

A Report Pursuant to Section 44-130-40(D) of the South Carolina Code of Laws

**Prepared for
the Members of the S.C. General Assembly**



**By the S.C. Department of Health and Environmental
Control**

December 29, 2016

DISCLAIMER: The South Carolina Department of Health and Environmental Control cannot provide legal advice. Accordingly, this report is for informational purposes only, and nothing herein should be considered a legal opinion.

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Executive Summary

In 2016, the South Carolina General Assembly amended the State's "Overdose Prevention Act."¹ The revisions, in pertinent part, direct the South Carolina Department of Health and Environmental Control (the "Department" or "DHEC") to conduct two studies relating to medical marijuana. Specifically, the General Assembly charged DHEC with studying the following and reporting to the General Assembly by January 1, 2017:

- (1) the possibility that a person experiencing an opioid-related overdose would be decreased if access to cannabis was legally permitted; and
- (2) the extent to which states have latitude by federal law for a Veterans Affairs' physician licensed in the State of South Carolina to provide a written certification that a veteran would benefit from the use of marijuana for medicinal purposes rather than being prescribed opioids.²

As to the first issue, DHEC found only one peer-reviewed research paper responsive to the question presented, and while that article showed some limited evidence to support a relationship between access to medical cannabis and a decrease in opioid-related overdose, limitations in that paper combined with the lack of any additional relevant research suggests that further study is needed to fully determine the effects of legal access to medical cannabis on opioid-related overdoses.

As to the second issue, by virtue of the fact that VA physicians are federal employees whose employment is governed by federal laws and directives from the Veterans Health Administration, DHEC was unable to discern any latitude afforded to the

¹ S.C. Code Ann. § 44-130-10, *et seq.* (1976, as amended).

² S.C. Code Ann. § 44-130-40(D) (1976, as amended).

states allowing VA physicians to provide written certification for a veteran to obtain medical marijuana, regardless of their state of licensure.

Study 1: The Possibility That A Person Experiencing An Opioid-Related Overdose Would Be Decreased If Access To Cannabis Was Legally Permitted

A. Introduction.

Drug overdose deaths have increased over the last fifteen years, and a majority of those deaths (more than six out of ten) involve an opioid.³ Opioid use continues to rise in the United States, driven by a variety of factors, including increases in prescriptions for opioid pain relievers and increases in use of heroin and other synthetic opioids.⁴ According to the Centers for Disease Control and Prevention (the “CDC”), since 1999, deaths from opioids (including prescription opioids and heroin) have quadrupled.⁵ This “opioid overdose epidemic” has become a national public health challenge, and prevention has focused on a variety of approaches, including encouraging changes to prescribing habits, expanding access to evidence-based substance abuse treatment, expanding access to medications to reverse opioid overdose, promoting prescription drug monitoring programs and supporting law enforcement strategies to reduce illicit opioid supply.⁶

It is theorized by some that increased legal access to medical cannabis may reduce opioid analgesic use by patients with chronic pain and, therefore, potentially reduce opioid

³ Rose A. Rudd, *et al.*, *Increases in Drug and Opioid-Involved Overdose Deaths—United States, 2010-2015*, MMWR Morbidity and Mortality Weekly Report (December 16, 2016).

⁴ *Id.* at 1.

⁵ National Center for Health Statistics, Centers for Disease Control and Prevention, Wide-ranging Online Data for Epidemiologic Research (WONDER), <http://wonder.cdc.gov> (2016).

⁶ Rudd, *supra* note 3 at 1.

analgesic overdoses.⁷ As of November 1, 2016, a total of twenty-eight states, the District of Columbia, Guam and Puerto Rico have enacted laws establishing medical cannabis programs.⁸ The purpose of this first study is to evaluate, based upon existing research, the possibility that a person experiencing an opioid-related overdose would be decreased if access to medical cannabis was legally permitted.

B. Methods.

In order to obtain peer-reviewed research articles, the Department conducted a systematic search of indexed bibliographic databases, including MEDLINE.⁹ MEDLINE is the National Library of Medicine's bibliographic database maintained by the National Center for Biotechnology Information.¹⁰ The database is international in scope and contains over 26 million citations from a variety of fields including medicine, nursing, healthcare systems and health policy.¹¹ Peer-reviewed research articles from MEDLINE contain science-based information that has undergone expert screening before publication.¹² As such, this process ensures meaningfulness within the context of other research in the discipline.¹³

In utilizing the database, the Department performed keyword searches, including Boolean operators ("AND", "OR", "NOT"), using terms and combinations of terms present in the research question (i.e. "Legal", "Cannabis", "Opioid", "Overdose"). Approximately fifty-

⁷ See Marcus A. Bachhuber, *et al.*, *Medical Cannabis Laws and Opiate Analgesic Overdose Mortality in the United States, 1999-2010*, JAMA Internal Medicine, Vol. 174, No. 10, Pg. 1668-1673 (October 2014).

⁸ See National Conference of State Legislatures, <http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx>.

⁹ See generally PubMed, <http://www.ncbi.nlm.nih.gov/pubmed/>.

¹⁰ See generally MEDLINE® Fact sheet, <https://www.nlm.nih.gov/pubs/factsheets/medline.html>.

¹¹ *Id.*

¹² See generally Paul Levett, Health Sciences Library, George Washington University, *Systematic Reviews: Medical Literature Databases to Search* (December 8, 2016), <http://libguides.gwumc.edu/c.php?g=27797&p=170444>.

¹³ Marco Pautasso, *Ten Simple Rules for Writing a Literature Review*, Pub. Library of Science, Computational Biology, Vol. 9, No. 7 (July 18, 2013).

two citations were identified, and the citation abstracts were reviewed based on the study question to determine appropriateness for inclusion. In addition, references cited in a relevant article¹⁴ and in a working paper¹⁵ were reviewed to find other potentially germane research not found in the MEDLINE search. Through these methods, the Department identified eight appropriate citations for further review and obtained electronic copies of the articles via existing subscription services and the Information Services Librarian at the South Carolina State Library. These full journal articles were then assessed for relevancy to the study question and for qualifying as peer-reviewed. Any studies determined not to be relevant to the study question¹⁶ or not peer-reviewed¹⁷ were not included in the results of this study, but were nevertheless examined.

The Department also spoke with subject matter experts from the Veterans Affairs Health System, including Rollin Gallagher, MD, MPH, the Deputy National Program Director for Pain Management, Sanjog Pangarkar, MD, an Assistant Clinical Professor at the UCLA David Geffen School of Medicine,¹⁸ and Michael Mithoefer, MD, a psychiatrist and clinical researcher,¹⁹ and also consulted with other states in the Southeast region.²⁰

C. Results.

The Department found only one peer-reviewed article responsive to the research question – “Medical Cannabis Laws and Opioid Analgesic Overdose Mortality in the United

¹⁴ See Bachhuber, *supra* note 7.

¹⁵ David Powell, *et al.*, *Do Medical Marijuana Laws Reduce Addiction and Deaths Related to Pain Killers?*, RAND Corp. Working Papers, Doc. No. WR-1130, DOI: 10.7249/WR1130 (November 2015).

¹⁶ See *Id.*

¹⁷ See Appendix A for list of articles evaluated but determined not to be relevant to the study question.

¹⁸ R. Gallagher and S. Pangarkar, personal communication (September 2, 2016).

¹⁹ M. Mithoefer, personal communication (December 22, 2016).

²⁰ N. Smith, personal communication (November 21, 2016).

States, 1999-2010,"²¹ published in *JAMA Internal Medicine* in October 2014. Two commentaries written in response to the article were also reviewed, including an invited commentary²² and a letter to the editor of *JAMA Internal Medicine*.²³

The article, by Marcus A. Bachhuber and others, describes a time-series analysis conducted to evaluate the association between the presence of state medical cannabis laws and opioid analgesic overdose mortality.²⁴ The authors included states which had medical cannabis laws effective prior to 2010 (a total of 13 states) and utilized cause-of-death data from the CDC abstracted by state from 1999-2010.²⁵ The authors defined opioid analgesic overdose deaths as fatal drug overdoses of any intent (utilizing the ICD-10 coding system)²⁶ where an opioid analgesic was also coded.²⁷ Therefore, the overdose definition included those overdose deaths where a patient used an opioid along with other drugs or those who used illicit drugs such as heroin. Several different analyses were performed with this data.²⁸

²¹ See Bachhuber, *supra* note 7.

²² Marie J. Hayes, et al., *Legalization of Medical Marijuana and Opioid Mortality*, *JAMA Internal Med.*, Vol. 174, No. 10, Pg. 1673-1674 (October 2014).

²³ John W. Finney, et al., *What Ecologic Analysis Cannot Tell Us About Medical Marijuana and Opioid Pain Medication Mortality*, *JAMA Internal Med.*, Vol. 175, No. 4, Pg. 655-657 (April 2015).

²⁴ See Bachhuber, *supra* note 7.

²⁵ *Id.* at 1669.

²⁶ Within the healthcare industry, providers, coders, IT professionals, insurance carriers, government agencies and others use codes from an international cataloging system known as the International Classification of Diseases, or ICD, to properly note diseases on health records, track epidemiological trends, and assist in medical reimbursement decisions. The World Health Organization (WHO) owns, develops and publishes ICD codes, and national governments and other regulating bodies adopt the system. The International Classification of Diseases, Tenth Edition (ICD-10) went into effect for the U.S. healthcare industry on Oct. 1, 2015. Accounting for modern advances in clinical treatment and medical devices, ICD-10 codes offer many more classification options, compared to those found in predecessor ICD-9.

²⁷ Bachhuber, *supra* note 7 at 1669.

²⁸ *Id.* at 1669-70.

The authors report that in the adjusted model,²⁹ medical cannabis laws were associated with a statistically significant mean 24.8% lower annual rate of opioid analgesic overdose deaths compared with states without laws allowing for the use of medical cannabis.³⁰ Additional analyses were performed to adjust for several state-level factors such as presence of a prescription drug monitoring program and unemployment rates, which the authors report were not significantly associated with opioid analgesic mortality rates.³¹

Although the analysis showed lower mean opioid analgesic overdose mortality rates in states with medical cannabis laws as compared to states without such laws, there are several limitations to this study. As stated by Bachhuber, these analyses were “ecologic,” so they “cannot adjust for characteristics of individuals within states, such as socioeconomic status, race/ethnicity, or medical and psychiatric diagnoses.”³² Ecologic studies by design are observational and do not determine causality.³³ There is no way to know if individuals are using cannabis instead of opioids in those states with medical cannabis laws or if there is less potential for opioid overdose if medical cannabis is legal. The overdose data used was based on death certificates, which creates a potential for misclassification and either over or underestimation of opioid-related deaths. The authors conclude that “although the present study provides evidence that medical cannabis laws

²⁹ *Id.* at 1673 (noting in Table 1 that the additional variables (i.e., the fixed effects of state and year) were adjusted for in the reported analyses).

³⁰ *Id.*

³¹ *Id.* at 1670.

³² *Id.* at 1671.

³³ Sander Greenland, *Ecologic versus individual-level sources of bias in ecologic estimates of contextual health effects*, *International Journal of Epidemiology*, Vol. 30, Issue 6, Pg. 1343-1350 (October 2001).

are associated with reductions in opioid analgesic overdose mortality on a population level, proposed mechanisms for this association are speculative and rely on indirect evidence.”³⁴ They state that further studies are needed, including examination of medical cannabis policies and whether increased access to cannabis could affect opioid misuse.³⁵

D. Discussion.

Bachhuber’s research into medical cannabis laws and opioid analgesic overdose mortality in the United States compared states with and without medical cannabis laws up to 2010.³⁶ States with medical cannabis laws had a lower mean annual opioid overdose mortality rate compared to states without medical cannabis laws.³⁷ The authors of this study stated that a connection between medical cannabis laws and opioid overdose mortality among individuals who misuse or abuse opioids is less clear.³⁸ The authors also found that state-specific characteristics, such as trends in attitudes or health behaviors, may explain variation in medical cannabis laws and opioid analgesic overdose mortality.³⁹ In addition, the authors stated that increased access to cannabis through medical cannabis laws could influence opioid misuse in either direction and further study is required.⁴⁰ In response to a letter to the editor of *JAMA Internal Medicine* regarding their study,⁴¹ the authors supported that large, prospective studies of the effects of medical

³⁴ Bachhuber, *supra* note 7 at 1672.

³⁵ *Id.* at 1671.

³⁶ *Id.* at 1669.

³⁷ *Id.* at 1671.

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ Marcus A. Bachhuber, *et al.*, *What Ecologic Analysis Cannot Tell Us About Medical Marijuana and Opioid Pain Medication Mortality - Reply*, *JAMA Internal Medicine*, Vol. 175, No. 4, Pg. 656-57 (April 2015).

cannabis in individuals with chronic pain are warranted.⁴² Studies of people with chronic pain could further clarify whether cannabis is a substitute for opioids and whether people who misuse opioids might reduce their use and potentially switch to cannabis.⁴³ The conclusions presented in response to queries of their initial study stated that the effect of medical marijuana laws on individual behavior remains unclear and questions remain regarding different regulatory schemes states use in legalizing medical marijuana.⁴⁴ A review of the literature conducted by the Arkansas Department of Health raised the same concerns regarding the Bachhuber article and its conclusions.⁴⁵

E. Conclusion.

This review was performed in order to identify and evaluate the scientific literature regarding the possibility that a person experiencing an opioid-related overdose would be decreased if access to cannabis was legally permitted. Only one relevant peer-reviewed research study was found,⁴⁶ and the results and limitations of that paper have been discussed. While the results of this research provide some evidence to support the hypothesis, no other supporting research was identified and, as stated previously, ecologic studies cannot prove causality. In conclusion, while there is some limited evidence to support the hypothesis of this review, further research is needed to evaluate the effects of legal access to cannabis on opioid-related overdoses.

⁴² *Id.* at 656.

⁴³ *Id.*

⁴⁴ *Id.* at 657.

⁴⁵ N. Smith, personal communication (Nov. 21, 2016).

⁴⁶ See Bachhuber, *supra* note 7.

Study 2: The Extent To Which States Have Latitude *By Federal Law* For A Veterans Affairs' Physician Licensed In The State Of South Carolina To Provide A Written Certification That A Veteran Would Benefit From The Use Of Marijuana For Medicinal Purposes Rather Than Being Prescribed Opioids

A. Federal Law and Policy.

1. The Controlled Substances Act.

In 1970, the United States Congress passed the Comprehensive Drug Abuse Prevention and Control Act, more commonly referred to as the Controlled Substances Act or CSA.⁴⁷ The Act's main objectives "were to conquer drug abuse and to control the legitimate and illegitimate traffic in controlled substances."⁴⁸ Congress devised the CSA as a closed regulatory system, making it unlawful to manufacture, distribute, dispense, or possess any controlled substance except as authorized by the CSA.⁴⁹

The CSA categorizes all controlled substances into one of five schedules, depending on a substance's accepted medical uses, potential for abuse, and psychological and physical effects on the body.⁵⁰ Contemporaneously with enactment of the CSA, Congress classified marijuana as a Schedule I substance, in part because marijuana was considered to have "no accepted medical use" and a "high risk of dependency."⁵¹ As a Schedule I substance, it is illegal under federal law to manufacture, distribute, or possess marijuana;

⁴⁷ Comprehensive Drug Abuse Prevention and Control (Controlled Substances) Act, 21 U.S.C. §§ 801 - 904 (1970).

⁴⁸ *Gonzales v. Raich*, 545 U.S. 1, 12-13, 125 S. Ct. 2195, 2203 (2005) (citing *Id.* at § 801 (1970)).

⁴⁹ Controlled Substances Act, *supra* note 47 at §§ 841(a)(1), 844(a)).

⁵⁰ *Id.* at §§ 811 & 812.

⁵¹ *Id.* at § 812(b)(1) & (c).

the sole exception being use of the drug as part of a Food and Drug Administration preapproved research study.⁵²

Despite the fact that marijuana remains an illegal substance at the federal level, twenty-eight states, the District of Columbia, Guam and Puerto Rico have now passed legislation to allow for its medicinal use.⁵³ While there has been no change in marijuana's scheduling under the CSA, steps have been taken at the national level affecting the law's enforcement.

2. Department of Justice Memoranda.

The Department of Justice ("DOJ") issued at least four separate memoranda outlining federal policy on the cannabis industry beginning in 2009. The first, from Deputy Attorney General David Ogden, set the stage for today's medical marijuana market under a permissive Obama administration.⁵⁴ In that memo, Ogden outlined the core priorities of DOJ's efforts against narcotics and emphasized that it would be toward those priorities that DOJ's resources should be directed.⁵⁵ Addressing his U.S. attorneys, Ogden wrote that "[a]s a general matter, pursuit of these [federal] priorities should not focus federal

⁵² *Id.* at §§ 823(f), 841(a)(1), 844(a). Additional information concerning the availability of marijuana for research purposes can be found at the United States Food and Drug Administration's website: <http://www.fda.gov/NewsEvents/PublicHealthFocus/ucm421173.htm>.

⁵³ Medical Marijuana Laws by State, <http://www.ncsl.org/research/health/state-medical-marijuana-laws.aspx#3> (listing the following states with medical marijuana programs: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Hawaii, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont, Washington, Washington D.C.).

⁵⁴ David W. Ogden, Dep. Att'y Gen., U.S. Dept. of Justice, *Memorandum to Selected United States Attorneys* (October 19, 2009), <https://www.justice.gov/sites/default/files/opa/legacy/2009/10/19/medical-marijuana.pdf>.

⁵⁵ *Id.* at 1.

resources in your States on individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana.”⁵⁶

A second memo in June 2011, this time from Deputy Attorney General James Cole, built upon the first, but emphasized that Ogden’s memo “was never intended to shield such activities [as commercial cultivation, sale, and distribution of marijuana for purported medical purposes] from federal enforcement action and prosecution, even where those activities purport to comply with state law.”⁵⁷

In 2013, Cole issued a third DOJ memorandum, this time addressing the seeming contradiction between federal prohibition of cannabis and two state ballot initiatives that legalized the possession of small amounts of marijuana for recreational use.⁵⁸ Described as a guidance document to all U.S. attorneys, Cole explained that DOJ would exercise its discretion not to prosecute certain individuals for acts that continue to be federal crimes under the Controlled Substances Act so long as states implement strong and effective regulatory and enforcement systems when enacting their marijuana programs, including adequate enforcement in a manner that does not undermine stated federal enforcement priorities.⁵⁹ On the other hand, if state marijuana laws are enacted or enforced contrary to federal priorities, for example, allowing the distribution of marijuana to minors or the

⁵⁶ *Id.* at 1-2.

⁵⁷ James M. Cole, Dep. Att’y Gen., U.S. Dept. of Justice, *Memorandum for United States Attorneys* (June 29, 2011), <https://www.justice.gov/sites/default/files/oip/legacy/2014/07/23/dag-guidance-2011-for-medical-marijuana-use.pdf>.

⁵⁸ James M. Cole, Dep. Att’y Gen., U.S. Dept. of Justice, *Memorandum for All United States Attorneys* (August 29, 2013), <https://www.justice.gov/iso/opa/resources/3052013829132756857467.pdf>.

⁵⁹ *Id.*

revenue from the sale of marijuana to go to criminal enterprises or the diversion of marijuana to other states, then the Department of Justice will certainly intervene.⁶⁰

Finally, in February 2014, Cole issued a fourth memorandum from the DOJ, this time attempting to alleviate the concerns of banks that did not want to work with cannabis businesses operating under state marijuana laws.⁶¹ Again, Cole emphasized to his U.S. attorneys that the primary consideration in exercising their discretion to use limited DOJ investigative and prosecutorial resources was whether the actions of individuals and institutions were consistent with, and did not violate, the federal enforcement priorities discussed in the DOJ memoranda.⁶²

While these DOJ memoranda suggest that by policy the Department of Justice will not prosecute those individuals and entities participating in state marijuana programs that are consistent with federal priorities, it is important to note that all four memoranda contain what can be described as a disclaimer, each similar to the other. As an example:

[T]his memorandum is intended solely as a guide to the exercise of investigative and prosecutorial discretion. This memorandum does not alter in any way the Department's authority to enforce federal law, including federal laws relating to marijuana, regardless of state law. Neither the guidance herein nor any state or local law provides a legal defense to a violation of federal law, including any civil or criminal violation of the CSA *This memorandum is not intended to, does not, and may not be relied upon to create any rights, substantive or procedural, enforceable at law by any party in any matter civil or criminal* [N]othing herein precludes investigation or prosecution, even in the absence of any one of the factors listed above [related to federal priorities], in particular circumstances where

⁶⁰ *Id.*

⁶¹ James M. Cole, Dep. Att'y Gen., U.S. Dept. of Justice, *Memorandum for All United States Attorneys* (February 14, 2014), <http://www.dfi.wa.gov/documents/banks/dept-of-justice-memo.pdf>.

⁶² *Id.* at 2-3.

investigation and prosecution otherwise serves an important federal interest.⁶³

3. The Appropriations Rider.

Separate from the policy guidelines outlined by the Department of Justice, but similar in application, Congress enacted the following rider in an omnibus appropriations bill funding the government through September 30, 2015:

None of the funds made available in this Act to the Department of Justice may be used, with respect to the States of Alabama, Alaska, Arizona, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Hawaii, Illinois, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, Oregon, Rhode Island, South Carolina, Tennessee, Utah, Vermont, Washington, and Wisconsin, to prevent such States from implementing their own State laws that authorize the use, distribution, possession, or cultivation of medical marijuana.⁶⁴

Various short-term measures extended the appropriations and the rider through December 22, 2015. On December 18, 2015, Congress enacted a new appropriations act, which appropriated funds through the fiscal year ending September 30, 2016, and included essentially the same rider as above.⁶⁵

At least one court, the Ninth Circuit Court of Appeals, has determined that the rider prevents the Department of Justice from taking federal enforcement actions that interfere with a state's ability to implement its own state medical marijuana law.⁶⁶ However, that same court cautioned that despite the lack of available funding to prosecute those seeking

⁶³ *Id.* at 4 (emphasis added).

⁶⁴ Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, § 538, 128 Stat. 2130, 2217 (2014).

⁶⁵ Consolidated Appropriations Act, Pub. L. No. 114-113, § 542, 129 Stat. 2242, 2332-33 (2015) (adding Guam and Puerto Rico and changing "prevent such States from implementing their own State laws" to "prevent any of them from implementing their own laws").

⁶⁶ *United States v. McIntosh*, 833 F.3d 1163 (9th Cir. 2016).

to implement state medical marijuana programs, those programs remain illegal under federal law:

The [Controlled Substances Act] prohibits the manufacture, distribution, and possession of marijuana. Anyone in any state who possesses, distributes, or manufactures marijuana for medical or recreational purposes (or attempts or conspires to do so) is committing a federal crime. The federal government can prosecute such offenses for up to five years after they occur. Congress currently restricts the government from spending certain funds to prosecute certain individuals. But Congress could restore funding tomorrow, a year from now, or four years from now, and the government could then prosecute individuals who committed offenses while the government lacked funding. Moreover, a new president will be elected soon, and a new administration could shift enforcement priorities to place a greater emphasis on prosecuting marijuana offenses.

Nor does any state law “legalize” possession, distribution, or manufacture of marijuana. Under the Supremacy Clause of the Constitution, state laws cannot permit what federal law prohibits. Thus, while the CSA remains in effect, *states cannot actually authorize the manufacture, distribution, or possession of marijuana*. Such activity remains prohibited by federal law.⁶⁷

On September 29, 2016, Congress passed a new appropriations act effective through September 30, 2017.⁶⁸ The new appropriations act does not reference the rider, and it is unclear at this time whether Congress will extend the rider into 2017.

4. VHA Directive 2011-004.

The conflicts created through the passage of these state marijuana laws are not solely legal, but extend to clinical and ethical dilemmas for physicians, particularly those practicing in medical facilities owned and operated by the United States Veterans Health Administration (“VHA”). As employees of the federal government, these physicians are required to conform their practices not only to federal law, but also to the policy directives

⁶⁷ *Id.* at 1179, n. 5 (internal citations omitted) (emphasis added).

⁶⁸ Continuing Appropriations and Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, and Zika Response and Preparedness Act of 2017, Pub. L. No. 114-223, 130 Stat. 857 (2016).

of the VHA.⁶⁹ The most recent relevant directive, VHA Directive 2011-004, restricts VA physicians from participating in state medical marijuana programs:

Department of Veterans Affairs (VA) providers must comply with all Federal laws, including the Controlled Substances Act. Marijuana is classified as a Schedule I drug under the Controlled Substances Act Veterans who receive their care from [the] VA and who have a desire to participate in one of several State marijuana programs might ask their VA physicians to complete State authorization forms State laws authorizing the use of Schedule I drugs, such as marijuana, even when characterized as medicine, are contrary to Federal law. The Controlled Substances Act designates Schedule I drugs as having no currently-accepted medical use and there are criminal penalties associated with production, distribution, and possession of these drugs. *State law has no standing on Federal properties It is VHA policy to prohibit VA providers from completing forms seeking recommendations or opinions regarding a Veteran's participation in a State marijuana program.*⁷⁰

With there being VA hospitals and clinics located in every state that has passed medical marijuana legislation, veterans are eligible to obtain medical marijuana by virtue of their residence in these states.⁷¹ However, federal law and the current VHA Directive prohibit VA physicians from aiding their patients who desire to participate in these state medical marijuana programs. As a result, VA physicians cannot provide the full range of medical services available to veterans in the private sector, requiring veterans to seek such services outside of the VA.

⁶⁹ Robert A. Petzel, *Access to Clinical Programs for Veterans Participating in State-Approved Marijuana Programs*, VHA Directive 2011-004 ("Department of Veterans Affairs (VA) providers must comply with all Federal laws, including the Controlled Substances Act.") (January 31, 2011).

⁷⁰ *Id.* at 1 (emphasis added) (internal citations omitted).

⁷¹ Cynthia M.A. Geppert, *Legal and Clinical Evolution of Veterans Health Administration Policy on Medical Marijuana*, Vol. 31 Fed. Pract. 3, 6 (March 2014).

5. The Veterans Equal Access Amendment.

Section 44-130-40(D) of the South Carolina Code, under which DHEC initiated these studies, refers to the federal Veterans Equal Access Amendment (the "Amendment").⁷² Intended to supersede the current VHA Directive and allow VA physicians freedom to issue written certifications to veterans to obtain medical marijuana under state programs, it is from the Amendment the Department expected to find latitude under federal law.

On May 19, 2016, the United States House of Representatives passed the Amendment, adding the following language to the Military Construction and Veterans Affairs and Related Agencies Appropriations Act:

None of the funds made available by this Act may be used to implement, administer, or enforce Veterans Health Administration directive 2011-004 (or directive of the same substance) with respect to the prohibition on "VA providers from completing forms seeking recommendations or opinions regarding a Veteran's participation in a State marijuana program."⁷³

The bill was received in the U.S. Senate on May 26, read twice, and placed on the Senate Legislative Calendar.⁷⁴ No further action was taken by the Senate at that time.

In June 2016, a bicameral conference committee of the United States Congress removed the language of the Amendment from the overall Appropriations Act.⁷⁵ Ultimately, both the House and Senate passed a multi-faceted spending package on September 28, 2016, containing the Appropriations Act, but not the Amendment.⁷⁶

⁷² S.C. Code Ann. § 44-130-40(D) (1976, as amended).

⁷³ Military Constr. and Veterans Affairs and Related Agencies Appropriations Act of 2017, H.R. 4974 (quoting H. Amdt. 1062 (the "Blumenauer Amendment") (consideration: CR H2861-2862)) 114th Cong. (2nd Sess. 2016).

⁷⁴ Cong. Rec. H2837, Vol. 162 No. 80 (daily ed. May 19, 2016), 114th Cong. (2nd Sess. 2016).

⁷⁵ See Steven Nelson, Staff Writer, U.S. News & World Report, *Veteran Pot Amendment that Passed House and Senate Won't Reach Obama's Desk* (September 29, 2016), <http://www.usnews.com/news/articles/2016-09-29/high-hopes-dashed-for-pot-amendment-that-passed-house-and-senate>.

⁷⁶ See Continuing Appropriations Act of 2017, *supra* note 68.

Other legislation containing language similar to the Amendment met with the same fate. The Veterans Equal Access Act, a bill introduced by U.S. House Representative Earl Blumenauer (D-OR), was referred to the Subcommittee on Health on February 13, 2015.⁷⁷ A comprehensive marijuana-reform bill introduced in the Senate, known as the Compassionate Access, Research Expansion, and Respect States Act of 2015 or “C.A.R.E.R.S. Act”, was read twice and referred to the Committee on the Judiciary on March 10, 2015.⁷⁸ An identical bill was introduced in the House and referred to the Subcommittee on Crime, Terrorism, Homeland Security, and Investigations by the House Judiciary Committee on April 21, 2015.⁷⁹ Finally, the Veterans ACCESS Act was introduced in the Senate, read twice, and referred to the Committee on Veterans Affairs on May 16, 2016.⁸⁰ None of these bills made it out of committee.

As of the writing of this study, the VHA Directive prohibiting VA physicians from writing certifications to veterans for medical marijuana remains effective.

B. Discussion and Conclusion.

The narrow question before the Department is “the extent to which states have latitude by *federal law* for a Veterans Affairs’ physician licensed in the State of South Carolina to provide written certification that a veteran would benefit from the use of marijuana for medicinal purposes rather than being prescribed opioids.”⁸¹ Under the

⁷⁷ Veterans Equal Access Act, H.R. 667, 114th Cong. (1st Sess. 2015).

⁷⁸ Compassionate Access, Research Expansion, and Respect States (C.A.R.E.R.S.) Act of 2015, S. 683, 114th Cong. (1st Sess. 2015).

⁷⁹ Compassionate Access, Research Expansion, and Respect States (C.A.R.E.R.S.) Act of 2015, H.R. 1538, 114th Cong. (1st Sess. 2015).

⁸⁰ Veterans ACCESS Act, S. 2933, 114th Cong. (2nd Sess. 2016).

⁸¹ S.C. Code Ann. § 44-130-40(D) (1976, as amended) (emphasis added).

present circumstances, the Department has not identified any latitude to the States afforded by federal law outside of a research context.

Whether a VA physician is licensed in South Carolina or any other state appears to be irrelevant to the question at hand.⁸² The fact remains that VA physicians are federal employees subject to the requirements of the Veterans Health Administration. Congress did not pass the Veterans Equal Access Amendment or any legislation containing similar language during the previous two sessions. As a result, VHA Directive 2011-004 remains in full force and effect.⁸³ The Directive prohibits VA providers from completing forms seeking recommendations or opinions regarding a veteran's participation in a State marijuana program.⁸⁴ As a result, VA physicians presently cannot write certifications for veterans to obtain medical marijuana regardless of their state of licensure. While current DOJ policy and the Appropriations Rider may give some comfort in terms of prosecution, neither confers latitude to the states to override the directives of the VHA.

At least one federal court implicitly agrees with the Department's assessment. In *Americans for Safe Access v. Drug Enforcement Administration*,⁸⁵ the United States Court of Appeals for the District of Columbia addressed the question of whether petitioners had standing to challenge the DEA's denial of a request to reschedule marijuana under the CSA.

⁸² A physician employed by the Veterans Health Administration and practicing in a VHA facility in South Carolina is not necessarily licensed by the State of South Carolina. According to the Veterans Health Administration, only one active state medical license is necessary to practice in any VA facility across the country. See William H. Campbell, *VA Handbook 5005/7*, Part II, Ch. 3, Pg. II-77 ("Any physician . . . appointed under 38 U.S.C., chapter 73 or 74 is required to possess an active, current, full and unrestricted license to practice medicine, in a State . . .") (June 16, 2004).

⁸³ Although the Directive expired on January 31, 2016, its policy will continue to be the status quo for VA physicians unless it is officially replaced or rescinded. See David J. Shulkin, *Controlled National Policy/Directives Management System*, VHA Directive 6330 (June 24, 2016).

⁸⁴ Petzel, *supra* note 69 at 1.

⁸⁵ 706 F.3d 438 (D.C. Cir. 2013).

The court did not face the question that is before the Department; however, it recognized that the ability of a veteran to obtain a written certification for medical marijuana rests with the VHA and the federal government:

The record before the court clearly shows that the VA's refusal to complete [state] medical marijuana forms is traceable to the DEA's continued decision to classify marijuana as Schedule I. VHA Directive 2011-004, which prohibits VA providers from completing state medical marijuana forms, cites three times to marijuana's Schedule I status. Indeed, compliance with the CSA is the only justification the Directive cites for this policy.

* * *

Under existing regulations and VHA Directive 2008-071, VA clinicians are subject to a non-discretionary duty to "honor all requests by patients for completion of non-VHA medical forms." The only thing stopping VA clinicians from performing this duty . . . is VHA Directive 2011-004. The only reason the VA cites for implementing VHA Directive 2011-004 is the classification of marijuana as a Schedule I drug. Therefore, were marijuana rescheduled to reflect its potential for medical use, the VA would have no expressed reason to retain VHA Directive 2011-004 and VA clinicians would likely be subject to a non-discretionary duty to complete . . . state medical marijuana forms.⁸⁶

Based upon the above, so long as marijuana remains a Schedule I controlled substance and the VHA Directive remains effective, the Department cannot discern any latitude for a state to allow a Veterans Affairs' physician, whether licensed in the State of South Carolina or not, to provide written certification that a veteran would benefit from the use of marijuana for medicinal purposes rather than being prescribed opioids.

⁸⁶ *Id.* at 447-448.

Appendix

In addition to the sources cited throughout the report, the Department reviewed other sources as part of its two studies, including, but not limited to:

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United States v. Oakland Cannabis Buyers' Cooperative, 532 U.S. 483, 121 S. Ct. 1711 (2001).

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