

# **SHOULD MARIJUANA BE RESCHEDULED?**

*Research by ProCon.org (July 2007; updated Oct. 2009)*

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There have been various discussions on marijuana's position in Schedule I of the five Controlled Substances Act drug schedules.

Some say it is in the correct Schedule, as it meets all three scheduling criteria (see section I., #1 below). Others say it should be moved to Schedule II or III or lower because it has current accepted medical use in the United States, and it is allegedly safer than other currently prescribed drugs.

Normally ProCon.org only quotes 3<sup>rd</sup> party sources directly. In the case of this educational pamphlet, ProCon.org presents the information in its own words for brevity.

## **I. Definitions of Schedules I – V (with three examples of drugs in each schedule):**

### **1. Schedule I (LSD, Heroin, Marijuana)**

- (A) The drug or other substance has a high potential for abuse.
- (B) The drug or other substance has no currently accepted medical use in treatment in the United States.
- (C) There is a lack of accepted safety for use of the drug or other substance under medical supervision.

### **2. Schedule II (Cocaine, Opium, Amphetamine)**

- (A) The drug or other substance has a high potential for abuse.
- (B) The drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions.
- (C) Abuse of the drug or other substances may lead to severe psychological or physical dependence.

### **3. Schedule III (Anabolic steroids, Marinol, Ketamine)**

- (A) The drug or other substance has a potential for abuse less than the drugs or other substances in schedules I and II.
- (B) The drug or other substance has a currently accepted medical use in treatment in the United States.
- (C) Abuse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence.

### **4. Schedule IV (Valium, Xanax, Halcion)**

- (A) The drug or other substance has a low potential for abuse relative to the drugs or other substances in schedule III.
- (B) The drug or other substance has a currently accepted medical use in treatment in the United States.
- (C) Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in schedule III.

### **5. Schedule V (Robitussin A w/codeine, Parepectolin w/opium, Centroton)**

- (A) The drug or other substance has a low potential for abuse relative to the drugs or other substances in schedule IV.
- (B) The drug or other substance has a currently accepted medical use in treatment in the United States.
- (C) Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in schedule IV.

## **II. Who Can Change Marijuana's Schedule:**

**US Attorney General** (202-353-1555 as of 10/23/09) can initiate rescheduling on his or her own, at request of Health and Human Services Secretary, on petition of interested party, or if obligated by international treaties. (21 USC Sec. 811 01/22/02); **US Secretary of Health and Human Services** (202-619-0257 Main HHS # as of 10/23/09) can issue a binding recommendation to Attorney General to reschedule marijuana. (21 USC Sec. 811 01/22/02); **US Congress** can amend the Controlled Substances Act it passed in 1970 to reschedule marijuana; and **DEA and FDA together** can reschedule marijuana if clinical trials show it is "safe" and "effective."

### III. Pros and Cons of Rescheduling Marijuana (with counterpoints for each argument)

| Pro Rescheduling Marijuana   | Con Rescheduling Marijuana  |
|--|---|
| <p><b>1. 28 scientific studies published in peer-reviewed medical journals since 1990 demonstrated that marijuana had positive therapeutic effects in treating various medical conditions</b> including HIV-associated neuropathy (<i>Neurology</i>, 02/07), Alzheimer’s Disease (<i>Journal of Neuroscience</i>, 02/05), chronic pain (<i>Pain</i>, 12/04), multiple sclerosis-related spasticity (<i>Multiple Sclerosis</i>, 08/04), cancer-related nausea (<i>Nature Reviews – Cancer</i>, 10/03), immune function of HIV/AIDS patients (<i>Annals of Internal Medicine</i>, 08/03), bladder control and muscle spasms (<i>Clinical Rehabilitation</i>, 02/03), etc.</p> <p>[Counterpoint: 14 other peer-reviewed studies were Con medical marijuana and 22 others were not clearly pro or con.]</p> <p><b>2. Schedule I limits research access to marijuana while the Institute of Medicine and the American Medical Association (among others) call for increased marijuana research.</b> On February 12, 2007, the DEA’s Administrative Law Judge Mary Ellen Bittner declared in her written opinion “In the matter of Lyle E. Kraker, PhD (Docket No. 05-16)” that “...there is currently an inadequate supply of marijuana available for research purposes, that competition in the provision of marijuana for such purposes is inadequate...”</p> <p>[Counterpoint: As of July 14, 2007, the DEA reported that 19 researchers were approved to perform studies involving smoked marijuana.]</p> <p><b>3. DEA Administrative Law Judge, Francis Young, recommended in his Sep. 6, 1988 ruling “In the Matter of Marijuana Rescheduling Petition” that marijuana be moved to Schedule II.</b> In his decision he wrote: “<i>Marijuana, in its natural form, is one of the safest therapeutically active substances known to man. By any measure of rational analysis marijuana can be safely used within a supervised routine of medical care.</i>”</p> <p>[Counterpoint: In Dec. 1989, a DEA Administrator revisited the evidence used in Judge Young’s 1988 ruling and rejected the conclusion in <i>Alliance for Cannabis Therapeutics and NORML vs. DEA</i> (930 F. 2d 936). A DC District Court in 1991 affirmed that the rejection was “appropriate.”]</p> <p><b>4. 13 states have laws permitting the medical use of marijuana</b> (and Arizona and Maryland have laws favorable to medical marijuana). The total 2006 population of those 13 “legal” states is 70,990,823 or about 23% of the total US population. Including Maryland and Arizona, the total population of residents in states with laws favorable to medical marijuana is 80,818,269 (over 26% of the US total).</p> <p>[Counterpoint: 37 states (about 77% of the population) do not have laws permitting medical marijuana.]</p> | <p><b>1. Prominent medical organizations advocate retaining marijuana in Schedule I.</b> The American Medical Association “recommends that marijuana be retained in Schedule 1” as does the US Food and Drug Administration. Rescheduling is not recommended by the National Multiple Sclerosis Society, the Glaucoma Research Foundation, or the American Academy of Ophthalmology (as of Oct. 20, 2009 for all these organizations).</p> <p>[Counterpoint: Many major medical organizations say marijuana has medical value, including: American Academy of Family Physicians, American Nurses Association, Federation of American Scientists, Kaiser Permanente, and at least 25 others]</p> <p><b>2. Congress had had authority to reschedule marijuana since 1970 and has not done so.</b> For over 25 years and shifting party control, Congress has held numerous hearings, heard testimony from dozens of experts, and despite those efforts, it has still not found enough justification to reschedule marijuana. The Hinchey-Rohrabacher amendment to restrict federal funds from being used to stop medical marijuana users has failed four successive sessions of Congress, the most recent being a 262-165 loss on July 25, 2007.</p> <p>[Counterpoint: The fact that over 38% of the US House voted on July 25, 2007 in favor of medical marijuana indicates that Congress has strong interest in rescheduling.]</p> <p><b>3. Alternatives to marijuana exist thus making rescheduling unnecessary.</b> Marinol, a synthetic THC pill, is currently available as a Schedule III drug. Sativex, a pharmaceutical product containing natural THC is legal in Canada and currently in Phase III trials in the U.S. Some national medical organizations say that existing medications are more effective than marijuana and with fewer side effects, including the Glaucoma Research Foundation (“...less effective than safer and more available medicines.”) and the American Cancer Institute (“...other antiemetic drugs or combinations of antiemetic drugs have been shown to be more effective than synthetic THC as “first-line therapy” for nausea and vomiting caused by anticancer drugs.”).</p> <p>[Counterpoint: Physicians normally consider options and alternatives when making recommendations. They sometimes find that marijuana is the best medication option for a patient since some of the other products contain unwanted side effects or do not adequately treat a particular patient’s needs.]</p> <p><b>4. 37 states do not permit the medical use of marijuana.</b> The total 2006 population of those 38 states is about 249,009,277 or about 77% of the total US population, according to the US Census Bureau.</p> <p>[Counterpoint: 13 states representing 23% of the US population do have laws permitting medical marijuana.]</p> |

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| <p><b>5. Americans broadly favor policies permitting the medical use of marijuana.</b> Of 82 national polls and state initiatives on medical marijuana since 1995, 81 of them (98.78%) showed a majority of people favored policies permitting the medical use of marijuana.</p> <p>[Counterpoint: Some say voters may have been tricked by drug legalization advocates financed by people like George Soros, and that medicine should be regulated by laws and science not by polls.]</p> <p><b>6. Prominent medical organizations say marijuana has medical value.</b> Some of those organizations include: American Academy of Family Physicians (94,000 members), American Nurses Association (2.6 million members), American College of Physicians (125,000 members), American Public Health Association (40,000 members), Federation of American Scientists (43,000 members), Kaiser Permanente (8.1 million members), Muscular Dystrophy Association (200 offices throughout US), <i>New England Journal of Medicine</i>, and numerous state medical organizations.</p> <p>[Counterpoint: The American Medical Association and the US Food and Drug Administration (both as of 10/21/09) recommend that marijuana remain in Schedule I.]</p> <p><b>7. The 1999 Institute of Medicine (IOM) study on marijuana recommended that marijuana be used in certain circumstances and that more studies should be conducted.</b> The IOM study, commissioned by former Office of National Drug Control Policy Director Barry McCaffrey in January 1997, listed among its conclusions: “Recommendation: Short-term use of smoked marijuana (less than six months) for patients with debilitating symptoms (such as intractable pain or vomiting)...[provided certain conditions are met]” (p. 179) and “Recommendation: Clinical trials of cannabinoid drugs for symptom management should be conducted with the goal of developing rapid-onset, reliable, and safe delivery systems.” (p. 179) and “Clinical trials of marijuana use for medical purposes should be conducted...[under certain circumstances]”(p. 179).</p> <p>[Counterpoint: The IOM did not recommend that marijuana’s schedule should be changed.]</p> <p><b>8. It is the right thing to do.</b> Incarcerating sick and dying people for using a drug recommended by their doctors is wrong, especially when their state has laws protecting them from such criminal treatment. Even the Dept. of Justice has reversed its long-held position when it announced that it will no longer prosecute medical marijuana patients in states where such use is legal.</p> <p>[Counterpoint: Causing people harm by giving them addictive unregulated medicine with harsh side effects is never the right thing to do.]</p> | <p><b>5. Rescheduling will not make marijuana a legal medicine.</b> Controls vary by schedule and include factors such as manufacturer registration, distributor registration, product labeling, production quotas for manufacturer, recording and storing of related paperwork, proper prescription forms, and other restrictions. Distribution of any controlled substance without adherence to these restrictions is a felony. Rescheduling will not necessarily increase patient access to marijuana.</p> <p>[Counterpoint: Marijuana should not be classified in Schedule I because it simply does not meet the requirements of that schedule. The ultimate impact of rescheduling marijuana is speculative and difficult to determine.]</p> <p><b>6. Rescheduling will violate an international treaty that US has signed.</b> The US signed onto the 1971 UN Convention on Psychotropic Substances which placed tetrahydrocannabinol (the primary active ingredient in marijuana) including four variants and all salts into Schedule 1 – the most restrictive category. The Controlled Substances Act obligates the US to abide by this Convention.</p> <p>[Counterpoint: The US Attorney General may override this obligation with approval from the US Secretary of Health and Human Services.]</p> <p><b>7. The 1999 Institute of Medicine (IOM) study on marijuana did not recommend that marijuana should be rescheduled.</b> The IOM study, commissioned by former Office of National Drug Control Policy Director Barry McCaffrey in January 1997 did not recommend moving marijuana out of Schedule 1.</p> <p>[Counterpoint: The IOM report made many favorable recommendations regarding medical marijuana including the approval of its use in specific circumstances with terminally ill patients. Lead IOM report author, Dr. John Benson, is on record as being “Pro” to medical marijuana.]</p> <p><b>8. It is the right thing to do.</b> America has enough problems with alcohol and cigarettes, and opening the Pandora’s box of marijuana rescheduling may yield unintended consequences such as increased teen use, increased public tolerance of a non-benign substance, increased underground crime related to sales and distribution, profiteers who sell non-standardized possibly tainted marijuana to sick people making their conditions worse, and who knows what else. Using marijuana is wrong, and keeping it in Schedule I is right.</p> <p>[Counterpoint: Several studies have disproved the “gateway” theory and other fear-mongering strategies to prevent marijuana rescheduling. Depriving sick and dying people of doctor recommended medication with known efficacy and risks is the wrong thing to do.]</p> |

## MEDICAL ORGANIZATIONS\* - PRO and CON MEDICAL MARIJUANA

*\*Medical organizations are considered those groups who exist to study and practice medicine and are licensed to do so. They are generally composed of MDs and RNs. We have listed only those medical organizations that have been quoted or otherwise referenced on Medical Marijuana ProCon.org.*

### **SOME PRO MEDICAL MARIJUANA ORGs**

*(date of last found Pro statement)*

1. **American Academy of Family Physicians** (2001)
2. **American College of Physicians** (Feb. 15, 2008)
3. **American Medical Students Association** (Mar. 1993)
4. **American Nurses Association** (June 2003)
5. **American Public Health Association** (Jan. 1, 1995)
6. **American Society of Addiction Medicine** (May 2006)
7. **Australian Medical Association (AMA)** (Dec. 2006)
8. **British Epilepsy Association** (Mar. 2002)
9. **British Medical Association** (Nov. 1997)
10. **California Academy of Family Physicians** (Feb. 1994)
11. **California Medical Association** (Jan. 2004)
12. **California Nurses Association** (Mar. 6, 2002)
13. **California Pharmacists Association** (Mar. 6, 2002)
14. **Canadian AIDS Society** (Jun. 29, 2005)
15. **Canadian Medical Association** (Nov. 8, 2001)
16. **Gay/Lesbian Medical Assoc.** (Mar. 6, 2002)
17. **Hawaii Nurses Association** (Mar. 6, 2002)
18. **Health Canada** (2005)
19. **Institute of Medicine** (Mar. 17, 1999)
20. **Colorado Nurses Association** (1995)
21. **Florida Medical Assoc.** (Jun. 1997)
22. **Kaiser Permanente** (Apr. 1997)
23. **Lymphoma Foundation of America** (Jan. 20, 1997)
24. **Montana Dept. of Health and Human Services** (Oct. 3, 2008)
25. **Muscular Dystrophy Assoc.** (Oct. 2003)
26. **Natl. Women's Health Network** (Mar. 6, 2002)
27. **New England Journal of Medicine** (Jan. 30, 1997)
28. **New Mexico Nurses Assoc.** (Jul. 28, 1997)
29. **New York State Nurses Assoc.** (June 7, 1995)
30. **North Carolina Nurses Assoc.** (Sep. 17, 2007)
31. **Oregon Department of Health Services** (Aug. 31, 2006)
32. **San Mateo County Health Dept.** (Mar. 2001)
33. **Syracuse Behavioral Healthcare** (Jan. 22, 2003)
34. **Virginia Nurses Association** (Oct. 7, 1994)
35. **Whitman-Walker Clinic** (Apr. 1998)
36. **Wisconsin Nurses Association** (Oct. 29, 1999)

### **SOME CON MEDICAL MARIJUANA ORGs**

*(date of last found Con statement)*

1. **American Academy of Ophthalmology** (Aug. 17, 2009)
2. **American Medical Association (AMA)** (Nov. 2008)
3. **Cleveland Clinic** (May 21, 2009)
4. **Crohn's & Colitis Foundation of America** (Oct. 13, 2009)
5. **Epilepsy Ontario (Canada)** (Oct. 12, 2009)
6. **Glaucoma Research Foundation** (Oct. 13, 2009)
7. **NW Center Health & Safety** (Mar. 3, 2002)
8. **Natl. Center on Addiction & Substance Abuse** (June 18, 2008)
9. **Natl. Eye Institute** (May 13, 2009)
10. **Natl. Multiple Sclerosis Society** (Mar. 17, 2009)
11. **US Food & Drug Administration** (Sep. 25, 2009)