MARIJUANA - JUST WHAT THE DOCTOR ORDERED? A Review of the Medico-Legal and Political Debate in the United States of America on Medicinal Use of Marijuana and Implications for Australia

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I. INTRODUCTION

Two recent referendums in California and Arizona resulted in votes for the legalisation of marijuana use for medicinal purposes. This has focussed the long running 'drug war' debate in the United States of America onto the area of medicinal uses for marijuana. The decisions have been welcomed by members of the medical and legal professions as well as advocates for the legalisation of marijuana. There is now a legal sanction for marijuana use in the treatment of various diseases and illness where the drug is believed to be effective as a medicine.

The results have garnered responses from all sides of the political spectrum in America and raise a number of medico-legal issues, including the application of medicinal marijuana laws and the difficulties inherent in prescribing an illegal drug. These issues will need to be addressed not only by state and federal governments and the medical and legal professions, but by the broader community as well.

This article reviews the history of marijuana use and the 'prohibitionist' policies both in America and Australia which have influenced the medical use debate. Various claims about the medicinal effects of marijuana will be considered in addition to a review of the latest scientific research and government sponsored reports.

The article will also examine the referendum results and their possible impact on federal policy and legislation in America, which continue to criminalise marijuana use and possession. The common law defence of medical necessity,

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used with varying degrees of success in marijuana offences, and the regulatory frameworks governing marijuana use at the federal level, are reviewed. Although the article focuses on the 'medical uses of marijuana', such a discussion cannot be divorced from the broader 'legalisation of marijuana' issue, which is also briefly considered.

The resulting conflict which has developed between State and Federal laws in America is examined along with a consideration of the ethical and legal dilemmas facing both doctors, in prescribing marijuana, and patients, who use marijuana as a medicine.

The article concludes with a consideration of the implications of this debate for Australia, including a review of Australia's international drug treaty obligations and recent law reform recommendations as they pertain to drug reform and the medicinal marijuana debate.

II. THE HISTORY OF MEDICAL MARIJUANA USE

The cannabis plant, commonly known as marijuana, is one of the oldest psychoactive substances known to humankind and was cultivated as early as 4000 BC in China.[1] It has been widely used over 5000 years for medicinal purposes in India, China, the Middle East, Africa, South America and South East Asia.[2] William O'Shaughnessy, an Irish physician, first introduced cannabis to Western medicine after practicing in India where he used the drug to treat pain, muscle spasms and convulsions in patients suffering from tetanus, rabies and epilepsy.[3] European and American medical journals published more than 100 articles on the therapeutic uses of cannabis between 1840 and 1900[4] during which time it became used as a common medicine in the West. By 1930, there were 28 medicinal cannabis preparations for sale on the pharmaceutical market, manufactured by such companies as Parke-Davis, Squibb and Lilly.[5]

The active constituents of cannabis were not isolated until the second half of the twentieth century. Before then, it had mainly been used in its natural crude preparation which often resulted in varying grades of purity and effectiveness in treating various symptoms and disease.[6] Consequently, variable drug potencies, erratic individual responses to marijuana and the difficulty doctors encountered

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1 L Grinspoon (MD) and J Bakalar *Marijuana - the Forbidden Medicine*, York University Press (1993) p 3.

2 *Ibid*

3 GG Nahas, "The Medical Use of Cannabis" in GG Nahas (ed.) *Marijuana in Science and Medicine*, Raven Press (1984) 247

4 L Grinspoon (MD), "Marihuana as Medicine" (1995) 273 *Journal of the American Medical Association* at 1875. It was also recommended as an appetite stimulant, muscle relaxant, analgesic, hypnotic, anticonvulsant and for the treatment of migraines.

5 S Sussman, A Stacy, C Dent, T Simon and CA Johnson, "Marijuana Use. Current Issues and New Research Directions" (1996) 26 *Journal of Drug Issues* 695 at 697

6 National Drug Strategy, "The Health and Psychological Consequences of Cannabis Use", Monograph Series No 25, W Hall, N Solowij, J Lemon, National Drug and Alcohol Research Centre, Australian Government Publishing Service (1994) at 185

in reproducing accurate clinical results meant that marijuana never became widely accepted as a medicine and its use started to decline.[7] By the 1930s, cannabis was overtaken by drugs with known potencies and reliably measured results such as aspirin, barbiturates, opiates (pethidine) and anaesthetics (chloral hydrate).[8]

Marijuana first became available to the general population in America following the Mexican Revolution in 1910. A wave of immigrants fled Mexico, bringing marijuana plants and the smoking culture with them, and it was soon to be used recreationally in New Orleans.[9] In 1915, as a response to the growing fear by the general public that marijuana would corrupt the social fabric, California prohibited marijuana possession without a doctor's prescription. By 1936, 18 states had enacted similar legislation.[10]

In 1937, the *Marihuana Tax Act* was passed by the Federal Government, restricting the possession of marijuana to authorised medical and industrial users.[11] Users of the hemp plant for industrial and medical purposes were required to register and pay US$1 an ounce, with large fines or even prison terms for failing to comply. Even though the *Act* was initially designed to prevent non-medical use, the passing of one act made it almost impossible to obtain marijuana for medical purposes.[12] The introduction of the Act was the start of the general move to discourage all uses of cannabis, even medical, and was followed by other laws which defined cannabis as a narcotic, thereby further restricting its general availability in America. Cannabis was eventually removed from the American pharmacopoeia in 1941 (although it continued to be used in Australia until the 1960s).[13]

Following World War Two, State penalties in America progressively increased but it is interesting to note that from the mid 1960s, marijuana use became a general pastime of "middle class youth".[14] The number of people who had tried marijuana rose from one million in 1965 to 24 million in 1972, with some eight million people regularly using the drug recreationally.[15]

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7 Note 1 *supra*, pp 7-8

8 Note 3 *supra* at 247 The newer drugs were also more widely available.

9 JB Slaughter, "Marijuana Prohibition in the United States: History and Analysis of a Failed Policy" (1988) 21 *Columbia Journal of the Law and Social Problems* 417 at 419

10 *Ibid.* The article cites R Bonnie and C Whitebread, *The Marijuana Conviction A History of Marijuana Prohibition in the United States* (1974) pp 14, 32-40. In that period, marijuana was identified with minorities such as Mexicans, blacks and jazz musicians Lurid tales of criminals using the drug became part of popular mythology, the implication being that the response against marijuana was rooted in racism.

11 *Ibid*, citing D Musto, *The American Disease* (1973) pp 225-9 Note that marijuana is also sometimes spelt 'marihuana' in America.

12 Note 1 *supra*, p 8 The law was aimed at discouraging recreational use, but it made medical use difficult because of the extensive paperwork required to be completed by doctors in order to use it

13 Note 6 *supra* at 185

14 Note 9 *supra* at 420, citing Mandel and Feldman, *The Social History of Teenage Drug Use in Teen Drug Use* (1986) pp 26-7. See also note 1 *supra*, p 123

15 *Ibid*, citing the National Commission on Marijuana and Drug Abuse (the Schafer Commission), *Marijuana: A Signal of Misunderstanding*, Signet New American Library (1972) pp 6-7. The number of arrests for marijuana offences by State and Federal law enforcement agencies rose from 20 000 in 1965 to 421 000 in 1973, mainly for possession. Congress responded to this rapid increase in marijuana

The initial use of marijuana as a medicine was based on empirical and anecdotal evidence from patients. Nevertheless, there have been attempts to scientifically prove its clinical efficacy and a number of government sponsored studies have been undertaken to investigate cannabis and its use.

Some of the major reports which have commented on medicinal marijuana use, albeit cursorily, include:

- the British East Indian Hemp Commission study (1893) which said that a ban on hemp drugs would likely do "more harm than good";[16]
- Mayor La Guardia's Committee Report, New York (1944) which found no direct relation between marijuana use and violent crimes, addiction or mental or physical deterioration;[17]
- the Wootton Report of the UK Advisory Committee on Drug Dependence (1968) which found that marijuana was much less dangerous than opiates, amphetamines and alcohol such that any legislation should deal specifically and separately with marijuana use;[18]
- the Le Dain Report, Canada (1972) which advised the repeal of prohibition against the simple possession of cannabis;[19] and
- the Schafer Report by the US National Commission on Drug Abuse - First Report (1972) which found little proven danger of physical or psychological harm from experimental or intermittent use of marijuana.[20]

Major Australian studies include the Senate Select Committee on Drug Trafficking and Drug Abuse in Australia (1971), the South Australian Royal Commission discussion paper on the social control of drug use (the 'Sackville' Inquiry 1979), the Australian Royal Commission of Inquiry into Drugs (1980) and the Select Committee on HIV, Illegal Drugs and Prostitution - Third Interim Report, ACT (1991).[21] These have not examined the medicinal uses of

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use and other illicit drugs by passing the *Comprehensive Drug Abuse and Control Act* 1970, which lowered the fines for marijuana possession to a $5 000 fine with a judge's discretion to offer conditional discharge.

16 G Griffith and R Jenkin, A *Current Issues Background Paper* prepared by Research Officers in the NSW Parliamentary Library, "Cannabis: The Contemporary Debate" Volume II (1994) at 9, citing the *Report of the Indian Hemp Drugs Commission*, Government Central Printing Office, Simla

17 *Ibid*, citing *The Marijuana Problem in the City of New York*, The Jaques Cattell Press (1944).

18 *Ibid* at 10, citing *The Rehabilitation of Drug Addicts Report by the Advisory Committee on Drug Dependence*, Her Majesty's Stationery Office (1968).

19 *Ibid* at 11, citing Report of the Commission of Inquiry into the Non-Medical Uses of Drugs, *The Non-Medical Use of Drugs: Report of the Canadian Government's Commission of Inquiry*, Queen's Printer (1972) The report states that, on the whole, the physical and mental effects at the levels at which marijuana is used in North America appeared much less serious than those resulting from excess alcohol use. See also R Fox and I Matthews, *Drug Policy Fact, Fiction and the Future*, Federation Press (1992) p 31

20 Note 16 *supra* at 11, *Marijuana: A Signal of Misunderstanding First Report of the National Commission on Marijuana and Drug Abuse*, US Government Printing Office, 1972. See also note 16 *supra* at 12 - A second Report in 1973 entitled *Drug Use in America - Problem in Perspective* found that the risk potential of marijuana is low but that because of the powerful symbolism of marijuana, it has obstructed the emergence of a national policy in America

21 Note 16 *supra* at 11-19.

marijuana in any great depth given the primary concern of legislators with marijuana prohibition and criminal sanctions.

III. MARIJUANA LEGISLATION IN AMERICA - A HISTORICAL PERSPECTIVE

Cannabis was classified as a Schedule I drug in America in 1970 under the *Controlled Substances Act*, alongside LSD and heroin. The Act lists all illicit and prescription drugs into five schedules and was the most significant piece of legislation to affect cannabis use since the *Marihuana Tax Act*. At the time, marijuana had been illegal for more than 30 years and its medicinal uses largely forgotten. Schedule I drugs are defined as drugs with a high potential for abuse, no accepted medical use and lacking accepted safety for use even under medical supervision.[22] The sole exception to the general prohibition on use of Schedule I drugs is for research purposes. Doctors require permission from the Drug Enforcement Administration ("DEA") for a special license as well as Federal Drug Authority ("FDA") approval for any research protocols. The legal supply of marijuana for research is provided by either the National Institute on Drug Abuse ("NIDA") or from the DEA which imports, cultivates or provides confiscated supplies of marijuana.[23] However, the possession and use of marijuana remained a Federal criminal offence and the classification of cannabis as a Schedule I drug meant that treating doctors were unable to prescribe marijuana medically or to obtain the necessary research funds in order to prove its medicinal value.

In 1972, a report by the National Commission on Marijuana and Drug Abuse encouraged State Legislatures to reduce sanctions for possession offences and to legalise possession of small amounts for personal use.[24] The report found that marijuana use did not "constitute a major threat to public health" and that there were little proven dangers for experimental or intermittent use.[25] President Nixon disagreed with the report and opposed legalisation of the sale, possession and use of marijuana on the basis that he did not support "something that is half legal and half illegal".[26] In spite of this, by the late 1970s marijuana become the

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22 Note 4 *supra* at 1875 See also note 1 *supra*, p 13. In Australia, drugs are listed under nine different Schedules according to their toxicity, potency, addictive qualities and potential for abuse and safety The Schedules control the way drugs and poisons are distributed, presented, dispensed, advertised and marketed They were adopted by all Australian States and Territories in June 1990 pursuant to the Standard for the Uniform Scheduling of Drugs and Poisons (SUSDP) No 5 which was prepared by a sub-committee of the National Health and Medical Research Council - see Australian Health and Medical Law Reporter, CCH, para 23-230 at 26, 263. See also Part XB of this article.

23 *Ibid.*

24 Note 9 *supra* at 419.

25 Note 9 *supra* at 422-3, citing the 'Schafer Report', note 15 *supra*, pp 80-1, 112.

26 Note 9 *supra* at 423, citing The President's News Conference of 24 March 1972, Published Papers (1974) at 495.

third most popular drug in America after alcohol and tobacco.[27]

Attempts to overcome the blanket prohibition against marijuana gained support and momentum in the early 1970s. In 1972, the National Organisation for the Reform of Marijuana Laws ("NORML") petitioned the DEA (then known as the Bureau of Narcotics and Dangerous Drugs) to transfer marijuana to Schedule II of the controlled substances list so that it could be legally prescribed by physicians.[28] A Schedule II classification signifies that a drug has a high potential for abuse which may lead to severe psychological or physical dependence but that it has an accepted medical use. Schedule II drugs include morphine and cocaine, which are considered more dangerous than cannabis.[29]

In 1986, the DEA held public hearings, lasting two years, on the issue of medicinal marijuana, during which time many doctors and patients testified about their positive experiences with marijuana as a medicine.[30] On 6 September 1988, the DEA's administrative law judge, Justice Francis L Young, declared that marijuana in its natural form fulfilled the legal requirement for currently accepted medical use and treatment. He commented:

> Marijuana, in its natural form, is one of the safest therapeutically active substances known.
>
> [The] provisions of the [Controlled Substances] Act permit and require the transfer of marijuana from Schedule I to Schedule II.
>
> It would be unreasonable, arbitrary and capricious for DEA to continue to stand between those sufferers and the benefits of this substance.[31]

Despite these findings, the DEA refused to reclassify cannabis.[32] In rejecting claims that marijuana had medicinal uses, the DEA said:

> It is clear that marijuana cannot meet the criteria ... for safety under medical supervision. The chemistry of cannabis is not known and reproducible. [The] marijuana plant material is variable from plant to plant. The quantities of the active

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27 Note 9 *supra* at 424, citing J Fort, *The Addicted Society: Pleasure Seeking and Punishment Revisited* (1981) pp 81-5. As a result, 11 states enacted laws increasing penalties for use and possession of marijuana between 1973-8.

28 Note 3 *supra*, p 249 NORML is a powerful Washington lobby group committed to ending Federal prohibition of cannabis as a medicine and to "construct a medically meaningful, ethically correct and compassionate system of regulation which permits the seriously ill to legally obtain cannabis", note 38 *infra* at 7.

29 Marijuana Policy Project Foundation, "How Can a State Legislature Enable Patients to Use Medicinal Marijuana Despite Federal Prohibition?", September 1996 http://www.mpp.org at 3. (Address PO Box 77492, Capitol Hill, Washington DC, USA). Cocaine is commonly used as an anaesthetic in topical eye surgery

30 Note 4 *supra* at 1875.

31 *Ibid.* See also Marijuana Policy Project, *Medicinal Marijuana Briefing Paper 1997 The Need to Change State Law*, http://www.mpp org at 2

32 Note 1 *supra*, p 14. Contrast this with the opioid analgesic drug pentazocine being classified as a Schedule IV drug available on medical prescription, despite testimonies of addiction, deaths from overdose and evidence of abuse at its DEA hearing Grinspoon believes that Winthrop, the drug company manufacturing the drug, had enormous financial resources to successfully argue the classification because of its large vested commercial interest.

constituents, the cannabinoids, vary considerably. In addition, the actions and potential risks of several of the cannabinoids have not been studied.[33]

Further appeals to the Federal Courts for reclassification were rejected in March 1992[34] and a final appeal to the US Court of Appeals (DC Circuit) resulted in the DEA decision to keep marijuana as a Schedule I drug being upheld on 18 February 1994.[35] The DEA continues to have delegated authority to determine the schedule into which a controlled substance is placed but it will not do so without a determination of the drug's safety and efficacy by the FDA.[36]

Attempts to circumvent this Federal prohibition on medicinal use have occurred at the State level. Since 1978, a number of American States have passed laws establishing controlled substances therapeutic research programs despite Federal regulations which make them difficult to implement.[37] The Investigative New Drug treatment ("IND") programs administered by State health departments were designed so that patients with specific diseases could receive marijuana as part of their medical treatment.[38] Patients required approval by a board of medical examiners and needed to demonstrate that they were suffering from a narrow range of defined illnesses which had failed to respond to conventional drug treatments, such as cancer or glaucoma.[39] The marijuana was supplied by the Federal Government as the only source of 'legally' supplied marijuana.

The FDA also approved an Individual Treatment Investigative New Drug Program (referred to as "Compassionate IND") for patients who required marijuana in circumstances where no other drug would produce the same therapeutic effect.[40] The compassionate IND program peaked in 1985 with 208 enrolled patients receiving 6000 government supplied marijuana cigarettes over the course of four years.[41] Despite reports of successful trials, all IND programs were disbanded by the late 1980s, due in part to the 'drug wars' policies of successive Federal American Governments, commencing with the Reagan Administration.

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33 National Drug Strategy, *Legislative Options for Cannabis in Australia*, Monograph Series No 26, D McDonald, R Moore, J Norberry, G Wardlaw, N Ballenden, AGPS Canberra (1994) at 104, citing the US Government *Federal Register*, vol 54, No 249, 29 December 1989 at 53,734.

34 Note 4 *supra* at 1875 Justice Young's decision was overruled not by a medical body, or even in consultation with doctors, but by the DEA itself, leading to charges of abuse of due process.

35 Marijuana Policy project, note 31 *supra*

36 Note 29 *supra* at 4

37 Note 4 *supra* at 1875

38 NORML Special Report, "A Closer Look at State Efforts to Allow Marijuana as a Medicine (And How They Relate to Proposition 215)", October 1996, http.//www norml.org/medical/p215.closer.shtml at 2.

39 *Ibid.*

40 Note 4 *supra* at 1875

41 Note 38 *supra* at 2, citing RC Randall, *Cancer Treatment and Marijuana Therapy*, Galen Press (1990) pp 217-43. State run trials occurred in New York, Michigan, New Mexico, California, Georgia, Tennessee and Washington

The reasons included:

- minimal publicity, extensive paperwork and complicated application requirements - this discouraged many patients, pharmacists and physicians (who were already wary of prescribing marijuana because of the potential adverse effects on their career) from enrolling in the programs;[42]
- refusal of State Legislatures to implement and allocate significant funds for programs considered controversial;
- the 1986 approval of dronabinol (a synthetic pill form of cannabis) by the FDA for limited medical use. It was marketed as Marinol and classified as a Schedule II drug, so that it could be prescribed by doctors to treat symptoms associated with AIDS wasting syndrome and chemotherapy (nausea, vomiting);[43] and
- a rash of applications to the FDA in 1989 from people with AIDS (when a record 34 approvals for the Compassionate IND programs were granted in a year) which raised fears of an avalanche of similar applications.[44]

The programs were finally suspended and closed to new applicants in June 1991 because they were seen as undercutting the Federal Administration's opposition to the use of illegal drugs.[45] The Clinton Administration decided against reopening the programs on 18 July 1994, and no new Compassionate IND programs have been approved since.[46]

As of November 1996, 26 states still hold legislation approving marijuana research programs although none are currently operational.[47] Another bill

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42 Note 4 *supra* at 1875.

43 Note 38 *supra* at 3 The decision to market the pill was seen as an indication that synthetic/oral cannabis was superior to smoked/inhaled marijuana Consequently, many States closed the therapeutic research programs and some repealed their State laws altogether See also Part IV D of this article.

44 Note 4 *supra* at 1875

45 Note 4 *supra* at 1876 See also "US Rescinds Approval of Marijuana as Therapy", *New York Times*, 11 March 1992, p A21, where a spokesperson for the Public Health Service said that the decision was made because existing scientific evidence did not support recommending smoked marijuana as a treatment of choice for any of the medical conditions of patients who had applied for government supplied marijuana

46 Note 35 *supra* at 2 See also note 4 *supra* at 1876, and note 29 *supra* As of August 1996, eight patients are still receiving marijuana under the Federal IND Program. Unfortunately, the research programs did not generate any data to allow the FDA to approve marijuana as a prescription medicine.

47 Marijuana Policy Report, "Medicinal Marijuana Legislation in the States", (1996-1997) http://www.mpp org/instates html at 1. These include bills establishing controlled substance therapeutic research programs, licensing physicians to prescribe marijuana for certain conditions, rescheduling marijuana for certain medical purposes, and resolutions requesting the Federal Government to lift restrictions for medical purposes. The Washington and Massachusetts State Legislatures passed measures in 1996 reasserting approval of their State sponsored therapeutic research programs and seeking to bypass the Federal moratorium on medical marijuana. Washington enacted laws on 30 March 1996 providing US$130,000 for projects to make marijuana available to the medically ill, including studies on effects and research on cultivation Massachusetts approved a *Medical Marijuana Bill* on 8 August 1996 for the creation of a medical marijuana therapeutic research program to allow patients arrested on marijuana charges to use the medical necessity defence, provided they were registered and certified to participate in the programs and possessed marijuana for personal use pursuant to the programs The proposed law raises the possibility that courts will accept the medical necessity

similar to previous defunct bills was introduced in the House of Representatives in November 1995 to allow eligible physicians to prescribe marijuana under certain conditions.[48] However, it is arguable whether, in the current political climate prevailing against illegal drugs, not only in America but across the developed world, any patients will be supplied with marijuana under such programs.[49] While Congress retains the ultimate authority to reclassify cannabis under the *Controlled Substances Act*, there has been no indication that it would move to do so. That may change in light of the recent referendum results but Federal laws still dictate that possession of even a small amount of marijuana for personal or medicinal use is subject to one year sentence in Federal prisons or a US$10 000 fine.[50]

At the Federal level, the possession and/or use of marijuana for medicinal purposes remains illegal and fraught with risk and uncertainty for many patients. Patients outside California and Arizona still must face the options of continuing to suffer their symptoms or illegally obtaining the drug, which may be of an insufficient amount or from a contaminated supply, or run the risk of arrest, fines, court costs, property forfeiture and a criminal record.[51]

IV. MARIJUANA'S MEDICINAL VALUE - USES AND EFFECTS

Since the 1970s, the popular consensus has been that marijuana use (like heroin or cocaine) endangers American society. Marijuana's widespread use amongst young Americans and its symbolic use as a rejection of traditional social values has seen a resurgence in marijuana prohibition and arguably hindered pharmaceutical research into the drug's therapeutic value.[52] Marijuana's therapeutic value was accidentally rediscovered by young adults who discovered it could alleviate a number of their leukaemia symptoms while using cannabis recreationally prior to undergoing chemotherapy.[53] From the mid 1970s, clinical research was undertaken on the therapeutic value of cannabis but in many instances, the results relied heavily upon anecdotal evidence and testimonies from a few physicians and individuals who claimed to have derived

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defence so long as patients fit the criteria. See also Marijuana Policy report, "Medicinal Marijuana in the States", (1996) http //www.mpp.org/theest html at 1.

48 Marijuana Policy Report, "Medicinal Marijuana Bill Introduced in Congress" (1995) http://www.mpp org/hr2618 html at 1. Bill HR2618 would allow eligible doctors to prescribe marijuana to patients undergoing cancer chemotherapy or radiotherapy, as well as patients with glaucoma, AIDS wasting syndrome, multiple sclerosis or other forms of paraplegia and quadriplegia

49 Note 38 *supra* at 3 All IND Programs received their marijuana from the National Institute on Drug Abuse (NIDA) but it no longer supplies marijuana for medicinal purposes

50 *Ibid* at 4-5. Cultivation of one plant is subject to a sentence of up to five years in prison and a US$250 000 fine, and persons distributing marijuana to patients outside a Federally approved program can be arrested and tried as drug dealers, which may attract a maximum Federal sentence of life imprisonment.

51 Note 35 *supra* at 2

52 Note 6 *supra* at 185

53 Note 1 *supra*, p 18

medical benefits.[54]

A distinction between the use of marijuana for medicinal purposes, and the use of marijuana for recreational purposes fails to be drawn, thus contributing to the confusion and rhetoric surrounding use of the drug as a whole.[55] The debate about medicinal uses of cannabis has failed to acknowledge that deaths from alcohol and tobacco are greatly in excess of those from cannabis. Furthermore, distinction between 'legal' and 'illegal' drugs on the basis of addiction fails to account for the fact that alcohol, tobacco, caffeine and many prescription drugs (such as Valium) are 'addictive'. Marijuana appears to have fallen victim to an illogical fear that because it is illegal and open to abuse, it cannot therefore have any medicinal purpose.

Despite results suggesting an anti-emetic effect and relief of glaucoma, marijuana has not been widely used nor have there been any detailed clinical pharmacological studies to determine the precise effects of cannabis as a medicine.[56] Part of the explanation lies in the classification of cannabis in America as a Schedule I drug. Opponents of medicinal use argue that marijuana has little or no substantial therapeutic use because the few potential uses it does have are equally or better met by other drugs, which do not have the psychoactive effects of marijuana, or by oral preparations of cannabis such as Marinol, which deliver a defined and measured dose.[57] However, preliminary studies suggest that cannabis is a safe drug with little effect on major physiological functions, has a very low incidence of lethal overdose[58] and is far less open to abuse and addiction compared to legally prescribed drugs such as relaxants and analgesics.[59]

A. Pharmacology

Cannabis is the generic name for a variety of preparations derived from the plant *cannabis sativa*. It is a sticky resin covering the plant's upper leaves and contains more than 60 cannabinoid substances.[60]

Cannabinoids is a collective term for a variety of active compounds which are extracted from the cannabis plant. Some of these compounds are biologically active on cells and body tissue whilst others are psychoactive and affect mood and state of mind. The major psychoactive ingredient, isolated in 1964, is delta-9-tetrahydrocannabinol ("THC") which is, for most purposes, the most

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54 Note 6 *supra* at 185-6 See also R Fox and I Matthews, note 19 *supra* p 19, quoting the Le Dain Commission Report, 1972 p 15, which found that few of the reports on cannabis met accepted scientific standards and that many were ambiguous, poorly documented, emotion laden and biased

55 R Fox and I Matthews, see note 19 *supra* at 699

56 Note 6 *supra* at 196

57 *Ibid* at 197.

58 Note 4 *supra* at 1875. Animal studies suggest that the ratio of lethal to effective dose is 40 000:1 compared to 10.1 for ethanol in alcohol.

59 See C Taylor, "Narcotics Trade One of World's Top Businesses", *Sydney Morning Herald*, 27 June 1997, p 9 Recent World Drug Report prepared by the UN Drug Control Program estimates that 140 million people tried marijuana in 1995 worldwide which was dwarfed by the 227 million people who legally used sedatives

60 Note 6 *supra* at 3

significant ingredient.[61] The cannabinoids interact variably with THC and there are an additional 360 identified chemicals in the cannabis plant.[62] As a result, the amount of chemicals contained in each preparation of marijuana varies over a wide range and no two plants have the same chemical composition.[63] However, it is unlikely that each chemical will be isolated to determine its therapeutic potential (as with THC) because they are probably not as effective acting alone compared to acting in combination with each other.[64]

Cannabis can be classified as a stimulant, sedative, analgesic and hallucinogen.[65] Legally, it is classified with the opiate narcotics, a classification which has undesirable implications. However, despite the mild euphoric and analgesic effects it has in common with opiate narcotics like morphine, cannabis is not a narcotic substance and unlike the narcotics, is not strongly addictive.[66] Cannabis resembles the opioid drugs by acting upon specific receptors in the brain.[67] The receptors are highly concentrated in the hypocampus of the brain, suggesting that they play a role in cognitive functions, as well as in the cerebellum, which has a role in movement control.[68] In that respect, cannabis differs from alcohol, cocaine and other illicit drugs which primarily act by disrupting brain processes.[69]

The brain produces its own endogenous molecule which binds to cannabinoid receptors and is called anandamide.[70] This may encourage more research into the biology of cannabinoids with therapeutic effects and it may be possible in future to differentiate between cannabis receptors which mediate *therapeutic* uses from those responsible for *psychoactive effects* so that drugs can be manufactured to target specific sites in the brain responsible for the different therapeutic effects.[71] Such attempts would be costly and are arguably unnecessary given that crude marijuana is already easily available to patients at a fraction of the cost of expensive synthetics.

B. Medicinal Uses

Proponents of medicinal cannabis say that it is one of the safest therapeutically active substances known to humans. Interestingly, no other drug is similarly administered by smoking.

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61 *Ibid* at 34. See also note 16 *supra* at 5.

62 Note 3 *supra* at 249 See also note 6 *supra* at 3

63 *Ibid.*

64 Note 1 *supra*, p 156

65 Note 6 *supra* at 5.

66 *Ibid* The drug was included as a narcotic because Indian hemp was classified as a narcotic in the UN *Geneva Convention on Drugs* in 1925.

67 *Ibid* at 29.

68 *Ibid* at 30, citing a study by Herkenham et al, "Cannabinoid Receptor Location in the Brain", in *Proceedings of the National Academy of Sciences*, USA (1990) pp 87, 1932-6 and Hollister, "Health Aspects of Cannabis" (1986) 38 *Pharmacological Reviews* at 1-20

69 *Ibid* at 3.

70 *Ibid* at 4. Anandamide is the Sanskrit word for 'bliss'.

71 *Ibid* at 31. Recent studies by Munro et al (1993) have found a cannabinoid receptor in the spleen which does not exist in the brain, suggesting there are different receptor types and that it may be possible to differentiate between therapeutic and psychoactive effects

Major research and policy reviews were undertaken in the 1980s under the aegis of the American National Academy of Sciences, which urged more research into cannabis and discredited many of the charges made against it.[72] A 1982 report commissioned by the Institute of Medicine Division of Health Policy[73] analysed the available data on the potential therapeutic value and health benefits of marijuana in a variety of medical disorders. Results suggested that marijuana and its derivatives might be useful in glaucoma, severe nausea and vomiting control following chemotherapy, some form of epileptic seizures and specific spastic disorders of the nervous system.[74] The Institute also found that cannabis has a broad range of psychological and biological effects some of which are harmful to health but it could not find any conclusive evidence that it causes permanent brain damage or that it leads to other illicit substance use.[75]

Marijuana is claimed to be beneficial in conditions as diverse as the following:

- nausea and vomiting: Marijuana's greatest potential is considered to be as an *anti-emetic agent*, and has been shown to be effective in preventing severe nausea and vomiting;[76]
- HIV/AIDS: evidence shows it can reduce symptoms of nausea, vomiting and loss of appetite which are caused by *HIV/AIDS* and from various treatments such as AZT and antiviral combination drugs;[77]
- glaucoma: evidence shows *glaucoma* is a leading cause of blindness in America and Australia because the increase in eye pressure causes irreparable damage to the optic nerve. Marijuana can reduce intra-ocular pressure which alleviates pain and sometimes slows disease progression;[78]

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72 Note 9 *supra* at 427-8. The Academy has recommended that sanctions against cannabis possession be removed.

73 Institute of Medicine, *Marijuana and Health*, National Academy Press (1982) p 145.

74 *Ibid* p 4

75 Note 9 *supra* at 428, citing Institute of Medicine study, note 73 *supra*, p 5.

76 Note 6 *supra* at 186-90 The consensus is that THC is equal in effect to other anti-emetic drugs used to reduce nausea and vomiting in chemotherapy patients The most effective dose, the types of nausea against which it will work and tolerance to side effects in older patients (euphoria, relaxation, drowsiness) still need to be investigated. See also note 73 *supra*, pp 142-4. A research study in New Mexico between 1978 and 1986 provided marijuana or synthetic THC to 250 cancer patients receiving chemotherapy after conventional medications failed to relieve their nausea and vomiting A physician who worked on the program testified that those who smoked marijuana had better resolution of their symptoms than those using Stemetil or oral THC The studies, however, did not accord with FDA scientific standards mainly because of financial obstacles and problems obtaining legal supplies of marijuana.

77 *Ibid* at 195 The bulk of the evidence derives from individual patient case reports.

78 Note 73 *supra*, p 191 Glaucoma affects more than 23 million people in the US While the acute effects are accepted, there are few controlled studies of the effectiveness and safety of cannabis in long term management of glaucoma The American Academy of Opthalmology does not recommend the use of marijuana until such time as a large scale study ascertains its safety in daily use. See also pp 140-2. Curiously, common glaucoma drugs can cause lethal responses even when properly used but marijuana is often excluded as a therapy because of its possible long term risks: see M Moore, MLA, "Medicinal Cannabis - An Opportunity", unpublished manuscript at 11.

- cancer: evidence shows marijuana can stimulate the appetite and alleviates nausea and vomiting in many forms of *cancer*, especially after chemotherapy;[79]
- multiple sclerosis: evidence shows *multiple sclerosis* is the leading cause of neurological disability among young and middle-aged adults in the USA and marijuana can limit muscle pain and spasticity caused by it. Cannabis can also relieve tremor and unsteady gait in patients with movement problems arising from neurological disorders (Parkinson's disease) and has been shown to relieve spasticity in spinal cord injuries;[80]
- *epilepsy:* it is thought that marijuana can prevent *epilepsy* in some patients and at least relieve the frequency and severity of attacks in others, allowing some patients to decrease the use of traditional anti-epileptic medications which can cause drowsiness and concentration difficulties;[81] and
- *chronic pain*: marijuana is known to alleviate *chronic and debilitating pain* caused by a myriad of disorders and injuries and is considered a very effective analgesic.

The use of marijuana in the above conditions has been deemed legitimate by courts or legislatures in America.[82] In addition, many patients have reported that cannabis is useful in treating arthritis, migraines, menstrual cramps, itching, withdrawal symptoms from alcohol and opiate addiction,[83] depression, anxiety and a variety of mood disorders including 'stress'.[84] There is also evidence that it can assist in lung bronchodilation which may benefit asthma patients.[85]

C. Side Effects and Contra-indications

One of the most significant problems with cannabis is that concentrations of the active ingredients vary according to the route of ingestion (smoked or oral). When smoked, new chemical compounds are created depending on the temperature of the cigarette, the pH of the plant, its moisture content and particle size. Puff frequency, duration and smoking volume also affect the levels and bioavailability of THC, which makes it difficult to study dose related effects of cannabis in patients.[86]

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79 *Ibid* p 145.

80 Note 6 *supra* at 193. See also note 73 *supra*, p 147.

81 *Ibid* at 192. Some case studies show it enhances the effect of other drugs but there have been very few proper studies undertaken. See also note 73 *supra*, pp 145-6

82 Note 35 *supra* at 2. Some of the professional organisations which support the medicinal use of marijuana include the National Academy of Sciences (1982), California Medical Association (1993), Federation of American Scientists (1994), the American Public Health Association (1995) and the Australian Commonwealth Department of Human Services and Health (1994). See also Marijuana Policy Project, "About Medical Marijuana" (1997) http://www.norml org/medical/medmj.shtml at 1-2

83 Note 73 *supra*, pp 149-50.

84 Note 35 *supra* at 2.

85 Note 6 *supra* at 194. However, the irritant effect experienced by asthmatics when inhaling smoke may preclude its use in an inhaled form See also note 73 *supra*, pp 147-8

86 Note 3 *supra* at 249-50.

It is acknowledged that smoking marijuana has a greater effect than tobacco on the lungs because of higher level in tars and particulate matter[87] although the amount of smoked cannabis is usually far less than tobacco.[88] Cannabis also contains toxic substances such as benzopyrene,[89] Aspergilli fungus and Salmonella bacteria, suggesting that it would not comply in its natural form with various pure food and drug legislation in America.[90] Proponents of medicinal marijuana argue that legalising the drug for medicinal use would eliminate or significantly reduce these risks by controlling the manufacture of standardised and chemically treated marijuana cigarettes.[91] It would also reduce stress in patients who must illegally obtain the drug, thereby exposing themselves to a risk of criminal prosecution.[92]

Opponents argue that cannabis lacks any specificity for use in disease and that it is unlikely that therapeutically useful compounds will be extracted from the crude marijuana plant to develop a pharmacological substance, as was the case with penicillin (derived from the Penicillium notatum mould) or digoxin (from the foxglove plant).[93] They also cite an Institute of Medicine study which found that the effects of cannabis on the respiratory and cardiovascular systems were similar to those of stress which, while not permanent, could raise heart rate and blood pressure in a diseased heart.[94] The study concludes that because of these potential side effects, the greatest therapeutic potential lies in the use of synthetic marijuana derivatives which will have a higher therapeutic ratio.[95]

However, there is evidence to suggest that smoked cannabis is superior to, and has lower incidences of unwanted psychoactive effects compared with oral cannabis. There is a greater bioavailability of THC via smoking, producing a more dependable effect which users can better control by altering their smoking habit to titrate the dose and maximise beneficial effects.[96] A 1990 survey of oncologists revealed that 44 per cent had advised their patients that smoked

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87 Note 4 *supra* at 1876 See also note 5 *supra* at 700-1. One marijuana cigarette is equal to five tobacco cigarettes in terms of carbon monoxide intake and one marijuana cigarette equals four tobacco cigarettes for tar intake

88 See note 1 *supra*. A lucrative project may be the development of filters and methods to screen out the harmful ingredients· see S Okie, "Marijuana initiatives sow seeds of conflict", *Washington Post*, 19 November 1996, p 7 at 8

89 Note 3 *supra* at 249 Benzopyrene is a cancer causing compound formed by the burning process and is 70 per cent more abundant in marijuana smoke than in tobacco smoke

90 *Ibid* Such legislation requires all medicine to be labelled with the exact amount of chemicals it contains which would be difficult with marijuana. The risk of inhaling aspergilli fungi is of great concern to AIDS patients, where exposure could prove fatal

91 Note 6 *supra* at 197

92 Note 4 *supra* at 1876

93 Note 3 *supra* at 250.

94 Note 73 *supra*, pp 72, 104. There is also an effect on the reproductive system with a decrease in sperm numbers and motility in males and irregular ovulation in females

95 *Ibid*, pp 4-5 The Institute found that Federal investment in research on the health related effects of marijuana had been small, both in relation to the expenditure on other illicit drugs and in absolute terms, which is inadequate given the extent of marijuana's current recreational use.

96 Note 6 *supra* at 197, citing studies by Grinspoon (1988), Merritt (1988), Mikuriya (1990), Morgan (1990) and Weil (1988).

marijuana should be tried to relieve the symptoms of nausea.[97] Such a recommendation from medical specialists would be unlikely if, as its Schedule I classification suggests, marijuana is unsafe for use even under medical supervision.

D. Marinol

The synthetic form of the main ingredient in cannabis, THC, has been available in America since 1985 as Marinol, a Schedule II drug.[98] Sales reached US$6 million in 1985 and is marketed with claims that, unlike marijuana, it does not vary from batch to batch, is safe, contains no carcinogens and has been thoroughly tested in controlled clinical trials.[99] Marinol is registered for specific use in the treatment of nausea and vomiting associated with cancer and radiation therapy and is taken as a capsule. Opponents of medical marijuana say that Marinol should be used as first line treatment in those conditions where marijuana is said to be effective.

Proponents of medicinal marijuana point to studies that suggest the other cannabinoids modify and enhance the action of THC when it is smoked, which is not present in Marinol.[100] Other arguments in favour of smoked marijuana include the cost of Marinol, which can be as much as US$30 000 a year, no requirement to swallow a pill when a patient is vomiting, and faster absorption of marijuana through the lungs when smoked.[101] At the very least, the development of Marinol supports an argument that cannabis does have medicinal effects.

Despite the oral capsule, the American Medical Association has not supported the rescheduling of cannabis for medical uses. Arguably, this is due to conservative attitudes within the profession and a preference for drugs manufactured under strict guidelines.[102] While there is a clear need to investigate the development of other synthetic cannabinoids, financial support has also not been forthcoming from drug companies, given their reticence to promote a controversial substance which is readily available as a plant. It remains unlikely that there will be further testing to develop other synthetic drugs, but proponents of medical marijuana argue that the immediate legalisation

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97 R Doblin and MAR Kleiman, "Marijuana as Anti-Emetic Medicine· A Survey of Oncologists' Attitudes and Experiences" (1991) 9 *Journal of Clinical Oncology* 1275. Almost two thirds agreed that marijuana was an effective anti-emetic and 77 per cent said that they believed smoked marijuana was more effective than oral THC Forty-eight per cent said they would prescribe marijuana if it was legal.

98 Note 4 *supra* at 1876

99 R Stodghill, "Why Grass is Greener", *Business Week*, 20 January 1997, p 34. The biotechnology company marketing the tablet believes that the tablet form is often maligned in an attempt to force the legalisation of marijuana.

100 Note 4 *supra* at 1876

101 Note 99 *supra*.

102 Marijuana Policy Project, "Debating the Medical Marijuana Issue" http://www.mpp.org/debating html at 2

of marijuana to alleviate illness and suffering is required until such time as specific therapeutic cannabinoids are identified and synthesised.[103]

E. Australian National Task Force on Cannabis

A wide ranging study by the Australian National Task Force on Cannabis[104] summarised some of the acute (after a single dose) and chronic effects (daily use over a period of years) of cannabis.[105] The report was undertaken in April 1992 following a meeting of the Ministerial Council on Drug Strategy and included a review of the literature on the health and psychological effects of cannabis use.[106]

The task force recommended that the National Health and Medical Research Council consider the funding, facilitation and promotion of further research:

> into the biomedical studies of health and the psychological consequences of cannabis use with regard to respiratory disease from long term use, and risks during pregnancy;[107] and
>
> controlled research into the efficacy of synthetic cannabinoid products as treatments for nausea associated with cancer chemotherapy, for HIV/AIDS related conditions, including HIV/AIDS associated depression and weight loss, for glaucoma and as an anticonvulsant, anti-spasmodic, and analgesic agent.[108]

The report acknowledged that despite evidence that THC is an effective anti-emetic, there was no proof that it is more effective than newer forms of anti-emetics and there are still uncertainties as to the optimal doses and routes of administration for cannabis.[109] The report said there was reasonable evidence to suggest that cannabis is effective in glaucoma but recommended further research to establish safety following long term use (although this reason alone should not prevent supervised use of marijuana in patients with severe glaucoma).[110]

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103 Note 4 *supra* at 1876 See also NSW HIV/AIDS Legal Centre, "HIV/AIDS Sentencing Kit" at 8, [3.2.1] citing Plasse et al, "Recent Clinical Experience with Dronabinol" (1991) 40 *Pharmacology, Biochemistry and Behaviour* 695

104 Note 6 *supra* See also "Cannabis - A Review of Some Important National Inquiries and Significant Research Reports" prepared by the Department of Health, AGPS (1979) for a discussion of historical inquiries into marijuana use and studies on the effects of the drug. The report noted that long term studies were needed requiring research dollars to study the effects of marijuana use, but realised there were many methodological flaws in research Such flaws were said to result from problems with small sample sizes, selection of subjects, differences in levels of use and variable potencies, making it difficult to compare findings and determine results (p 91). See also note 16 *supra* at 7-17

105 See also W Hall, "The Health and Psychological Effects of Cannabis Use", paper presented to Institute of Criminology Seminar, 28 July 1994. He cites various studies which have been used to confirm these effects

106 National Drug Strategy, *Report of the Task Force on Cannabis*, AGPS (1994) p 1 The review of international literature on the health and psychological effects of cannabis was thought necessary because there had been no major review on the effects since 1981, when the Addiction Research Foundation and World Health Organisation jointly reviewed the literature. See also note 6 *supra* at 21

107 *Ibid*, p xiv - Recommendation 26

108 *Ibid*, p xiv - Recommendation 27

109 Note 6 *supra* at 14.

110 *Ibid* at 15.

The report made findings on potentially adverse cannabis effects, including:[111]

Acute effects

- anxiety, dysphoria, panic and paranoia;
- cognitive impairment of attention and memory; and
- psychomotor impairment with use of cars and machines;

Probable and possible chronic effects for daily users

- respiratory disease associated with smoking;
- increased dependence;
- increased risk of oro-pharyngeal and oesophageal cancers;
- decline in occupational performance due to under-achievement;
- low birth weights and birth defects; and
- evidence of decreased fertility in men.

There is also a suggestion that cannabis increases the risk of precipitating or exacerbating symptoms in patients including:

- coronary artery disease and hypertension;
- asthma and bronchitis;
- increased schizophrenic episodes in those with mental illness; and
- a lowering effect on the immune system, raising doubts whether marijuana can be useful in patients whose immunity is already compromised, as in AIDS or chemotherapy.[112]

A comparison of the health risks of alcohol, tobacco and cannabis was also undertaken given that they have features in common. Like alcohol, cannabis produces psychomotor impairment which can cause accidents, impairs occupational performance and may lead to dependence and brain injury with chronic use, but there is no acute toxicity with cannabis use.[113] Compared to tobacco, both have irritant effects on the lungs with an increased risks of respiratory disease and oral and lung cancers.[114]

The public health significance of cannabis ultimately depends on the number of persons affected by any health consequences. Overall, this appears small in comparison to alcohol (which can cause cirrhosis) and tobacco (causing addiction) because relatively fewer people smoke marijuana.[115] Opponents of marijuana use argue that the current knowledge about the adverse health effects of tobacco and alcohol demonstrate why prohibition on cannabis use should be maintained, even if the risks are known to be less.[116] Yet possible long term side effects are of minor concern to those terminally and seriously ill patients who would derive the maximum benefit from short-term marijuana use.

While cannabis is not as dangerous as its opponents might believe, it is not

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111 *Ibid* at ix-x

112 *Ibid* at 9-10, 195

113 Note 105 *supra* at 7-8

114 *Ibid* at 7-9.

115 *Ibid* at 11, citing Drug Abuse statistics in 1992 which show the proportion of the Australian population who are weekly users of the drugs: alcohol 66 per cent, tobacco 29 per cent and cannabis 5 per cent.

116 *Ibid* at 12

completely without risks.[117] Results on medicinal effects are often based on clinical observations with inferences mostly drawn from laboratory results because of a lack of proper epidemiological studies. Although cannabis use is discouraged, the Task Force concluded that total prohibition was unwarranted given that the social harm of outright prohibition outweighed the harm from moderate use.[118]

F. Problems with Clinical and Research Evaluation

Critics of medicinal marijuana say the lack of conclusive clinical studies proving the therapeutic effects of cannabis demonstrates that it is not an established remedy. The diverse pharmacology and variable actions of cannabis in individual patients, including (sometimes undesirable) psychotic effects, would largely account for the lack of such studies.[119] There are problems in performing controlled research studies to determine statistically valid patient responses in group experiments, in circumstances where cannabis offers varying responses and forms of relief to individual patients.[120] The fact that THC also has psychoactive and mood-altering effects sought by recreational users also contributes to the general reluctance among governments and drug companies to fund research.[121]

Since the Institute of Medicine study in 1982, there have been few Federally funded research programs in America to increase knowledge about cannabis, without which "the present level of public anxiety and controversy over the use of marijuana is not likely to be resolved in the near future".[122] The evaluation of marijuana's medical uses continues to remain difficult due to a number of factors, including:

- the length of time needed to demonstrate a causal connection between marijuana use and effect;
- the current 'prohibition of cannabis' debate based on anecdotes of the individual and social harms caused by illicit drug use;[123]
- the difficulty in drawing inferences from laboratory trials, which are precisely dose related, to human use, where the dose varies depending on puff volume and frequency of smoking marijuana;
- the fact that there is over 420 chemicals in cannabis, each with variable concentrations acting individually or in combined effect; and
- the fact that most studies have only looked at the effects of short-term

117 Note 106 *supra*, p 43

118 Note 6 *supra* at 43. Nevertheless, there was strong disapproval for large scale cultivation and trafficking which are dealt with by the criminal law The findings lend strong support to the concept of separating the control of widespread personal use from the control of the criminal sector.

119 Note 3 *supra* at 257

120 Note 4 *supra* at 1876 Much of the knowledge derived on plant and synthetic medicines is anecdotal

121 Note 6 *supra* at 199. The fear in the non-medical community that the therapeutic use of THC would send a mixed message to adolescents has probably discouraged further research.

122 Note 73 *supra*, p 167

123 Note 6 *supra* at 2.

cannabis use.[124]

Some 'single subject' studies where active and placebo treatments are alternated randomly in a single patient have shown promising results whereas large scale programs are inappropriate because the medical disorder is rare or patient response is idiosyncratic.[125] The difficulty with 'single-subject' studies arises because most patients can easily differentiate between a marijuana cigarette and a placebo and can anticipate the effects. The symptoms of nausea, pain and loss of appetite are also difficult to study through controlled experiments because individual patients tend to vary puff volumes and inhale different amounts of marijuana to manipulate dose and effect.[126]

G. Anecdotal Evidence - How Reliable?

Most of the evidence for the therapeutic effects of cannabis derives from anecdotal evidence. From a clinical point of view, such evidence must be distrusted as firm clinical evidence for a number of reasons. People with chronic medical conditions often have fluctuating histories of symptom control and disease progression. In those circumstances, it is difficult to exclude other explanations for the apparent relationship between cannabis use and clinical improvement, such as placebo effect or pure coincidence.[127] For these reasons, and despite practical difficulties, controlled studies are still required properly to assess the therapeutic uses of cannabis.

Grinspoon and Bakalar undertook one of the largest studies on the medical effects of marijuana and have argued that a double standard applies when anecdotal evidence of cannabis harm is accepted by medical authorities but anecdotal evidence of any benefit is discounted.[128] Arguably, opponents of therapeutic cannabis set an unreasonably high standard for assessing the safety and efficacy of marijuana which, if applied to other prescription drugs, would "denude the pharmacopoeia".[129] This may be justified on the basis that it is necessary to require stronger evidence of drug benefits to ensure that possible risks do not outweigh those benefits. This has been accepted practice in the appraisal of any drug registered for therapeutic use in America (and most developed countries).[130]

Grinspoon and Bakalar have recounted numerous anecdotes from patients and doctors on the medical effects of marijuana in a variety of conditions and illnesses.[131] Despite criticisms of their methods,[132] they defend the use of

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124 Note 16 *supra* at 6-7.

125 Note 4 *supra* at 1876

126 "HIV/AIDS Sentencing Kit", note 103 *supra* at 13, 16 See also R Voelker, "NIH Panel Says More Study is Needed to Assess Marijuana's Medicinal Use", (1997) 227 *The Journal of the American Medical Association* 867 at 868

127 Note 6 *supra* at 196.

128 See note 1 *supra*, pp 133-6 "In Defence of Anecdotal Evidence".

129 Note 6 *supra* at 199.

130 *Ibid* at 196.

131 Note 128 *supra*.

132 See for example note 3 *supra*.

anecdotal evidence on the basis that controlled drug studies have limitations.[133] Controlled studies focus on therapeutic effects on a group rather than on the individual and they cite the example of aspirin where, as early as 1976, small studies on individuals were showing that taking one aspirin a day could prevent a second heart attack. Large scale experiments later demonstrated these same effects and this recommendation has been in place since 1988.[134] This analogy could be applied to cannabis wherever it brings immediate relief to patients although Grinspoon and Bakalar acknowledge that anecdotal evidence is problematic, for example, where patients report positive effects but fail to report on the lack of any drug effect.[135]

H. Australian Research

Cannabis is not currently registered as a therapeutic agent in Australia. Nabilone, a synthetic preparation used to treat nausea in terminally ill patients, is imported under a 'special access scheme' but there are no applications pending to register the drug in Australia.[136] Marinol is also available to some 100 people in NSW and a register of prescribing doctors has been established through a special access scheme.[137] The development of synthetic cannabinoids which act therapeutically but avoid psychoactive effects may be the most promising developments in the future. However, pharmaceutical companies both in Australia and America would be reluctant to invest in such research because of fears that any investment would prove risky. Marijuana cannot be patented as a plant and synthetic drugs may pose marketing problems given the public perception of marijuana and its general availability.[138] Individual applications are required by the State Governments for cannabis research but none are pending at present.[139]

The most recent study conducted was at the Royal Children's Hospital in Melbourne on the effect of marijuana as an anti-emetic in patients receiving chemotherapy.[140] The trial was a double blind study of THC, placebos and current anti-emetics. The results showed that THC was an effective anti-emetic

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133 Note 1 *supra*, p 133

134 *Ibid*, p 134

135 *Ibid*, p 135.

136 Note 16 *supra* at 18 Also at 3-4: cannabis cultivation is illegal in every State and Territory in Australia unless grown for therapeutic purposes or for research Permits can be granted for medical or botanical research but the only one currently issued is for a study of the cultivation of the hemp fibre in Tasmania for non-medical purposes.

137 "HIV/AIDS Sentencing Kit", note 103 *supra* at 8, [3.2 1] Becoming an approved recipient is complex. There are delays of up to a month and treatment costs about $250 per month. The Australian Federation of AIDS Organisations believes that in light of these problems, legal access to marijuana would be preferable

138 A Caswell, "Marijuana as Medicine" (1992) 156 *Medical Journal of Australia* 497 at 498, citing Dr Greg Chesher, pharmacologist Indeed, publicly funded research into marijuana as an illicit drug has declined in the US because money is being diverted to more pressing problems such as cocaine research. See also note 1 *supra*, p 159.

139 Note 16 *supra* at 18

140 Note 138 *supra* at 497 Cannabis was used in mixtures in Australia until the mid 1960's when it was declared prohibited

although it often caused drowsiness and was not successful in all patients.[141] There is a belief within some sections of the Australian medical community that while other drugs may be more effective, marijuana should be used in those cases where it has a positive medical effect because "if something is good, even for a small percentage of patients, it should be allowed...".[142] Whether this belief leads to more research in Australia remains to be seen.

I. Ulterior Motives?

Though the debate about rescheduling marijuana for medical use has ostensibly concerned health and safety, it has also been driven by the debate on legalisation for recreational use.[143] Groups such as NORML are strong advocates of medical use but also support general legalisation. On the other hand, opponents have consistently opposed inquiries into the therapeutic effects of marijuana based on fears that the community will be persuaded that if cannabis is appropriate for a range of medical purposes, it cannot be all bad, leading to other drug use.[144] These arguments often belie the fact that opponents want to prevent *any* marijuana use and exaggerate its dangers, thereby obstructing any debate on marijuana's effectiveness for medical purposes. Ultimately, an open exploration of the medical potential of cannabis is necessary and requires the support of both the legal and scientific professions to promote research into its benefits.[145]

V. THE REGULATORY FRAMEWORK

In America, drugs must be certified to regulate commercial distribution and protect against false claims about their effects. The FDA tests for safety and clinical efficacy, and drug companies are expected to present evidence from controlled studies. Research is expensive, and drug companies will commercially invest money only if a drug has good prospects of approval and its success as a medicine is assured, in order to earn a profit and recover the investment.[146]

Despite years of use, efficacy and safety, the FDA classifies marijuana as a new drug and demands the same testing regime applied to unknown substances.[147] Even if plant marijuana became available for prescription, it is likely it would be given a Schedule II rating - like Marinol - signifying a high potential for abuse and limited medical use which might discourage doctors from

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141 *Ibid.* It is licensed only for the treatment of nausea and vomiting associated with cancer chemotherapy in patients who have not responded to conventional therapy.

142 *Ibid* at 498, citing Lorna Cartwright, lecturer at Department of Pharmacology, Sydney University.

143 Note 6 *supra* at 198

144 *Ibid.*

145 Note 4 *supra* at 1876.

146 Note 1 *supra*, p 156

147 *Ibid*, p 157

prescribing it more widely.[148] Pharmacies might also be cautious in stocking marijuana because of possible monitoring by the DEA of patient prescriptions and the potential for harassment by drug enforcement agencies.[149] On the other hand, scheduling would make medical distribution inexpensive because the Federal government does not tax drugs used for medical purposes. This might create problems if non-medical users obtain scripts to buy the marijuana cheaply and then sell it.[150] This, in turn, could divert relatively cheap marijuana onto the black market where its value would be much higher than the initial cost of purchasing it from a pharmacy.[151]

In Australia, cannabis could be easily regulated so that its production, distribution and sale for medical purposes is controlled by the Health Department and trafficking outside the system remains a strict offence.[152] A regulatory regime already applies to tobacco, alcohol and other pharmaceutical products although regulation of marijuana would involve a complex system of licensing and monitoring with attendant high administrative costs, potentially decreasing the attractiveness of marijuana to governments and patients alike.[153]

Ironically, attempts to conduct the necessary research to prove the medicinal effects of cannabis and establish regulations have been hampered. Dr Abrams, assistant director of the AIDS program at San Francisco General Hospital and professor of clinical medicine at the University of California, spent four years attempting to win Federal approval to analyse the effects of marijuana on AIDS wasting. He requested US$300 000 from the Federal Government legally to obtain marijuana in order to study the safety and effectiveness of smoked marijuana in stimulating appetites in patients with AIDS 'wasting syndrome'.[154] Despite support from the FDA, the NIDA refused to supply the marijuana and criticised the study design because it "ignored the toxic effects of the drug".[155]

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148 *Ibid.*

149 *Ibid*, p 158

150 B Streisand, "Thank You For Not Toking" *US News & World Report*, 19 May 1997, p 28 at 29.

151 Note 1 *supra*, p 158.

152 Note 33 *supra* at xiv No working model for this option exists although the Dutch experience of cannabis being distributed in youth centres and coffee shops operates under strictly defined conditions

153 *Ibid*

154 Marijuana Policy Report, "NIH Rejects Medicinal Marijuana Study" (1996) http://www.mpp org/nihrejects.html at 1 NIDA has a monopoly on the legal supply of marijuana for clinical research in America and will only provide marijuana if an NIH peer panel review determines that the research protocol has scientific merit. This approval is in addition to FDA approval, which was sufficient alone to grant approval in the late 1970s and early 1980s Compare this to a recent University of Michigan study of marijuana use in multiple sclerosis patients where they received marijuana from NIDA without the NIH peer review process (at 2) See also Marijuana Policy Report "Marijuana Policy Project Continues to Fight for Medicinal Marijuana Research" (1996) http://www mpp.org/research.html, 21 May 1997, at 2· pharmaceutical companies can start immediate research into new drugs following FDA approval of the research protocol, which should also be the standard which applies to marijuana research, given previous FDA approvals

155 S Lehrman, "Acceptance of Marijuana Therapy Prompts Call for More Research" *Nature News*, 14 November 1996, http·//www nature com/Natu .. 6636.7202/newsitem022.html at 2. This included concerns about potential atherosclerosis development in AIDS patients if they absorbed too many calories after smoking the drug! However, there were well founded concerns that AIDS patients could be exposed to potentially fatal fungi and bacteria from smoking marijuana

The reason Dr Abrams wished to undertake the study was "not at all clear, given the knowledge that marijuana smoking may result in immune suppression and respiratory disease and that marijuana itself may be carcinogenic".[156] Without supplies of the drug itself, or government funding, it is impossible for scientific organisations to study legally the medical effects of the marijuana.[157]

Attempts to reclassify marijuana at the State level under local equivalents of the *Controlled Substances Act* have been made but they would be symbolic given Federal classification of marijuana as a Schedule I drug.[158] Without a change of scheduling at the Federal level, a doctor's prescription would still be invalid and patients would still be unable legally to fill a script.[159] A simple rescheduling of marijuana from Schedule I to II under Federal law would overcome the cumbersome exercise of each state enacting separate legislation which would still be in conflict with Federal law.

VI. COMMON LAW DEVELOPMENTS IN AMERICA

Prior to the November 1996 referendum results, patients convicted of marijuana use or possession in America could attempt to use the common law defence of 'medical necessity'. This defence was established in 1975 when a man was arrested for cultivating marijuana for the treatment of severe glaucoma.[160] The continuing utility of this defence remains to be seen following the referendum results in California and Arizona, but it has been used by patients to circumvent Federal laws and courts have employed it to recognise a right to use marijuana for medical purposes in certain situations.

The defence is still important in those states not proposing to follow the initiatives in California and Arizona or for those people convicted of Federal marijuana charges. Defendants must satisfy the following criteria in order to use it:

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156 Marijuana Policy Report "Marijuana Policy Project Continues to Fight for Medicinal Marijuana Research", note 154 *supra* at 3. See also L Grinspoon and J Bakalar, "Marijuana, the AIDS Wasting Syndrome and the US Government" (1995) 333 *New England Journal of Medicine* 670; Marijuana Policy Project, note 35 *supra* at 5, and note 38 *supra* at 7. The rejection was the second in two years and the Federal officials have declined to explain the decision which took 9 months after the research protocol was first submitted. See also
S Okie, "Plan to Test Drug's Effectiveness in Bureaucratic Limbo" *Washington Post*, 19 November 1996, p 7.

157 NORML, "NORML to target 105th Congress with Marijuana Law Reform Legislation" (1997) http.//www natinorml.org/activist/fedleg shtml at 2 A Federal Bill could require NIDA to provide marijuana to all research projects which are FDA approved, have received review board and peer approval, and are directed by physicians with DEA licences. This would overcome the 'Catch 22' situation in which Dr Abrams finds himself - NIDA refusing marijuana for FDA approved research and then arguing against rescheduling because there is lack of approved research studies

158 Note 38 *supra* at 4.

159 *Ibid* at 5 It is unlikely that doctors would risk such sanction in the absence of a guaranteed legal supply of the drug

160 Note 35 *supra* at 3. The success of the defence in *United States v Randall*, 104 Daily Wash L Rep, 2249 (DC Super Ct 1976) precipitated the establishment of the Federal IND Programs in order to provide Mr Randall with legal supplies of his medicine.

(i) That they did not intentionally bring about the circumstances which precipitated the unlawful act.
(ii) That they could not accomplish the same objective using a less offensive alternative available, and
(iii) That the evil sought to be avoided was more heinous than the unlawful act perpetrated to avoid it.[161]

One of the most significant cases involved two AIDS patients, Ken and Barbara Jenks, who were arrested for growing marijuana. Mrs Jenks suffered nausea as a result of her treatment and claimed that marijuana relieved the condition. Despite evidence from her physician and an expert witness, the trial judge rejected the medical necessity defence and found the Jenks guilty of manufacturing marijuana.[162] The decision was reversed on appeal to the District Court of Appeal of Florida on the basis that a Schedule I classification for cannabis did not preclude the use of the medical necessity defence, which has been clearly established by the Jenks. They could demonstrate that they did not intentionally bring about the circumstances that precipitated their use of marijuana (ie. they did not intend to contract AIDS) and that no other treatment effectively relieved their nausea which, if not controlled, would place their lives in danger.[163] Following the appeal, the Jenks were admitted to the Federal IND Program.[164]

The medical necessity defence does little to allow access to a legal and regulated supply of medical marijuana and the prohibitive court costs involved in arguing the defence often preclude defendants from using it. In Australia, the defence would apply to situations of imminent peril but would not normally be applied to cases of therapeutic use of marijuana or other unlawful substances.[165]

VII. PROPOSITIONS 215 AND 200

In November 1996, voters in California and Arizona went to the polls to vote on two separate but related referendums.

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161 MW Grey, "Medical Use of Marijuana: Legal and Ethical Conflicts in the Patient/Physician Relationship" (1996) 30 *University of Richmond Law Review* 249 at 250

162 Note 38 *supra* at 5

163 *Ibid* at 5-6.

164 *Ibid* at 6 Mrs Musikka was admitted to the program in 1988 for treatment of glaucoma after a trial judge in Florida found jailing her for marijuana possession was incorrect and that "[the] absolute prohibition against marijuana use, even when such use may be therapeutically required to avoid grave and irreversible injury, appears on the face to be irrational", see *The Miami Herald*, 9 February 1997, citing the case of *State v Musikka*, Fla 17th Cir Ct, 28 December 1988, http://www.herald.com See also *Seely v State of Washington*, Docket No.94-2-11862-1, 13 October 1995 cited in note 38 *supra* at 6 where a patient's need for medicinal marijuana overrode the state interest in prohibiting it.

165 *HIV/AIDS Legal Guide* (1994 edition) p 304 in section "Prisoners and the Criminal Justice System", Australian Federation of AIDS Organisations, Federation Press (1993) at [9 10 2]. The guide cites *R v Conway* [1989] QB 290, *R v Martin* [1989] 1 All ER 652; *Limbo v Little* (1989) 65 NTR; 98 FLR 421, 45 A Crim R 61 as examples where the defence has been used

A. Proposition 215

Proposition 215 arose from a belief that the issue of therapeutic marijuana had to be medicalised and taken out of the hands of the criminal justice system.[166] There were high levels of public support for ending the prohibition of medicinal marijuana in California, demonstrated by a 1991 ballot initiative in San Francisco which passed with an 80 per cent majority declaring that marijuana should be medically available.[167] Proposition 215 also grew out of the experience of the 'cannabis buyer's clubs' which provided marijuana to chemotherapy, AIDS and chronic pain patients. The largest club in San Francisco held 6000 registered members and was supported by police on the basis that it strictly supplied cannabis for medical purposes.[168] Two medical marijuana bills were passed by the California Legislature in 1994 and 1995 but they were vetoed by the Governor. After 750 000 registered voters signed a petition supporting a State ballot for legalising medicinal marijuana use, Proposition 215 became the latest in two decades of reform efforts in California to permit the use of marijuana for medical purposes.[169]

The initiative read in part:

> Patients or defined caregivers, who possess or cultivate marijuana for medical treatment recommended by a physician, are exempt from general provisions of law which otherwise prohibit possession or cultivation of marijuana.[170]

The measure was passed by 54 per cent in favour to 46 per cent opposed on 5 November 1996. It immediately became effective law by the addition of the *Compassionate Use Act* 1996 to California's Health and Safety Code. This Act ensures, among other things, that:

> seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief.[171]

It also ensures that patients and their 'primary caregivers' who obtain and use marijuana for medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction.[172] One of the aims of the legislation is to encourage Federal and State governments to provide the safe and affordable distribution of marijuana to all patients in medical need of it.[173] It seeks to circumvent the Federal prohibition of marijuana by preventing State prosecution of patients who grow marijuana, thereby establishing a de facto 'legal supply'

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166 N Gilespie, "Prescription: Drugs", *Reason Online* http //wwwreasonmag.com/9702/fe nick.html at 3.

167 Note 35 *supra* at 4. But note these regions had a demographically high proportion of patients with AIDS which may explain the results

168 Note 166 *supra* at 2. See also note 195 *infra*

169 S Ferguson, "The Battle for Medical Marijuana" *The Nation*, 6 January 1997, p 14 at 15

170 Note 38 *supra* at 1

171 Medical Marijuana Initiative (1996) http://www marijuana org/prop htm at 1. This section will be added at section 11362.5 to the Health and Safety Code as (1)(A) [emphasis added]

172 *Ibid.* Added at section 11362 5 to the Health and Safety Code as (1)(B)

173 *Ibid* Added at section 11362 5 to the Health and Safety Code as (1)(C).

under State law. However, the danger remains that Federal agents can arrest and prosecute Californians who violate Federal law. This appears unlikely however, given that it will be difficult for Federal authorities with limited resources to monitor the smoking habits of Californians who comprise some ten per cent of the American population.[174]

The Act specifies that it shall not be construed to supersede legislation prohibiting persons from engaging in conduct which endangers others, nor to condone the diversion of marijuana for non-medical purposes. However, patients with a doctor's recommendation will no longer be arrested or prosecuted by State officials and will have a legal defence under State law. The measures will also protect doctors who recommend its use.[175]

Proposition 215 was very broadly worded and differed from previous State measures in that it focused solely on patients and doctors. It did not include any 'positive measures' other than for the State to liaise with the Federal Government to implement plans for the safe distribution of marijuana.[176] It avoids either creating new bureaucracies or impacting on California's financial budget, but it fails to provide a guaranteed legal supply of marijuana.[177] Patients will still need to obtain the drug from the black market or cultivate their own supply, thereby exposing themselves to the potential risk, albeit remote, of Federal charges.[178]

B. Proposition 200

Proposition 200 was the equivalent Arizona initiative which succeeded by 65 per cent in favour, and 35 per cent opposed, on 5 November 1996. Its success was even more surprising given Arizona's high proportion of elderly voters and historically strong support for conservative Republican Governments. One of the major reasons for its success was a general objection to the Government not allowing doctors to prescribe a drug with documented benefits as well as a belief that the war on drugs is failing and requires a shift away from marijuana prohibition to stricter control of dangerous drugs.[179]

The initiative was broader than the California proposition and sought to amend local drug statutes by the *Drug Medicalisation, Prevention, and Control Act* 1996. The initiative acknowledged that Arizona's current approach to drug control needed to be 'medicalised' to recognise drug abuse primarily as a public health problem.[180] The declaration stated:

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174 Marijuana Policy Report "Voters Enact Laws to Give Patients Legal Access to Marijuana" (1996-7) http.//www mpp.org/voters.html at 2.

175 Note 171 *supra* at 1-3 The 'primary caregiver' is any individual designated by the patient who consistently assumes responsibility for the housing, health or safety of that patient.

176 Note 38 *supra* at 1.

177 *Ibid* at 2.

178 *Ibid* at 7.

179 T Fiedler, "Using Marijuana as Medication Merits Political Debate", *Miami Herald*, 9 February 1997. See also note 169 *supra* at 16. The Arizona initiative was seen as a rejection of the 'lock-em-up' approach towards drug treatment and prevention.

180 State of Arizona, "'Proposition 200' Initiative". http.//www.norml.org/az/az200 shtml at 1. In Section 2 titled "Findings and Declarations", the Arizona Criminal Justice Commission found that marijuana use

> Thousands of Arizonans suffer from debilitating diseases such as glaucoma, multiple sclerosis, cancer and AIDS, but cannot have access to the necessary drugs they need. Allowing doctors to prescribe Schedule I controlled substances could save victims of these diseases from loss of sight, loss of physical capacity and greatly reduce the pain and suffering of the seriously ill and terminally ill.[181]

Section 7 paragraph 2 states:

> A medical doctor must document that scientific research exists which supports the use of a controlled substance listed in Schedule I to treat a disease ... before prescribing the controlled substance. [A doctor must] obtain the written opinion of a second medical doctor that the prescribing of the controlled substance is appropriate to treat a disease or relieve the pain and suffering of a seriously ill patient or terminally ill patient.

Failure to comply with these provisions may result in an investigation and appropriate disciplinary action by the Board of Medical examiners.[182] Patients who receive and use a controlled substance prescribed by a doctor will not be subject to (State) criminal penalties. The Arizona initiative is broader than Proposition 215 in allowing doctors to prescribe *all* Schedule I drugs as well as marijuana (including LSD and heroin). In addition, Proposition 200 went beyond the medicinal marijuana issue and included other broad measures to tackle the overall drug problem in Arizona, including:

- truth-in-sentencing provisions for violent drug offenders;
- court supervised mandatory drug treatment programs for persons convicted of non-violent drug crimes;
- prisoners convicted of personal use drug offences (and not serving a concurrent sentence for another crime) to be eligible for immediate parole, treatment, education, counselling and community service to "free up prisons" for violent drug offenders.[183]

C. Debates For and Against

There were a number of arguments presented for and against the propositions in the course of the referendum debates. Proponents argued that government drug policies had failed and pointed to the American Medical Association's original opposition in 1937 to the *Marijuana Tax Act* which made it illegal for

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had quadrupled among middle school students between 1990-3. See also NORML, "Argument for Proposition 200" http.//www.norml.org/az/az200.shtml at 8. The former US Deputy Secretary of Agriculture, Mr John Norton, supported Proposition 200 on the basis that the Federal Government was spending billions of dollars to incarcerate low level drug users (61 per cent of Federal inmates were imprisoned for drug offences and 38 per cent of State drug offenders were imprisoned for simple drug possession in 1995)

181 *Ibid* at 1 Section 2, para 3 Section 7, para 3 also declares that "in prescribing such a controlled substance, the medical doctor shall comply with professional medical standards".

182 *Ibid* at 4. Section 7, para 3 This would include the doctor being required to provide scientific research which supports the use of the controlled substance.

183 *Ibid* at 2 Section 3 'Purpose and Intent' The Act provides that personal possession or use of a controlled substance does not include possession for sale, production, manufacture or sale of the substance (Section 10, para 3) note 166 *supra* at 12. Judge Rudolph Gerber of the Arizona Court of Appeals noted that court supervised treatment programs and probation alternatives were not 'decriminalisation' reforms and will only apply to people convicted of personal possession or use of a controlled substance Drug dealers will still be prosecuted and incarcerated

doctors to prescribe cannabis.[184] Various community and professional organisations urged voters to support the propositions and called upon the Federal Administration to move expeditiously to make cannabis available as a legal medicine wherever it is shown to be safe and effective.[185] A number of local Arizonan physicians also supported Proposition 200 on the basis that the Act was a "moderate, well reasoned proposal that enhances the physician's ability to help suffering patients".[186]

In the lead up to the debate, opponents focused on general arguments against the legalisation of drugs to persuade voters that:

- marijuana is harmful and can lead to short term memory loss, impaired judgement and motor skills (users are more likely to be involved in motor accidents), anxiety, low motivation and low work productivity;[187]
- medical legalisation will encourage younger people to use it as an acceptable drug, leading to greater truancy;[188] and
- marijuana is a 'gateway drug' leading to use of other, harder illicit drugs.[189]

While the propositions will stimulate patients to ask their doctors about the uses of medicinal marijuana, opponents believed that patients would be more likely to 'doctor shop' in order to obtain an 'easy' supply.[190] The lack of scientific evidence supporting the therapeutic uses of cannabis suggested to opponents that the two state initiatives were an "enormously high-risk social experiment" which would affect overall drug prevention programs and eventually lead to full legalisation.[191] There was also a belief that voters had been 'duped' by expensive campaigns seeking to legalise marijuana and that the results did not reflect the true will of the voters because they were not fully informed of the implications.[192] However, opponents of the California measure

184 "Argument for Proposition 200", note 180 *supra* at 8.

185 Note 180 *supra* at 10.

186 *Ibid.* This is on the basis that medical marijuana is prescribed in compliance with Arizona Board of Medical Examiner standards.

187 Note 5 *supra* at 701.

188 D Shalala, US Secretary of Health and Human Services, "Say 'No' to Legalisation of Marijuana" *Wall Street Journal*, 18 August 1995, p A8

189 Note 5 *supra* at 702.

190 R Voelker, "New Marijuana Laws in 2 States Prompts Caution" (1996) 276 *The Journal of the American Medical Association* 1786

191 A Mecca, Director of California Department of Alcohol and Drug Programs quoted in C Wren, "Votes on medical marijuana are stirring debate", *New York Times*, 17 November 1996, p 116.

192 J Hewitt, "Just Say Yes", *Sydney Morning Herald*, 4 January 1997, p 18, citing Retired General Barry McCaffrey, White House 'Drug Czar'. See also Marijuana Policy Report, "Drug Warriors on Rampage Against Medicinal Marijuana" (1996/7) http //www.mpp.org/rampage html at 2. Wealthy business entrepreneur, George Soros donated US$550 000 to support Proposition 215 as did former Secretary of State George Schultz (US$1 000) and Nobel Laureate economist Milton Friedman (US$ 150). see "Marijuana a Burning Issue in California", *Washington Post*, 3 November 1996, p A8 The support given to the two propositions was also questioned by suggestions that the pro-drug legalisation movement had swayed voters. See for example, R Ehrenfeld, "The Movement to Legalise Drugs in the United States. Who's Behind It?", *Organisation Trends* http.//www capitalresearch org/crc/trends/ot-0596.html at 1 The article focussed (at 8) on the financial support of non-governmental organisations such as the Open Society Fund and NORML, which also promotes marijuana and drug legalisation policies in the US, Italy, Netherlands, Canada and Australia

raised less than US$30 000 to fight it.[193]

Supporters of the initiatives argued that clinical research on medical marijuana had been continually held up by politically motivated inactivity. The laws did not create a legal supply of marijuana and only gave a special defence to people who could still be subject to the scrutiny of the court, thereby minimising the risk that the laws would be abused. Proponents also relied on anecdotal evidence showing marijuana to be less toxic than most prescribed medications, less addictive and less subject to abuse than commonly available hypnotics and analgesics to argue that it was "time to acknowledge more openly that the present classification (of marijuana) is scientifically, legally and morally wrong".[194]

VIII. RESPONSES TO THE RESULTS - FEDERAL v STATE CONFLICT

One of the first judicial responses following Proposition 215 was a Superior Court ruling that the Cannabis Buyer's Club in San Francisco could re-open for business. The club was America's largest distributor of marijuana for medical use and was raided in August 1996 by State agents following complaints that healthy persons were using it.[195] Judge Garcia allowed the club to resume its activities to terminally ill patients but stated that the club could not operate at a profit and that a member's medical condition had to be verified by their doctor.[196] He commented: "I don't think that you or I are going to say that the people of California were totally ineffectual in trying to pass a medical marijuana law".[197]

However, opponents were also heartened by a recent Arizona Senate decision requiring that any drug dispensed as a medicine must first be approved by the FDA. This is not possible under the *Controlled Substances Act* and defeats a central element of Proposition 200.[198]

The referendum results have launched a public debate between those who wish to maintain a hard line against illegal drugs and those who want to challenge general prohibition. The initiatives were arguably the first time since the repeal of the Alcohol Prohibition that the American public has approved a

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193 "Marijuana a Burning Issue in California", *Washington Post*, 3 November 1996, p A8.

194 "Making a Case for Marijuana", *Washington Post*, 27 June 1995, p 8, quoting Grinspoon and Bakalar

195 "With Judge's Approval, Marijuana Club is Set to Bloom Again", *New York Times*, 9 January 1997, p 17 The club was established in 1992 to distribute marijuana although over time it included epilepsy and migraine sufferers. Members had to have evidence of their diagnosis verified by a doctor and could buy a number of products including marijuana brownies, breads and varying grades of the drug.

196 *Ibid*

197 *Ibid.* See also T Golden, "Doctors Are Focus of Plan to Fight New Drug Laws", *New York Times*, 23 December 1996, p A10 The clubs are now expected to require strict identification and diagnosis from patients before prescribing cannabis, with a weekly limit of one ounce per patient

198 T Golden, "Medical Use of Marijuana to Stay Illegal in Arizona" *New York Times*, 17 April 1997, p A16 The governor is now free to design an appropriate bill to neutralise Proposition 200

pullback in the war on drugs.[199] It seems ironic then, that by exaggerating the impact of the two ballots and decrying the use of medical marijuana, the Federal Government has also undermined the credibility of any prohibitionist arguments.[200] The results have at least indicated to the Federal Government that legislation permitting access to medical marijuana is favoured by large sections of the American public.[201] Whether or not this results in a Federal marijuana bill permitting the legal prescription and use of marijuana and the funding of further research remains to be seen.[202]

A. Practical Problems with the Propositions

The laws have created much controversy since their passage. Despite the referendums, medical access to marijuana remains ambiguous. This stems from the difficulty in framing the bills so that they were not so narrow so as only to assist a small group of patients, nor too broad by allowing 'spurious' conditions to be treated. The overriding difficulty remains that a patient will still be in violation of Federal laws which make it illegal to manufacture, possess or distribute marijuana, even if they follow their doctor's recommendation to use medical marijuana in compliance with the State laws.

The Arizona proposition uses the word "prescribe" instead of "recommend" to describe the manner in which doctors can advise their patients. Given that it is still illegal to prescribe marijuana under Federal law, a doctor in Arizona theoretically could be exposed to a criminal sanction. In California, the word "recommend" is used to overcome this obstacle. The recommendation may be either written or oral but written advice could be used as evidence in court and oral recommendations would be difficult to substantiate without a doctor's prescription. The purpose of the medical prescription is to provide a valid legal defence against drug use or possession charges. Organisers of the propositions were emphatic that the laws were designed to cover only legitimate and defensible medical use of marijuana.[203] Doctors, however, will be cautious to prescribe marijuana or any other Schedule I drug given a certain increase in the scrutiny of their prescribing habits which they may have to justify later before Federal and professional bodies.

The propositions primarily fail to address the problem of patients obtaining a *legal supply* of marijuana or the mechanisms for its sale and distribution given the Federal prohibition. The propositions have also been criticised for failing, among other things, to set age restrictions, to define 'medical necessity', to quantify the dose and amounts of marijuana to be used, to set established limits on the amount of marijuana that can be possessed or cultivated, to establish the conditions of use, to establish quality standards for growing marijuana plants or

199 C Wren, "Votes on Medical Marijuana are Stirring Debate" *New York Times*, 17 November 1996, p 116, quoting Ethan Nadelmann, Director of Lindesmith Centre, New York.

200 Note 169 *supra* at 14

201 Note 157 *supra* at 1 NORML hopes that Congress members from California and Arizona are better informed to influence their colleagues in other States.

202 *Ibid.*

203 Note 166 *supra* at 3.

to determine the period in which cannabis use will be considered 'medicinal'. Some commentators even argue that the laws simply shift marijuana drug control away from the criminal justice system to the 'paternalistic' medical profession.[204]

Many of these issues are matters for discussion between the doctor and the patient in the clinical setting. It is questionable whether the laws should expressly deal with these concerns although the lack of guidelines potentially opens the way for the laws to be abused by unscrupulous doctors or healthy persons seeking legal supplies of marijuana. In some ways, the framers of the propositions 'overplayed their hand' by not including rigid standards.[205] Had standards been included, the laws could have been tested and later expanded through court litigation with a possible broadening of the definition of 'medicinal uses'.[206]

B. Federal Responses to the Initiatives

Anecdotal stories of marijuana's medical benefits and general voter suspicion that the Federal Government's anti-drug polices were preventing studies to prove its benefits probably convinced voters to support the initiatives. The Californian Medical Association ("CMA") called the vote a "mandate for research into both the potential therapeutic effects of the drug and its potential dangers"[207] and urged the National Institute of Health to conduct controlled marijuana studies because it was a "science question" rather than a "law enforcement question".[208]

The initial Federal response to the votes was swift given the Administration's awareness of figures showing an increase in marijuana use, particularly amongst teenagers.[209] The Clinton Administration sought to leave the prosecution of marijuana possession to State authorities while the Federal authorities would focus their efforts on doctors who prescribed it.[210] The Federal Administration has, for the moment, ruled out contesting the State laws in a Federal court,

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204 *Ibid* at 6

205 J Leo, "The Voters Go To Pot", *US News & World Report*, 28 October 1996, p 23.

206 *Ibid* Leo cites *Doe v Bolton*, where the Supreme Court found that an abortion for 'health reasons' would cover "all factors - physical, emotional, psychological, familial and the woman's age - relevant to the well being of the patient" Whilst that case would be distinguished on the facts, it suggests the Federal Courts might be willing to determine the definition of "medicinal uses".in an expansive fashion, thereby obviating the need to strictly define such uses in legislation Again, that would depend on the political and judicial climate prevailing at the time.

207 Note 155 *supra* at 1

208 *Ibid*, quoting Steve Thompson, Vice-President of Government Affairs for the California Medical Association in Sacramento While the CMA, which represents some 34,000 physicians, opposed Proposition 215 it supports efforts to expedite medical use of cannabis to see whether it works and in which patients see "Initiative on Medical Use of Marijuana Pits Unlikely Foes", *Los Angeles Times* 16 September 1996, http.//www.marijuana.org/foes.htm at 2.

209 Note 5 *supra* at 696. The percentage of high school students reporting the use of marijuana in the last 30 days increased from 11.9 per cent in 1992/3 school year to 15.5 per cent in 1993/4 year, citing Johnson et al study (1994) See also "Just Say What? Kids and Pot", *TIME*, 9 December 1996, p 28, quoting a Department of Health and Human Services study of 18 000 Americans showing that marijuana use for 12-17 years old rose 105 per cent between 1992 and 1994 and 37 per cent between 1994 and 1995.

210 "Doctors are Focus of Plan to Fight New Drug Laws", note 197 *supra*, p A10.

despite the conflict with Federal laws, because there is little constitutional or statutory grounds for such a challenge.[211] Such action could also provoke a public backlash if terminally ill patients were forced to appear in court to testify that they are being denied medicinal marijuana as a result of the conflict.[212] However, the DEA will continue to treat the cultivation and possession of marijuana as a Federal crime.[213] The Federal Attorney General, Janet Reno, stated that the Federal Government would not send agents to enforce Federal laws because of lack of resources, although she confirmed that the Federal Government would be involved in cases where a patient was prosecuted at a State level and sought to argue that the drug was prescribed or recommended by a doctor.[214] Federal agents pursue only a small fraction of the nation's drug cases where charges are brought for the cultivation of at least 1000 outdoor plants and possession of 1000 pounds of cannabis. In any event, Federal involvement would not be practical in the majority of cases where only small amounts of marijuana are being used for medicinal purposes.[215]

The Secretary of Health and Human Services, Ms Donna Shalala, responded to the initiatives: "All available research has concluded that marijuana is dangerous to our health. [It] harms the brain, heart, lungs and immune system",[216] while the Director of the Office of National Drug Control Policy, General (retired) Barry R McCaffrey said: "These propositions are not about compassion, they are about legalising dangerous drugs".[217] Opponents of the State initiatives consider the Federal response to be correct on the basis that States should not be allowed to opt out of laws with which they do not agree especially in an area where Federal authority is unambiguous, because to do otherwise might jeopardise national legal standards.

One of the first official responses was a warning on 12 December 1996 that a doctor's prescription for marijuana would not excuse transport workers such as pilots, truck drivers and bus drivers who tested positive for marijuana.[218] The Office of National Drug Control Policy ("ONDCP") also released a statement on 30 December 1996 detailing Federal plans to oppose the initiatives,[219] including

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211 R Suro, "US to Issue Warnings on Medical Marijuana Laws", *Washington Post*, 31 December 1996, p A1

212 W Claiborne and R Suro, "Medicinal Marijuana Brings Legal Headache", *Washington Post*, 5 December 1996, p A1 at A17. In addition, the prisons could be swamped with people charged with minor possession offences

213 Note 155 *supra* at 1

214 Note 211 *supra*, p A1

215 Note 210 *supra* 1996, p A10.

216 "Doctors Given Federal Threat on Marijuana", *New York Times*, 31 December 1996, p A1.

217 *Ibid.* McCaffrey said that the result would be "a stalking horse for legalisation of drugs"; see "Marijuana a Burning Issue in California", *Washington Post*, 3 November 1996, p A8.

218 E Shogren, "US Officials Issue Prop, 215 Warning", *Los Angeles Times*, 13 December 1996. A glaucoma patient who worked heavy equipment was prosecuted under a random drug test and was dismissed under a 1988 Federal law He is now seeking to defend his case on the basis that he used cannabis medically. See also M Janofsky, "Worker Fights Dismissal for Medical Marijuana Use", *New York Times*, 2 March 1997, p 118.

219 "Drug Warriors on Rampage Against Medicinal Marijuana" note 192 *supra* at 2. See also US Information Agency Washington, "Administration rejects use of marijuana for medicinal purposes", 30 December 1996 The policy objectives are to maintain effective enforcement controls under the

plans to revoke the registrations of any doctors prescribing or recommending marijuana (effectively denying their ability to prescribe other medications), and jeopardising their participation in Federal Medicare and Medicaid programs on the grounds that such recommendations are "against the public interest".[220]

The ONDCP report highlights concerns that the propositions will threaten the national drug control strategy. The American Medical Association ("AMA") filed a statement in response on 30 December 1996 urging "federal funding of research to determine the validity of marijuana as an effective medical treatment" whilst advising its members to only prescribe *legal* medications to treat disease, given the conflict between the State initiatives and Federal law.[221] The CMA also issued guidelines advising doctors to discuss the risks and benefits of cannabis use but to avoid any recommendation to use it while reminding patients that marijuana use remains illegal under Federal law. The CMA advised doctors not to assist a patient in buying marijuana and to document any discussions on the understanding that it will be privileged from production to a court if a patient wants to use the medical notes in defending a charge.[222]

Americans for Medical Rights have filed a class action in a Federal Court against the ONDCP response on behalf of patients and doctors, contending that it is a violation of doctors' constitutional right to free speech to sanction doctors for advising patients to use marijuana.[223] Plans to strip doctors of their prescribing licence for endorsing marijuana is seen as a violation of the doctor-patient relationship and fails to deal with the real issue of whether marijuana is an effective drug.[224] Despite the Federal threats, US District Judge Fern Smith issued a temporary restraining order in early 1997 barring the government from acting against physicians.[225] The judge said that Proposition 215 was unclear on what doctors could "discuss" and "recommend" to their patients but that the ONDCP response raised "at least a serious question" whether the threats undermined a physician's right to free speech.[226]

Controlled Substances Act (1970), to ensure the integrity of the medical-scientific process by which substances are approved as safe and effective medicines, to preserve the drug free workplaces and to protect minors from marijuana use

220 P Baker and W Claiborne, "Plan Targets Medical Use of Marijuana", *Washington Post*, 29 December 1996, p A1. There will not be widespread investigation of doctors unless they prescribe the drug in such amounts that they are effectively considered to be dealers See also note 210 *supra*, p A10. The *Controlled Substances Act* 1970 allows the Attorney General to deny, suspend or revoke a doctor's licence to prescribe controlled substances if a doctor acts in a manner inconsistent with the "public interest"

221 See http.//www calyx.com/~olsen/MEDICAL/ama html at 1

222 E Bailey, "Medical Leaders Seek Truce in battle Over Marijuana", *Los Angeles Times*, 18 March 1997, p 3.

223 "Drug Warriors on Rampage Against Medicinal Marijuana", note 192 *supra* at 3. See also W Claiborne, "Federal Warning on Medical Marijuana Leaves Physicians Feeling Intimidated", *Washington Post*, 1 January 1997, p A6.

224 T Golden, "Marijuana Advocates Sue to Stop Federal Sanctions", *New York Times*, 15 January 1997, p A10 Doctors should be free to provide the full range of information about cannabis use with their patients For example, abortion can be still discussed even though it is illegal in some States

225 E Bailey, "Medicinal Pot Sanctions Suspended", *Los Angeles Times*, 12 April 1997, p 20

226 *Ibid*

It is unlikely that many doctors will discuss marijuana use with patients until there is further clarification from the Federal Government. The difficulty for doctors in California and Arizona is that the Federal response is ambiguous and does very little to assist them in applying and complying with the State laws to benefit their patients and to protect their professional positions.

C. Other Responses

Americans for Medical Rights was formed following the referendums to press for similar legislation in other states in the hope that a Federal bill would be introduced.[227] In answer to some of the concerns raised above in Part VIIIA, the CMA will assist in drafting a bill to define clearly the terms by which doctors can prescribe marijuana and establish research programs to develop a system for the safe supply and distribution of marijuana through authorised buyers' clubs.[228] Until such time, it seems unlikely that researchers will be able legally to procure adequate amounts of marijuana to conduct research studies.

A recent editorial in the *New England Journal of Medicine* has added respected weight to those supporting medicinal cannabis use by suggesting the Federal response is a "defence of drug orthodoxy" rather than a rational approach to the issue.[229] It believes that a Federal policy which prohibits physicians from prescribing marijuana for seriously ill patients is misguided, heavy handed and inhumane. Neither the long term adverse effects of marijuana nor possible risks of addiction are relevant to such patients and it is hypocritical to allow doctors to prescribe morphine to relieve pain (where the difference between a therapeutic and fatal dose is narrow) and not marijuana (where there is no risk of a fatal dose).[230] The editorial also notes that the demand for scientific evidence of marijuana's efficacy is hypocritical because the effects produced by marijuana are difficult to quantify in controlled experiments. The real issue should be whether a seriously ill patient feels relief as a result of marijuana intervention, not whether a controlled trial proves its efficacy.[231] It urges the Federal Government to rescind the Federal prohibition on marijuana and to allow doctors to treat patients without the fear of bureaucratic decisions based on "reflex ideology rather than on compassion".[232]

Other articles suggests that the ban on medical use of cannabis is a spill over from the war on drugs and that the drug problem must be fought 'intelligently' so that Federal laws are not used to harass the sick.[233] Even the conservative journal *The Economist* supports the medicalisation of marijuana.[234] It argues that

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227 Note 169 *supra* at 16.

228 *Ibid.*

229 JP Kassirer MD, "Federal Foolishness and Marijuana" (1997) 336(5) *New England Journal of Medicine* 366 at 366-7.

230 *Ibid* at 366

231 *Ibid.*

232 *Ibid* at 367 See also Nahas, Sutin, Manger and Hyman, "Marijuana is the Wrong Medicine", *Wall Street Journal*, 11 March 1997, p A22, which argues that Dr Kassirer's editorial contains a number of errors, including an underestimation of the toxic properties of marijuana smoke.

233 R Brookhisher, "Pot Luck", *National Review*, 11 November 1997, p 28

234 See "The Last Smoke", *The Economist*, 28 March 1992, p 23

the Clinton Administration's response to the Propositions is based on two fears: (a) the unwillingness of authorities to concede the medical benefits of a controversial drug; and (b) describing marijuana as a prescription drug could be the 'thin wedge' that precipitates a move to full legalisation of marijuana. The idea that cannabis is not therapeutic is deemed 'implausible' given the Federal government approval of synthetic THC and the best way to allay such fears is for scientific trials and experiments into the drug's efficacy.[235] That requires a political will which has not yet materialised in America.

At the State level, the California Attorney General, Dan Lungren, acknowledged that the State could only enact laws to modify Proposition 215, such as measures to prevent cannabis users harming others in the workplace.[236] He said: "A physician must affirmatively recommend marijuana, not just approve of (or 'rubber stamp') its use. The physician is bound by the Hippocratic oath and should find that the benefits of marijuana use for the specific patient clearly outweigh the risks to the patient".[237] He recommended that State law enforcement officials interpret the law narrowly and require proof from those arrested that marijuana was being used medically.[238] Guidelines to assist law enforcement officials in deciding whether to arrest persons suspected of marijuana offences included:

- early questioning to determine why the person is taking marijuana and whether it was on a doctor's direction;
- whether the person is a patient or care-giver;
- the presence of large amounts of cash or marijuana; and
- whether the individual has a prior criminal history.[239]

The first attempt to dismiss a marijuana charge following Proposition 215 is the case of *The People of California v Martinez and Miller*.[240] Martinez and Miller were convicted of cultivating marijuana in August 1996. Martinez claimed that marijuana reduced his epileptic seizures and allowed him to go out socially. Miller claimed the status of 'primary care giver' as a defence to the charge of cultivating marijuana. The trial judge found that persons arrested on cannabis charges still had to mount a defence despite the wording of Proposition 215 that people "shall not be prosecuted". The judge wanted the recommending doctor to testify in court and adjourned the hearing until such time as the doctor agreed but said that he would not grant the doctor immunity. It is therefore unlikely that the doctor will present evidence and the case may ultimately go to

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235 "Clinton's Judgment Goes to Pot", *The Economist*, 4 January 1997, p 18.

236 See note 190 *supra*.

237 Attorney General Dan Lungren, California Department of Justice News Release, "Lungren and State Law Enforcement" (3 December 1996) http://www.marijuana.org/azone htm at 2

238 Attorney General Dan Lungren, California Department of Justice News Release (1996) at http.//www.marijuana.org/guid2 htm at 2. He also acknowledged that the laws could not be changed except by another ballot initiative.

239 *Ibid* at 2.

240 F Gardner, "Proposition 215 on Trial", *Village Voice*, 31 December 1996, p 43

appeal.[241] The case is an early demonstration of the difficulties courts will encounter in interpreting State law, which will do little to ease the concerns of patients and doctors.

One issue that does not appear to be in dispute is the need for research into marijuana and its medicinal effect. Scientific research will improve knowledge about cannabis and allow other States to make a more informed choice about their approach to medical marijuana. The propositions may in fact assist future research projects and overcome hurdles to those seeking permission to undertake studies.

In California, a Proposition 215 implementation bill (SB 535) has been filed to establish a US$6 million three year research program at the University of California to study safety and efficacy of medical marijuana and determine a safe and affordable means of distributing cannabis to doctors and patients.[242] Recent initiatives have also been proposed in Connecticut, Hawaii, New Mexico, Oregon and New York,[243] and the White House recently announced (shortly after denouncing the proposition results) that it would spend up to US$1 million for the Institute of Medicine to gather scientific, clinical and medical evidence for the health efficacy of marijuana as a medical treatment, to be reported within 18 months.[244]

D. Solutions?

The Clinton Administration has no constitutional legal authority to prevent State governments from changing laws to remove State criminal penalties for medical uses of marijuana.[245] It could decide not to enforce Federal laws in circumstances where the marijuana is strictly used for medical purposes and where the States agree to tighten their marijuana laws to avoid potential abuse. This would avoid any arguments about States' rights and address some of the problems raised by the Propositions. Other States may decide to pass laws which mirror California's initiative but with added restrictions such as parental consent for use by minors, prohibiting use which may affect others (for example, driving while under the influence) and the monitoring of diversion of marijuana for non-medical purposes.[246] Alternatively, Congress could simply reschedule cannabis under the *Controlled Substances Act*, thereby enabling doctors to prescribe marijuana and allow patients to obtain it from a pharmacy.[247]

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241 *Ibid.* The preliminary hearing was held on 5 February 1997 but there has been no result as at the date of printing

242 Marijuana Policy Report, "State Legislatures to Decide on Wide Range of Marijuana Bills in 1997" (1997) http //www natinorml.org/activist/stateleg.shtml at 1

243 *Ibid.* The summary of the New York legislative bill says: "This legislature finds that thousands of New Yorkers have serious medical conditions that can be improved by medically-approved use of marijuana The law should not stand between them and life and health-sustaining treatment under a practitioner's supervision This legislation follows the well established public policy that a controlled substance can have a legitimate medical use"

244 Note 195 *supra*, p B10

245 Note 35 *supra* at 4.

246 *Ibid.*

247 *Ibid* at 5.

However, the current anti-drug climate prevailing not just in America but across the developed world suggests that it is unlikely that this issue will be effectively dealt with by the Federal Government (See also Part XF of this article: Heroin Trials - Signs for the Future?).

E. British Developments

Whether by coincidence or design, doctors in Britain have recently voted overwhelmingly for cannabis products to be made legally available for medicinal use. The British Medical Association ("BMA") recommended a chemically pure version of cannabis in either pill or injection form for patients suffering certain medical conditions.[248] The BMA stressed that it was not advocating the use of recreational marijuana but acknowledged that people were breaking the law to buy marijuana for their conditions.

If the law was changed in the UK, a list of conditions would be drawn up where cannabis could be prescribed, such as cancer or multiple sclerosis, but not for minor complaints, such as headaches.[249] That would differ from the American initiatives which do not specify the illnesses that can be treated. However, in common with America, research in Britain is hampered because of the illegal status of cannabis although it is acknowledged that there is a difference between laboratory produced cannabinoids and raw cannabis which contains other chemicals.[250]

A formal report on the issue is due to be delivered in October 1997 and is expected to support the proposition that "the sick and the dying should be able to turn to their doctor for help, not a drug dealer".[251]

IX. ETHICAL AND LEGAL PROBLEMS FOR DOCTORS AND PATIENTS

Doctors and patients have always faced obstacles in prescribing and using illegal but effective drugs for the treatment of various illnesses, as demonstrated by the case of *Jenks v State*.[252] Despite the referendum results which have focused attention on the legality of prescribing marijuana, the two Propositions have also raised a number of ethical issues including the availability of treatment options, the interface of medicine and the law, patient confidentiality, and doctor-patient autonomy. For many doctors, marijuana will still be considered a 'last option' when clinical decisions are made to treat patients. However, if marijuana is effective in treating a patient's symptoms and disease and there are no other readily available therapies, then the doctor will need carefully to examine his or her decision not to prescribe marijuana. If a patient is denied a

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248 C Mihill, "Doctors Aim to Give Patients the Dope on Cannabis", *Sydney Morning Herald*, 4 July 1997, p 13.

249 *Ibid.*

250 *Ibid.*

251 *Ibid*, citing Dr Steven Hajioff, senior lecturer in general practice at Bart's Hospital, London

252 582 So 2d 676, 677 (Fla Dist Ct App 1991). See also note 164 *supra.*

form of therapy because of the doctor's personal or ethical concerns, there may be a potential conflict with the doctor's primary duty to act in his or her patient's best interests and to provide the best available medical care. Another major consideration following the Propositions is whether doctors will be prepared to support the medicinal use of marijuana in a general climate of prohibitionist governmental drug policy.

Given marijuana's status as an illegal drug under Federal law, doctors still need to satisfy themselves that marijuana can be defined as a *medicinal treatment* and, if so, whether they are entitled to prescribe it as a drug. Despite the new State laws, a recommendation that a patient use marijuana to relieve certain symptoms still places a doctor in the difficult position of encouraging or advising his or her patient to commit an offence under Federal law which carries the risk of prosecution. Patients too face a dilemma in choosing to obey Federal law by not using marijuana or deciding to take advantage of the State initiatives and smoke marijuana for medicinal purposes. [253]Ideally, such decisions should not have to be made by patients who are terminally ill or may be preoccupied with other health concerns. Another major problem that has not been addressed by the Propositions is a guaranteed supply of legal marijuana. If anything, the current controversy surrounding the Propositions has made patient decision making even more difficult because it has exposed the range of legal risks that patients and doctors now face in making these choices.[254]

There is no doubt that doctors must respect patient autonomy at all times and provide as much information as is necessary to the patient so that they can make an informed choice about medicinal marijuana use and their health. Yet given certain claims that marijuana may have adverse health effects, there is also an obligation on doctors to advise of the potential harms in using marijuana in order to avoid harming their patients. The doctor's duty to act in his or her patient's best interests in prescribing marijuana may also lead to a conflict with a wider social interest in not promoting illegal drug use in any form. The rights of the patient must then be balanced against the right of society to be free from the potentially damaging effects of illicit drugs.[255]

Resolution of these conflicts will not always be easy, especially when the medicinal effects of marijuana have yet to be conclusively proven and are largely based on anecdotal evidence. By assuming the care of the patient, a doctor still has an overriding duty to avoid harming the patient and is duty bound to treat the patient to the best of his or her ability.[256] Of course, a doctor also has a duty to society to ensure in his or her own mind that only patients with specific diseases are prescribed marijuana as the best treatment option. The Propositions assist in resolving these questions by differentiating for the first time between 'medicinal uses' and 'recreational uses' of marijuana. Before the State initiatives, it was open for doctors to decide that the illegal status of cannabis precluded any

253 Note 161 *supra* at 256
254 *Ibid* at 257
255 *Ibid* at 265
256 *Ibid* at 260

exercise of their medical discretion to prescribe it as treatment.[257] Now that there is 'popular sanction' of medicinal marijuana use, it is arguably easier for doctors to justify recommending marijuana use to their patients, notwithstanding the Federal prohibition.

Any recommendation, however, requires a full and frank disclosure by the doctor of the latest available medical information on the effects of marijuana, whether clinical or anecdotal, so that the patient can make an informed decision before using it. The lack of scientific studies on medicinal marijuana unfortunately means that doctors may be unable adequately to advise on the risks and benefits of marijuana use. While the medical advice might include a reminder of the legal risks that patients might face under Federal law, the doctor will be precluded from providing legal advice. In the event that a patient is questioned about his or her use of marijuana by Federal or State authorities, the content of the medical advice will be open to scrutiny. That raises issues of patient-doctor confidentiality and the extent to which Governments will be entitled to become privy to any such communication in order to determine whether a doctor's recommendation is legally valid or appropriate under the new State laws. To be effective, the State laws must protect the confidential nature of the doctor-patient relationship and ensure that it is protected from unnecessary intrusion by the Government. Although yet to be tested in the State courts, any indication that the courts or Federal law enforcers will investigate doctor-patient communication to assess and if there has been a breach of Federal law may ultimately dissuade doctors from prescribing marijuana at all.

Another issue arises if a doctor's decision to prescribe medicinal marijuana is based solely on legal rather than medical considerations, because there may be a risk that the doctor is influenced by concerns other than his or her primary duty to the patient and their health. Doctors are entitled to hold moral viewpoints on marijuana use but their primary duty remains the provision of the best medical care and advice to patients. Should other concerns, whether legal or moral, influence that advice, and the patient's health is found to be adversely affected as a result, the doctor may be exposed to a potential finding that he or she failed to discharge his or her professional duty to treat the patient appropriately.

It is interesting to note that while the IND Programs allowed doctors to legally prescribe marijuana without fear that Federal laws would hamper the treatment of patients,[258] the Propositions have done little to fully protect doctors and patients legally in their decision making on marijuana use. Patients still assume a risk of Federal prosecution if they process a marijuana prescription, there is no assistance for patients to obtain a safe legal supply of marijuana and there is very little protection of the doctor-patient relationship, which is open to increased scrutiny. The referendums have certainly raised as many questions as they have solved. However, the State laws fail to fully appreciate that doctors and patients are solely responsible for the decision to use marijuana as a medicine and that it

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257 *Ibid* at 262, 264. There is often a 'trade-off' between competing principles - if doctors do not provide all the information on marijuana, they may be compromising patient autonomy If they fail to warn of the potential hazards, they may be avoiding their duty to prevent harm.

258 *Ibid* at 270

is this decision which should be protected by the Propositions from any consequences of the Federal law.[259] The doctor-patient relationship must be paramount in any decision to use marijuana medicinally so that the issue becomes a *medical* rather that a *legal* one whenever it applies to sick or terminally ill patients. The role of the law in that clinical decision making process must assist in the provision of the best treatment options for patients. While the Propositions go some way towards focussing the debate onto the doctor-patient relationship, the legal uncertainties surrounding the operation of State laws suggests that any medical recommendation to use marijuana will be open to careful scrutiny by law enforcement authorities, potentially hampering the provision of the best medical care to patients. What is clear, however, is the need for legal certainty concerning the above issues to ease the current, and very real, concerns of patients and doctors alike.

X. IMPLICATIONS FOR AUSTRALIA

Marijuana is the most widely used illicit drug in Australia. A 1993 report suggests that a third of all adults have used the drug and 72 per cent of all adults between the ages of 20 and 24 have reported marijuana use at some time.[260] The rates of marijuana use are not as high as those for alcohol and tobacco use, which are known to have adverse effects on health. The increase in cannabis use over the last 25 years has come about despite the fact that the drug is illegal and prohibited.[261]

Australian drug laws have closely followed laws in America, which in turn have influenced the development of international drug treaties.[262] These laws have failed to distinguish between medicinal use and recreational use of drugs and have led to the adoption in Australia of the 'total prohibition' approach to drugs favoured in America, whereby the total eradication of illicit drugs (including cannabis) is the goal.[263]

There are no legislative or administrative rulings in Australia that specifically prevent the medical use of cannabis. There is also no Federal monopoly on drug laws as in America, although Australia's obligations under various international treaties relating to drugs mean that the States are hampered in enacting legislation which is inconsistent with Federal law. At present, there are no medical uses of cannabis officially recognised by the medical profession in

259 *Ibid* at 272

260 National Drug Strategy, "Public Perceptions of the Health and Psychological Consequences of Cannabis Use", Monograph Series No 29, AGPS (1995) at 9. Surveys indicate marijuana use has increased from 12 per cent of all adults in 1973 to 34 per cent by 1993.

261 National Drug Strategy, "Patterns of cannabis use in Australia", Monograph Series No 27, AGPS (1995) at 65.

262 Note 33 *supra* at x, 20. American pressure led to the very gradual expansion of Australian drug laws to cover cannabis, in addition to pressure from the British government, which represented Australia at overseas conventions until the 1930s.

263 *Ibid* at xi. This has not led to decreased use of marijuana despite the enormous financial and social costs of law enforcement.

Australia although trials are currently taking place.[264]

The United Nations Conventions to which Australia is a party do not specifically prohibit the medicinal use of cannabis so the introduction of legislation to allow the use of cannabis for medical purposes would appear to be relatively simple. For example, clauses authorising the therapeutic use of cannabis could be inserted into relevant drug legislation and therapeutic product schedules.[265] However, such changes would be difficult politically because cannabis has a negative image and is widely seen as being dependence producing and damaging to people's health. Recognising the medical benefits of cannabis would certainly challenge the dominant legal view of cannabis in Australia and assist in any move to change the laws.[266]

A. History of International Treaties Governing the Use of Marijuana in Australia

Cannabis is a proscribed drug in all States and Territories in Australia although until 1900 there were few legal controls on the sale or use of drugs in Australia, including cannabis.[267] One of the reasons why cannabis was classified as illegal in Australia was as a consequence of international efforts to control the production of opium which sparked the international trend towards drug prohibition.[268] The *Hague Convention* of 1911/12 limited the use of opium, cocaine, morphine and heroin to medical purposes. The *Geneva Conventions* in 1925 and 1931 added cannabis to the list of illegal substances, which established the framework for Australia's future drug laws.[269] They prohibited the non-medical use of Indian hemp or cannabis and the Australian government enacted controls in 1926 to control cannabis importation under the *Customs Act* 1901.[270] Up until that time, there had been no perceived problem with cannabis use in Australia.[271]

In 1961 the United Nations *Single Convention on Narcotic Drugs* was instigated at the urging of America and included cannabis alongside heroin as a narcotic drug. Article 2(5) set controls for cannabis and heroin as 'particularly dangerous' narcotics.[272] The 1961 Convention was ratified by Australia on 1

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264 See Queensland Advisory Committee, *Report on Cannabis and the Law in Queensland*, Criminal Justice Commission (1994)

265 *Ibid* at 104. For example, Nabilone is a synthetic cannabinoid listed in the Australian Standard Uniform Scheduling of Drugs and Poisons as a Schedule 8 drug, ie a drug of dependence which can only be prescribed under special authority.

266 *Ibid* at 104-5

267 Note 16 *supra* at 21

268 *Ibid*, citing National Campaign Against Drug Use, *Comparative Analysis of Illicit Drug Strategy* (1992) p 1. See S Morgan and MR Liverani, "Cautious Support for Decriminalising Personal Use of Marijuana" (1994) 32(1) *Law Society Journal* 38 at 40

269 Note 16 *supra* at 21

270 *Ibid* at 22.

271 *Ibid*, citing Queensland Advisory Committee on Illicit Drugs, *Cannabis and the Law in Queensland - a Discussion Paper*, July 1993, p 7

272 *Ibid*. It was the first international prohibition on cannabis See also note 55 *supra* the list of dangerous drugs was undertaken as a result of a mixture of racial prejudice, religious belief and purely political

December 1967 and has continued to shape the public and political perceptions of the drug in Australia.[273] The Convention did not absolutely prohibit cannabis, which could still be supplied for therapeutic, medical or scientific purposes, but it was not clear what 'medical purposes' meant. The preamble recognised that "the medical use of narcotic drugs continues to be indispensable for the relief of pain and suffering" so that adequate provision of narcotics be made available for such purposes.[274] The UN *Convention on Psychotropic Substances* 1971 extended the 1961 Convention to a range of behaviour and mood altering drugs but distinguished between those drugs completely prohibited and those used for restricted medical purposes, such as marijuana.[275]

Generally, the Conventions forbid countries from supplying or using cannabis except for medical or scientific purposes. Theoretically, cannabis can be treated as a medical drug although the imprecise nature of these definitions leave the laws open to interpretation. Some jurisdictions, notably the Netherlands, attempted liberal regulation of drug laws and made amendments to their *Opium Act* in 1976, which decriminalised minor cannabis offences by drawing a distinction between drugs presenting unacceptable risks (attracting prescribed penalties) and other hemp products.[276]

The Australian laws which stem from the 1961 and 1971 Conventions do not provide absolute prohibitions on marijuana, but the fact that heroin and cannabis are subject to maximal restraint is due more to international politics than chemistry.[277]

International obligations undertaken by the Commonwealth Government become domestic law once legislation is put into effect. The States are not prevented from passing laws inconsistent with the international conventions although generally, the Commonwealth will override an inconsistent State law.[278]

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considerations rather than clinical considerations (at 3) A 1972 Amendment to the Convention did not include alcohol, nicotine or caffeine which are also considered recreational drugs.

273 Note 33 *supra* at 28

274 Note 55 *supra* at 6 See also note 33 *supra*, citing Article 4c of the 1961 Convention

275 Note 264 *supra* at 49.

276 See note 16 *supra* at 23. See also note 33 *supra* at xii The Code of Criminal Procedure permits prosecuters to decide whether to enforce a law on the basis of whether it is in the public interest. Dealing, possessing or producing small amounts of cannabis do not require police investigation. The stated aim is for a pragmatic approach to the drug problem to reduce health problems so that the issue is medical rather than moral or legal

277 Note 55 *supra* p 99

278 Queensland Advisory Committee, *Report on Cannabis and the Law in Queensland*, Criminal Justice Commission (1994) p 49. Section 109 of the *Constitution Act* 1900 (Cth) provides "When a law of a state is inconsistent with a law of the Commonwealth, the later shall prevail, and the former shall, to the extent of the inconsistency, be invalid". The Commonwealth government can enter into international treaties for Australia and it has authority under s 51 (xxix) of the Australian Constitution to pass such domestic laws provided, among other things, the law is an appropriate means of giving effect to the treaty and must not be a mere device for attracting jurisdiction - see L Zines, *The High Court and the Constitution*, Butterworths (3rd ed, 1992) pp 236-8.

B. Australian Legislation

One of the first studies on cannabis in Australia to respond to the increasing international debate on marijuana was the *Royal Commission into the Non-Medical Use of Drugs* in South Australia (the "Sackville Inquiry").[279] The report looked at the definition of "drug" in a pharmaceutical context (chemical substance), medicinal context (treatment of a diagnosed physical or mental disease) and popular recreational context (loaded with emotional and moral issues).[280] The report found that most people can take 'over-the-counter' mood altering drugs such as antihistamines, and cough medicines with codeine, without experiencing any difficulties or major adverse effects. Even though such drugs may alter mood, there is no suggestion that they are used irresponsibly.

Consequently, use of cannabis, which also alters mood, should not always be labelled as 'irresponsible use'[281] because, from a social policy point of view, the most important question is the impact cannabis use has on the health of the individual and the wider community. The Sackville Inquiry concluded that the assumption that non-medical use of drugs (as distinct from medical use) is not approved by the community and should be eliminated has underscored much of Australia's legislative response to drug control.[282] This assumes that the distinction between 'medical' and 'non-medical' use is clear, the implication being that where there are no medical uses, the drug ought to be prohibited and where there are medical uses, non-medical use should be prohibited.[283] The first implication is unrealistic if the drug is used industrially or is a naturally growing plant, and the second implication problematic if a society allows any unsupervised private behaviour at all. The report recommended a 'partial prohibition' approach by which personal use cultivation of marijuana for small scale private distribution would not be a criminal offence. It also recommended the reclassification of marijuana, for legal purposes, away from opiate narcotics.[284]

Despite the report, penalties for marijuana offences increased in Australia from the 1980s, although they varied from State to State.[285] Australia ratified the *Convention Against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances* on 16 November 1992, which reinforced earlier UN conventions. It became law on 14 February 1993 by effect of the *Crimes (Traffic in Narcotic*

279 Royal Commission into the Non-Medical Use of Drugs, *The Social Control of Drug Use - a Discussion Paper*, South Australia, 1978, Commissioners Ronald Sackville, Earle Hackett and Richard Nies.

280 *Ibid* at 5 The authors noted that the popular usage was avoided where the lay usage referred to drugs such as alcohol, tobacco or doctors' medications

281 *Ibid* at 8

282 *Ibid* at 35.

283 *Ibid.*

284 Note 16 *supra* at 23.

285 *Ibid* at 24 The *Drugs Misuse and Trafficking Act* 1985 (NSW) created offences for commercial supply, cultivation and manufacture of quantities of cannabis, while South Australian and ACT laws allowed for on the spot fines for simple marijuana offences with criminal convictions not recorded if fines were paid. Queensland, on the other hand, proscribes heavy penalties for even simple possession.

Drugs and Psychotropic Substances) Act 1990.[286] The Convention requires nations to prevent the illicit cultivation of plants with narcotic or psychotropic substances, including cannabis, which is defined as a narcotic or opiate for the purposes of inclusion.[287] Although these labels are incorrect, they have contributed to the confusion about cannabis and its effects because it is unjustifiably identified with more dangerous drugs.[288] It would appear that legislation in America and Australia has been enacted on the basis of the UN Conventions without an adequate medical investigation of the potential uses and effects of marijuana. One commentator states: "The repeated failure to open public debate and to consult the medical and pharmacological professions, sociologists, economists and others with expert knowledge is quite sinister".[289]

In New South Wales, the combined effect of the *Poisons Act* 1966 (NSW) and the *Drug Misuse and Trafficking Act* 1985 (NSW) has resulted in a ban on the supply of heroin and cannabis as prohibited substances.[290] Cannabis is included in Schedule 8 of the *Poisons Act* 1966 (NSW) as a drug of addiction.[291] The cultivation, manufacture, production, supply, possession and use of marijuana is prohibited and illegal under the *Poisons Act* except for possession for the purposes of scientific research or under lawful prescription.[292]

It is notable that the Commonwealth and some State laws have started to distinguish between offences relating to 'trafficable quantities' of drugs, including cannabis, and offences for possession. There is also a greater distinction made between simple possession of cannabis and other illicit drugs, reflecting an acknowledgment of its widespread use and relatively minor risk of

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286 *Ibid* Cannabis and resin are narcotic substances under the *Customs Act* 1901 (Cth) Schedule VI and declared a prohibited import and export without reasonable excuse under section 233B.

287 *Ibid.* Section 15 provides for imprisonment of convicted of selling, manufacturing or possessing cannabis plants for the purpose of dealing in the drug on Australian planes and ships, or outside Australia.

288 Note 264 *supra* at 50 It is argued that society should not dismiss the possibility of therapeutic uses simply because cannabis is the subject of current sociopolitical controversy. See M Booth, "Up in Smoke - Thoughts About Medical Marijuana", *The Canberra Review*.

289 Note 55 *supra* at 22 Again, government inactivity and fears of a possible public backlash against a more 'liberal' approach to drugs might explain the general reticence of politicians to challenge the current status quo surrounding marijuana laws In addition, general conservatism within the medical profession itself might explain why there have not been more representations from doctors calling for legislative changes with respect to marijuana and other illegal drugs.

290 See note 55 *supra* at 229. Psychoactive drugs (such as morphine and methadone) and tranquillisers (such as Valium, serepax and rohypnol) require prescriptions but are not covered by the Conventions and are arguably more dangerous and addictive.

291 Note 16 *supra* at 25 It is accepted that the legitimate use of illicit drugs, particularly narcotic pain killers, requires controlled access by patients through the medical system See C Reynolds, *Public Health Law in Australia*, Federation Press (1995) p 208.

292 See sections 10-14 It is an offence to possess except where a person is licensed or authorised to have possession of the prohibited drug under the *Poisons Act* 1996 (NSW) (s 10(2)(a)), a person has authority from the Department of Health for the purpose of scientific research or study (s 10(2)(b)) or the person has been legally prescribed or supplied (s 10(2)c) In addition, it is an offence to administer a prohibited drug to another person unless licensed to do so under the *Poisons Act* 1966 (NSW) (s 13(2)(a)) or by the Department of Health (s 13(2)(b))

harm.[293] It is possible that, in order to meet its treaty obligations, the Federal Government may have to override various State laws by using its 'external affairs power' under the Constitution.[294]

The recent change in approach to drug laws may be linked to the greater availability of 'over-the-counter' medications in Australia. Patients can buy mood altering substances over the counter and despite the absence of a doctor, the drug taking cannot be called 'non-medical'.[295] In the course of self medicating, patients will often assess their own needs and purposes in taking drugs which may not be generally accepted by doctors but is nevertheless 'medical'. The term 'medical use' is often vague and any social disapproval of a drug should be based on its social cost and effects (rather than its effects as a medical drug, which is traditionally how UN treaties have approached the issue).[296]

C. Related Drug Legislation

In Australia, the *Therapeutic Goods Act* 1989 (Cth) provides a national control over the manufacture, availability and distribution of therapeutic goods and would apply to marijuana if it was ever licensed as a therapy.[297] Drugs must conform to internationally recognised standards, and companies which supply, import, export or manufacture the drug must obtain written consent from the Department of Health.[298] Marijuana could be classified as a Schedule 9 drug under the *Therapeutic Goods Regulations* 1990 (Cth) and defined as a poison "which is a drug of abuse, the manufacture, possession, sale or use of which should be prohibited by law except for amounts which may be necessary for

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293 Note 106 *supra*, p 21. Under the *Controlled Substances Act* 1984 (SA), regulations were added in 30 April 1997 known as the 'expiation of simple cannabis offences' whereby personal possession of up to 100 grams is expiable and there are 'on the spot' monetary fines for possession up to 100 grams ranging from A$50 - A$150. If the money is not paid within 60 days, court proceedings may be taken The *Drugs of Dependence (Amendment) Act* 1992 (ACT) provides for fines where a simple cannabis offence has occurred, namely the cultivation of less than five cannabis plants or possessing less than 25 grams. The prescribed penalty is A$100 These laws might be in breach of the 1988 UN Treaty which advocates total prohibition with criminal penalties. The *Drugs of Dependence (Amendment) Bill* 1994 (ACT) was a further attempt to enact a defence for persons charged with possession or administration of small quantities of marijuana provided it was under medical authorisation The provisions were passed in the ACT Assembly but were removed a week later due to a major uproar among politicians who failed to appreciate that the purpose of the amendment was to legalise the prescription use of marijuana where conventional medicines fail See M Moore, MLA, "Medicinal Cannabis - An Opportunity", unpublished manuscript at 5

294 See S Morgan and MR Liverani, note 268 *supra* at 40. See also M Moore, MLA, note 293 *supra*

295 S Morgan and MR Liverani, note 268 *supra* at 35.

296 *Ibid* at 36

297 See *Australian Health and Medical Law Reporter* CCH Australia (1997) para 23-310 at 26,252 A therapeutic good includes any product used in the prevention, diagnosis, cure or alleviation of disease, defect or injury

298 *Ibid* at para 23-460. Drugs must be submitted to an evaluation by the Drug Safety and Evaluation Branch of the Department of Health before they are approved. Clinical trials must demonstrate the drug's benefit, confirm that there are no adverse reactions, and show that the drug's pharmacology and toxicology are well characterised However, the overriding policy on narcotic and addictive drugs suggests that it is unlikely that cannabis would satisfy the criteria for therapeutic drugs See M Moore, note 293 *supra* at 16.

medical or scientific research conducted with the approval of Commonwealth or State or Territory Health Authorities".[299] Alternately, a Schedule 4 classification would allow cannabis use which "should, in the public interest, be restricted to medical, dental or veterinary prescription or supply, together with substances or preparations intended for therapeutic use, the safety or efficacy of which requires further evaluation".[300] Cannabis could also be governed by the *Narcotic Drugs Act* 1967 (Cth) to ensure that manufacturers kept records of the production and supply of marijuana if it were made commercially available.

A 1992 National Health Strategy paper on Pharmaceutical Drug Use in Australia recommended measures to reduce the adverse consequences of prescription drugs, including the establishment of epidemiological databases, education programs, drug review processes and quality assurance programs to guide doctors and patients who use medicinal cannabis.[301] Licensed centres which distribute marijuana for medical purposes could also be established with requirements for patients to carry identity cards that show the disease being treated and the dose and duration of cannabis therapy, which could raise patient confidentiality issues.[302] More recently, a bill to allow South Australian pharmacists to sell marijuana produced by licensed growers was defeated by a conscience vote in Parliament.[303] The proposal was an effort to reduce the 'black market' in cannabis but will be reintroduced as a private member's bill at a later date.[304]

Ultimately, one of the more effective options would be for cannabis to be licensed. Drug manufacturers would need to develop different strengths of the plant for specific medical uses, and packaging would require labels showing information such as THC content, cannabis usage, and specific health warnings in order to comply with therapeutic goods guidelines.[305]

D. Australian Case Law

Unlike America, there is a lack of case law in Australia which examines medical uses of marijuana. A few recent cases have, however, suggested that the courts will be lenient towards patients convicted of marijuana possession who can demonstrate that it was used for therapeutic, not recreational, purposes.

Mr Terrence Lee Falconer was convicted by a local magistrate in January 1991 on charges of cultivating 6 plants of prohibited cannabis and being in

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299 Note 297 *supra* at para 23-320 at 26,271 The Regulation contains the Poisons Schedule (see note 22 *supra*) The current Standard for the Uniform Scheduling of Drugs and Poisons (SUSDP) No 11 (effective since 24 September 1996) provides a national poisons standard by the National Health and Medical Research Council

300 *Ibid.* Even a Schedule I classification would allow cannabis to be used under strict medical supervision. "Poisons of plant origin of such danger as to warrant their being available only from medical practitioners, pharmacists or veterinary surgeons.

301 *Ibid* at 23-460.

302 Note 55 *supra* at 244

303 "Drug Bill Defeated", *Australian Doctor*, 1 August 1997, p 11

304 *Ibid.*

305 Note 297 *supra* at para 23-460.

possession of less than 1 gram of cannabis.[306] He was fined A$500. On appeal, Mr Falconer's doctor provided evidence that he suffered from HIV infection which had progressed to AIDS and that his drug therapy caused nausea and vomiting. His doctor cited American studies which showed the benefits of marijuana in the treatment of HIV and said that Mr Falconer's use of marijuana was personal rather than commercial.

The appeal judge was aware of the American studies and agreed it was anomalous that Mr Falconer could freely and legally access large doses of pethidine and morphine by prescription but was in breach of the law for marijuana possession. The judge's task was to apply the law, not amend it, but Mr Falconer's good character and poor health status persuaded him to dismiss the conviction and fine. However, His Honour qualified his judgment thus:

> [A]nything I can do here will not legalise [Mr Falconer's] future use of marijuana. He will have to take his chances notwithstanding the beneficial effects he says he obtains from it ... [He has] been in breach of the law ... whether [he takes] the risk in the future, it is entirely a matter for [him].[307]

E. Australian Reports and studies

- The Alcohol and other Drugs Council of Australia recently produced a discussion paper on cannabis policy. It said that while the medical uses of cannabis are "limited", despite claims of beneficial properties which have yet to be substantiated,[308] the available evidence suggested that the use of cannabis in small quantities was no worse and possibly less harmful than other 'soft' drugs such as alcohol and tobacco.[309]

- In 1991, the Select Committee on HIV, Illegal Drugs and Prostitution of the Legislative Assembly for the Australian Capital Territory in its Third Interim Report noted the therapeutic uses of cannabis in the treatment of HIV and AIDS and recommended changes to cannabis laws.[310] The report found that many of the drugs used in HIV and AIDS treatment produced the same effects as chemotherapy in cancer patients and recommended a study of medicinal cannabis use for HIV and AIDS patients.[311]

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306 *In the matter of the Appeal of Terrence Lee Falconer*, District Court of NSW Special Jurisdiction, 22 March 1991 at 1. See also *The West Australian*, 15 September 1992, p 27 - an AIDS sufferer was convicted of trafficking in marijuana as well as possession. He pleaded that the drug was for the relief of pain in other AIDS sufferers The magistrate released him without conviction saying that he understood the reasons behind his actions

307 *Ibid* at 3-4

308 ADCA, "Cannabis - The Key Issues", June 1994 paper It said that there was still a need to research, develop and trial better methods to deal with the way cannabis is being used in Australian society.

309 ADCA, *Cannabis Discussion Paper 1993, An Analysis of responses*, at 4

310 "The Courage of Our Convictions - HIV/AIDS· The National Strategy and the Laws of New South Wales", Report to the Minister for Health by the NSW Ministerial Review HIV/AIDS Legal working party, November 1993 at 133.

311 *Ibid* at 134. See also note 16 *supra* at 19. The report found that current research on cannabis was inconclusive but did not necessarily indicate that it was more harmful than alcohol or tobacco.

- The HIV/AIDS Legal Centre of New South Wales produced an HIV/AIDS Sentencing Kit in January 1996.[312] It acknowledged that some people living with HIV/AIDS smoke marijuana for medical purposes despite its illegality and the risk of being charged with cultivation, possession[313] and self administration offences.[314]

- The Queensland Advisory Committee on Illicit Drugs prepared a substantial report entitled *Cannabis and the Law in Queensland* in June 1993, as a discussion paper pursuant to the 1989 recommendations of the Fitzgerald Commission of Inquiry. The report looked at the effects of cannabis and summarised that:

> In spite of two decades of scientific enquiry, negative effects of cannabis on human populations have not been unequivocally demonstrated.[315]

The Committee also noted that cannabis is not a narcotic (although it is classified as such both here and in America for the "purposes of control"[316]) and does not adequately belong to any one drug class because of its sedative, euphoriant and hallucinogenic properties.[317] The subsequent paper by the Criminal Justice Commission in Queensland *Report on Cannabis and the Law in Queensland*[318] did not comment on medical uses of cannabis because the Commission took the view that the complex medical and policy issues involved need to be addressed by those with specialist expertise in the area.[319]

F. Heroin Trials - Signs for the Future?

A recent Federal Government veto of a decision by the Australian Ministerial Council on Drug Strategy to approve a heroin trial in the Australian Capital Territory (ACT) suggests that any attempts to formally legalise medicinal use of marijuana may be fraught with obstacles. A meeting of Australian State Health and Police Ministers in Cairns on 31 July 1997 agreed to a controversial trial to distribute heroin to approved addicts living in the ACT as part of a series of trials designed to investigate alternative drug treatments.[320]

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313 *Drug Misuse and Trafficking Act* 1985 (NSW), ss10, 11.

314 *Ibid* s12

315 Queensland Advisory Committee on Illicit Drugs, *Cannabis and the Law in Queensland - a Discussion Paper*, July 1993, p 20. Reasons included variable drug potencies, limitations on research methods, the illegal status of the drug and the lack of measurable toxic effects in humans See also Department of Health, Canberra, *Cannabis - A Review of Some Important Inquiries and Significant Research Reports*, June 1979.

316 *Ibid.*

317 *Ibid*

318 Note 264 *supra.*

319 *Ibid* at x.

320 B Lagan, "NSW Boost for Free Heroin Trial", *Sydney Morning Herald*, 31 July 1997, p 5 The decision was influenced in part by recent National Drug and Alcohol Centre research showing that the number of people dying from heroin overdoses rose from 70 in 1979 to 550 in 1995 The trial was prepared over 5 years by the Australian National Centre for Epidemiology and Public Health

The strictly monitored trial involved three stages:

Stage 1 40 heroin users would be given daily doses of heroin from specially established clinics over a 6 month period.

Stage 2 If successful, the trial would be extended to 250 heroin users with more detailed questionnaires.

Stage 3 If successful, the trial would be extended to 1000 users in three Australian capital cities.[321]

The final stage would have involved heroin users who have never been in treatment programs before to determine whether defined heroin doses would be attractive as a treatment option.[322]

Despite the agreement and support from the Federal Health Minister, Federal Cabinet vetoed the trial on the basis that it would send "the wrong signal" to the community about dealing with drug abuse.[323] Even though the trial was to be strictly monitored and studied, ill-informed talk-back radio comments and press speculation appear to have influenced the political response on the issue. The trial was not accurately publicised and there was widespread fear that the trial would lead to eventual legalisation of heroin use. It appears that the veto was politically motivated and passed up an opportunity to scientifically test an alternative solution to the longstanding problem of drug abuse.[324]

There was also an issue about the need to amend Commonwealth legislation in order to allow for the importation of pharmaceutical grade heroin for the trial. Federal advice suggested that the *Customs Act* 1901 (Cth) could be used to allow the government to issue licences for prohibited goods, including A$150 million worth of heroin for the trial, without infringing the Act.[325] However, the *Crimes (Traffic in Narcotic Drugs and Psychotropic Substances) Act* 1990 (Cth) would need to have been amended because it does not contain exceptions for the importation of heroin for medical or scientific purposes.[326] As a result, the trials

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321 *Ibid* p 5

322 B Lagan, "Heroin on Trial", *Sydney Morning Herald*, 25 June 1997, p 13 A similar trial in Switzerland in 1994 supplied heroin to 800 addicts in 17 clinics across the country. Results show vastly improved health and employment prospects in those on the program for a year It was held on 28 September 1997 that a majority agreed with the proposal that the trilas be continued

323 J Brough, "No Go· PM Blocks ACT Heroin Trial", *Sydney Morning Herald*, 20 August 1997, p 1 The Prime Minister told Cabinet that he would not countenance the trial on the basis that he was not convinced the potential benefits would outweigh the detriments and that a "majority of parents" would support his decision

324 M Millett, "PM Breaks Own Code", *Sydney Morning Herald*, 22 August 1997, p 22. The Premier of Victoria, Mr Jeff Kennett, raised the possibility that a similar trial might go ahead in Victoria at a later date because "we must be prepared to try things which we may not personally like but may in fact address a problem which none of us have the solution for"· see J Brough, "Coalition Split as Cabinet Meets on Heroin", *Sydney Morning Herald*, 19 August 1997, p 1

325 J Klein and J Ferrari, "Heroin Trial's Fans Highlight Research Benefits", *The Australian*, 16-17 August 1997, p 6.

326 *Ibid.* This is because ss 10-13 relate to dealing in drugs on Australian flights and ships and in foreign countries, such that criminal activity could attach to the importation of heron for trials see J Short, "Comment", *The Australian*, 16-17 August, p 6

could have potentially contravened the UN Convention on the legal use of narcotic drugs although a simple amendment allowing heroin importation for medical purposes could have overcome this problem. However, there was some debate whether the trial could be classified as one for medical or scientific purposes or one that was based instead on social research seeking to combat the effects of drug crime.[327]

In any event, the Federal Government veto effectively deprived the trial of essential financial support and the means to make amendments to legislation in order to allow the trial to proceed. While the heroin trial debate is distinguishable from the issues involved in medicinal marijuana use, it nevertheless demonstrates the various current social, political and legislative hurdles that must be crossed before longstanding government drug policy can be changed. The fact that the heroin trial was overturned on the basis of media misinformation and government concerns about adverse public reaction augurs poorly for any positive developments in the medicinal marijuana debate in Australia.

XI. CONCLUSION

In reviewing the debate on medicinal marijuana use, it is appropriate to note the following comments:

> It is unfortunate that a connection has been forged between the debates about the legal status of cannabis as a recreational drug and the use of cannabinoids for therapeutic use. Any such connection is spurious since there is a world of difference between the use of controlled doses of a purified drug under medical supervision and the recreational use of crude preparations of a drug. In a rational world, clinical decisions about whether to use pure cannabinoid drugs should not be abrogated because crude forms of the drug may be abused by those who use it recreationally. As a community, we do not allow this type of thinking to deny us the use of opiates for analgesia. Nor should it be used to deny access to any therapeutic uses of cannabinoids derivatives that may be revealed by pharmacological research.[328]

Issues involving illegal drugs are generally viewed as moral rather than medical problems. Prohibition stems from a belief that the problem is best dealt with by 'obliterating' illegal drug use even though governments have made significant exceptions for alcohol and tobacco.[329] Not surprisingly, marijuana use has been caught up in the wider political debate surrounding drug policies. The public perception of marijuana as a recreational drug has hindered the study of its therapeutic effects and deprived numerous people of its potentially useful effects. Any reform in favour of therapeutic cannabis use will require broad community awareness and understanding that terminally or severely ill patients can and do obtain relief from marijuana, so that therapeutic use should not be

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327 B Montgomery, "Poppy Growers Predict International Backlash", *The Australian*, 16-17 August 1997, p 6

328 Note 6 *supra* at 199

329 "The War on Drugs - Editorial" (1995) 311 *British Medical Journal* 23-30 December 1995, http://www calyx.com/~olsen/MEDICAL/bmj.html.

penalised.[330] Arguments for medicinal marijuana will also need to be addressed from scientific and medical, rather than political, points of view.[331]

The referendums in California and Arizona represent a significant shift in American drug policy not only because there is now legislation which sanctions use of medicinal marijuana, but also because the general prohibitionist policy on drugs has been questioned.[332] Both Propositions focussed on the opinions of ordinary citizens who supported the view that terminally ill people should be provided with relief, regardless of the drug source. While the goal of some supporters was to press for the general legalisation of marijuana, most voters in California and Arizona supported strict medical use rather than total decriminalisation.[333]

The Federal response against Proposition 200 and Proposition 215 was designed to avoid sending a "terrible and wrong message" to the community and young people in particular.[334] However, it has raised a host of issues as diverse as voter rights, States' rights, doctor-patient privilege, scientific research on marijuana and the effectiveness of Federal drug policy. There is concern that the referendums were so vaguely worded that there will be little or no restrictions on recreational marijuana use, leading to increased use and availability. Much of that response stems from American middle class fears of the increase in marijuana use among teenagers since 1992.[335]

The initiatives also contain a number of legal ambiguities. For example, Proposition 215 contains no limit to the amount of marijuana that can be prescribed and does not list specifically defined illnesses for which it can be used. The requirement for simple oral recommendations from doctors was designed to avoid conflict with Federal laws prohibiting the prescription of illegal substances, but will cause problems if proof of a recommendation is required. Proposition 215 also fails to address medicinal cannabis use in minors or those operating transport vehicles or dangerous equipment. Proposition 200 allows other illicit drugs, such as LSD and heroin, to be used medicinally on the recommendation of two doctors but this may ultimately damage Federal attempts to legalise medicinal marijuana use given the fears attached to those other substances.

The most significant problem is that it is impossible for either measure to be used without a violation of Federal drug laws. Rather than enforcing Federal laws without question, it is submitted that the Federal Government ought to address the concerns of patients and doctors that a legitimate use of marijuana is being denied because of community fears of marijuana abuse. Despite the lack of firm evidence showing marijuana to be effective medically, it is difficult to

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330 M Moore, note 293 *supra* at 5-6

331 *Ibid* at 8.

332 Note 166 *supra* at 2

333 *Ibid.* Mr Dennis Peron, an organiser of the California initiative, proclaimed that legitimate medical use included smoking marijuana to relieve stress and said, "I believe all marijuana use is medical - except for kids"

334 "Just say Yes", note 192 *supra* at 18, quoting retired General Barry McCaffey

335 *Ibid*, 5.3 per cent of all teenagers in 1992 and 10.9 per cent of all teenagers by 1995

dismiss the testimonies of patients and their doctors that marijuana, among other things, reduces nausea and pain, stimulates appetite and relieves glaucoma. It ought to be possible for the government to limit strictly the availability of cannabis as a prescription drug for the benefit of sick patients.[336]

Recent calls in America, Europe and Australia for a more liberal approach to drugs stems from a perceived failure of current prohibitionist policies and has made possible a more open debate about medicinal marijuana use. The recent Royal Commission into the New South Wales Police Service looked at the issue of drug reform, particularly in the area of heroin abuse. The Final Report in May 1997 recommended the provision of approved and safe 'injecting rooms' for heroin users to reduce the spread of disease, given that it was 'fanciful' to believe that addicts could be prevented from obtaining and using prohibited drugs.[337] A move towards dealing with personal use of prohibited drugs as a medical rather than a criminal problem was "worthy of consideration".[338]

Such findings will no doubt have an effect on the legalisation of marijuana debate which may obviate the need (in Australia at least) for a specific review of the medicinal marijuana use if marijuana is legalised. The Australian Parliamentary Group for Drug Law Reform recently called for the medical use of cannabis to be made available to a wide range of people. In light of the current medical evidence, any policy dealing with medicinal cannabis will need to consider that prohibition is "a system that lacks compassion and any rational, reasonable person would allow people who are suffering in this way access to cannabis as a medicine".[339]

Although the scientific evidence is still inconclusive, the wealth of anecdotal evidence indicates that therapeutic marijuana uses are worth scientific research and epidemiological studies. There must also be a differentiation between general drug prohibition and policies governing medicinal drug use.[340] Restrictions and conditions on medicinal cannabis use are of course required, including parental consent for minors, regular reviews of responses, strict periods of use, safe supply and information on risks and benefits. While marijuana may have some adverse effects, it should not follow that possession for medicinal purposes is prohibited because a similar standard would also need to apply for alcohol and tobacco use.

There are no real justifications for maintaining a prohibitionist policy on marijuana when it can be made legally available to genuine patients without affecting the control of other illicit drug use. This will involve control and regulation of commercial marijuana production and supply. There is also no valid medical reason why marijuana should be prohibited for terminally ill patients when drugs of abuse like valium and morphine are readily prescribed. These substances are easily regulated for patient access, without compromising

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336 *Ibid*

337 See note 16 *supra*, Volume II at 225-6 (recommendation 2 19)

338 *Ibid* at 228

339 M Moore MLA, "Contemporary Comment: Legislative Changes in the Australian Capital Territory", (1994) 6 *Current Issues in Criminal Justice* 290 at 292

340 Note 105 *supra*.

public safety. In the same way, marijuana could be prescribed and regulated to minimise the legal and health risks which are currently faced by patients in obtaining cannabis.[341]

Proposition 215 and Proposition 200 have 'medicalised' the marijuana debate and attempted to place the issue into the hands of doctors and patients rather than politicians and law enforcers, who are more concerned with broader drug control than medical issues. The referendums have shown that it is possible to undertake a rational and compassionate review of medicinal marijuana, divorced from the drug legalisation and prohibition debate, to make cannabis available to sick and terminally ill patients. Whether this will result in drug policy changes or encourage the use of medicinal marijuana in Australia and elsewhere remains to be seen.

341 Note 161 *supra* at 274.