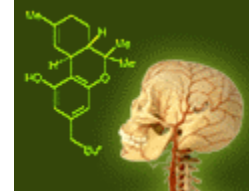


The more things change, the more they stay the same...

OUT OF JOINT

The case for medicinal marijuana.
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Published:
July 15 & 22, 1991 in the NEW REPUBLIC

Last week the Public Health Service announced that it will phase out its program of allowing seriously ill patients to smoke marijuana. The reason seems to have little to do with the effectiveness of pot in relieving various medical symptoms and a lot to do with the politics of the "drug war." With the recent attention pot has received as an appetite enhancer in AIDS cases, the government correctly anticipated a flood of applications from AIDS patients for "compassionate" approval of the drug. AIDS activists, who have had much success in liberalizing the prescription drug approval process, may have met their match.

The debate over the medical use of marijuana started two decades ago and has hinged on its effectiveness in treating glaucoma, spasticity, and chemotherapy-induced nausea. Pot, like heroin, is classified by the Drug Enforcement Administration as a Schedule I drug, which means it has a high potential for abuse, induces harmful side effects, and has "no currently accepted medical use in treatment in the United States." Pot advocates argue that marijuana should be moved to the category of Schedule II drugs, which also have a high potential for abuse and can have bad side effects, but are considered to be useful medically and thus can be prescribed by physicians. Interestingly, cocaine -- the drug war's No. 1 bogey -- is a Schedule II drug.

In 1985 the government did recognize that the principal active ingredient in marijuana -delta-9-tetrahydrocannabinol, or THC-has medical use. A synthetic drug containing THC is now available by prescription under the name Marinol, manufactured by Unimed Pharmaceuticals.

Why does the government allow THC pills but not marijuana joints? THC has been put through a level of testing acceptable to the Food and Drug Administration. Because of the expense, this typically requires a pharmaceutical-industry corporate sponsor, which pot -- a plant that grows like a weed and requires no processing -- is unlikely to attract.

Nevertheless, in response to a 1972 petition for rescheduling filed by NORML and other pot advocacy groups, in 1988 DEA administrative law judge [Francis L. Young](#) ruled that the ban on prescription pot is "unreasonable, arbitrary, and capricious."

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The DEA chose to ignore his recommendation for rescheduling, calling the medical use of marijuana a "cruel and dangerous hoax." Then this April the U.S. Court of Appeals in D.C. ordered the DEA to change three of its eight criteria for reclassification. Under those three criteria, a drug can be removed from Schedule I only if it is generally (i.e., legally available and used in the medical community; by definition, the court noted, these are conditions that an illegal drug can never meet. The decision might appear to be a big victory for the medical rise of marijuana. But the court did approve five of the DEA criteria, and pot advocates, who think the DEA will have no trouble reshaping the other three to satisfy the court, see this judicial path to rescheduling as effectively closed.

The only other path (short of congressional action) is through the FDA, which has the authority to tell the DEA that a drug has "currently accepted medical use" and that it should be rescheduled. The hope among pot and AIDS activists had been that the onslaught of "compassionate" approval applications by AIDS patients and their doctors -- which began last year when two AIDS patients, Barbara and Kenny Jenks, were arrested for growing marijuana to treat themselves -- would force the FDA to recognize marijuana's medical use. Instead, the Public Health Service, which oversees the FDA, has supported its decision with the same argument the DEA has been using for years: evidence of the medical value of marijuana is purely anecdotal and the drug has not been rendered safe.

Pot advocates acknowledge that although there is copious research on marijuana, they are short on the kinds of institutionally sponsored studies that would typically satisfy the FDA. And since marijuana treatment of appetite loss in AIDS patients is very new, there are no formal studies. Nevertheless, there is plenty of evidence to suggest that the medical benefits of using marijuana outweigh the risks. The debate can be boiled down to three questions

1. Is the drug safe?
2. Does it work? and
3. How does it compare with other available drugs?

The DEA argues that marijuana contains more than 400 chemicals, which appear in widely varying proportions and whose chemical properties are not completely known, Marijuana's side effects, it claims, are intensive, though not fully understood. Pot causes acute changes in heart and circulation rates, has "produced genetic and non-genetic birth defects in many animal species," can reduce sperm count, and "may also have a toxic effect on the human brain." Lately the government, especially Herbert Kleber of the Office of National Drug Control Policy, has been pointing out the irony of using marijuana -- which itself suppresses the immune system -- in treating Acquired Immune Deficiency Syndrome.

Although pot advocates dispute the extent of marijuana's side effects, they point out that all drugs have side effects, and that in the case of pot, as with other drugs, such reactions (even immune suppression) need to be weighed against the benefits. They

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note that government-approved THC also suppresses the immune system (it gets you high too.) They add that common anti-emetic (anti- vomiting) drugs such as Compazine and Decadron can have side effects far worse than those of marijuana, such as liver damage and death. Dr. Ivan Silverberg, an oncologist who has spoken with hundreds of cancer patients who use marijuana, testified in 1988 that "the only side effect I've seen would bill be sedation," which he characterized as "mild." A study conducted by the state of 'New Mexico found adverse effects in only three of 250 patients tested.

And if we may venture into the realm of "anecdotal" evidence, it is worth noting that tens of million of Americans -- including U.S. senators, prospective Supreme Court judges, and maybe even First Ladies -- have smoked pot without suffering noticeable damage. No one has ever died of a marijuana overdose; the lethal dosage is so high that no human could ever smoke enough pot to kill himself.

So is pot effective? The DEA, argues that its use in treating nausea, glaucoma, and spasticity has not been sufficiently proved by double-blind studies.

And the evidence for AIDS treatment, it claims, is nonexistent. Yet in 1973, Dr. Leo E. Hollister of the Veterans Administration Hospital in Palo Alto proved scientifically what anyone who has ever smoked pot will tell you: marijuana gives you the munchies. Dr. Ernest Abel of Berkeley confirmed Hollister's results later that year. In a now famous 1975 study, Drs. Steven Sallan and Norman Zinberg at Boston's Sidney Farber Cancer Research Center also confirmed that pot is effective as an anti-emetic. And a 1979 double-blind and placebo-controlled study by Dr. Alfred Chang of the National Cancer Institute confirmed the 1975 results. Several states, including New Mexico, Michigan, and New York, in independent studies over the last twenty years, have also proved pot's effectiveness as an anti-emetic. And besides, notes Dr. John Morgan of CUNY Medical School, there is no rule that saves a drug must be the best at what it does to warrant approval. If it is effective in even a small number of cases, it deserves serious attention as a therapeutic product.

The new Health and Human Services policy directive says that patients applying for medicinal marijuana must first try Marinol. But pot advocates point out that marijuana is more effective than Marinol. In a 1988 study by Dr. Vincent Vinciguerra published in the New York State Journal of Medicine, 29 percent of those who did not respond to oral THC did respond to smoked marijuana. The NCI/Chang study found that smoke from marijuana, absorbed through the lungs, acts on the brain almost immediately, while orally ingested pills can leave a nauseous cancer patient to suffer for several hours. Besides, notes CUNY's Morgan, "It is absurd that we only have an oral tablet" to treat vomiting. It's like treating diarrhea with a suppository.

But if the government is truly looking to satisfy its "currently accepted medical use" criteria, officials should turn to a just-published study in the Journal of Clinical Oncology, conducted by Richard Doblin and Mark A. R. Kleiman of Harvard's Kennedy School. Forty-eight percent of oncologists responding said they would prescribe

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marijuana to some of their patients if it were legal. Fifty-four percent said they thought smoked marijuana should be available by prescription, and 44 percent said they had recommended pot to a patient, even though it is illegal.

In justifying the new decision. PHS chief James O. Mason told me: "It puts the government in sort of a tenuous situation to be passing out marijuana cigarettes that can be used by a person that can cloud their judgment if they choose to use an automobile or get out in the street or in the context of sexual behavior. I think it sends a signal that's not the best signal." Mason's rationale was uncannily prophesied by Judge Young in his 1988 decision: "There are those who, in all sincerity, argue that the transfer of marijuana to Schedule II will 'send a signal' that marijuana is , 'ok' generally for recreational use. This argument is specious. . . . If marijuana should be placed in Schedule II, in obedience to the law, then that is where marijuana should be placed, regardless of misinterpretation of the placement by some." The fact that AIDS has been added to the list of conditions treatable by pot should have helped, not hindered, efforts at reclassification.

Marijuana, it seems, does indeed cloud the mind. But in this instance, the clouded minds are in government buildings, not in doctors' offices or patients' sick rooms.