ILLINOIS STATE MEDICAL SOCIETY

Resolution 05.2024-11
(A-25)

Introduced by: Jerrold B. Leikin MD, ISMS Member

Subject: Rescheduling of Cannabis

Referred to: Council on Medical Service

Whereas, the Drug Enforcement Administration (DEA) is a federal law enforcement agency; and

Whereas, the DEA classifies controlled substances into five (5) distinct categories or schedules depending upon the drug's acceptable medical use along with the drug's abuse or dependency potential; and

Whereas, Schedule I drugs, substances, or chemicals are defined as drugs with no currently accepted medical use and a high potential for abuse. Some examples of Schedule I drugs are: heroin, lysergic acid diethylamide (LSD), 3,4-methylenedioxymethamphetamine (ecstasy), methaqualone, and peyote; and

Whereas, Schedule II drugs, substances, or chemicals are defined as drugs with a high potential for abuse, with use potentially leading to severe psychological or physical dependence. These drugs are also considered dangerous. Some examples of Schedule II drugs are: combination products with less than 15 milligrams of hydrocodone per dosage unit (Vicodin), cocaine, methamphetamine, methadone, hydromorphone (Dilaudid), meperidine (Demerol), oxycodone (OxyContin), fentanyl, Dexedrine, Adderall, and Ritalin; and

Whereas, Schedule III drugs, substances, or chemicals are defined as drugs with a moderate to low potential for physical and psychological dependence. Schedule III drugs abuse potential is less than Schedule I and Schedule II drugs but more than Schedule IV. Some examples of Schedule III drugs are: products containing less than 90 milligrams of codeine per dosage unit (Tylenol with codeine), ketamine, anabolic steroids, testosterone, and buprenorphine; and

Whereas, Schedule IV drugs, substances, or chemicals are defined as drugs with a low potential for abuse and low risk of dependence. Some examples of Schedule IV drugs are: Xanax, Soma, Darvon, Darvocet, Valium, Ativan, Talwin, Ambien, and Tramadol; and

Whereas, the DEA plans to move cannabis from Schedule I to Schedule III under the Controlled Substance Act (CSA); and

Whereas, the prohibition on business deductions in Section 280E of the Internal Revenue (IRS) Code applies to any trade or business that "consists of trafficking in controlled substances (within the meaning of schedule I and II of the Controlled Substances Act) which is prohibited by federal law or the law of any state in which such trade or business is conducted;" and

Whereas, because the provision applies only to activities involving substances in Schedule I or II, moving cannabis from Schedule I to Schedule III would allow cannabis to deduct business expenses on federal tax filings; and

Whereas, due to these changes in the IRS code, analysts project near-term financial outcomes could include approximately $1.1 billion in cash flow improvements across the sector due to the removal of tax burdens under the IRS's 280E that disallows cannabis companies from deducting normal business expenses; and

Whereas, in 2022, cannabis use had an estimated lifetime prevalence of 38% among 12th grade students in the United States, a 17% increase compared to 1992; and

Whereas, a recent meta-analysis which included youth and adult studies reported that among individuals who used cannabis, 22% met criteria for Cannabis Use Disorder (CUD) (95% CI 18%–26%. CUD was most prevalent in young adults, there being among the cohort of cannabis-using 21-year-old emerging adults a very high risk of CUD (41.1%, 95% CI 38.4%–43.8%); and

Whereas, prospective evidence suggests higher potency cannabis which is now exceedingly common (THC content averaging >=12.3%), increases risk for onset of first cannabis use disorder symptom by almost five-fold within the first year of use; and

Whereas, the primary beneficiary of cannabis rescheduling is the cannabis industry for financial purposes with no benefit to patient care and an increase in recreational use/availability leading to all the potential adverse consequences associated with this use; and

Whereas, cannabis is a drug with high potential for abuse, particularly in young adults, with use potentially leading to severe psychological or physical dependence and is not a drug with a moderate to low potential for physical and psychological dependence and is therefore more in line with Schedule II drugs as opposed to Schedule III drugs; therefore, be it

RESOLVED, that the Illinois State Medical Society advocate and support rescheduling cannabis from a Schedule I drug to a Schedule II drug; and be it further

RESOLVED, that this resolution be forwarded to the American Medical Association for adoption.

References:

1. https://crsreports.congress.gov/product/pdf/LSB/LSB11105
2. Mikos, Robert A. "The False Promise of Rescheduling." Vanderbilt Law Research Paper 24-21 (2024).
3. https://markets.businessinsider.com/news/stocks/post-cannabis-rescheduling-what-s-next-for-marijuana-giants-potential-1-1b-cash-flow-boost-from-irs-280e-removal-1033339812
4. Leung J, Chan GCK, Hides L, et al.: What is the prevalence and risk of cannabis use disorders among people who use cannabis? a systematic review and meta-analysis. Addict Behav 2020; 109:106479
5. Hinckley, Jesse D., Jacqueline-Marie N. Ferland, and Yasmin L. Hurd. "The developmental trajectory to cannabis use disorder." American Journal of Psychiatry 181, no. 5 (2024): 353-358.
6. Arterberry BJ, Treloar Padovano H, Foster KT, Zucker RA, Hicks BM. Higher average potency across the United States is associated with progression to first cannabis use disorder symptom. Drug Alcohol Depend. 2019 Feb 1;195:186-192. doi: 10.1016/j.drugalcdep.2018.11.012. Epub 2018 Dec 17. PMID: 30573162; PMCID: PMC6376862.
7. Leikin J.B. How Physicians Can Combat the Cannabis Epidemic, Chicago Medicine, September 2021, Pages 8-9
8. https://www.dea.gov/sites/default/files/2024-05/Scheduling%20NPRM%20508.pdf

Fiscal Note:

n/a

Existing ISMS policy related to this issue:

It is ISMS policy that all relevant medical stakeholders, including ISMS, be provided the opportunity for input into any rulemaking or other processes establishing regulation of recreational marijuana; should recreational marijuana be legalized in Illinois, ISMS remain committed to maximizing the safeguard to limit adverse events and the advancement of continued scientific study; ISMS supports legislation that urges lawmakers to slow the process of legalizing recreational marijuana in Illinois, so that lawmakers, stakeholders, and experts alike have the chance to consider the societal impact of legalization and examine all the data from other states that have passed similar legislation. (2019 Annual Meeting; BOT 2019-JAN; Last BOT Review 2019)

ISMS endorses the following principles to regulate recreational marijuana, should legislation be proposed and enacted that legalizes its use in Illinois: 1. The stance of the State toward recreational marijuana should be that, because of health concerns, promotion of use should be as minimal as possible. 2. All forms of recreational marijuana that might be attractive to children (e.g. soda, candy, cookies, flavored marijuana) should be prohibited. 3. The State should maintain strict control over all direct and indirect forms of marketing, advertising, promotion and sponsorships, in order to avoid marketing that appeals to children. Advertising limitations, consistent with anti-smoking norms, should be maintained and risk perception should be high. Advertising other than at the website of the business and at the physical location of the business should be prohibited. 4. If the State decides to allow more advertising, ISMS advocates for: • Limiting any marketing within 1,000 feet of places that children and young adults frequent, such as schools, childcare facilities, parks, on public spaces, bus/train stops and college campuses. • Limiting the number and size of dispensary signs on premises. • Prohibiting promotional giveaways, discounts, coupons or games. • A prohibition on the depiction of persons under the age of 35 years. • Prohibiting any health or therapeutic claims. • Prohibiting mass marketing campaigns (including TV, internet, radio) toward audiences that may be comprised of a significant amount of minors. • The inclusion of warning labels on any and all marketing pieces. 5. The State should maintain regulation over packaging such that the package cannot be used as a marketing tool. Packaging should prominently display the potency of the product by indicating the quantities of the active ingredients tetrahydrocannabinol (THC) and cannabidiol (CBD). Packaging should be in a single dull color chosen by the state with one format for the packaging. Lettering should be in one font with restrictions on the font size. A health warning should be on each package. For cannabis products: “GOVERNMENT WARNING: THIS PRODUCT CONTAINS CANNABIS, A SCHEDULE I CONTROLLED SUBSTANCE WITH A HIGH POTENTIAL FOR ABUSE AND THE POTENTIAL TO CREATE SEVERE PSYCHOLOGICAL AND/OR PHYSICAL DEPENDENCE. KEEP OUT OF REACH OF CHILDREN AND ANIMALS. CANNABIS PRODUCTS MAY ONLY BE POSSESSED OR

CONSUMED BY PERSONS 21 YEARS OF AGE OR OLDER UNLESS THE PERSON IS A QUALIFIED PATIENT. THE INTOXICATING EFFECTS OF CANNABIS PRODUCTS MAY BE DELAYED UP TO TWO HOURS. CANNABIS USE BEFORE AGE 25 MAY AFFECT BRAIN DEVELOPMENT. CANNABIS USE WHILE PREGNANT OR BREASTFEEDING MAY BE HARMFUL. CONSUMPTION OF CANNABIS PRODUCTS IMPAIRS YOUR ABILITY TO DRIVE AND OPERATE MACHINERY. PLEASE USE EXTREME CAUTION." 6. THC concentration should be limited to 10% in all inhalational products and 15% in all other products, and individual serving size should be regulated and limited to 10 mg, with individual packaging required for each serving. 7. Public use of marijuana should be prohibited, as well as its use in any setting where tobacco/nicotine smoking or vaping are prohibited. 8. State regulatory review of all new products should occur before the new products come to the market. 9. Laboratory confirmation of quantities of THC and CBD in products should be required and documented on package labeling. 10. The State should set up a process to determine that all products sold on the market are free of pesticides and contaminants (e.g., mold). 11. At least 10% of the State's revenue from the sale of marijuana products should be dedicated to public education regarding risks of recreational marijuana use, particularly risks to children, and an additional 10% to medical and public health research on the harms and benefits of marijuana to individual and public health. 12. Marijuana blood levels should always be measured in any case where alcohol blood levels are measured, and State funds should be allocated to measure these levels. Funds should also be allocated to educate and train law enforcement on drug recognition expert (DRE) training and the Illinois Department of Transportation to implement a statewide impaired driving education campaign. 13. Marijuana should be regulated primarily by the Illinois Department of Public Health, and the Department's highest priority should be the preservation of the public's health. The controlling board for such regulation should have representation and input from all interested stakeholders with no financial connections to the marijuana industry, including the Illinois State Medical Society, organizations representing interested medical specialties as well as other professional healthcare organizations (nurses, dentists, hospitals, substance use disorder treatment centers, etc.). Representatives of the marijuana industry, including cultivators and dispensaries, should not sit on the board of any entity overseeing or controlling the marijuana industry. 14. No additives to marijuana products should be allowed, especially any substances that may increase the addictive potential of the products. 15. Local governmental authorities should be allowed to opt out of marijuana sales in their areas of jurisdiction without the need to have a public referendum. (HOD 2018; BOT 2019-JAN, 2021-OCT; Amended 2022; Last BOT Review 2019)

The Board of Trustees adopted Resolution 10.2018-07 (A-19) as amended: RESOLVED, that ISMS not endorse legislation seeking to legalize recreational marijuana in Illinois; and be it further RESOLVED, that the ISMS adopt policy that all relevant medical stakeholders, including ISMS, be provided the opportunity for input into any rulemaking or other processes establishing regulation of recreational marijuana; and be it further RESOLVED, that should recreational marijuana be legalized in Illinois, ISMS remain committed to maximizing the safeguards to limit adverse events and the advancement of continued scientific study. (BOT - JAN 2019)

Board of Trustees adopted Substitute Resolution 02.2019-17 (A-19) in lieu of Resolution 02.2019-17 (A-19), Decriminalization of Marijuana Use. (BOT – APR 2019)

ISMS adopted Substitute Resolution 10.2018-07 (A-19), Legalization of Marijuana for Recreational Use, in lieu of Resolutions 10.2018-07 (A-19) and 01.2019-12 (A-19), which states: RESOLVED, that ISMS not endorse legislation seeking to legalize recreational marijuana in Illinois; and be it further RESOLVED, that the ISMS adopt policy that all relevant medical stakeholders, including ISMS, be provided the opportunity for input into any rulemaking or other processes establishing regulation of recreational marijuana; and be it further RESOLVED, that should recreational marijuana be legalized in Illinois, ISMS remain committed to maximizing the safeguard to limit adverse events and the advancement of continued scientific study; and be it further RESOLVED, that ISMS support legislation that urges lawmakers to slow the process of legalizing recreational marijuana in Illinois, so that lawmakers, stakeholders, and experts alike have the chance to consider the societal impact of legalization and examine all the data from other states that have passed similar legislation. (2019 Annual Meeting)

ISMS opposes legalization of the use of recreational marijuana, or marijuana for non-medical purposes. (HOD 2018)

ISMS supports the following policies related to medical marijuana dispensing organizations: 1. As part of the licensing requirements for marijuana dispensing entities, a detailed explanation of cannabis' adverse effects and risks should be disseminated to each individual at the time of dispensing. 2. Such patient education material should include: A) Updated information about the purported effectiveness of various forms and methods of medical cannabis administration; B) Updated information about the purported effectiveness of strains of medical cannabis on specific conditions; C) Current educational information issued by IDPH about the health risks associated with the use or abuse of cannabis; D) Whether possession of cannabis is illegal under federal law; E) Information about possible adverse effects; F) Prohibition on smoking medical cannabis in public places; and G) Any other appropriate patient education or support materials (68 Ill. Adm. Code 1290.425). 3. Receipt of such patient education information should be individually documented by the dispensing organization. 4. The written information

should be standardized and approved by the Illinois Department of Public Health (IDPH). (HOD 2015; Reaffirmed 2016)

ISMS does not endorse the legalization of the possession or use of marijuana. (HOD 1976; Last BOT Review 2011)

ISMS supports a total ban on edible recreational cannabis products. (2019 Annual Meeting; BOT 2019-APR; Last BOT Review 2019)

ISMS adopted Substitute Resolution 10.2018-07 (A-19), Reaffirm ISMS Policy Against Recreational Use of Cannabis, in lieu of Resolution 10.2018-07 (A-19) and Substitute Resolution 01.2019-12 (A-19), which states: RESOLVED, that the Illinois State Medical Society reaffirm the current policy adopted by the ISMS House of Delegates in April, 2018, opposing any legislation supporting the use of recreational cannabis in Illinois. (2019 Annual Meeting)

ISMS affirmed the Board's adoption of Resolution 01.2019-13 (A-19), Banning Edible Cannabis Products, as amended, which states: RESOLVED, that the Illinois State Medical Society supports a total ban on edible recreational cannabis products; and be it further RESOLVED, that the Illinois State Medical Society assist in introducing legislation to ban all edible recreational cannabis products; and be it further RESOLVED, that this resolution be forwarded to the American Medical Association for adoption. (2019 Annual Meeting)

Existing AMA policy related to this issue:

Cannabis and Cannabinoid Research H-95.952

Our American Medical Association calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease.

Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product.

Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include:

- disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation;
- sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes;
- confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support.

Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding.

Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use.

Our AMA will advocate for urgent regulatory and legislative changes necessary to fund and perform research related to cannabis and cannabinoids.

Our AMA will create a Cannabis Task Force to evaluate and disseminate relevant scientific evidence to health care providers and the public.