

POLICY ESSAY

PUFF, PUFF, PASS . . . THAT LAW: THE CHANGING LEGISLATIVE ENVIRONMENT OF MEDICAL MARIJUANA POLICY

REPRESENTATIVE DINA TITUS*

TABLE OF CONTENTS

I. INTRODUCTION	40
II. MARIJUANA POLICY IN CONTEXT	40
III. CONSTITUTIONAL AND LEGAL QUAGMIRE	41
IV. VETERANS AND MEDICAL MARIJUANA	45
V. THE NEED FOR TESTING	52
VI. POLICY PROPOSALS	56
VII. CONCLUSION	57

Recent years have brought about a rapid shift in the approach that many states take towards the utilization of medical marijuana. Currently, thirty-nine states, the District of Columbia, and Guam have legalized some form of medical marijuana. Despite this progress, federal policies continue to inhibit United States veterans from obtaining the relief that such laws provide to other citizens. There are many sobering statistics regarding the abnormally high rate of drug addiction and suicide among veterans. Currently, too many veterans suffering from lingering pain or post-traumatic stress disorder are unable to obtain access to medical marijuana and instead must resort to self-medication or reliance on potentially addictive opioids. Policymakers need to act now to ensure that the men and women who served their country in the armed forces have access to the medical care they need. The federal government must formalize its current practice of not prosecuting under federal marijuana laws in states that have adopted medical marijuana programs. Congress and the executive branch must act to give Veterans Affairs doctors the latitude to openly discuss medical marijuana with their patients and help them obtain medical marijuana cards and treatment in the growing number of states with medical marijuana programs. Further, this administration needs to lift the remaining barriers to research on and testing of the medical benefits of medical marijuana.

“In fact, sometimes marijuana is the only thing that works.”¹

Dr. Sanjay Gupta

* Member, United States House of Representatives (D–NV1). A.B., College of William and Mary, 1970; M.A., University of Georgia, 1973; Ph.D., Florida State University, 1976. Congresswoman Titus is a member of the House Committee on Veterans’ Affairs, and is Ranking Member of the Subcommittee on Disability Assistance and Memorial Affairs. The author would like to thank congressional staff members Dick Cooper and Ben Rosenbaum for their research contributing to this article.

¹ Sanjay Gupta, *Why I Changed My Mind on Weed*, CNN (Aug. 8, 2013), <http://www.cnn.com/2013/08/08/health/gupta-changed-mind-marijuana/> [http://perma.cc/2JS4-GCRY].

I. INTRODUCTION

One of the most rapid policy shifts in recent United States history is the public acceptance, state legalization, and widespread use of medical marijuana. In more than twenty states, legislators have eliminated the penalties for medical marijuana possession and allowed grow houses, kitchens, and dispensaries to flourish as legitimate businesses. As a result, veterans with post-traumatic stress disorder (“PTSD”), children with epilepsy, cancer patients, and others who were similarly suffering are now able to turn to medical marijuana for relief. This legal transformation has occurred despite the federal government maintaining marijuana’s classification as a Schedule I controlled substance. This classification puts marijuana in the same category as cocaine and heroin, drugs with no currently accepted medical value.²

This Essay briefly chronicles the history of this evolving constitutional dilemma, analyzes the competing legal and political forces at play, and argues that the federal government should follow the path set forth by many states in legalizing medical marijuana. This need is especially acute for the Department of Veterans Affairs (“VA”), where outdated attitudes and regulations do a great disservice to our nation’s returning warriors who need and deserve help.

II. MARIJUANA POLICY IN CONTEXT

Nearly two decades ago in 1996, California voters passed Proposition 215 by a convincing margin of 55.6% to 44.4%, making the Golden State the first to legalize the medical use of marijuana.³ Two years later, the voters of Washington and the Oregon legislature followed suit by passing Initiative 692⁴ and the Medical Marijuana Act,⁵ respectively, legalizing the medical use of marijuana in both states. Nevada followed close behind those two states, with 65% of its voters voting in favor of “Question 9,” the Nevada Medical Marijuana Act, in 2000.⁶ Since then, twenty-one additional states, Washington, D.C., and Guam have legalized comprehensive public medical marijuana and cannabis programs. Today, thirty-nine states, the District of

² See 21 U.S.C. § 802(32)(A) (2012); 21 U.S.C. §§ 812(B)–(C) (2012); 21 U.S.C. § 813 (2012).

³ See *California Proposition 215*, CORNERSTONE RESEARCH COLLECTIVE (2015), <http://cornerstonecollective.com/california-proposition-215/> [<http://perma.cc/Z4C8-6CWV>]; Cal. Health & Safety Code § 11362.5 (West 2007).

⁴ See Vitaliy Mkrtchyan, *Initiative 692, Now and Then: The Past, Present, and Future of Medical Marijuana in Washington State*, 47 GONZ. L. REV. 839, 840, 843–46 (2012).

⁵ See OR. REV. STAT. §§ 475.300–346 (2013), <https://public.health.oregon.gov/DiseasesConditions/ChronicDisease/MedicalMarijuanaProgram/Pages/475a.aspx> [<https://perma.cc/543S-DUM5>].

⁶ See STATE OF NEVADA DEP’T OF STATE, PROPOSED AMENDMENT TO THE NEVADA CONSTITUTION, AN INITIATIVE RELATING TO THE USE OF THE PLANT OF THE GENUS CANNABIS FOR MEDICAL PURPOSES (Nev. 2000), <http://www.leg.state.nv.us/Division/Research/VoteNV/BalotQuestions/2000.pdf> [<http://perma.cc/6X3C-8JHQ>].

Columbia, and Guam—states with populations totaling half of the American people—allow for some form of marijuana, including cannabidiol, to treat medical conditions.⁷ Medical marijuana bills are currently pending in nineteen state legislatures, and the question of legalizing medical marijuana will once again be on the ballot in Florida in November 2016, after similar legislation failed to pass in 2014.⁸

While the specific provisions vary from state to state, the programs have some common characteristics. First, in order for an individual to legally obtain and use medical marijuana, a doctor must recommend the drug for use in treating a diagnosed medical condition. Most states require that the user register and receive an identification card, limit the amount of medical marijuana that a patient can obtain in a given period, and restrict the locations and methods of purchase and use. Perhaps most significantly, these state laws all stand in direct defiance of the federal Controlled Substances Act (“CSA”) passed in 1970 as Title II of the Comprehensive Drug Abuse Prevention and Control Act.⁹ The CSA places various plants, drugs, and chemicals into five categories, or “Schedules,” based on their medical use and potential for abuse and addiction.¹⁰ Because marijuana is a Schedule I drug, its possession and sale are subject to the most severe criminal penalties.

III. CONSTITUTIONAL AND LEGAL QUAGMIRE

This inconsistency between federal and state laws raises serious constitutional questions that have yet to be resolved by the courts. For example, in *Gonzales v. Raich*,¹¹ the Supreme Court upheld Congress’s power to prohibit the cultivation and possession of marijuana.¹² On the other hand, the Supreme Court has consistently ruled that the Tenth Amendment prevents the federal government from “commandeering” state legislatures and from forcing the executive branches of state governments to enforce federal law.¹³

The doctrine of preemption, as it applies to state medical marijuana laws, is equally convoluted. Courts have consistently held that federal law does not preempt the exemption of certain classes of individuals from state

⁷ See *23 Legal Medical Marijuana States and DC: Laws, Fees, and Possession Limits*, PROCON.ORG: MEDICAL MARIJUANA, <http://medicalmarijuana.procon.org/view.resource.php?resourceID=000881> [http://perma.cc/FU8U-G4VH] (last updated Oct. 12, 2015).

⁸ It should also be noted for context, that the push to legalize all adult recreational use and efforts to decriminalize possession of small amounts of marijuana are also moving forward in a number of states. See *Marijuana Overview*, NAT’L CONFERENCE OF STATE LEGISLATURES (June 10, 2015), <http://www.ncsl.org/research/civil-and-criminal-justice/marijuana-overview.aspx> [http://perma.cc/KB9Z-C7F8]. That trend is not the focus of this Essay.

⁹ See 21 U.S.C. §§ 801–971 (2012).

¹⁰ See *id.*

¹¹ 545 U.S. 1 (2005).

¹² See *id.* at 6–31.

¹³ See *New York v. United States*, 505 U.S. 144, 145 (1992); *Printz v. United States*, 521 U.S. 898, 898 (1997).

prohibitions of marijuana possession by permitting such individuals to use the substance for medical purposes.¹⁴ However, preemption concerns have been raised and addressed very differently by the courts in California and Oregon in cases involving state-issued identification cards, after those states attempted to affirmatively authorize and regulate the use, sale, and production of medical marijuana.¹⁵ Preemption becomes even more complex when local governments get involved, as courts must consider whether state statutes preempt local growing laws.¹⁶

In short, the legal status of state medical marijuana laws remains ambiguous, which leaves many doctors, patients, and businesses in limbo. In recent years, the discretionary restraint by the federal government coupled with its lack of enforcement resources has created a temporary environment of stability, but this offers little reassurance to the burgeoning medical marijuana industry and its growing market of users.

Meanwhile, both the executive and legislative branches of the federal government waded cautiously into the medical marijuana debate. Through the exercise of prosecutorial discretion, the Department of Justice, under former Attorney General Eric Holder, has issued four memoranda since 2009 outlining the Obama Administration's position on medical marijuana. The first, referred to as the Ogden Memorandum, stated that federal resources should not focus "on individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana."¹⁷ This memorandum was well received by advocates of medical marijuana legalization.¹⁸ In contrast, the 2011 Cole Memorandum was viewed by such advocates as a step backward because it narrowed the policies set forth in Ogden and drew a clear distinction between individual patients and commercial dispensaries.¹⁹

¹⁴ See TODD GARVEY, CONG. RESEARCH SERV., R42398, MEDICAL MARIJUANA: THE SUPREMACY CLAUSE, FEDERALISM, AND THE INTERPLAY BETWEEN STATE AND FEDERAL LAWS 10–17 (2012); see also U.S. CONST. art. VI, § 2 ("The Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land.").

¹⁵ See, e.g., *Cty. of San Diego v. San Diego NORML*, 81 Cal. Rptr. 3d 461, 467–68 (Ct. App. 2008); *Emerald Steel Fabricators v. Bureau of Labor and Indus.*, 230 P.3d 518, 520 (Or. 2010).

¹⁶ See, e.g., *City of Riverside v. Inland Empire Patients Health & Wellness Ctr.*, 300 P.3d 494, 499–513 (Cal. 2013); Recent Case, *Dual Sovereignty - Preemption - California Supreme Court Upholds Local Zoning Ban on Medical Marijuana Dispensaries. - City of Riverside v. Inland Empire Patients Health & Wellness Ctr.*, 300 P.3d 494 (Cal. 2013), 127 HARV. L. REV. 1204 (2014).

¹⁷ See Memorandum from David W. Ogden, Deputy Att'y Gen., to Selected U.S. Atty's, Re: Investigations and Prosecutions in States Authorizing the Medical Use of Marijuana (Oct. 19, 2009), <http://www.justice.gov/opa/blog/memorandum-selected-united-state-attorneys-investigations-and-prosecutions-states> [<http://perma.cc/8CZY-A9X8>].

¹⁸ See Jacob Sullum, *Reactions To DOJ Marijuana Memo: Dismay, Exuberance, Skepticism*, FORBES (Aug. 29, 2013), <http://www.forbes.com/sites/jacobsullum/2013/08/29/reactions-to-doj-marijuana-memo-dismay-exuberance-skepticism/> [<http://perma.cc/Z9LX-EZ3Q>].

¹⁹ See Memorandum from James M. Cole, Deputy Att'y Gen., to All U.S. Atty's Re: The Ogden Memo in Jurisdictions Seeking to Authorize Marijuana for Medical Use (June 29,

Following the legalization of marijuana for recreational use in Colorado and Washington, a second Cole Memorandum was issued in 2013.²⁰ This memorandum outlined eight priority enforcement activities of particular importance to the federal government, and advised federal prosecutors and law enforcement officers to direct their resources accordingly.²¹ The administration was praised for backing off its focus on large-scale, for-profit commercial enterprises.²² In 2014, the Justice Department clarified that the same eight priority activities should guide the allocation of resources when pursuing potential medical marijuana offenses involving financial transactions.²³

These directives unfortunately provide little clarity and stability because they are all temporary statements of policy that can be changed by future administrations or attorneys general. Loretta Lynch, who replaced Eric Holder as Attorney General in the Obama Administration, stated in her confirmation hearing on January 28, 2015, that she opposes the legalization of marijuana.²⁴ Furthermore, she stated that “it is not the position of the Department of Justice currently to support legalization, nor would it be the position if I were confirmed as attorney general.”²⁵ Likewise, the actions of federal prosecutors around the country often vary when it comes to the level of enforcement aggressiveness.

Based on the current political environment, it seems unlikely that Congress will address the problem by rescheduling marijuana. For instance, Senators Cory Booker (D–N.J.), Kirsten Gillibrand (D–N.Y.), Rand Paul (R–Ky.), and Dean Heller (R–Nev.), in March 2015 introduced the Compassionate Access, Research Expansion, and Respect States Act,²⁶ which would move marijuana from Schedule I to Schedule II, and would amend the Controlled Substances Act to prevent prosecution of individuals acting in com-

2011), <http://www.justice.gov/sites/default/files/oip/legacy/2014/07/23/dag-guidance-2011-for-medical-marijuana-use.pdf> [http://perma.cc/QD2Z-PS2C].

²⁰ See Memorandum from James M. Cole, Deputy Att’y Gen., to All U.S. Atty’s Re: Guidance Regarding Marijuana Enforcement (Aug. 29, 2013), <http://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf> [http://perma.cc/727C-AEGB].

²¹ *Id.*

²² See Ashley Southall & Jack Healy, *U.S. Won’t Sue to Reverse States’ Legalization of Marijuana*, N.Y. TIMES (Aug. 29, 2013), <http://www.nytimes.com/2013/08/30/us/politics/us-says-it-wont-sue-to-undo-state-marijuana-laws.html?hp> [http://perma.cc/3WGW-9YE2].

²³ See Memorandum from Monty Wilkinson, Director, Executive Office for United States Atty’s, to All U.S. Atty’s, First Assistants to U.S. Atty’s, Criminal Chiefs, Appellate Chiefs, OCDETF Coordinators and Tribal Liasons, Re: Marijuana Issues in Indian Country (Oct. 28, 2014), <http://www.justice.gov/sites/default/files/tribal/pages/attachments/2014/12/11/policystatementregardingmarijuanaissuesinindiancountry2.pdf> [http://perma.cc/8ZYX-EV7H].

²⁴ See Matt Ferner, *Loretta Lynch Says She Doesn’t Support Marijuana Legalization Or Obama’s Views On Pot*, HUFFINGTON POST (Jan. 28, 2015), http://www.huffingtonpost.com/2015/01/28/loretta-lynch-marijuana_n_6565962.html [http://perma.cc/7B4V-4V7L].

²⁵ *Id.*

²⁶ See Compassionate Access, Research Expansion, and Respect States Act of 2015, S. 683, 114th Cong. (2015), <https://www.congress.gov/bill/114th-congress/senate-bill/683> [http://perma.cc/9VPN-S6VR].

pliance with state medical marijuana laws.²⁷ However, the bill has yet to even receive a hearing in the Senate Judiciary Committee.²⁸

Similarly, in July 2015, Republican Congressmen H. Morgan Griffith (Va.-09) and Andy Harris, M.D. (Md.-01), along with Democratic Congressmen Sam Farr (Cal.-20) and Earl Blumenauer (Or.-03) introduced the Credible Research on Medical Efficacy of Marijuana Amendment to the 21st Century Cures Act.²⁹ In addition to encouraging the National Institutes of Health (“NIH”) and the Drug Enforcement Administration (“DEA”) to collaborate on research regarding the medical risks and benefits of marijuana, the amendment would also create a new federal sub-classification within Schedule I for marijuana, “Schedule 1R,” to make it easier for research to be conducted.³⁰ Despite its bipartisan support, Republicans on the House Rules Committee denied the proposal the opportunity to be considered by the full House.

Several medical marijuana-related measures, however, have been passed by Congress in the last few years. These measures have come as amendments to annual appropriations bills and prohibit the Department of Justice from using its funds to prosecute patients, businesses, and doctors who are operating within state laws.³¹ Unfortunately, these measures are built into expiring authorities that require annual renewal, and thus they hardly provide the kind of protection upon which patients can rely.

There have also been anti-marijuana provisions introduced and passed by Congress during this same timeframe. In 2013, the Republican-led House approved a measure that allowed states to mandate drug testing as part of nutrition assistance programs while shielding recipients of generous farm subsidies from the same requirements.³² Provisions in the Agriculture Act of 2014 prohibit the cost of medical marijuana from being considered a deduction from income calculated for SNAP (food stamps) eligibility.³³ And amidst this turmoil, those who suffer most are American veterans.

²⁷ *See id.*

²⁸ *See Actions—S. 683—114th Congress (2015-2016): Compassionate Access, Research Expansion, and Respect States Act of 2015*, LIBRARY OF CONG., <https://www.congress.gov/bill/114th-congress/senate-bill/683> [<http://perma.cc/9VPN-S6VR>].

²⁹ *See* Press Release, Congressman Sam Farr, Bipartisan Medical Efficacy Of Marijuana Amendment Introduced In House (July 8, 2015), <http://farr.house.gov/index.php/newsroom/press-releases/1175-bipartisan-medical-efficacy-of-marijuana-amendment-introduced-in-house> [<http://perma.cc/C46D-2VJ9>].

³⁰ *Id.*

³¹ *See* Final Vote Results for Roll Call 283, Office of the Clerk, U.S. HOUSE OF REPRESENTATIVES, <http://clerk.house.gov/evs/2015/roll283.xml> [<http://perma.cc/N3VP-W5C9>]; Final Vote Results for Roll Call 258, Office of the Clerk, U.S. HOUSE OF REPRESENTATIVES, <http://clerk.house.gov/evs/2014/roll258.xml> [<http://perma.cc/TT4G-UN7X>].

³² *See* Agricultural Act of 2014, Pub. L. 113-79, 128 Stat. 649 (codified as amended in scattered sections of 7 U.S.C.).

³³ *See id.*

IV. VETERANS AND MEDICAL MARIJUANA

Over the years, hundreds of thousands of American veterans have returned to the United States, carrying with them the physical and mental wounds of war. These men and women are often victims of severe pain and/or PTSD, and they are being failed by a VA system that treats their conditions mainly with opiate drugs.³⁴ Rather than healing, these drugs often lead to addiction, overdose, and even suicide.³⁵ This tragedy is compounded by the federal government's unwillingness to allow veterans access to medical marijuana, which many veterans have found is preferable to opioids in helping them cope with the nightmares, flashbacks, depression, and pain stemming from their wartime experiences.³⁶

Congress needs to lift the gag order that prohibits VA doctors from even discussing, much less recommending, medical marijuana to veterans who could benefit from it. The federal government needs to give veterans living in the thirty-nine states with medical marijuana laws the ability to obtain medical marijuana from VA doctors, just as they would any other prescription drug, rather than having to go to a private physician and pay out-of-pocket. Finally, Congress needs to remove the barriers to testing medical marijuana so scientific researchers can determine its long-term medical benefits and risks in treatment of PTSD and other conditions.

The number of veterans with PTSD is staggering: almost thirty-one percent of Vietnam veterans; as many as ten percent of Gulf War veterans; eleven percent of veterans who fought in Afghanistan; and twenty percent of Iraq War veterans.³⁷ Without the care they need, veterans with PTSD are more prone to drug addiction, alcoholism, unemployment, homelessness, and family breakups. Every day in the United States, twenty-two veterans, many of whom suffer from PTSD, commit suicide.³⁸ The number of fatal

³⁴ See Aaron Glantz, *VA's Opiate Overload Feeds Veterans' Addictions, Overdose Deaths*, CTR. FOR INVESTIGATIVE REPORTING (Sept. 28, 2013), <http://cironline.org/node/5261> [<http://perma.cc/V94V-HMAW>]; Tom Cramer, *By the Numbers: VA Making Progress in Reducing Opioid Use in Veteran Patients*, U.S. DEPT OF VETERANS AFF.: VANTAGE POINT (Aug. 7, 2015, 8:00 AM), <http://www.blogs.va.gov/VAntage/21796/va-making-progress-reducing-opioid-use-veteran-patients/> [<http://perma.cc/DP75-HY6B>].

³⁵ See Shannon Firth, *Congress to VA: More Oversight Needed for Vets in Pain*, MEDPAGETODAY: WASHINGTON-WATCH (June 11, 2015), <http://www.medpagetoday.com/Washington-Watch/Washington-Watch/52086> [<http://perma.cc/9NHF-6UNJ>].

³⁶ See Emily Wax-Thibodeaux, *More Veterans Press VA to Recognize Marijuana as Treatment Option*, WASH. POST (Nov. 15, 2014), http://www.washingtonpost.com/politics/more-veterans-press-va-to-recognize-medical-marijuana-as-treatment-option/2014/11/15/51666986-6a7b-11e4-b053-65cea7903f2e_story.html [<http://perma.cc/S9NA-2TS4>].

³⁷ See *How Common is PTSD?*, U.S. DEPT OF VETERANS AFF. NAT'L CTR. FOR PTSD, <http://www.ptsd.va.gov/public/PTSD-overview/basics/how-common-is-ptsd.asp> [<http://perma.cc/R5NA-9S6E>] (last updated Aug. 13, 2015).

³⁸ See Nefi Alarcon, *22 Veterans Kill Themselves Every Day*, CNN (Apr. 17, 2014), <http://www.cnn.com/2015/02/04/politics/22-veterans-kill-themselves-every-day/> [<http://perma.cc/LL7X-FE94>].

opiate drug overdoses among veterans is almost double the national average.³⁹ The longer Congress delays action, the larger this human toll becomes.

Behind the statistics are human stories that demand change. One such story is that of Iraq War veteran Justin Bailey, who grew up in Las Vegas, Nevada. Justin joined the Marine Corps in 1998, signing up for four years.⁴⁰ After the September 11 terrorist attacks, his tour of duty was extended and he was deployed to Nasiriya, Iraq, southeast of Baghdad. Justin was honorably discharged in 2004.⁴¹ His father, Tony Bailey, a Gulf War veteran, said Justin had trouble adjusting when he returned home:⁴² he could neither keep a job nor pay his rent.⁴³ “It seemed like something happened over there that really changed him a lot,” recalled Tony Bailey.⁴⁴ Justin’s mother, Danielle Floyd, related, “He came back saying, ‘Mom, I shot women and children. I can’t deal with this.’”⁴⁵ Justin Bailey was among the one-in-five combat veterans who suffered from PTSD after returning from Iraq.⁴⁶ He also had a groin injury that was treated in part with painkillers.⁴⁷

As is too common among veterans with PTSD, Justin turned to prescription medications and street drugs to cope.⁴⁸ His parents were relieved when he decided to check himself into the West Los Angeles VA Medical Center just after Thanksgiving 2006.⁴⁹ The VA Medical Center rehabilitation center, however, put Justin on a regimen of prescription drugs for his pain.⁵⁰ On January 25, 2007, he picked up a two-week supply of methadone, a blood-vessel relaxer prescribed for PTSD, a sedative and antidepressant for insomnia and nightmares, some generic Xanax, and a two-week prescription for another antidepressant.⁵¹ One day later, Justin Bailey was dead of a drug overdose at the age of 27.⁵² His father told the *Los Angeles Times*, “My son had made a decision to get help, and they didn’t help him. They gave him the bullet.”⁵³

A similar story unfolded in Oregon in 2008. Jeffrey Waggoner, an Army paratrooper veteran who had been struck by shockwaves from a

³⁹ See Aaron Glantz, *VA’s Opiate Overload Feeds Veterans’ Addictions, Leading to Overdose Deaths*, PBS: THE RUNDOWN (Oct. 3, 2013, 5:30 PM), <http://www.pbs.org/newshour/rundown/vas-opiate-overload-feeds-veterans-addictions-leading-to-overdose-deaths/> [http://perma.cc/6ELJ-PHVR].

⁴⁰ See Mary Engel, *Parents Blame VA in Fatal Overdose*, L.A. TIMES (Mar. 12, 2007), <http://articles.latimes.com/2007/mar/12/local/me-vet12> [http://perma.cc/WBS5-PY3G].

⁴¹ See *id.*

⁴² See *id.*

⁴³ See *id.*

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ See *id.*

⁴⁷ See *id.*

⁴⁸ See *id.*

⁴⁹ See *id.*

⁵⁰ See *id.*

⁵¹ See *id.*

⁵² See *id.*

⁵³ *Id.*

rocket-propelled grenade in Afghanistan, was prescribed addictive painkillers by the VA.⁵⁴ One fateful morning, Waggoner was transported by government van to the VA hospital in Roseburg, Oregon, where he was to undergo detoxification for his addiction.⁵⁵ Reveal, an investigative radio pilot from The Center for Investigative Reporting and PRX, detailed what happened to Jeffrey Waggoner once he was admitted to the hospital:

[I]nstead of keeping Waggoner away from his vice, medical records show the VA hospital in Roseburg kept him so doped up he could barely stay awake. Then, inexplicably, the VA released him for the weekend with a cocktail of 19 prescription medications, including 12 tablets of highly addictive oxycodone. Three hours later, Waggoner, 32, was dead of a drug overdose, slumped in a heap in front of his room at the Sleep Inn motel.⁵⁶

Waggoner's father said, "As a parent, you'd want to know how this happened to your child. You send your child to a hospital to get well, not die."⁵⁷

The deaths of Justin Bailey and Jeffrey Waggoner were the consequences of what the Center for Investigative Reporting described as the "VA prescription epidemic."⁵⁸ The Center noted that prescriptions for four opiates—hydrocodone, oxycodone, methadone, and morphine—surged 270% in twelve years as veterans returned from Iraq and Afghanistan.⁵⁹ Too often, addictive painkillers were prescribed to veterans with PTSD, even if they had no serious physical pain.⁶⁰ Tim Fazio, a Marine who came home after serving tours in Iraq and Afghanistan, was supplied with nearly 4,000 oxycodone pills in two years, despite not having any serious physical pain.⁶¹ He was diagnosed with anxiety, PTSD, and a traumatic brain injury.⁶²

There is considerable evidence that veterans are being bombarded with prescription drugs. In March 2012, the Journal of the American Medical Association published a study concluding that veterans of the Iraq and Afghanistan conflicts who experienced pain accompanied by PTSD were significantly more likely to be prescribed opiates than veterans with pain but without a diagnosis of PTSD.⁶³ Researchers at the San Francisco VA Medical Center and the University of California, San Francisco studied the

⁵⁴ Glantz, *supra* note 39.

⁵⁵ *See id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.*

⁵⁹ *See id.*

⁶⁰ *See id.*

⁶¹ *See id.*

⁶² *See id.*

⁶³ *See generally* Karen H. Seal et al., *Association of Mental Health Disorders With Prescription Opioids and High-Risk Opioid Use in Veterans of Iraq and Afghanistan*, 307:9 [J]AMA 940 (Mar. 7, 2012), <https://jama.jamanetwork.com/article.aspx?articleid=1105046> [<https://perma.cc/PNL9-CGF6>].

records of 141,029 veterans who served in Iraq and Afghanistan from 2005 to 2010.⁶⁴ The researchers found that veterans who had both pain and PTSD were much more likely than those without PTSD to receive high-dose prescriptions, two or more opiate prescriptions, and additional prescriptions for sedatives such as Valium.⁶⁵ They also were more likely to seek early refills of their prescriptions.⁶⁶ Dr. Karen Seal of the San Francisco VA Medical Center, one of the co-authors of the study, stated that primary care physicians treating patients with a high level of distress “may have concerns about prescribing opiates, but they want to relieve the pain and continue to maintain contact with their patient.”⁶⁷

The painkillers so often prescribed to veterans have been found to be highly addictive. In March 2014, the American Academy of Pain Medicine released a study of nearly one million veterans who had received opiate painkillers.⁶⁸ The study found that more than half of those veterans used the drugs for longer than ninety days, or chronically.⁶⁹ The researchers also found that veterans with PTSD were more likely than other veterans to use opiate painkillers chronically.⁷⁰

Opiate painkillers do more harm than good for veterans with PTSD, according to Dr. Stephen Xenakis, a psychiatrist and retired brigadier general who served as commanding general of the Army’s Southeast Regional Medical Command.⁷¹ “They make sleep more difficult, because they disrupt your usual sleep patterns, and as your sleep gets worse, your mood and anxiety get worse, and you find yourself not being able to think as clearly,” said Xenakis.⁷² According to Xenakis, because opiates are depressants, they tend to worsen the depression from which many veterans already suffer.⁷³ This pattern explains why veterans with PTSD are at greater risk for suicide than other returning veterans.⁷⁴ For these veterans, the “cure” being offered by the VA is worsening their mental health.

President Obama has recognized that there are better ways to treat our veterans with PTSD. He has put in place several initiatives that increase access to counseling-based treatment. The VA’s overall \$6 billion mental

⁶⁴ See *id.*

⁶⁵ See *id.*

⁶⁶ See *id.*

⁶⁷ Steve Tokar, *Iraq, Afghanistan Veterans With Pain, PTSD Prescribed More Opiates Than Other Veterans With Pain*, U.C. S.F. (Mar. 6, 2012), <https://www.ucsf.edu/news/2012/03/11625/iraq-afghanistan-veterans-pain-ptsd-prescribed-more-opiates-other-veterans-pain> [<https://perma.cc/E975-PYGE>].

⁶⁸ See Press Release, American Academy of Pain Medicine, *Half of Veterans Prescribed Medical Opioids Continue to Use Them Chronically, Study Finds* (Mar. 6, 2014) <http://www.painmed.org/2014press/files/half-of-veterans-prescribed-medical-opioids-continue-to-use-them-chronically.pdf> [<http://perma.cc/4PUM-D85F>].

⁶⁹ *Id.*

⁷⁰ *Id.*

⁷¹ See Glantz, *supra* note 34.

⁷² *Id.*

⁷³ See *id.*

⁷⁴ See *id.*

health budget grew thirty-nine percent between 2009 and 2012.⁷⁵ In addition, the VA added nearly 2,000 mental health technicians to treat veterans with one-on-one, cognitive behavioral therapy.⁷⁶ Despite President Obama's funding boosts and relentless push for increases in VA psychiatric staff, the culture of VA doctors is not changing fast enough. VA psychiatrists have recently begun to acknowledge that there is really no effective drug treatment for PTSD—that there is no silver bullet.⁷⁷ Nevertheless, VA doctors are still giving many veterans a cocktail of drugs for their PTSD and pain with little or no one-on-one therapy.

As a member of the House Committee on Veterans Affairs, I have been moved by the stories of veterans who were forced to wait months for therapy, and in the meantime were at risk of developing an addiction to prescription opiate drugs. That is why I have focused not only on reducing the claims backlog and increasing access to private care, but also on making medical marijuana available to these veterans as an alternative to prescription drugs. The barriers to providing medical marijuana as an option for veterans, however, are enormous.

I have worked with other members of Congress to break down these obstacles to better health care for veterans. In February, I joined eight of my colleagues to reintroduce the bipartisan Veterans Equal Access Act,⁷⁸ initially introduced in November 2014, which would make it easier for qualified veterans to access medical marijuana.⁷⁹ Currently, the VA specifically prohibits its medical providers from completing forms brought by veterans seeking recommendations or opinions regarding participation in state medical marijuana programs. The proposed legislation would overturn this prohibition for veterans who live in the states where some form of medical marijuana is legal.⁸⁰ In practical terms, H.R. 667 would lift the gag order within the VA that prohibits physicians from even talking about medical marijuana as a potential treatment option with their patients.⁸¹ The VA doctors would then have the option of recommending medical marijuana for veterans with PTSD. Unfortunately, the Veterans Equal Access Act was narrowly defeated in April by a vote of 213–210 as an amendment to the VA appropriations bill approved by the House of Representatives.⁸² The Senate

⁷⁵ See Press Release, Dep't of Veterans Aff., VA to Increase Mental Health Staff by 1,900 (Apr. 19, 2012), <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2302> [<http://perma.cc/G3YD-JRWT>].

⁷⁶ See *id.*

⁷⁷ Matt Ferner, *VA Doctors Still Can't Recommend Medical Marijuana to Veterans*, HUFFINGTON POST (May 1, 2015, 11:59 AM), http://www.huffingtonpost.com/2015/04/30/house-veterans-medical-marijuana_n_7185394.html [<http://perma.cc/LC76-GY5K>]; see also Wax-Thibodeaux, *supra* note 36.

⁷⁸ Veterans Equal Access Act, H.R. 667, 114th Cong. (2015), <https://www.congress.gov/114/bills/hr667/BILLS-114hr667ih.pdf> [<https://perma.cc/UG8G-ATK6>].

⁷⁹ See *id.*

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² See Ferner, *supra* note 77.

Appropriations Committee did pass a similar bipartisan amendment in its version of the bill, setting up the possibility that the measure could be part of an ultimate compromise in budget negotiations.⁸³

There has been some progress within the VA to reduce the penalties for medical marijuana use by veterans, and the penalties for physicians recommending such use in states that have legalized some form of medical marijuana. The VA had previously taken a staunch position against medical marijuana, with its general counsel issuing a memorandum in 2008 saying doctors could have their licenses revoked and face criminal charges if they recommended medical marijuana to a patient, regardless of whether the patient lived in a state where medical marijuana was legal.⁸⁴ Due in large part to the efforts of disabled Air Force veteran Michael Krawitz and his advocacy group, Veterans for Medical Marijuana, that policy changed in 2010. They negotiated a compromise whereby the VA allowed veterans to use medical marijuana in conjunction with prescriptions, thus reversing a policy that required VA doctors to cut off patients from prescription drugs if they were discovered using cannabis.⁸⁵ Currently, VA physicians can monitor a patient's medical marijuana use in conjunction with prescription drugs if they live in a state where medical marijuana is legal, though they are still barred from recommending medical marijuana.⁸⁶ Veterans living in states without medical marijuana programs do not have that option.

Some physicians who have worked in the VA have gone on record stating that veterans with pain and/or PTSD should have full access to medical marijuana. Shortly before the House of Representatives voted down the Veterans Equal Access Act on April 30, retired VA physician Dr. E. Deborah Gilman sent an impassioned letter to Congress.⁸⁷ Dr. Gilman wrote:

It would be cruel to deny access to any medication for any patient when his or her doctor decides the benefits outweigh the risks and recommends it, but that's particularly true for veterans and medical marijuana. Our men and women in uniform make incredible sacri-

⁸³ See Press Release, Drug Policy Alliance, In Historic Vote, Senate Appropriations Committee Approves Veterans Medical Marijuana Amendment (May 21, 2015), <http://www.drugpolicy.org/news/2015/05/historic-vote-senate-appropriations-committee-approves-veterans-medical-marijuana-amend> [<http://perma.cc/J93P-URXW>].

⁸⁴ See Cynthia M.A. Geppert, *Legal and Clinical Evolution of Veterans Health Administration Policy on Medical Marijuana*, FEDERAL PRACTITIONER 6, 6 (Mar. 2014), http://www.amc.edu/Academic/bioethics/documents/Geppert_Publication.pdf [<http://perma.cc/N7QF-HJFE>].

⁸⁵ VHA Directive 2011-004, *Access to Clinical Programs for Veterans Participating in State-Approved Marijuana Programs*, U.S. DEPT OF VETERANS AFFAIRS VETERANS HEALTH ADMIN. (Jan. 31, 2011), http://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2362 [<http://perma.cc/X79K-W7TV>].

⁸⁶ See *id.*

⁸⁷ Steph Sherer, *Congress Should End Medical Marijuana Gag Order on V.A. Doctors*, HUFFINGTON POST: THE BLOG (Apr. 29, 2015, 2:31 PM), http://www.huffingtonpost.com/steph-sherer/congress-should-end-medical-marijuana-gag-order_b_7173066.html [<http://perma.cc/QF2P-XAET>].

lices for our country, and the least we could do [is] make every possible treatment option available to them when they come home.⁸⁸

Dr. Gilman quoted various statistics that demonstrated the benefits of prescribing medical marijuana over highly addictive opioid painkillers, which have severe side effects, particularly for long-term users.⁸⁹ Recent research has shown that states where medical marijuana is legal have a twenty-five percent lower rate of fatal overdoses from opiates.⁹⁰ Further research has demonstrated a ten percent reduction in suicide rates of males aged 20–39 in states with medical marijuana laws following passage of those laws.⁹¹ Dr. Gilman argued to Congress that “even those who don’t support the idea of medical marijuana have reason to support changing the VA’s medical marijuana policy.”⁹²

Veterans who find VA-prescribed opiates inadequate or debilitating have few alternative sources of relief from pain and PTSD symptoms. Those who live in states where medical marijuana is legal must pay out-of-pocket to see a physician who can authorize them to obtain a medical marijuana card. Veterans who live in a state that has not approved medical marijuana use have no legal avenue for obtaining medical marijuana. Without changes to federal policy, veterans may resort to criminal activities to obtain the help they desperately need and deserve, jeopardizing their access to benefits. Depending on where they live, such criminal behavior jeopardizes veterans’ benefits if the VA discovers their marijuana use.

Veterans advocate Michael Krawitz says these restrictions have spawned a culture of “don’t ask, don’t tell” among veterans and their doctors.⁹³ In November 2014, the Washington Post reported that “VA medical staff have warned that this culture is making for a dangerous situation . . . because doctors do not know about all of the medications their patients are using.”⁹⁴ Scott Murphy, a retired Army specialist who is the head of Veterans for Safe Access and Compassionate Care, wrote a petition to Congress, explaining, “Veterans in states without medical marijuana laws feel they need to lie to their physicians for the justifiable fear of losing their earned

⁸⁸ *Id.*

⁸⁹ *See id.*

⁹⁰ Marcus A. Backhuber et al., *Medical Cannabis Laws and Opioid Analgesic Overdose Mortality in the United States, 1999–2010*, 174:10 [J]AMA 1668, 1670 (Oct. 2014), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4392651/pdf/nihms672222.pdf> [http://perma.cc/3QNZ-YXAS].

⁹¹ *See* Robert Pursell, *Studies Claim Medical Marijuana May Reduce Suicide Rates, Traffic Fatalities*, PBS: THE RUNDOWN (Feb. 6, 2014, 1:02 PM), <http://www.pbs.org/newshour/rundown/studies-claim-medical-marijuana-may-reduce-suicide-rates-traffic-fatalities/> [http://perma.cc/EM4J-TCYX].

⁹² Sherer, *supra* note 87.

⁹³ Wax-Thibodeaux, *supra* note 36.

⁹⁴ *Id.*

benefits.”⁹⁵ The system in place now is discriminatory. Veterans make the same sacrifices and should receive equal treatment regardless of which state they live in.

V. THE NEED FOR TESTING

There are also practicing VA doctors who want to see more research on medical marijuana. The *Washington Post* recently reported that:

Several VA doctors who specialize in pain management and PTSD said in interviews that they are eager for more research on the medical benefits of marijuana. The doctors, who spoke on condition of anonymity because they do not have permission from VA to discuss marijuana with the news media, said they feel frustrated because prescription drugs are not helping patients who are suffering. ‘Anecdotally, we know it works, and more and more studies are saying this,’ said one VA doctor, a PTSD expert who leads a large East Coast VA pain center. ‘But we aren’t allowed to study it.’⁹⁶

Marijuana’s Schedule I status has been a huge barrier to testing the potential positive effects that medical marijuana could have for veterans with PTSD and the larger patient population.⁹⁷ There are tight restrictions on how Schedule I drugs can be studied, and there is an additional requirement for marijuana—only cannabis strains grown at the University of Mississippi can be used by researchers in tests approved by the Food and Drug Administration (“FDA”).⁹⁸ There is no such requirement for testing other drugs. Dan Riffle, Director of Federal Policies at the Marijuana Policy Project, has summed up this situation: “So you had that Catch-22, where marijuana is a Schedule I drug because there’s no evidence, and there’s no evidence because marijuana is a Schedule I drug.”⁹⁹

Following the passage of California’s medical marijuana law in 1996, Barry McCaffrey, President Clinton’s Drug Czar, directed the Institute of Medicine, the research arm of the National Academy of Sciences, to conduct a comprehensive review of the science on medical marijuana. Unexpectedly,

⁹⁵ *Id.*

⁹⁶ *Id.*

⁹⁷ See Russ Juskalian, *Why It’s Hard to Do Marijuana Research*, NEWSWEEK (Nov. 3, 2010), <http://www.newsweek.com/why-its-hard-do-marijuana-research-69753> [<http://perma.cc/FNE7-GWGS>].

⁹⁸ See Evan Halper, *Mississippi, Home to Federal Government’s Official Stash of Marijuana*, L.A. TIMES (May 28, 2014), <http://www.latimes.com/nation/la-na-pot-monopoly-20140529-story.html> [<http://perma.cc/XUH8-LQBX>].

⁹⁹ Jacob Sullum, *More Than Zero: Reclassifying Marijuana Could Have a Significant Impact on Drug Policy*, FORBES (Feb. 7, 2014, 7:00 AM), <http://www.forbes.com/sites/jacobsullum/2014/02/07/more-than-zero-reclassifying-marijuana-would-have-a-significant-impact-on-drug-policy/> [<http://perma.cc/Z9LX-EZ3Q>].

the authors concluded, “Scientific data indicate the potential therapeutic value of cannabinoid drugs, primarily THC, for pain relief, control of nausea and vomiting, and appetite stimulation[.]”¹⁰⁰ Instead of adjusting regulations in response to the scientific evidence, however, McCaffrey suppressed the science to support existing policy. Accordingly, the Department of Health and Human Services clamped down on any research that could lead to the development of smoked marijuana as a licensed drug, as articulated in its *Guidance on Procedures for the Provision of Cannabis for Medical Research*.¹⁰¹

Currently, researchers seeking to test medical marijuana first must apply to the U.S. Food and Drug Administration, the Drug Enforcement Administration (“DEA”), and the National Institute on Drug Abuse (“NIDA”). In addition, until recently medical marijuana researchers had to go through a second review by the U.S. Public Health Service (“PHS”), which has an Institutional Review Board process dictating that the only source of marijuana which can legally be used for research is marijuana grown at the University of Mississippi, which is under contract with NIDA. This cumbersome process delayed research into potential medical benefits of marijuana for years. It was changed in June 2015 when the administration announced that non-federally funded researchers looking into the therapeutic benefits of marijuana would no longer need to go through the additional PHS review. Yet even with this hurdle gone, the fact remains that the sole source of federally-grown marijuana is woefully inadequate and is under the lock and key of NIDA.

In June 2014, I joined twenty-nine other members of Congress in writing a letter to U.S. Secretary of Health and Human Services, Sylvia Burwell, asking that she take action to lift the additional requirements for medical marijuana testing:

There is overwhelming anecdotal evidence from patients, their family members and their doctors of the therapeutic benefits of marijuana for those suffering from cancer, epilepsy, seizures, Post-Traumatic Stress Disorder, glaucoma, anxiety, chronic pain, and more. We believe the widespread use of medical marijuana should necessitate research into what specific relief it offers and how it can best be delivered for different people and different conditions.¹⁰²

¹⁰⁰ JANET E. JOY, STANLEY J. WATSON, JR. & JOHN A. BENSON, JR., *MARIJUANA AND MEDICINE: ASSESSING THE SCIENCE* BASE 4 (Institute of Medicine ed., 1999).

¹⁰¹ See Press Release, National Institutes of Health, *Guidance on Procedures for the Provision of Medical Marijuana for Medical Research* (May 21, 1999), <http://grants.nih.gov/grants/guide/notice-files/not99-091.html> [<http://perma.cc/ET9F-TSCU>]; see generally BRUCE BARTCOTT, *WEED THE PEOPLE: THE FUTURE OF MEDICAL MARIJUANA IN AMERICA* (2015).

¹⁰² Letter from Thirty Members of Congress to Sylvia Mathews Burwell, Sec’y, Dep’t of Health and Human Servs. (June 17, 2014), <http://big.assets.huffingtonpost.com/mmj.pdf> [<http://perma.cc/W2KT-4V8R>].

The letter is based on the view that, just as opiates and barbiturates have been thoroughly researched and evaluated for medical use, it is reasonable to investigate the legitimate medical uses of marijuana.¹⁰³ Considering the number of states with medical marijuana laws and the growing number of patients who use marijuana medicinally in the United States, it is clear that we need more scientific information about the therapeutic benefits and risks of marijuana.

Secretary Burwell replied to the letter in September 2014, saying, “HHS [U.S. Department of Health and Human Services] and its agencies have approved or supported several hundred research projects for marijuana and its constituent compounds and uses its authorities to encourage research in this area.”¹⁰⁴ She further noted that since 1999, when HHS established a Public Health Service review process of all non-federally funded scientific investigations of marijuana, eighteen proposals have been received and sixteen of them were approved for the purchase of marijuana through NIDA.¹⁰⁵ She concluded, “I appreciate your suggestions,” but she has not removed the barriers to more expeditious testing, such as the sole-source supply of marijuana that can be tested.¹⁰⁶

Medical marijuana research is needed to show the FDA that medical marijuana should be recognized like any other drug to treat medical conditions. In 2014, the DEA issued new rules to increase the federal government’s production of marijuana for research from 21,000 grams to 650,000 grams.¹⁰⁷ At the beginning of 2014, NIDA records showed that there were twenty-eight active grants for research into the potential benefits of medical marijuana, although most of the studies focused on the benefits of chemicals derived from cannabis rather than the smoking of marijuana itself.¹⁰⁸ A study of how medical marijuana could help veterans with PTSD took nearly four years to gain the necessary federal approvals.¹⁰⁹

The Multidisciplinary Association for Psychedelic Studies (“MAPS”) was founded in 1986 to initiate medical marijuana research and to demonstrate its effectiveness in treating medical conditions.¹¹⁰ In November 2010, MAPS submitted a proposal to the FDA for a pilot study of the safety and efficacy of five different potencies of smoked or vaporized marijuana for

¹⁰³ See *id.*

¹⁰⁴ Letter from Sylvia Mathews Burwell, Sec’y, Dep’t of Health and Human Servs., to Dina Titus, Congresswoman (Sept. 22, 2014) (on file with author).

¹⁰⁵ See *id.*

¹⁰⁶ *Id.*

¹⁰⁷ See Serge F. Kovalski, *Medical Marijuana Research Hits Wall of U.S. Law*, N.Y. TIMES (Aug. 9, 2014), http://www.nytimes.com/2014/08/10/us/politics/medical-marijuana-research-hits-the-wall-of-federal-law.html?_r=0 [http://perma.cc/9MKP-6U7J].

¹⁰⁸ See *id.*

¹⁰⁹ See *id.*

¹¹⁰ *Mission*, MULTIDISCIPLINARY ASS’N FOR PSYCHEDELIC STUDIES, <http://www.maps.org/about/mission> [http://perma.cc/AU37-5XAB].

veterans with chronic, treatment-resistant post-traumatic stress disorder.¹¹¹ Participants were limited to U.S. veterans aged eighteen or older, who had been diagnosed with PTSD, and who had not improved after trying either medication or psychotherapy.¹¹² In December 2010, the FDA placed the study on clinical hold pending receipt of more information regarding the details of the risks associated with the testing. MAPS provided the FDA with the requested information, and in March 2011 submitted a revised testing protocol. This protocol was accepted by the FDA in April 2011 and submitted to HHS.

In July 2011, HHS told MAPS that NIDA and Public Health Service review had been completed and it would receive a decision soon.¹¹³ In September 2011, HHS informed MAPS that NIDA and Public Health Service reviewers had unanimously rejected the protocol as it was designed, claiming that safety issues were not adequately addressed.¹¹⁴ MAPS redesigned the protocol with provisions for closer daily monitoring of participants' psychiatric symptoms.¹¹⁵ A year later, in October 2012, an Institutional Review Board at the University of Arizona approved a revised protocol, incorporating its own changes.¹¹⁶ MAPS resubmitted the study protocol to HHS in October 2013, with a plea to HHS to drop the additional requirement of yet another review by PHS.¹¹⁷ That review was not eliminated, and PHS finally approved the MAPS application in March 2014, paving the way for MAPS to purchase marijuana for its study from the NIDA facility at the University of Mississippi.¹¹⁸

In December 2014, MAPS was awarded a \$2 million grant by the State of Colorado to complete the study.¹¹⁹ But a new problem arose. *The New York Times* reported in August 2014: "After the study received approval in March from federal health officials, the lone supplier of research marijuana said it did not have the strains the study needed and would have to grow more – potentially delaying the project until early next year."¹²⁰

Dr. Suzanne Sisley is one of the researchers conducting the MAPS study. Previously, she treated veterans with PTSD with prescription drugs. When discussing this experience, she stated:

¹¹¹ *Marijuana for Symptoms of PTSD in U.S. Veterans*, MULTIDISCIPLINARY ASS'N FOR PSYCHEDELIC STUDIES, http://www.maps.org/index.php?option=com_content&view=category&id=248&Itemid=593 [http://perma.cc/6BEF-G9UP] (last modified Sept. 22, 2015).

¹¹² *See id.*

¹¹³ *Medical Marijuana Research News Timeline*, MULTIDISCIPLINARY ASS'N FOR PSYCHEDELIC STUDIES, http://www.maps.org/index.php?option=com_content&view=category&id=110&Itemid=636 [http://perma.cc/3L66-SNC5] (last updated Sept. 25, 2015).

¹¹⁴ *See id.*

¹¹⁵ *See id.*

¹¹⁶ *See id.*

¹¹⁷ *See id.*

¹¹⁸ *See id.*

¹¹⁹ *See id.*

¹²⁰ Kovaleski, *supra* note 107.

I fully admit that I participated in this for years, pummeling those veterans with all kinds of FDA-approved meds. I'd have them on ten to 12 [sic] different meds, each to treat one of these active target symptoms. These veterans would be completely useless because they were so riddled with side effects and drug interactions. The notion that there could be a single plant that could manage the entire myriad of PTSD symptoms Well, that would be an incredible breakthrough.¹²¹

The MAPS study consists of seventy-six veterans diagnosed with PTSD who, over twelve weeks, inhale smoked or vaporized marijuana from plants grown at the NIDA facility.¹²² The goal of the study is to determine an effective treatment regimen for veterans with PTSD.¹²³ The study will evaluate various strains, potencies and the overall effects by conducting in-depth psychological testing before, during, and after the twelve-week period.¹²⁴ After years of back and forth among various federal agencies, with permits and authorizations in hand, Dr. Sisley and the other researchers continue to face numerous roadblocks and challenges in getting their studies off the ground.

VI. POLICY PROPOSALS

It is clearly time to bring federal policy into alignment with the compassionate policies of those states that have recognized the value of medical marijuana. Such policies aid in the treatment of patients with cancer, epilepsy, and other conditions, as well as help veterans cope with the mental and physical wounds of war. While the current administration has taken a more tolerant approach towards state-sanctioned growers and dispensers of marijuana, there is no guarantee a future administration will continue these policies. The federal government should formalize as law its current practice of not prosecuting federal marijuana laws in states that have adopted medical marijuana programs.

To do so, Congress must pass legislation formally preventing the DEA and other federal agencies from taking enforcement actions against businesses and individuals that are legally permitted within their states to grow, dispense, and consume medical marijuana. To ensure lasting protection, this action should be accomplished through stand-alone legislation, rather than as

¹²¹ T. Kid, *Why Aren't Veterans Allowed to Treat Their PTSD With Medical Marijuana?*, VICE (Jan. 26, 2015), http://www.vice.com/en_ca/read/when-will-americas-war-veterans-with-ptsd-get-weed-126 [http://perma.cc/8G5S-9F4R].

¹²² See MULTIDISCIPLINARY ASS'N, *supra* note 111.

¹²³ See *Protocol MJP-1: Placebo-Controlled, Triple-Blind, Randomized Crossover Pilot Study of the Safety and Efficacy of Four Different Potencies of Smoked Marijuana in 76 Veterans with Chronic, Treatment-Resistant Posttraumatic Stress Disorder (PTSD)*, MULTIDISCIPLINARY ASS'N FOR PSYCHEDELIC STUDIES (June 8, 2015), http://www.maps.org/research-archive/mmj/MJP1_Protocol_FINAL_Amend3V2_8Jun2015_web.pdf [http://perma.cc/CRT5-PEJF].

¹²⁴ See *id.*

amendments to appropriations bills that must be reauthorized each fiscal year. This will make clear that the federal government once and for all has recognized the rights of states to enact and implement medical marijuana laws.

Congress and the Executive Branch also must give VA doctors the latitude to openly discuss medical marijuana with their patients and help them obtain medical marijuana cards and treatment in states that permit medical marijuana programs. Currently, VA doctors can monitor a patient's use of medical marijuana in conjunction with other treatment, but this policy needs to be updated so that VA doctors can prescribe medical marijuana just as they would write prescriptions for any other medication. Under the current policy, veterans face the unfair burden of paying for the services of another physician to assess their conditions and determine their need for a medical marijuana card. These veterans should have a consistent continuum of care by their VA physician that includes the option of medical marijuana and is guaranteed by formal legislation.

Finally, the administration needs to lift the remaining barriers to researching and testing medical marijuana's benefits. Given the rapid widespread adoption of medical marijuana laws by the states, it is critical that research be expedited to weigh the benefits and risks of medical marijuana use. Hundreds of thousands of Americans, including veterans, are now using medical marijuana. It should take months, not years, for the U.S. Department of Health and Human Services to review and act on applications for controlled testing of marijuana. Currently all supplies and strains of marijuana for clinical testing must be grown at one facility that is authorized by the federal government as the sole supplier. To expedite testing, additional facilities need to be authorized to provide a ready and diverse supply of marijuana to researchers. This supply expansion will allow researchers to proceed quickly in their work once the U.S. Department of Health and Human Services has approved their applications.

VII. CONCLUSION

Americans have supported the legalization of medical marijuana since 1997, when CBS News first began conducting polls on the subject.¹²⁵ In the years since those polls, support for legalization of medical marijuana has grown substantially. In April 2015, a CBS News poll found that eighty-four percent of Americans support medical marijuana as a treatment if prescribed by a doctor.¹²⁶ As more states move in this direction, through legislation or voter initiatives, it is likely that a tipping point will be reached in the near

¹²⁵ See Sarah Dutton et al., *Poll: Support for Legal Marijuana Use Reaches All-Time High*, CBS NEWS (Apr. 20, 2015), <http://www.cbsnews.com/news/poll-support-for-legal-marijuana-use-reaches-all-time-high/> [<http://perma.cc/K34V-FLHF>].

¹²⁶ See *id.*

future. At that time, additional members of Congress, regardless of their personal attitudes about marijuana use, will likely join the effort to legalize medical marijuana, compelled by arguments of states' rights, criminal justice reform, quality of veteran services, and the need for scientific research. Eventually, given this groundswell, Congress will respond with legislation recognizing the rights of states to authorize medical marijuana, giving our veterans access to and use of medical marijuana under the direction of their VA physicians and establishing a streamlined process for testing and measuring the benefits and risks of long-term medical marijuana use. Above all, compassion for our veterans and other Americans suffering through debilitating injuries or diseases should drive these decisions.