

Medical Marijuana: Drug free or less free?

by
Grant W. Smith
romerodep2@yahoo.com

American University
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In the days before there were public health inspectors directed by a Food and Drug Administration, there was a high degree of uncertainty as to the safety, purity and effectiveness of medicine. Since the turn of the 20th century, however, the federal government has strengthened not only its oversight role for the benefit of consumers, but restricted what drugs may be considered medicine and sold or prescribed by doctors.

Cannabis, or marijuana, is one such drug that the government has classified as a narcotic that has no medicinal value. Yet, many individuals and medical experts have countered the government's position on cannabis with claims that marijuana is a legitimate medicine that is being denied to seriously ill people. Whether individuals are deprived of liberty when the government interferes in their ability to use (or choose) marijuana is hotly contested between advocates for the drug and those who oppose legal access. Advocates argue that unrestricted access to marijuana reflects their belief that individuals have a right to choose any drug that works to remedy pain or illness. Advocates contend that the government is ignoring both the will of the people and evidence that support recognizing the drug as medicine. On the other hand, prohibitionists defend the government's position on cannabis, which reflects the uncertainty about the drug's safety and effectiveness. Prohibitionists see the ban on marijuana use for all purposes as a means of protecting the public from a harmful drug that causes crime. Therefore,

prohibitionists argue that the ban strengthens individual liberty against the threat of harm caused by others.

Many arguments for legal access to medical cannabis begin with the story of how Valerie Corral started a non-profit hospice to grow and distribute marijuana to fellow cannabis users who demonstrated illness. Even though she was operating a cannabis farm in cooperation with local and state authorities, and legally under California law, Valerie Corral was visited by “federal DEA agents (who were) armed with automatic weapons and wearing flak jackets (who)... took her into custody while she was still in her pajamas!” According to Drug Policy Alliance, one of several public interest groups that advocates for medical marijuana rights, the federal government views Valerie Corral as “a danger to society (who) needs to be behind bars (Drug Policy Alliance, 2003).” Effectively, this DEA raid “did much to terrorize American citizens and absolutely nothing to protect or improve their health, welfare or safety (Nadelmann, 2002).”

Advocates for medical marijuana argue that the government deprives seriously ill people of the liberty to use a drug that scientific studies and medical experts say has medical benefits. An individual, they say, should be free to use any drug that they choose, and physicians should feel unrestrained to prescribe any drug that would be beneficial to their patients. Until 1996, cannabis use of any type was illegal nationwide (Elders, 2002). It was in that year that three multi-millionaires spearheaded the funding of efforts by advocates to place voter initiatives on the ballot in California (Proposition 215) and Arizona (Proposition 200) that would give the public an opportunity to extend legal protection to seriously ill people who used marijuana. Since these two ballot initiatives passed, advocates have won initiatives before voters in eight states. Although some states now accommodate medical marijuana, federal laws prohibiting all

cannabis use have not changed. Thus, advocates decry federal raids like the one of Valerie Corral's hospice as a prime example of the government's unwillingness to be accountable to the will of the people. "The hundreds of thousands of Americans who use marijuana for medical reasons deserve a (Congressional) hearing in which they can defend their use of this unconventional medicine (Nadelmann, 2002)." Advocates also believe that the federal government is actively defending a massive drug war bureaucracy when it refuses to yield to medical marijuana. *Time* reported that "one of the major conspiracy theories of the pro-legalization movement ... (is) that the government is keeping pot illegal so it can maintain its giant drug-war bureaucracy (Stein, 2002)."

Author Mike Gray has forecasted that the medical benefits of cannabis "(would erode) ...public support for ... sending non-medical users to prison." "Take reefer out of the equation," Gray contends, "and the number of illegal drug users instantly drops from thirteen million to three million, and the drug war shrinks from a national crusade to a sideshow (Gray, 1998)." This statement reflects the hope of medical marijuana defenders, who want the government to stop preventing and interfering with cannabis use in general. Yet, advocates do not disfavor government involvement entirely. In those states where legal access laws exist, some advocates have worked with state and local officials to construct a registration system for "patients" and advocated for the state-sponsored dispensing of cannabis.

Indeed, the crux of the advocates' argument for legal access to medical marijuana is that the state-licensed physician is the most appropriate authority to "serve as a 'gatekeeper' to ensure that users of medical marijuana are, indeed, patients whose health would benefit from the use of marijuana." These words are those of Joan Jerzak who testified before a Congressional hearing

of the Subcommittee on Criminal Justice, Drug Policy, and Human Resources. As Chief of Enforcement for the Medical Board of California, Ms. Jerzak emphasized that her agency “(did) not pursue disciplinary actions against physicians merely for recommending medicinal marijuana,” but has filed charges against four doctors since 1996 for inappropriately prescribing medical marijuana (Jerzak, 2004). Ms. Jerzak supports the role of physicians as having dual roles as advocates for their patients and agents of the state. This is precisely the profile that medical marijuana advocates hope to achieve for physicians across the country. Although physicians remain accountable to the state, they are not penalized for recommending or prescribing cannabis. In the advocates’ view, officials like Ms. Jerzak and physicians are the most appropriate authorities of the state to ensure that a patient’s liberty to use cannabis for medical reasons will not be tampered with.

However, could not physicians and government officials potentially abuse their power in exercising medical marijuana oversight? Could an arrangement between the state medical board and physicians that was originally intended to preserve the rights of patients evolve into a paternalistic or even coercive program? At this juncture, classical liberals, or libertarians might ask “who will guard us from the guardians (Schaler, 1998)?” Although libertarians and advocates agree that individuals should be free to choose cannabis and other drugs without government interference, classical liberals such as Thomas Szasz argue that medical marijuana advocates are “replacing legal sanctions with medical tutelage.” In other words, the recent ballot initiatives replace criminal laws with mandates empowering physicians to determine when medical marijuana is appropriate (Szasz, 1998). Invariably, the influence that physicians and the medical community have over patients would grow to a point where the rights of an individual to choose freely would no longer be served. In essence, physicians would eventually assume the same role

that criminal laws once had in interfering with cannabis use and individual freedom to choose. Szasz argues that “the advocates of medical marijuana have embraced a tactic that retards the repeal of drug prohibition.” Yet, what concerns libertarians like Szasz most is that the medical community would gain more control over “everyday behavior.” Individuals should be free of coercion when deciding what medical treatment to seek. However, a coercive medical apparatus would effectively censure patient rights. Szasz argues that medical marijuana advocates should abandon their “(advocacy) of medical ‘responsibility’ towards sick patients” and focus on repealing drug laws that erroneously make it “the government’s business to protect individuals from harming themselves (Szasz, 1998).”

One California physician who has enthusiastically carried out the mandates of Proposition 215 is Dr. Claudia Jensen. Not only did she agree to testify before a Congressional subcommittee on her medical practice, but Dr. Jensen detailed her effort to prescribe cannabis to adolescents who report symptoms of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD). In the hearing, she spoke of her belief that cannabis is safer and has fewer side effects than amphetamines, and that “if cannabis was approved for use in just the ADD/ADHD market alone, it could significantly impact the \$1 billion-a-year sales for traditional ADD/ADHD pharmaceuticals.” Many advocates of medical marijuana like Dr. Jensen express confidence in the medicinal benefits of cannabis to such a degree that they predict that “a simple plant-based drug like cannabis would threaten expensive pharmaceuticals (Jensen, 2004).” Dr. Joycelyn Elders, a former Surgeon General under President Clinton, exclaimed that “30% of pharmaceutical companies might close when cannabis is eventually legalized” since cannabis would “save HMOs and health care companies lots of money in not having to compensate for so many anti-arthritis and anti-anxiety drugs (Elders, 2002).” *Time* magazine

captured this confidence when it reported the general advocates' belief that "politicians are in the pocket of the pharmaceutical companies who fear marijuana is such good medicine that their own products will suffer (Stein, 2002)."

Indeed, advocates lean principally on the opinions and findings of leading scientists and medical journals to argue that cannabis has legitimate medical value. Some of the most quoted findings come from a comprehensive National Institutes of Health study that the White House Office for National Drug Control Policy (ONDCP) commissioned in response to the wave of medical marijuana initiatives. This research body concluded that "there are patients with debilitating symptoms for whom smoked marijuana might provide relief" and the "long-term risks (of smoking marijuana) are not of great concern for ... the terminally ill or those with debilitating symptoms...(National Institutes of Health, 1999, p. 7)." Most definitively, the study concluded that "there is no clear alternative for people suffering from chronic conditions (such as pain or AIDS wasting) that might be relieved by smoking marijuana (National Institutes of Health, 1999, p. 6)." Rob Kampia, the executive director of Marijuana Policy Project, a public interest group that has organized several cannabis-focused ballot initiatives, maintains that the "principal investigator of (this) study added at the news conference at which the report was released that 'there are some limited circumstances in which we recommend *smoking* marijuana for medical uses (Kampia, 2004)."

Other signs of support came from the American Psychiatric Association, which stated that "effective patient care requires the free and unfettered exchange of information on treatment alternatives (that) should not subject either party to any criminal penalties (Psychiatric News, 1998)." The *Lancet* wrote that marijuana can "inhibit pain in virtually every experimental pain

paradigm” and that it could be “the aspirin of the 21st century (Lancet Neurology, 2003).” An editorial in the *New England Journal of Medicine* asserts that “what really counts for a therapy ...is whether a seriously ill patient feels relief as a result of the intervention.” The *New England Journal* editorial added: “the government should change marijuana’s status from that of a Schedule I drug ... to that of a Schedule II drug (Kassirer, 1997).”

In addition to amassing evidence that supports a medical use for cannabis, advocates have echoed opinions like that of the *New England Journal* to reschedule marijuana from a Schedule I to Schedule II drug. A Schedule I classification under the Controlled Substances Act of 1970 defines marijuana as having no medicinal value. A rescheduling of marijuana to Schedule II would define the drug as having some limited medicinal properties, and lift some of the toughest restrictions on research. In order for legitimate research to be conducted on a Schedule I drug, scientists “must apply...for a special dispensation from the government.” However, “for the last twenty years, the government has said no...to qualified medical researchers (Gray, 1998).” Therefore, studies like one conducted in 1983 by Emory University - that found smoked marijuana and a THC capsule deliver equal benefits in relieving the nausea of cancer chemotherapy patients - often do not get the needed supply of cannabis from the government.

Advocates contend that the government disfavors dispensing marijuana for “scientific (inquiries) into the therapeutic benefits of marijuana” but effortlessly supplies research that further examines the potential for drug abuse (Kampia, 2004). The unwillingness of the federal government to consider moving marijuana from a Schedule I to Schedule II drug can be traced back to 1986. It was at this point that the Drug Enforcement Administration held public hearings that generated “a two-year court record that is the most thorough review of the evidence

(supporting medical benefits in cannabis) in our time (Gray, 1998, p.174-176).” In 1988, DEA Administrative Law Judge Francis Young weighed this evidence and ruled that “there is accepted safety for use of marijuana under medical supervision.” Yet, the DEA administrator “brushed aside the ruling” that would have rescheduled marijuana as a Schedule II drug (Gray, 1998, p.174-176).

Perhaps the most visible evidence that the government is aware of, but refuses to formally acknowledge the medicinal value of cannabis has been the existence of the Investigational New Drug (IND) program for nearly thirty years. IND started in 1975 when several individuals “applied for special permission to use cannabis to relieve pain and suffering.” In response, “the government began dispensing cannabis through the U.S. Mail, and seven Americans continue to receive the prescription today (Jensen, 2004).” For many advocates of medical marijuana, this program represents true government hypocrisy. As seven Americans benefit from the IND, the government is officially leading “the opposition to medical marijuana (that) isn’t based on science, but rather lies and myths that are refutable by indisputable facts (Kampia, 2004).”

While medical marijuana advocates argue that “it is clearly inhumane and a violation of (one’s) ‘right to life, liberty and pursuit of happiness’ to be forbidden access to any medication that can relieve (one’s) torment (Jensen, 2004),” prohibitionists, or drug warriors, do not want to draw a legal or ethical distinction between cannabis for medical and recreational use. Generally, drug warriors perceive drug use as harmful behavior that threatens society, disturbs public order, and endangers the health of children. Therefore, prohibitionists defend the state position and seek to enforce the law as it is written to strictly prohibit all forms of cannabis and other illegal drug

use. Many warriors view the recent ballot initiatives such as California's Proposition 215 as "millionaire ventures into initiative politics (Broder, 2000)." The resulting conflict between federal and state law in these states is seen as an opportunity to "put into sharp focus the competing scientific claims about the value of marijuana (and its components) as 'medicine,' which many warriors contend is "anecdotal (Souder, 2004)."

Given that there are competing interpretations of the medicinal properties of cannabis, prohibitionists express concern that "state laws purporting to legalize marijuana for medical purposes bypass" the Food and Drug Administration's (FDA) process of conducting three-phase clinical trials on experimental drugs to determine their safety, consistency and effectiveness (Souder, 2004). Drug warriors like Rep. Mark Souder (R-IN) advocate for the government's FDA drug-approval process, and admonish advocates for pushing ballot initiatives that place "few, if any, restrictions ... on what conditions marijuana may be used to treat (people)" and no restrictions on the potency and amount of cannabis that can be prescribed (Souder, 2004). Defending the classification of marijuana as a Schedule I drug, warriors maintain that "the FDA (has not) conducted a study to determine the safety and effectiveness of botanical marijuana (Meyer, 2004)." However, "government agencies (such as the National Institute on Drug Abuse and the Department of Health and Human Services) advocate an alternative means of delivering THC – the primary active ingredient in marijuana - (due to) the belief that smoked marijuana delivers many cancer-causing chemicals (Volkow, 2004)." Indeed, two synthetic oral forms of THC have been approved by the FDA for use in combating nausea associated with cancer chemotherapy and as an appetite stimulant for patients with AIDS (Karel, 1994).

Prohibitionists discount accusations that the government intentionally ignores credible scientific evidence supporting the medicinal purpose of marijuana. Additionally, warriors charge that medical marijuana initiatives are deceitful efforts to “legitimize the use of marijuana by changing the common public perception of marijuana from a harmful drug to a useful medicine (Dupont, 2004).” Such efforts run counter to the prohibitionist view that government efforts to ban all uses of a drug defends public health and individual freedom since cannabis has not received official approval for use as a medicine. Behind this strict resistance to medical marijuana is a prohibitionist understanding that “the era of drug legalization” that ended in the 19th century was an “era of ‘let the buyer beware.’” The emergence of a “powerful ‘social contract for drug use’”...is the basis of current drug laws, as it “established that potentially addictive drugs would be available only ...to treat illnesses other than addiction... (which) explains why the (legalizers) ... are proponents of medical marijuana...for widespread public use (Dupont, 2004).”

The general public has endured a constant barrage of conflicting messages on providing legal access to medical marijuana since the issue was first electrified by the passage of ballot initiatives in California and Arizona in 1996. The extent of this battle of wits becomes clear when a statement made by a DEA agent is compared with that of a medical doctor who advocates legal access of marijuana. While Dr. David Hadorn appealed to a conference crowd to “keep (a) pebble in your shoe for a while to know chronic pain... (and) have empathy for those medical marijuana patients (Hadorn, 2002),” Ken Magee told *The Oregonian*, “(medical marijuana) is a matter of federal law. The U.S. government doesn’t recognize marijuana as a medicine. It’s a drug (Sabo, 2002).” The general public, however, seems to side with advocates

on the legitimacy of medical marijuana as having a useful purpose in providing relief to individuals who experience pain and suffering (Stein, 2002).

In my opinion, the advocates' role in providing legal protections for medical marijuana enhances individual liberty. The case of Dr. William Hurwitz exemplifies this point. When the State Board of Medical Examiners accused a Virginia physician of prescribing narcotics in amounts that threatened society, patients from "all over the country (came to beg) the officials not to sanction (their doctor)." His patients defended him as the "only doctor with the courage to help." One man from Tennessee testified that "nerve endings damaged (during amputation of his legs) are still active, and he claims he needs morphine to deal with the sensation that his lower half is still in the process of being sawed off." Another patient of Dr. Hurwitz said that he would kill himself if "the board lifted Hurwitz's license and cut off his prescription." The patient went ahead with the suicide, "but first he made a video" where he said that 'suicide was not what I wanted. Pain treatment and control is what I wanted.' The Virginia Board of Medicine responded to the patient's video with assurances that the Board "'may have saved other lives by this action.'" "In other words, a greater good may have been served by making sure these powerful narcotics did not somehow fall into the hands of young people (Gray, 1998, p. 184-185)." In this example, the prohibitionist response is needlessly inflexible and insensitive towards the needs of individuals that seek the freedom to alleviate their pain by whatever means necessary.

Classical libertarians like Thomas Szasz argue that the medical marijuana movement is empowering physicians to exert more control over individual medical rights, and further legitimize the therapeutic state. Indeed, marijuana advocates have viewed the union between medicine and the state as an opportunity to improve and better define the relationship that the

medical community has with marijuana, and reform the public perception of marijuana as a drug with accepted medical value. However, medical marijuana advocates seek to ultimately remove all aspects of government interference in the patient-doctor relationship. Whether this interference is in the form of criminal penalties or censorship of what a doctor can prescribe or recommend to a patient, advocates seek to restore the same tradition of contractual doctor-patient relationships that libertarians cherish. However, medical marijuana advocates do place much trust in physicians and bureaucratic licensing boards to defend the freedoms of individuals from other forces of the state that are eager to take freedoms away. I agree that this scenario presents considerable risk to individual freedom, just as Szasz asserts that “no government is...committed to freedom... (but, rather,) government...has a vested interest in enlarging its freedom of action, thereby necessarily reducing the freedom of individuals (Szasz, 1998).” The propensity of medical marijuana advocates to refer to individuals seeking care as “patients” raises the question, as Szasz has, of whether “a person may be sick and not be a patient, (or) that a person may be called a ‘patient’ and not be sick (Szasz, 2001).” Such could be the case with Dr. Claudia Jensen, who prescribes medical cannabis for ADD and ADHD, which are two psychological profiles that do not qualify as a physical illness because they are diagnosed solely on the basis of the patient’s behavior.

Does the medical marijuana effort, then, reinforce the notion that individuals seeking cannabis are the property of a paternalistic, state-run program? I would argue that, however much the initiatives have contributed to the authority of the therapeutic state, the medical marijuana movement has the potential to be entirely independent of government. Most medical cannabis users are producers in that they grow their own drug, or obtain the drug by their own private means. Other individuals who are too sick to obtain the drug have turned to private

charities like Valerie Corral's farm. If the government was to begin providing the drug to the public in a paternalistic but non-coercive manner, many cannabis users would continue to utilize the free market to grow or obtain marijuana that had a higher potency or was available in larger amounts than the state-dispensed version.

Only if medical marijuana advocates continue to defend the autonomy of patient-doctor relationships and push towards the legalization of all drugs can the contingency of the public that chooses cannabis for medical reasons remain free and independent of state interference. Marijuana advocates must continue to battle the myth that marijuana has no accepted medical value, and is therefore a useless, but abused drug that demonstrates the need for drug control laws and government coercion. This legal fiction continues to serve as the government's justification for its 'war on drugs,' just as psychiatrists "(need) the fiction of mental illness, with its implications of disease, dangerousness, and incompetence, to help (them) perceive responsible adults as if they were helpless infants (Szasz, 2002)." In the end, medical marijuana advocates seek to advance both the freedom from need, and freedom from state coercion.

Despite continuing controversy over whether marijuana has medical value, and the government's refusal to recognize cannabis as anything but a dangerous and abusive Schedule I drug, medical marijuana advocates have successfully won several ballot initiatives that establish legal protections for medical marijuana use. Regardless of who decides whether cannabis is medicine is irrespective of the point that advocates want to stress, which is that individuals should have unfettered access to any resource that relieves pain or suffering. Even as prohibitionists and advocates exchange political attacks and make appeals to the public, the

essence of the controversy is captured by the words of Dr. Joycelyn Elders who told a crowd of medical marijuana supporters: “we’re not drug free, we’re just less free (Elders, 2002).”

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Medical marijuana is casting a cloud of confusion over Corporate America. Indeed, employers that operate in the 14 states where pot is now legal as a prescription painkiller are struggling to reconcile zero tolerance drug policies with a patient's right to get high. The matter is more complicated than it sounds. Legal Ps & Qs of THC Human resources managers, for example, are grappling with such questions as whether random drug tests constitute discrimination under the Americans with Disabilities Act, what they are legally allowed to ask job candidates and whether they are required to accommodate medical marijuana uses the marijuana plant or chemicals in it to treat diseases or conditions. It's basically the same product as recreational marijuana, but it's taken for medical purposes. The marijuana plant contains more than 100 different chemicals called cannabinoids. Each one has a different effect on the body. Delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD) are the main chemicals used in medicine. The National Institute on Drug Abuse says marijuana can be addictive and is considered a "gateway drug" to using other drugs. "The higher the level of THC and the more often you use, the more likely you are to become dependent," Bonn-Miller says. "You have difficulty stopping if you need to stop. More and more, marijuana is being legalized for medicinal or recreational purposes, but what are the health benefits and risks of the drug? We investigate. However, the Food and Drug Administration have not deemed marijuana safe or effective in the treatment of any medical condition, although cannabidiol, a substance that is present in marijuana, received approval in June 2018 as a treatment for some types of epilepsy. Share on Pinterest. Marijuana is being increasingly legalized in the U.S., but is it safe? This tension, between a widespread belief that marijuana is an effective treatment for a wide assortment of ailments and a lack of scientific knowledge on its effects, has been somewhat exacerbated in recent times by a drive toward legalization. Medical marijuana is our expertise and we are dedicated to advancing public knowledge of cannabinoids. It's being called a miracle drug and is widely regarded as the United States' fastest growing industry. With a truly mystifying amount of incorrect information out there on the subject, getting up to speed on the truth behind medical marijuana is surprisingly difficult. To make things easier, Medical Marijuana, Inc. is here with the fundamentals you need to know to decide if medical marijuana is right for you. These are the basics of medical marijuana: what it is, why it might be good for you, how long it's been around, whether it's legal, and how you can get legal access where you live. What Medical marijuana is a drug used to treat glaucoma and other conditions. Learn about side effects, drug interactions, dosages, warnings, and more. Schedule I drugs are recognized as having a high potential for abuse with insufficient evidence for safety and efficacy with no currently accepted medical use for treatment in the U.S. Marijuana is not approved by the U.S. Food and Drug Administration (FDA) for medical use in the U.S. and remains classified as an illicit drug by the DEA. However, several states have adopted individual State Medical Marijuana Laws including: Alaska, California, Colorado, Hawaii, Maine, Maryland, Michigan, Montana, Nevada, New Mexico, Oregon, Rhode Island, Washington, and Vermont.