

REPORT 1 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-09)
Health Care Disparities in Same-Sex Households
(Reference Committee K)

EXECUTIVE SUMMARY

Objective. This report: (1) reviews the legal definitions relevant to same-sex unions in the United States; (2) examines health care disparities affecting same-sex households; and (3) evaluates the effect that exclusion from civil marriage to a same-sex partner may have on these dynamics.

Data Sources. English-language reports on studies using human subjects were selected from a PubMed search of the literature from 1990 to August 2009 using the MeSH terms “homosexuality” “(male or female),” “marriage/*legislation & jurisprudence,” *family characteristics,” “parent-child relations,” “healthcare disparities,” and “health policy.” Additional articles were identified by manual review of the references cited in these publications. Web sites of the Human Rights Campaign, the Gay and Lesbian Medical Association, the Institute for Gay and Lesbian Strategic Studies, Lambda Legal, National Center for Lesbian Rights, Williams Institute, National Conference on State Legislatures, Kaiser Family Foundation, and the Employee Benefit Research Institute also were searched for relevant resources. Members of the AMA Advisory Committee on Gay, Lesbian, Bisexual, and Transgender Issues also were consulted for relevant background information.

Results. The federal government defines marriage as “a legal union between one man and one woman as husband and wife” and spouse as “only...a person of the opposite sex who is a husband or a wife.” At least 1138 statutory provisions confer rights to spouses and dependent children based on federal recognition of civil marriage. Forty-one states have statutes defining marriage as between one man and one woman, and thirty have constitutional language defining marriage; six states currently recognize, or will soon recognize same-sex marriages. Based on census and survey data, approximately 1% of the households in the U.S. are same-sex households.

Marriage is a strong predictor of health insurance in the U.S. Women, in particular, in same-sex households are significantly less likely than women in opposite sex relationships to have health insurance coverage. Same-sex households also do not experience the tax benefits for health insurance premiums, and lack the protection afforded married couples under COBRA and FMLA. Several other federal benefits that affect the socioeconomic status of the household are not available to same-sex households including parenting-related federal income tax breaks, spousal benefits under retirement plans, social security survivor benefits, and long term care. Children in same-sex households may be disadvantaged because of barriers to coparent or second parent adoption.

Conclusions. Many of the statutory advantages enjoyed by married partners, including those derived from tax laws, employee benefits, inheritance, rights, and entitlement programs. Some benefits, such as access to employer-provided health insurance and the authority to make medical decisions on behalf of a spouse, have significant implications for health care access and delivery of care. Survey data on same-sex households have less access to health insurance. If they have health insurance, they are less likely than married heterosexual workers, and also lack other financial protections. Cultural, provider and patient-based barriers to health care access and culturally competent care for lesbian individuals continue to exist, and children in same-sex households are less likely to receive the protections afforded children in heterosexual households.

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF
CALIFORNIA

Case number: 3:09-cv-02292-VRW

PLTF EXHIBIT NO. PX0188

Date admitted: _____

By: _____

CCSF 003324

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Conclusions. Many of the statutory advantages enjoyed by married partners are financial, including those derived from tax laws, employee benefits, inheritance, insurance and survivorship rights, and entitlement programs. Some benefits, such as access to employer-based health insurance and the authority to make medical decisions on behalf of a spouse, have more direct implications for health care access and delivery of care. Survey data confirm that same-sex households have less access to health insurance. If they have health insurance, they pay more than married heterosexual workers, and also lack other financial protections. Additionally, both provider and patient-based barriers to health care access and culturally competent care for gay and lesbian individuals continue to exist, and children in same-sex households lack the same protections afforded children in heterosexual households.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-I-09

Subject: Health Care Disparities in Same-Sex Partner Households

Presented by: C. Alvin Head, MD, Chair

Referred to: Reference Committee K
(Peter C. Amadio, MD, Chair)

1 INTRODUCTION

2
3 Resolution 522 (A-08), introduced by the Wisconsin Delegation and the American Academy of
4 Pediatrics and adopted (with a title change) at the 2008 Annual Meeting, asked that our American
5 Medical Association (AMA) evaluate existing data concerning same-sex couples and their
6 dependent children and determine whether health care disparities exist for these couples and
7 children because of their exclusion from civil marriage.

8
9 The pursuit of legally-recognized marriage for same-sex couples is a relatively recent phenomenon
10 and remains a divisive topic. Same-sex marriage has been principally framed by advocates as a
11 human rights issue, and also supported on the belief that marriage promotes physical well-being
12 and mental health.¹⁻³ This report: (1) reviews the legal definitions relevant to same-sex unions in
13 the United States; (2) examines health care disparities affecting same-sex households; and (3)
14 evaluates the effect that exclusion from civil marriage to a same-sex partner may have on these
15 dynamics. Related policy statements of Federation members also are summarized.

16
17 Although germane to the overall topic of same-sex marriage, this report does not review the
18 psychosocial qualities of same-sex relationships and the context they provide for rearing healthy
19 and well-adjusted children. Gay and lesbian couples in the United States function in an often
20 hostile social environment that lacks a normative and legal template for establishing their status,
21 and they often experience less support from family members and community institutions than their
22 married heterosexual counterparts.^{2,4,5} However, the emotional qualities contributing to satisfaction
23 and stability in same-sex relationships are similar to those found in heterosexual relationships, and
24 same-sex couples are comparable to heterosexual couples on standardized measures of relationship
25 satisfaction.⁶⁻¹⁰ Nevertheless, because civil marriage is not generally available for same-sex
26 couples, more research on the implications of same-sex marriage for gay and lesbian individuals is
27 needed.^{11,12} Finally, although considerably more research has been done on lesbian households,
28 most reviews support the view that children raised in same-sex households display emotional,
29 psychosocial, and behavioral adjustments comparable to children raised in heterosexual
30 households.¹³⁻¹⁶

31
32 Although the broader issues surrounding same-sex marriage are not covered in depth in this report,
33 the Council acknowledges that the inherent characteristics and qualities of committed same-sex
34 relationships and the parenting ability of gay and lesbian partners should not be considered
35 fundamental barriers to legal recognition of same-sex marriage. Finally, it is important to note that
36 although the term “same-sex” connotes a homogenous group, the characteristics and behaviors of
37 gay versus lesbian-partnered relationships differ qualitatively, and (like heterosexual ones) vary
38 based on location (urban vs. rural), religion, race and ethnicity, and socioeconomic status.

METHODS

English-language reports on studies using human subjects were selected from a PubMed search of the literature from 1990 to August 2009 using the MeSH terms “homosexuality” “(male or female),” “marriage/*legislation & jurisprudence,” *family characteristics,” “parent-child relations,” “healthcare disparities,” and “health policy.” Additional articles were identified by manual review of the references cited in these publications. Web sites of the Human Rights Campaign, the Gay and Lesbian Medical Association, the Institute for Gay and Lesbian Strategic Studies, Lambda Legal, National Center for Lesbian Rights, Williams Institute, National Conference on State Legislatures, Kaiser Family Foundation, and the Employee Benefit Research Institute also were searched for relevant resources. Members of the AMA Advisory Committee on Gay, Lesbian, Bisexual, and Transgender Issues also were consulted for relevant background information.

LEGAL HOUSEHOLD RELATIONSHIPS

Civil Marriage

Civil marriage in the United States is a legal status established through a state-issued license granting certain legal rights and obligations to two individuals. Civil marriage has been described as providing a “context for legal, financial, and psychosocial well-being, an endorsement of interdependent care, and a form of public acknowledgement and respect for personal bonds.”¹³ Judges, other public officials, and clergy are authorized to establish civil marriages. Religious marriage is a rite conducted according to the rules and requirements of the religious organization. Although religious ceremonies vary, their authority to establish civil marriage emanates from the state, not the religious group.

Defense of Marriage Act. Congress enacted the Defense of Marriage Act (DOMA) in 1996.¹⁷ DOMA defines *marriage* as “a legal union between one man and one woman as husband and wife” and *spouse* as “only...a person of the opposite sex who is a husband or a wife.” DOMA also granted states the ability to not recognize same-sex marriages enacted in other states. Accordingly, forty-one states have statutes defining marriage as between one man and one woman, and thirty have constitutional language defining marriage.²¹ Normally, under the “Full Faith and Credit Clause” of the United States Constitution, states are required to recognize and honor the public laws of other states.²⁰

The Act affects the interpretation and application of federal laws in which marital status is a factor. Several categories exist including: (1) social security and related programs; (2) housing and food stamps; (3) the internal revenue service (IRS) code; (4) federal civilian and military service benefits; (5) employment benefits (6) immigration and nationality status; (7) trade, commerce, and intellectual property; (8) remedies and protections for crimes and family violence; and (9) certain loans and other financial guarantees. The General Accounting Office identified 1138 statutory provisions that confer rights to spouses and dependent children based on federal recognition of civil marriage.¹⁸

States Recognizing Same-Sex Marriage. Three states (Massachusetts, Connecticut, Iowa) extend state-level rights and benefits of marriage to same-sex couples, and three others (Vermont, Maine, New Hampshire) have passed same-sex marriage statutes scheduled to take effect between September 2009 and January 1, 2010.¹⁹ California allowed same-sex marriage for a period of time in 2008 until a ballot initiative (Proposition 8) was approved limiting marriage to one man and one woman.

1 *Civil Union*

2
3 A civil union is a legal status extending state-based benefits, protections, and responsibilities that
4 are granted during marriage, to same-sex couples. Civil unions are not reciprocally recognized in
5 most states nor by the federal government. States allowing civil unions include New Jersey and
6 New Hampshire.^{22,23} Some states that previously legalized civil unions have subsequently
7 legalized same sex marriages. Vermont will continue to recognize already established civil unions,
8 whereas New Hampshire established a grace period to convert civil unions to marriages.

9
10 *Domestic Partnerships*

11
12 A domestic partnership is a legally recognized partnership between two individuals who may or
13 may not be of the same sex; benefits vary by jurisdiction. They do not provide the same degree of
14 protection as civil unions, and also do not confer federal rights, benefits, or protections. Domestic
15 partnership laws are state-, community-, or employer specific, and therefore are not “portable.”
16 Several states currently offer domestic partnership benefits.²³ Some (California, Oregon,
17 Washington) provide nearly all state-level spousal rights to unmarried couples in domestic
18 partnerships, whereas others (Hawaii, Maine, District of Columbia) are more limited in their extent.
19 At least 6 other states offer domestic partner benefits to state-level employees.²³

20
21 Approximately 57% of Fortune 500 companies offer domestic partner benefits.²⁴ Overall, 36% of
22 employers surveyed by the Society for Human Resource Management offered domestic partner
23 benefits to same-sex partners, more often in large companies (>500 employees) and in publicly-
24 owned, for-profit organizations. More than 9,000 companies and organizations currently offer
25 domestic partner benefits. Several other cities and counties also maintain domestic partner
26 registries.²⁵ According to data compiled by the Williams Institute at UCLA Law School, as of
27 2009, roughly one-third of the same-sex couples in the United States resided in a jurisdiction
28 offering them some form of state-level recognition of their relationships.²⁵

29
30 *Demographics of Same Sex Households*

31
32 2000 Census. The 2000 Census surveyed relationships in two broad categories—related persons
33 (e.g., husband/wife, son/daughter) and unrelated persons (e.g., unmarried partner; roomer/boarder).
34 If the household responder designated another adult of the same sex as his or her “husband/wife” or
35 “unmarried partner,” the Census classified this household as a “same-sex, unmarried partner
36 couple.” Using this method, same-sex households accounted for 0.6% of all households captured
37 by the 2000 Census, and were recorded in 96% of counties in the U.S.²⁶ In households that were
38 classified as same-sex, approximately 34% of female couples and 22% of male couples were
39 raising children in the United States in 2000.²⁶

40
41 For a variety of reasons, the 2000 Census probably underestimated the actual number of same-sex
42 households. Undercount projections vary from 16% to 62%, in which case the prevalence of same-
43 sex households in the U.S. may approach 1%.²⁷

44
45 California Survey Data. California contains more same-sex households than any other state. As
46 noted above, California also offers domestic partnership benefits. Based on independent,
47 population-based telephone surveys conducted biannually from 2001 to 2005 and the use of adult
48 self reports, 37% to 46% of gay men, and 51% to 62% of lesbians aged 18 to 59 are in cohabitating
49 partnerships, and are more likely to be white and highly educated. Approximately half of these
50 lesbian couples are officially registered as domestic partners with the local or state governments,
51 while less than 25% of gay couples are officially registered.²⁸ The fact that more lesbian couples

1 are registered is consistent with the experience in states that have legalized marriage or civil
2 unions. In such states, lesbians account for two-thirds of such legalized entities.

3
4 National Health Interview Survey. The National Health Interview Survey (NHIS) collects
5 information on health behaviors and health care access among the civilian, non-institutionalized
6 population in the United States.²⁹ Among adults 18 to 64 years of age who were living with a
7 spouse or partner between 1997 and 2003, 0.65% reported they were involved in a same-sex
8 relationship, and 99.35% reported they were involved in an opposite sex relationship. This
9 percentage of same-sex couples (0.6%) is similar to the percentage reported in the rudimentary
10 2000 Census data.

11 12 AMA POLICY

13
14 Our AMA has extensive policy (Appendix A) supporting equal treatment and elimination of
15 discriminatory practices for the gay and lesbian population and for reducing health disparities
16 affecting sexual minorities. Specifically, our AMA: (1) supports adoption of a child by same-sex
17 partners; (2) opposes discrimination based on sexual orientation or gender identity, and supports
18 inclusion of “sexual orientation, sex, or gender identity” in nondiscrimination statements; (3)
19 supports better physician education, improved workforce diversity, and cultural competence and
20 training in managing the health care needs of gay men and lesbians; (4) supports providing same-
21 sex couples and their dependent children the same hospital visitation privileges accorded married
22 couples; (5) opposes denying health insurance on the basis of sexual orientation or gender identity;
23 and (6) supports equality in laws affecting health care of members in same-sex partner households
24 and their dependent children.

25 26 *Federation Members*

27
28 The American Academy of Pediatrics, American Academy of Family Physicians, American
29 College of Obstetricians and Gynecologists, American Academy of Child and Adolescent
30 Psychiatry, and the American Psychiatric Association have endorsed various policy statements on
31 same-sex marriage, and the legal status and privileges that should be accorded same-sex couples,
32 including adoption rights (see Appendix B).³⁰⁻³⁴

33 34 HEALTH DISPARITIES AFFECTING GAY MEN AND LESBIANS

35
36 Health disparities are differences in the incidence, prevalence, mortality, burden of diseases and
37 other adverse health conditions or outcomes that exist among specific population groups in the
38 United States. The Council previously addressed optimizing medical care for gay men and
39 lesbians.³⁵ Gay men and lesbians have many of the same health issues as their heterosexual
40 counterparts, but also have certain unique conditions related either to sexual or other disease risk
41 factors or to less frequent use of preventive services. Gay men and lesbians are disproportionately
42 at risk for sexually transmitted diseases, mental health disorders including substance misuse, and
43 certain cancers.³⁵

44
45 Thus, it is already established that gay men and lesbians experience a range of health disparities.
46 As noted in the previous Council report, studies involving gay and lesbian health are limited by
47 selection bias and the use of sexual orientation *per se* as the variable. None of the studies reviewed
48 in the previous Council report on health disparities in gay men and lesbians controlled for the
49 concurrent existence of a legal partnership status, including state-sanctioned marriage.

1 HEALTH CARE DISPARITIES AFFECTING SAME SEX HOUSEHOLDS

2
3 In contrast to health disparities, Resolution 522 (A-08) seeks to determine whether same-sex
4 couples and their dependent children experience *health care disparities* because of their exclusion
5 from civil marriage. Health care disparities are the differences or gaps in care experienced by one
6 population compared with another population.

7
8 Gay men and lesbians encounter barriers to accessing care or experience gaps in care clustering
9 around 4 main issues:^{35,36} (1) reluctance of some gay and lesbian individuals to disclose their sexual
10 identity, in part because of fear of negative reactions; (2) insufficient numbers of physicians who
11 feel competent to provide care; (3) barriers emanating from lack of financial resources, lack of
12 insurance, or impediments that limit visiting and medical decision-making rights for gays and
13 lesbians and their partners; and (4) lack of culturally appropriate prevention services. Thus, within
14 the scope of health care delivery, health care disparities can be due to differences in access to care,
15 provider biases, poor provider-patient communication, poor health literacy, and other factors. The
16 importance of health care access as a component of overall health status is illustrated by its
17 inclusion as one of the 10 leading health indicators in Healthy People 2010. Access to care
18 involves not only geographic availability of quality health services but also financial, social,
19 cultural, and structural issues.

20
21 The following discussion evaluates how the institution of marriage provides certain benefits related
22 to health care delivery, and how the inability to form such legally recognized relationships with a
23 same-sex partner impacts health care disparities.

24
25 *Health Insurance*

26
27 Health insurance is the most important factor in determining access, and the receipt of timely and
28 appropriate health care for residents of the United States.³⁷ Uninsured adults, regardless of their
29 sexual orientation, and uninsured children are far less likely to receive the health care they need.
30 Health care access also is influenced by employment status, education, race/ethnicity, age,
31 socioeconomic status, and location of residence.

32
33 Effect of Marriage. Marriage is a strong predictor of health insurance coverage in the United
34 States. Nationwide, people who have never been married (27%) and those who are living with a
35 partner (32%) are more likely to be uninsured than those who are married (13%).³⁸ Currently,
36 approximately 62% of individuals under the age of 65 are insured through their employer, and 19%
37 rely on public benefits.³⁹ Employer-sponsored insurance covers almost two-thirds of women
38 between the ages of 18 and 64, but women are less likely to be insured through their own job than
39 are men (39% vs 49%, respectively), and also are twice as likely as men to be insured through
40 another person (25% vs 13%).⁴⁰

41
42 Most employer sponsored health plans extend coverage to the married spouses and children of their
43 employees. Although more companies are offering domestic partnership benefits to unmarried
44 individuals, the majority of employers do not provide this option. If a working gay or lesbian
45 parent cannot establish a legal relationship to the child, the child also is more likely to be
46 uninsured.

47
48 Among adults 18 to 64 years of age who were surveyed and living with a spouse or partner
49 between 1997 and 2003, women in same-sex households were significantly less likely than women
50 in opposite sex relationships to: (1) have health insurance coverage; (2) have seen a health care
51 provider in the previous 12 months; and (3) have an established, usual source of health care. This

1 survey however demonstrated a difference between lesbian and gay couples in that health care
 2 access among men in same-sex households was at least equivalent to that among men in opposite
 3 sex relationships.²⁹

4
 5 The Current Population Survey (CPS) is a monthly household survey conducted by the Census
 6 Bureau, and is the primary source of information on the labor force characteristics of the U.S.
 7 population. The Annual Social and Economic Supplement to the CPS is conducted each March
 8 and includes detailed questions about health insurance coverage, as well as partner relationships
 9 from 60,000 households. Pooled data of this survey from 1996 to 2003 indicate that gay and
 10 lesbian partners were twice as likely to be uninsured as married people.⁴¹

11
 12 Taxation on Employer-Provided Health Insurance Premiums. Employee-sponsored domestic
 13 partner benefits, unlike health benefits provided to married heterosexual couples, are taxed as
 14 income. This may affect the ability of some same-sex households to afford domestic partner-based
 15 coverage and coverage for their children.

16
 17 Continuation of Health Coverage. The Consolidated Omnibus Budget Reconciliation Act of 1985
 18 (COBRA) requires most employers with group health plans to offer employees the opportunity to
 19 temporarily continue their group health care coverage under their employer's plan if their coverage
 20 otherwise would cease due to termination, layoff, or other change in employment status (referred to
 21 as "qualifying events"). When a gay or lesbian employee loses or leaves a job, federal law does not
 22 guarantee the employee the opportunity to purchase continuing health coverage for an unmarried
 23 partner, even if the employer-sponsored plan originally covered the partner. Employers are only
 24 required to offer continuation coverage to the employee and to "qualified beneficiaries," defined as
 25 the employee's spouse and dependent children. However, nothing prevents an employer from
 26 extending COBRA benefits to domestic partners, and employers may choose to extend such
 27 benefits of their own accord. This can result in discrimination against both the same sex partner
 28 and dependent children, if the employer chooses not to extend these benefits.

29
 30 Family and Medical Leave Act. As currently interpreted, the Family and Medical Leave Act does
 31 not provide leave to care for a domestic partner or child in the domestic partner's family. This has
 32 potential implications for the care of the child (i.e., maternity/paternity leave; one partner is
 33 hospitalized and the other must care for children at home), as well as potential financial
 34 consequences in terms of job security.

35
 36 In summary, less access to health insurance, the lack of tax benefits for health insurance premiums,
 37 and loss of protections offered married couples under COBRA and FMLA contribute to health care
 38 disparities for same-sex households.

39
 40 *Financial Implications of Marriage*

41
 42 The socioeconomic status of the household has direct implications for health care access. The
 43 following federal benefits are extended only to married couples and have implications for financial
 44 security.

45
 46 Federal Income Tax. The impact of parenting-related federal income tax depends on the working
 47 status of both parents. In general, IRS regulations negatively affect tax burdens in same-sex
 48 households when one parent stays at home, whether or not that parent has a legal relationship with
 49 the child. If both same-sex parents work, the tax burden may be less than heterosexual couples
 50 depending on the combined income. These principles apply assuming the married heterosexual
 51 couple files as "married filing jointly" and in the same-sex household the "income earner" files as

1 head of household, and the other parent files as single. The actual impact will depend on the
2 number of children, and eligibility for dependent exemptions, child tax credits, dependent and child
3 care tax credits, and earned income tax credits. The greatest impact occurs when only the stay-at-
4 home parent has a legal relationship to the children. For example, under these circumstances with
5 two children and a family earning \$60,000, if a married heterosexual couple owed ~\$2500 in
6 federal income tax, the comparable same-sex household would owe ~\$7000. Other tax situations
7 that can result in significant financial penalties for same-sex households are the gain from sale of
8 the taxpayer's principal residence and estate taxes.

9
10 Retirement Plans. Although defined-benefit pension plans are increasingly scarce, partners in
11 same-sex households do not receive the same legal and financial protections as do married spouses.
12 The latter are entitled to the accumulated value of defined benefit plans (or a certain percentage
13 based on the plan description) which can be rolled-over into an IRA without tax consequences if
14 the spouse dies. Some, but not all defined benefit pension plans allow for the accumulated value to
15 be distributed to a named nonspouse beneficiary, but the tax protections afforded rollovers of these
16 distributions are available only to a legal spouse.⁴² The same penalty (20% federal withholding
17 tax) holds true for 401(k) plans if the surviving named beneficiary is a same-sex partner.

18
19 Social Security Survivor Benefits. Social Security survivor benefits are made available to
20 surviving spouses and children. When a gay or lesbian parent dies, the loss of Social Security
21 benefits to children and a surviving partner can be substantial. For example, when a spouse who
22 earned \$60,000 dies and leaves behind a 10-year old child, approximately \$240,000 in benefits are
23 available to the child and surviving parent in a civil marriage.⁴² A surviving gay or lesbian partner
24 is in all cases deprived of benefits available to surviving spouse. Surviving children also are
25 deprived of benefits if the deceased parent was unable to establish a legal relationship with the
26 child.

27
28 Long Term Care. Individuals without long term care coverage who end up in nursing homes may
29 be required to spend all of their assets on care, and then apply for Medicaid when resources are
30 depleted (i.e., Medicaid "spend down"). Medicaid regulations allow one member of a married
31 couple to remain in the couple's home for the rest of his or her life without jeopardizing the
32 spouse's right to nursing home coverage. Same-sex partners are not covered under this provision,
33 and therefore are at risk of more rapid depletion of available financial resources, including the
34 value of the home.⁴³

35
36 Immigration. More than one out of 10 same-sex couples raising children includes at least one
37 parent who was born outside of the United States. American citizens or permanent residents are
38 not permitted to petition for their same-sex partners to immigrate. This lack of protection places
39 some same-sex households at risk of being broken up or forced to move to another country,
40 although no data is available on the extent of this practice.

41
42 The variables noted above affecting income and financial security, as well as long term care are
43 especially relevant for senior gay men and lesbians.⁴³ Nearly two-thirds of U.S. retirees rely on
44 Social Security for more than half of their annual income; for 15% of retirees Social Security is
45 their only source of income. Although specific studies of how the loss of the financial benefits
46 described in this section contributes to health care disparities for same-sex households have not
47 been conducted, their loss is relevant to the extent financial variables affect health care disparities.

1 *Children in Same Sex Households*

2
3 Various pathways to parenthood exist in same-sex households, including custody of children from
4 previous civil marriages, the use of surrogate mothers, foster care, adoption, and for lesbian
5 women, artificial insemination. Coparent adoption is a legal process that allows both parents to
6 adopt a child at the same time. Second parent adoption is a process whereby the partner of the
7 biological or primary adoptive parent is allowed to adopt at a later time.

8
9 Adoption. Only eleven states and the District of Columbia guarantee that same-sex parents can
10 jointly establish themselves as the legal parents of children living in the household; in two states
11 (Nevada and New Hampshire) same-sex couples have successfully petitioned to jointly adopt in
12 some jurisdictions.⁴³ Ten states and the District of Columbia provide second-parent adoption as an
13 option for same-sex couples, and as many as 15 states have allowed second-parent adoption in
14 some jurisdictions. Overall, approximately two-thirds of children being raised by same-sex parents
15 nationwide live in states that do not guarantee the right of both parents to establish a legal
16 relationship with the child via second parent or joint adoption.⁴⁴

17
18 When joint or second parent adoption is not available, both parents cannot authorize medical
19 treatment in an emergency. If same-sex parents can access a jurisdiction that authorizes joint or
20 second parent adoptions, medical consequences may be mitigated, however adoption is constrained
21 in several states by residency requirements. When adoption by same-sex parents is successful,
22 other states must recognize its validity, even if the state has a statute expressly prohibiting such a
23 practice. If a medical emergency involving the adopted child of a same-sex household occurs in a
24 state where such adoptions are not legal, the right of both parents to authorize medical treatment
25 would have to be recognized. Failure to do so may result in liability exposure for the health care
26 provider or organization that failed to recognize the adoptive parent's ability to authorize treatment
27 in the case of an emergency.

28
29 **CONCLUSION**

30
31 In the United States, civil marriage (as defined by the federal government) is recognized across
32 state and national borders. State-authorized same-sex civil marriages, civil unions, and domestic
33 partnerships are not accorded the same status.

34
35 Many of the statutory advantages enjoyed by married partners are financial, including those
36 derived from tax laws, employee benefits, inheritance, insurance and survivorship rights, and
37 entitlement programs.⁴ Some benefits, such as access to employer-based health insurance and the
38 authority to make medical decisions on behalf of a spouse, have more direct implications for health
39 care access and delivery of care. Access to civil marriage is an opportunity for gay men and
40 lesbians to receive increased legal and financial protections, parental rights, and the potential for
41 enhanced social and extended family support. Recent survey data from Massachusetts where
42 same-sex marriages have existed since 2004 show that marriage has been perceived as a positive
43 factor in these areas.⁴⁵ For example, 85% of same-sex married couples listed legal recognition as
44 one of their main motivations for marrying; 70% felt more accepted by their communities; 48%
45 reported less worry about legal problems; 89% reported that all or most family members supported
46 their marriage; 93% reported their children were happier as a result of their marriage; and 83%
47 reported they were now more likely to confide in their healthcare providers. Although a subjective
48 bias in favor of the positive effects of same-sex marriage would be anticipated, this study offers an
49 example of how the opportunity for same-sex marriage may be expected to decrease health care
50 disparities resulting from social, attitudinal, and financial issues described above.

1 Health care disparities experienced by gay and lesbian families are multifaceted, and therefore it is
2 difficult to empirically examine the specific effects that governmental prohibition of same-sex
3 marriage has on such disparities. However, it is somewhat self-evident that marriage, as a package
4 of numerous financial and social benefits, creates a *de facto* health care disparity between married
5 and unmarried populations. Survey data confirm that same-sex households have less access to
6 health insurance. If they have health insurance, they pay more than married heterosexual workers,
7 and also lack other financial protections. Additionally, both provider and patient-based barriers to
8 health care access and culturally competent care for gay and lesbian individuals continue to exist,
9 and children in same-sex households lack the same protections afforded children in heterosexual
10 households.

11

12 RECOMMENDATIONS

13

14 The Council on Science and Public Health recommends that the following statements be adopted
15 and the remainder of the report be filed:

16

17 1. That our American Medical Association (AMA):

18

19 a) recognize that exclusion from civil marriage may contribute to health care disparities
20 affecting same-sex households;

21

22 b) work to reduce health care disparities among members of same-sex households including
23 minor children; and

24

25 c) support measures providing same-sex households with the same rights and privileges to
26 health care, health insurance, and survivor benefits, as afforded opposite-sex households.
27 (New HOD Policy)

28

29 2. That our AMA rescind Policy D-160.979 "Health Care Disparities in Same-Sex Partner
30 Households." (Rescind HOD Policy)

Fiscal Note: Less than \$500

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Appendix A
AMA Policies Relevant to Same Sex Households

H-60.940 Partner Co-Adoption

Our AMA will support legislative and other efforts to allow the adoption of a child by the same-sex partner, or opposite sex non-married partner, who functions as a second parent or co-parent to that child. (Res. 204, A-04)

H-65.976 Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population

Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement. (Res. 414, A-04; Modified: BOT Rep. 11, A-07)

H-65.983 Nondiscrimination Policy

The AMA affirms that it has not been its policy now or in the past to discriminate with regard to sexual orientation or gender identity. (Res. 1, A-93; Reaffirmed: CCB Rep. 6, A-03; Modified: BOT Rep. 11, A-07)

H-65.992 Continued Support of Human Rights and Freedom

Our AMA continues (1) to support the dignity of the individual, human rights and the sanctity of human life, and (2) to oppose any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies. (Sub. Res. 107, A-85; Modified by CLRPD Rep. 2, I-95; Reaffirmation A-00; Reaffirmation A-05; Modified: BOT Rep. 11, A-07)

H-160.991 Health Care Needs of the Homosexual Population

1. Our AMA: (a) believes that the physician's nonjudgmental recognition of sexual orientation and behavior enhances the ability to render optimal patient care in health as well as in illness. In the case of the homosexual patient this is especially true, since unrecognized homosexuality by the physician or the patient's reluctance to report his or her sexual orientation and behavior can lead to failure to screen, diagnose, or treat important medical problems. With the help of the gay and lesbian community and through a cooperative effort between physician and the homosexual patient effective progress can be made in treating the medical needs of this particular segment of the population; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of homosexuality and the need to take an adequate sexual history; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of their homosexual patients; (iii) encouraging the development of educational programs for homosexuals to acquaint them with the diseases for which they are at risk; (iv) encouraging physicians to seek out local or national experts in the health care needs of gay men and lesbians so that all physicians will achieve a better understanding of the medical needs of this population; and (v) working with the gay and lesbian community to offer physicians the opportunity to better understand the medical needs of homosexual and bisexual patients; and (c) opposes, the use of "reparative" or "conversion" therapy that is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his/her homosexual orientation. 2. Our AMA will (a) educate physicians regarding: (i) the need for women who have sex exclusively with women to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (b) support our partner medical organizations in educating women who have sex exclusively with women on the need for regular cancer screening exams, the risk for sexually transmitted infections, and the appropriate safe sex techniques to avoid that risk. 3. Our AMA will use the results of the survey being conducted in collaboration with the Gay and Lesbian Medical Association to serve as a needs assessment in developing such tools and online continuing medical education (CME) programs with the goal of increasing physician competency on gay, lesbian, bisexual, and transgender health issues. 4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to physicians to enable the provision of high quality and culturally competent care to gay men and lesbians. (CSA Rep. C, I-81; Reaffirmed: CLRPD Rep.

F, I-91; CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08)

H-180.980 Sexual Orientation and/or Gender Identity as Health Insurance Criteria

The AMA opposes the denial of health insurance on the basis of sexual orientation or gender identity. (Res. 178, A-88; Reaffirmed: Sub. Res. 101, I-97; Reaffirmed: CMS Rep. 9, A-07; Modified: BOT Rep. 11, A-07)

H-200.951 Strategies for Enhancing Diversity in the Physician Workforce

Our AMA supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, gender, sexual orientation/gender identity, socioeconomic origin and persons with disabilities. (CME Rep. 1, I-06; Reaffirmed: CME Rep. 7, A-08)

H-215.965 Hospital Visitation Privileges for GLBT Patients

Our AMA encourages all hospitals to add to their rules and regulations, and to their Patient's Bill of Rights, language permitting same sex couples and their dependent children the same hospital visitation privileges offered to married couples. (Res. 733, A-06)

H-295.878 Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education

Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care-without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, and Transgender communities; and (3) encourages the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education to include Lesbian, Gay, Bisexual, and Transgender health issues in the cultural competency curriculum for medical education. (Res. 323, A-05)

H-440.885 National Health Survey

Our AMA supports a national health survey that incorporates a representative sample of the U.S. population of all ages (including adolescents) and includes questions on sexual orientation, gender identity, and sexual behavior. (CSA Rep. 4, A-03; Modified: BOT Rep. 11, A-07)

D-65.996 Nondiscriminatory Policy for the Health Care Needs of the Homosexual Population

Our AMA will encourage and work with state medical societies to provide a sample printed nondiscrimination policy suitable for framing, and encourage individual physicians to display for patient and staff awareness-as one example: "This office appreciates the diversity of human beings and does not discriminate based on race, age, religion, ability, marital status, sexual orientation, sex, or gender identity." (Res. 414, A-04; Modified: BOT Rep. 11, A-07)

D-65.995 Health Disparities Among Gay, Lesbian, Bisexual and Transgender Families

Our AMA will work to reduce the health disparities suffered because of unequal treatment of minor children and same sex parents in same sex households by supporting equality in laws affecting health care of members in same sex partner households and their dependent children. (Res. 445, A-05)

Appendix B
Policies of Federation Members on Same Sex Households

Medical Specialty Society	Policy Statement or Position
American Academy of Pediatrics	Children who are born to or adopted by 1 member of a same-sex couple deserve the security of 2 legally recognized parents. Therefore, the Academy “supports legislative and legal efforts to provide the possibility of adoption of the child by the second parent or coparent in families.
American Academy of Family Physicians	Is supportive of legislation which promotes a safe and nurturing environment, including psychological and legal security, for all children, including those of adoptive parent, regardless of the parents’ sexual orientation.
American College of Obstetricians and Gynecologists	Endorses equitable treatment for lesbians and their families, not only for direct health care needs but also for indirect health care issues, which includes the same legal protections afforded married couples.
American Academy of Child and Adolescent Psychiatrists	Opposes any discrimination based on sexual orientation against individuals in regard to their rights as custodial or adoptive parents.
American Psychiatric Association	Supports the legal recognition of same-sex civil marriage with all rights, benefits, and responsibilities conferred by civil marriage, and opposes restrictions to those same rights, benefits, and responsibilities.

REPORT 3 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-09)

Use of Cannabis for Medicinal Purposes

(Resolutions 910, I-08; 921, I-08; and 229, A-09)

(Reference Committee K)

EXECUTIVE SUMMARY

Objective. This report: (1) provides a brief historical perspective on the use of cannabis as medicine; (2) examines the current federal and state-based legal envelope relevant to the medical use of cannabis; (3) provides a brief overview of our current understanding of the pharmacology and physiology of the endocannabinoid system; (4) reviews clinical trials on the relative safety and efficacy of smoked cannabis and botanical-based products; and (5) places this information in perspective with respect to the current drug regulatory framework.

Data Sources. English-language reports on studies using human subjects were selected from a PubMed search of the literature from 2000 to August 2009 using the MeSH terms “marijuana” “cannabis,” and tetrahydrocannabinol,” or “cannabinoids,” in combination with “drug effects,” “therapeutic use,” “administration & dosage,” “smoking,” “metabolism,” “physiology,” “adverse effects,” and “pharmacology.” Additionally the terms “abuse/epidemiology,” and “receptors, cannabinoid” in combination with “agonists,” or “antagonists & inhibitors” as well as “endocannabinoids,” in combination with “pharmacology,” “physiology,” or “metabolism” were used. Additional articles were identified by manual review of the references cited in these publications. Web sites of the Food and Drug Administration, Drug Enforcement Administration, National Institute on Drug Abuse, Marijuana Policy Project, ProCon.org, and the International Association for Cannabis as Medicine also were searched for relevant resources.

Results. The cannabis sativa plant contains more than 60 unique structurally related chemicals (phytocannabinoids). Thirteen states have enacted laws to remove state-level criminal penalties for possessing marijuana for qualifying patients, however the federal government refuses to recognize that the cannabis plant has an accepted medical benefit. Despite the public controversy, less than 20 small randomized controlled trials of short duration involving ~300 patients have been conducted over the last 35 years on smoked cannabis. Many others have been conducted on FDA-approved oral preparations of THC and synthetic analogues, and more recently on botanical extracts of cannabis. Federal court cases have upheld the privileges of doctor-patient discussions on the use of cannabis for medicinal purposes but also preserved the right of the federal government to prosecute patients using cannabis for medicinal purposes. Efforts to reschedule marijuana from Schedule I of the Controlled Substances Act have been unsuccessful to date. Disagreements persist about the long term consequences of marijuana use for medicinal purposes.

Conclusions. Results of short term controlled trials indicate that smoked cannabis reduces neuropathic pain, improves appetite and caloric intake especially in patients with reduced muscle mass, and may relieve spasticity and pain in patients with multiple sclerosis. However, the patchwork of state-based systems that have been established for “medical marijuana” is woefully inadequate in establishing even rudimentary safeguards that normally would be applied to the appropriate clinical use of psychoactive substances. The future of cannabinoid-based medicine lies in the rapidly evolving field of botanical drug substance development, as well as the design of molecules that target various aspects of the endocannabinoid system. To the extent that rescheduling marijuana out of Schedule I will benefit this effort, such a move can be supported.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 3-I-09

Subject: Use of Cannabis for Medicinal Purposes

Presented by: C. Alvin Head, MD, Chair

Referred to: Reference Committee K
(Peter C. Amadio, MD, Chair)

1 This report responds to three resolutions related to the use of marijuana for medicinal purposes.

2

3 Resolution 910 (I-08), submitted by the Medical Student Section and referred to the Board of
4 Trustees (BOT), asked:

5

6 That our American Medical Association (AMA) support reclassification of marijuana’s status
7 as a Schedule I controlled substance into a more appropriate schedule.

8

9 Resolution 921 (I-08), submitted by the Washington Delegation and referred to the BOT, asked:

10

11 That our AMA support reclassification of marijuana’s status from a Schedule I controlled
12 substance to a more appropriate schedule; and

13

14 That our AMA support efforts to cease criminal prosecution and other enforcement actions
15 against physicians and patients acting in accordance with states’ medical marijuana laws.

16

17 Resolution 229 (A-09), submitted by the New York Delegation and referred to the BOT, asked:

18

19 That our AMA offer assistance in seeking clear, indisputable confirmation from the federal
20 government that physicians who follow the proposed New York State legislation if passed and
21 regulation when subsequently developed will not be prosecuted for allegedly failing to follow
22 the Presidential order still in place making it illegal for a physician to prescribe or even advise
23 a patient to use marijuana for medical purposes; and

24

25 That our AMA seek a reversal of the Executive Order itself that makes it illegal for a physician
26 to prescribe or advise medical marijuana.

27

28 The Council has issued two previous reports on “Medical Marijuana” in 1997 and 2001.^{1,2} The first
29 report is the basis for the current AMA policy on medical marijuana (Policy H-95.992, AMA
30 Policy Database (Appendix A)) and was developed largely in response to emerging state initiatives
31 designed to facilitate the medical use of marijuana. The second report in 2001 reviewed legal,
32 regulatory, and scientific developments on this topic that had transpired since the first report. As of
33 2001, the Council had concluded that sufficient evidence existed to support further research on the
34 potential use of marijuana:

35

- 36 • In HIV-infected patients with cachexia, neuropathy, or chronic pain, or who are suffering
37 adverse effects from medication, such as nausea, vomiting, and peripheral neuropathy, that
38 impede compliance with antiretroviral therapy;

- 1 • In patients undergoing chemotherapy, especially those being treated for mucositis, nausea, and
2 anorexia, and those patients who do not obtain adequate relief from either acute or delayed
3 emetic episodes from standard therapy;
- 4 • To potentiate the analgesic effects of opioids and to reduce their emetic effects in the treatment
5 of postoperative, traumatic, or cancer pain;
- 6 • In patients suffering from spasticity or pain due to spinal cord injury, or neuropathic or central
7 pain syndromes; and
- 8 • In patients with chronic pain and insomnia.

9
10 In 2001, the AMA House of Delegates reaffirmed that marijuana should be retained in Schedule I
11 of the Controlled Substances Act pending the outcome of further controlled studies.

12
13 The Institute of Medicine (IOM) published a comprehensive report in 1999 commissioned by the
14 Office of National Drug Control Policy, entitled “Marijuana and Medicine: Assessing the Science
15 Base.”³ The findings in this report (see Appendix B) generally agreed with the Council’s
16 assessment of the evidence on the potential medical utility of synthetic and plant-derived
17 cannabinoids. The IOM report also concurred with the Council that further research on the medical
18 utility of marijuana and individual cannabinoids was warranted and that resources should be
19 devoted to developing alternative, smoke-free delivery systems. The IOM further noted:

20
21 “because marijuana is a crude THC delivery system that also delivers harmful substances,
22 smoked marijuana should generally not be recommended for medical use. Nonetheless,
23 marijuana is widely used by certain patient groups, which raises both safety and efficacy
24 issues. If there is any future for marijuana as a medicine, it lies in its isolated components, the
25 cannabinoids and their synthetic derivatives. Isolated cannabinoids will provide more reliable
26 effects than crude plant mixtures. Therefore, the purpose of clinical trials of smoked marijuana
27 would not be to develop marijuana as a licensed drug but rather to serve as a first step toward
28 the development of nonsmoked rapid-onset cannabinoid delivery systems.”

29
30 Accordingly, the IOM report supported the availability of a compassionate-use protocol as an
31 interim measure whereby the clinical use of medical cannabis would be allowed for symptom relief
32 in seriously ill patients in limited and locally implemented peer-reviewed treatment trials. Recently
33 the American College of Physicians (ACP) issued a policy statement on medical marijuana
34 (Appendix C).⁴ Like the AMA, the ACP supports approaches to conduct rigorous scientific
35 evaluation of the potential therapeutic benefits of marijuana, and development of non-smoked
36 forms. Additionally, ACP urged federal review of marijuana’s status as a Schedule I substance to
37 determine if it should be reclassified, and strongly supported exemption from federal criminal
38 prosecutions, civil liability, or professional sanctions for physicians who issue recommendations
39 for medical marijuana in accordance with state law, as well as protection from criminal or civil
40 penalties for patients under such circumstances.

41
42 In light of the foregoing discussion, this report evaluates the merits of Resolutions 910 (I-08), 921
43 (I-08) and 229 (A-09). In so doing, the Council: (1) provides a brief historical perspective on the
44 use of cannabis as medicine; (2) examines the current federal and state-based legal envelope
45 relevant to the medical use of cannabis; (3) provides a brief overview of our current understanding
46 of the pharmacology and physiology of endogenous cannabinoid receptors and substances
47 (endocannabinoids); (4) reviews the more recent clinical trial evidence on the relative safety and
48 efficacy of smoked cannabis and other cannabis-based products; and (5) places this information in
49 perspective with respect to the current drug regulatory framework, and the rights and
50 responsibilities of physicians to provide optimal care for their patients. In many places the term

1 “cannabis” is used. Marijuana is a slang term for the dried flowers and bracts of the cannabis plant.
 2 In cases where the term “marihuana” or “marijuana” is used in the statute, policy statement or other
 3 legal way, such terms are retained.

4

5 METHODS

6

7 English-language reports on studies using human subjects were selected from a PubMed search of
 8 the literature from 2000 to August 2009 using the MeSH terms “marijuana” “cannabis,” and
 9 tetrahydrocannabinol,” or “cannabinoids,” in combination with “drug effects,” “therapeutic use,”
 10 “administration & dosage,” “smoking,” “metabolism,” “physiology,” “adverse effects,” and
 11 “pharmacology.” Additionally the terms “abuse/epidemiology,” and “receptors, cannabinoid” in
 12 combination with “agonists,” or “antagonists & inhibitors” as well as “endocannabinoids,” in
 13 combination with “pharmacology,” “physiology,” or “metabolism” were used. Additional articles
 14 were identified by manual review of the references cited in these publications. Web sites of the
 15 Food and Drug Administration, Drug Enforcement Administration, National Institute on Drug
 16 Abuse, Marijuana Policy Project, ProCon.org, and the International Association for Cannabis as
 17 Medicine also were searched for relevant resources.

18

19 BACKGROUND

20

21 Cannabis is one of the oldest psychotropic drugs in human history. Originating from central Asia,
 22 and then spreading to China and India, the first modern description of its pharmacological
 23 properties was provided by an Irish physician (William O’Shaughnessy) in 1839.⁵ First listed in
 24 the United States Dispensary in 1854, cannabis was promoted for a variety of conditions based on
 25 its putative analgesic, sedative, anti-inflammatory, antispasmodic, anti-asthmatic, and
 26 anticonvulsant properties.^{1,6,7} Many cannabis-containing oral extracts and tinctures were
 27 subsequently manufactured. Interest in the medical use of cannabis waned somewhat in the late
 28 nineteenth and early twentieth centuries with the advent of opiates, barbiturates, chloral hydrate,
 29 and aspirin and the widespread availability of hypodermic syringes for injection of water-soluble
 30 compounds. Nevertheless, cannabis remained available in the British Pharmacopoeia in extract
 31 and tincture form until 1971.

32

33 The U.S. government and popular media began condemning the use of smoked cannabis in the
 34 1930s, linking its use to homicidal mania. The Marihuana Tax Act of 1937 introduced the first
 35 federal restrictions on marijuana. This federal law required industrial or medical users to register
 36 and pay a tax on marijuana of \$1/ounce. Individuals using marijuana for recreational or other
 37 purposes were required to pay a tax of \$100/ounce. A combination of the paperwork required of
 38 physicians who wished to use the drug in their practice, and regulations later imposed by the
 39 Federal Bureau of Narcotics designed to prevent diversion, quickly dampened enthusiasm for
 40 pursuing medical applications of cannabis.

41

42 At the time, the AMA was virtually alone in opposing passage of the Marihuana Tax Act. The
 43 AMA believed that objective data were lacking on the harmful effects of marijuana, and that
 44 passage of the Act would impede future investigations into its potential medical uses.⁸ The AMA’s
 45 Committee on Legislative Activities recommended that marijuana’s status as a medicinal agent be
 46 maintained.⁹ Nevertheless, secondary to governmental pressures, marijuana was removed from the
 47 U.S. Pharmacopoeia in 1942, thus losing its remaining mantle of therapeutic legitimacy.

48

49 In 1964, delta-9-tetrahydrocannabinol (hereafter referred to as THC) was identified as the primary
 50 psychoactive cannabinoid in *Cannabis sativa* (see below) and successfully synthesized.¹⁰ The
 51 1960s witnessed a resurgence in the recreational use of smoked cannabis, and the ability of

1 cannabis to relieve certain disease symptoms was “rediscovered.” Thereafter the recreational and
2 “medical” forms of smoked cannabis became merged. This contrasts with the path of medicinal
3 opioid development and the recreational use of smoked botanical opium, which became clearly
4 distinct.

5
6 Receptors in the brain and periphery that bind THC (cannabinoid receptors) were discovered in the
7 early 1990s, and the identification of endogenous compounds that act at cannabinoid receptors
8 (endocannabinoids) soon followed. The last decade has seen an explosion in research about the
9 “endocannabinoid system” (see below). Information gleaned from these investigations has shed
10 light on the pharmacologic activity of phytocannabinoids, and created opportunities for the
11 development of pharmaceuticals interacting with this system.

12 13 CANNABINOIDS AND THE ENDOCANNABINOID SYSTEM

14
15 *Cannabis Sativa*. The plant contains over 400 chemical compounds.¹¹ The main psychoactive
16 substance is generally believed to be THC, but more than 60 other cannabinoids (C₂₁-containing
17 compounds) have been identified in the plant (phytocannabinoids) and pyrolysis products.¹⁰⁻¹²
18 Cannabinoids are chemical compounds that are unique to the cannabis plant. Delta-8-THC is
19 similar in potency to THC, but is present in only small concentrations.¹³ Cannabinol and
20 cannabidiol are the other major cannabinoids present. The former is slightly psychoactive, but not
21 in the amounts delivered by smoking marijuana.¹³ Cannabidiol is not psychoactive and has
22 distinctive properties (see below). The average content of THC in cannabis plants is highly
23 variable depending on the strain, climate, soil and growing conditions, and handling after harvest.¹⁴
24 THC is a resinous weak acid, pKa = 10.6, with a very high lipid solubility and very low aqueous
25 solubility.¹⁵ It binds to glass, diffuses into plastic, and is photo labile and susceptible to heat, acid,
26 and oxidation; these characteristics have served as barriers to the development of traditional
27 pharmaceutical dosage forms. The (-) enantiomer is up to 100 times more potent than the (+)
28 enantiomer depending on the pharmacological test.¹⁶

29 30 ENDOCANNABINOIDS

31 32 *Cannabinoid Receptors*

33
34 Two types of cannabinoid receptors (CB1 and CB2) have been clearly identified and both are
35 members of the superfamily of G-protein-coupled receptors. The CB1 receptor, first cloned in
36 1990, is mainly expressed in the brain and spinal cord.¹⁷ Distribution is heterogeneous with the
37 highest densities present in the basal ganglia, hippocampus, and cerebellum, with comparatively
38 fewer receptors in the brainstem.^{18,19} CB1 receptors are among the most abundant G-protein
39 coupled receptors in the brain.²⁰ By coupling predominately to inhibitory G proteins, CB1 receptors
40 inhibit certain inwardly directed calcium channels, activate outwardly directed potassium channels,
41 and activate various mitogen-activated protein (MAP) kinases.²¹ The latter may play a role in the
42 modulation of synaptic plasticity, cell migration, and neurite remodeling. CB1 receptors are
43 located on the terminals of central and peripheral neurons. Generally, their activation inhibits the
44 ongoing release of a number of different excitatory and inhibitory transmitters, or hyperpolarizes
45 neurons, which also inhibits activity.²¹

46
47 The CB2 receptor, first cloned in 1993 is predominantly expressed in cells of the immune and
48 hematopoietic systems but also is present in nonparenchymal cells of the liver, endocrine pancreas,
49 and bone.²² Some CB2 receptors also are functionally expressed in the CNS, notably on microglial
50 cells.^{23,24} CB2 receptor activation alters the release of cytokines from immune cells and participates

1 in the regulation immune function.²⁰ CB2 agonists generally suppress the functions of these cells.
2 CB2 modulates immune cell migration both within and outside the central nervous system^{25,26}

3 4 *Endocannabinoids*

5
6 In parallel with the discovery of cannabinoid receptors, endogenous substances that bind and
7 activate these receptors were identified (endocannabinoids). The two best characterized are
8 arachidonoyl ethanoamide (AEA or anandamide) and 2-arachidonoylglycerol (2-AG), although
9 other putative endocannabinoids also have been identified. In contrast to conventional
10 neurotransmitters, endocannabinoids are not stored in synaptic vesicles, but are produced on
11 demand via cleavage of membrane lipid precursors and then released after *de novo* synthesis.^{27,28}
12 Once formed in response to presynaptic depolarization, endocannabinoids function as “retrograde”
13 messengers, diffusing back across the synapse and signaling the presynaptic (upstream) neuron to
14 decrease neurotransmitter release and/or activity. These effects have been implicated in the
15 modulation of both short- and long term synaptic plasticity, events which are integral to the
16 remodeling of synaptic networks in the CNS, as well as fundamental processes such as learning
17 and memory.

18
19 Termination of the action of AEA and 2-AG is accomplished by re-uptake into the neuron and
20 subsequent enzymatic degradation. These transport proteins and degradative enzymes represent
21 other targets for manipulating the endocannabinoid system.

22
23 AEA primarily activates CB1 receptors, and also stimulates TRPV1 receptors.²⁹ The latter is an
24 important component of pain signaling pathways. AEA is a partial or full agonist at CB1 receptors,
25 depending on the species, tissue, and biological response being examined.²⁹ Partial agonists are
26 capable of binding to a receptor, but do not cause maximal activation. Pharmacologically, they can
27 function as agonists or antagonists, depending on the dose, and endogenous activity of the
28 biological system they are interacting with. This fact complicates the interpretation of
29 endocannabinoid effects that have been observed in animal models, as well as findings which may
30 be relevant to phytocannabinoids such as THC. Although AEA binds to CB2 receptors, it has a
31 low efficacy, and may act primarily as an antagonist.²⁹ 2-AG has approximately equivalent activity
32 at CB1 and CB2 receptors, is much more abundant than AEA in the brain, and is believed to act
33 primarily as an agonist at cannabinoid receptors.³⁰ Other putative endocannabinoids also tend to be
34 considerably more active as CB1 receptor agonists.³¹ Additionally, other receptor systems appear
35 to respond to endocannabinoids.^{31,32}

36
37 THC is also a partial agonist at the CB1 and CB2 receptors. Cannabidiol displays anti-oxidant
38 activity, is a TRPV1 agonist like AEA, and inhibits the uptake and metabolism of AEA. It has low
39 efficacy for CB1 and CB2 receptors.

40
41 Taken together, the endocannabinoid system is widely dispersed and it modulates the activity of
42 several prominent neurotransmitters, immune regulating cells, and other tissue and organs.
43 Accordingly, endocannabinoids likely play a role in the regulation of a wide variety of functions
44 and disease states. Some of the most prominent include appetite regulation, peripheral energy
45 metabolism, obesity and associated metabolic abnormalities, pain and inflammation,
46 gastrointestinal motility and secretion, central nervous system disorders,
47 neurotoxicity/neuroinflammation/neuroprotection, and certain mental disorders, including
48 substance misuse.³²⁻³⁸

1 STATE MEDICAL CANNABIS LAWS

2
3 Thirteen states (Alaska, California, Colorado, Hawaii, Maine, Michigan, Montana, Nevada, New
4 Mexico, Oregon, Rhode Island, Vermont, and Washington) have enacted laws since 1996 which
5 remove state-level criminal penalties for qualifying patients (with physician recommendations or
6 certifications) for cultivation, possession, and use of cannabis.³⁹ Most of these measures were
7 adopted by ballot initiative, but some have been passed by state legislatures. Typically, these laws
8 identify a number of “qualifying conditions.” In California vagaries such as the presence of a
9 “debilitating condition” or “chronic ailment” or any *other illness for which marijuana provides*
10 *relief* are introduced. Most state laws provide a specific allowance for cannabis possession, and a
11 few require/maintain registries or offer certification cards which may assist patients if they are
12 confronted by police officers.

13
14 Two other state laws address medical marijuana to a lesser extent. Maryland’s law does not create
15 a medical marijuana program but protects patients from jail time for possession of marijuana if they
16 can prove in court that their use of marijuana was a medical necessity; the maximum penalty is a
17 \$100 fine. Arizona allows physicians to prescribe marijuana, but such a system is not in place
18 since federal law prohibits physicians from prescribing Schedule I substances. At least 13 other
19 states have pending legislation or ballot measures to legalize medical marijuana.⁴⁰

20
21 The number of patients who use cannabis in states that have removed state-level penalties and
22 permit medical use is not clearly established. According to one compilation, approximately 7,000
23 physicians have authorized the use of cannabis for at least 400,000 patients.⁴¹

24
25 FEDERAL POLICIES

26
27 *Controlled Substances Act*

28
29 As recreational drug use proliferated during the 1960s, legislative concern led to passage of the
30 Comprehensive Drug Abuse Prevention and Control Act of 1970 (commonly referred to as the
31 Controlled Substances Act). This Act classifies certain psychoactive drugs into 5 categories, or
32 schedules that impose varying restrictions on access to the drugs under direction of the DEA.

33
34 A drug is placed in Schedule I if (1) it has a high potential for abuse; (2) it has no currently
35 accepted medical use in treatment in the United States; and (3) there is a lack of accepted safety for
36 use of the drug under medical supervision. In contrast, Schedule II criteria are that the drug (1) has
37 a high potential for abuse; (2) has a currently accepted medical use in treatment in the United States
38 or a currently accepted medical use with severe restrictions; and (3) abuse of the drug may lead to
39 severe psychological or physical dependence.

40
41 Marijuana and tetrahydrocannabinols naturally contained in the cannabis plant (as well as synthetic
42 equivalents and derivatives with similar activity) are assigned by statute to Schedule I, along with
43 many other drugs such as heroin, lysergic acid diethylamide (LSD), mescaline and other
44 hallucinogenic amphetamine derivatives, methaqualone, and illicit fentanyl derivatives. Certain
45 other psychoactive botanical substances (e.g., peyote, psilocybin) also are in Schedule I. With
46 regard to the placement of marijuana in Schedule I, the following definition is applied:

47
48 The term "marihuana" means all parts of the plant *Cannabis sativa*, whether growing or not;
49 the seeds thereof; the resin extracted from any part of such plant; and every compound,
50 manufacture, salt, derivative, mixture, or preparation of such plant, its seeds or resin. Such term
51 does not include the mature stalks of such plant, fiber produced from such stalks, oil or cake

1 made from the seeds of such plant, any other compound, manufacture, salt, derivative,
 2 mixture, or preparation of such mature stalks (except the resin extracted there from), fiber, oil,
 3 or cake, or the sterilized seed of such plant which is incapable of germination (21 U.S.C. 802).
 4

5 Some botanical products that serve as raw materials (i.e., coca leaves; raw opium, opium poppy
 6 and poppy straw) for controlled substances are themselves placed in Schedule II. These raw
 7 materials are imported into the U.S. from other countries under international treaty and convention.
 8 FDA-approved pharmaceutical preparations containing THC are in Schedule III, whereas a
 9 synthetic analogue (nabilone) is in Schedule II. Schedule III criteria are that the drug (1) has less
 10 potential for abuse than drugs or other substances in schedules I and II; (2) has a currently accepted
 11 medical use in treatment in the United States; and (3) abuse of the drug or other substance may lead
 12 to moderate or low physical dependence or high psychological dependence.
 13

14 *Federal Court Cases Relevant to Medical Marijuana*

15
 16 Three prominent federal court cases evolved out of California’s 1996 passage of its medical
 17 marijuana ballot initiative (Proposition 215).
 18

19 Conant v. Walters (2002). After California passed its medical marijuana regulation in 1996, Barry
 20 R. McCaffrey, Director of the Office of National Drug Control Policy (ONDCP) issued a statement
 21 entitled “The Administration’s Response to the Passage of California Proposition 215 and Arizona
 22 Proposition 200.” This statement threatened physicians who recommended marijuana with the loss
 23 of their license to prescribe controlled substances and the ability to participate in Medicaid and
 24 Medicare. Physicians and patients filed a class action lawsuit, claiming a constitutional free-speech
 25 right, in the context of a doctor-patient relationship. In *Conant v. Walters* the United States Court
 26 of Appeals in a permanent injunction recognized that physicians have a constitutionally-protected
 27 right to discuss the use of marijuana as a treatment option with their patients and to make oral or
 28 written recommendations for medical marijuana (the AMA had already endorsed this view).⁴²
 29 However, the court cautioned that physicians could exceed the scope of this constitutional
 30 protection if they conspire with, or aid and abet, their patients in obtaining medical marijuana. The
 31 U.S. Supreme Court denied the appeal.
 32

33 USA v. Oakland Cannabis Buyer’s Cooperative (OCBC) and Jeffrey Jones (2001). A medical
 34 cannabis buyer’s cooperative was established in Oakland (Oakland Cannabis Buyer’s Cooperative).
 35 Its proprietor (Jeffrey Jones) distributed marijuana based on the theory that the cooperative could
 36 operate as each patient’s “caregiver” and use a medical necessity defense. The U.S. government
 37 disagreed and the Department of Justice filed a civil suit in January 1998 to close six medical
 38 marijuana distribution centers in northern California. Ultimately, the case went to the U.S.
 39 Supreme Court which ruled unanimously that a medical necessity exception for marijuana was at
 40 odds with the terms of the Controlled Substances Act (i.e., the CSA classified marijuana as lacking
 41 a recognized medical benefit).⁴³
 42

43 Gonzales v. Raich (2005). In response to DEA agents’ destruction of their cannabis plants, two
 44 patients and caregivers in California brought suit. They argued that applying the CSA to a situation
 45 in which cannabis was being grown and used locally for medicinal purposes (and not being sold)
 46 exceeded the federal government’s constitutional authority under the Commerce Clause, which
 47 allows federal regulation of interstate commerce. The U.S. Supreme Court eventually ruled that
 48 Congress’s power to regulate commerce “extends to purely local activities” that are “part of an
 49 economic class of activities that have a substantial effect on interstate commerce.”⁴⁴ While not
 50 invalidating state medical marijuana laws, this ruling preserved the ability of the DEA to enforce
 51 the CSA against medical marijuana patients and their caregivers.

1 Another relevant case is the *County of San Diego v. State of California* (2009) in which the U.S.
2 Supreme Court denied an appeal by the County of San Diego allowing a lower court's ruling to
3 stand which held that federal law does not preempt California's medical marijuana law. The
4 County had argued that it did not have to comply with the state-mandate to implement an
5 identification card program for patients based on federal preemption.

6
7 Accordingly, states can create medical marijuana laws protecting patients and caregivers from
8 prosecution under their own state-level controlled substance laws, but federal agents can still
9 investigate, arrest, and prosecute medical marijuana patients, caregivers, and physicians (if they
10 willfully aid and abet) in such states.

11 RESCHEDULING

12 *Efforts to Remove Marijuana from Schedule I*

13
14
15
16 Advocates of decriminalizing marijuana have attempted to have it removed from Schedule I ever
17 since its original placement. A petition was first filed in 1972 by the National Organization for the
18 Reform of Marijuana Laws (NORML) to the Bureau of Narcotics and Dangerous Drugs seeking to
19 reschedule marijuana to Schedule II. After this petition was denied and public hearings were not
20 conducted, NORML filed suit in 1974 against the Bureau and in 1975 against its successor, the
21 DEA. After further legal maneuvering, the petition was eventually sent back to the DEA for
22 consideration in 1980 by the U.S. Court of Appeals for the District of Columbia. Eventually,
23 public hearings were held over a 2-year period from 1986 to 1988, at which time the DEA
24 Administrator once again rejected the position of NORML (now joined by the Alliance for
25 Cannabis Therapeutics [ACT], the Drug Policy Foundation, and the Physicians Association for
26 AIDS Care, among others) despite recommendations to the contrary by the DEA administrative
27 law judge in the case which called for reclassification of marijuana to Schedule II. The latter
28 parties petitioned the District Court for review of this order; after once again remanding the case in
29 1991, the District Court denied the petition for review on February 18, 1994. Subsequent
30 rescheduling petitions also have been rejected.

31
32 Although the petition for review was denied, it led to a revised formulation by the DEA for
33 determining whether a drug has a "currently accepted medical use." The 5-part test for fulfilling the
34 accepted medical use criteria of Schedule II is now comprised of the following:

- 35
36
- 37 • the drug's chemistry must be known and reproducible;
 - 38 • there must be adequate safety studies;
 - 39 • there must be adequate and well-controlled studies proving efficacy;
 - 40 • the drug must be accepted by qualified experts; and
 - 41 • the scientific evidence must be widely available.

42 A drug must meet all 5 criteria to be considered for rescheduling by the DEA.

43
44 Even if marijuana were rescheduled under current law it could not be marketed or medically
45 available for general prescription use unless it was reviewed and approved by FDA under the
46 Federal Food, Drug, and Cosmetic Act (FFDCA) (see below). Conceivably, a physician may be
47 able to write a prescription for an individual patient with the cooperation of a compounding
48 pharmacist with a schedule II license. However, the FDA treats compounded products as "new
49 drugs" subject to all the requirements of the FFDCA if pharmacists attempt to compound large
50 quantities of medication.

1 Congress or the Executive branch (through regulatory procedures authorized by the CSA) could
2 reschedule marijuana. Over the last decade various federal amendments (e.g., Hinchey-
3 Rohrabacher) have been submitted that would prevent the Justice Department from using
4 appropriated funds to interfere with the implementation of medical cannabis laws, and bills have
5 been introduced that would reschedule marijuana and/or prevent provisions of the CSA and
6 FFDCA from restricting activities in states that have adopted medical marijuana programs. These
7 have all been defeated to date, but others are pending.

8
9 *“Executive Order”*

10
11 Resolution 229 (A-09) makes reference to a “Presidential/Executive” order. To the Council’s
12 knowledge no such order exists. As previously mentioned, in 1996, the Director of ONDCP issued
13 a statement that threatened physicians with loss of certain privileges. However, this was not an
14 Executive Order, but rather a compilation of strategies developed by several federal agencies. It
15 never had the force of an Executive Order, and is nonetheless moot because of the permanent
16 injunction issued against implementation of this strategy in *Conant v. Walters*.

17
18 During the 2008 Presidential campaign, then-Senator Obama pledged to avoid the use of federal
19 resources in cracking down on medical marijuana activities in states where medical marijuana laws
20 were in place. This view has since been reiterated by the Attorney General in press briefings,
21 although DEA raids on a medical marijuana dispensaries in California have occurred in the same
22 time frame. Resolution 229 (A-09) was prompted by pending medical marijuana legislation in the
23 state of New York, and perhaps a provision authored by Congressman Maurice Hinchey (D-NY)
24 that seeks to clarify the Obama administration’s medical marijuana enforcement policy. The
25 Hinchey provision was included in the report accompanying the Commerce, Justice, Science and
26 related Agencies appropriation bill for fiscal year 2010. The provision (referring to the Department
27 of Justice) reads:

28
29 “There have been conflicting public reports about the Department’s enforcement of medical
30 marijuana policies. Within 60 days of enactment, the Department shall provide to the
31 Committee clarification of the Department’s policy regarding enforcement of federal laws and
32 use of federal resources against individuals involved in medical marijuana activities.”

33
34 CONDUCTING CLINICAL RESEARCH ON SCHEDULE I VS SCHEDULE II COMPOUNDS

35
36 Researchers who propose to conduct investigations in humans on Schedule I drugs must obtain
37 FDA review of the protocol and fulfill the FDA’s Investigational New Drug (IND) requirements
38 for safety. They also must submit the protocol to the DEA as part of the process to obtain a valid
39 registration for a Schedule I substance. When DEA receives the Schedule I research application,
40 they forward it to another division within FDA for scientific review as part of their decision-
41 making process. Investigators conducting research with a Schedule I substance must submit a
42 protocol for each study involving each Schedule I substance to obtain approval to conduct that
43 research. If a new protocol for a research study, even with the same substance is devised, the DEA
44 registration must be amended by submitting the new protocol for review to the DEA. This is a
45 requirement under the CSA and is separate from the FFDCA requirements for submitting INDs for
46 human studies to the FDA, whereby FDA assesses whether the study design is safe.

47
48 Investigators seeking to do human research on Schedule II substances must still procure FDA
49 safety review of the protocol and apply for a Schedule II registration with the DEA. Once granted,
50 this Schedule II license is sufficient for all future studies on that substance.

1 The only legal federal source of marijuana is grown under the auspices of the National Institute on
2 Drug Abuse (NIDA), and prior to 1999 only NIH-funded studies on marijuana could qualify for
3 access to the NIDA supply. In May 1999, the Department of Health and Human Services
4 announced a new guidance on procedures for the provision of marijuana for medical purposes on a
5 cost-reimbursable basis.⁴⁵ For protocols submitted by non-NIH funded sources, institutional peer
6 review and IRB approval precede the submission, after which the scientific merits of each protocol
7 are evaluated through a Public Health Service interdisciplinary review process. This guidance
8 created an avenue for externally funded investigators to acquire marijuana for research purposes,
9 but retains additional review and approval steps that are not required of other traditional IND-
10 sponsors.

11
12 In an effort to promote research on medical cannabis, California's State Assembly appropriated \$3
13 million to establish a university-based Center for Medicinal Cannabis Research, to be administered
14 jointly by the University of California's San Diego and San Francisco campuses.⁴⁶ Subsequently,
15 many of the randomized controlled trials on smoked cannabis have been supported by this
16 program. The cannabis used in such studies is obtained from NIDA in accordance with the
17 procedures outlined above.

18 19 BOTANICALS AS DRUG PRODUCTS

20
21 Many drugs have been derived from plants, and the *National Formulary* and *U.S. Pharmacopoeia*
22 formerly contained numerous botanical agents. Interest in the use of such agents waned with
23 advances in the understanding of physiologic, biochemical, and cellular functioning.
24 Pharmaceutical development evolved with a focus on identifying specific cellular targets
25 (receptors) amenable to drug intervention, although plants may provide the starting material for
26 certain products. The 1994 passage of the Dietary Supplement and Health Education Act fostered
27 a return to the public's use of botanical products in the form of "dietary supplements." Such
28 products are regulated as foods, and are not subject to FDA approval for safety and efficacy. They
29 can use so called "structure and function" claims but cannot claim to be useful in the treatment of a
30 disease or condition. In order to make a disease-based claim, the product must go through the FDA
31 drug approval process.

32
33 In 2004, the FDA issued a *Guidance for Industry Botanical Drug Products* monograph.⁴⁷ This
34 document provides the pathway by which botanical agents can be approved as prescription drugs.
35 The crude botanical substance can become a "botanical drug substance" through processes of
36 extraction, blending, addition of excipients, formulation, and packaging in a defined manner.
37 Particular attention is devoted to product composition because botanicals are complex mixtures of
38 chemical/structural components. Similar to conventional products, a botanical drug substance must
39 undergo animal toxicity studies, and demonstrate its safety and efficacy in randomized, double-
40 blind, placebo-controlled trials. Additional pharmacologic and toxicologic studies are required if a
41 non-oral route (e.g., inhalation) of administration is contemplated. If the substance is intended to
42 treat chronic conditions, 6 to 12 months in long-term safety extension studies is considered
43 sufficient.

44
45 An example of a drug that is seeking FDA approval through this pathway is an extract prepared
46 from two different breeds of cannabis that have been genetically developed to produce either high
47 quantities of THC or cannabidiol. Chemovars of cannabis were selected via Mendelian genetics to
48 express one predominant phytocannabinoid. Cloned plants undergo extraction to produce botanical
49 drug substances that contain predominately THC or cannabidiol, or an approximate 1:1
50 combination of the two. The final product is a botanical extract (Nabiximols) comprising an
51 oromucosal spray that delivers 2.7 mg of THC and 2.5 mg of cannabidiol per spray. Patients self-

1 titrate their overall dose and pattern of dosing according to their response and tolerance of the
 2 medicine. This botanical drug substance is approved in Canada (Sativex®) for the symptomatic
 3 relief of neuropathic pain in patients with multiple sclerosis, and as an adjunctive analgesic to
 4 opioids in patients with advanced cancer pain.⁴⁸⁻⁵⁰ Nabiximols is progressing through the FDA
 5 pathway for botanical drug substance approval as a treatment for patients with advanced cancer
 6 whose pain has not been adequately relieved by optimized treatment with opioid medications.

7
 8 Other cannabinoid based botanical drug substances have been developed in other countries (e.g.,
 9 Cannador®), and several are in development in the U.S. with various modes of action (botanical
 10 extracts; CB receptor agonists or antagonists; inhibitors of endocannabinoid uptake or
 11 degradation). Cannador® is an extract delivered in an oral dosage form containing primarily 2.5
 12 mg THC and 1 mg cannabidiol. It has demonstrated benefit in randomized controlled trials
 13 involving patients with multiple sclerosis experiencing pain due to spasm, and in decreasing post-
 14 operative pain.^{51,52} The development of pharmaceutical grade cannabis-based extracts with proven
 15 medical benefits provides further evidence on the therapeutic potential of components of the
 16 cannabis plant.

17 18 SMOKED CANNABIS STUDIES

19
 20 Currently cannabinoids are “available” in three different categories:⁴¹ FDA approved oral
 21 preparations of THC (Dronabinol; Marinol®) and a synthetic analogue (Nabilone; Cesament®);
 22 *Cannabis sativa* extracts (e.g., Nabiximols [Sativex®], [Cannador®]) not currently approved in the
 23 U.S.; and crude botanical sources made available under state laws. Since 2001, systematic reviews
 24 have been conducted on smoked cannabis and other cannabinoids (mostly oral THC and botanical
 25 extracts).⁵³⁻⁵⁶ The following discussion focuses on randomized, placebo-controlled human trials
 26 that have evaluated smoked cannabis. Table 1 summarizes the characteristics and findings of such
 27 trials.

28 29 *Randomized Trials on Smoked Cannabis*

30
 31 Cancer chemotherapy. Three randomized, double-blind, controlled trials involving a total of 43
 32 patients have evaluated the efficacy of smoked cannabis to alleviate nausea and vomiting
 33 accompanying cancer chemotherapy; one directly compared smoked cannabis with oral THC but
 34 was never published in a peer reviewed journal.⁵⁷⁻⁵⁹ These trials revealed a modest antiemetic
 35 effect of smoked cannabis greater than placebo.

36
 37 Several research/treatment studies were conducted by state departments of health during the late
 38 1970s and early to mid-1980s under protocols approved by the FDA. These open label studies
 39 involved patients who had responded inadequately to other antiemetics. In such patients, smoked
 40 cannabis was reported to be comparable to or more effective than oral THC, and considerably more
 41 effective than prochlorperazine or other previous antiemetics in reducing nausea and emesis.
 42 Results of these studies generally were based on patients’ and/or physicians’ subjective ratings.
 43 These programs were noted in the 1997 Council report and another independent review that was
 44 published in 2001.⁵⁶ Smoked cannabis (as well as THC and other synthetic cannabinoids) is more
 45 effective than older antiemetic drugs (neuroleptics) and placebo.⁵³ All of these trials in cancer
 46 patients were conducted before the advent of 5-HT₃ and neurokinin-1 receptor antagonists.
 47 Smoked cannabis has been compared with the 5-HT₃ receptor antagonist ondansetron in an
 48 experimental emesis model. This randomized double-blind included 13 healthy volunteers who
 49 received syrup of ipecac.⁶⁰ Smoked cannabis significantly reduced ratings of queasiness and
 50 slightly reduced the vomiting induced by the syrup compared with placebo. Ondansetron
 51 completely eliminated episodes of vomiting.

1 Appetite stimulation. Three randomized, placebo-controlled trials involving a total of 97 HIV+
2 adult patients have compared the effects of smoked cannabis with oral THC or dronabinol; two
3 used a “within subjects” design. Generally, the effects of smoked cannabis (2% or 3.9% THC)
4 were comparable to oral cannabinoids in increasing caloric intake and triggering weight gain,
5 although the dose of oral THC was substantially higher than normally recommended.⁶¹⁻⁶³ HIV viral
6 load and the pharmacokinetics of concurrent protease inhibitors were unaffected over a three week
7 period.⁶¹

8
9 Pain Management. Two randomized, double-blind, placebo-controlled trials involving a total of
10 89 patients with HIV-associated peripheral neuropathy, and one (n = 38) involving an experimental
11 pain model (capsaicin) have been reported.^{64,65} The latter was a randomized, double-blind,
12 placebo-controlled crossover trial in 15 healthy volunteers examining the effects of cannabis
13 cigarettes (2%, 4%, or 8%) on pain and cutaneous hyperalgesia induced by intradermal capsaicin.⁶⁵
14 The medium dose exhibited delayed analgesia, significantly inhibiting capsaicin-induced pain at 45
15 minutes after drug exposure; the low dose was ineffective, and the high dose increased capsaicin-
16 induced pain at 45 minutes. Smoked cannabis did not significantly affect acute painful heat, cold,
17 and mechanical thresholds.⁶⁴

18
19 In patients with HIV-associated neuropathic pain, cannabis cigarettes of varying concentration and
20 number consumed over a 5-day period significantly reduced pain intensity. Approximately half of
21 patients experienced more than a 30% reduction, which is a standard benchmark for efficacy.
22 Analysis of the number-needed-to-treat also compared favorably with historic values associated
23 with other drugs used to treat neuropathic pain.^{66,67}

24
25 Generally, side effects typically attributable to THC (anxiety, sedation, confusion, dizziness,
26 fatigue, tachycardia, dry mouth) were noticeable in these studies but were tolerable and not
27 considered dose-limiting. The use of higher potency cigarettes was more likely to be associated
28 with drug-related cognitive decline on psychological testing.

29
30 The overall evaluation of the clinical effects of smoked cannabis in stimulating appetite and
31 relieving neuropathic pain (and to a certain degree, nausea) correlates with patterns of use reported
32 in surveys of HIV+ patients. In this population, cannabis use also has been associated with
33 adherence to antiretroviral therapy in patients who experience nausea, and for the self management
34 of HIV-associated peripheral neuropathy.^{68,69} In one consecutive series, 23% of HIV+ patients
35 reported smoking cannabis in the prior 30 days to improve appetite or relieve pain, but also to
36 relieve anxiety or depression or “increase pleasure” which are characteristics of substance misuse
37 or recreational use.⁷⁰ Another survey found a similar percentage of HIV-positive patients (27%)
38 used cannabis to improve appetite, relieve nausea and pain, and for anxiety and depression. Nearly
39 half of these users reported memory deterioration.⁷¹

40
41 Multiple Sclerosis and Spasticity. Surveys reveal that 36% to 68% of patients with multiple
42 sclerosis have experimented with smoked cannabis for symptom relief, and approximately 15% are
43 continuing users.^{72,73} Two randomized, double-blind, placebo-controlled trials involving a total of
44 40 patients have been reported in patients with multiple sclerosis and spasticity.^{74,75} In a pilot study
45 involving 10 patients who smoked one cannabis cigarette of low potency (1.54% THC) some
46 patients reported subjective improvements, but exhibited impairment of posture and balance.⁷⁴
47 When higher potency cannabis cigarettes were used for three days, reduced scores for pain (50%)
48 and spasticity (30%) were observed, along with some cognitive impairment, dizziness, and fatigue;
49 the majority of these patients had prior experience smoking cannabis.⁷⁵

1 Glaucoma. In one randomized, double-blind, placebo-controlled crossover study of 18 adults with
 2 glaucoma, smoking one cannabis cigarette (2% THC) caused a significant reduction in intraocular
 3 pressure, along with alterations in sensory perception, tachycardia/palpitations, and postural
 4 hypotension.⁷⁶

5
 6 **ADVERSE EFFECTS OF SMOKED CANNABIS**

7
 8 Determining the adverse effects of smoked cannabis used as medicine is problematic since only
 9 short-term controlled trials have been conducted. Most research on the harmful consequences of
 10 cannabis use has been conducted in simulated laboratory environments and in individuals who use
 11 cannabis for nonmedical purposes. One independent health assessment of four of the remaining
 12 seven patients obtaining cannabis cigarettes through the federal government’s Compassionate Use
 13 Treatment IND (see Council report from 1997),¹ showed no demonstrable adverse outcomes
 14 related to their chronic medicinal cannabis use. Some of cannabis’ adverse effects differ in
 15 experienced versus inexperienced users, and it is not clear to what extent the adverse effects
 16 reported in recreational users are applicable to those who use cannabis for the self-management of
 17 disease or symptoms. Most data on adverse effects has come from observational population-based
 18 cohort studies of recreational cannabis users, an unknown portion of whom may be using the
 19 substance for medicinal purposes. Adverse reactions observed in short-term randomized, placebo-
 20 controlled trials of smoked cannabis to date are mostly mild without substantial impairment. A
 21 systematic review of the safety studies on medical cannabinoids published over the last 40 years
 22 (not including studies on smoked cannabis) found that short term use was associated with a number
 23 of adverse events, but less than 4% were considered serious.⁷⁷

24
 25 *Nonmedical Use*

26
 27 Nonmedical use of marijuana continues to be problematic in society. Approximately one third of
 28 all Americans over 12 years of age have tried marijuana, usually experimenting first during
 29 adolescence.⁴ According to the most recent NSDUH Survey, marijuana continues to be the most
 30 commonly used illicit drug (14.4 million past month users).⁷⁸ Among persons aged 12 or older, the
 31 rate of past month marijuana use in 2007 (5.8 percent) was similar to the rate in 2006 (6.0 percent).
 32 The prevalence of past month marijuana use among adolescents (i.e., youths aged 12 to 17)
 33 generally decreased from 2002 (8.2 percent) to 2005 (6.8 percent), and then remained constant
 34 between 2005 and 2007. Adolescents who perceived great risk from smoking marijuana once a
 35 month were much less likely to have used marijuana in the past month than those who perceived
 36 moderate to no risk (1.4 vs. 9.5 percent). The specific illicit drugs that had the highest levels of
 37 past year dependence or abuse in 2007 were marijuana (3.9 million), followed by pain relievers
 38 (1.7 million) and cocaine (1.6 million). It is not clear how any of these trends have been influenced
 39 by the medical cannabis debate.

40
 41 Acutely, smoked cannabis increases heart rate, and blood pressure may decrease on standing.
 42 Cannabis intoxication is associated with impairment of short-term memory, attention, motor skills,
 43 reaction time, and the organization and integration of complex information.¹ Although dependent
 44 on the setting, smoked cannabis can cause relaxation and enhance mood. However, some
 45 individuals experience acute anxiety or panic reactions, confusion, dysphoria, paranoia, and
 46 psychotic symptoms (e.g., delusions, hallucinations).¹

1 *Substance Dependence*

2

3 Chronic cannabis use is associated with development of tolerance to some effects and the
4 appearance of withdrawal symptoms (restlessness, irritability, mild agitation, insomnia, sleep
5 disturbances, nausea, cramping) with the onset of abstinence. Depending on the measures and age
6 group studied, 4% to 9% of cannabis users fulfill diagnostic criteria for substance dependence.
7 Although some cannabis users develop dependence, they are considerably less likely to do so than
8 users of alcohol and nicotine, and withdrawal symptoms are less severe.^{4,79,80} Like other drugs,
9 dependence is more likely to occur in individuals with co-morbid psychiatric conditions.

10

11 Whether or not cannabis is a “gateway” drug to other substance misuse is controversial and
12 whether the medical availability of cannabis would increase drug abuse is not known. Analysis of
13 trends in emergency room visits for marijuana do not support the view that state authorization for
14 medical cannabis use leads to increased signals of substance misuse.⁸¹ The IOM concluded that
15 marijuana use is not the cause or even the most serious predictor of serious substance use
16 disorders.⁴ A systematic review of longitudinal studies on the use of cannabis concluded its use
17 was consistently associated with reduced educational achievement and the use of other drugs, but
18 not other measures of psychosocial harm.⁸²

19

20 *Cognitive Deficits and Mental Health*

21

22 Other concerns about long-term cannabis use include cognitive effects, and its intersection with
23 mental disorders. Acute intoxication with cannabis causes marked changes in subjective mental
24 status, brain functioning, and neuropsychological performance. A meta-analysis conducted in 2003
25 found evidence of subtle impairments in the ability to learn and remember new information in
26 chronic cannabis smokers, but no general persistent neuropsychological deficits.⁸³
27 Neuropsychological deficits and differences in brain functioning are most consistently observed
28 among frequent, heavy users.⁸⁴

29

30 A recent systematic review on cannabis use and the risk of psychotic or affective mental health
31 outcomes renewed the debate about the potential role of smoked cannabis as a cause or sequelae of
32 mental disorders.⁸⁵ Whether cannabis use contributes to mental disorders, is used for self-
33 management of mental disorders, or the mental disorder itself leads to cannabis use is not clear.
34 The recent discontinuation of clinical trials on a CB1 receptor antagonist because of suicidal
35 ideation indicates some involvement of endocannabinoids in the regulation of mood.

36

37 *Respiratory Illness and Cancer*

38

39 Like tobacco, chronic cannabis smoking is associated with markers of lung damage and increased
40 symptoms of chronic bronchitis.⁸⁶⁻⁸⁸ However, results of a population-based case control study of
41 cannabis smokers found no evidence of increased risk for lung cancer or other cancers affecting the
42 oral cavity and airway.⁸⁹ Another population-based case-control study of marijuana use and head
43 and neck squamous cell carcinoma (HNSCC) concluded that moderate marijuana use is associated
44 with reduced risk of HNSCC.⁹⁰ Furthermore, although smoking cannabis and tobacco may
45 synergistically increase the risk of respiratory symptoms and COPD, smoking only cannabis is not
46 associated with an increased risk of developing COPD.⁹¹ One recent study suggests that use of
47 smoked cannabis is associated with an increased risk for testicular cancers.⁹²

48

49 The use of a vaporizing device may mitigate some of these symptoms. Cannabis vaporization is a
50 technique aimed at suppressing the formation of irritating respiratory toxins by heating cannabis to
51 a temperature where active cannabinoids are volatilized, but below the point of combustion where

1 smoke and associated toxins form. The use of a vaporizer is associated with higher plasma THC
2 concentrations than smoking marijuana cigarettes, little if any carbon monoxide production, and
3 significantly fewer triggered respiratory symptoms.^{93,94}

4
5 *Immunosuppression*

6
7 Cannabinoids exert immunosuppressive and anti-inflammatory effects.⁹⁵⁻⁹⁷ Plant-derived and
8 synthetic cannabinoids exert antiproliferative effects on a wide spectrum of human tumor cell lines
9 in culture, although mitogenic responses also have been observed.^{98,99} Apoptosis, inhibition of
10 proliferation, suppression of cytokine and chemokine product and induction of T regulatory cells
11 have been identified. CB2 receptors are associated with activated microglia in the CNS.¹⁰⁰
12 Clearly endocannabinoids are immune modulators, but how they regulate various elements of the
13 human immune response is unclear, and how exogenous cannabinoids may interact with these
14 processes also is not established. Short-term use of smoked cannabis did not affect viral load in
15 HIV-positive patients and also is associated with adherence to therapy and reduced viral loads in
16 patients with hepatitis C infections.^{61,101}

17
18 **SUMMARY AND CONCLUSION**

19
20 Despite more than 30 years of clinical research, only a small number of randomized, controlled
21 trials have been conducted on smoked cannabis. These trials were short term and involved a total
22 of ~300 patients. Results of these trials indicate smoked cannabis reduces neuropathic pain,
23 improves appetite and caloric intake especially in patients with reduced muscle mass, and may
24 relieve spasticity and pain in patients with multiple sclerosis. Substantially better alternatives than
25 smoked cannabis are available to treat patients with glaucoma or chemotherapy-induced nausea
26 and vomiting. Smoked cannabis has not been subject to any sort of rigorous study in any other
27 indication. Results obtained from oral cannabinoid products (including botanical extracts) are not
28 directly applicable to smoked cannabis for a number of reasons including substantial differences in
29 constituents, pharmacokinetics of active ingredients, and active metabolite patterns. However,
30 development of botanical extracts as prescription medications lends further credence to the
31 therapeutic potential of components of the cannabis plant.

32
33 There is a contrast between the relatively small number of patients who have been studied over the
34 past 30 years in controlled clinical trials involving smoked cannabis and survey data from patients
35 with chronic pain, multiple sclerosis, and amyotrophic lateral sclerosis that indicates a significant
36 use of cannabis for self management. Additionally, surveys of patients with HIV or hepatitis C
37 infection suggest that smoked cannabis is used to relieve a constellation of symptoms (pain,
38 nausea, appetite suppression, sleep disorders) and as a source of palliation from antiviral
39 medication side effects.

40
41 Marijuana is the most common illicit drug used by the nation's youth and young adults. However,
42 the fact that cannabis is prone to nonmedical use does not obviate its potential for medical product
43 development. Many legal pharmaceutical products that are used for pain relief, palliation, and
44 sleep induction have more serious acute toxicities than marijuana, including death. Witness the
45 evolving series of steps that the FDA has taken in recent months to address the inappropriate use
46 and diversion of certain long-acting Schedule II opioid drugs. However, the patchwork of state-
47 based systems that have been established for "medical marijuana" is woefully inadequate in
48 establishing even rudimentary safeguards that normally would be applied to the appropriate clinical
49 use of psychoactive substances. Recent documentaries have noted the ease with which individuals
50 can "qualify" for access to cannabis products in certain parts of California.

1 The AMA supports the concept of drug approval by scientific and regulatory review to establish
2 safety and efficacy, combined with appropriate standards for identity, strength, quality, purity,
3 packaging, and labeling, rather than by ballot initiative or state legislative action. The future of
4 cannabinoid-based medicine lies in the rapidly evolving field of botanical drug substance
5 development, as well as the design of molecules that target various aspects of the endocannabinoid
6 system. To the extent that rescheduling marijuana out of Schedule I will benefit this effort, such a
7 move can be supported. In the meantime, physicians who comply with their ethical obligations to
8 “first do no harm” and to “relieve pain and suffering” should be protected in their endeavors,
9 including advising and counseling their patients on the use of cannabis for therapeutic purposes.

10
11 **RECOMMENDATION**

12
13 The Council on Science and Public Health recommends that the following statement be adopted in
14 lieu of Resolutions 910 (I-08), 921 (I-08), and 229 (A-09) and the remainder of the report be filed.

15
16 Our American Medical Association (AMA) urges that marijuana’s status as a federal Schedule
17 I controlled substance be reviewed with the goal of facilitating the conduct of clinical research
18 and development of cannabinoid-based medicines. This should not be viewed as an
19 endorsement of state-based medical cannabis programs, the legalization of marijuana, or that
20 scientific evidence on the therapeutic use of cannabis meets the current standards for a
21 prescription drug product. (New HOD Policy)

Fiscal Note: Less than \$500

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APPENDIX A

AMA Policy On Medical Marijuana

H-95.952 Medical Marijuana

(1) Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease. (2) Our AMA recommends that marijuana be retained in Schedule I of the Controlled Substances Act pending the outcome of such studies. (3) Our AMA urges the National Institutes of Health (NIH) to implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research into the medical utility of marijuana. This effort should include: a) disseminating specific information for researchers on the development of safeguards for marijuana clinical research protocols and the development of a model informed consent on marijuana for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of marijuana for clinical research purposes; c) confirming that marijuana of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the Drug Enforcement Agency who are conducting bona fide clinical research studies that receive Food and Drug Administration approval, regardless of whether or not the NIH is the primary source of grant support. (4) Our AMA believes that the NIH should use its resources and influence to support the development of a smoke-free inhaled delivery system for marijuana or delta-9-tetrahydrocannabinol (THC) to reduce the health hazards associated with the combustion and inhalation of marijuana. (5) Our AMA believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions. (CSA Rep. 10, I-97; Modified: CSA Rep. 6, A-01)

APPENDIX B

Institute of Medicine

Marijuana and Medicine: Assessing the Science Base

RECOMMENDATION 1: Research should continue into the physiological effects of synthetic and plant-derived cannabinoids and the natural function of cannabinoids found in the body. Because different cannabinoids appear to have different effects, cannabinoids research should include, but not be restricted to, effects attributable to THC alone.

Scientific data indicate the potential therapeutic value of cannabinoid drugs for pain relief, control of nausea and vomiting, and appetite stimulation. This value would be enhanced by a rapid onset of drug effect. (See Recommendation #2)

RECOMMENDATION 2: Clinical trials of cannabinoid drugs for symptom management should be conducted with the goal of developing rapid-onset, reliable, and safe delivery systems.

RECOMMENDATION 3: Psychological effects of cannabinoids such as anxiety reduction and sedation, which can influence medical benefits, should be evaluated in clinical trials.

The psychological effects of cannabinoids are probably important determinants of their potential therapeutic value. They can influence symptoms indirectly which could create false impressions of the drug effect or be beneficial as a form of adjunctive therapy.

RECOMMENDATION 4: Studies to define the individual health risks of smoking marijuana should be conducted, particularly among populations in which marijuana use is prevalent.

Numerous studies suggest that marijuana smoke is an important risk factor in the development of respiratory diseases, but the data that could conclusively establish or refute this suspected link have not been collected.

RECOMMENDATION 5: Clinical trials of marijuana use for medical purposes should be conducted under the following limited circumstances: trials should involve only short-term marijuana use (less than six months), should be conducted in patients with conditions for which there is reasonable expectation of efficacy, should be approved by institutional review boards, and should collect data about efficacy.

Because marijuana is a crude THC delivery system that also delivers harmful substances, smoked marijuana should generally not be recommended for medical use. Nonetheless, marijuana is widely used by certain patient groups, which raises both safety and efficacy issues. If there is any future for marijuana as a medicine, it lies in its isolated components, the cannabinoids and their synthetic derivatives. Isolated cannabinoids will provide more reliable effects than crude plant mixtures. Therefore, the purpose of clinical trials of smoked marijuana would not be to develop marijuana as a licensed drug but rather to serve as a first step toward the development of nonsmoked rapid-onset cannabinoid delivery systems.

RECOMMENDATION 6: Short-term use of smoked marijuana (less than six months) for patients with debilitating symptoms (such as intractable pain or vomiting) must meet the following conditions:

- failure of all approved medications to provide relief has been documented,
- the symptoms can reasonably be expected to be relieved by rapid-onset cannabinoid drugs,
- such treatment is administered under medical supervision in a manner that allows for assessment of treatment effectiveness, and
- involves an oversight strategy comparable to an institutional review board process that could provide guidance within 24 hours of a submission by a physician to provide marijuana to a patient for a specified use.

Appendix C

American College of Physicians Position Statement

Position 1: ACP supports programs and funding for rigorous scientific evaluation of the potential therapeutic benefits of medical marijuana and the publication of such findings.

- Position 1a: ACP supports increased research for conditions where the efficacy of marijuana has been established to determine optimal dosage and route of delivery.
- Position 1b: Medical marijuana research should not only focus on determining drug efficacy and safety but also on determining efficacy in comparison with other available treatments.

Position 2: ACP encourages the use of nonsmoked forms of THC that have proven therapeutic value.

Position 3: ACP supports the current process for obtaining federal research-grade cannabis.

Position 4: ACP urges an evidence-based review of marijuana's status as a Schedule I controlled substance to determine whether it should be reclassified to a different schedule. This review should consider the scientific findings regarding marijuana's safety and efficacy in some clinical conditions as well as evidence on the health risks associated with marijuana consumption, particularly in its crude smoked form.

Position 5: ACP strongly supports exemption from federal criminal prosecution; civil liability; or professional sanctioning, such as loss of licensure or credentialing, for physicians who prescribe or dispense medical marijuana in accordance with state law. Similarly, ACP strongly urges protection from criminal or civil penalties for patients who use medical marijuana as permitted under state laws.

Table 1. Randomized, Placebo-Controlled Trials of Smoked Cannabis					
Study	n	Design	Product and dosage	Efficacy	Adverse Effects
<i>Antiemetic effects in patients receiving cancer chemotherapy</i>					
Chang et al ⁵⁷	15 patients with osteogenic sarcoma undergoing high dose methotrexate chemotherapy (median age 24 years)	R, DB, CR, PC	Oral THC 10 mg/m ² 5 times daily or smoked cannabis (1.93% THC) cigarette substituted if vomiting occurred	Oral THC alone or the combination of oral and smoked cannabis had an antiemetic effect > placebo. THC reduced the number of retching and vomiting episodes, the degree and duration of nausea, and the volume of emesis. Clinical responses appeared to correlate with plasma THC values. Smoked THC yielded plasma concentrations more than 5 ng/mL on 70% of occasions compared with 44% of the time with oral THC.	Sedation in 80% of patients, most of whom had prior experience with smoked cannabis
Chang et al ⁵⁸	8 patients with various tumors undergoing adjuvant therapy with doxorubicin and cyclophosphamide (median age 41 years)	R, DB, CR, PC	Oral THC 10 mg/m ² 5 times daily or smoked cannabis (1.93% THC) cigarette substituted if vomiting occurred	No antiemetic effect. Seven of eight patients inexperienced in the use of cannabis.	Mood alteration and episodes of tachycardia
Levitt et al ⁵⁹	20 patients with various tumors	R, DB, CR, PC	One cannabis cigarette + placebo oral THC x 4; oral THC 15 mg + placebo cannabis cigarette x 4	Treatments were effective in only in 25% of patients; 35% preferred oral THC; 20% preferred smoked cannabis; 45% had no preference.	Seven individuals exhibited distortions of time perception or hallucinations; four that had received THC; two with cannabis, and one with both
<i>Appetite stimulation</i>					
Abrams et al ⁶¹	67 adults with HIV infection	R, DB for oral THC or P, PL	One to three cannabis cigarettes/day (3.95% THC) or oral THC 2.5 mg tid for 21 days	Smoked cannabis and oral THC equivalent on weight gain and superior to placebo; viral load and pharmacokinetics of protease inhibitors unaffected	Generally well tolerated; one cannabis recipient discontinued due to emergence of neuropsychiatric symptoms; two oral THC recipients dropped out due to side effects (paranoia; headache)

Haney et al ⁶²	30 HIV+ experienced cannabis smokers, half with less than 90% ideal body mass	R, DB, PC	Dronabinol zero to 30 mg or cannabis cigarettes zero to 3.9% THC), administered in eight 7 hour sessions over three to four weeks	Cannabis and dronabinol significantly increased caloric intake in the low body mass group	Few adverse effects reports, except intolerance of high (30 mg) dronabinol dose
Haney et al ⁶³	10 HIV+ experienced cannabis smokers	R, DB, PC	Dronabinol 5 or 10 mg, or cannabis cigarettes 2% or 3.9% THC each four times daily for four days	Cannabis and dronabinol increased calorie intake in a dose dependent fashion, and body weight at the highest doses	Relative absence of cognitive impairment. Improved mood and objective and subjective sleep measures.
<i>Pain Management/Analgesia</i>					
Abrams et al ⁶⁶	55 patients with HIV-associated neuropathic pain	R, DB, PC, PL	Up to three cannabis (3.95% THC) cigarettes daily for 5 days	Smoked cannabis relieved chronic neuropathic pain (34% reduction), and more than 50% of patients experienced at least a 30% reduction in pain intensity. Smoked cannabis also reduced experimentally induced hyperalgesia	All patients had prior cannabis smoking experience. Anxiety, sedation, disorientation, confusion, and dizziness occurred more often in cannabis recipients, but were rated as between “none” and mild.
Ellis et al ⁶⁷	34 adult patients with HIV-associated neuropathic pain	R, DB, CR, PC	Cannabis cigarettes of varying THC concentration (1-8%) administered 4 times daily for 5 days	46% more patients achieved at least a 30% reduction in pain relief with cannabis vs placebo	All patients were taking additional analgesics. Concentration difficulties, fatigue, sedation, dry mouth, tachycardia more frequent but not dose limiting. Two dropouts for “psychosis” and “cough”
Wilsey et al ⁶⁴	38 adult patients experienced cannabis smokers with central and peripheral neuropathic pain	R, DB, CR, PC	Cannabis cigarettes zero, 3.5% or 7% THC administered in graded puffs over 2 hours	Smoked cannabis reduced pain intensity at 4 hours compared with placebo; no difference was noted between the 2 doses. No effects observed on evoked pain responses. Most patients had complex regional pain syndrome.	Cannabis recipients were more likely to report subjective and psychoactive drug effects including impairment and sedation. General cognitive decline on psychological testing.

<i>Multiple sclerosis</i>					
Greenberg et al ⁷⁵	10 adult patients with multiple sclerosis and spasticity	R, DB, PC	One cannabis cigarette (1.54% THC) smoked over 10 minutes	Subjective feeling of clinical improvement in some patients	Impairment of posture and balance as measured by dynamic posturography
Cory-Bloom et al ⁷⁴	30 adult patients with multiple sclerosis and spasticity	R, DB, CR, PC	One cannabis cigarette (3.95%) daily for 3 days	Reduced pain (~50%) and spasticity (~30%) scores.	Cognitive impairment; dizziness; fatigue, "too high." 80% had prior cannabis use
<i>Glaucoma</i>					
Merritt et al ⁷⁶	18 adults with glaucoma (ages 28-71)	R, DB, CR, PC	One cannabis cigarette containing 2% THC	Significant reduction in intraocular pressure	Alteration in sensory perception (100%); tachycardia and palpitations (44%), postural hypotension (28%)

R = randomized; DB = double-blind; CR = crossover trials, PL = parallel group study; PC = placebo-controlled