CAUGHT IN THE CROSSFIRE: THE DILEMMA OF MARIJUANA "MEDICALIZATION" FOR HEALTHCARE PROVIDERS

WILLIAM VERTES[†] AND SARAH BARBANTINI[‡]

I. INTRODUCTION

No plant in American culture is more glorified—nor more vilified—than *Cannabis Sativa*, known commonly as marijuana.[1] When smoked, or otherwise ingested, marijuana produces psychoactive effects that can include changes in time and space perception, lightheadedness, and

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† Principal and leader of the Medical Marijuana Practice, Kitch Drutchas Wagner Valitutti & Sherbrook, Detroit, Michigan. B.A. 1980, in Political Science, *cum laude*, Michigan State University; J.D.,1983, University of Notre Dame Law School.

‡ Law Graduate, Insurance Practice, Kitch Drutchas Wagner Valitutti & Sherbrook, Detroit, Michigan. B.A. in Psychology, 2007, *cum laude*, Kalamazoo College. M.S.W., 2008, University of Michigan School of Social Work; J.D. May 2012, Wayne State University Law School. The authors would like to thank Gregory Drutchas, Daniel Shirey, Adam Kutinsky, and Michael Shpiece, of Kitch; Brian Hodgman, former Voting Note and Comment Editor, Wayne Law Review; and Jacqueline Marszalkowski and Helen Engelhard, Mr. Vertes's administrative assistants, for their assistance and support in the preparation of this article.

1. *See* LARRY "RATSO" SLOMAN, REEFER MADNESS: A HISTORY OF MARIJUANA (1998).

euphoria.[2] As such, marijuana is certainly a drug.[3] But is it medicine?[4] This question has fueled debate for decades,[5] and has impacted political ideology, sociology, law enforcement policy, and, not insignificantly, healthcare. This Article explores marijuana's long, often arduous, path from panacea to pariah, and more recent attempts to resurrect and redefine its reputation. In the process, it examines how healthcare providers have been drafted into the battle and, often unwillingly, have been marched to the front lines.

II. HISTORY

Records suggest marijuana has been used as medical treatment for centuries.[6] The earliest known reference to marijuana's medicinal use exists in a Chinese text from 1500 B.C.[7] As such, medical treatment with marijuana has been "accepted" far longer than it has been rejected. Even in the United States, marijuana has been a recognized "medicine" within the past century, being listed in the United States Pharmacopoeia as early

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2. H.H. Van Hell et al., *Evidence for Involvement of the Insula in the Psychotropic Effects of THC in Humans: A Double-Blind, Randomized Pharmacological MRI Study*, 14 INT'L J. NEUROPSYCHOPHARMACOLOGY 1377 (2011). *See also* W. Hall, N. Solowij, & J. Lemon, *The Health and Psychological Consequences of Cannabis Use*, NAT'L DRUG STRATEGY MONOGRAPH SERIES NO. 44, AUSTL. GOV'T PUBL'G SERV. (2001).

3. Thomas Lathrop Stedman, STEDMAN'S MEDICAL DICTIONARY (28th ed. 2005). "Drug" is defined by Stedman Dictionary in three ways. The first given definition of a "drug" is a "[t]herapeutic agent; any substance, other than food, used in the prevention, diagnosis, alleviation, treatment, or cure of disease." *Id.* Another given definition for "drug" provided by Stedman is a "[g]eneral term for any substance, stimulating or depressing, that can be habituating or addictive, especially a narcotic." *Id.*

4. *Definition of Medicine,* MERRIAM-WEBSTER'S DICTIONARY (2012), *available at* http://www.merriam-webster.com/dictionary/medicine (defining medicine as "a substance or preparation used in treating disease."). *See also* JANET JOY & ALISON MACK, MARIJUANA AS MEDICINE: THE SCIENCE BEYOND THE CONTROVERSY (2000).

5. *See* ROBERT DEITCH, HEMP: AMERICAN HISTORY REVISITED: THE PLANT WITH A DIVIDED HISTORY 2 (2003).

6. *Id.*

7. NAT'L INST. ON DRUG ABUSE, RESEARCH MONOGRAPH 14, MARIJUANA RESEARCH FINDINGS, 196 (1977), *available at* http://archives.dgabuse.gov/pdf/monographs/download14.html. One of the worlds' oldest known pharmacopoeias identified marijuana as being effective in treating ailments including, but not limited to, gout, rheumatism, and absent mindedness. Michael Aldrich, *History of Therapeutic Cannabis*, CANNABIS IN MEDICAL PRACTICE: A LEGAL, HISTORICAL, AND PHARMACOLOGICAL OVERVIEW OF THE THERAPEUTIC USE OF MARIJUANA (Mary Lynn Mathre, ed., 2d ed. 1997)(internal citations omitted).

as 1850.[8] It continued to be recognized as medicine through the early twentieth century.[9] However, in 1913, California became the first state to make the sale and possession of marijuana illegal,[10] and by the 1930s its use garnered stricter review throughout the United States.[11] In 1937, Congress passed the Marijuana Tax Act.[12] Although the Act did not criminalize marijuana use, it regulated, and imposed taxes on, that use.[13] Further scrutiny and changes in public perception led to marijuana's eventual removal from the U.S. Pharmacopoeia and ended its official recognition as a substance acceptable for medical use.[14]

Over time, marijuana use was further restricted, culminating in the Federal Controlled Substances Act, which made marijuana's use in any form illegal by classifying it as a Schedule I controlled substance.[15] Marijuana's status as a Schedule I controlled substance underscores the irony of the current debate regarding "medical" marijuana, in that a common attribute of all Schedule I controlled substances is that they, by definition, have no accepted medical use.[16]

Yet this federal view and classification of marijuana did not prevent states from considering, and eventually enacting, laws permitting its use for medical purposes.[17] California, the first state to make marijuana use

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8. Moira Gibbons, *The Cannabis Conundrum: Medication v. Regulation*, 24 THE HEALTH LAW 2, 5 (2011). Ms. Gibbons's article gives a thorough description of the legal and pharmaceutical history of marijuana and its use. *Id.*

9. *Id.*

10. 1913 Cal. Stat. Ch. 342, §8a; *see also* Gonzales v. Raich, 545 U.S. 1, 6 (2005).

11. *Raich,* 545 U.S at 6.

12. Marihuana Tax Act of 1937, Pub. L. No. 238, §§ 1-14 (1937), *available at* http://www.druglibrary.org/schaffer/hemp/taxact/mjtaxact.htm.

13. *Id.* Marijuana was also regulated by the 35 states which adopted the Uniform State Narcotic Drug Act in 1934.The Boggs Act of 1952 and the Narcotics Control Act of 1956 increased the criminal penalties for marijuana possession and established mandatory sentencing for first-time offenses. MOLLY M. GILL, CORRECTING COURSE: LESSONS FROM THE 1970 REPEAL OF MANDATORY MINIMUMS, 7, 16 (2008), *available at* http://www.famm.org/reposition/files/8189_ FAMM_BoggsAct_final.PDF. Both Acts were repealed in 1970. *Id.*

14. *See* THE U.S. PHARMACOPOEIAL CONVENTION, THE PHARMACOPOEIA OF THE UNITED STATES OF AMERICA (12th Rev. 1942).

15. *See* 21 U.S.C.A. §§ 801-904 (West 1970). Marijuana is placed on Schedule I. 21 U.S.C.A. § 812. *See also, Controlled Substance Schedules,* DEA, http://www.justice.gov/dea/pubs/scheduling.html (last visited Apr. 12, 2012).

16. *See* 21 U.S.C.A. § 812(b)(1)(B).

17. *See* Ballot Measure 8 (Alaska 1998); Prop. 203 (Ariz. 2010); Prop. 215 (Cal. 1996); Ballot Amend. 20 (Col. 2000); H.B. No. 5389 (Conn. 2012); Amend. Act B18-622 (D.C. 2010); S.B. 17 (Del. 2011); S.B. 862 (Haw. 2000); Ballot Question 2 (Me. 1999); Prop.1 (Mich. 2008); Initiative 148 (Mont. 2004); Ballot Question 9 (Nev. 2000); S.B. 119 (N.J. 2010); S.B. 523 (N.M. 2007); Ballot Measure 67 (Or. 1998); S.B.0710 (R.I.

and possession illegal in 1913,[18] passed the first state statute permitting medical marijuana use in 1996.[19] Over the ensuing decade, multiple states passed similar legislation,[20] and marijuana use for medical purposes is currently permitted in some form in seventeen states and the District of Columbia.[21]

Statutes authorizing medicinal use in these jurisdictions commonly cite marijuana for its beneficial effects on various health problems.[22] These statutes consistently reference marijuana's medicinal value as well as its use in the compassionate care of patients.[23] Importantly, all these statutes currently mandate at least some form of physician participation,[24] including the uniform requirement of a physician assessment before permitting patient use.[25] Although this physician "seal of approval" may lend credibility to marijuana use and is consistent with the goal of evaluating marijuana's potential health benefits, mandating physician participation places physicians in an unusual and potentially awkward position. The physician certification mandate requires physicians to assess the propriety and effectiveness[26] of a "medicine" which the federal government has determined has no accepted medical use[27] and, by extension, forbids physicians from prescribing.[28]

A. What is a "Drug?"

Before examining the issues facing physicians attempting statutory compliance, it is important to consider the nature of marijuana itself. Simply put, from a medical standpoint, what is marijuana and what should it be?

2006); S.B. 76 (Vt. 2004); Initiative 692 (Wash. 1998) [hereinafter Ballot Measures and Proposed Legislation].

18. *See* sources cited, *supra* note 10.

19. Prop. 215 (Cal. 1996).

20. *See* Ballot Measures and Proposed Legislation, *supra* note 17.

21. *Id.*

22. *See, e.g.*, MICH. COMP. LAWS ANN. § 333.26422(2)(a) (West 2008) (stating "[t]he National Academy of Sciences Institute of Medicine in a March 1999 report, has discovered beneficial uses for marihuana in treating or alleviating the pain, nausea, and other symptoms associated with a variety of debilitating medical conditions.").

23. *See* MICH. COMP. LAWS ANN. § 333.26422(2)(b) (West 2008).

24. *See* Ballot Measures and Proposed Legislation, *supra* note 17.

25. *Id.*

26. *See, e.g.*, MICH. COMP. LAWS ANN. § 333.26423(1) (West 2008).

27. *See* 21 U.S.C.A. § 812(b)(1)(B).

28. United States v. Oakland Cannabis Buyers' Co-op., 532 U.S. 483, 492 n. 5 (2001) (noting "[u]nlike drugs in other schedules . . . schedule I drugs cannot be dispensed under a prescription."); *see also* 21 U.S.C.A. § 829 (omitting Schedule I substances from amongst those which may be lawfully prescribed).

The Comprehensive Drug Abuse Control Act (CDACA) was designed to regulate and control the manufacture, importation, distribution, possession, and proper use of controlled substances within the United States.[29] The CDACA defines the term "drug" to include four different categories of "articles."[30] First, a drug is an article that is recognized in a book of public pharmacopeial standards published by the authority of the United States government, a medicalor pharmaceutical society.[31] Second, a drug is an article that is "intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals."[32] Third, a drug is an article, other than food, which is used with intent to affect the structure or function of the human body, or the body of an animal.[33] Lastly, a drug is also any "article[,] intended for use as a component of any article specified in" any of the previous clauses.[34] Simply because an article is labeled as a drug does not mean the article is legally considered a drug under the CDACA.[35]

Whether used recreationally or under physician auspices for its medicinal value, marijuana certainly is used with the intent to affect the function of the human body and is unquestionably considered a drug under the CDACA. It, with numerous other controlled substances, is included in the federal drug scheduling system as discussed below.

The current debate surrounding "medical" marijuana is whether it should qualify under the second CDACA category; namely, whether it should be used to prevent, diagnose, cure, mitigate, or treat disease in humans. Proponents of "medical" marijuana contend marijuana is, or should be, used for such therapeutic purposes.[36] Proponents further argue that marijuana should be rescheduled under the Controlled Substances

29. 21 U.S.C.A. § 801(2) (West 2008).

30. 21 U.S.C.A. § 321(g)(1) (West 2008).

31. 21 U.S.C.A. § 321(g)(1)(A). The authorized medical or pharmaceutical societies are the United States Pharmacopeial (USP) and the Homoeopathic Pharmacopoeia Convention of the United States (HPCUS), which publish the official United States Pharmacopoeia and the official Formulary (USP-NF), and the official Homoeopathic Pharmacopoeia of the United States (HPUS), respectively. *See About USP*, U.S. PHARMACOPEIA, http://www.usp.org/aboutUSP/ (last visited Apr. 12, 2012); *What is the HPUS*, THE HOMOEOPATHIC PHARMACOPOEIA OF THE U.S., http://www.hpus.com/whatishpus.php (last visited Apr. 12, 2012). A drug is also considered to be any article that is recognized in a supplement to any of the aforementioned publications. 21 U.S.C.A. §321(g)(1)(A).

32. 21 U.S.C.A. §321(g)(1)(B).

33. 21 U.S.C.A. §321(g)(1)(C).

34. 21 U.S.C.A. §321(g)(1)(D).

35. *Id.*

36. *See generally* INST. OF MED., MARIJUANA AND MEDICINE: ASSESSING THE SCIENCE BASE (Janet E. Joy et al. eds., 1999), *available at* http://www.nap.edu/openbook.php?record_id=6376.

Act (CSA) which, arguably, would remove some of the current impediments to marijuana use.[37] Putting such arguments in context requires examining the current controlled substances classification system.

B. Federal Drug Scheduling and Classification

The United States utilizes a five-schedule system for classifying drugs and substances, and is described in title 21 of the United States Code, section 812.[38] The five schedules, identified as Schedules I,[39] II,[40] III,[41] IV,[42] and V,[43] are updated and republished on an annual basis.[44] Currently, Schedule I drugs or substances include some opiates and opiate derivatives, as well as hallucinogenic substances, including any drug or substance containing Tetrahydrocannabinols, like marijuana.[45] The findings required to place a controlled substance on Schedule I are that: "(a) The drug or other substance has a high potential for abuse. (b) The drug or other substance has no currently accepted medical use and

37. John A. Benson, Jr., M.D., Janet E. Joy, Ph.D., and Stanley J. Watson, Jr., M.D., Ph.D., *From Marijuana to Medicine*, ISSUES IN SCI. & TECH., Mar. 22, 1999, *available at* http://www.issues.org/15.3/stalk.htm.

38. 21 U.S.C.A. § 812.

39. Schedule I drugs have three qualifying characteristics: first, they have a high potential for abuse; second, there is no currently accepted use for the drug in the United States' medical treatment community; and third, even under medical supervision, there is no level of accepted safety for the drug's use. 21 U.S.C.A. § 812(b)(1)(A)-(C).

40. Schedule II drugs have the following qualifying characteristics: one, there is a high potential for abuse of the drug; two, there is a current acceptable method of use for the drug for medical treatment within the United States; and three, the use of the drug could lead to either severe mental or physical dependence. 21 U.S.C.A. § 812(b)(2)(A)-(C).

41. Schedule III drugs also have three qualifying characteristics: first, the drug has "a potential for abuse less than the drugs or other substances in Schedule I or II;" second, the drug has a currently accepted medicinal use in the United States; and third, that if the drug or other substance is abused, it only has a moderate or low potential for "physical or high psychological dependence." 21 U.S.C.A. § 812(b)(3)(A)-(C).

42. Schedule IV drugs or substances have a low potential for abuse compared to Schedule III drugs or substances, have an accepted medical use in the United States, and have a limited potential for physical or psychological dependence when compared to Schedule III drugs or substances. 21 U.S.C.A. § 812(b)(4)(A)-(C).

43. Schedule V drugs present the least amount of risk for abuse, have "a currently accepted use in medicinal treatment in the United States," and have an even more limited likelihood of leading to physical or psychological dependence compared to Schedule IV drugs and substances. 21 U.S.C.A. § 812(b)(5)(A)-(C).

44. 21 U.S.C.A. § 812(a). However, from October 27, 1971 until October 27, 1973, the schedules were updated and republished on a semiannual basis. *Id.*

45. 21 U.S.C.A. § 812.

treatment in the United States. (c) There is a lack of accepted safety for use of the drug or other substance under medical supervision."[46]

A controlled substance is described as "a drug or other substance, or immediate precursor, included in Schedule I, II, III, IV, or V . . . ."[47] Controlled substances do not include alcoholic beverages or tobacco as described in subtitle E of the Internal Revenue Code of 1986.[48] Michigan essentially adopts the Federal classification structure, and defines a controlled substance as "a drug, substance, or immediate precursor [to a drug or substance]" which is included in one of the five schedules established within the Controlled Substances Act (CSA).[49]

The placement of a drug or substance on one of the five schedules can be modified or determined according to the provisions of title 21, section 811.[50] The process of evaluating a drug or other substance can be initiated by the Department of Health and Human Services (DHHS), the Drug Enforcement Agency (DEA), or by a petition filed by an interested party with the DEA.[51] The DEA must formally submit a request to the Food and Drug Administration (FDA) to evaluate the appropriateness of a drug or substance's placement within the five schedules, and FDA will not begin such an evaluation until a formal request from the DEA is received.[52]

The Attorney General of the United States is to apply the provisions of section 811 based on the advice of the DHHS Secretary.[53] In turn, the DHHS Secretary relies on the evaluative testing conducted by FDA.[54] The FDA's role is outlined in section 393 of title 21,[55] and this role, as it

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46. *Id.*

47. 21 U.S.C.A. § 802(6) (West 2009).

48. *Id.*

49. MICH. COMP. LAWS ANN. § 333.7204(2) (West 1994).

50. 21 U.S.C.A. § 811 (West 2005).

51. *Id.*

52. *Scheduling of Drugs Under the Controlled Substances Act: Hearing Before the Sub. Comm. on Oversight and Investigations, H. Comm. on Commerce,* 106th Cong. (1999) (statement of Nicholas Reuter, M.P.H. Assoc. Dir. For Domestic and Int'l Drug Control, Office of Health Affairs, Food and Drug Admin. Dept. of Health and Human Services). As of December 2011, the governors of Colorado, Rhode Island, and Washington have formally requested that the DEA reschedule marijuana, placing it on Schedule II instead of its current placement on Schedule I. *See* Kevin A. Sabet, Ph.D., *Clearing the Smoke on Medical Marijuana, Part I,* NAT'L DRUG ABUSE SUMMIT (Feb. 12, 2012), http://www.drugfree.org/join-together/drugs/clearing-the-smoke-on-medical-marijuana-part-i (citing John Ingold, *Colorado Asks DEA to Reclassify Marijuana,* THE DENVER POST (Dec. 28, 2011), *available at* http://www.denverpost.com/breakingnews/ci_19634321).

53. 21 U.S.C.A. § 811 (West 2005).

54. *Id.*

55. 21 U.S.C.A. § 393 (West 2011).

relates to the scheduling of drugs and other substances, is primarily to "provide the Secretary of [DHHS] with our scientific and medical evaluation of drugs."[56]

After reviewing the evidence collected by the FDA obtained through different phases of evaluative testing,[57] the DHHS Secretary advises the Attorney General whether the drug or substance tested should be considered a controlled substance, be removed from the category of controlled substances, and/or what level of regulation is appropriate for the tested drug or substance.[58] Based on the DHHS Secretary's recommendation, the Attorney General considers the following eight factors before placing, or changing the drug or substance's placement, within the five schedules:

(1) Its actual or relative potential for abuse.

(2) Scientific evidence of its pharmacological effects, if known.

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56. *See Scheduling of Drugs Under the Controlled Substances Act*, *supra* note 52.

57. *The FDA's Drug Review Process: Ensuring Drugs Are Safe and Effective,* FDA, http://www.fda.gov/drugs/resourcesforyou/consumers/ucm143534.htm (last visited Apr. 12, 2012). After being tested in animal analogs, a pharmaceutical company, research institution, or other organization can apply to begin the process of evaluating a drug for human usage with what is called an Investigational New Drug Application (IND). *Id.* The FDA determines if, based on the IND, whether it is reasonably safe for the IND's sponsor to test the drug or substance for human usage. *Id.* An institutional review board (IRB) that is located near the sponsor also reviews the IND. *Id.* Once the FDA determines it is reasonably safe to conduct further testing of the drug on humans and the IRB has approved the research protocols (i.e., including but not limited to, who participates, the timing of tests and procedures, the drug and its dosages, the length of time, and the study's objectives), the sponsor can begin human testing. *Id.* Human testing is conducted in three phases. *Id.* Phase I studies are on healthy human volunteers to determine if the drug is toxic or harmful. *Id.* Phase II studies begin once it is determined that the drug is not unacceptably toxic, and seeks to determine the drug's effectiveness. *Id.* Phase III studies begin if the side effects are not overly detrimental and it the drug is shown to be effective for its intended purpose. *Id.* Phase III looks to see what the drug's effectiveness is in different populations, in different dosages, and in combination with other drugs. *Id.* Once this phase is completed, the sponsor can submit a New Drug Application (NDA), which includes all the data on the drug collected from animal and human testing. *Id.* The FDA has sixty days to review the NDA and decide if it should be filed and accepted or denied. *Id.* This traditional approach to drug approval can be circumvented if the new drug is for serious and life-threatening illnesses that currently do not have satisfactory treatment options. *The FDA's Drug Review Process: Ensuring Drugs Are Safe and Effective,* FDA, http://www.fda.gov/drugs/resourcesforyou/consumers/ucm143534.htm (last visited Apr. 12, 2012). Instead of phases, these drugs are tested using surrogate endpoints to evaluate the drug's effectiveness. *Id.*

58. *Scheduling of Drugs Under the Controlled Substances Act*, *supra* note 52.

(3) The state of current scientific knowledge regarding the drug or other substance.

(4) Its history and or current pattern of abuse.

(5) The scope, duration, and significance of abuse.

(6) What, if any, risk there is to the public health.

(7) Its psychic or physiological dependence liability.

(8) Whether the substance is an immediate precursor of a substance, already [placed on one of the five schedules].[59]

C. What is Medicine?

Under federal law, marijuana is certainly a drug[60] and a controlled substance.[61] Whether it is, or should be, considered medicine is a matter of both scientific and philosophical debate.[62] As scientific evaluation progresses, numerous studies espouse marijuana's therapeutic properties.[63] Simply because a substance has medicinal value,[64] however,

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59. 21 U.S.C.A. § 811(c) (West 2005).

60. *See* 21 U.S.C.A. § 812(b)(1)(A)-(C).

61. *Id.*

62. *See* Benson et al., *supra* note 37. The American Medical Association's statement from November 10, 2009 provides:

> Our AMA urges that marijuana's status as a federal Schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This 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.

AMA Policy: Medical Marijuana, AM. MED. ASSOC., http://www.ama-assn.org/assets/meeting/mm/i-09-policy-marijuana.pdf (last visited Apr. 12, 2012); John Hoeffel, *Medical Marijuana Gets A Boost From Major Doctors Group,* LOS ANGELES TIMES, (Nov. 11, 2009), *available at* http://articles.latimes.com/2009/nov/11/nation/na-marijuana-ama11.

63. *See 101 Peer-Reviewed Studies on Marijuana: Medical Studies Involving Cannabis and Cannabis Extracts (1990-2012),* PROCON.ORG, http://medicalmarijuana.procon.org/view.resource.php?resourceID=000884 (last visited Apr. 12, 2012). As of the date of publication such studies include: Jody Corey-Bloom, M.D., Ph.D., et al., *Smoked Cannabis for Spasticity in Multiple Sclerosis: A Randomized, Placebo-Controlled Trial,* 184 CMAJ 1143 (July 10, 2012); Alena Novotna, M.D., et al., *A Randomized, Double Blind, Placebo-controlled, Parallel-group, Enriched-design Study of Nabiximols (Sativex), as Add-on Therapy, in Subjects with Refractory Spasticity*

does not make it medicine or medication.[65] Red wine, vitamin supplements and herbal remedies are commonly felt to provide health benefits, yet are not considered medicine.[66]

By definition, medicine is a substance or preparation used in treating disease.[67] Rather than providing clarity, however, this definition leads to a circular argument when considering the proper classification of medical marijuana. As currently scheduled under the CSA, marijuana is not considered medicine because it has no currently accepted medical use in treatment in the United States.[68] Proponents point to various scientific studies, however, to argue that marijuana use, if permitted, would effectively treat numerous medical conditions. As such, they contend that the categorical dismissal of marijuana's potential treatment value is inaccurate and outdated.[69] Some argue that the only impediment to marijuana's "medical use" is its inappropriate classification, and that classifying marijuana as a Schedule I controlled substance becomes a self-fulfilling prophecy.[70] As a Schedule I controlled substance, any use

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Caused by Multiple Sclerosis, 18 EUR. J. OF NEUROLOGY 1122, 1127 (2011); Mark A. Ware, M.D., M.S.C., et al., *Smoked Cannabis for Chronic Neuropathic Pain: A Randomized Controlled Trial,* 182 CAN. MED. ASS'N J. E694, E697-E699 (2010); Jeremy R. Johnson, MBChB, et al., *Multicenter, Double-blind, Randomized, Placebo-controlled, Parallel Group Study of the Efficacy, Safety, and Tolerability of THC: CBD Extract and THC Extract in Patients with Intractable Cancer-related Pain,* 39 J. PAIN SYMPTOM MGMT. 167, 176 (2009).

64. *See, e.g.,* sources cited, *supra* note 63.

65. *See, e.g.,* OFFICE OF NAT'L DRUG CONTROL POL'Y, NATIONAL DRUG CONTROL STRATEGY 201122 (2011), *available at* http://www.whitehouse.gov/sites/default/files/ondcp/ndcs2011.pdf (stating "[d]espite successful political campaigns to legalize "medical" marijuana in 15 states and the District of Columbia, the cannabis (marijuana) plant itself is not medicine.")

66. *See, e.g., Red Wine and Reservatrol: Good for Your Heart?,* MAYOCLINIC, (Mar. 4, 2011), http://www.mayoclinic.com/health/red-wine/HB00089.

67. *See* MERRIAM-WEBSTER'S DICTIONARY, *supra* note 4. *See also Definition of Medicine,* OXFORD DICTIONARIES, http://oxforddictionaries.com/definition/english/medicine (last visited Apr. 12, 2012) (defining medicine as "a drug or other preparation for the treatment or prevention of disease.").

68. 28 U.S.C.A. § 812(c)(10) (West 1990).

69. *See* Gardiner Harris, *F.D.A. Dismisses Medical Benefit From Marijuana,* N.Y. TIMES (Apr. 21, 2006), *available at* http://www.thecre.com/pdf/20060424_NewYorkTimes.Apr.21.06.pdf (discussing "a 1999 review by the Institute of Medicine, a part of the National Academy of Sciences, the nation's most prestigious scientific advisory agency. That review found marijuana to be 'moderately well suited for particular conditions . . . .'").

70. *See* PROCON.ORG, *supra* note 63.

of marijuana, medical or otherwise, is illegal.[71] This creates a classic "catch 22"—marijuana is placed on Schedule I because it has no currently accepted medical use, but the reason it has no medical use is because it is a Schedule I controlled substance.[72]

Yet marijuana's CSA classification has not prevented numerous states from enacting laws allowing marijuana use for medical purposes.[73] In many cases, the statutory language explicitly repudiates the federal view and specifically recognizes marijuana's medical efficacy, essentially determining that it is, in fact, medicine.[74] Ironically, despite the Schedule I classification, a few patients have even received marijuana for medical use from the federal government itself.[75] Despite an increase in medical studies evaluating marijuana's therapeutic value, there remains no clear consensus on its health benefits.[76] Given the complex nature of the marijuana plant and its 400 active chemical compounds, it is unlikely that conclusive studies are imminent.[77]

Currently, some marijuana derivatives are approved and in use.[78] Medical marijuana opponents contend that derivatives such as Marinol

71. *Controlled Substance Schedules,* OFFICE OF DIVERSION CONTROL, U.S. DEP'T OF JUSTICE, DRUG ENFORCEMENT ADMIN., http://www.justice.gov/dea/pubs/scheduling.html (last visited Apr. 12, 2012).

72. *See* Francie Diep, *Clearing the Smoke: Lost Chances to Study Marijuana's Potential: Marijuana Remains Tightly Controlled, Even Though Its Compounds Show Promise,* SCI. AM. MAG. (2011), *available at* http://www.scientificamerican.com/article.cfm?id=clearing-the-smoke.

73. *17 Legal Medical Marijuana States and DC: Laws, Fees, and Possession Limits,* PROCON.ORG, http://medicalmarijuana.procon.org/view.resource.php?resourceID=000881 (last visited Apr. 12, 2012). These states include: Alaska, Arizona, California, Colorado, Connecticut, Delaware, Hawaii, Maine, Michigan, Montana, Nevada, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, and Washington, as well as the District of Columbia. *Id.*

74. *See, e.g.*, MICH. COMP. LAWS ANN. § 333.26422.

75. Moira Gibbons, *The Cannabis Conundrum: Medication v. Regulation,* 24 THE HEALTH LAWYER, 2, 5-6, n. 48 (2011) (citing NAT'L. INST. ON DRUG ABUSE, *Drug Facts Chat Day 2009 – The Transcript,* http://drugfactsweek.drugabuse.gov/chat/2009/index.php (accessed Aug. 27, 2012)).

76. *See, e.g.*, Giovanni Frazzetto, *Does Marijuana Have a Future in Pharmacopoeia?,* PUBMED.ORG, www.ncbi.nih.gov/pmc/articles/PMC1326332 (last visited Apr. 10, 2012); *see also* PROCON.ORG, *supra* note 63. *See also* Kevin A. Sabet, Ph.D., *Clearing the Smoke on Medical Marijuana Part II,* NATIONAL RX DRUG ABUSE SUMMIT (Feb. 17, 2012), http://www.drugfree.org/join-together/drugs/clearing-the-smoke-on-medical-marijuana-part-ii.

77. Brian Vastag, *Medical Marijuana Center Opens Doors,* 290 J. AM. MED. ASS'N 877, 879 (2003), *available at* http://www.maps.org/mmj/jama8.20.03.pdf.

78. *See Pharmaceutical Drugs Based on Cannabis,* PROCON.ORG, http://medicalmarijuana.procon.org/view.resource.php?resourceID=000883#copy, (last visited Apr. 10, 2012) (listing drugs using marijuana or marijuana synthetics). *See also* Sabet, *supra* note 76.

and Sativex should suffice to address the medical marijuana patient's needs. The crux of the medical marijuana debate, however, centers on using the plant itself as a prescription drug or medicine.[79]

Marijuana, in its organic state, has varying effects that may depend on its particular strain, maturity, and other broad-ranging variables.[80] Medical marijuana proponents content that marijuana's therapeutic benefit can, in many cases, only be achieved through its use in plant form and similar results are impossible with synthetic marijuana derivatives. The marijuana plant's extensive variability presents challenges to obtaining consistent and reproducible scientific test results this may cause, marijuana research has been clouded by sociological and political factors typically absent from other drug research.[81] Given such factors, although the degree of tolerance for marijuana use may be increasing,[82] it appears likely that marijuana, in its plant form, will remain a Schedule I controlled substance for the foreseeable future.[83]

D. Significance to the Medicine Distinction?

Whether marijuana is medicine, or should be rescheduled, is more than just a semantic argument or philosophical debate. As noted, under current scheduling, physicians cannot prescribe marijuana in its plant form.[84] Transferring marijuana to a less restrictive CSA schedule would provide more than simply a moral victory for proponents or official recognition of potential medical benefits.[85] Proponents argue that rescheduling marijuana would allow physicians to prescribe it just as

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79. *See, e.g., "Medical" Marijuana-The Facts*, DEA, http://www.justice.gov/dea/ongoing/marinol.html (last visited Apr. 10, 2012).

80. Marta Di Forti, M.D., et al., *High-Potency Cannabis and the Risk of Psychosis*, 195 (6) BRIT. J. PSYCHIATRY 488 (2009).

81. Donald I. Abrams, *Medical Marijuana: Tribulations and Trials*, J. OF PSYCHOACTIVE DRUGS, 163 (1998).

82. Frank Newport, *Record-High 50% of Americans Favor Legalizing Marijuana Use*, GALLUP.COM (2001), http://www.gallup.com/poll/150149/record-high-americans-favor-legalizing-marijuana.aspx (last visited Apr. 10, 2012). *See also Illegal Drugs*, POLLINGREPORT.COM, http://www.pollingreport.com/drugs.htm (last visited Apr. 10, 2012).

83. *The DEA Position on Marijuana*, DEA, (Jan. 2011) http://www.justice.gov/dea/marijuana_position.pdf (last visited Apr. 10, 2012).

84. *See AMA Policy: Medical Marijuana*, *supra* note 62.

85. *See* Michael Cooper, *2 Governors Asking U.S. to Ease Rules on Marijuana to Allow for its Medical Use*, N.Y. TIMES (Nov. 30, 2011), *available at* http://www.nytimes.com/2011/12/01/us/federal-marijuana-classification-should-change-gregoire-and-chafee-say.html.

other prescription drugs.[86] The ability to "prescribe" marijuana is controversial and would depend greatly upon which schedule it was placed.[87] Simply reclassifying marijuana from Schedule I to Schedule II may not achieve the goals currently sought by rescheduling advocates.[88]

Even if one assumes that rescheduling marijuana in its plant form would remove impediments to its prescription, both advocates and opponents should heed the adage, "[b]e careful what you wish, for you may receive it."[89] Official recognition of marijuana's medicinal value may remove current stigma and increase a physician's willingness to consider its therapeutic benefits. The stronger the push for its inclusion as a prescription drug, however, the weaker the argument becomes that marijuana merits a special place or treatment among other prescription medications.

Although recognition as medicine may be the goal, current economic and distribution models do not treat marijuana like prescription medicine. Under most medical marijuana laws, patients obtain marijuana by growing it themselves or obtaining it from designated caregivers or private dispensaries.[90] While some dispensaries may require state certification, they do not, and cannot, require a physician's marijuana prescription.[91] Similarly, no statutes require that caregivers or dispensary workers are licensed pharmacists.[92] If reclassified as a prescription drug, marijuana would arguably be subject to the same restrictions imposed on other prescription medications—unavailable without a physician prescription and obtained only through a state-licensed pharmacy.[93]

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86. *Id. See* Jonathan Benson, *Groups Push Obama Administration to Reschedule Marijuana*, NATURALNEWS.COM, (May 28, 2011), http://www.naturalnews.com/032546_marijuana_Obama.html (last visited Apr. 11, 2012).

87. *List of Controlled Substances*, DEA, (last visited Apr. 11, 2012), http://www.deadiversion.usdoj.gov/ schedules/index.html; *see also* 28 U.S.C.A. § 829 (West 2009).

88. *See* 28 U.S.C.A. § 829. *See also* Sabet, *supra* note 76.

89. W.W. JACOBS, THE LADY OF THE BARGE AND OTHER STORIES (Harper & Brothers Publishing, 6th ed. 1906). This well-known maxim has not been attributed to any one author. The quote made an appearance in the forward to the W.W. Jacobs short story, "The Monkey's Paw," which was first published in 1902. *Id.* The story revolves around a monkey's paw, which operates as a talisman that grants the person who possesses it three wishes. *Id.* These wishes at an enormous price, however, because the wishes interfere with fate. *Id.*

90. *See* PROCON.ORG, *supra* note 73.

91. *Id.*

92. *Id.*

93. *See* Kevin Sabet, *Much Ado About Nothing: Why Rescheduling Won't Solve Advocates' Medical Marijuana Problem*, 58 WAYNE L. REV. (forthcoming 2012). *See also* DENIAL OF PETITION; NOTICE, 66 FED. REG. 20,037 (Apr. 18, 2001) (DEA denial of a

Even if categorized as an "over the counter" medicine, marijuana presumably would be as carefully regulated and licensed as other such drugs.[94] Individuals would be no more able to manufacture and distribute "marijuana medicine" than homemade aspirin. In seeking reclassification to a different CSA schedule, proponents often blur the distinction between legalization and proposed "medicalization," and fail to recognize or appreciate the consequences of the boundary that exists between the two.[95]

Conversely, opponents of marijuana's rescheduling must accept, or at least acknowledge, current reality, and strongly consider what goals they hope to achieve by maintaining marijuana's current Schedule I status. Despite harsh criminal penalties and the decades long "war on drugs," marijuana use remains prevalent.[96] The Drug Policy Alliance has stated that 42% of American adults admit to having used marijuana.[97] Even if one assumes that such statistics are skewed by including past but not current use, or fail to consider potential decreased use among older people, it is naive to suggest that simply maintaining current policies will eliminate marijuana use.[98] If anything, the trend is toward greater tolerance, if not acceptance.[99] With medical marijuana use permitted in over a quarter of American states,[100] and with another seventeen considering similar legislation,[101] it is conceivable that a majority of states could allow medical marijuana use by the end of this decade.

Ignoring these factors and maintaining the status quo may have unintended effects. The current approach fails to address, much less change, the present system of illegal or quasi-underground distribution. Allowing marijuana to become prescription medication would arguably

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petition to reschedule marijuana) http://www.gpo.gov/fdsys/pkg/FR-2001-04-18/html/01-9306.htm (last visited Apr. 12, 2012).

94. *See* Sabet, *supra* note 93.

95. The Wayne Law Review, *2012 Wayne Law Review Symposium (Part 3)*, YOUTUBE (Mar. 12, 2012), http://www.youtube.com/watch?v=Hmd2VmiUbYQ.

96. *See Research Report Series: Marijuana Abuse*, NAT'L INST. ON DRUG ABUSE, 2 (2010), http://www.drugabuse.gov/publications/research-reports/marijuana-abuse (last visited Apr. 11, 2012).

97. *See Marijuana Facts*, DRUG POLICY ALLIANCE, http://www.drugpolicy.org/facts/drug-facts/marijuana-facts (last visited Apr. 11, 2012).

98. *See* Jerald G. Bachman, et al., *Explaining the Recent Decline in Marijuana Use: Differentiating the Effects of Perceived Risks, Disapproval, and General Lifestyle Factors*, 29 J. HEALTH & HUMAN BEHAVIOR 92 (1998).

99. *See id.*

100. *See* PROCON.ORG, *supra* note 73.

101. *See 18 States with Pending Legislation to Legalize Medical Marijuana*, PROCON.ORG, http://medicalmarijuana.procon.org/view.resources.php?resoucreID=002481 (last visited Apr. 11, 2012).

ensure regulation with associated monitoring and imposition of safety and purity standards. While estimates range widely about associated revenue and cost savings,[102] there is no question that allowing "prescription" marijuana would substantially alter the current "state models involving loosely regulated and monitored marijuana distribution."[103]

III. MICHIGAN MEDICAL MARIHUANA ACT (MMMA)

Because the provisions of the individual states' medical marijuana laws differ considerably, an exhaustive comparison of the individual statutes is beyond the scope of this Article. Despite this, the following analysis of the provisions of the Michigan Medical Marihuana Act (MMMA),[104] illustrates the issues which potentially face all healthcare providers and, ultimately, the healthcare community. To some extent, the issues presented by the Michigan statute apply to physicians and healthcare providers attempting compliance with medical marijuana laws throughout the country.

A. Protections Are Limited

The MMMA provides certain, specific protections to physicians who comply with the statute.[105] Although at first blush the protections afforded physicians in Michigan appear broad and all-encompassing,

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102. *See* Jeffrey A. Miron, *The Budgetary Implications of Marijuana Prohibition,* PROHIBITIONCOSTS.ORG (2005) http://prohibitioncosts.org/mironreports.pdf.

103. *Id.*

104. MICH. COMP. LAWS ANN. §§ 333.26421-30 (West 2008).

105. The Michigan statute provides that:

> A physician shall not be subject to arrest, prosecution or penalty in any manner, or denied any right or privilege, including but not limited to civil penalty or disciplinary action by the Michigan board of medicine, the Michigan board of osteopathic medicine and surgery, or any other business or occupational or professional licensing board or bureau, solely for providing written certifications, in the course of a bona fide physician-patient relationship and after the physician has completed a full assessment of the qualifying patient's medical history, or for otherwise stating that, in the physician's professional opinion, a patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the patient serious or debilitating medical condition or symptoms associated with the serious or debilitating medical condition, provided that nothing shall prevent a professional licensing board for sanctioning a physician for failing to properly evaluate a patient's medical condition or otherwise violating the standard of care for evaluating medical conditions.

MICH. COMP. LAWS ANN. § 333.26424(f) (West 2008).

these protections are only available if the physician's actions do not exceed the scope of practice permitted under the statute.[106] Michigan municipalities, law enforcement agencies, and prosecutors, have urged that the MMMA's statutory protections be narrowly construed.[107]

The trend of recent court decisions has adopted this view.[108] Some recent state and federal court decisions interpreting the statute have limited the scope of the MMMA's protections in employment law, business development, and criminal prosecutions.[109] Other cases have shown the MMMA, if strictly complied with, may provide properly certified citizens with protection from criminal charges and alleged zoning violations.[110] While the extent of protections afforded physicians under the statute has not yet been tested, one can reasonably assume that physicians and health care practitioners will be held to the same strict compliance standards.[111]

Despite popular misperception, the MMMA does not legalize marijuana use, cultivation and distribution.[112] Similarly, the MMMA does not create an unqualified right to use marijuana or an unequivocally

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106. *Id.*

107. *See* Medical Marihuana Act, Prohibits the Collective Growing or Sharing of Marihuana Plants, 2011 MICH. ATT'Y GEN. OP. NO.7259 (2011). *See also* Return of Marihuana to Patient or Caregiver upon Release from Custody, 2011 MICH. ATT'Y GEN. OP. NO.7262 (2011).

108. *See, e.g.,* People v. Redden, 799 N.W.2d 184 (Mich. Ct. App. 2010). *See also* People v. King, 804 N.W.2d 911 (Mich. Ct. App. 2011), *rev'd*, People v. Kolanek, 491 Mich. 382 (2012).

109. *See* People v. Hinzman, Nos. 308909 and 308910, 2012 WL 3023825 (Mich. Ct. App. July 24, 2012); People v. Kolanek, 804 N.W.2d 870 (Mich. Ct. App. 2011), *aff'd in part, rev'd in part*; 491 Mich. 382 (2012). People v. Anderson, 809 N.W.2d 176 (Mich. Ct. App. 2011), *vacated*, 817 N.W.2d 95 (Mich. 2012) (mem.); State v. McQueen, 811 N.W.2d 513 (Mich. Ct. App. 2011), *appeal granted*, 491 Mich. 890 (2012).

110. *See* People v. Kolanek, 817 N.W.2d 528 (2012) (holding that a criminal defendant may assert their status as a certified medical marijuana patient as provided in section 8, but is not required to meet all of the requirements set forth in section 4. However, proper and timely physician certification is the foundation of a section 8 affirmative defense); *See also* TerBeek v. City of Wyoming, No. 306240 (Mich. Ct. App., July 31, 2012) (holding that a city ordinance banning the cultivation of marijuana within the city limits was preempted by the MMMA); People v. Walburg, No. 295497, 2011 WL 475197 (Mich. Ct. App. Feb. 10, 2011).

111. *See* MICH. BD. OF MED. & BD. OF OSTEOPATHIC MED. & SURGERY, *Statement of the Board of Medicine and Board of Osteopathic Medicine and Surgery Regarding Certification for Medical Use of Marihuana by Michigan Physicians* (2012), *available at* http://www.michigan.gov/lara/0,4601,7-154-35299_28150_51869_60732---,00.html.

112. *See McQueen*, 293 Mich. App. 644.

113. Casias v. Wal-mart Stores, Inc., No. 11-1227, 2012 WL 4096153 (6th Cir. Sept. 19, 2012).

protected class of patients.[113] Apart from federal proscription, states have enacted statutory bans prohibiting marijuana use.[114] Laws prohibiting marijuana use, cultivation and distribution remain in effect and actively enforced.[115] Under current analysis, strict statutory compliance, at best, protects individuals from prosecution for what has been, and still is, an illegal activity.

B. Who Is Protected?

Before describing Michigan's statutory certification process and the resulting issues facing the health care community, it is important to understand who qualifies for the healthcare provider protections. Currently, those protections only explicitly apply to physicians as defined under Michigan's Public Health Code.[116] The MMMA contains no similar protections for others providing healthcare, including physicians' assistants, nurses, podiatrists, or other members of the healthcare community.[117]

A broader protection to those individuals may be implied, however, under other sections of the Act.[118] Under specific circumstances, protections may extend to not just physicians, but any "person" who assists a patient with medical marijuana use. Under the Act, medical use is not limited solely to marijuana ingestion, but includes numerous activities associated with use including delivery, transfer or transportation.[119] Although, taken together, such provisions could imply an extension of statutory protection to other health care providers currently, only physicians are explicitly covered.[120]

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114. *See, e.g.*, MICH. COMP. LAWS ANN. § 333.7403 (West 2010).

115. *See* People v. Orlando, No. 303644, 2012 WL 933978 (Mich. Ct. App. Mar. 20, 2012); People v. Vanderbutts, No. 299347, 2011 WL 6186831 (Mich. Ct. App. Nov. 8, 2011); People v. Danto, Nos. 303525, 302991, 303064, 302986, 2011 WL 5374778 (Mich. Ct. App. Nov. 8, 2011).

116. MICH. COMP. LAWS ANN. §§ 333.17001-84 (West 2006) (individuals licensed as allopathic physicians); MICH. COMP. LAWS ANN. §§ 333.17501-56 (West 2006) (individuals licensed as osteopathic physicians).

117. MICH. COMP. LAWS ANN. § 333.17062 (West 1986).

118. MICH. COMP. LAWS ANN. § 333.26424(i) (West 2008) (providing various protections for "a person . . . solely for being in the presence or vicinity of the medical use of marihuana . . . or for assisting a registered qualifying patient with using or administering marihuana.").

119. MICH. COMP. LAWS ANN. §333.26428(3) (West 2008).

120. MICH. COMP. LAWS ANN. § 333.26424.

C. Physician Participation Is a Required Element

Although a physician cannot prescribe marijuana, physician participation is an essential first step in the certification process. A physician evaluation is required to obtain a registry identification card permitting medical marijuana use.[121] Essentially, the physician's role in this process is similar to that in other fields of medical practice.[122] In evaluating patients, certifying physicians engage in functions traditionally associated with medical care: examining patients and diagnosing their medical condition.[123]

The statutory design was perhaps intended to insulate a physician from participation in marijuana-related activities prohibited by the CSA or related statutes.[124] Under the MMMA, a physician cannot require, or even recommend, that the patient use marijuana.[125] A valid patient registry identification application must include a written certification, signed by the physician, describing the patient's debilitating medical condition and stating "in the physician's professional opinion, the patient is likely to receive therapeutic or palliative benefit from the medical use of marihuana to treat or alleviate the patient's debilitating medical condition or symptoms associated with the debilitating medical condition."[126] Thus, under the MMMA, the physician's role is simply to assess whether the patient's condition may benefit from marijuana use.[127] Physician participation is voluntary. The MMMA does not require a doctor to participate in the certification process, nor does the MMMA create a patient right to compel in any specific medical circumstances.

The MMMA designates various specific medical conditions which are considered to be debilitating.[128] In addition to the individual conditions listed, the Act further extends the definition to include essentially any chronic or debilitating disease or medical condition that produces a variety of medical complaints, including severe and chronic pain and severe nausea.[129] The Michigan Department of Community Health has indicated that chronic pain and severe nausea are the two most common conditions set forth in registry identification card

121. MICH. COMP. LAWS ANN. § 333.26426 (West 2008).
122. MICH. COMP. LAWS ANN. § 333.26423(l) (West 2008).
123. MICH. COMP. LAWS ANN. §333.26424(f).
124. MICH. COMP. LAWS ANN. § 333.26423(l).
125. *Id.*
126. *Id.*
126. *Id.*
127. *Id.*
128. MICH. COMP. LAWS ANN. § 333.26423(a)(1)-(3).
129. *Id.*

applications.[130] Under its present construction, the MMMA does not require the certified patient's medical condition to be "currently" debilitating.[131] For example, cancer patients who are in remission may still qualify for medical marijuana use. Under the most liberal construction, patients with a chronic disease that produces one of the designated complications could qualify even if that disease was asymptomatic, provided the disease was potentially debilitating in the future.

D. The Quandary of Marijuana as Medicine

Characterizing cannabis as "medical" marijuana, however, presents challenges to the medical practitioner. The MMMA and similar statutes require a physician to evaluate "medicine" that is illegal, and attest to the medical efficacy of a drug that, by definition, has no currently accepted medical use.[132] As discussed above, a physician does not, and legally cannot, prescribe medical marijuana.[133] In this respect, marijuana's place in a physician's arsenal of medicine is certainly unique. Currently, medical marijuana is one of the few, if not only, "medicines" a physician does not recommend a dose. Under the MMMA, a physician does not direct a patient on how to use it, when to take it, how often to use it, and how much to take.[134] A physician cannot legally provide marijuana in any form,[135] and there is no legal requirement for a physician to even

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130. *See also* Dawson Bell & John Wisely, DETROIT FREE PRESS, *Med Pot Prescribed Mostly for Aches, Pains* (Apr. 21, 2011) *available at* http://www.freep.com/article/20110421/NEWS15/104210430/Medical-pot-prescribed-mostly-aches-pains.

131. MICH. COMP. LAWS ANN. § 333.26423.

132. *See* SLOMAN, *supra* note 1 and accompanying text.

132. *See, e.g.*, Conant v. Walters, 309 F.3d 629, 632 (9th Cir. 2002) (noting that federal policy declares that a doctor's "action of recommending or prescribing Schedule I controlled substances is not consistent with the 'public interest' (as that phrase is used in the federal Controlled Substances Act)" and that such action would lead to revocation of the physician's registration to prescribe controlled substances).

133. *See* MICH. COMP. LAWS ANN. § 333.26423(l). Although physicians may not be required to direct certified patients on how to use and take marijuana and in what amount and how often that amount is to be taken, a physician's failure to do so can be detrimental to a certified patient in criminal court. *See* People v. Hinzman, Nos. 308909, 308910, at *3 (Mich. Ct. App. July 24, 2012). In *Hinzman*, the failure of the certifying physician to instruct the certified patient was viewed by the Michigan Court of Appeals to suggest the certified patient was not using marijuana for medicinal purposes and therefore allowing the certified patient's criminal conviction to be upheld on appeal. *Id.*

134. *See supra* Part II (discussing inability of physicians to prescribe Schedule I substances).

instruct a patient how to obtain it.[136] In essence, once the physician determines marijuana may help address the patient's health problem, the patient is left to obtain, dose and monitor marijuana use at their own discretion and largely without physician supervision.[137]

Similar problems arise in physician assessment of the efficacy of the patient's medical marijuana treatment. Commonly, physicians determine a patient's response to medication through objective tests that measure vital signs, laboratory values, or other reproducible parameters.[138] With medical marijuana, such uniform standards for assessment may not even be available, much less required. Currently, marijuana is recommended for a wide variety of largely unrelated medical conditions.[139] As noted, physicians are granted wide latitude in determining the signs, symptoms and conditions for which medical marijuana may be effective.[140] Given the broad spectrum of conditions for which medical marijuana can be recommended, clinical research and peer review studies have not kept pace with current treatment.

Without scientific support or uniform standards,[141] a physician is often left to determine the efficacy of treatment based primarily on the patient's subjective feedback.[142] This aspect alone does not render the

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135. *See* MICH. COMP. LAWS ANN. § 333.26423(l). *See also* Larry Gabriel, *"The Hold-Up on Cards," Higher Ground*, METRO TIMES, 80 (Feb. 8-14, 2012). Rae Ramsdell, the manager of Michigan's Medical Marijuana Program through the state's Department of Licensing and Regulatory Affairs (LARA), was asked by members of a Michigan House of Representatives Committee where certified medical marijuana patients were to obtain their medical marijuana once marijuana dispensaries were closed. *Id.* Her initial response was that certified patients could get their marijuana at either local high schools or universities, and when confronted later regarding her answer, she replied that since the law did not say where a certified patient could obtain medical marijuana, she did not know. *Id.*

137. MICH. COMP. LAWS ANN. § 333.26428.

137. *See, e.g., Medication Therapy Management*, AM. PHARMS. ASS'N (2012), http://www.pharmacist.com/medication-therapy-management-services.

139. *See Marijuana Policy Project*, MEDICAL MARIJUANA RESEARCH, http://www.mpp.org/assets/pdfs/library/MedConditionsHandout.pdf (last visited Apr. 12, 2012).

139. *See, e.g.*, Jonathan Martin, *No Medical Records? No problem. Got my pot card at Hempfest*, SEATTLE TIMES, Aug. 21, 2011, *available at* http://seattletimes.com/html/localnews/2015969811_marijuana21m.html.

140. *See generally* Daniel Mortensen, *California and Uncle Sam's Tug-of-War over Mary Jane Is Really Harshing the Mellow*, 30 J. NAT'L ASS'N ADMIN. L. JUDICIARY 127, 151-52 (2010) (describing medical marijuana regulation in California as "a mess," and stating the "regulatory void" has resulted in "self-interested California doctors with financial incentives to give out as many [marijuana] 'recommendations' as possible").

141. *See* COUNCIL ON SCI. & PUB. HEALTH, AM. MED. ASS'N, REPORT 3: USE OF CANNABIS FOR MEDICINAL PURPOSES (RESOLUTIONS 910 AND 921, I-08; AND 229, A-09), at 201, *available at* http://www.ama-assn.org/resources/doc/hod/i-09-csaph-reports.pdf

physician's evaluation or treatment improper. Patient assessment is made more challenging under the MMMA because the patient is not required to continue physician care for follow-up assessments.[143] In fact, the only "required" reassessment set forth in the statute is that a patient who wishes to renew their certification card must return for a physician certification on an annual basis.[144]

E. The Mysterious "Bona Fide Physician-Patient Relationship"

A physician issuing written certifications can invoke the MMMA's protections against criminal prosecution and professional sanctions only if that physician is providing such care "in the course of a bona-fide physician-patient relationship."[145] The statute, however, does not expressly define the extent and parameters of this relationship.[146]

The elements constituting a "bona-fide" physician-patient relationship for medical practitioners were never codified or established in any court holding before the MMMA's passage.[147] The statutory parameters are not amenable to clear delineation in part due to the diverse scope of various physician practices. Certainly, a "bona-fide" relationship between a patient and a pediatrician, family practitioner, or gynecologist differs significantly from a patient's relationship with an emergency physician, radiologist, or pathologist. Depending on the medical specialty, prior treatment, record review and a physical examination may not be required to establish a legal duty or physician-patient relationship.[148]

(calling for "further adequate and well-controlled studies of marijuana" and declaring the "AMA believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives").

143. MICH. COMP. LAWS ANN. § 333.26428.

144. MICH. COMP. LAWS ANN. § 333.26423.

145. MICH. COMP. LAWS ANN. §333.26428.

146. MICH. COMP. LAWS ANN. §333.26424(f).

147. *See Kolanek*, 491 Mich. at 393-400; *see also* 17 MICH. CIV. JUR. *Medicine and Surgery* § 129 (2012) (noting legal standards differ between specialty physicians and general practitioners) (citing Swanek v. Hutzel Hosp., 320 N.W.2d 234 (Mich. Ct. App. 1982) and McCullough v. Hutzel Hospital, 276 N.W.2d 569 (Mich. Ct. App. 1979)).

148. In *People v. Kolanek*, Justice Mary Beth Kelly, writing the opinion for the Michigan Supreme Court, cited to the joint statement issued by the Michigan Board of Medicine and Michigan Board of Osteopathic Medicine and Surgery, which states that the term "bona fide physician-patient relationship" in the context of the MMMA is a "pre-existing, ongoing relationship with the patient as a treating physician." *Kolanek*, 491 Mich. at 396 n.30. Although dicta, Justice Kelly's reference to the statement in a published and binding court decision makes it likely that future cases may use the statement and its guidelines to determine whether a physician has properly certified medical marijuana patients.

In the context of the MMMA, however, uncertainty regarding what constitutes a bona-fide physician-patient relationship has led to physician assessments which certainly extend the notion of traditional medical care. In the wake of the MMMA's passage, Michigan saw the rapid growth of "certification clinics"—centers advertising quick, convenient certifications and competitive pricing.[149] Critics argue such clinics, often connected to dispensaries or other marijuana-related businesses, are thinly veiled certification "assembly lines" which violate the presumed intent of the certification process.[150]

In an effort to address this issue, the Michigan Legislature has introduced proposed legislation that seeks, in part, to define parameters of a "bona-fide physician-patient relationship."[151] Although these specific parameters vary, to establish a bona fide relationship, the proposed bills would require a physician to take a patient's medical history, perform a physical examination, review prior treatment, create and maintain patient records, and provide follow-up assessments to monitor treatment efficacy.[152]

F. What Constitutes a "Full-Assessment?"

Despite the ambiguity surrounding the parameters of a "bona-fide physician-patient relationship," the MMMA sets forth minimum evaluation requirements.[153] In order to enjoy the statutory protections, physicians must provide a "full assessment" of the qualifying patient's medical history.[154] Although the MMMA suggests that the patient's medical history be evaluated,[155] physicians are not currently required to review, or even obtain, any of the patient's prior medical records.[156] How this "full assessment" is undertaken remains undefined within the statute

149. Kris Turner, *State Medical Marijuana Law Creates Haze of Ambiguity for Medical Community, Spurs Growth of Certification Clinics*, THE FLINT JOURNAL (Oct. 30, 2011), *available at* http://www.mlive.com/news/flint/index.ssf/2011/10/state_medical_marijuana_law_cr.html.

150. *See* Brandon Howell, *Lansing, Jackson Medical Marijuana Clinics Raided for Alleged Illegal Distribution,* MLIVE.COM, http://www.mlive.com/lansing-news/index.ssf/2011/09/lansing_jackson_medical_mariju.html (last visited Apr. 12, 2012).

151. H.B. 4851, 96th Leg. Reg. Sess. (Mich. 2011); S.B. 0506, 96th Leg. Reg. Sess. (Mich. 2011).

152. *Id.*

153. MICH. COMP. LAWS ANN. § 333.24624(f).

154. *Id.*

154. *See* MICH. COMP. LAWS ANN. § 333.26423(l).

155. *See id.*

and in the medical community as a whole,[157] and appears largely within the physician's discretion. Unlike more traditional approaches which entail a physical examination before arriving at a diagnosis,[158] it appears the physician is entitled to reach his medical conclusions based on the patient's medical history alone.[159]

Arguably, even a full assessment of the patient's history may not be a prerequisite to providing written patient certifications. The physician is not subject to arrest, prosecution or other penalties solely for providing written certifications after completing a full assessment of history "or" for "otherwise stating" in the physician's professional opinion, a patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana.[160] Without further legislative or judicial guidance, a physician could arguably qualify for the statutory protections without even seeing the patient.[161]

Such a broad interpretation is currently subject to close scrutiny. In one case, the Michigan Attorney General and the Department of Licensing and Regulatory Affairs (LARA) filed an administrative complaint and ordered a summary suspension of a Michigan physician's medical license, alleging the physician issued improper certifications based on insufficient examinations.[162] The physician allegedly issued pre-signed medical marijuana physicians certificates, which were then sold for cash from an appliance store which was advertised as the location for a so-called "safe access clinic."[163]

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156. In Michigan, a bona-fide relationship and proper examination were described and detailed by the State's Department of Licensing and Regulatory Affairs' (LARA) Bureau of Health Professions (BHP) in a letter sent to licensed Michigan physicians. Letter from Michigan Department of Licensing and Regulatory Affairs, Bureau of Health Professionals (Jan. 13, 2012), *available at* http://www.michigan.gov/documents/lara/lara_Medical_Marihuana_Final_Written_Certification_Statement_8-15-11_376283_7.pdf. The letter included the assessment of the Board of Medicine and Board of Osteopathic Medicine and Surgery on the appropriate physician-patient relationship required by the MMMA and an appropriate examination's contents. *Id.*

157. MICH. COMP. LAWS ANN. §§ 333.26421-30.

158. *See* MICH. COMP. LAWS ANN. § 333.26423(l).

160. *Id.*

161. *Id.*

162. *See* Press Release, State of Mich., Att'y Gen. Bill Schuette, Schuette, Hilfinger Announce Summary Suspension of Medical License for Doctor Who Allegedly Sold Medical Marijuana Certificates for Cash. Press (May 24, 2011) *available at* http://www.michigan.gov/ag/0,4534,7-164-46849_47203-256732--,00.html. *See also* LARA, *supra note* 156.

163. *See* Schuette, *supra* note 162. *See also* Kirk Pinho, *Lawmakers Call for Sweeping Changes in State's Existing Law*, SPINAL COLUMN NEWSWEEKLY, July 6, 2011, *available at* http://spinalcolumnonline.com/lawmakers-call-for-sweeping-changes-in-states-

Although certifications may require no more than a physician's opinion, the basis for that opinion may be challenged, particularly if the opinion is not supported by records or other documentation.[164] The MMMA specifically declares that modern medical research has discovered beneficial uses for marijuana in treating or alleviating pain, nausea, and other symptoms associated with a variety of debilitating medical conditions.[165] Research and clinical trials regarding marijuana's efficacy in treating specific conditions are currently ongoing.[166] There is little scientific consensus, however, regarding its "therapeutic or palliative benefit" for treatment of any one specific medical condition.[167] Although research is promising in some areas,[168] physicians must be cautious when rendering general pronouncements regarding marijuana's overall medical efficacy, particularly if those opinions are the basis for a written certification.[169]

G. What Makes an Evaluation Proper?

Despite the protections afforded under the Michigan statute, a physician does not enjoy total immunity from prosecution, disciplinary action or other sanctions under the MMMA. The statute explicitly states that a professional licensing board retains the ability to sanction "a physician for failing to properly evaluate a patient's medical condition or otherwise violating the standard of care for evaluating medical conditions."[170] The scope of what constitutes a "proper evaluation" is likely to be the subject of debate for years to come and may have a chilling effect on a physician's willingness to engage in the certification process. Without defined guidelines or minimum standards setting forth

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existing-law/ (reporting that the proposed bills "would require 'traditional doctor-patient relationships' in an effort to curb a practice in which some doctors certify patients for the drug without seeing the patient or knowing the patient's medical history").

163. *See, e.g., Hinzman*, Nos. 308909 and 308910. *See also, Kolanek*, 491 Mich. 390-93 (2012).

164. MICH. COMP. LAWS ANN. § 333.26422(a).

165. *See, e.g.,* David Baker, et al., *The Therapeutic Potential of Cannabis*, LANCET NEUROLOGY 291 (2003); *see also* Gareth Pryce & David Baker, *Emerging Properties of Cannabinoid Medicines in Management of Multiple Sclerosis*, TRENDS NEUROSCIENCES 272 (2005).

166. *See* DEA, *supra*, note 83.

167. *See* PROCON.ORG, *supra* note 63.

169. One of the main ethical responsibilities a physician has is to "do no harm." *See* The Hippocratic Oath. With the knowledge that smoking is harmful, it is ironic for a physician to now determine that smoking marijuana may produce a therapeutic or palliative effect despite the harm smoking a substance presents to the patient.

170. MICH. COMP. LAWS ANN. § 333.26424(f).

the elements of a "proper" evaluation, a physician may be at the mercy of a retrospective, third-party analysis evaluating their statutory compliance and, by extension, their professional conduct.

While this vulnerability can be partly accredited to the nature of practicing in any emerging medical field, it highlights the perils faced by a physician who wishes to participate in the medical marijuana arena. Physicians may find statutory compliance difficult since the elements of a "proper" evaluation may vary widely given the physician's medical specialty and the nature of the medical practice.[171] For example, the nature and extent of a "proper" neurologic evaluation may be vastly different depending on whether that examination is performed by an emergency physician, an internist, or a neurologist.[172] The extent of a "proper" evaluation must, by necessity, also depend on the patient's medical condition and complaints. Under the MMMA, a physician may determine that marijuana may provide a therapeutic benefit for a widely disparate number of medical conditions.[173] Presumably, the elements of a proper evaluation of the potential benefits of marijuana use for a patient with Crohn's disease or multiple sclerosis would differ significantly than those for a patient with chronic pain. While some of the debilitating medical conditions enumerated in the statute may be amenable to confirmation through diagnostic testing, other diagnoses may depend solely on a patient's subjective complaints.[174]

H. Standard of Care for Whom?

Although determining what may constitute a "proper" evaluation may prove challenging, determining what actions constitute "otherwise violating the standard of care for evaluating medical conditions" could prove even more difficult. Under Michigan law, the concept of the "standard of care" is most commonly invoked in civil medical malpractice cases.[175] The Michigan jury instructions define "professional

171. *See*, Daniel Shirey, *Physician Licensing: Beware of Increased Scrutiny*, Kitch Drutchas Valutti & Sherbrook (forthcoming 2012), *http://www.kitch.com/news/updates/*.

172. MICH. COMP. LAWS ANN. 333.26423(a)(1).

173. *Id. See also Lee Banville, States, Communities Struggling With Medical Marijuana Regulations*, PBS ONLINE NEWSHOUR (June 28, 2010, 8:08 p.m.) http://www.pbs.org/newshour/rundown/2010/06/states-communities-struggling-with-medical-marijuana-regulations.html.

174. *See* MICH. COMP. LAWS ANN. § 600.2912a(1) (West 2010).

175. *See, e.g.*, MICH. CIV. JI. 30.01; McDougall v. Schanz, 597 N.W.2d 148, 175 (Mich. 1999) (Cavanagh, J., dissenting) (observing that "[c]learly, different types of experts and different standards of care" are applicable in a surgical malpractice case versus a failure-to-diagnose case).

negligence" or "malpractice" as the failure to do something which a medical professional of ordinary learning, judgment or skill would do under the same or similar circumstances involved in the individual lawsuit.[176] This standard of care must be established by medical experts whose qualifications are strictly delineated.[177] In order to qualify as an expert in such a case, the proposed expert must be board certified in the same or similar specialty as the accused practitioner, and share the same board certification, if that practitioner is board certified.[178]

Applying such concepts to evaluate a physician's treatment under the MMMA, poses difficult issues. The MMMA allows any licensed doctor of medicine or osteopathy to provide written certifications, regardless of that practitioner's specialty.[179] There is no recognized medical specialty, and certainly no board certification for, a "medical marijuanaist."[180] As such, it becomes difficult to determine not only who would qualify as a standard of care expert, but, more fundamentally, how the "standard of care" is determined. It remains unsettled whether the standard of care is uniform among all physicians issuing certifications, or whether the standard of care differs according to the individual physician's medical specialty.[181] Generally speaking, the standard of care is commonly thought of as the action taken by a reasonable physician under similar circumstances.[182] Given the threat of physician sanctions[183] and uncertainty present in the MMMA,[184] the physicians' "standard of care" may become refraining from providing medical marijuana certifications at all.

I. The Spectre of Sanctions

Presumably in response to the ambiguities facing healthcare professionals, both the Michigan legislature and regulatory agencies have taken steps to help clarify the MMMA provisions.[185] Although these measures may help resolve some problems the MMMA presents, they may cause new ones.

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176. MICH. CIV. JI. 30.01.

177. *See, e.g.*, MICH. R. EVID. 702. *See also* MICH. COMP. LAWS ANN. § 600.2912a; Dawe v. Bar-Levav & Assoc. 808 N.W.2d 240, 260 (Mich. Ct. App. 2010).

178. MICH. COMP. LAWS ANN. § 333.226423(f).

179. MICH. COMP. LAWS ANN. § 333.226423(f).

180. *See* LARA *supra* note 156.

181. *See* Shirey, *supra* note 171.

182. MICH. CIV. JI. 30.01.

183. *See* LARA, *supra* note 156.

184. MICH. COMP. LAWS ANN. § 333.26424(f) (West 2008).

185. *See* LARA, *supra* note 156.

Both the Michigan Senate and House of Representatives have proposed bills which seek to define and place parameters on the bona fide patient-physician relationship.[186] The proposed House legislation, H.B. 4851, sets forth various elements necessary to form a bona fide patient-physician relationship.[187] Such a relationship would exist only if a physician establishes a treatment or counseling relationship which includes the following elements: (1) The physician must complete a full assessment of the patient's medical history and current medical and psychological condition, including an in person, physical examination; (2) the physician must have provided prior treatment or consultations with the patient for reasons other than the patient's application for a registry identification card, complete with records of the patient's condition; (3) the physician must form a reasonable expectation that follow-up care, examination and treatment will be provided to monitor the efficacy of the patient's medical marijuana use; and (4) if appropriate, physician notification of the patient's primary care physician of the patient's debilitating medical condition and certification for medical marijuana use.[188]

The provisions of the House bill seem to target physicians who currently provide assessments in temporary or transient locations, which critics contend are no more than "certification mills."[189] The most striking change of the proposed legislation is the requirement that the physician have an established, pre-existing relationship with any patient seeking a certification.[190] The proposed legislation also envisions that physicians establish an ongoing assessment and care plan, which is not presently part of the "one time visit" system used by some physicians currently providing written certifications.[191]

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186. H.B. 4851, 2011-2012 Sess. (Mich. 2011); S.B.0506, 2010-2011 Sess. (Mich. 2011).

187. H.B. 4851.

188. *Id.*

189. *Id.*

190. *Id.*

191. *Id.*, *accord Redden*, 799 N.W.2d at 217 (O'Connell, P.J., concurring) (asserting "[A] certain Livingston County doctor was selling written [medical marijuana] certifications for $50. Apparently all one had to do to obtain a written certification to use marijuana was to show up at this doctor's house and slip $50 under the door"). Judge O'Connell took his concurrence in *Redden* a step further, suggesting Michigan law be reformed such that physicians be required to "attest that each patient has a serious or debilitating condition and name that condition . . . [and] [d]octors who are indiscriminately selling written certifications could then be penalized by the courts for issuing false certificates." *Redden*, 799 N.W.2d at 217 n.27.

The proposed Senate bill, S.B. 0506, includes additional elements to those set forth in the House bill.[192] Under the Senate bill, the physician-patient relationship is not "bona fide" unless the physician reviews prior treatment and treatment responses, obtains and reviews relevant diagnostic test results, and discusses the advantages, disadvantages and alternatives to medical marijuana use, including the expected response to the recommended treatment.[193] A plan for follow-up care is also required to determine the response to, and any side effects of, the proposed treatment.[194]

More ominously, the proposed statute sets forth specific and significant consequences for failing to establish this bona fide patient-physician relationship. If the relationship is not established pursuant to the statutory requirements, the patient's registry identification card is not valid and provides no defense to a criminal prosecution.[195] Importantly, the failure to establish the bona fide relationship would also deny the physician the right to assert any protection provided in the act in a civil action or in a professional disciplinary or licensing proceeding.[196] Both proposed bills remain under consideration by legislative subcommittees and have not yet been ratified.[197]

The Michigan Department of Licensing and Regulatory Affairs (LARA), through the Bureau of Health Professions (BHP), is responsible for administering the Michigan Medical Marijuana Program under the MMMA.[198] Independently from the proposed related legislation, the BHP has issued a memorandum and related statement which not only sets forth the BHP position on the bona fide physician-patient relationship, but also establishes the components of a full medical evaluation necessary to comply with the applicable standard of practice.[199] Although the statement is not an administrative rule which would have the force of law, there may be little practical difference when considering the potential consequences.

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192. H.B. 4851, 96th Leg. Reg. Sess. (Mich. 2011); S.B. 0506, 96th Leg. Reg. Sess. (Mich. 2011). *Cf.* 20 C.F.R. § 416.902 (2011) (under the Social Security Disability regime, the 'general' requirement for an 'ongoing treatment relationship' is such that the patient "see, or have seen, the [treating] source with a frequency consistent with accepted medical practice for the type of treatment and/or evaluation required" for the alleged medical condition(s)).

193. S.B. 0506 § 3A(1)-(5).

194. S.B. 0506 § 3A(6).

195. *See Kolanek*, 491 Mich. 382; *see also Hinzman*, Nos. 308909 and 308910.

196. S.B. 0506 § 3B(2).

197. *See Michigan Medical Marihuana Program*, LARA (Jan. 31, 2012), http://www.michigan.gov/lara/0,4601,7-154-35299_28150_51869---,00.html.

198. *See* LARA, *supra* note 156.

199. *Id.*

The BHP administers boards for each licensed health profession in the state, and those boards are bound by the guidelines set forth by the BHP.[200] The boards can use established guidelines to discipline physicians, and courts will commonly defer to the board's decisions.[201] As such, it is likely that the statement's directives will serve as a template for any disciplinary actions against physicians authoring certifications under the MMMA.

The statement sets forth the standard of care applicable to the evaluation of an individual for the purpose of certification to use marijuana for any medical condition.[202] It lists the "generally accepted" components of a full medical evaluation to determine suitability and appropriateness for recommending treatment "of any kind, including certification for medical marijuana."[203] Those components include:

> [A] hands-on physician-patient encounter; a full assessment and recording of a patient's medical history; a relevant physical examination; a review of prior records of relevant examinations, treatments and treatment response including substance abuse history; a receipt and review of relevant diagnostic test results; a discussion of advantages, disadvantages, alternatives, potential adverse effects and expected response to treatment; the development of plan of care with state [sic] goals of therapy; the monitoring of the response to treatment and possible adverse effects; the creation and maintenance of patient records documenting the information above; and communication with patient's primary care physician when applicable.[204]

Additionally, the document sets forth the expectation that these medical encounters would be completed at "permanent locations" to enable the patient to return for follow-up care.[205] Importantly, the statement indicates that physicians failing to meet generally accepted standards of practice when issuing certifications for medical marijuana use may be found to be practicing below the acceptable standard of care and therefore subject to disciplinary action.[206]

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200. *See About the Bureau of Health Professionals*, BHP (2012), http://www.michigan.gov/lara/0,4601,7-154-35299_28150-43559--,00.html.

201. MICH. COMP. LAWS ANN. § 333.16221 (West 2010); BHP, *Allegation Process-FAQs* (2012), http://www.michigan.gov/lara/0,4601,7-154-35299_28150_27647-43590--,00.html.

202. *See* LARA, *supra* note 156.

203. *See, e.g., In re* Handley, No. 298621, 2011 WL 4953482 (Mich. Ct. App. Oct. 18, 2011).

204. LARA, *supra* note 156.

205. *Id.*

206. *Id.*

These components incorporate, to large extent, the elements set forth in the proposed legislation described above.[207] The assertion that these elements describe the "same standards that would be anticipated in any physician-patient relationship" may, however, be an overstatement.[208] In large part, this again relates to the unrestricted scope of the MMMA which allows a physician of any specialty to issue written certifications. While the LARA statement may reflect treatment elements common to primary care physicians,[209] those elements certainly do not apply to all physicians' practices. Some physicians, pathologists and radiologists for example, may provide patient "treatment" without ever having personally met or examined the patient.[210] Virtually none of the listed components in the LARA statement are applicable to such physicians as radiologists and pathologists, nor are those components actions required to establish a patient-physician relationship within those specialized fields.

Further, even in medical fields involving a "hands-on physician-patient encounter," such care may often be rendered on a one-time basis. For example, anesthesiologists play a crucial role in assessing a patient's suitability for surgery, but such "treatment" generally entails a one-time encounter with no expectation for a follow-up treatment plan or care.[211] In other cases, patients often seek care for acute conditions at walk-in clinics. Such care is frequently provided by physicians with whom the patient has no pre-existing relationship. Patients with non-specific complaints of back and stomach pain commonly receive medication without the physician first obtaining prior records to verify the patient's subjective complaints.[212]

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207. *See* H.B. 4851; S.B. 0506.

208. *See* Shirey, *supra* note 171.

209. *See* LARA, *supra* note 156.

210. *See, e.g., About the Anethesiology Profession*, AM. SOC'Y OF ANESTHESIOLOGISTS (2012), http://www.asahq.org/For-the-Public-and-Media/About-Profession.aspx.

211. *See, e.g.,* Kirsten M. Moder, *The Continuing Care Exception: Is This Bubble About to Burst?* Montgomery v. South County Radiologists, Inc., 46 ST. LOUIS U. L.J. 1059, 1086 (2002) ("Often, the diagnostic radiologist is nothing more than a faceless specialist acting behind the scenes, making conclusions that affect a patient's whole course of treatment without ever having met the patient. For this reason, courts have found that radiology traditionally has not involved the close personal relationship likely to develop between a patient and a treating physician in other specialties.").

212. Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 926 (1994) ("Surgical anesthesiology, for example, is performed by physicians with whom the patient ordinarily has no prior or subsequent relationship. Surgery often (and hopefully) involves only a one-time encounter. Many physicians who prescribe birth control pills have little contact with the patient thereafter.").

Even when considering the common practice of a primary care physician, the treatment components outlined by the BHP may not be part of every patient encounter. A primary care physician regularly evaluates and treats new complaints, both from new and established patients.[213] It is unclear whether the BHP statement was intended to address, and potentially change, practice requirements for all physicians, even those treating non-medical marijuana patients.

The practice regimens unique to various medical specialties are too diverse to easily identify the components of proper care applicable to each discipline. Although there is nothing inherently improper in the BHP statement which attempts to do so, it is also unusual for an administrative agency to attempt prospectively determining the standard of practice applicable to future medical care.[214] If the intention was truly to address the "appropriateness for recommending treatment of any kind" the guidelines may have a profound impact on the medical community at large, and require significant changes in medical practice throughout various disciplines.[215] If this was not the intent, and the statement was meant to apply only to physicians authoring medical marijuana certifications, the document may be viewed as singling out those physicians as targets for disciplinary action.[216]

Before medical marijuana proponents complain that physicians who provide written certifications are being subjected to excessive scrutiny or discriminatory treatment there must be some appreciation that the "proper evaluation" issue partly is of the proponents' own making. Since the MMMA's passage, the physician certification process has taken place in many forums unique to the medical marijuana field. Examples include instances in which certifications are issued at traveling "clinics" sometimes located at medical-marijuana conventions, at medical-marijuana- related businesses, and even through internet assessments.[217] These non-conventional approaches make the certifying physicians easy targets. Critics argue that these treaters have crossed the line from medical providers to medical salesmen.[218] Through legislation and regulatory guidelines, the governmental agencies are ostensibly attempting to instill public confidence that the level of medical care

213. *See, e.g., Primary Care: Definition #3 Primary Care Physician*, AM. ACAD. OF FAMILY PHYSICIANS (2012).

214. *See* LARA, *supra* note 156.

215. *Id.*

216. *See* LARA, *supra* note 156.

217. *See* Martin, *supra* note 139.

218. U.S. DEP'T OF HEALTH & HUMAN SERVS., NAT'L INSTS. OF HEALTH, *Anxiety Disorders, NIH Publication No. 06-3879* 14 ("[i]n general, anxiety disorders are treated with medication, specific types of psychotherapy, or both.")..

provided in the medical marijuana arena is as carefully monitored and regulated as that of other fields.

Despite these goals, medical marijuana proponents may argue the very nature of the "medicine" involved here requires greater flexibility when assessing the propriety of medical care.[219] Even the LARA memo concedes that "medical marijuana physician certifications are quite different from other types of medical certifications a physician may routinely complete."[220] Although there appears to be some appreciation of the unique circumstances facing a physician who provides written certifications for medical marijuana, reaching an acceptable compromise has proved challenging.

Certainly, neither side in the debate disputes the importance of patient safety. Medical marijuana's proponents' greatest fear, however, appears to be the potential chilling effect such legislation and regulations may produce.[221] Recent data indicates fifty-five physicians in Michigan are responsible for 70% of the medical marijuana certificates in the entire state.[222] A possible concern for medical marijuana proponents in Michigan is the proposed statutes and administrative regulations including, and, in particular, the real threat of sanctions, may discourage new physicians from participating in the certification process, which in turn may weaken the resolve of those physicians currently issuing certifications. The cynical view is, whether by design or practical effect, the ultimate result of physician regulation such as the BHP statement issued in January 2012, may be to achieve circumstantially what opponents of medical marijuana could not do directly—namely abolishing the MMMA or rendering it ineffective.

The trail is not hard to follow. By requiring physician certifications for medical marijuana, the MMMA makes physician participation an essential step in the process.[223] Regardless of the number and willingness of potential patients and caregivers, they cannot legally exist without a

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219. *See* Martin, *supra* note 139.

220. *See* LARA, *supra* note 156.

221. *See* People v. Gorden, No. A100582, 2003 WL 22049156 (Cal. Ct. App. Sept. 3, 2003) ("[w]e take no position as to whether appellant has correctly been diagnosed by his physician as having fibromyalgia or the propriety of that physician's prescription of medical marijuana rather than a more conventional medication. We conclude only that the trial court's determinations that the diagnosis was incorrect or, if correct, that appellant could successfully be treated by conventional drugs . . . 'exceeds the bounds of reason, all of the circumstances being considered.'") (internal citation omitted).

222. Catherine Kavanaugh, *Cancer Victim Credits Medical Marijuana with Improvement*, DAILY TRIBUNE (Oct. 4, 2011, 12:01 a.m.), http://www.dailytribune.com/article/20111004/NEWS/310049956/cancer-victim-credits-medical-marijuana-with-improvement.

223. MICH. COMP. LAWS ANN. § 333.26428(a)(1).

physician issued certification. Both the proposed legislation and administrative guidelines explicitly extinguish the statutory protections for any physician who does not form a proper physician-patient relationship or comply with the newly outlined standard of care.[224]

As the threat of professional sanctions grows, so too might physicians' resistance to participating in the certification process. Not only would this potentially affect patients seeking yearly recertification, but may also impact patients with currently valid cards. The statutory protections afforded patients are only applicable to those holding valid registry identification cards.[225] Such cards are only as good as the physician certification process on which they were based.[226] If it is determined the card was not issued pursuant to a bona fide patient-physician relationship, or the evaluation was not performed within the standard of care, both the registry identification card, along with the attendant physician, caregiver and patient protections, become invalid.[227] If medical marijuana opponents' objective was to attack the chain of protection the MMMA provides, physician participation is the weak link. The practical effects of the proposed legislation and administrative guidelines could be startling. In Michigan, preventing just the right fifty-five physicians from authoring certifications would invalidate medical marijuana use by 70% of current certified patients.[228]

IV. CONCLUSION

The concept of "medical" marijuana continues to fuel national debate. Characterizing marijuana as medicine, and interjecting healthcare providers into the approval or certification process may help legitimize marijuana use and draw the focus away from the drug's recreational aspects. But, not unlike other medical treatment, the concept of "medical" marijuana is not without its side effects. Its fundamental

224. *See* H.B. 4851; S.B. 0506.

225. *See* OP. MICH. ATT'Y GEN. NO. 7259, *supra* note 107, at *1 ("In order to qualify for these legal protections, patients and caregivers must apply for and receive a registry identification card.") (citing MICH. COMP. LAWS ANN. § 333.26424(a)-(b)).

226. *See, e.g., Kolanek*, 491 Mich. at 391-92.

227. *Redden*, 799 N.W.2d at 206 n.12 ("Accordingly, regardless of whether an individual has a registry identification card, that individual is not a 'qualifying patient' under the MMMA and, therefore, is not entitled to the act's protections unless a physician has determined that the patient suffers from an identifiable debilitating condition. . . . Thus, an individual is not entitled to protection under the MMMA if a physician has acknowledged only that the individual suffers from symptoms of a disease or illness (such as pain, nausea, or anxiety) but has not actually diagnosed that person as having a debilitating disease or illness.").

228. *See* Kavanaugh, *supra* note 220.

differences with traditional medicine, current federal prohibition, and controversial history produce challenges to marijuana's acceptance as medicine not faced by other drugs.

If the goal proponents seek is to truly obtain marijuana's equal status as medicine, the issues outlined in this Article will engender continued discourse and debate, and an easy resolution is unlikely. Some argue, however, that the push for marijuana "medicalization" is simply an intermediate step towards legalization. If this is indeed the ultimate goal, pursuing the process of medicalization may not only be unnecessary, but counterproductive. For the reasons set forth in this Article, proponents marching the road to medicalization may arrive at a destination they did not intend to reach.

Marijuana use constitutes a large enough part of the public experience such that debate on legalization should be addressed on its merits. Treating it as medicine is in many ways forcing the proverbial square peg into the round hole. Even if its medicinal value is conceded, marijuana in its plant form is simply too different from prescription medication to seamlessly allow similar treatment.

Moreover, a more fitting model for marijuana distribution is already in use. Tobacco and alcohol, while still drugs, are available commercially. These substances are closely regulated, with strict regulations regarding their sale. In the case of alcohol, even private manufacture for personal use is permitted under limited circumstances. Whether marijuana should be legalized will remain the subject of vigorous debate. More to the point, however, is that its characteristics and use align more closely with alcohol and tobacco than with prescription medication.

Forcing marijuana into a traditional medical model leads to obstacles that could otherwise be avoided. Its continued use as a recreational drug makes "medical marijuana" an easy target for opponents who contend that the real purpose of the statutes is to permit and foster that continued recreational use. Additionally, proponents who pursue medicalization but continue to urge that marijuana be treated differently from other prescription medicine must logically acknowledge that it is substantially different from such medicine.

Most importantly, requiring physicians to become an indispensable part of the certification process risks encountering resistance from the very people from whom participation is required. Physician participation in the certification process is voluntary. Current participation appears limited to a relatively small number of physicians. This alone helps critics marginalize and portray such physicians as a rogue, fringe element within the larger medical community. Practice uncertainties and risks may force more physicians from the current pool. While treatment

guidelines are in development, the scope and nature of acceptable practice remains uncertain. Failing to comply with often nebulous statutory provisions places physician licenses at risk. Simply put, if physician participation is an integral part of the process, what is the solution if physicians refuse to participate? Medical marijuana statutes which require a physician participation in order to function inject physicians into a process in which they may not want to be, and perhaps do not belong. Making physicians a required part of the process risks the possibility that doctors may "just say no."