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Provider Concerns When Recommending Medical Marijuana

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When it comes to medical marijuana, health care providers are in an awkward – but not impossible – spot. Patient demand for the drug to treat conditions including chronic pain, nausea, multiple sclerosis and Alzheimer's disease is strong. But in many cases, the state and federal laws governing medical marijuana are in direct conflict, leaving providers who want to encourage their patients to use marijuana on shaky legal ground.

This conundrum has not prevented medical marijuana from blossoming into a multibillion-dollar nationwide industry, and thousands of providers have incorporated cannabis into their practices. Providers who want to help their patients access medical marijuana need to understand the substance's legal status and how they can (and cannot) recommend it to patients.

Tension Between Federal and State Law

Since California first legalized the recommendation of marijuana for patient care in 1996, acceptance of marijuana as a form of treatment has grown significantly. As of May 2017, 29 states, Washington, D.C., Puerto Rico and Guam have enacted laws that allow the use of medical marijuana.[1] Many other states have laws allowing the use of cannabis extracts that are high in CBD (which is nonpsychoactive) and low in THC (which is psychoactive) to treat severe epilepsy.

Despite widespread state action in favor of medical marijuana, federal law remains firm that marijuana – used recreationally or medicinally – is illegal. Marijuana remains classified as a Schedule I drug under the Controlled Substances Act, the federal law regulating all drugs. According to the Drug Enforcement Administration, Schedule I drugs are "drugs with no currently accepted medical use and a high potential for abuse" and include, along with marijuana, LSD, ecstasy and heroin.[2] Based on marijuana's place on Schedule I, providers cannot prescribe it to their patients.

In August 2016, the DEA specifically declined petitions by the governors of Rhode Island and Washington to reclassify cannabis to a different schedule.[3] The DEA acknowledged that cannabis is less dangerous than some drugs in other schedules, but stated that the classification is not about "relative danger," but about whether the drug has proven medical value. According to the DEA, marijuana "does not have a currently accepted medical use in treatment in the United States, there is a lack of accepted safety for its use under medical supervision, and it has a high potential for abuse." However, the DEA left open the door for future re-evaluation of marijuana as a Schedule I drug, stating, "If the scientific understanding about marijuana changes – and it could change – then the decision could change."

Limited Enforcement of Federal Marijuana Prohibition

While marijuana's illegal status under federal law is not in question, the federal government to date has not taken a strong enforcement stance in states that have legalized marijuana. Both Congress and the U.S. Department of Justice have made decisions that appear to limit the likelihood of federal enforcement against individuals who possess, cultivate or dispense marijuana.

Rohrabacher-Farr Amendment

In December 2014, Congress passed the Rohrabacher-Farr Amendment to the 2015 Omnibus Appropriations Bill, prohibiting the DOJ from using federal funds to prevent states that have legalized medical marijuana "from implementing their own State laws that authorize the use, distribution, possession, or cultivation of medical marijuana." The Rohrabacher-Farr Amendment was renewed in December 2015, in December 2016 and again in May 2017.[4] Its most recent extension is set to expire in September 2017.

Concurrent with signing the legislation that most recently extended the Rohrabacher-Farr Amendment, however, President Donald Trump issued a signing statement that could be read to cast doubt on his commitment to honor its prohibition. The statement reads, in relevant part, the legislation "provides that the Department of Justice may not use any funds to prevent implementation of medical marijuana laws by various States and territories. I will treat this provision consistently with my constitutional responsibility to take care that the laws be faithfully executed."[5]

There has been some debate over exactly what it means to "prevent" states from "implementing their own state laws" (i.e., exactly what the DOJ is barred from doing), but in August 2016, the Ninth Circuit ruled that the DOJ cannot take action against an individual who is participating in medical marijuana–related activity unless there is evidence that the individual is in clear violation of state law.[6]

Ogden and Cole Memoranda

In addition to the limitations that the Rohrabacher-Farr Amendment imposes on federal law enforcement, the DOJ has also released a series of four memoranda (the 2009 Ogden memo and the Cole memos of 2011, 2013 and 2014) proclaiming the message that "it is not likely an efficient use of federal resources to focus enforcement efforts on individuals with cancer or other serious illnesses who use marijuana as part of a recommended treatment regimen consistent with applicable state law, or their caregivers."[7] The DOJ's memorandum from Deputy Attorney General James Cole in August 2013 guides U.S. attorneys to focus their marijuana enforcement efforts on the following federal priorities, and otherwise rely on state and local law enforcement to police marijuana-related activity in accordance with state laws:

- Preventing the distribution of marijuana to minors;
- Preventing revenue from the sale of marijuana from going to criminal enterprises, gangs and cartels;
- Preventing the diversion of marijuana from states where it is legal under state law in some form to other states;
- Preventing state-authorized marijuana activity from being used as a cover or pretext for the trafficking of other illegal drugs or other illegal activity;
- Preventing violence and the use of firearms in the cultivation and distribution of marijuana;
- Preventing drugged driving and the exacerbation of other adverse public health consequences associated with marijuana use;
- Preventing the growing of marijuana on public lands and the attendant public safety and environmental dangers posed by marijuana production on public lands; and
- Preventing marijuana possession or use on federal property.[8]

The DOJ emphasized in its 2013 memorandum that its guidance does not diminish the authority of U.S. attorneys to prosecute individuals for marijuana-related activities, even in the absence of one of the federal priorities above, "in particular circumstances where investigation and prosecution otherwise serves an important federal interest."

Potential Changes Under a New Congress and Administration

When considering the federal enforcement landscape with respect to medical marijuana, providers should bear in mind that there is no guarantee the Rohrabacher-Farr Amendment will be extended beyond September 2017. Indeed, as evidenced by Trump's signing statement regarding the most recent extension of the

Rohrabacher-Farr Amendment, there is little comfort that the executive branch will honor the legislative commitment not to interfere with states' implementation of their marijuana laws.

Additionally, Trump's Attorney General Jeff Sessions may take a different view of enforcement priorities than the relatively medical marijuana–friendly guidance to U.S. attorneys in the Ogden and Cole memoranda. Already, Sessions has formed a subcommittee of the Department of Justice Task Force on Crime Reduction and Public Safety specifically to evaluate "existing policies in the areas of charging, sentencing, and marijuana to ensure consistency with the Department's overall strategy on reducing violent crime and with Administration goals and priorities."[9] The task force has been asked to make recommendations to the attorney general no later than July 27, 2017.[10] Sessions has been an outspoken critic of marijuana.

Recommending Cannabis to Patients: What Health Care Providers Should Know

Based on the historical lack of federal enforcement against individual patients and caregivers related to medical marijuana, providers in many states that have legalized the drug for medicinal use are successfully incorporating it into their practices. Because of marijuana's continued presence on the list of Schedule I drugs, though, one fact is common in every state: Providers cannot prescribe marijuana. But the protections of the First Amendment mean providers have the constitutional right to recommend it to their patients.

State-Specific Requirements

Because state laws govern all permissible activities related to medical marijuana, the rules for a provider recommending cannabis to his or her patients are unique to each state where medical marijuana is legal. It is beyond the scope of this article to cover the details of each state's medical marijuana program, but below are a few questions (not an exhaustive list) that a provider should ask when determining how to recommend cannabis to patients:

1. Is a special certificate or license needed to recommend marijuana?
2. How much contact must a provider have with a patient before recommending marijuana?
3. Are there ongoing treatment requirements after recommending marijuana?
4. Are there limits on the conditions for which a provider can recommend marijuana?
5. Is there a maximum number of patients a provider can recommend marijuana to?
6. What kind of documentation must a provider maintain for recommendations of marijuana?
7. How long can a recommendation for marijuana last?
8. Are there restrictions on a provider recommending marijuana to a family member or friend?
9. Does recommendation of marijuana impact whether a provider can bill insurance for the visit?
10. Is there required notice to or consent from patients receiving a marijuana recommendation?

States also take different approaches to regulating businesses that dispense medical marijuana. For example, some states cap the number of dispensaries at a hard number or a percentage of the total licensed pharmacies in the state, some states have organized a statewide dispensary system, and some states require dispensaries to be nonprofit organizations. In some cases, states have determined that dispensaries are illegal, meaning patients must grow their own cannabis or obtain it from an authorized caregiver.

States that have legalized medical marijuana typically operate the program through a state office, most often (but not always) housed in the U.S. Department of Health. Providers who are interested in helping their patients access medical marijuana, or individuals interested in opening a dispensary, should contact the appropriate state office to determine the applicable requirements and restrictions, including the answers to the questions identified above.

Medical Malpractice Implications of Recommending Cannabis

Physicians in different states will also face different levels of malpractice liability risk depending on what standard of care the states' courts apply in malpractice cases. Most states use some variation of one of two basic standards to determine whether a physician's care was acceptable: a "custom-based" standard, which is based on what is typical conduct by physicians in a region, or a "reasonable physician" standard, which asks whether the physician acted reasonably given the current state of medical knowledge at the time the care was provided. The difference is subtle, but important: what do most physicians actually do (custom-based) versus the factual determination (usually made by the jury) of what should a physician reasonably be expected to do (reasonable physician).

If a physician in a state that has legalized medical marijuana recommends medical marijuana to a patient, and the patient experiences a negative result and brings a malpractice suit against the physician, the state's applicable standard of care could change the result of the case:

- In a custom-based state such as Tennessee (which allows patients to possess cannabis oil containing no more than 0.9 percent THC for treatment of seizures), liability will turn on whether a physician in the region would typically recommend marijuana to a patient in the plaintiff's situation.[11] If medical marijuana is well-established in the state, the answer to that question might be yes (meaning no liability for the physician); but if medical marijuana has only recently been legalized and few physicians in the area actually recommend it, the answer could be no (meaning liability for the physician). In Tennessee, whose cannabis law was enacted in 2014, the outcome could be difficult to predict.
- In a reasonable physician state such as Oregon (whose medical marijuana statute was passed a decade ago), local custom with respect to marijuana recommendation is irrelevant, and the test is how an "ordinarily careful physician" would act.[12] The question of liability could easily devolve into an argument over the reasonableness of recommending marijuana to patients at all, with dueling experts attempting to persuade the jury that marijuana does or does not have medical benefits.

Physicians who wade into the medical marijuana space should know what standard of care their states apply in malpractice cases and, if the standard is custom-based, whether it is customary to recommend marijuana to patients.

Conclusion

As medical marijuana grows in popularity, there are opportunities for physicians in many states to consider cannabis another tool in their shed for helping patients find relief from disease. But because federal and state laws governing medical marijuana are in conflict, and state laws are widely varied, it is critical that providers understand the legal landscape and ask the right questions in their states before incorporating cannabis into their practices.

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[1] See State Medical Marijuana Laws, National Conference of State Legislatures, April 21, 2017, available at http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx. In addition, Louisiana has enacted laws related to medical marijuana, but because of the language of the statute, some policy organizations, including the Marijuana Policy Project and the National Conference of State Legislatures, do not classify Louisiana having a medical marijuana program.

[2] See Drug Schedules, United States Drug Enforcement Administration, available at https://www.dea.gov/druginfo/ds.shtml.

[3] Letter from Chuck Rosenberg, Acting Administrator of the DEA, Aug. 11, 2016, available at https://www.dea.gov/divisions/hq/2016/Letter081116.pdf.

[4] Public Law No: 115-31 (May 5, 2017).

[5] Statement by President Donald J. Trump on Signing H.R. 244 into Law, Office of the Press Secretary, The White House, May 5, 2017, available at https://www.whitehouse.gov/the-press-office/2017/05/05/statement-president-donald-j-trump-signing-hr-244-law.

[6] U.S. v. McIntosh, 833 F.3d 1163 (9th Circuit, August 2016).

[7] Memorandum for United States Attorneys re Guidance Regarding the Ogden Memo in Jurisdictions Seeking to Authorize Marijuana for Medical Use, from Deputy Attorney General James M. Cole, U.S. Department of Justice, June 29, 2011, available at https://www.justice.gov/sites/default/files/oip/legacy/2014/07/23/dag-guidance-2011-for-medical-marijuana-use.pdf; see also Memorandum for Selected United States Attorneys re Investigations and Prosecutions in States Authorizing the Medical Use of Marijuana, from Deputy Attorney General David W. Ogden, U.S. Department of Justice, Oct. 19, 2009, available at https://www.justice.gov/sites/default/files/opa/legacy/2009/10/19/medical-marijuana.pdf.

[8] Memorandum for All United States Attorneys re Guidance Regarding Marijuana Enforcement, from Deputy Attorney General James M. Cole, U.S. Department of Justice, Aug. 29, 2013, available at https://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf.

[9] Memorandum for Head of Department Components and United States Attorneys re Update on the Task Force on Crime Reduction and Public Safety, from Attorney General Jeff Sessions, U.S. Department of Justice, April 5, 2017, available at https://www.justice.gov/opa/press-release/file/955476/download.

[10] Id.

[11] "In a health care liability action, the claimant shall have the burden of proving by evidence as provided by subsection (b): The recognized standard of acceptable professional practice in the profession and the specialty thereof, if any, that the defendant practices in the community in which the defendant practices or in a similar community at the time the alleged injury or wrongful action occurred [and] [t]hat the defendant acted with less than or failed to act with ordinary and reasonable care in accordance with such standard." Tenn. Code Ann. § 29-26-115(a)(1)-(2).

[12] "A physician licensed to practice medicine or podiatry by the Oregon Medical Board has the duty to use that degree of care, skill and diligence that is used by ordinarily careful physicians in the same or similar circumstances in the community of the physician or a similar community." Or. Rev. Stat. § 677.095(1) (emphasis added).