Testimony of Mr. Rob Kampia
Executive Director, Marijuana Policy Project

Before the Government Reform Committee's Subcommittee on Criminal Justice, Drug Policy, and Human Resources

April 1, 2004

Introduction

Thank you Chairman Souder, Ranking Member Cummings, and the other distinguished members of this subcommittee. My name is Rob Kampia, and I am executive director of the Marijuana Policy Project, the largest organization in the United States that is solely dedicated to ending marijuana prohibition. The Marijuana Policy Project has 15,000 dues-paying members and — as of today — nearly 70,000 e-mail subscribers. (MPP's e-mail list is currently growing at the rate of 1,000 new names per day.)

The Marijuana Policy Project works to minimize the harm associated with marijuana — both the consumption of marijuana and the laws that are intended to prohibit such use. MPP believes that the greatest harm associated with marijuana is imprisonment.

The threat of imprisonment is especially dangerous and harmful when the individuals in question are seriously ill patients who use marijuana — with the approval of their physicians — to alleviate severe nausea, pain, muscle spasticity, and other debilitating medical conditions.

But today's hearing is not designed to debate the moral implications of throwing cancer patients in prison when their doctors have agreed that marijuana is the best therapeutic option for them. Today we are here to talk about the science of medical marijuana.

With respect to the title of this hearing, "Marijuana and Medicine: The Need for a Science-Based Approach," I would like to say upfront that the Marijuana Policy Project welcomes a "science-based approach" to this subject. In fact, we would celebrate such an approach because it would undoubtedly bring an end to the unnecessary and immoral federal attacks on doctors, patients, and caregivers who are acting legally under state law.

Unfortunately, current federal policies are not based on science; rather, they are based on myths and lies. Worse yet, the federal government is currently blocking scientific inquiry into the therapeutic benefits of marijuana. This collusion in support of delusion is an outrage and must be stopped. State medical marijuana laws must be respected, and research into the therapeutic benefits of marijuana must be allowed to proceed expeditiously.

The medical benefits of marijuana are widely recognized.

Opponents of medical marijuana claim that marijuana has no medical benefits. The chairman of this subcommittee gave a typical demonstration of this tactic in July 2003 during a debate on the House floor. During that debate he said that marijuana "does not help sick people. … There are no generally recognized health benefits to smoking marijuana."

The chairman, and those who agree with him, could not be more wrong.

The appropriate starting point for demonstrating the inaccuracy of the chairman's claim is a 1999 report by the National Academy of Sciences' Institute of Medicine entitled, "Marijuana and Medicine: Assessing the Science Base." This study was commissioned by the White House Office of National Drug Control Policy and directly addressed the question of smoked marijuana. It concluded in a section entitled "Use of Smoked Marijuana": "It will likely be many years before a safe and effective cannabinoid delivery system, such as an inhaler, is available for patients. In the meantime, there are patients with debilitating symptoms for whom ***smoked*** marijuana might provide relief." The Principal Investigator of this study added at the news conference at which the report was released, "[W]e concluded that there are some limited circumstances in which we recommend ***smoking*** marijuana for medical uses." It is unfortunate that the authors of this study are not here to testify today.

The recognition of marijuana's medical benefits goes well beyond the Institute of Medicine. For those familiar with the scheduling of controlled substances, marijuana is a Schedule I drug, which is defined as having "no currently accepted medical use," while Schedule II drugs are defined as having a "currently accepted medical use." Therefore, anyone who suggests that marijuana should not be a Schedule I drug believes that it has generally recognized health benefits. With this in mind, let's review what some medical professionals say about marijuana.

An editorial in the *New England Journal of Medicine* — while calling the federal war on medical marijuana patients "misguided, heavy-handed, and inhumane" — suggested that the government "should change marijuana's status from that of a Schedule I drug to a Schedule II drug and regulate it accordingly."

In June 2003, the 2.6 million-member American Nurses Association passed a resolution supporting the rescheduling of marijuana out of Schedule I.

The American Public Health Association, the oldest and largest organization of health professionals in the world, "overwhelmingly" adopted a resolution concluding, "marijuana was wrongfully placed in Schedule I." In this resolution, the APHA noted that marijuana has been reported to be effective in (1) reducing the intraocular pressure caused by glaucoma, (2) reducing the nausea and vomiting associated with chemotherapy, (3) stimulating the appetite of patients

living with AIDS and suffering from wasting syndrome, (4) controlling the spasticity that is associated with spinal cord injuries and multiple sclerosis, (5) decreasing the suffering from chronic pain, and (6) controlling seizures associated with seizure disorders.

Even non-political government officials have supported the rescheduling of marijuana. In 1988, the DEA's chief administrative law judge, Francis L. Young, ruled: "Marijuana, in its natural form, is one of the safest therapeutically active substances known … [T]he provisions of the [Controlled Substances] Act permit and require the transfer of marijuana from Schedule I to Schedule II. It would be unreasonable, arbitrary and capricious for DEA to continue to stand between those sufferers and the benefits of this substance."

The Marijuana Policy Project has compiled a list of more than 100 organizations with favorable positions on medical marijuana.

The federal government is blocking research on marijuana.

It is disturbing that some members of Congress are unwilling to acknowledge the overwhelming evidence that marijuana has recognized medical uses. But it is even more offensive that these members of Congress sit idly as the executive branch of the federal government blocks research into the therapeutic benefits of marijuana. If this subcommittee is truly interested in a science-based approach to marijuana's therapeutic uses, it should use its authority and influence to help remove the barriers to this research.

Here are some examples of how the federal government has impeded research on the therapeutic benefits of marijuana:

In December 1999, the U.S. Department of Health and Human Services (HHS) established guidelines that researchers must follow if they wish to study the therapeutic benefits of marijuana. These guidelines place a much greater burden on medical marijuana researchers than on drug companies that develop and study newly synthesized pharmaceuticals. For example, HHS's guidelines require marijuana research protocols to undergo a review by an ad hoc, marijuana-specific panel within HHS, which is in addition to FDA approval of the protocols. This is an unnecessary and cumbersome hurdle that pharmaceutical companies do not face. Medical marijuana researchers should not receive special treatment, but they should receive equal and fair treatment. In November 1999, more than 30 U.S. representatives sent a letter to HHS Secretary Donna Shalala, urging her to promulgate guidelines that would simply treat marijuana research like research on any other drug.

Second, the National Institute on Drug Abuse currently has a monopoly on the cultivation of marijuana for research in the United States. Unfortunately, NIDA's marijuana is only available for research, not for prescriptive use. Therefore, how could a pharmaceutical company be expected to invest millions of dollars in researching a product that it could not eventually sell

on the market? Can you imagine any private firm conducting research under these conditions? Moreover, there have been many complaints about the quality of NIDA's marijuana. Five U.S. representatives sent a letter to the DEA in support of an alternative source of research-grade marijuana, expressing concerns such as those described in this paragraph.

Finally, the Drug Enforcement Administration has played its own important role in blocking medical marijuana research. For nearly three years, the DEA has delayed action on an application from the University of Massachusetts for a license to cultivate marijuana for federally approved research. In fact, the comment period on this application closed more than six months ago. Yet the DEA still has not approved or rejected this application. The proposed production facility is needed because — as described above — NIDA's monopoly is preventing effective research from moving forward. Significantly, the regulations governing this application process direct the DEA to provide for "adequate competition" in the production of Schedule I and II drugs. Massachusetts Senators John Kerry and Edward Kennedy wrote a letter to the DEA in October 2003 underscoring this point and urging the agency to approve the application.

As a final point, it should be noted that the DEA — according to federal regulations — should only be concerned with the possible diversion of marijuana by the University of Massachusetts. So far, there is no indication that such a concern exists. Instead, a letter from the DEA to the University indicated that the DEA's primary objection to the University's application was that NIDA's supply of marijuana was sufficient. This subcommittee should inform the DEA that this should not be a consideration in its decision on the University of Amherst's application.

Opposition to medical marijuana is based on lies and myths.

As noted, there is almost no way that a science-based approach can lead to the conclusion that marijuana — even smoked marijuana — is not medicine. The opposition to medical marijuana isn't based on science, but rather lies and myths that are refutable by indisputable facts.

The lead mythmakers with respect to medical marijuana are the officials at ONDCP. Here are a couple of good examples, both taken from a column by ONDCP Deputy Director Andrea Barthwell, published in the *Chicago Tribune* on February 17, 2004.

The first is related to Marinol, the prescription drug that contains a synthetic version of one of the active ingredients in marijuana — THC. Barthwell wrote that "marijuana advocates refuse to acknowledge Marinol as a viable option. Interestingly enough, the only property that Marinol lacks is the ability to create a 'high'."

Barthwell's assertions about Marinol are false. First, Marinol most certainly produces a high. This is stated clearly in the *Physician's Desk Reference*. In the list of adverse reactions on page 3326, the very first entry is "a cannabinoid dose-related 'high'." This high is enough of a

concern that the *PDR* warns, “Patients receiving treatment with Marinol should be specifically warned not to drive, operate machinery or engage in any hazardous activity until it is established that they are able to tolerate the drug and perform such tasks safely.”

And, to contradict another of Barthwell’s claims, natural marijuana has at least two properties that Marinol lacks: Rapid onset of action, and superior control over dosage. As noted in the article, “Therapeutic Potential of Cannabis,” in the May 2003 issue of *The Lancet Neurology*, “Oral administration is probably the least satisfactory route for cannabis.” The journal noted that the oral route “makes dose titration more difficult and therefore increases the potential for adverse psychoactive effects.” Barthwell got the science exactly backwards.

The second myth Barthwell propounded in her op-ed is the claim that allowing seriously ill patients to use medical marijuana somehow increases teenage marijuana use. In fact, research has shown otherwise. In California, marijuana use by teens was rising until the 1996 passage of Proposition 215, the medical marijuana law. After that law took effect, teen marijuana use in California dropped dramatically over the next six years — as much as 40% in some age groups. A special analysis commissioned by the California state government found absolutely no evidence that Prop. 215 had increased teen marijuana use.

Both of Barthwell’s myths were refuted in a recent op-ed in the *Providence Journal* by former U.S. Surgeon General Joycelyn Elders. She also addressed some other common myths, such as “Marijuana is too dangerous to be medicine. It’s bad for the immune system, endangering AIDS and cancer patients,” and “Smoke is not medicine. No real medicine is smoked.” With respect to the latter myth, Dr. Elders offered the following:

“The truth: Marijuana does not need to be smoked. Some patients prefer to eat it, while those who need the fast action and dose control provided by inhalation can avoid the hazards of smoke through simple devices called vaporizers. For many who need only a small amount — like cancer patients simply trying to get through a few months of chemotherapy — the risks of smoking are minor.”

Regarding the claim that marijuana is too dangerous to be a medicine, it is interesting to note that there has never been a death attributed to an overdose of marijuana. Clearly, most prescription drugs are far more dangerous than marijuana. Even over-the-counter drugs like aspirin and Tylenol cause numerous overdose deaths each year.

Since we are accustomed to responding to misconceptions about medical marijuana, the Marijuana Policy Project has prepared factual responses to 33 common challenges to marijuana’s therapeutic uses. These responses can be found in “Effective Arguments for Medical Marijuana Advocates.” Anyone opposed to the medical use of marijuana should read this document before arguing publicly against its use in the future.

This hearing is a witch hunt, not a quest for knowledge.

The goal of this subcommittee, under its current leadership, is not to adopt a true scientific approach to the subject of marijuana. If that were the case, the authors of the Institute of Medicine report and physicians and patients from the eight medical marijuana states would have been invited. Or a representative from the American Nurses Association. Or a representative from the American Public Health Association.

No, the clear goal of the current chairman is to expend federal funds in a fruitless quest to find evidence that supports his own baseless belief. For example, the panel I'm speaking on is composed of representatives from two state boards that are currently investigating possible wrongdoing under state medical marijuana laws, even though no wrongdoing has been established. The chairman also invited two physicians whose activities have come into question, while ignoring the thousands of physicians who have recommended marijuana to their patients under state law without controversy. Finally, the chairman invited Mr. DuPont, whose value as a witness seems to be that he is one of the leading medical marijuana mythmakers.

But this is not the first time Chairman Souder has expended government funds to "expose" medical marijuana. In June 2001, Chairman Souder requested, on behalf of the subcommittee, that the General Accounting Office investigate state medical marijuana programs. At taxpayer expense, the GAO traveled to Alaska, California, Hawaii, and Oregon to carry out this request.

When this lengthy report was completed in November 2002, it contained few, if any, controversial findings. The researchers commented generally on the small number of patients who are registered, and the paucity of doctors who are recommending marijuana as a treatment option. Even the law-enforcement officials interviewed for the report seemed to be unfazed by state medical marijuana laws.

Most of the 37 selected law enforcement organizations interviewed in the report "indicated that medical marijuana laws had had little impact on their law enforcement activities for a variety of reasons." Nearly two-thirds of these law enforcement officials did not believe that "the introduction of medical marijuana laws have, or could make it, more difficult to pursue or prosecute some marijuana cases." And nearly three-quarters of these officials denied that "there has been a general softening in public attitude toward marijuana or public perception that marijuana is no longer illegal."

Conclusion

In sum, the Marijuana Policy Project strongly supports a science-based approach to medical marijuana. We hope that Chairman Souder eventually abandons his reliance on myths and lies, stops the federal witch hunt for medical marijuana patients and doctors, and embraces an approach that is based on science.