

Harnessing Medical Discord to Influence Marijuana Policy

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*The dividing line in medicine, even between use and abuse, is so zigzag and invisible that common mortals, in groping for it, generally stumble beyond it.*¹

I. The Medicolegal History of Alcohol Till Repeal

At the time of the discovery of distillation, the action of alcohol on the human system “could be judged only by its *seeming* effects,” and “[a]s these were pleasing, it was supposed that a great medical discovery had been made.”² Healers proclaimed alcohol “a panacea for all . . . ills, . . . if not the very *aqua vitae* itself.”³ Hence, “[a]lcohol [was] a widely counseled, readily available, and relatively cheap remedy for thousands of years.”⁴

In Colonial America, alcohol still was “universally honored as a medicine for almost every physiological malfunction, whether temporary or permanent, real or imagined.”⁵ Of course, medicinal alcohol is no less enjoyable than any other alcohol, and “as time advanced, people began prescribing it for themselves, until its use both as medicine and beverage became almost general.”⁶

In 1774, a Quaker intellectual argued—in his pamphlet, *The Mighty Destroyer Displayed*—that alcohol “was the cause of most afflictions of the body, the soul, and human society.”⁷ The pamphlet impressed Dr. Benjamin Rush, surgeon general of the Revolutionary Army, who became the first American physician to scientifically gather

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data “correlat[ing] the drinking of liquor to ‘vices, diseases . . . suicide, [and] death’”⁸ However, Rush’s prescription for alcoholics—that they should abstain from ardent spirits and instead take in regular dosages his compound of wine and opium—indicated a failure to understand that “the terrors of whiskey or rum could be evoked as forcefully by plain wine if the drinker were adequately motivated.”⁹

In 1851, Chicago physician Dr. Nathan S. Davis presented his research to the American Medical Association (AMA or the Association) “show[ing] that alcohol, instead of . . . promoting nutrition and strength, actually produced directly opposite effects”¹⁰ The Association rejected Davis’s conclusions as “opposed . . . to the generally accepted teachings of the day.”¹¹ But, in 1871, the Association did resolve that alcohol should be “classed with other powerful drugs, and . . . prescribed . . . with conscientious caution, and a sense of great responsibility.”¹²

In the 1880s, the Women’s Christian Temperance Union (WCTU or the Union) campaigned for state laws mandating “scientific temperance instruction” in public schools.¹³ The Union subsidized the publication of two textbooks—The Child’s Health Primer and Young People’s Physiology—and organized “an examining committee of medical experts,” which included two past presidents of the AMA.¹⁴ The committee reported that the Union’s textbooks contained “no errors . . . [and] [n]o statement . . . at variance with the most reliable studies of especially competent investigators.”¹⁵

Medicinal alcohol, however, had a deleterious effect on the WCTU’s campaign against alcoholic beverages: “[t]he wide-spread belief in the necessity and efficacy of alcoholics as remedies [was considered by some to be] the greatest hindrance to the

success of the temperance cause.”¹⁶ Indeed, despite the resistance of many physicians to prescribe it, “[t]he medical use of alcohol [was] the great bulwark of the liquor traffic.”¹⁷

In 1917, at the annual meeting of the House of Delegates (HOD)—the AMA’s principal policy-making body—the WCTU presented a letter asking that the Association warn the public “against alcoholic liquors” so as to “strengthen the hands of . . . temperance organizations . . . combating the liquor evil.”¹⁸ The Union argued that a “chief cause[]” of alcoholism was the false claim of brewers and distillers that their products were “endorsed and recommended by physicians”¹⁹ Hence, “[t]he medical profession owe[d] it to itself and to the public to offset this dangerous and misleading advertising by a statement of the truth.”²⁰ Responding quickly, the HOD considered a resolution “declar[ing] it[self] opposed to the use of alcohol by individuals either as a medicine or as a beverage.”²¹

Three days later, the Reference Committee on Legislation and Political Action amended the following language to the resolution, which was ultimately put and carried:

WHEREAS, We believe that the use of alcohol as a beverage is detrimental to the human economy, and

WHEREAS, Its use in therapeutics, as a tonic or a stimulant or as a food has no scientific basis, therefore be it

Resolved, That the American Medical Association opposes the use of alcohol as a beverage, and be it further

Resolved, That the use of alcohol as a therapeutic agent should be discouraged.²²

The delegate from the Section on Pharmacology and Therapeutics moved—unsuccessfully—to substitute the Reference Committee’s language with the following: “the question of the therapeutic value of alcohol which has been long in dispute remains

yet undetermined, and . . . hasty action . . . would not be wise, and would not reflect fully the best therapeutic and pharmacologic opinions.”²³

Soon thereafter, in the correspondence section of the Journal of the American Medical Association, one doctor protested the Association’s political organ “dealing with a matter . . . outside of its sphere and which belongs to the Council on Pharmacy and Chemistry, which deals with matters therapeutic.”²⁴ He argued that the HOD did not have “a right to pass dogmatic resolutions which differ absolutely from what thousands of members of the Association believe to be true.”²⁵ But, other commentators favored the anti-alcohol resolution. For example, one Dr. Charles E. Hawkes was “only one of a large number of physicians who st[oo]d ready to sacrifice alcohol for other stimulants and drugs, for the uplift of humanity.”²⁶

“[T]he prohibition forces . . . made good use of the ill-advised resolution of 1917.”²⁷ Congress passed the Eighteenth Amendment on December 18, 1917, and it was ratified by the necessary thirty-sixth state on January 16, 1919.²⁸ Since the Eighteenth Amendment lacked implementing language, Congress passed the National Prohibition Act (Volstead Act), assigning enforcement responsibility to the Department of the Treasury.²⁹ Despite the AMA’s express resolution “discourag[ing]” the use of medicinal alcohol,³⁰ the Volstead Act included an exception for “medicinal purposes when prescribed by a physician . . .”³¹ Notably, this was the *only* exception in the Act authorizing the distribution of *hard* liquor.³²

Hence, some “accuse[d] the [AMA] of being the main cause of the adoption of the Eighteenth Amendment, and that its members ma[d]e an enormous profit through their monopoly of prescribing alcohol for medicinal purposes.”³³ And records do show that

“some physicians defied the AMA’s [1917] resolution and doled out alcohol more frequently than ever before, quite likely in a bid to profit from their rare privilege.”³⁴

Such a view, however, fails to comport with the tremendous resistance doctors demonstrated to the burdens the Volstead Act imposed on their practice.³⁵ As an example, “[t]he new laws required [doctors] to use special prescription pads issued by the U.S. Treasury Department and regulated how much liquor each patient could receive.”³⁶ Many physicians denounced such limitations as “dispens[ing] with the[ir] judgment” and “interfer[ing] with the proper relation of the physician with his patient”³⁷ But some doctors were content with the limitation, concerned that many physicians were “willing for a price to prostitute their ability and their profession by issuing as many prescriptions for liquor as the law [would] allow and on the slightest pretext”³⁸

In 1920, the HOD *tabled* a resolution that would have reaffirmed the 1917 anti-alcohol resolution—the first hint of the Association’s fast-approaching reversal on the alcohol issue.³⁹ In December 1921, the editorial staff of the Journal of the American Medical Association distributed a questionnaire to gather the opinions of 53,900 physicians on the therapeutic value of alcohol.⁴⁰ Fifty-eight percent of the questionnaires were returned, representing the opinions of 31,115 physicians—twenty-one percent of physicians nationwide.⁴¹ Fifty-one percent of respondents indicated that, yes, whisky was a “necessary therapeutic agent.”⁴² It was also noted that “[i]n practically every community . . . moonshine [was] freely available, and that it was unnecessary to write prescriptions in order for patients to secure beverages for medicinal . . . purposes.”⁴³ Thousands of respondents said they resented serving as the primary source of alcohol in

their communities—“they did not wish to be the ‘goats’ for the government in controlling [the alcohol] problem, nor did they wish to serve as saloonkeepers or bartenders.”⁴⁴

Unsurprisingly, in 1922, the House of Delegates unanimously resolved:

WHEREAS, The medical profession has been subjected to criticism and unfavorable comment because of present conditions associated with the enforcement of the Volstead Law, and

WHEREAS, The results of a referendum conducted by [*JAMA*], covering 54,000 physicians, indicates that fifty-one per cent. of physicians consider whisky “necessary” in the practice of medicine, and

WHEREAS, The dosage, method, frequency and duration of administration of this drug in any given case is a problem of scientific therapeutics and is not to be determined by legal or arbitrary dictum, and

WHEREAS, The experience of physicians, as reported in [*JAMA*], indicates that the present method of control, limitation of quantity and frequency of administration, licensure, and supply of a satisfactory product constitutes a serious interference with the practice of medicine by those physicians who are convinced of the value of alcohol in medical practice, therefore be it

Resolved, That the [HOD] . . . appeals to the Secretary of the Treasury and to the Congress of the United States for relief from present unsatisfactory conditions⁴⁵

But AMA resolutions were not the only mechanism available to physicians itching to resist the Volstead Act’s mandates. In *Lambert v. Yellowley*, Dr. Samuel W. Lambert brought suit in federal court asking to enjoin the acting federal prohibition director from limiting his ability to prescribe alcohol.⁴⁶ In 1926, the Supreme Court affirmed the Second Circuit’s reversal of the district court’s grant of the injunction.⁴⁷ The Court’s holding depended in part on the dissonance of medical opinion on the matter: “[h]igh medical authority being in conflict as to the medicinal value of . . . liquors taken as a beverage, it would, indeed, be strange if Congress lacked the power to determine that the necessities of the liquor problem require a limitation of permissible prescriptions⁴⁸ One year later, the AMA announced its contrary opinion: “legislative

bodies composed of laymen should not enact restrictive laws regulating the administration of any therapeutic agent by physicians legally qualified to practice medicine.”⁴⁹

Near the end of Prohibition, even the federal government ultimately accepted that the restrictions placed on physicians were untenable.⁵⁰ Senate Bill 3090—prepared by the AMA’s Bureau of Legal Medicine and Legislation, and introduced to the Senate on January 18, 1932—would have responded to these concerns by removing the “arbitrarily fixed” number of prescriptions available to each physician.⁵¹ But the bill came too late to be of use; the Twenty-first Amendment was ratified on December 5, 1933, repealing Prohibition.⁵²

II. A Medicolegal History of Marijuana Through Modern Day*

For thousands of years, the leaves and flowering tops of *Cannabis sativa* “have been used by many primitive societies as a folk medicine for a wide variety of ailments.”⁵³ Irish physician Dr. William B. O’Shaughnessy introduced marijuana into the Western pharmacopoeia in 1839, where it was “promptly recommended for an utterly endless list of disorders.”⁵⁴ Cannabis was legal to grow and consume in the United States until the 1910s, when several state legislatures set about to criminalize it.⁵⁵ In 1931 alone—just two years before *alcohol* prohibition ended—the introduction of sixteen drug-related state bills and resolutions demonstrated “wide public interest in the *narcotic* problem.”⁵⁶ The

[*The terms “cannabis,” “marijuana,” and “marihuana” are used interchangeably throughout this paper. Where a term is used in a quotation, the original is retained.]

AMA's Bureau of Legal Medicine warned "physicians to watch all such legislation, to see that no unnecessary restrictions [were] imposed"57

At the same time, the Association expressed its support of "all legitimate efforts to prevent the diversion of narcotic drugs into illegitimate channels,"58 going so far as to encourage states to "supplement" federal drug law, noting the "impotence of federal activities . . . forcibly demonstrated by experience under the Eighteenth Amendment and the [Volstead A]ct."59 The AMA and the American Bar Association jointly approved the Uniform Narcotic Drug Act (UNDA), written by the National Conference of Commissioners on Uniform State Laws.60 By 1936, twenty-nine states had approved the original UNDA, or a strengthened form of the UNDA, which applied also to cannabis.61

In 1937, the Federal Bureau of Narcotics (FBN)—an agency under the umbrella of the Treasury Department—announced it had received evidence "that certain physicians played a part in facilitating the development and continuation of narcotic addiction."62 In response, the Secretary of the Treasury "introduced a bill proposing to impose certain restrictions on the production, manufacture and use of cannabis"63 The AMA opposed the bill primarily for two reasons: first, "[t]here [was] positively no evidence to indicate the abuse of cannabis as a medicinal agent or to show that its medicinal use [was] leading to the development of cannabis addiction;"64 and, second, cannabis had therapeutic potential that could only be demonstrated by "a restudy of the drug by modern means."65 Notwithstanding the AMA's—solitary66—opposition, Congress passed the Marihuana Tax Act in August 1937.67 The statute required "medical users to register and pay a tax of \$1/ounce,"68 and later regulations "designed [by FBN] to prevent diversion . . . dampened enthusiasm for pursuing medical applications."69 Finally, after

being removed from the United States Pharmacopoeia in 1942, *Cannabis sativa* “los[t] its remaining mantle of therapeutic legitimacy.”⁷⁰

Still, research rolled on. The psychoactive cannabinoid responsible for cannabis’s euphoric effect, THC, was first isolated in 1942.⁷¹ Twenty-two years later, Israeli chemists elucidated the chemical structure of THC, and performed the first total synthesis of the molecule from commercially available starting materials.⁷² All the while, the AMA did not consider the marijuana issue again until 1969.

In that year, an AMA policy reference committee considered Resolution 26, which would “direct[] the [Association’s] Board of Trustees to have an appropriate committee . . . study the problems relating to marihuana use and addiction in order to present an official, clear statement that [would] inform the American people accurately of the medical profession’s appraisal of the effects of its use”⁷³ In response to the resolution, the HOD adopted Report K—developed by the Council on Mental Health—resolving that, because it is a “dangerous drug,” marijuana should “not be legalized.”⁷⁴ But, additional research on marijuana “should be encouraged.”⁷⁵ Through “diligent[]” research, the Board of Trustees anticipated that it would update its policy on marijuana “as scientific evidence accumulate[d].”⁷⁶

Congress reclassified marijuana as a Schedule I drug under the Comprehensive Drug Abuse Prevention and Control Act of 1970 (Controlled Substances Act or CSA).⁷⁷ The Controlled Substances Act prohibited the manufacture, distribution and possession of Schedule I narcotics, subjecting large-scale violators to punishments as severe as life imprisonment.⁷⁸ The CSA made clear that “Schedule I narcotics are not approved for any

medical use, [so] doctors cannot prescribe them”⁷⁹ But—importantly—the CSA did not close the door on clinical research of cannabis as a therapeutic.

In 1972, the Association’s Board of Trustees adopted the findings of the Council on Mental Health and the Committee on Alcoholism and Drug Dependence, which—as required by Report K—had spent the last two years “continu[ing] to review evidence obtained from scientific research into [marijuana].”⁸⁰ The findings noted that marijuana was “currently used primarily as a recreational drug.”⁸¹ While the AMA did “not condone the production, sale or use of marihuana,” it “urge[d] that there be *increased* research” on the substance, its “therapeutic possibilities certainly deserv[ing] further exploration.”⁸² In 1977, the HOD encouraged—“in the interests of both the individual and society”—the “trend toward modifications of marihuana possession laws to reduce the severity of penalties”⁸³ However, it also recognized that “[m]arihuana is potentially damaging to health in a variety of ways,” and can have “serious consequences for those individuals who are especially vulnerable, [e.g., c]hildren and adolescents[, the] emotionally unstable[, and] persons with physical illnesses or diseases who may suffer complications through non-medical use of certain drugs.”⁸⁴

Two years later, the AMA’s Council on Scientific Affairs recognized “a growing number of states permitting physicians to utilize the drug in clinical research contexts,” interpreting this to indicate public “pressure[] to accelerate investigation into the therapeutic possibilities of marihuana”⁸⁵ But, as a Schedule I narcotic, marijuana’s use is “strictly criminally prohibited except as part of a research study preapproved by the US Food and Drug Administration (FDA).”⁸⁶ The Council noticed that the published clinical research was performed by “physicians in private practice [who we]re not in a

position to conduct adequate double-blind cross-sectional investigations.”⁸⁷ Hence, these physicians were likely “providing treatment responsive to users’ self-reports of beneficial effects, under a research guise necessitated by requirements of federal law.”⁸⁸

Nevertheless, the Council foresaw that as clinical research became more widely available, “[t]he public may . . . come to realize more fully what pharmacologists have known all along: that marihuana, as any other drug, has potential for harm as well as for good”⁸⁹

Soon after the Council made its prediction, “[w]ell-designed clinical studies” demonstrated the “superiority of THC over placebo” in the “treatment of extreme nausea for patients who undergo cancer chemotherapy,” and in the reduction of intra-ocular pressure in glaucoma.⁹⁰ By the time of these publications, eleven states were participating in FDA-approved clinical trials.⁹¹ The AMA encouraged states contemplating participation to be sure their statutes would not be “in conflict with rules and regulations imposed by current federal laws [by] requir[ng] coordination with FDA, NIDA, DEA and other relevant federal agencies[;] . . . recogniz[ing] abuse potential[;] and provid[ing] mechanisms to prevent diversion and misuse”⁹² And the AMA emphasized: “[t]he fact that marijuana may prove to have therapeutic value in medical practice does not indicate that is a safe drug for recreational use.”⁹³

In 1996, California voters passed Proposition 215—55.6% to 44.4%—making California the first state to allow the use of marijuana for medical purposes outside of federally regulated clinical trials.⁹⁴ The AMA immediately expressed its direct opposition to the legalization of marijuana for sale or possession.⁹⁵ Then, on December 30, 1996, the Clinton Administration “warned that physicians who tried to make use of the [Proposition

215] could (1) lose their federal [DEA] license for prescribing controlled substances, (2) be excluded from participation in the Medicare and Medicaid programs, and (3) be subject to criminal prosecution.”⁹⁶

In response, several California physicians and patients filed a federal class action lawsuit, *Conant v. McCaffrey*, seeking an “injunction on First Amendment grounds against federal enforcements of (or threats to enforce) statutes or regulations that would punish or penalize physicians for communicating with patients about the risks and benefits of medical marijuana”⁹⁷ The Administration clarified its position: physicians were not under a “gag rule” preventing them from discussing how any treatment might affect a patient’s health.⁹⁸ Still, the Department of Justice forbade physicians from “intentionally provid[ing] their patients with oral or written statements to *enable* them to obtain controlled substances in violation of federal law.”⁹⁹ The AMA took neither side in the litigation, declining an invitation from the plaintiffs to file an *amicus* brief.¹⁰⁰ But, the Association reiterated its support of the “free and unfettered exchange of information” between patients and physicians, noting that the medical “principles of free disclosure apply *even if the effectiveness of a potential treatment . . . is not yet fully proven.*”¹⁰¹

The federal District Court for the Northern District of California preliminarily enjoined the Government “from threatening or prosecuting physicians, revoking their licenses, or excluding them from Medicare/Medicaid participation”¹⁰² However, the court could not—for reasons of constitutional separation of powers—enjoin the Government from prosecuting violations of federal *criminal* statutes.¹⁰³ The Court of Appeals for the Ninth Circuit affirmed the district court’s decision, issuing a permanent

injunction and recognizing physicians' First Amendment right to discuss marijuana as a treatment option.¹⁰⁴

In 2009, the AMA updated its policy on medical marijuana, urging—for the first time, then reaffirming its position in 2012—that Congress should review marijuana's Schedule I status “with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines”¹⁰⁵ The Association made clear that “[t]his should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.”¹⁰⁶

Despite the Association's hesitancy, twenty-three states and the District of Columbia have legalized marijuana for medical purposes,¹⁰⁷ authorizing its use for the treatment of glaucoma, Crohn's disease, posttraumatic stress disorder, epilepsy, Alzheimer's disease, and chemotherapy-induced nausea and vomiting.¹⁰⁸ It is expected that “[b]oth the number of states and the number of approved indications for medical marijuana [will] increase.”¹⁰⁹ And while federal officials may criminally prosecute patients for possessing medical marijuana recommended by a physician in accordance with state law,¹¹⁰ the Obama Administration published a memorandum indicating that the federal government will be less likely to prosecute in states where the practice is sufficiently regulated.¹¹¹

Opponents of legalization describe medical marijuana as “a smoke screen[:] [t]he only reason [for] the medical debate is because advocates want it legalized for recreational use.”¹¹² They point to “respiratory problems” associated with smoked marijuana, increased risk of “psychosis,” and “structural brain changes as well as a

decline in IQ.”¹¹³ Others say these claims are unfounded “pseudoscien[ce].”¹¹⁴ This conflict is resolving itself slowly because complex bureaucracy and limited federal interest curtails research.¹¹⁵

III. Lessons for Policymakers and Regulators Considering Marijuana Research or Medicalization

FIRST, all policymakers and regulators—both state and federal—should support scientific research into the potential therapeutic value of cannabis. Whether or not to legalize medical marijuana is a separate and distinct issue that is—for good reason—political and open for debate.*

As a scientific matter, the medical community was not unified in its opinion of the potential therapeutic effects of alcohol when the political matter—the ratification of the Eighteenth Amendment—concluded.¹¹⁶ True, the AMA’s House of Delegates made its official position clear in 1917: “the use of alcohol as a therapeutic agent [was to] be discouraged.”¹¹⁷ But this position reflected political—not scientific—influences,¹¹⁸ as the editorial staff of the Journal of the American Medical Association recognized when it noted that “the question as to whether whisky is a necessary therapeutic agent is a scientific one and cannot be decided by resolutions or by votes.”¹¹⁹

The Supreme Court’s 1926 holding in *Lambert v. Yellowley*—sanctioning the federal government’s authority to tightly regulate the prescription of alcohol—depended, for its reasoning, upon this very discord in the medical community; indeed, the point was

[* The author takes no position on the normative question as to whether medical or recreational adult-use marijuana ought to be legalized.]

made in the concluding sentence of the majority’s opinion.¹²⁰ The various state legislatures also seem to have noticed the medical disagreement, propagating a wide range of laws defining, without medical reason, whether—and what type of—alcohol could be prescribed within their borders.¹²¹ Fortunately, that same medical disagreement appears to have discouraged any attempts to stifle research into the potential therapeutic value of alcohol.

Today, too, the medical discord regarding marijuana’s therapeutic value is a thumb on the scale in *favor* of continuing research and open discussion.¹²² The AMA specifically distinguishes the issue of legalization—a “complex social and medical issue which should not be resolved by [vote]”¹²³—from the issue of regulated investigation, which it strongly encourages.¹²⁴

And, when the AMA has yet to come down on one side of the medical marijuana debate, a state legislator would be both cautious and reasonable in concluding that any efforts to legalize medical marijuana would “essentially [be] legalizing recreational marijuana but forcing physicians to act as gatekeepers for those who wish to obtain it.”¹²⁵ Indeed, similar concerns motivated some physicians to support the prescription restrictions in the Volstead Act, noting that others in their profession were “willing for a price to prostitute their ability and their profession by issuing as many prescriptions for liquor as the law [would] allow and on the slightest pretext.”¹²⁶ So it is with marijuana today as it was with alcohol in the early twentieth century: without a unified medical opinion as to marijuana’s therapeutic value, politics can—and, indeed, should—break the tie.

That said, the AMA recently urged Congress to reconsider marijuana’s classification in Schedule I to “facilitat[e] the conduct of clinical research and development of cannabinoid-based medicines”¹²⁷ Congress should align itself with the AMA on the research issue. And, in the meantime, policymakers—in states both with and without medical marijuana laws—should work with the federal government to encourage and participate in clinical trials to more quickly develop a science-based understanding as to whether marijuana has genuine therapeutic value.

SECOND, policymakers and regulators should invite the early participation of the American Medical Association when crafting medically relevant legislation; and they should do so *because* of—not in spite of—the AMA’s internal scientific differences.

One year before the Eighteenth Amendment was ratified, the AMA expressed its position that alcohol ought not to be encouraged as a therapeutic drug.¹²⁸ Entirely contrary to the Association’s official disapproval, the Volstead Act included a “medicinal use” exception for “patients who obtained a prescription from a licensed physician.”¹²⁹ This infuriated the profession: “the great majority of physicians objected to being made the main [agents] in the distribution of alcohol.”¹³⁰ And even for those who were comfortable with the exception, its strict limitations on the number, size and duration of alcohol prescriptions per physician were seen as an unacceptable “interfere[nce] with the proper [physician-patient relationship].”¹³¹

After its experience with Prohibition, and with hints of marijuana classification in the air, the AMA Bureau of Legal Medicine, in 1931, warned “physicians to watch all [narcotics] legislation . . . to see that no unnecessary restrictions [were] imposed on their professional use.”¹³² But rather than opposing state narcotics legislation, the

Association—noting the “impotence of federal activities” during Prohibition—*encouraged* state legislators to develop well-crafted drug control policy.¹³³ In short, the Association is a highly organized, educated, opinionated and influential group—it is also highly motivated to work collaboratively with legislators. Hence, legislators, lacking medical and scientific training, should engage the Association at the outset of policy development.¹³⁴ This will legitimize any policies developed, and ensure the support of the Association, decreasing the likelihood that the Association—or an independent physician—will fight the policy through direct democracy or judicial appeal.¹³⁵

IV. Conclusion

During Prohibition, many state legislatures “pave[d] the way” for Congress to repeal the Eighteenth Amendment by rescinding state alcohol prohibition laws.¹³⁶ With marijuana legal in twenty-three states and the District of Columbia, “legalization advocates are understandably hopeful that history is repeating itself.”¹³⁷ And some experts in alcohol policy believe that the United States has moved “beyond the tipping point,” and that nationwide legalization—in some form or other—is inevitable.¹³⁸

As clinical research regarding medical marijuana becomes more widely available, “[t]he public may . . . come to realize . . . that marihuana, as any other drug, has potential for harm as well as for good”¹³⁹ But, with the AMA suspending judgment pending further research, policymakers and regulators should engage the Association to harness its deep understanding, working alongside the Association to develop medically current and politically accountable marijuana policy.¹⁴⁰

ENDNOTES

¹ MARTHA M. ALLEN, *ALCOHOL: A DANGEROUS AND UNNECESSARY MEDICINE* 100 (1900) (internal quotation marks omitted).

² *Id.* at 9 (emphasis in original).

³ *See id.* at 9–10 (“It sloweth age, it strengtheneth youth, it helpeth digestion, it cutteth phlegme, it cureth the hydropsia, it healeth the strangurie, it pounces the stone, it expelleth gravel, it keepeth the head from whirling, the teeth from chattering, and the throat from rattling; it keepeth the weasen from stifling, the stomach from wambling, and the heart from swelling; it keepeth the hands from shivering, the sinews from shrinking, the veins from crumbling, the bones from aching, and the marrow from soaking.” (internal quotation marks omitted)).

⁴ Jennie Cohen, *Drink Some Whiskey, Call in the Morning: Doctors & Prohibition*, HISTORY (2012) (“Healers and doctors in ancient China, Egypt, Greece and Rome—to name just a few civilizations—treated everything from chronic illnesses to migraines to infections with fermented beverages, recognized for their antiseptic and analgesic properties.”), <http://www.history.com/news/drink-some-whiskey-call-in-the-morning-doctors-prohibition>.

⁵ NORMAN H. CLARK, *DELIVER US FROM EVIL: AN INTERPRETATION OF AMERICAN PROHIBITION* 14 (Harold M. Hyman ed., 1st ed. 1976).

⁶ ALLEN, *supra* note 1, at 10.

⁷ CLARK, *supra* note 5, at 22–23.

⁸ *Id.* at 23–24.

⁹ *Id.* at 23.

¹⁰ ALLEN, *supra* note 1, at 11.

¹¹ *Id.* at 11–12.

¹² *Id.* at 14 (internal quotation marks omitted).

¹³ CLARK, *supra* note 5, at 85–86 (noting that the WCTU pushed for “hygiene education advocating total abstinence and stressing the conviction that alcohol was a poison”).

¹⁴ *Id.* at 86.

¹⁵ ALLEN, *supra* note 1, at 18 (internal quotation marks omitted).

¹⁶ *See id.* at 97 (“It is impossible to convince the mass of the people that what is life-giving as medicine can be death-dealing as beverage.”); *see also id.* at 291 (“There is

a deep-rooted prejudice in favor of alcohol as a remedy in the minds of the great multitude of people, and they are ready to distrust as fanatical, or incompetent, any physician who does not use it.”).

¹⁷ *Id.* at 96; *see id.* at 361 (“It is upon the members of the medical profession, and the exceptional laws which it has always demanded, that the whole liquor fraternity depends, more than upon anything else, to screen it from opprobrium . . . and it is because the rum-seller, and the rum-drinker, hide under this cloak of seeming respectability that they are so difficult to reach by moral suasion, or by law.” (internal quotation marks omitted)).

¹⁸ Anna A. Gordon & Martha M. Allen, President & Superintendent of the Department of Medical Temperance, WCTU, *Communication from the National WCTU, Minutes of the HOD 68th Annual Session* 11 (1917).

¹⁹ *Id.*

²⁰ *Id.*

²¹ Council on Health and Public Instruction, *Minutes of the HOD 68th Annual Session* 11 (1917).

²² Reference Committee on Legislation and Political Action, *Minutes of the HOD 68th Annual Session* 68 (1917).

²³ *Id.* (“Furthermore, while recognizing the possible need of prohibition of the use of alcohol as a measure of public safety, it would ask that the two questions be considered separately on their respective merits.”).

²⁴ Hobart A. Hare, *The Action of the House of Delegates of the A.M.A. on the Alcohol Question*, LXIX(3) *JAMA* 226 (1917); *see* VICTOR G. VECKI, *ALCOHOL AND PROHIBITION IN THEIR RELATION TO CIVILIZATION AND THE ART OF LIVING* 124 (1923) (“The [HOD] is a political, not a scientific body. . . . [It] is not competent to decide any therapeutic question at any time, least of all on the spur of the moment.”).

²⁵ Hare, *supra* note 24, at 226 (“[T]he resolutions already quoted are not justified. Alcohol has been much abused as a drug, as have all powerful drugs; but that it has no drug value, no food value, and is detrimental when used as a therapeutic agent, I earnestly deny.”); *see* VECKI, *supra* note 24, at 126 (noting that the New York Medical Society adopted a resolution opposing the AMA resolution, decrying it as “irrational and unscientific and in opposition to the accepted usages of all civilized nations throughout the world”).

²⁶ *See* Charles E. Hawkes, *Medical Science on the Side of Alcohol?*, LXIX(15) *JAMA* 1289 (1917).

²⁷ *See* VECKI, *supra* note 24, at 126.

²⁸ NATIONAL ARCHIVES AND RECORDS ADMINISTRATION, http://www.archives.gov/exhibits/charters/constitution_amendments_11-27.html (last visited Nov. 16, 2014).

²⁹ RICHARD MENDELSON, *FROM DEMON TO DARLING: A LEGAL HISTORY OF WINE IN AMERICA* 59–60 (2009).

³⁰ See Reference Committee on Legislation and Political Action, *supra* note 22, at 68.

³¹ National Prohibition Act, Pub. L. No. 66, 41 Stat. 305, 310 (Title II, § 6) (1919); see Cohen, *supra* note 4 (“Why did Prohibition’s authors keep the provision on the books even though the medical community had formally dismissed the need for medicinal alcohol? In all likelihood, many of the most fervent teetotalers had grown up soothing their toothaches and calming their coughs with trace amounts of whiskey, brandy or rum.”).

³² See DANIEL OKRENT, *LAST CALL: THE RISE AND FALL OF PROHIBITION* 193 (2010) (emphasis added).

³³ VECKI, *supra* note 24, at 126.

³⁴ Cohen, *supra* note 4; cf. Editorial, *The Referendum on Alcohol*, 78(3) JAMA 194 (1922) (“[T]he medical profession has been subjected to ridicule and criticism on account of the actions of a small number of its members who are abusing their privileges and who have assumed a position in the public eye not creditable to the profession as a whole.”).

³⁵ VECKI, *supra* note 24, at 126 (“Everybody knows that the men behind the 1917 anti-alcohol resolution never took out a permit to prescribe alcohol, and the protests against the present day alcohol prescribing rules and regulations prove how little the medical profession cares, in fact, how much it detests any profiteering a few black sheep may practi[c]e.”); *id.* at 132 (“As to the enormous PROFITS from the prescribing of alcoholic fluids, it takes a great deal of fantasy to see them. Even the few scamps who were caught selling their prescription books to a criminally inclined druggist made two hundred and fifty dollars every three months. What an enormous profit!” (emphasis—and sarcasm—in original)).

³⁶ Cohen, *supra* note 4 (parentheses omitted) (“When Prohibition dawned, many doctors continued to prescribe alcohol for anemia, tuberculosis, pneumonia and high blood pressure, among other disorders.”); see OKRENT, *supra* note 32, at 193–94 (“For most of the 1920s a patient could fill a prescription for one pint every ten days, and a doctor could write a hundred prescriptions a month on numbered, government-issued forms that resembled stock certificates and were as dearly cherished.”).

³⁷ See VECKI, *supra* note 24, at 127.

³⁸ See Final Report, *The Referendum on the Use of Alcohol in the Practice of Medicine*, 78(3) *JAMA* 210, 229 (1922).

³⁹ See VECKI, *supra* note 24, at 127–28.

⁴⁰ See Editorial, *Questionnaire on Alcohol as a Therapeutic Agent*, 77(23) *JAMA* 1820 (1921).

⁴¹ Final Report, *supra* note 38, at 210.

⁴² *Id.* (thirty-two percent considered wine therapeutic; twenty-six percent considered beer therapeutic).

⁴³ *Id.* at 218 (internal quotation marks omitted).

⁴⁴ *Id.*

⁴⁵ VECKI, *supra* note 24, at 130–31.

⁴⁶ 272 U.S. 581, 588 (1926) (Dr. Lambert “alleged that to treat the diseases of his patients and to promote their physical well-being, according to the untrammelled exercise of his best skill and scientifically trained judgment, and, to that end to advise the use of such medicines and medical treatment as in his opinion are best calculated to effect their cure and establish their health, is an essential part of his constitutional rights as a physician.”).

⁴⁷ *Lambert*, 272 U.S. at 588–89, 597.

⁴⁸ *Id.* at 596–97.

⁴⁹ See Cohen, *supra* note 4 (internal quotation marks omitted).

⁵⁰ National Commission on Law Observance and Enforcement (Wickersham Commission), *Report on the Enforcement of the Prohibition Laws of the United States* 215 (1931) (“Physicians should be permitted, under reasonable regulations, to prescribe whatever liquor in their judgment is necessary for a patient. If a physician can be trusted to prescribe dangerous drugs he can be trusted to prescribe liquors as medicines.”).

⁵¹ Editorial, *Legislation on Medicinal Liquor*, 98(4) *JAMA* 321 (1932) (“The enactment of this bill will . . . remove the principal grounds for [physicians’] resentment against the national prohibition laws . . .”).

⁵² See MENDELSON, *supra* note 29, at 93 (“In only one of thirty-seven states, South Carolina, did voters prefer to retain the Eighteenth Amendment. Altogether, fifteen million out of a total twenty-one million voters favored Repeal.”).

⁵³ Sidney Cohen, *Marijuana: Does It Have a Possible Therapeutic Use?*, 240(16) *JAMA* 1761 (1978); see, e.g., Beverly J. Montgomery, *High Interest in Medical Uses of Marijuana and Synthetic Analogues*, 240(14) *JAMA* 1469 (1978) (some archaeologists

maintain that the Iranian equestrian tribes of the seventh century BCE used cannabis, which is also found in China's oldest known pharmacopoeia, the *PEN TS'AO*).

⁵⁴ John F. Greden, *Marihuana*, 228(4) *JAMA* 506–07 (1974) (reviewing *MARIJUANA: MEDICAL PAPERS, 1839–1972* (Tod H. Mikuriya, ed., 1973)).

⁵⁵ Erwin Chemerinsky, et al., *Cooperative Federalism and Marijuana Regulation*, 61 *UCLA L. REV.* (forthcoming in 2015) (manuscript at 3) (citations omitted), available at <http://ssrn.com/sol3/abstract=2411707>; see *id.* (manuscript at 3–4) (“[T]he move to regulate marijuana was motivated in large part by racism and xenophobia[,] . . . [as] marijuana came to be associated in the public imagination with both crime and black and Hispanic migrant workers.”) (citations omitted); see Cohen, *supra* note 53, at 1761 (noting that, in the 1920s, “extracts of *C[annabis] sativa* were on every pharmacist’s shelf”).

⁵⁶ Bureau of Legal Medicine and Legislation, *Minutes of the HOD 82nd Annual Session* 16 (1931) (emphasis added).

⁵⁷ *Id.*

⁵⁸ *Id.*

⁵⁹ HOD, *Minutes of the HOD 84th Annual Session* 17 (1933).

⁶⁰ HOD, *Minutes of the HOD 86th Annual Session* 17 (1935).

⁶¹ HOD, *Minutes of the HOD 87th Annual Session* 16 (1936).

⁶² See HOD, *Proceedings of HOD 88th Annual Session* 62 (1937).

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ Council on Science and Public Health, *Proceedings of HOD 63rd Interim Mtg.* 191 (2009) (“[T]he AMA was virtually alone in opposing passage of the Marihuana Tax Act.”).

⁶⁷ Chemerinsky, *supra* note 55 (manuscript at 4) (citations omitted).

⁶⁸ Council on Scientific Affairs, *Proceedings of HOD 51st Interim Mtg.* 346 (1997) (“Individuals using marijuana for recreational or other purposes were required to pay a tax of \$100/ounce.”).

⁶⁹ *Id.*; *United States v. Sanchez*, 340 U.S. 42, 45 (1950) (“The tax in question is a legitimate exercise of the taxing power despite its collateral regulatory purpose and effect.”).

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- ⁷⁰ Council on Scientific Affairs, *supra* note 68, at 346.
- ⁷¹ H. Wollner, et al., *Isolation of a Physiologically Active Tetrahydrocannabinol from Cannabis sativa Resin*, 64(1) J. AM. CHEM. SOC. 26–29 (1942).
- ⁷² R. Mechoulam & Y. Gaoni, *A Total Synthesis of dl- Δ^1 -Tetrahydrocannabinol, the Active Constituent of Hashish*, 87(14) J. AM. CHEM. SOC. 3273–75 (1965).
- ⁷³ Reference Committee E, *Proceedings of HOD 23rd Clinical Conv.* 300 (1969).
- ⁷⁴ *Id.* at 163–64.
- ⁷⁵ *Id.*
- ⁷⁶ Board of Trustees, *Proceedings of HOD 24th Clinical Conv.* 201 (1970).
- ⁷⁷ See 21 U.S.C. § 812(b)(1), (c)(c)(10).
- ⁷⁸ Chemerinsky, *supra* note 55 (manuscript at 4–5), citing 21 U.S.C. § 841(b).
- ⁷⁹ *Id.* (manuscript at 5); see 21 U.S.C. § 812(b)(1)–(2) (A drug is placed in Schedule I if “(A) it has a high potential for abuse; (B) it has no currently accepted medical use in treatment in the United States; and (C) there is a lack of accepted safety for use of the drug under medical supervision.” In contrast, Schedule II criteria are that the drug “(A) has a high potential for abuse; (B) has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions; and (C) abuse of the drug may lead to severe psychological or physical dependence.”).
- ⁸⁰ Board of Trustees, *Proceedings of HOD 121st Ann. Conv.* 77 (1972).
- ⁸¹ *Id.* at 78.
- ⁸² *Id.* at 80 (emphasis added).
- ⁸³ Board of Trustees, *Proceedings of HOD 31st Interim Mtg.* 193 (1977) (“[S]tringent laws have stigmatized a considerable number of young people for their use of marihuana . . .”).
- ⁸⁴ *Id.* at 189.
- ⁸⁵ Council on Scientific Affairs, *Proceedings of HOD 33rd Interim Mtg.* 178, 180 (1979).
- ⁸⁶ Lawrence O. Gostin, *Medical Marijuana, American Federalism, and the Supreme Court*, 294(7) *JAMA* 843 (2005), citing *United States v. Oakland Cannabis Buyers’ Coop.*, 532 U.S. 483, 490 (2001).
- ⁸⁷ Council on Scientific Affairs, *supra* note 85, at 180.

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ See Council on Scientific Affairs, *Proceedings of HOD 34th Interim Mtg.* 186 (1980) (citations omitted) (“The remaining therapeutic uses of marijuana are in preliminary stages of research,” the Council noted, with “[m]uch of the clinical applicability of future studies . . . depend[ing] on isolating and determining the action of marijuana’s numerous constituents.”).

⁹¹ *Id.*

⁹² *Id.* at 186–87.

⁹³ Council on Scientific Affairs, *Marijuana: Its Health Hazards and Therapeutic Potentials*, 246(16) *JAMA* 1826 (1981).

⁹⁴ See Chemerinsky, *supra* note 55 (manuscript at 6) (citation omitted); see Board of Trustees, *Proceedings of HOD 146th Annual Mtg.* 153 (1997) (“Proposition 215 declared that (1) seriously ill patients ‘have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended [though not prescribed] by a physician who has determined that the person’s health would benefit from the use of marijuana . . .’ and, (2) patients and primary caregivers can possess and cultivate marijuana for medical use ‘upon the written or oral recommendation or approval of a physician.’”).

⁹⁵ *HOD 146th Annual Mtg.*, *supra* note 94, at 153.

⁹⁶ *Id.*

⁹⁷ *Id.*

⁹⁸ *Id.* at 153–54

⁹⁹ *Id.* at 154 (emphasis added).

¹⁰⁰ *Id.*

¹⁰¹ Council on Scientific Affairs, *Proceedings of HOD 51st Interim Mtg.* 345 (1997) (internal quotation marks omitted) (emphasis added).

¹⁰² *Conant v. McCaffrey*, 172 F.R.D. 681, 701 (N.D. Cal. 1997).

¹⁰³ *Id.*

¹⁰⁴ *Conant v. Walters*, 309 F.3d 629, 639 (9th Cir. 2002).

¹⁰⁵ Council on Science and Public Health, *supra* note 66, at 201; see Reference Committee B, *Proceedings of HOD 66th Interim Mtg.* 220–21 (2012).

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- ¹⁰⁶ Council on Science and Public Health, *supra* note 66, at 201.
- ¹⁰⁷ See GOVERNING, <http://www.governing.com/gov-data/state-marijuana-laws-map-medical-recreational.html> (last visited Nov. 16, 2014).
- ¹⁰⁸ Samuel T. Wilkinson & Deepak C. D’Souza, *Problems with the Medicalization of Marijuana*, 311(23) *JAMA* 2377 (2014).
- ¹⁰⁹ *Id.*
- ¹¹⁰ See *Gonzales v. Raich*, 545 U.S. 1, 22 (2005).
- ¹¹¹ See Memorandum from James M. Cole, Deputy Attorney General, for All United States Attorneys (Aug. 29, 2013), available at <http://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf>.
- ¹¹² Rebecca Voelker, *Medical Marijuana: A Trial of Science and Politics*, 271(21) *JAMA* 1645 (1994) (insertion omitted).
- ¹¹³ See Wilkinson & D’Souza, *supra* note 108, at 2377 (citations omitted).
- ¹¹⁴ Voelker, *supra* note 112, at 1647 (“[P]seudoscientific’ claims made in the 1970s that marijuana is immunopathogenic, impairs fertility, causes brain cell damage and chronic obstructive pulmonary disease, and results in amotivational syndrome have never been documented.”).
- ¹¹⁵ See Gostin, *supra* note 86, at 843 (“The FDA must approve research on scientific grounds and an institutional review board must approve on ethics grounds. The only legal source of marijuana is a farm in Mississippi run by [the National Institute on Drug Abuse (NIDA)]. As gatekeeper of the supply, NIDA must also approve the research project. The marijuana supplied by the NIDA facility lacks purity and strength, depriving researchers of a stable source of raw material. Once a study is approved, the DEA monitors distribution of marijuana to physicians and patients and requires tight security (e.g., locked safes, adequate ventilation, secure transportation, and accurate scales to weigh the arriving and dispensed product). Since the mission of NIDA does not include development of marijuana as a prescription medicine, private funding sources are required.” (citation omitted)).
- ¹¹⁶ Editorial, *What is So-Called Scientific Drink Control?*, 74(7) *JAMA* 64 (1920) (“The legal controversies and debates that have been initiated by the enforcement of nation-wide prohibition in the United States have unexpectedly emphasized that many of the essential facts regarding alcohol and its action are not yet known to science. . . . [I]t is true that there exist scarcely any manuals which may be referred to by the general reader for authoritative statements of unbiased expert opinion regarding a subject of such widespread interest.”).
- ¹¹⁷ Reference Committee on Legislation and Political Action, *supra* note 22, at 68.

¹¹⁸ See Hare, *supra* note 24, at 226.

¹¹⁹ Editorial, *supra* note 34, at 194.

¹²⁰ See *Lambert*, 272 U.S. at 597 (“High medical authority being in conflict as to the medicinal value of . . . liquors taken as a beverage, it would, indeed, be strange if Congress lacked the power to determine that the necessities of the liquor problem require a limitation of permissible prescriptions” (emphasis added)).

¹²¹ See Final Report, *supra* note 38, at 211 (map of state law restrictions on alcoholic liquor prescriptions).

¹²² Cf. *Conant*, 309 F.3d at 643 (Kozinski, J., concurring) (“The evidence supporting the medical use of marijuana does not prove that it is, in fact, beneficial. There is also much evidence to the contrary, and the federal defendants may well be right that marijuana provides no additional benefit over approved prescription drugs, while carrying a wide variety of serious risks. What matters, however, is that there is a genuine difference of expert opinion on the subject, with significant scientific and anecdotal evidence supporting both points of view.” (citations omitted)).

¹²³ Cf. Resolutions, *Proceedings of HOD 119th Annual Convention* 337 (1970).

¹²⁴ See Council on Scientific Affairs, *supra* note 85, at 180.

¹²⁵ Cf. Wilkinson & D’Souza, *supra* note 108, at 2378.

¹²⁶ See Final Report, *supra* note 38, at 229.

¹²⁷ Council on Science and Public Health, *supra* note 66, at 201.

¹²⁸ Reference Committee on Legislation and Political Action, *supra* note 22, at 68.

¹²⁹ Cohen, *supra* note 4.

¹³⁰ Final Report, *supra* note 38, at 218.

¹³¹ See VECKI, *supra* note 24, at 127.

¹³² Bureau of Legal Medicine and Legislation, *supra* note 56, at 16.

¹³³ See HOD, *supra* note 59, at 17.

¹³⁴ See VECKI, *supra* note 24, at 132 (“Why should, in a medical sense, ignorant persons create ridiculous laws . . . ? Why do they not ask someone who knows? . . . Can our government ignore the honest opinion, or the legitimate wishes of a large percentage of the educated?”).

¹³⁵ *Contra Lambert*, 272 U.S. at 581; *Conant v. Walters*, 309 F.3d at 629.

¹³⁶ Talal Al-Khatib, *Prohibition Repeal Echoes in Marijuana Legalization?*, DISCOVERY NEWS, at <http://news.discovery.com/history/marijuana-legalization-prohibition-parallel-121109.htm> [*sic*] (last visited Nov. 16, 2014).

¹³⁷ *Id.*

¹³⁸ *See, e.g.*, Wendell Lee, General Counsel, THE WINE INSTITUTE, *Marijuana Legalization: A New Post-Prohibition Era*, WINE LAW FORUM (Nov. 6, 2014) (arguing that “the weight of public opinion” is pro-legalization, and that without a “catastrophic [marijuana-related] event,” eventual national legalization cannot be stopped).

¹³⁹ Council on Scientific Affairs, *supra* note 85, at 180.

¹⁴⁰ *Cf.* Wilkinson & D’Souza, *supra* note 108, at 2378 (though policymakers do invite physician participation in marijuana policy development, it is often too late, and sometimes well after a statute has already been adopted).