THE MEDICAL MARIJUANA MESS
A prescription for fixing a broken policy

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MARCH 22, 2016

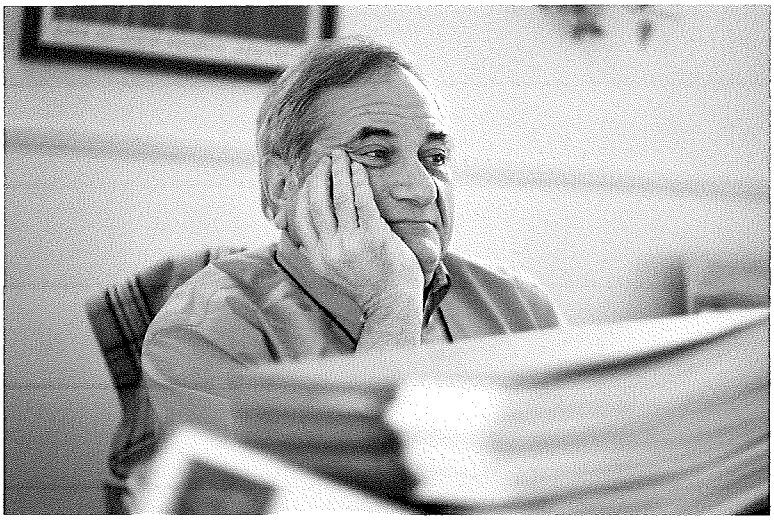
IN 2013, PATRICK AND BETH COLLINS WERE DESPERATE. Thirteen-year-old Jennifer, the younger of their two children, faced a life-threatening situation. In response, the Collins family took extreme measures—sending Jennifer thousands of miles away in the company of her mother. Beth and Jennifer became refugees from a capricious government whose laws threatened Jennifer's health, the family's safety, and the life they had built together.

Beth and Jennifer did not run from crime or war or famine. They did not flee from some country ruled by a murderous despot to a less dangerous place. They are Americans who found it necessary to move from their home in Virginia to another state in order to seek treatment for Jennifer's serious medical condition—a treatment that was illegal according to the laws of both Virginia and the federal government.

And so, in December 2013, Beth and Jennifer said goodbye to Patrick and to Jennifer's older sister, Alexandra. They moved to Colorado, joining thousands of other people who'd gone there wanting to avail themselves of one version or another of this taboo treatment: marijuana-based medicine. Their hope? That Colorado cannabis would do what prescription drugs could not—treat Jennifer's epilepsy.

AN ANCIENT, HONORABLE MEDICAL TRADITION

Patients like Jennifer Collins seek out medical marijuana every day. In the United States, it is currently only available in certain states, for certain people, and under specific conditions, though the number of venues where it can be obtained has been growing ever since California legalized medical marijuana in 1996. At the time of writing, 22 other states and the District of Columbia have followed suit. Privately owned but state licensed and regulated dispensaries dole out medical marijuana in most of these places.



Rabbi Jeffrey Kahn, owner of the Takoma Wellness Center, a Medical Marijuana dispensary in Washington, D.C.

Jeffrey Kahn, a congregational rabbi, owns one such supplier—the Takoma Wellness Center, which is described on its website as "D.C.'s Family-Run Medical Marijuana Dispensary." A five minute walk from the owner's home, it also happens to be located just six miles away from the White House. Like many such owners, Rabbi Kahn feels he is providing his customers with a critical medical treatment. In fact, his decision to go into this business was inspired in part by the suffering of his in-laws. When he opened the Center, he dedicated it to them. Their 1952 honeymoon photo—which could double for a black-and-white beach movie still—hangs in a prominent position across from the welcome desk. A half century after that photo was taken he watched them suffer and eventually die from serious medical issues. His father-in-law had spent decades battling multiple sclerosis—a battle occasionally alleviated by puffing on black-market marijuana. His mother-in-law had lung cancer. The doctor who diagnosed it told her she might be able to mitigate the devastating effects of chemo and radiation by using marijuana. But she died before the family could find a dealer.

Those experiences gave Rabbi Kahn a new perspective on pot, and a desire to serve those in need of it. Now he has patients suffering from the same illnesses his in-laws died of who are finding relief at his dispensary.

The federal government, however, views the rabbi not as a health care provider offering much needed treatment to the afflicted and the vulnerable, but as a drug dealer. A mild-mannered, middle-aged gentleman, Rabbi Kahn is a devoted husband and father who bears no resemblance to the stereotypical marijuana dealer. Nor does his dispensary resemble the stereotype of a drug-dealer's place of business. The Takoma Wellness Center looks part pharmacy, part acupuncture clinic. Though the smell is quite different—the aroma of disinfectant replaced by the scent of grade-A cannabis—the Center is clean; it is welcoming; it is relaxing. The waiting area could double for that of a doctor's office, and the experience of being in the consultation room with Rabbi Kahn is very much like what happens in a doctor's office as well. Rabbi Kahn spends an hour or longer with each new patient, getting to know her, her diagnosis, and her previous experience with cannabis. Only then does he begin to map out a plan of action.

Takoma Wellness may be less than three years old, and its business an exotic novelty in the District of Columbia, but Rabbi Kahn is part of a long line of healers—some of them religious leaders like himself—who have been treating the sick with cannabis for millennia. During earlier eras, marijuana was much more commonly recommended for medical purposes than it is now. Five

thousand years ago the Chinese, for example, were using cannabis as an appetite stimulant, pain reliever, and anesthetic. British physicians used cannabis for a variety of illnesses and disorders, even administering it to Her Majesty Queen Victoria for pain. As recently as the early 20th century, doctors in the United States, too, found medical applications for marijuana, using it as an anti-convulsive drug, a pain reliever, and an anti-inflammatory.

Jennifer Collins, a 16-year-old high school student in Virginia, suffers from Jeavons Syndrome, a rare form of epilepsy.

FIRST DO NO HARM

When Jennifer Collins showed signs of a serious disease, her parents counted on modern medicine to provide the best care possible. The medical community not only failed them, it could even be said to have violated the Hippocratic Oath, because the side effects Jennifer suffered from the legal medicines her doctors prescribed for her condition—Jeavons Syndrome—did little to help her, and much to harm her.

The most distinctive symptom of Jeavons is a series of short seizures with jerking movements in the eyelids and eyeballs. The seizures are frequent and can occur spontaneously, or because of something as simple as seeing a bright light or closing one's eyes. It is a lifelong disorder that can only be managed; there is no cure.

Luckily, most people have never heard of Jeavons Syndrome. It is a rare form of epilepsy that can be debilitating in severe cases. Jennifer's case is severe.

Her seizures began when she was quite young. When Patrick and Beth noticed the jerking motions in her eyes, which were occurring in short stints over dinner and at other times during the day, they took her to a neurologist, who diagnosed her with a mild form of epilepsy. For several years, the condition was manageable. Seizures were few and Jennifer was living the normal life of a girl her age.

Over time, however, Jennifer's condition worsened. Sporadic eye twitches gave way to dramatically more frequent, more noticeable seizures. Some days, these small seizures would occur in dense clusters—close together and in rapid succession. There were days when Jennifer had more than 300 seizures, as many as 15-50 of them in the space of an hour. On New Year's Eve 2011, one of those clusters led to a more dangerous, full-body grand mal seizure. This was her first grand mal seizure, but it would not be her last. Soon she was having repeat episodes.

When her condition was mild, her parents had opted to forego prescription drug treatment, largely because the possible side effects alarmed them. As Jeavons began to affect Jennifer's daily activities and quality of life, however, they knew they had to change course. The doctors they went to prescribed anti-seizure medications, which Patrick and Beth opted to give to her, despite the potential side effects, in the hope that they would relieve the worst of her frightening symptoms.

Eventually, they found themselves consulting a seemingly endless round of specialists—pediatricians, neurologists, epileptologists, psychiatrists—who put her on a constantly changing regimen of drugs, in a perpetual search for something that would work well and cause minimal collateral damage. But all that came of these efforts was an ever sicker, more frightened pre-teen, taking prescription drugs that brought virtually no relief.

Jennifer's seizure disorder is considered "intractable." That is, it is not well treated by conventional drugs. Clinically, it is said that Jennifer failed a dozen different medications. In reality, each one failed Jennifer, who continued to suffer hundreds of daily seizures, as well as the side effects of the drugs.

As time went on, the cumulative effect of all these drugs, and of the high-fat diet recommended as a treatment for seizure disorders, changed Jennifer dramatically. She became depressed. Once a gifted and talented student, she saw her grades plummet as the medications caused cognitive impairment and decline, undermining her ability to think and learn. The special diet she was on caused her to gain 30 pounds, which only compounded her depression. One drug regimen resulted in Jennifer planning suicide. Another drug sent her into spontaneous, manic rages, during which she physically attacked her mother, father, and sister.

Since none of the doctors or their drugs were able to help Jennifer, Patrick and Beth began to research alternatives themselves. They read books, consulted online resources, and spoke to doctors in other parts of the country.

One alternative that was suggested was marijuana. Medical marijuana comes in many forms, some of them intoxicating, some not. Intoxicating products are those rich in psychoactive chemicals, namely THC. The non-intoxicating versions have been stripped of those psychoactive chemicals. Patrick and Beth read that one of marijuana's non-intoxicating components, CBD (cannabidiol)

—had been used in treating epilepsy, even in children. Desperate for help, they were willing to do what they would previously have found unthinkable: give their daughter marijuana.

There was a problem, however. Despite the fact that board-certified neurologists told Patrick and Beth that Jennifer might get relief from medical marijuana, they could not give it to her. Under federal law, marijuana—even its non-psychoactive chemicals—is illegal under all circumstances. While many states have defied that prohibition and legalized access to medical marijuana, Virginia, their home state, was not among them at that time. Virginia law held that distribution of an ounce or more of marijuana to a minor was a felony punishable with a mandatory minimum sentence of five years in prison.

Nor would it have been an option for them to take Jennifer to Rabbi Kahn's dispensary, a mere 30 miles away from their home across the Potomac in Northern Virginia. Not only was possessing CBD oil in Virginia a felony, but crossing state lines with marijuana was—and still is—a federal offense.

The Collins family had come face-to-face with a public policy that threatened the well-being of their daughter. They'd discovered a substance that might provide her much needed medical help, but their government—at both federal and state levels—told them she was not allowed to have it. Laws intended to limit drug abuse, stop trafficking, and combat cartels were keeping sick children (and adults) from trying a drug with the potential to benefit them. Patrick and Beth Collins are not the criminals that America's drug laws were intended to stop, but if they had provided Jennifer with CBD oil, they would have been criminals nonetheless.

The Collinses had to choose between remaining together in Virginia and watching their daughter suffer, or breaking up their family, violating federal law, and getting Jennifer the medical marijuana they hoped would help her.

Patrick and Beth didn't want to get their daughter high; they wanted to get her well. They wanted to get her CBD oil.

Before Jennifer was prescribed Medical Marijuana, her parents tried numerous other treatments—none of which worked.

Beth and Jennifer relocated to Colorado, became official residents of the state, found a doctor, procured a medical marijuana recommendation, and applied for and received a "red card" designating Jennifer a state-approved medical marijuana patient. Finally they were able to purchase

CBD oil, which Jennifer used in conjunction with a cocktail of her prescription medicines. It didn't work; in fact, it seemed to make her seizures worse.

Beth and Jennifer did not give up, however; instead, they sought information and support from other cannabis refugees in Colorado. Some recommended they try a similar oil, THCA, which other epilepsy patients had found helpful. Like CBD, it was a non-psychoactive component of cannabis, which wouldn't get Jennifer high.

With THCA, they finally found a drug that helped. Jennifer's seizures began to reduce in number and intensity. On a good day she would have only about 10 small seizures—a dramatic decrease that was confirmed by a brain scan.

Eventually Jennifer was able to cut her drug cocktail to only two prescriptions, each prescribed at lower doses than before. In addition to experiencing far fewer seizures, she lost the weight she had gained, and her violent manias, cognitive decline, and thoughts of suicide disappeared.

The improvement went beyond Jennifer herself. Any medical crisis affects not just the patient but her caregivers, too. Every member of the Collins family had endured physically and emotionally draining stress, sleepless nights, and constant worry as they tried to help Jennifer cope with her illness. As medical marijuana helped Jennifer, it indirectly helped her family by minimizing the demands her illness had put upon them.

Beth Collins holds an oral syringe that her daughter uses to take Medical Marijuana.

LEGAL LIMBO

The Collinses are not alone. Tens of thousands of families across America seek relief from all forms of cannabis every day, and for many, the drug improves their quality of life, sometimes dramatically. The journey to relief can be fraught with tension, uncertainty, and fear, however, for not only is the treatment unconventional, but the conflicting signals about its legal status make people very unsure about what to expect, even in states where it has been legalized.

On the one hand there is a reassuringly orderly, official-feeling process for obtaining the drug in such states. It's usually something similar to what Rabbi Kahn's patients in the District of Columbia go through before they get to him, which culminates in their being able to register as approved medical marijuana users with a get-out-of-jail-free card for buying pot. Typically the process begins in a doctor's office with a physical exam, consultation, and diagnosis. But that's where things get weird, because doctors cannot write prescriptions for marijuana. Instead they must offer "recommendations," because to write "marijuana" on a prescription pad is a fast path to losing their prescribing rights—and their livelihood.

Such problems stem directly from rules issued by the U.S. Drug Enforcement Administration—headquartered just eight miles from the Takoma Wellness Center—which is the federal agency responsible for regulating controlled substances. The DEA determines who can prescribe which drugs and under what conditions. Violating those rules has consequences: jail time, fines, loss of medical privileges for healthcare professionals, and asset seizure to name a few.

Under federal law, there are no conditions that allow a doctor to prescribe marijuana, a pharmacy to dispense it, or a patient to buy or use it. Marijuana is illegal. Period.

The reason for this is that according to federal law—the Controlled Substances Act—marijuana is classified as a "Schedule I" substance. As explained on the DEA's website, federal law reserves the Schedule I classification for the "most dangerous class of drugs with a high potential for abuse and potentially severe psychological and/or physical dependence" and with "no currently accepted medical use." In addition to marijuana this category also includes drugs like heroin, LSD, and ecstasy.

The decision about what drugs should appear in each of the five "Schedules," which range from the most dangerous and addictive to the least, with only Schedule I drugs ranked as having no medical value, was not made by anyone in the medical community, but by Congress. In 1970, Congress passed the Controlled Substances Act—a politically motivated law enacted at a time of national hysteria over drug abuse, and President Richard Nixon signed it into law. With the exception of a few relatively minor changes in the years since, the drug schedules included in the Controlled Substances Act have remained the same, including the Schedule I designation for marijuana.

The fact that marijuana's therapeutic effects are real—as evidenced by what science says about its effects on the human body, and supported by hundreds, indeed thousands of years of effective treatments in places around the globe—has not sufficed to get it removed from that list. This is unfortunate, because the Schedule I designation has consequences that extend beyond the legal restrictions. It has created negative cultural norms—biases—that permeate much of society. Patients wanting to be treated with marijuana are often embarrassed and scared—even after a doctor has recommended that they use it, and they've gotten the approval of state authorities to do so. For some first-time medical marijuana patients, a trip to the dispensary is not like a stroll to

the pharmacy with a prescription for a drug like amphetamines, or oxycodone, or morphine, or compounds that include cocaine, all of them Schedule II drugs; it's more like a teenager's trip to the corner store for condoms.

That social stigma likely keeps many sick people from even considering marijuana as an option. For them, there will never be an opportunity for responsible dispensary owners like Rabbi Kahn to have the chance to calm their nerves and show them that purchasing pot is not shameful—and that using it can be helpful.

Doctors are often fearful, too. Some are uncomfortable with medical marijuana if only because their training excluded it as a treatment option. Many are unfamiliar with the rules, and with the protections that the federal courts have afforded them against federal punishment. In *Conant v. Walters*, the U.S. Court of Appeals ruled that the government cannot investigate doctors or remove their prescribing rights simply because they recommend marijuana to their patients. The U.S. Supreme Court let that ruling stand in 2003. Despite this decision, doctors fear for their practices and prescription pads, and also for their patients. In medicine, marijuana is a frontier, and not every physician is a brave pioneer ready to forge a new path.

THE RESEARCH GAP

Part of the fear physicians feel is due to what some consider insufficient medical research into marijuana. Clinical research and observational studies have shown that medical marijuana can make chemotherapy more tolerable, boost appetite, reduce the eye pressure of glaucoma, relieve pain, stop muscle spasms, treat depression or anxiety, alleviate PTSD, and help with a whole host of other medical conditions. But these findings, some of which have emerged from hospitals that are among the finest in the world, are only the beginning of what we need to know about the medical potential of marijuana. Any effort to learn more is seriously hindered by the legal obstacles thrown up by the federal government's prohibition on marijuana, which makes it very difficult for researchers to conduct clinical testing.

The result is that we cannot answer even some of the most basic questions about how to make the best use of marijuana. We don't know every disorder marijuana can treat—and just as important, we don't know which ones it can't. We don't know the ideal way to get cannabis into the body (smoking vs. vaping vs. edibles vs. creams vs. oils). We know even less about dosing, potency, interactions, and side effects.

These knowledge limitations exist because the U.S. government has made cannabis illegal on the basis of its having no medical value. And by prohibiting it, the government has made it harder for researchers to investigate what its medical value might actually be. This is the vicious cycle of marijuana prohibition.

Rabbi Kahn wants the system to change. He wants to know more, and he wants his patients to be better informed. He wants expanded research that will give physicians as much clinical knowledge about marijuana as they have about any other medication they prescribe. Right now, the federal government has created an environment that is anti-science, suppressing research and information. It refuses to allow science to provide us sufficient answers about the benefits and (just as important) risks of marijuana.

The U.S. government has funded research that helped cure some of the world's most devastating diseases. With medical marijuana, the U.S. government's prohibition doesn't cure patients; it keeps them sick. And it also keeps them in ignorance.

Cannabis used for Medical Marijuana comes in a variety of strains and strengths.

THE INFORMATION GAP

Marijuana offered hope for Jennifer Collins and her family, but it was a source of fear and uncertainty, too. When Patrick and Beth considered whether or not to try to get medical marijuana for their daughter, they found it almost impossible to get any of their doctors to discuss even the limited information they had about medical cannabis. Prohibition comes with a gag order. Jennifer's doctors in Virginia were barred, often by their practices, from talking to the family about marijuana. In medicine, the doctor-patient relationship is protected by rules of confidentiality that allow patients to discuss anything with their doctors, thus ensuring that treatment will be based on a full understanding of the patients' circumstances. For marijuana, no such protection exists.

In the absence of expert advice, the Collinses turned to the Internet, where they found information from parents and patients facing similar medical crises, who told their stories online, and offered anecdotal information about dosing, strength, side effects, interactions, and benefits. Patrick calls this "message board medicine" or "social media medicine." Helpful as it is, its drawbacks are obvious.

Ultimately, the Collins family found a few compassionate doctors—often in other states—who were willing to speak to them about marijuana. These doctors encouraged them to find a legal avenue to the drug. Some of them suggested that Colorado offered them their best option, because it included epilepsy among the conditions that qualified for treatment with medical marijuana, had no long-term residency requirements to qualify for access to the drug, and no age minimum, which meant that Jennifer, a minor, was eligible. Colorado also offered a wide choice of products, which would allow Jennifer to find what worked best for her. Finally and most important, Colorado had a well-regulated system in place that included product testing. The Collinses demanded a product that was safe. They wanted to know exactly what they were giving their daughter. Colorado's system gave them the information they required.

In the end, even though Beth and Jennifer had to move thousands of miles away from their home, the Collins family could be said to be among the fortunate, in that they were ultimately able to find a drug that worked, in a place that offered them both access to it and information about it. But the obstacles they confronted along the way were formidable, and many other people who could benefit from medical marijuana have not had their good fortune. It is harder, riskier, and more confusing to get medical marijuana than any other medicine—but it shouldn't be. Although the federal government generally looks the other way in states that have legalized marijuana, turning a blind eye is not a remedy for the gaps in public policy.

Jennifer Collins at her home in Virginia. Her seizures have reduced in number and intensity since she began using Medical Marijuana.

BUsINEss LIMBO

It is no secret that Rabbi Jeffrey Kahn, a healer and man of God, is also a businessman. He owns and operates a facility that serves hundreds of District of Columbia customers, and offers a diverse array of products. Those "products" are marijuana-based (whole flower, vaporization cartridges, oils, creams, edibles, and more) and those "customers" are patients.

Takoma Wellness Center incorporated in 2010 but didn't open its doors until 2013. The long gap is explained by the fact that after incorporating, Rabbi Kahn faced a seemingly endless set of hurdles, each standing between sick patients and their medicine. During that time, the Kahn family endured a level of bureaucratic red tape few businesses face. They waded through standard processes like licensing, zoning, and business plan approval, but also faced additional challenges like forms that required them to affirm they knew they were breaking the law and would not point a finger at the District if they were busted.

The waiting room at the Takoma Wellness Center could be taken for a doctor's office.

Signing such a form has to be an unnerving experience. But it's necessary because the District government was unsure how to oversee a program that the federal government—the District's own landlord—says is illegal. By the letter of the law, Rabbi Kahn is some kind of drug kingpin and District government officials are conspirators at best, racketeers at worst. The District developed an intricately regulated system in an effort to inoculate itself from federal punishment.

But the District government was not the only roadblock. Opening a business is hard work; opening a marijuana enterprise, as Rabbi Kahn would come to find out, is nearly impossible. The most basic requirements for doing business —things most companies take for granted—are often out of reach for a "cannabusiness." It took years before Takoma Wellness Center had a checking account. Bank officers often dismissed the rabbi, typically refusing him an account and in one instance asking him to leave the premises. Even though he had approval from the District of Columbia for what he was doing, bank officers don't take their cues from local government. They get guidance from higher powers: the U.S. Department of the Treasury and the Federal Reserve. Those two institutions consider Rabbi Kahn to be a criminal and his revenue to be drug money. Under federal law, those institutions are right.

And so, Jeffrey Kahn spent years trying to find a bank that would take his money, and on the rare occasion a bank said it would, he often found his accounts closed within months. Even as the White House and Treasury Department issued guidance to banks letting them know that they weren't interested in shutting down medical marijuana dispensaries that played by the (state-level) rules, bankers remained understandably concerned over unchanged federal laws and regulations.

COMPREHENSIVE REFORMS IN THREE AREAS

Federal marijuana policy is contradictory and unsustainable. It has consequences for state and local governments, business owners, doctors, patients, and families. Marijuana prohibition was designed to criminalize the illicit drug trade, but it has victimized innocent Americans like Rabbi Jeffrey Kahn, Jennifer Collins, and thousands of others like them. The president and Congress have a duty to design laws that reflect modern policy realities and that advance medical research. Comprehensive reform is needed in three key areas: research, access, and legal protection.

GROWING KNOWLEDGE

Allowing medical marijuana research to proceed without unnecessary obstacles is central to answering patients' and providers' questions about its safety, efficacy, and applications. Talented doctors and scientists across the United States are ready to do this research. The government should remove the barriers that stop them from performing their work. Not only should it facilitate the research, it should also take clear steps to expand and fund it in the service of science.

Changing marijuana's classification in the drug schedules from Schedule I (which lists substances deemed to have no medical value) to Schedule II (or better yet III) is the first step toward opening the door to more research. A bill currently before Congress—the Compassionate Access, Research Expansion, and Respect States Act (CARERS), which calls specifically for "research into the medicinal properties of marijuana"—would move it to Schedule II. Such a change would mean less red tape around clinical research. A Schedule II designation would also officially affirm that marijuana may have medicinal value, while still acknowledging that it has a potential for abuse—just like cocaine and the various opiates that currently appear in the Schedule II classification. Even groups like the American Medical Association, the American Cancer Society, and the New England Journal of Medicine have called for a reconsideration of marijuana's status in order to expand research.

Expanding research involves more than just re-labeling marijuana. Federal law requires that the government must provide researchers an adequate supply of the marijuana. That mandate has gone unfulfilled. All medical marijuana studies are required to use cannabis produced from a single source: a farm at the University of Mississippi. Researchers have complained that the farm consistently fails to provide marijuana in the form, strength, and composition that their research requires. In some cases, the farm doesn't even provide a sufficient amount. Since Mississippi's medical marijuana monopoly disrupts rather than facilitates research, the federal government should license additional grow facilities to ensure both product diversity and safety.

The White House should convene a summit focusing on research into the efficacy of marijuana as medicine, and call on Congress to direct additional resources to the topic.

The U.S. government can also partner with local governments, businesses, and research institutions to conduct research in states where medical marijuana is legal. Since more than 149 million Americans live in states with medical marijuana programs, these public-private research partnerships could serve as the world's most comprehensive clearinghouses for data on medical cannabis's uses, successes, failures, side effects, doses, and strengths.

ACCEss

Reform should take government out of the doctor-patient relationship entirely. It should also ensure that when a doctor decides that medical marijuana could help a patient, the government will not obstruct safe access to the drug.

To improve access, the government has some bold options to consider. As called for in the CARERS Act, Congress or the administration could use their separate authorities to remove cannabidiol as well as cannabis's other non-intoxicating components from the federal drug schedules. Because these substances are used strictly as medicine, with no recreational value, Congress should authorize the creation of a new regulatory system that is more suitable for those chemicals.

The government should also do what it can to help patients who could benefit from medical marijuana but live in states that don't have such programs. There is precedent in the now-shuttered Compassionate Investigational New Drug Program. From the late 1970s until 1992, this U.S. government program shipped monthly supplies of joints to qualifying patients—mostly people suffering from AIDS, cancer, or glaucoma. But then President George H.W. Bush killed it as part of his "war on drugs," at a time when victims of the AIDS epidemic were flooding the program with requests. The government should consider restarting it and expanding its eligibility requirements to reflect the latest in medical science.

This Medical Marijuana growing and processing facility in Washington, D.C. is a source for Rabbi Kahn's dispensary.

LEGAL PROTECTION

Medical marijuana programs like the Takoma Wellness Center operate in a legal gray area that leaves those who run them—as well as doctors, patients, and local government officials—vulnerable to legal sanctions. The White House and Justice Department suggest that federal prosecutors not order drug raids on businesses abiding by state laws. However, that suggestion is not always followed, and dispensaries can be closed under the auspices of federal law, regardless of their compliance with state-level legislation. The White House should stop governing by "suggestion" and put an end to the federal government's ad hoc, haphazardly stitched together, totally incoherent drug policy. Policy should be based on stable, predictable laws that protect these businesses against prosecution and unwarranted closings, ensuring that medical marijuana enterprises that play by the rules are not treated like Colombian drug cartels.

Instead, cannabis businesses like Rabbi Kahn's should be treated like any other business in the United States. At a minimum this would mean giving them routine access to financial products like checking accounts and bank loans. To make that possible,

Congress should legislate specific protections for banks and bankers working with medical marijuana firms that are in compliance with state laws and regulations. In addition, relabeling marijuana as a Schedule III substance would allow dispensary owners like Rabbi Kahn to take advantage of something almost every other business in America enjoys: business tax deductions. Such deductions will lower operating costs and therefore the price of drugs such as the one Jennifer Collins uses every day.

Doctors and patients need legal cover as much as business owners do. Congress should formalize the protection that federal courts have given doctors, ensuring they cannot be prosecuted or penalized for recommending medical marijuana to patients. There should be laws to shield patients from arrest for purchasing and using state-approved medical marijuana, or for growing their own in states where it is legal.

Congress should also reform the law in order to allow patients who abide by state medical marijuana policies a defense in federal court. As of now, patients are barred from using the claim that they buy or grow marijuana for medicinal purposes as a defense, often resulting in convictions. If the federal government is willing to tolerate state medical marijuana programs, it should also tolerate a patient's right to defend herself in court. Jennifer Collins and the doctors who try to help her manage the symptoms of her epilepsy should have the right to tell a jury what they are doing, why they are doing it, and that it is legal in the state where they live.

Medical marijuana policy in the United States is putting Americans at risk. The federal government keeps people who live in states that don't have medical marijuana programs from accessing a product that could benefit their health. And even as it prevents some people from having it, it erects barriers against research into the safety and efficacy of a product used by tens of thousands if not hundreds of thousands of people who do live in states that have legalized it.

Although there are a number of policy changes, large and small, that Congress and the administration could make to overcome the deficiencies of this system, thus far they have chosen not to do so. Yet, as numerous organizations like the Marijuana Policy Project and the National Organization for the Reform of Marijuana Laws have documented, a substantial majority of Americans in every state that has been polled supports changes (in some form) to the nation's medical marijuana laws. Gallup and CBS News polls have pegged national support for reform at between 70 and 85 percent.

While elected officials cling to the status quo, failing to recognize and address the inherent hypocrisies in the nation's laws, patients like Jennifer Collins and her family, and business owners like Rabbi Kahn and his family, are enduring unnecessary hardships. Far from being outliers, they are typical of the many people victimized by an unjust, arbitrary, and downright harmful system that hinders access to a clinically proven medical benefit.

It is time for government to transform medical marijuana policy into a system that is rational, functional, consistent, and informed by science—not politics.

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Graphics and design by Cameron Zotter and Jessica Pavone. Web development by Yohann Paris. Photography by Mark Williams Hoelscher. Research support by Grace Wallack. Editorial by Beth Rashbaum and Fred Dews.