

B. “Because marijuana and delta-9-THC often produce troublesome psychotropic or cardiovascular
side-effects that limit their therapeutic usefulness, particularly in older patients, the greatest
therapeutic potential probably lies in the use of synthetic analogues of marijuana derivatives with
higher ratios of therapeutic to undesirable effects.”-Marijuana and Health, Report of a Study by a
Committee of the Institute of Medicine, National Academy Press, Washington, D.C., 1982.

THE PROCESS OF FORMING POLICY

When the task force opened debate on the following policy positions, a most remarkable event occurred.
The task force members, who were chosen to represent a cross section of the addiction medicine society, found
themselves in virtually unanimous agreement on all the proposed positions-without need of discussion! How was
it that the society had failed to consider taking a position before the Compassionate Use Act was passed when we
had already reached consensus? How had we achieved unanimity so unknowingly?

These questions are chillingly answered by Dan Baum (1996) in Smoke and Mirrors: The War on Drugs and
the Politics of Failure when he wrote the following:

Just Say No finished the . . . job of closing debate. In fact, it reduced the debate to a single word.
Don’t talk about why people use drugs, the slogan said. Don’t ask why Halcion and malt liquor are legal
drugs while marijuana and cocaine are not. Don’t talk about the difference between drug use and drug abuse.
Don’t talk about the tendency of prohibition to promote violence and the use of stronger and more dangerous
drugs. Don’t talk about the lives, taxpayer dollars and civil liberties sacrificed for the Drug War. Don’t talk
about the culture and race wars waged under the Drug War battle flag. Don’t talk about the medical potential
of illegal drugs. Don’t talk at all. Just say no.

The country’s ability to discuss the problems of drug abuse and debate solutions had been
withering for years . . . .

Just Say No, ostensibly aimed at children, finished the debate off. What replaced it was an unquestionable
antidrug orthodoxy that skewed the work of every government agency, elevated drug users to national enemies, and
limited even the language permissible in drug discussions. From Reagan through Clinton, the merest suggestion that
the country pursue any path but total prohibition has been tantamount to forbidden speech.
Along with the country as a whole, CSAM members had been bullied out of free debate and became reluctant to communicate even among themselves. Worse yet, most were unaware of how pervasive the prohibition against free debate had become. At the moment that members of the CSAM Task Force on Medical Marijuana unexpectedly experienced the common ground which existed among them, the truth of Dan Baum’s analysis became evident.

CSAM POLICY POSITIONS

The following policy positions developed by the task force were accepted by the board governing the California Society of Addiction Medicine. Their goal is to provide California physicians who are prescribing or recommending cannabis for medical reasons with appropriate practice guidelines and to identify enabling legislation and regulatory changes required to implement California State Health and Safety Code 11362.5.

1. Standards Of Practice In Prescribing
   CSAM urges the Medical Board of California to take formal action to adopt the position that all physicians who recommend cannabis should be held to the accepted standards of practice for prescribing as they were cited in an article in the January 1997, issue of the California Medical Board’s Action Report: “history and physical examination of the patient; development of a treatment plan with objectives; provision of informed consent, including discussion of side effects; periodic review of the treatment’s efficacy and, of critical importance especially during this period of uncertainty, proper record keeping that supports the decision to recommend the use of marijuana.” (California Medical Board 1997).

2. Diagnosis
   CSAM suggests that the above statement be expanded to include a requirement for notation of a diagnosis, or differential diagnosis, which can be coded according to ICD 10 or DSM-IV, or a notation of the specific symptoms being addressed.

3. Voluntary Compliance
   CSAM urges all California physicians to adhere voluntarily to these standards until such time as the Medical Board takes formal action.

4. Research
   CSAM supports controlled studies of the medical usefulness of marijuana, including all routes of administration, and especially supports studies of the therapeutic effects of the essential ingredients and the congeners of cannabis sativa.

5. Epidemiological Studies, Especially With High Risk Populations
   CSAM urges immediate funding for research directed towards understanding the populations seeking medical use of marijuana at cannabis centers and the impact of marijuana’s medicalization on the general public’s attitudes toward and use of marijuana and other psychoactive drugs, with special emphasis on minors, the mentally ill, the chemically dependent, and women of childbearing age.

6. Rescheduling
   CSAM urges the DEA to remove cannabis from Schedule I and move it to an appropriate schedule, below Schedule I, as determined by what is known about its therapeutic benefit and its potential for abuse in proportion to other drugs of abuse.

7. Distribution
Regarding the way in which marijuana is distributed, the task force expressed concern about the unregulated nature of the practices currently in use (i.e., cannabis “clubs”) and the lack of standardization for such cannabis distribution sites.

BACKGROUND REQUIRED FOR INFORMED CONSENT

There is no drug package insert or DEA study to set the standards for what information must be given to patients in order to assure that they are capable of giving truly informed consent when marijuana is used for medical purposes. The task force had identified the following information as necessary for any physician recommending medical use of marijuana.

Psychopharmacology

Cannabinoids possess psychoactivity by virtue of agonizing endogenous anandamide neurotransmitter systems (Adams & Martin 1996; Rinaldi-Carmona et al. 1994; Matsuda, Bonner & Lolait 1992; Herkenham et al. 1990). The systems of neurons using anandamide have yet to be conceptualized in any unified way. There is still no clear understanding of the normal function of these systems, or excessive or deficient activity within them.

Delineation of the psychological effects of cannabis is complicated by the fact that its impact varies in response to set and setting. Set refers to the subject’s psychological expectations of a drug’s impact and varies widely depending on whether the user is naive or experienced with cannabis, and especially whether the user is an adult, adolescent or child. Setting refers to the total environment in which the drug is taken. Set and setting regarding cannabis have continuously and substantially evolved within American culture over the past century as perceptions of both the drug’s value and dangers changed. It is quite likely that the new set and setting created by society’s recent sanctioning of medicinal use of cannabis, including the fact that patients will be ingesting the drug for the primary purpose of alleviating symptoms of serious physical illness, will significantly impact perceptions of its side effects. The practical consequences of this new set and setting will need to be discovered empirically, since it is impossible to predict human behavior of such complexity.

Psychoactive Effects

Research studies of cannabis have documented three categories of psychoactive effects.

Sensory. Time perception is altered, producing an overestimation of elapsed time (Chiat 1992). Users consistently describe a “heightened sensitivity” to sensory input, leading to greater appreciation of colors, patterns and music, for example.

Cognitive. Early studies established that cannabis does not grossly affect cognitive functions, although suggestions of subtle impairments remain. New technologies studying specific stages of information processing show that heavy frequency of cannabis use prolongs stimulus evaluation time (measured by P300 latency) while long duration use impairs the ability to effectively focus attention and reject irrelevant information (Solowij, Michie & Fox 1995, 1991). It is not known to what extent impaired organization and integration of complex information may recover with prolonged abstinence. Frontal lobe dysfunction may underlie these subtle impairments (Adams & Martin 1990), since cerebral blood flow studies demonstrate the greatest alterations in the frontal lobes, and EEG power is most altered over the frontal lobes in long-term cannabis users.

Motor. Cannabis produces a dose-dependent impairment in tracking, divided attention and vigilance tests (Hall 1996b). However, the extent to which cannabis contributes to traffic accidents is unknown, and driving simulator tests reveal relatively small effects. “Drivers under the influence of marijuana tended to overestimate the level of impairment and compensate by concentrating on driving and/or slowing down. In contrast, drivers under the influence of alcohol tended to underestimate the effects of alcohol and not make allowances for impairment.” (Adams & Martin 1990)
Adverse Psychological Effects

While recreational users seek the psychoactive effects of cannabis, these impacts are more likely to be seen as side effects by people seeking relief from a medical condition (except perhaps for those seeking relief from anxiety or depression). Addiction medicine should (1) educate medical patients regarding cannabis’ potential acute and chronic “side effects,” and (2) develop criteria for determining whether cannabis use is treating anxiety and depression or providing short term palliation (relief without cure) while simultaneously exacerbating the problems in the long run (the hallmark of drug abuse and dependence).

Acute adverse effects include:
- anxiety, dysphoria, panic and paranoia;
- sedation and drowsiness;
- cognitive impairment, especially attention and memory;
- psychomotor impairment;
- exacerbation of preexisting or latent psychiatric symptoms; and
- relapse of chemical dependence.

Chronic adverse effects include:
- cannabis dependence;
- subtle cognitive impairment characteristic of frontal lobe dysfunction;
- impaired educational performance and professional performance; and
- exacerbation of preexisting or latent psychiatric symptoms.

The risk of developing psychiatric problems appears to be very small among the general population of cannabis users (Hall, Solowij & Lemon 1995; Thornicroft 1990). However, there is considerable evidence that preexisting psychiatric conditions, including psychotic episodes in schizophrenics, can be triggered by ingestion of cannabinoids (Negrete 1993). Marijuana also plays a significant role in complicating care for the chronically mentally ill, including their failure to comply with prescribed medication regimens.

Clinical reports of an “amotivational syndrome” among chronic, heavy cannabis users describe a narrowing of interests, apathy, withdrawal, lethargy, and impaired memory, concentration and judgment. All these studies have been uncontrolled, and it is impossible to untangle the effects of chronic cannabis use from those of poverty, low socioeconomic status, and preexisting psychiatric disorders (Hall, Solowij & Lemon 1995; Negrete 1983). The entire phenomenon may be more related to a comorbid (or secondary) depressive syndrome. While there is reasonable evidence that heavy use of cannabis can affect motivation, the existence of an identifiable syndrome outlasting the drug use has not been demonstrated.

Cannabis Abuse and Dependence

The American Society of Addiction Medicine asserts in its Public Policy Statement on Marijuana (adopted by its Board of Directors on April 16, 1997) that “Marijuana is a mood-altering drug capable of producing dependency”-a fact which remains unaltered by California’s Compassionate Use Act of 1996. Put another way, “Pot may be medicine, but getting high every day is still getting high every day.” (Rosin 1997)

While tolerance and withdrawal serve as the grossest markers for physical dependency, neither are obvious features in human use of cannabis. However, animal models have demonstrated tolerance (e.g., analgesia, catalepsy, depression of locomotor activity, hypothermia, hypotension, corticosteroid release, and ataxia) (Adams & Martin 1990). Humans develop tolerance to a variety of cannabinoid effects, including intoxication (Jones, Benowitz & Herning 1976). And several groups have demonstrated cannabinoid receptor down-regulation after tolerance develops (Rodrigues de Fonseca et al. 1994; Oviedo, Glowa & Herkenhan 1993).

Cannabinoids cause the release of dopamine in the nucleus accumbens (Gardner 1991) which is the neurophysiologic benchmark of addictive drugs; and physical withdrawal from cannabinoids does occur. Rats infused with THC exhibit head shakes, facial tremors, tongue rolling, wet-dog shakes, eyelid ptosis, and arched back ten minutes after intraperitoneal injection of an antagonist (Aceto et al. 1995). Withdrawal in humans primarily involves irritability, restlessness, insomnia, anorexia, mild nausea, increased body temperature and hand tremor, which are all alleviated by readministration of THC (Adams & Martin 1990; Jones 1983).
DSM-IV includes cannabis abuse and dependence within substance abuse/dependence disorders; and in 1993, marijuana was the primary drug of abuse in 119,444 treatment center admissions (Constantine 1997). When use becomes compulsive, when the drug user’s behavioral and psychological repertoire is narrowed in order to safeguard cannabis use, and when cannabis use takes on a high enough salience in a person’s life that problems are created in relationships, finances, employment, etc., then it can be said that psychological dependence has developed. Among those seeking primary treatment for cannabis dependence, the major complaints are loss of control over drug use, cognitive and motivational impairments interfering with academic/occupational performance, lowered self-esteem, depression, and partners’ complaints (Roffman et al. 1988).

The effects desired by recreational users include: euphoria; relaxation (which melds into sedation and drowsiness); perceptual alterations and intensification of sensory experience; an altered “state of consciousness” perceived as enabling sociability; greater introspection; creativity; and an enhanced sense of wonder, often in mundane matters. The experience can be integral to an unconventional, alternative lifestyle that is either encompassing or confined to evenings and weekends. As with alcohol, many people ingest cannabis as a reward, solace, or simply an announcement that they are temporarily “off duty.”

It has not been proven that use of cannabis “causes” the use of other drugs (alcohol, opiates, cocaine, speed, LSD), and many proponents of harm reduction argue that the availability of marijuana can decrease the use of more dangerous addictions (Rasmussen & Benson 1994). However, marijuana, alcohol and tobacco are often the first drugs experienced by children and adolescents who do slide into harmful addiction (Ferguson & Horwood 1997; Ferguson, Lynskey & Horwood 1996). and marijuana is often the first drug used in relapses involving more dangerous drugs (Brand 1997).

Informed Consent

CSAM has announced its intention to produce a pamphlet to be used with the general public in obtaining their informed consent. The contents of this pamphlet are likely to contain many of the thoughts outlined in Figure 1.

ADDITION MEDICINE PERSPECTIVE
ON MEDICAL USE OF MARIJUANA

Addiction medicine should strive to document the addictive properties of marijuana while helping the public keep this fact in proper perspective. Abuse potential is no more sufficient rationale for excluding marijuana from medical usage than it is for benzodiazepines, barbiturates, amphetamines, or opiates. The known hazards of marijuana simply require that thoughtful safeguards be created (1) to minimize potential negative effects on individuals for whom medical use is justified and (2) to minimize legitimate public health risks.

The framework established by California’s Proposition 215 permitting physicians to “recommend” medical marijuana use is flawed and should not be accepted by the medical profession. Verbal legerdemain (i.e., substituting “recommend” for “prescribe”) can not absolve physicians of their ethical responsibilities to practice according to established standards. While the voting public has the right to “medicalize” marijuana, it does not have the power to alter the clinical standards of the medical profession, especially as enunciated by the medical board’s Action Report. (California Medical Board 1997).

Patients suffering adverse effects from cannabis will find ethical and legal recourse if their physicians fail to inform them of side effects commonly associated with its use. Specialists in addiction medicine have a role in delineating information necessary for effectively obtaining informed consent, and can communicate this directly to patients considering cannabis use and to other physicians who are recommending it.

While addiction specialists are not in a position to contribute substantially to research on the potential medical uses of cannabis, there are two perspectives on such research which they can contribute. First, we should encourage investigation into all modes of cannabis administration. There are well understood reasons why most users of tobacco prefer smoking, and these reasons may shed useful light on why many cannabis users prefer smoked marijuana to orally ingested Marinol.

Second, addiction medicine can help the public understand how the “medicalization of marijuana”
Patients using cannabis for medical purposes should be informed of the following:

In addition to whatever desired medical benefits you may receive from cannabis, you should be aware that cannabis has several potential side effects, including:

**Psychological Side Effects**

Marijuana can produce alterations in mood, including euphoria and relaxation, but also anxiety, paranoia and panic. Sedation and drowsiness may occur. Perceptual alterations and intensification of sensory experience may lead to distinct alterations in consciousness.

**Warning:** Marijuana is a mood-altering drug capable of producing dependency.

**Interference with Cognitive and Motor Performance**

Marijuana is known to affect judgment, thinking (especially attention and memory) and motor coordination. Patients should be strongly cautioned against operating hazardous machinery, including automobiles, until they are reasonably certain the effects of marijuana have worn off.

**Adverse Medical Consequences**

Respiratory System—Smoking cannabis causes the same lung damage as smoking tobacco, including bronchitis and increased risk of cancer.

Cardiovascular—Cannabis can case rapid heart rate, low blood pressure and changes in electrical conduction through the heart.

Endocrine Systems—Cannabis leads to alterations in many hormone levels and may affect ovulation.

Immune System—Cannabis effects on immunity have been demonstrated, but results have been contradictory and their practical significance is unknown.

Brain—Chronic use of cannabis causes EEG (brain wave) changes.

**Pregnancy**

There is no known safe dose of marijuana during pregnancy. Smoking cannabis causes the same problems as smoking tobacco (prematurity and low birth weight).

**Nigh Risk Populations**

- Children and adolescents are at high risk of delays and disturbances in their psychological development by frequent marijuana use.
- The developing fetus may be affected by low birth weight and shortened gestation.
- People with preexisting chemical dependence, or a family history of chemical dependence, are at greater risk of developing dependency or relapse into use of the other drug(s) of choice (including alcohol and tobacco) with even occasional marijuana use.
- People with preexisting or latent psychiatric illness are at risk of triggering or exacerbating their symptoms with even occasional use of marijuana.

Standards of medical practice in California require that medications, especially those with a potential for abuse or damaging side effects, be prescribed (or recommended) only within a context of the following conditions:

- A good faith history and physical examination are performed.
- A treatment plan with specific diagnosis and objectives is developed.
- Informed consent is received following proper patient education.
- Periodic review of effectiveness of the treatment is assessed.
- Proper records are kept.

We urge you to cooperate with your doctor’s adherence to these important standards.
may be a misleading concept. In the words of Adams and Martin (1990), “While there may be some merit in legalization arguments, the development of a potent and selective cannabinoid possessing greater efficacy than current drugs (and disconnecting the medically valuable effects from psychoactive effects) would, of course, end the ongoing debate.”

Finally, addiction medicine should lead the way in supporting the public health perspective on addiction, exemplified by the Addiction Research Foundation’s statement that “ . . . the use of alcohol, tobacco and other drugs should be seen primarily as a public health issue rather than one dominated by moral or legal principles. The main goal of public policy and practice should be twofold: to reduce harm and cost from drug use, and to minimize the harms and costs of drug policy (and drug treatment).” (Hall 1996a)

From a public health standpoint, social policies are considered part of the context within which psychoactive drugs exist, and bad policy contributes to the harm done by a given drug. California’s marijuana revolt is a wakeup call regarding the aggressive criminalization of cannabis by the federal government. The addictive potential of cannabis simply does not warrant its being a Schedule I drug, whether its eventual place in the medical pharmacopoeia is large or small.

The federal government’s problem with acknowledging that its cannabis policy has been overly restrictive is that it opens the door to a legitimate review of other drug policies. The entire War on Drugs, with its greater emphasis on criminalization and interdiction than on medicalization and treatment, could be open to scrutiny which many practitioners of addiction medicine would welcome.

Also called into question is the entire drug evaluation process involving the complex tapestry of pharmaceutical companies, the Food and Drug Administration, and the Drug Enforcement Agency. This complex has been driven by economic and political forces, in addition to scientific concerns, and the public is beginning to recognize that its interests are not always being adequately served.

Currently the state of California is faced with the people’s mandate “to implement a plan to provide for the safe and affordable distribution of marijuana to all patients in medical need . . . .” Federal laws and policies complicate the situation, and may prevent California’s state government from carrying out its legal responsibilities to the voters. The author’s purpose has been to explicate how the field of addiction medicine has perspectives to contribute to a framework that all sides can accept.

Ultimately, if marijuana is to be medicalized, it will have to fit into accepted guidelines governing the practice of medicine, and the distribution system held to the same standards as professional pharmacies. Any lower standards would put portions of the public at higher risk than necessary.

REFERENCES


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