

# Cannabis' Regulatory Void,

## Or, How Did We Become "Gatekeepers" Without a Gate?

*By Donald Lyman, M.D., Chair of Sierra Sacramento Valley Medical Society Public and Environmental Health Committee*

The article by Jesse Oehler that precedes this one relates his work in a local marijuana dispensary. He describes the workings of an awkward and perverse non-system in which we physicians are named as the authorizing access point for retail purchase of medical cannabis.

We physicians stand in an unhappy situation. On one side is the Drug Enforcement Administration (DEA), which declares that there is no medical utility to cannabis, and therefore is keeping it as a Schedule I prohibited substance ("illegal"). On the other side, California and 15 other states have decriminalized use of cannabis. This means that the state of California has declared that it will not enforce the federal declaration of the illegality of cannabis—the "feds" will have to do that themselves.

**This article by Dr. Lyman is adapted from a 2011 white paper prepared by the Legalization and Taxation of Marijuana Technical Advisory Committee of the California Medical Association entitled "Cannabis and the Regulatory Void: Background Paper and Recommendations" and appears in the January/February 2012 issue of SSV Medicine, published by the Sierra Sacramento Valley Medical Society. Copyright © 2012, SSV Medicine.**

We California physicians are authorized to "recommend" (not "prescribe") cannabis to patients with no state penalties for that action. A stand-alone recommendation for cannabis is protected under federal constitutional First Amendment free-speech rights and under California state statute. All this notwithstanding, if a physician advises the patient to break federal law, or participates in such illegal acts, then he is at risk of federal legal action under that law.<sup>1</sup> In reality, most of the cannabis that physicians "recommend" probably is used for non-medical purposes. And in truth, cannabis travels to the buyer from production to consumption on a totally unregulated track.

The California Medical Association (CMA) recently has adopted as policy a call for "legalization" and strict regulation of cannabis (not prohibition!). Its intention is twofold: to protect both the public and physicians from the abuses we see in the Oehler article, and to address the legitimate anxieties of those who favor continued strict prohibition.

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So, where is all this going? Here are current status descriptions and future projections on what is likely to come. We physicians seem “parked” in the position as gatekeepers to cannabis as this non-system of access evolves.

### Current Status

What's missing is a regulatory system (the “gate”) upon which we can depend to assure ourselves, our patients, and the public that the cannabis itself is “safe” and effective. Where did the stuff come from? Is it pure or contaminated with pesticides, herbicides, fecal material, and such? What is its strength? How much is toxic? What medical effects are documented and preferential to those of other drugs or procedures? I found one cannabis shop with a lollipop for sale listed as “Two Doses.” So what is one dose?

The CMA policy calls for a regulatory system to protect us all. While the press has referred to this as “legalization,” it is really a call for re-scheduling by the DEA—a regulatory action—with subsequent research upon which to base rational regulatory schemes. We can't get the research done while cannabis is listed on Schedule I, which includes drugs or other substances that have a high potential for abuse and for which no prescriptions may be written. Such substances have no currently accepted medical use in the United States, and there is a lack of accepted safety for their use under medical supervision. Moreover, they are subject to production quotas by the DEA. Other Schedule I substances are heroin and lysergic acid.

The CMA has produced two documents to help us navigate to some resolution of this conundrum. First, the Council on Scientific Affairs earlier this year issued a practice advisory on Physician Recommendation of Medical Cannabis.<sup>2</sup> It is consonant with similar guidelines by the California Medical Board and the California Attorney General. Second, a Technical Advisory Committee (TAC) produced a white paper entitled “Cannabis and the Regulatory Void,” which recommends steps to move this agenda forward.<sup>1</sup>

The TAC assumed that the cannabis issue is traveling on a trajectory much like alcohol prohibition did a century ago: that is, it is a freely available substance nationally despite its federal illegality. As was the case with alcohol near the time of repeal of Prohibition, we now see that state after state is decriminalizing the use of cannabis.

Also like the situation with alcohol, we currently are witnessing an “Al Capone-like” crescendo of violence related to gang control of the substance. While most of the visible parts of this crescendo are in Mexico, it is now also happening with more frequency in the United States.

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So why is the CMA acting so forcefully now? It is a reaction to a distribution non-system that is floridly out of control, and yet one in which physicians are being drawn into playing a major role. Indeed, there is a growing concern by many physicians that more of us are being asked to act as gatekeepers while our knowledge of medical cannabis remains grossly inadequate. Current federal policies are resulting in harm, with an escalation of violence both here and in Mexico. Importantly, there is a concomitant increase of public repudiation of those policies.

### **What Is to Happen Next for Medical Cannabis?**

For medical cannabis, the TAC recommends that the CMA take an active leadership role in joining with the 15 other state medical societies to petition the DEA to reschedule cannabis. For the past half century the DEA has functionally ignored such petitions. If the petition were granted, the CMA would also champion federally funded research into the uses and dangers of cannabis.

Let's briefly review the differing Schedules. Schedule II drugs have a high potential for abuse and may lead to severe psychological or physical dependence, but they have a currently accepted medical use in treatment. However, with such deployment there are severe restrictions, as with morphine and topical cocaine. Thus they are only available by prescription, and distribution is carefully controlled and monitored by the DEA. Schedule III drugs have a currently accepted medical use, but also a potential for abuse that is less than those of Schedules I and II (still may lead to moderate or low physical dependence or high psychological dependence). They also are available only by prescription; however, unlike Schedule II drugs, refills are permitted. Examples are ketamine, buprenorphine, thiopental and hydrocodone/codeine when compounded with a non-steroidal anti-inflammatory drug (such as Vicodin or Tylenol 3). Schedule IV drugs have a low potential for abuse and a currently accepted medical use, while abuse may lead to limited physical dependence or psychological dependence (such as benzodiazepines and phenobarbital).

The likelihood that the DEA would respond to a coalition of state medical societies is probably proportional to: a) the number of states that have decriminalized cannabis (now 16), and b) the public response to any violence in the drug wars among gangs in the United States and Mexico. As these actions unfold, the TAC recommends that we sustain our physician role as gatekeeper.

### **What Is to Happen Next for Non-medical Cannabis?**

For non-medical (recreational) cannabis, the TAC calls for either: a) a federal regulatory scheme similar to alcohol and tobacco, or b) federal permissive authority for states to regulate cannabis until the feds get their act together.

## **Cannabis' Regulatory Void (cont'd)**

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Realistically, neither of these are politically likely outcomes. Therefore, the TAC implies that a fallback option would be for the feds to simply ignore states with such regulations and passively let them function. Colorado already has taken this step.

In the next few years we are likely to see more propositions on the California ballot regarding cannabis. We also are likely to see state legislative actions, in California and elsewhere, to set up regulatory schemes to get this matter under some control. The TAC's white paper is intended to give the CMA a road map to help guide policy decisions that protect both the public and physicians.

### **References**

1. CMA White Paper: <http://www.cmanet.org/files/pdf/news/cma-cannabis-tac-white-paper-101411.pdf>
2. The Physician Guidelines by the CMA Council on Scientific Affairs: <http://www.cmanet.org/resource-library/detail?item=guidelines-of-the-council-on-scientific>

### **Website Information of Interest**

The Attorney General Physician Guidelines: [http://medicalmarijuana.procon.org/sourcefiles/Brown\\_Guidelines\\_Aug08.pdf](http://medicalmarijuana.procon.org/sourcefiles/Brown_Guidelines_Aug08.pdf)

The Medical Board of California Guidelines: [http://www.mbc.ca.gov/board/media/releases\\_2004\\_05-13\\_marijuana.html](http://www.mbc.ca.gov/board/media/releases_2004_05-13_marijuana.html)

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