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THE MICHIGAN MEDICAL MARIJUANA ACT: FIRST STEPS TOWARDS EFFECTIVE POLICY AND RESPONSIBLE PRACTICE

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Abstract

Medical marijuana is becoming a socially acceptable means of medicating patients who receive palliative relief for their symptoms from its use. This paper will examine the short history of the Michigan Medical Marijuana Act. Has the state of Michigan crafted an effective medical marijuana policy? Is this act effective for legislatures to implement and uphold? Is it effective for patients using marijuana for its medicinal purposes? Is it effective for providers trying to earn a living? The research presented in this article shows that there are many undefined aspects of the law that create problems and opportunities for improvement. Changes need to come from all parties involved. Patients and caregivers need to work with legislators to ensure that the law is fair and effective.

INTRODUCTION

On November 4, 2008, 68% of the voters in Michigan approved the Michigan Medical Marijuana Act. This law allows citizens with a valid prescription to purchase and/or cultivate marijuana for medical use. Challenges have been brought against the legality of the law and different interpretations of how to enforce and uphold it. Many patients have found relief from their symptoms and the law has allowed them to do this without fear of prosecution. Some aspects of the law are not clearly defined, which has made both enforcing and following it a difficult path.

LITERATURE REVIEW: MARIJUANA, MEDICINE, AND THE LAW

History

Before 1937, well-known pharmaceutical companies such as Bristol Myers Squibb and Eli Lilly created at least 27 legal medications that contained marijuana. In 1937 the Marijuana Tax Act was enacted, federally prohibiting the use of marijuana. Dr. William C. Woodward of the American Medical Association opposed the Act, testifying that “prohibition would ultimately prevent the medical use of marijuana.” The Controlled Substances Act of 1970 placed all illicit and prescription drugs into five ‘schedules’ (categories). Marijuana was placed in schedule 1, defining it as having a high potential for abuse, no currently accepted safety for use in treatment in the United States, and a lack of accepted safety for use under medical supervision. Of course, at the time of the Controlled Substances Act, marijuana had been prohibited for more than three decades. Its medicinal uses forgotten, marijuana was considered a dangerous and addictive narcotic (“Medicinal Benefits of Marijuana,” 2003). Marijuana has a Schedule 1 classification and, like heroin, it is illegal for scientists to test its medical benefits on human subjects in the United States.
It can be difficult for scientists and clinicians to perform research on a substance that has had a negative reputation for most of its existence and is currently classified as a Schedule 1 drug. In order for one to perform research on a drug, in this case, an illicit drug, the clinician must get governmental permission and a supply from the National Institute on Drug Abuse. Unless states decriminalize medical marijuana, obtaining it can be a questionable and illegal process. Noteworthy medical marijuana research has concluded that the use of marijuana was not fatal and did help those with chronic illnesses maintain their quality of life with minimal side effects. Furthermore, short term research suggests that cannabis, in its natural form, is an extremely safe and therapeutic substance when utilized in a supervised setting. Keeping marijuana in its natural form is what worries physicians who are actually allowed to prescribe the medication. Even when a person has been cleared to qualify for the use of medical marijuana, it still brings up the question as to where they may obtain this medicine, especially within the United States. Patients must obtain this on their own without help from their doctors or are allowed to grow their own within their home, as long as it does not exceed a certain amount or weight, which differs from state-to-state.

The Food and Drug Administration (FDA) is “the sole Federal agency that approves drug products as safe and effective for intended indications” (FDA, 2009). If a drug does not receive the FDA’s stamp of approval, it is deemed unsafe and, in the case of marijuana, is classified as an illegal substance. Although cannabis has been classified as an illegal substance, eighteen states have voted for its medical use. California alone has over 100,000 medical marijuana users (Jacobs, 2005).

**Medicinal Uses of Marijuana**

The use of marijuana is said to impair judgment and short term memory, increase infection within the upper respiratory system, cause hallucinations, increase one’s heart rate, and decrease coordination and psychomotor skills. So why would anyone choose to utilize such a drug for medicinal purposes? There are many positive medicinal qualities to marijuana that aid those with chronic illnesses. Some of these chronic illnesses where benefits are seen include AIDS, cancer, chronic pain, glaucoma, multiple sclerosis, and anxiety. Most of these illnesses force the patient to undergo extensive treatment in order to fight against their disease.

The Institute of Medicine has concluded that, “For patients such as those with AIDS or who are undergoing chemotherapy and who suffer simultaneously from severe pain, nausea, and appetite loss, cannabinoid drugs might offer broad spectrum relief not found in any other single medication (“Medicinal Benefits of Marijuana,” 2003). This is especially important for patients with diseases like AIDS because they suffer from multiple symptoms and are prescribed multiple drugs to treat their symptoms. Medical marijuana, however, can reduce and alleviate many of the aforementioned symptoms as well as eliminate the prescribed drugs side effects. Conversely, those with or who have had a previous history of immune system deficits are not encouraged to utilize such a drug because of a weakened immune system. Smoke tends to damage the cells in the lining of the bronchial passageway. These cells are what protect the body from outside microorganisms that can potentially increase the rate of bacteria and infection within this lining. Thus, those with HIV or AIDS may be more prone to pneumonia that may only advance the current stage of their disease. Harvard researchers reported in the journal Cancer Research in 2007 that “the active ingredient in marijuana can increase the risk for Kaposi’s sarcoma, a common cancer in HIV/AIDS patients” (Foreman, 2009).
Medical marijuana is used to treat glaucoma, the leading cause of blindness in the United States. Over time, one’s vision is damaged by increased intraocular pressure on the eye. This pressure can be reduced by smoking marijuana. Reducing this pressure also helps with the pain associated with the disease. In some cases it has even been shown to slow the progression of glaucoma. There are negative responses as well. “Some potentially serious side effects were noted, including an increased heart rate and a decrease in blood pressure in studies using smoked marijuana. The identification of side effects of smoked marijuana, coupled with the emergence of highly effective FDA-approved medications for glaucoma treatment, may have led to diminished research in this area” (Glaucoma and Marijuana Use, 2009).

Marijuana has also been found to be effective in the treatment of cancer and its side effects. When one determines that he or she has cancer, an option is to undergo chemotherapy to attack the cancer tumor. Like any drug or treatment protocol, side effects can be extremely hard on the body, making it difficult to live and carry out normal activities of daily living. A 2003 study found “Cannabinoids – the active components of Cannabis sativa and their derivatives – exert palliative effects in cancer patients by preventing nausea, vomiting and pain and by stimulating appetite. In addition, these compounds have been shown to inhibit the growth of tumor cells in culture and animal models by modulating key cell-signaling pathways. Cannabinoids are usually well tolerated, and do not produce the generalized toxic effects of conventional chemotherapies” (Medicinal Benefits of Marijuana, 2003). If indeed marijuana can inhibit the growth of cancer, the medical benefits would be significant in the oncology field. If more research can be performed on humans, now knowing that the use of cannabis is not fatal, however highly addictive, could marijuana be a potential outlet for those with cancer? In 1995, it was concluded, “based on thirty years of scientific research that the smoking of cannabis, even long term, is not harmful to health.” (British Medical Journal, 1995)

“An estimated 350,000 people in the United States are living with multiple sclerosis, a debilitating and sometime fatal disorder of the central nervous system. Symptoms vary considerably from person to person; however, one frequently noted concomitant is spasticity, which causes pain, spasms, loss of function and difficulties in nursing care” (“Medicinal Benefits of Marijuana,” 2003). Marijuana has been shown to relieve some of the symptoms of spasticity. When tested on animals, it was also shown to slow the progression on MS. “A 2003 study that the American MS Society calls ‘interesting and potentially exciting’ demonstrated that cannabinoids were able to slow the disease process in mice by offering neuroprotection against experimental allergic encephalomyelitis (“Medicinal Benefits of Marijuana,” 2003). Marijuana has been shown to be very effective in the treatment of chronic pain. Chronic pain is ongoing and affects an individual’s ability to function normally in their day to day life. The medicine given to alleviate the pain can cause nausea. “Marijuana can provide relief from the pain itself (either alone or in combination with other analgesics), and it can control the nausea associated with taking opioid drugs, as well as the nausea, vomiting and dizziness that often accompany severe prolonged pain (“Medicinal Benefits of Marijuana,” 2003). Because of its effectiveness with chronic pain, many unlikely advocates are coming forward. One of these advocates is Mary Duda, a former home health aide with four children and two granddaughters. “Marijuana,” says the 48-year-old Ware, Mass., resident, “is the only thing that even begins to control the migraine headaches that plagued me nine days a month.” She always had these painful headaches but they got much worse 10 years after two operations to remove life threatening aneurysms, weak areas in the blood vessels in her brain. None of the standard drugs her doctors prescribe help much with her post-surgical symptoms, which include nausea, vomiting, loss of appetite and pain on
her left side “as if my body were cut in half.” “With marijuana, however, I can leave the dark room,” she says, “and it makes me eat a lot of food (Foreman, 2009).”

**Delivery Methods**

“The federal government’s National Institute on Drug Abuse says that it has ‘not yet determined’ whether marijuana increases the risk for lung and other cancers (Foreman, 2009).” Many marijuana users also use other harmful products, such as tobacco, so this makes it difficult to pinpoint the exact causes of the cancer. “3-4 cannabis cigarettes a day are associated with the same evidence of acute and chronic bronchitis and the same degree of damage to the bronchial mucosa as 20 or more tobacco cigarettes a day” (British Lung Foundation, 2002). There was a study performed at the Medical Research Institute of New Zealand that “does acknowledge the difficulty of studying links between marijuana use and cancer, noting that the illegality of the drug, in addition to the tendency for its use to be combined with the use of other substances, can have an impact on the accuracy of the results. The study does find a clear link, however, between the regular use of cannabis and increased risk for lung cancer. From a common sense point of view, filling your lungs regularly with any type of smoke probably isn’t going to be good for your health” (Does Smoking Marijuana Give you Cancer, 2008).

There are some other options that could be utilized instead of inhaling smoke into the lungs. “The goal of clinical trials of smoked marijuana would not be to develop marijuana as a licensed drug, but rather as a first step towards the possible development of nonsmoked, rapid-onset cannabinoid delivery systems” (Marijuana and Medicine – Assessing the Science Base, 1999). Inhalers could play an important role in this process. Other options, such as ingesting the marijuana or using a vaporizer, eliminate the smoke inhalation. It can be incorporated into food products and eaten that way. The issue with putting it in food products is that it is difficult to control the THC level and produce a consistent product. “Vaporizing is a safe and effective way of getting THC, the active ingredient, into the bloodstream and does not result in the inhalation of toxic carbon monoxide, as smoking does,” according to a study by Abrams published in 2007 in Clinical Pharmacology and Therapeutics (Foreman, 2009). A new trend emerging that is very effective is making a cannabis tincture. In this process, marijuana is combined with a high proof alcohol and administered from a dropper sublingually. This allows the patient to control the dose and is easily administered in public if necessary. Tincture was the common delivery method prior to the 1937 Marijuana Tax Act.

In 1985, the FDA approved a synthetic pill form of medical marijuana called Marinol. This reduces the potential damage from smoking the plant. It does not seem to have the same impact that actual marijuana has on the various ailments and symptoms it is meant to alleviate. In many instances, marijuana is used to combat nausea. When you are smoking, you feel the effects immediately. With Marinol, it can take up to an hour and a half to feel its effects. It can also be hard to keep pills down when you are feeling nauseous. “Marinol is not the same thing as traditional smokable marijuana. It is a less complex substance lacking both some of the good components found in traditional marijuana (such as cannabidiol, which has been found to have anti-seizure effects) and the bad or not-yet-fully understood components (among them the potential carcinogens) that can also come with the drug” (Montoli, 2009). Because medical testing is not done on human subjects for the benefits of marijuana, it is difficult to know if there are medicinal affects received from the plant that are not able to be reproduced in Marinol. Dr. Herbert Kleber, a professor of Psychiatry at Columbia University and the former deputy drug
czar under President H.W. Bush asks “Are there actions in the plant that you don’t get from just the Marinol? I would be surprised if there wasn’t. The problem is that most of the data about the potential medical actions of the smoked form are anecdotal” (Montoli, 2009).

An interesting drug developed by GW Pharmaceuticals in the United Kingdom is very similar to the cannabis plant but has been modified into a pill form called Sativex. Sativex contains a cannabis extract containing THC that does not allow the patient to become intoxicated. “This drug is a sublingual spray that has been approved for clinical use in Canada on July 16, 2009 for those suffering from multiple sclerosis and neuropathic pain. This drug has been approved by the FDA in the United States for a Phase II clinical study” (GW Pharmaceuticals, 2010). The company is hopeful that they will have FDA approval by the end of 2013. Many other countries, including the United States, are beginning to jump on board with further research. Dr. Stephen Wright, GW’s R&D Director, said, “We are very pleased to have successfully completed two Phase II studies showing positive data supporting the efficacy of Sativex in cancer pain. We are now working closely with Otsuka in preparing for Phase III development of Sativex in the United States market” (GW Pharmaceuticals, 2010).

State vs. Federal Law

Since medical marijuana is one of the most widely supported issues in drug policy reform, it is important to discuss both federal and state stances on the issue. As many places started to legalize medical marijuana following the passage of California’s Compassionate Use Act, conflict between state and federal jurisdiction over the drug began to arise. The federal government does not permit cannabis to be used medicinally and has traditionally taken an active stance on enforcing this by various DEA drug raids into medical marijuana co-ops and dispensaries. Many times these raids result in the inability for a clinic to re-open and therefore many patients must seek medicine elsewhere. An employee of the Beach center Collective in Playa Del Ray said of the recent raid on their collective everything was taken. “You name it; they took it -- right down to the television. The computer, patient files, medicine, cash in the register -- that’s it, we’re done. It’s just too bad. [Our patients] have epilepsy, cancer, MS, diabetes -- two of our patients have one leg. They’re gonna have to travel a lot farther and go to places that aren’t as safe for them (Knoll, 2009).”

Despite the DEA’s strong stance on upholding the Controlled Substances Act through raids and arrests, President Obama’s Administration is loosening up on the medical marijuana industry. In October of 2009, Attorney General Eric Holder announced that the administration will encourage federal prosecutors to stop pursuing cases against medical marijuana patients that are in compliance with state law. Instead Holder suggests the DEA focus on cases involving higher level drug traffickers, money launderers or people who use the state laws as a cover. This change represents a huge shift in previously enforced federal control over states that permit the use of medicinal marijuana. Many people feel this is the first big step towards putting jurisdiction into the hands of the states and thus, has encouraged support from both patients and advocacy groups. Other people were not so happy, such as Republican Lamar Smith of Texas; also the top Republican on the House Judiciary Committee. “We cannot hope to eradicate the drug trade if we do not first address the cash cow for most drug-trafficking organizations -- marijuana (Johnson, 2009).” Currently the states that have enacted some version of legal medicinal marijuana into state law are, Alaska, Arizona, California, Colorado, Connecticut, Delaware,

Now the question arises, “What are the roles of both patients and caregivers in this new law?” Each participating medicinal marijuana state differs in the amount of marijuana allowed to be possessed and number of plants a patient or caregiver may grow. Michigan’s law states that the patients must begin the application process for a medical marijuana license through the Michigan Department of Community Health and must have a valid statement of need from a qualifying Michigan M.D or D.O. The qualifying physician does not actually write a prescription for marijuana as it is illegal to do so because of marijuana’s federal classification as a Schedule I drug. Instead, the physician provides a written certification that states the applicant is a qualifying patient indicating his or her medical condition. The patient must also submit a $100 new or renewal fee with their application, unless they are covered under a state health insurance plan in which they will pay $25.00. Currently, Michigan has over 200,000 registered patients. Once an individual is registered, a card is received that can be shown as proof of registration. The patient is allowed to designate one caregiver 21 years of age or older who is responsible to obtain and grow marijuana for them if they are too sick or unable to grow the plant themselves. The caregiver or patient can acquire 2.5 ounces of usable marijuana and grow up to 12 marijuana plants for each qualifying patient. The caregiver may assist up to 5 patients. The caregiver must sign a statement agreeing to provide marijuana only to the qualifying patients who have named the individual as their caregiver. The state does not provide information on where to obtain seeds or how to start the growing process; this is up to the patients and/or their caregivers (Department of Licensing and Regulatory Affairs).

Continuing to investigate the policy and regulations of Michigan’s Medical Marihuana Act (enacted November 4, 2008), there are rules associated with where you can smoke and grow your marijuana, employment related questions, and information regarding drug paraphernalia. Michigan law does not permit any person to do any of the following:

(1) Undertake any task under the influence of marijuana, when doing so would constitute negligence or professional malpractice.

(2) Possess marijuana, or otherwise engage in the medical use of marijuana:
   (a) in a school bus;
   (b) on the grounds of any preschool or primary or secondary school; or
   (c) in any correctional facility.

(3) Smoke marijuana:
   (a) on any form of public transportation; or
   (b) in any public place.

(4) Operate, navigate, or be in actual physical control of any motor vehicle, aircraft, or motorboat while under the influence of marijuana (MDCH).

Furthermore, the law leaves the right of a patient to smoke marijuana up to his/her employer to decide if it is permissible or not, as the Michigan Medical Marihuana Act (MMMA) states that employers are not required to accommodate employees who use medical marijuana. Another provision under the law is that no patient can be prosecuted for using paraphernalia relating to the consumption of marijuana (Department of Licensing and Regulatory Affairs).
Dispensaries

When the Michigan Medical Marihuana Act (MMMA) was enacted in 2008, legislatures, patients, and caregivers agreed that the law is ambiguous. A prime example of this is the ongoing debate of the legality of dispensaries. A medical marijuana dispensary is a business that a patient with a medical marijuana card can go to and purchase medicine. How does a dispensary work? Patients or caregivers bring in their excess medicine. Each caregiver can grow 12 plants per patient and can care for up to 5 patients. Including growing for personal consumption, a caregiver can poses a total of 60 plants. A total of 15 ounces of useable medicine can be possessed. That is 2.5 ounces per patient, plus what is allowed for the caregiver. 15 ounces is now called a Michigan Pound. In this scenario, a patient or caregiver may have extra medicine that they cannot legally have. Because the law states that patients can transfer medicine to another patient, they transfer their excess medicine to the dispensary. When the law originally passed, numerous dispensaries opened throughout the state and were thriving. This helped alleviate the complication of patients who are prescribed the medicine, but do not know anyone who could be their caregiver. Many of these patients are too sick to grow marijuana for their own use. On August 24, 2011, the Michigan Court of Appeals ruled the commercial sale of medical marijuana, patient to patient, illegal. This put dispensaries in violation of the law and in jeopardy of prosecution. Under Michigan’s Public Nuisance law, these businesses can be forced to close. Lansing is a great example of this boom and its subsequent demise (Kullgren, 2011).

Capital City Caregivers was owned by Michael and Anne Doyle and opened in May of 2010. Much time was spent working with local legislatures to ensure that the business was within the guidelines of the law. The dispensary was modeled after California and Colorado and opened as a non-profit organization. Donations of medicine were accepted and all profits were reinvested back to the company and community. They rented a building on Michigan Avenue. This area of Lansing is economically depressed and local business is imperative to its revitalization. The Doyles spent their time and resources renovating the space and rented out two other suites, one to a massage therapist, the other to a shop that supplied growing supplies to budding horticulturalists.

Lansing had lengthy council meetings to create and license dispensaries within its borders. Ann Arbor had already created licensing regulations and Lansing modeled theirs after Ann Arbor. One month after Lansing began accepting applications and licensing fees, Isabella County’s appellate court ruled that dispensaries were illegal according to the MMMA. The court ruled that patients were not able to transfer excess medicine to another patient. This was the premise that Capital City Caregivers operated under; that patient to patient transfer was legal. This appellate ruling shook things up in not only Lansing, but the entire state of Michigan. The city attorney, Brig Smith, sent letters advising all dispensaries to "cease and desist,” shut their doors, or face possible prosecution. In August 2011, Capital City Caregivers complied, under advice of their lawyer. The Doyle family had put all of their resources and efforts into this small business only to have to close their doors or risk having their family torn apart. On October 11, 2012, the Michigan Supreme Court heard arguments regarding the legality of dispensaries and is expected to rule sometime in early 2013.

Not allowing dispensaries creates problems for patients that are genuinely helped by this medicine. A patient of Capital City Caregivers was a 62 year old woman. She had cancer that had metastasized through her body. It was very painful and difficult for her to get around. She used marijuana in tincture form. In the past, when she had been out running errands, the pain
would become so unbearable that she would have to go home. With the tincture, when the pain would become unbearable, she would put a couple drops under her tongue and was able to continue on with her activities of daily living. When the dispensary closed, she was not comfortable going to a caregiver and unable to grow it for herself. She also preferred the tincture to inhaling smoke. Tincture is more discreet and did not have adverse effects on her lungs. She is a patient that was being helped but is now left behind.

Trust

Trust plays an important role in governance, especially if there are competing values. In the case of medical marijuana, there are two camps, one that thinks it should be legal, and the other that does not. There is no trust in the other side. Because of this, there is no transparency. Both sides display opportunistic behavior. Many medical marijuana patients are not in need of the drug to improve their health status. An example of this is a patient I spoke with. He was a large man, about 6’2” and 275 pounds, and 35 years old. He was prescribed marijuana because he has chronic pain in his knee. Though marijuana helps alleviate chronic pain, sitting all day and “getting high” does not facilitate rehabilitation for the underlying issue. Physical rehab and exercise, as well as losing weight could, and most likely would, get rid of the pain all together. An attempt should be made to alleviate this issue before a lifetime of misuse results in surgery. A common complaint of the opposition is that the state has been too lax in handing out medical marijuana cards to patients. Caregivers may not have any experience in growing marijuana or assisting patients, but they see an opportunity to make money. They are not taking into account that there are patients whose lives are improved by medicine and want the highest quality product. The legislature has no trust in patients or caregivers, and many see this as a slippery slope toward the legalization of marijuana. An example of this mistrust happened in Lansing. A Lansing citizen was a financial partner in Capital City Caregivers. He had been an outspoken advocate of medical marijuana. When the business was forced to close and he lost his investment, he became a caregiver and started growing a legal amount of marijuana in a warehouse with another caregiver. That warehouse was raided by federal agents and everything was confiscated, down to the mini-refrigerator with his lunch in it. He was arrested. When he was questioned about his business, he was told by the federal agents that he needed to remove himself from the spotlight. All of the serious drug charges were dropped and he was allowed to leave police custody, but, as of today, has not been returned any of his belongings. If the two sides could learn to trust each other, which will take time, there is a chance for learning, stability, and growth.

Economic Benefits

Can the legalization of medical marijuana play a role in reducing costs in our health care system? Medical marijuana, as a prescribed medication, is inexpensive to produce. Furthermore, it can be prescribed medication that virtually anyone can procure (with active dispensaries). Many pharmaceutical companies greatly oppose the legalization of medical marijuana and its coverage under health insurance; legalized medical marijuana takes money out of the pharmaceutical coffers. Health care costs for prescription drug coverage could be dramatically reduced if a cheaper alternative is introduced to the consumer market.
Pharmaceutical companies would have to compete and we could see many of the high priced pharmaceuticals drop in price.

For this reduction in cost, not only the patients, but the employers responsible for paying for these insurance packages need to take up the cause. “We’re not interested in marijuana as a gateway drug or any of that reefer madness. We want to talk about dollars and cents,” says Allen St. Pierre, executive director of NORML (the National Organization for the Reform of Marijuana Laws). “If the idea here is saving money, then there’s no question that medical marijuana should be a part of the gambit of choices that doctors, patients and employers can have (Marijuana Reimbursement Claims Highlight How Pot Could be Gold for Employers, 2010).” Though it seems logical that using medical marijuana would save us money on health care, this theory has really not been tested. “No formal, peer-reviewed study of the cost-effectiveness of medical marijuana has been conducted,” says Jeffery Miron, an economist at Harvard University who has written about the cost of the federal prohibition against marijuana. And while $1.1 billion has been budgeted to compare the effectiveness of different treatments for the same condition, there is no plan to research the effectiveness of medical marijuana, says a spokeswoman for the Agency for Healthcare Research and Quality (Marijuana Reimbursement Claims Highlight How Pot Could be Gold for Employers, 2010).”

With more and more states legalizing medical marijuana, one might wonder when this medication is prescribed if it is covered under any health insurance plans like other prescription drugs. At this time, the answer is no. Paying in cash is the common way to cover the costs of this treatment. Most insurance agencies are in multiple states, making it difficult to standardize policy when medical marijuana is legal in one state and not in another. Legalizing medical marijuana on a federal level would be the only way to eliminate this obstacle. A larger issue is the fact that medical marijuana is not approved by the FDA. “Lack of FDA approval means no coverage either by private insurers or through any public plan to be drafted by Congress (Walker, 2009).” Because marijuana is a plant it is very difficult to control its ingredients and insure that patients are getting a consistent product. The FDA’s Karen Riley told Hotsheet that “the organization does not discuss whether specific drugs are being considered for approval. But since marijuana lacks clear components or standardized doses – and since it is not even clear who might submit it for consideration – it seems extremely unlikely that medical marijuana is going through the process (Walker, 2009).”

**Court Cases**

Arguably the case with the most media presence has been that of Joseph Casias of Battle Creek, Michigan. Joseph has an inoperable brain tumor. He received his medical marijuana card and was following the guidelines of the law. In 2009, he was working at Walmart and had a workplace accident causing him to twist his knee. Drug testing post-accident is common company policy. Casias tested positive for marijuana and was subsequently fired. He maintains that his oncologist had suggested trying marijuana and that he was not using it on the job. On February 11, 2011, a federal judge ruled on the case. “The fundamental problem with (Casias’) case is that the (medical marijuana law) does not regulate private employment,” U.S. District Judge Robert Jonker wrote in a 20-page opinion. The law protects the patient from prosecution, but does not require employers to accommodate the use of the drug (Judge Upholds Walmart’s Firing of Michigan Medical Marijuana User, 2011).” Another issue is that Walmart is located in every state in the United States. They are headquartered in Arkansas. Medical marijuana is not
legal federally or in Arkansas. Allowing use in states that have legalized medical marijuana would create issues with the consistency of the policies and procedures that employees of the company are expected to follow.

In another case, a patient who prefers to remain anonymous had her home raided and the small amount of marijuana that she had confiscated. Her doctor had suggested marijuana to ease the pain of her fibromyalgia. The raid happened in March of 2010 and the state did not begin to issue cards until April 2010. Prior to this case, possession of a medical marijuana card was required. “A gray area of the law, attorneys have said, is that while police may be unable to determine if a person without documentation is legally possessing marijuana, a so-called “affirmative defense” provision in the law broadens the definition of a patient to anyone who can document a covered medical condition or to whom a physician recommends it for treatment, regardless of whether they can produce state documentation (Killian, 2010).” The misdemeanor marijuana charge was dropped against the woman. James Nicholson, an Ottawa County man was arrested for possession of marijuana. He had not received his card yet, but did have a copy of his application. Two lower courts did not side with Nicholson, but in June 2012, the Court of Appeals ruled that “medical marijuana patients can be given immunity from prosecution if they show their registry card to the courts (Miller, 2012).” Cases like this have helped out the movement to allow a doctor’s letter of approval or prescription to be used instead of requiring patients to register with the state. Currently, qualifying patients must register with the Michigan Department of Licensing and Regulatory Affairs, Bureau of Health Care Services and possess a card.

The city of Wyoming, Michigan tried to ban the use of medical marijuana through a city ordinance. Other cities within the state tried to do this as well. John Ter Beek, a medical marijuana patient, sued the city. In August 2012, the Court of Appeals ruled against the city. Their argument was that the state allows this, so cities within the state cannot ban it. Patients should not have to fear prosecution (Smith, 2012).

**RECOMMENDATIONS**

The federal government needs to remove marijuana as schedule 1 drug. A major hurdle that medical marijuana faces is that, due to its schedule 1 status, human testing cannot be done to get genuine results on the effects. Some studies talk about marijuana reversing low-level cancers. What if this is actually true and people could receive such a simple addition to their other treatments and potentially prolong their lives?

When the Michigan Supreme court rules in 2013, hopefully the result will be to allow for dispensaries to operate. The Michigan Supreme Court does not typically hear appeal cases. Traditionally when they do hear cases that have been ruled upon by the Michigan Court of Appeals, they see some issue with the lower court’s interpretation of the law. In this case, the law is silent and does not specifically allow for dispensaries, nor does it outlaw them. Currently, Michigan does not have an effective way for many patients who are aided by medical marijuana to acquire it. “This summer, the Michigan Court of Appeals ruled that local governments couldn’t use ordinances to criminalize medical marijuana and that a man could not be prosecuted because he did not have his registration card at the time of his arrest. A four-bill package now in the Legislature would clarify some of the murkier aspects of the original legislation, including mandating that patients actually see the doctors who approve their cards, rather than consult via teleconference or other means (Deringer, 2012).” All of this will help make interpretation of the
law easier for everyone involved. Part of the package is to allow patients to have their prescription from the doctor as proof of eligibility. Actually going to doctor will help weed out the individuals who are simply trying to use marijuana recreationally and are using the law to procure their marijuana.

The final recommendation would be for both sides to try to look at it from each other’s perspective. Has Bill Schuette, Michigan Attorney General, spent any time interviewing legitimate patients that medical marijuana has helped? Have dispensaries sat with legislatures as they try to untangle the Michigan Medical Marijuana Act? Has the 30 year old man with the bad knee thought about how getting his card has impacted how those outside of the industry view the average card holder? Perception can go a long way in bringing all sides together.

CONCLUSION

Medical marijuana has growing support from citizens across the United States. Michigan voters approved medical marijuana just over four years ago. In this time, slow progress has been made in untangling the nuances of the law. As more and more states legalize marijuana, Michigan will be looked at as an example for what should and should not be done. This fall, Colorado and Washington took marijuana one step further, and legalized it for recreational use. Michigan and its citizens need to come to consensus so that patients and caregivers can function legally within the constraints of the law without fear of prosecution.

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