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# Medical Marijuana and the ADA: Removing Barriers to Employment for Disabled Individuals

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# MEDICAL MARIJUANA AND THE ADA: REMOVING BARRIERS TO EMPLOYMENT FOR DISABLED INDIVIDUALS

*Russell Rendall*<sup>†</sup>

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## INTRODUCTION

Sixteen states and the District of Columbia have now legalized medical marijuana.<sup>1</sup> According to recent polls, popular support for medical marijuana hovers around 75 percent in the United States.<sup>2</sup> As of 2008, an estimated 270,000 Americans were using medical marijuana.<sup>3</sup> Despite those facts, medical marijuana use is prohibited by the federal Controlled Substances Act (CSA), and users risk criminal prosecution.<sup>4</sup> Undoubtedly, many medical marijuana users are also employees who risk being fired for their choice of treatment. State laws have provided a step forward, but one that is fraught with uncertainty.

Joseph Casias, a twenty-nine year old father of two, suffers from inoperable sinus and brain cancer.<sup>5</sup> Casias formerly worked for Walmart in Battle Creek, Michigan, earning about \$27,000 a year, and he has incurred substantial debt from his medical bills.<sup>6</sup> In 2008, Casias was named Associate of the Year.<sup>7</sup> His doctor prescribed medical marijuana, which is legal in Michigan, to treat pain that more traditional drugs could not alleviate.<sup>8</sup> Casias never used marijuana at work, nor did he come to work under the influence.<sup>9</sup> Following a

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<sup>1</sup> Alaska, Arizona, California, Colorado, District of Columbia, Delaware, Hawaii, Maine, Michigan, Montana, Nevada, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, Washington. *16 Legal Medical Marijuana States and DC: Laws, Fees, and Possession Limits*, PROCON.ORG, <http://medicalmarijuana.procon.org/view.resource.php?resourceID=000881> (last updated Sept. 19, 2011).

<sup>2</sup> See THE PEW RESEARCH CENTER FOR THE PEOPLE & THE PRESS, *MODEST RISE IN PERCENTAGE FAVORING GENERAL LEGALIZATION: BROAD PUBLIC SUPPORT FOR LEGALIZING MEDICAL MARIJUANA* (Apr. 1, 2010), <http://people-press.org/report/602/marijuana>; *Washington Post-ABC News Poll*, WASHINGTONPOST.COM, [http://www.washingtonpost.com/wp-srv/politics/polls/postpoll\\_011610.html](http://www.washingtonpost.com/wp-srv/politics/polls/postpoll_011610.html) (last visited Mar. 14, 2011); Peter Hart & William McInturff, *NBC NEWS/WALL STREET JOURNAL SURVEY 23* (Oct. 2009), available at <http://online.wsj.com/public/resources/documents/wsjnbc-10272009.pdf>.

<sup>3</sup> *How Many People in the U.S. Use Medical Marijuana?*, PROCON.ORG, <http://medicalmarijuana.procon.org/view.answers.php?questionID=001199> (last updated Mar. 11, 2009).

<sup>4</sup> 21 U.S.C. § 812(c)(c)(10) (2006); 21 C.F.R. § 1308.11 (2011); *Gonzales v. Raich*, 545 U.S. 1, 7-9 (2005).

<sup>5</sup> Eve Tahmircioglu, *Wal-Mart Worker Fired over Medical Marijuana*, MSNBC.COM (Mar. 17, 2010), <http://www.msnbc.msn.com/id/35913492/ns/business-careers>.

<sup>6</sup> *Id.*

<sup>7</sup> *Id.*

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*

work-related injury, Walmart required a drug test, which revealed Casias's marijuana use.<sup>10</sup> Casias explained that he was using marijuana for medical purposes and presented his Michigan marijuana registry card to Walmart. Walmart fired Casias.<sup>11</sup>

Jane Roe lives in Bremerton, Washington, with her children and has suffered from debilitating migraines for years. Her migraines cause chronic pain, nausea, blurred vision, and light sensitivity.<sup>12</sup> After other treatments proved inadequate, her doctor prescribed medical marijuana, which is legal in Washington.<sup>13</sup> In 2006, Roe was hired by Teletech Customer Care Management for a phone and email customer service position.<sup>14</sup> Teletech tests all new hires for illegal drugs, and Roe informed Teletech that she was using medical marijuana and offered to provide documentation.<sup>15</sup> Roe took the drug test, began work, and Teletech fired her a week later when they received the results of her drug test.<sup>16</sup>

Casias and Roe should not have to choose between effective treatment and gainful employment. Medical marijuana alleviates the debilitating symptoms of their illnesses. It gives them the ability to work and support their families. It enables them to be productive and self-sufficient. On the other hand, employers have a legitimate interest in workplace safety and productivity. The side effects of marijuana could create unacceptable risks in certain instances (e.g., airline pilots or structural steel workers). But, the interests of both employers and employees ought to be considered before employment decisions are made. An inflexible prohibition of medical marijuana short-circuits an important balancing process and tramples the rights of disabled employees for whom marijuana is an effective treatment. This note will examine whether the Americans with Disabilities Act (ADA) currently protects such individuals and recommend statutory changes that will ensure their protection.

Part I will analyze the efficacy of medical marijuana and argue that further research is necessary. Part II will discuss whether the ADA, in its current form, protects disabled persons for whom marijuana is an effective treatment. Part III will propose statutory

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<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

<sup>12</sup> Vanessa Ho, *Woman Fired Over Medical Marijuana to Get Day in High Court*, SEATTLE POST-INTELLIGENCER (Dec. 21, 2010), [http://www.seattlepi.com/local/432234\\_medical+marijuana.html](http://www.seattlepi.com/local/432234_medical+marijuana.html).

<sup>13</sup> *Id.*

<sup>14</sup> *Id.*

<sup>15</sup> *Id.*

<sup>16</sup> *Id.*

amendments to address the uncertain status of medical marijuana users under the ADA.

## I. MARIJUANA'S THERAPEUTIC VALUE

### A. The Center for Medicinal Cannabis Research

In 2000, the University of California, San Diego, created the Center for Medicinal Cannabis Research (CMCR), perhaps the most comprehensive attempt to investigate the medicinal value of marijuana to date.<sup>17</sup> CMCR has completed five clinical studies and four pre-clinical studies.<sup>18</sup> Six of the studies have been published or submitted for publication in medical journals.<sup>19</sup> There has long been serious doubt about the medical benefit of marijuana,<sup>20</sup> but CMCR studies have helped erase that doubt. Four CMCR studies showed that marijuana has an analgesic effect on nerve pain resulting from injury or disease, such as spinal cord injury or HIV.<sup>21</sup> Three of those studies achieved good results for subjects who had found other painkillers

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<sup>17</sup> UNIV. OF CAL. CTR. FOR MEDICINAL CANNABIS RESEARCH, REPORT TO THE LEGISLATURE AND GOVERNOR OF THE STATE OF CALIFORNIA PRESENTING FINDINGS PURSUANT TO SB847 WHICH CREATED THE CMCR AND PROVIDED STATE FUNDING 2 (Feb. 11, 2010) [hereinafter CMCR REPORT], [http://www.cmcrc.ucsd.edu/CMCR\\_REPORT\\_FEB17.pdf](http://www.cmcrc.ucsd.edu/CMCR_REPORT_FEB17.pdf).

<sup>18</sup> *Id.* Several studies (most related to cancer) were discontinued because it was difficult to recruit severely ill participants due to the demanding research protocol. *Id.* at 3.

<sup>19</sup> The following studies have been published or submitted for publication: Donald I. Abrams, *The Effect of Cannabis on Neuropathic Pain in HIV-Related Peripheral Neuropathy*; Donald Abrams, *Vaporization as a 'Smokeless' Cannabis Delivery System*; Jody Corey-Bloom, *Short-Term Effects of Cannabis Therapy on Spasticity in Multiple-Sclerosis*; Ronald J. Ellis, *Placebo-Controlled, Double Blind Trial of Medicinal Cannabis in Painful HIV Neuropathy*; Mark Wallace, *Analgesic Efficacy of Smoked Cannabis*; Barth Wilsey, *A Double-Blind, Placebo-Controlled Crossover Trial of the Antinociceptive Effects of Smoked Marijuana on Subjects with Neuropathic Pain*; synopsis of study results provided in CMCR REPORT, *supra* note 17, at 10-12. The following studies have not been published, but are completed or ongoing: Mark Barad, *Cannabinoids in Fear Extinction*; Sean Drummond, *Sleep and Medicinal Cannabis*; Thomas Marcotte, *Impact of Repeated Cannabis Treatments on Driving Abilities*; Daniele Piomelli, *Effects of Cannabis Therapy on Endogenous Cannabinoids*; Rachel Schrier, *Effects of Medicinal Cannabis on CD4 Immunity in AIDS*; Mark Wallace, *Efficacy of Inhaled Cannabis in Diabetic Painful Peripheral Neuropathy*; Barth Wilsey, *The Analgesic Effect of Vaporized Cannabis on Neuropathic Pain*; Howard Fields, *Mechanisms of Cannabinoid Analgesia*; synopsis of study results provided in CMCR REPORT, *supra* note 17, at 13-15.

<sup>20</sup> Gardiner Harris, *F.D.A. Dismisses Medical Benefit from Marijuana*, N.Y. TIMES, Apr. 21, 2006, at A1.

<sup>21</sup> CMCR REPORT, *supra* note 17, at 2.

inadequate.<sup>22</sup> Another study showed that marijuana also helps relieve headaches and facial pain.<sup>23</sup> Thus, marijuana can, and does, play a particularly important role for individuals who are suffering from debilitating pain and have exhausted other treatment options.

Another CMCR study showed that marijuana has a positive impact on muscle spasticity for persons with multiple sclerosis.<sup>24</sup> Multiple sclerosis causes “fatigue, loss of balance, muscle weakness, and muscle spasticity.”<sup>25</sup> Muscle spasms can be painful and affect the ability to walk, take care of oneself, or manage everyday activities.<sup>26</sup> Current treatments for muscle spasticity provide inconsistent results, often with serious side effects.<sup>27</sup> CMCR’s studies showed “significant improvement in both an objective measure of spasticity and pain intensity” for patients who used medical marijuana after finding other treatments ineffective.<sup>28</sup>

CMCR’s research regarding chronic pain is especially significant. Chronic pain is a widespread problem, estimated to affect 5–10 percent of the population.<sup>29</sup> It is caused by issues in the nervous system rather than stimulation of the pain receptors in nerve endings.<sup>30</sup> The treatments available for such pain are rather limited, and their effectiveness is inconsistent.<sup>31</sup> CMCR’s studies on chronic pain demonstrated “significant decrease in pain after cannabis administration.”<sup>32</sup> Marijuana’s effectiveness in treating chronic pain is an important development with the potential to help many people, including employees who might otherwise be unable to work. Marijuana could provide pain relief, increase productivity, and help individuals become more self-sufficient.

In addition, the side effects experienced in these studies were typically mild, receded quickly, and “tended to be no worse” than those of other strong pain relievers.<sup>33</sup> Side effects included “cough, nausea, dizziness, sedation and changes in cognition.”<sup>34</sup> One of the studies also found that marijuana did not “interfere with the function

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<sup>22</sup> *Id.*

<sup>23</sup> *Id.* at 3.

<sup>24</sup> *Id.* at 9.

<sup>25</sup> *Id.*

<sup>26</sup> *Id.*

<sup>27</sup> *Id.*

<sup>28</sup> *Id.*

<sup>29</sup> *Id.* at 8.

<sup>30</sup> *Id.*

<sup>31</sup> *Id.*

<sup>32</sup> *Id.* at 9.

<sup>33</sup> *Id.* at 3.

<sup>34</sup> *Id.*

of blood cells involved with immunity,” an especially important consideration for those who might use marijuana for chronic illness.<sup>35</sup>

## B. Current Uses of Medical Marijuana

Medical applications of marijuana have, in many instances, preceded any formal scientific research. Marijuana has been used to treat an array of physical and mental impairments, including multiple sclerosis, chronic pain, seizure disorders, anxiety disorders, severe nausea, glaucoma, schizophrenia, HIV/AIDS, and anorexia.<sup>36</sup> As discussed in the introduction, Joseph Casias uses medical marijuana to relieve pain resulting from cancer, and Jane Roe treats the debilitating migraines she experiences.<sup>37</sup> While these applications may not yet be fully supported by current findings, many patients have found medical marijuana to be an effective treatment.

For example, the plight of redeploying soldiers suffering from post-traumatic stress disorder (PTSD) provides a compelling argument for medical marijuana.<sup>38</sup> Paul Culkin was serving as member of an Army bomb squad in Kosovo in 2004 when he experienced the physical and mental trauma of a car bomb explosion.<sup>39</sup> The memory of that explosion made it difficult for Culkin to readjust to his life in America; he has PTSD and experiences fits of anger and is wary of social situations.<sup>40</sup> Culkin has found some relief through psychotherapy and anti-depressants, but he also uses a marijuana extract that he dissolves in tea or hot chocolate.<sup>41</sup> Culkin’s wife Victoria attests to the effectiveness of this treatment. She believes it has made her husband a “different,” “better,” “more open,” and “more communicative” person.<sup>42</sup> According to Victoria, medical marijuana “saved our marriage and our family.”<sup>43</sup>

Paul Culkin’s story exemplifies the controversy and contradictions that surround medical marijuana use. New Mexico, where the

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<sup>34</sup> *Id.*

<sup>36</sup> *Medical Uses*, INT’L ASS’N FOR CANNABINOID MED., <http://www.cannabis-med.org/index.php?tpl=page&id=21&lng=en> (last visited Jan. 7, 2012); James MacDonald, *Medical Marijuana: Informational Resources for Family Physicians*, 80 AM. FAM. PHYSICIAN 782, 783 (2009), available at <http://www.aafp.org/afp/2009/1015/p779.html>.

<sup>37</sup> See *supra* notes 5-16 and accompanying text.

<sup>38</sup> Jeff Brady, *Can Marijuana Ease PTSD? A Debate Brews*, NPR (May 19, 2010), <http://www.npr.org/templates/story/story.php?storyId=126827410>.

<sup>39</sup> *Id.*

<sup>40</sup> *Id.*

<sup>41</sup> *Id.*

<sup>42</sup> *Id.*

<sup>43</sup> *Id.*

Culkin's live, has approved medical marijuana use for PTSD, while neighboring Colorado recently prohibited that specific use.<sup>44</sup> Although legal in New Mexico, Culkin has had to pay out-of-pocket for his treatment because the Department of Veteran's Affairs refuses to pay for medical marijuana use.<sup>45</sup> The importance of helping people like Paul Culkin reinforces the need to accelerate medical research so that the therapeutic benefits of marijuana can be expanded.

### C. Further Research Recommended

In 2009, the American Medical Association (AMA) took a strong stand in favor of more research into the medicinal value of marijuana.<sup>46</sup> It reported that certain clinical trials showed a positive effect on neuropathic pain, muscle spasticity, and pain resulting from multiple sclerosis.<sup>47</sup> The AMA recommended that the federal government review the status of marijuana under the CSA because its current status "inhibits research on its potential medical benefits."<sup>48</sup> At the time of publishing of the AMA's report, "less than 20 small randomized controlled trials of short duration involving ~300 patients ha[d] been conducted in the last 35 years."<sup>49</sup> The AMA called for "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 . . . ."<sup>50</sup>

A position paper of the American College of Physicians (ACP) adopted a similar stance. The paper highlighted disagreement between the scientific community and federal agencies concerning the medicinal value of marijuana.<sup>51</sup> The ACP expressed optimism about the potential usefulness of marijuana, particularly for patients who may have exhausted other treatment options.<sup>52</sup> And, pursuing more

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<sup>44</sup> *Id.*

<sup>45</sup> *Id.*

<sup>46</sup> Scott Hensley, *AMA Broadens Its Social Agenda*, NPR'S HEALTH BLOG (Nov. 12, 2009, 10:56 AM), [http://www.npr.org/blogs/health/2009/11/what\\_is\\_the\\_ama.html](http://www.npr.org/blogs/health/2009/11/what_is_the_ama.html).

<sup>47</sup> AM. MED. ASS'N, REPORT 3 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (I-09): USE OF CANNABIS FOR MEDICINAL PURPOSES 12 (2009) [hereinafter AMA REPORT 3], *available at* <http://www.ama-assn.org/resources/doc/csaph/i09csaph3ft.pdf>.

<sup>48</sup> Hensley, *supra* note 46.

<sup>49</sup> AMA REPORT 3, *supra* note 47, at EXECUTIVE SUMMARY.

<sup>50</sup> *Id.* at 16.

<sup>51</sup> TIA TAYLOR, AM. COLL. OF PHYSICIANS, SUPPORTING RESEARCH INTO THE THERAPEUTIC ROLE OF MARIJUANA 8 (2008), *available at* [http://www.acponline.org/advocacy/where\\_we\\_stand/other\\_issues/medmarijuana.pdf](http://www.acponline.org/advocacy/where_we_stand/other_issues/medmarijuana.pdf).

<sup>52</sup> *Id.*

research would help clarify marijuana's therapeutic properties.<sup>53</sup> Unfortunately, without changing the status of medical marijuana under the CSA, it will be difficult to complete such research.<sup>54</sup>

## II. MARIJUANA AND THE ADA<sup>55</sup>

The purpose of the ADA is “to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities . . . .”<sup>56</sup> Subchapter I of the ADA prohibits employers from discriminating against employees or applicants on the basis of disability.<sup>57</sup> The ADA was amended in 2008 to relax the threshold determination of whether or not an individual actually suffers from a disability that entitles them to the protections of the ADA.<sup>58</sup> The Equal Employment Opportunity Commission (EEOC) has provided examples that illustrate the ADA's definition of disability.<sup>59</sup> For the purposes of this Note, it is sufficient to say that many

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<sup>53</sup> *Id.* at 1, 9.

<sup>54</sup> *Id.* at 1.

<sup>55</sup> For a thorough discussion of many of the issues *infra* Part II, see generally Ari Lieberman & Aaron Solomon, *A Cruel Choice: Patients Forced to Decide Between Medical Marijuana and Employment*, 26 HOFSTRA LAB. & EMP. L.J. 619, 633-57 (2009).

<sup>56</sup> 42 U.S.C. § 12101(b)(1) (2006) amended by ADA Amendments Act of 2008, Pub. L. No. 110-325, sec. 3, § 12101, 122 Stat. 3554.

<sup>57</sup> *Id.* § 12112(a) (Supp. II 2006).

<sup>58</sup> The basic definition remains the same: a disability is “a physical or mental impairment that substantially limits one or more major life activities of such individual . . . a record of such an impairment . . . or being regarded as having such an impairment.” *Id.* § 12102(1) amended by ADA Amendments Act of 2008, Pub. L. No. 110-325, sec. 4, § 12102, 122 Stat. 3555. However, the meaning has changed. EEOC, SUMMARY OF KEY PROVISIONS: EEOC'S NOTICE OF PROPOSED RULINGMAKING (NPRM) TO IMPLEMENT THE ADA AMENDMENTS ACT OF 2008 (ADAAA) 1, <http://www.eeoc.gov/laws/regulations/upload/adaaa-summary.pdf> (last visited Mar. 14, 2011) [hereinafter EEOC SUMMARY OF KEY PROVISIONS].

<sup>59</sup> “Examples Illustrating Definition of Disability

- Impairments for which an individualized assessment “can be conducted quickly and easily, and that will consistently result in a determination that the person is substantially limited in a major life activity”: deafness, blindness, intellectual disability (formerly known as mental retardation), partially or completely missing limbs, mobility impairments requiring use of a wheelchair, autism, cancer, cerebral palsy, diabetes, epilepsy, HIV/AIDS, multiple sclerosis, muscular dystrophy, major depression, bipolar disorder, post-traumatic stress disorder, obsessive-compulsive disorder, and schizophrenia.
- Impairments that may be substantially limiting for some individuals but not for others, and therefore may require somewhat more, though still not extensive, analysis: asthma, high blood pressure, back and leg impairments,

individuals using medical marijuana suffer from conditions that are disabilities according to the ADA.<sup>60</sup> This section will focus on the major hurdles that are uniquely relevant to a claim brought by a disabled person using medical marijuana.

### A. Illegal Use of Drugs

When an employer takes adverse action on the basis of illegal use of drugs, the employee or applicant is not protected by the ADA.<sup>61</sup> The Supreme Court has clearly held that medical marijuana use, even if authorized by state law, is illegal under the CSA.<sup>62</sup> However, the question here is whether or not the ADA regards such use as illegal. If so, an employer can take adverse action on the basis of prescription marijuana use without fear of liability. The ADA defines “illegal use of drugs” as follows:

The term “illegal use of drugs” means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act . . . Such term does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provisions of Federal law.<sup>63</sup>

Thus, the question is, does the ADA simply mirror the CSA, or does the ADA offer a more narrow view of what constitutes an illegal use of drugs?

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learning disabilities, panic or anxiety disorders, some forms of depression, carpal tunnel syndrome, and hyperthyroidism.

- Temporary, non-chronic impairments of short duration with little or no residual effects that usually will not substantially limit a major life activity: common cold, seasonal or common influenza, a sprained joint, minor and non-chronic gastrointestinal disorders, a broken bone expected to heal completely, appendicitis, and seasonal allergies.
- However, an impairment may still be substantially limiting even if it lasts or is expected to last fewer than 6 months, such as a 20-pound lifting restriction lasting several months.

EEOC SUMMARY OF KEY PROVISIONS, *supra* note 58, at 2.

<sup>60</sup> See *supra* Part I.A-B; see *supra* note 58.

<sup>61</sup> 42 U.S.C. § 12114(a) (Supp. II 2006) (“For purposes of this subchapter, a qualified individual with a disability shall not include any employee or applicant who is currently engaging in the illegal use of drugs, when the covered entity acts on the basis of such use.”). *Id.* § 12210(a).

<sup>62</sup> *Gonzales v. Raich*, 545 U.S. 1, 28-29 (2005).

<sup>63</sup> § 12111(6)(A).

### 1. *Current Federal Court Interpretation*

Only twice have federal courts addressed whether or not use of medical marijuana, when legal under state law, is considered an illegal use of drugs by the ADA.<sup>64</sup> In *Barber v. Gonzales*,<sup>65</sup> James Barber sought reconsideration of his case in light of the Supreme Court's landmark decision in *Gonzales v. Raich*, which determined that medical marijuana use is illegal under the CSA.<sup>66</sup> Barber was kicked out of university housing at Washington State University because of his marijuana use, and he had previously been arrested in Oregon for cultivating marijuana.<sup>67</sup> Barber asserted that he used the marijuana for medical reasons, although it is not clear from his rather wordy and imprecise complaint whether or not a doctor had actually prescribed the marijuana.<sup>68</sup> Barber claimed that his eviction was unlawful, apparently invoking the public services and public accommodation sub-chapters of the ADA.<sup>69</sup>

In rejecting Barber's claim, the district court invoked the ADA's illegal drug provision.<sup>70</sup> The court held that the second sentence of the definition—"such term does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provisions of Federal law"<sup>71</sup>—must be read consistently with the CSA. Under the CSA, marijuana is a Schedule I drug, and, as such, even medical use is not permitted.<sup>72</sup> The court rejected the idea that the ADA's definition included a distinct meaning for uses under medical supervision.<sup>73</sup> Instead, it determined that the second sentence of the definition was merely a reiteration of the first sentence, indicating that illegal drug

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<sup>64</sup> *Barber v. Gonzales*, No. CV-05-0173-EFS, 2005 WL 1607189 (E.D. Wash. July 1, 2005); *James v. City of Costa Mesa*, No. SACV 10-0402 AG (MLGx), 2010 WL 1848157 (C.D. Cal. Apr. 30, 2010).

<sup>65</sup> *Barber*, 2005 WL 1607189 (E.D. Wash. July 1, 2005).

<sup>66</sup> Individuals using marijuana under California's Compassionate Use Act challenged the constitutionality of the CSA's complete ban on marijuana. The Supreme Court upheld the constitutionality of the prohibition, as a valid exercise of Congress's Commerce Clause power. *Gonzales*, 545 U.S. at 9 (2005).

<sup>67</sup> Complaint at 30, *Barber v. Gonzales*, 2005 WL 1607189 (E.D. Wash. July 1, 2005) (No. CV-05-0173-EFS).

<sup>68</sup> *Id.* at 5-6.

<sup>69</sup> The complaint is long and difficult to understand, and the above explanation is probably the best guess as to the basis of his claim. *Id.* at 18.

<sup>70</sup> *Barber*, 2005 WL 1607189, at \*1.

<sup>71</sup> 42 U.S.C. § 12111(6)(A).

<sup>72</sup> See 21 C.F.R. § 1308.11 (2011).

<sup>73</sup> *Barber*, 2005 WL 1607189, at \*1.

use is that which violates the CSA.<sup>74</sup> In other words, “it is immaterial whether such drug use is authorized by state law.”<sup>75</sup>

In *James v. City of Costa Mesa*, several plaintiffs sought a preliminary injunction to prevent the cities of Costa Mesa and Lake Forest, California, from shutting down collectives that supplied the plaintiffs with medical marijuana.<sup>76</sup> The plaintiffs argued that the public accommodations subchapter of the ADA protected their right as disabled citizens to use medical marijuana in accordance with state law.<sup>77</sup> They sought a “reasonable accommodation from Defendants’ zoning laws and policies to obtain access to medical marijuana to treat their disabilities.”<sup>78</sup> This is not an employment case, but it is relevant because the district court denied the injunction based on its interpretation of the term “illegal use of drugs,” a definition that also applies to the employment subchapter.<sup>79</sup>

Plaintiffs, the court decided, were not entitled to relief under the ADA because they were engaged in illegal drug use. In determining the meaning of the second sentence of the “illegal use of drugs” definition, the court emphasized the relationship between the first clause (“[s]uch term does not include the use of a drug taken under supervision by a licensed health care professional”) and the second clause (“or other uses authorized by the Controlled Substances Act or other provisions of Federal law”).<sup>80</sup> The court placed particular emphasis on the word “other” in the second clause, arguing that its presence indicates that the meaning of the first clause depends on the second.<sup>81</sup> The first clause describes one type of use authorized by the CSA, while the second clause “encompasses all of the ‘other’ authorized uses” contemplated by the CSA.<sup>82</sup> In other words, the ADA’s definition of “illegal use of drugs” mirrors the CSA. As a result, the plaintiffs were barred from bringing an ADA claim despite taking marijuana under the supervision of licensed healthcare professionals.

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<sup>74</sup> *Id.*

<sup>75</sup> *Id.*

<sup>76</sup> *James v. City of Costa Mesa*, No. SACV 10-0402 AG (MLGx), 2010 WL 1848157, at \*1 (C.D. Cal. Apr. 30, 2010).

<sup>77</sup> *Id.* at \*1.

<sup>78</sup> *Id.* at \*2.

<sup>79</sup> *Id.* (quoting 42 U.S.C. § 12210(d) (2006)).

<sup>80</sup> *Id.* (quoting § 12210(d)).

<sup>81</sup> *Id.*

<sup>82</sup> *Id.*

## 2. *Alternative Interpretation*

These unreported district court opinions do not articulate the only or best interpretation of the definition of “illegal use of drugs.” The Code of Federal Regulations includes a section intended to clarify the ADA’s definition of “illegal use of drugs”:

The Act and the regulation distinguish between illegal use of drugs and the legal use of substances, whether or not those substances are “controlled substances,” as defined in the Controlled Substances Act (21 U.S.C. 812). Some controlled substances are prescription drugs that have legitimate medical uses. Section 36.209 does not affect use of controlled substances pursuant to a valid prescription, under supervision by a licensed health care professional, or other use that is authorized by the Controlled Substances Act or any other provision of Federal law.<sup>83</sup>

This explanation retains some of the ambiguity of the ADA (including that troublesome word “other”), but it more clearly focuses on prescribed substances as a legitimate and distinct use under the ADA.

The district courts, in the cases discussed above, held that the second sentence of the definition of “illegal use of drugs” simply explains what uses are permitted by the CSA. However, this interpretation renders most of the definition redundant or superfluous. If Congress intended that the definition be synonymous with the CSA, the drafters could have stopped after the first sentence—“The term ‘illegal use of drugs’ means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act.”<sup>84</sup> The CSA thoroughly explains how the various substances may or may not be used, and there is no need for an explanatory sentence if the ADA’s definition simply mirrors the CSA.

Full effect can be given to both sentences in the following manner. The first sentence sets forth a general rule: if a drug is illegal under the CSA, an employer will not face ADA liability if adverse action is taken on the basis of such drug use. The second sentence carves out exceptions to that rule: (1) uses under licensed medical supervision, (2) uses authorized by the CSA, and (3) uses authorized by other federal laws. Medical licensing is in the domain of state

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<sup>83</sup> 28 C.F.R. pt. 36, app. B, § 36.209 (2011).

<sup>84</sup> § 12111(6)(A).

law;<sup>85</sup> therefore, when a licensed doctor prescribes marijuana pursuant to state law, the marijuana user is not engaged in an “illegal use of drugs” under the ADA, even though she is violating the CSA.<sup>86</sup>

### 3. *ADA Not Intended to Exclude Treatment Choices*

The ADA’s illegal drug provision is intended to preclude individuals from claiming current drug use or addiction as a disability covered by the ADA: “[A] qualified individual with a disability shall not include any employee or applicant who is currently engaging in the illegal use of drugs, when the covered entity acts on the basis of such use.”<sup>87</sup> (The action of a covered entity refers to an employer taking adverse steps against an individual—firing an employee, for example.) In the present context, however, medical marijuana users are not seeking to have their prescription drug use treated as a disability. They already have underlying disabilities, which serve as the basis for an ADA claim. Although the above-referenced district court opinions imply otherwise, the ADA addresses drug use as disability and says nothing about drug use as treatment.

As the plaintiffs argued in *James v. City of Costa Mesa*, the initial draft of the ADA did not exclude coverage for those engaged in the illegal use of drugs.<sup>88</sup> That exclusion was added because of abuses that had occurred under the Rehabilitation Act.<sup>89</sup> Senator Jesse Helms supported the amendment because he believed that the war on drugs would fail if drug abusers could “hide behind the laws designed to help those who are seriously handicapped.”<sup>90</sup> Helms was upset that

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<sup>85</sup> *Medical Licensure*, AM. MED. ASS’N, <http://www.ama-assn.org/ama/pub/education-careers/becoming-physician/medical-licensure.page?> (last visited Jan. 6, 2012); *What is a State Medical Board?*, FED’N OF STATE MED. BDS., available at <http://www.fsmb.org/pdf/what-is-smb.pdf> (last visited Jan. 6, 2012).

<sup>86</sup> For further discussion of the legislative history of the ADA, see Lieberman & Solomon, *supra* note 55, at 650-53.

<sup>87</sup> 42 U.S.C. § 12114(a) (Supp. II. 2006).

<sup>88</sup> Memorandum in Opposition to Defendant Costa Mesa’s Motion to Dismiss at 12-14, *James v. City of Costa Mesa*, No. SACV 10-0402 AG (MLGx), 2010 WL 1848157 (C.D. Cal. Apr. 30, 2010), 2010 WL 2934614.

<sup>89</sup> The Rehabilitation Act was the predecessor to the ADA. *Id.* at 12.

<sup>90</sup> 101 CONG. REC. S10775 (Sept. 7, 1989) (statement of Sen. Jesse Helms), available at <http://thomas.loc.gov/home/LegislativeData.php?&n=Record&c=101> (search “Search Congressional Record – 101st Congress”: select “HELMS, Jesse (NC) from the ‘Member of Congress’ menu”; search “Americans with Disabilities Act”; then follow the hyperlink for “September 07, 1989”) (last visited Jan. 9, 2012), cited in Memorandum in Opposition to Defendant Costa Mesa’s Motion to Dismiss, *supra* note 88, at 12.

federal law treated current drug abuse as a disability.<sup>91</sup> The primary concern was with drug abusers being categorized as disabled, as opposed to concern that otherwise illegal drugs could be prescribed to treat disabilities. Medical marijuana users are not drug abusers; they have serious health issues and are taking marijuana pursuant to a lawful prescription.

The House Report that accompanied the ADA prior to its passage in 1990 made clear that the new illegal drug provision was not intended to affect disabled persons taking drugs under supervision of a licensed health care professional:

The term “illegal drugs” is defined in section 101(5) and does not include drugs taken under supervision by a licensed health care professional. The exempted category includes, for example, experimental drugs taken under supervision. Many people with disabilities, such as people with epilepsy, AIDS, and mental illness, take a variety of drugs, including experimental drugs, under supervision by a health care professional. Discrimination on the basis of use of such drugs would not be allowed.<sup>92</sup>

This passage only explicitly mentions experimental drugs as an example. However, it places special emphasis on whether or not a particular drug is used pursuant to licensed supervision. This particular focus supports an understanding of “illegal use of drugs” that allows for supervised medical use regardless of a drug’s status under criminal statutes like the CSA.

The executive branch took a similar position and relayed its concern to Congress. Deputy Assistant Attorney General John Mackey wrote a letter to the Senate Committee stating that the Bush administration did not want to exclude from ADA protection individuals who were using controlled substances in the course of treatment.<sup>93</sup> The evidence surrounding the ADA’s legislative history indicates that prescription drug treatment should not disqualify disabled persons from seeking the protection of the ADA.

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<sup>91</sup> 101 CONG. REC. S10775.

<sup>92</sup> H.R. REP. 101-485, pt. 2, at 79 (1989), *reprinted in* 1990 U.S.C.C.A.N. 303, 361.

<sup>93</sup> *Hearings on S.933 Before the S. Comm. on Labor and Human Resources*, 101st Cong. 828 (1989) (statement of John P. Mackey, Deputy Att’y Gen.), *cited in* Memorandum in Opposition to Defendant Costa Mesa’s Motion to Dismiss, *supra* note 88, at 12-13.

## B. Discrimination on the Basis of Disability

A disabled person bringing an ADA claim must show that she was subjected to discrimination “on the basis of disability.”<sup>94</sup> Employers who take action against medical marijuana users will argue that it was directed at the employee’s misconduct and has nothing to do with the individual’s disability. At first glance, it may appear that the discriminatory action is focused on the employee’s behavior, and not the underlying disability. However, there is good reason to believe that such adverse action is prohibited by the ADA.

### 1. Reasonable Accommodation

Discrimination on the basis of disability includes “not making reasonable accommodations to the known physical or mental limitations” of a disabled employee<sup>95</sup> or denying an employment opportunity to a person who needs accommodation.<sup>96</sup> An employer can avoid making reasonable accommodation only when it would impose an “undue hardship.”<sup>97</sup> Reasonable accommodation helps remove the barriers that often prevent disabled persons from accessing equal opportunities.<sup>98</sup>

Reasonable accommodation can take many forms. It might include improving facility accessibility, job restructuring, modified scheduling, modified equipment, or even job reassignment.<sup>99</sup> A claim of undue hardship is supported by an “individualized assessment” of the cost and difficulty of implementing a particular accommodation.<sup>100</sup> Undue hardship is determined by looking at several factors: (1) the nature and cost of accommodation, (2) the overall financial resources of the employer or facility, (3) the type of operation of the employer, and (4) the impact of the accommodation.<sup>101</sup>

For a disabled person whose best treatment option is marijuana, reasonable accommodation could be as simple as altering the em-

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<sup>94</sup> 42 U.S.C. § 12112(a) (Supp. II 2006).

<sup>95</sup> *Id.* § 12112(b)(5)(A).

<sup>96</sup> *Id.* § 12112(b)(5)(B).

<sup>97</sup> *Id.* § 12112(b)(5)(A).

<sup>98</sup> 29 C.F.R. § 1630.9 (2011).

<sup>99</sup> EEOC, NOTICE NO. 915.002, ENFORCEMENT GUIDANCE: REASONABLE ACCOMMODATION AND UNDUE HARDSHIP UNDER THE AMERICANS WITH DISABILITIES ACT (Oct. 17, 2002), *available at* <http://www.eeoc.gov/policy/docs/accommodation.html>.

<sup>100</sup> *Id.*

<sup>101</sup> *Id.*

ployer's drug policy. EEOC guidelines state that an employee's disability may necessitate modifying workplace policies, and that such modifications constitute reasonable accommodation if the employer does not suffer an undue hardship.<sup>102</sup> Under the ADA, the employer is not required to entirely discard the discriminatory policy. A policy still can be enforced with regard to all other employees; the employer only needs to make an exception for the disabled employee.<sup>103</sup>

As an example, the guidelines discuss an employee suffering from diabetes. The employer might have to modify a strict office food ban in order to accommodate the employee's specific needs.<sup>104</sup> With regard to medical marijuana, an employer could make an exception to a strict prohibition against marijuana use for those employees who are using it pursuant to state medical marijuana laws and under professional medical supervision. In analyzing the undue hardship factors, the accommodation proposed may be reasonable for many employers because (1) the cost would be low, and (2) the overall financial resources of the employer or facility would not be strained. The last two factors will depend upon the job, because the side effects of marijuana will have a different impact depending upon the job or workplace. Absent undue hardship, the ADA prohibits an employer from either refusing to accommodate or taking adverse action because of the need to accommodate an employee.<sup>105</sup>

## 2. *Policies That Screen Out Disabled Persons*

The ADA also states that discrimination on the basis of disability includes

[u]sing qualification standards, employment tests or other selection criteria that screen out or tend to screen out an individual with a disability or a class of individuals with disabilities unless the standard, test or other selection criteria, as used by the covered entity, is shown to be job-related for the position in question and is consistent with business necessity.<sup>106</sup>

The ADA provides employers wide latitude in drug testing their employees. Tests for illegal drugs are not subject to the same restrictions

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<sup>102</sup> *Id.*

<sup>103</sup> *Id.*

<sup>104</sup> *Id.*

<sup>105</sup> 42 U.S.C. § 12112(b)(5)(A) (2006).

<sup>106</sup> *Id.* § 12112(b)(6).

as medical examinations.<sup>107</sup> As a result, it is permissible for employers to test for the presence of marijuana. Even if it is established that medical marijuana is not an illegal use of drugs, nonmedical use remains illegal and the employer is entitled to test for it.

Despite the lawfulness of testing for marijuana, if an employer uses the results of the test in a way that “tends to screen out” disabled persons, the employer is engaging in unlawful discrimination, absent a showing of business necessity.<sup>108</sup> An employer can establish business necessity if it reasonably believes that the employee, because of impairment, cannot perform essential job functions or will pose a direct threat to the health and safety of herself or her coworkers.<sup>109</sup>

Recently, a federal district court decided a case that is an excellent analogue for medical marijuana use. In *Bates v. Dura Automotive Systems*, several former employees of Dura Automotive Systems brought suit after being fired for testing positive for certain legal prescription drugs.<sup>110</sup> In response to increased numbers of workplace injuries, the company had adopted a policy that prohibited any drug that carried a safety warning about operating machinery while using the drug.<sup>111</sup> Dura sought summary judgment, arguing that its policy did not screen out disabled individuals, but instead screened out individuals who were using certain legal and illegal drugs.<sup>112</sup> The court rejected this argument because testing for certain drugs, which are used to treat serious physical and mental ailments, “clearly tends to screen out” disabled individuals.<sup>113</sup>

Dura also argued that the screening was job-related and consistent with business necessity since Dura instituted the policy to improve the safety of a facility that had been more accident prone than others.<sup>114</sup> Dura argued that they ought to be able to take this preemptive action

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<sup>107</sup> *Id.* § 12114(d)(1); EEOC, NOTICE NO. 915.002, ENFORCEMENT GUIDANCE: DISABILITY-RELATED INQUIRIES AND MEDICAL EXAMINATIONS OF EMPLOYEES UNDER THE AMERICANS WITH DISABILITIES ACT (ADA) (July 27, 2000) [hereinafter EEOC DISABILITY-RELATED INQUIRIES] (“The ADA’s provisions concerning disability-related inquiries and medical examinations reflect Congress’s intent to protect the rights of applicants and employees to be assessed on merit alone, while protecting the rights of employers to ensure that individuals in the workplace can efficiently perform the essential functions of their jobs.”), available at <http://www.eeoc.gov/policy/docs/guidance-inquiries.html#5>.

<sup>108</sup> § 12112(b)(6).

<sup>109</sup> EEOC DISABILITY-RELATED INQUIRIES, *supra* note 107.

<sup>110</sup> *Bates v. Dura Auto. Sys.*, 650 F. Supp. 2d 754, 760-63 (M.D. Tenn. 2009).

<sup>111</sup> *Id.* at 770.

<sup>112</sup> *Id.*

<sup>113</sup> *Id.* (internal quotations omitted).

<sup>114</sup> *Id.* at 758, 770.

to protect employees and avoid potential liability.<sup>115</sup> The court pointed out that there needs to be “some realistic connection between the medical screening and the work performed.”<sup>116</sup> While Dura’s goal of workplace safety was legitimate, Dura did not appear to take into account “individualized circumstances,” and it reflexively fired any worker taking prohibited medications.<sup>117</sup> The court found the inflexibility of the policy problematic and denied Dura’s motion for summary judgment.<sup>118</sup> In addition, the court held that the determination of business necessity was best left to a jury.<sup>119</sup>

The determination of business necessity is based on “individualized circumstances.”<sup>120</sup> Inflexible prohibitions of medical marijuana short circuit the thoughtful deliberation that the ADA requires before a decision to fire an employee on the basis of the medical treatment they need for a disability. In some cases, it may be appropriate to prohibit medical marijuana (e.g., airline pilots or structural steel workers might pose a direct threat to the health and safety of themselves or others if they used medical marijuana). In other cases, however, it is difficult to imagine that the relatively mild side effects of marijuana would prevent the employee from performing essential job functions<sup>121</sup> (e.g., the email and telephone customer service position held by Jane Roe).<sup>122</sup> The employer must have a “reasonable belief, based on objective evidence” that taking adverse action is consistent with business necessity.<sup>123</sup> Otherwise, an employer cannot use a qualification standard or the results of a drug test in a way that “tends to screen out” disabled persons.

### 3. *Discrimination Construed Broadly*

ADA case law indicates that, generally, discrimination on the basis of disability is interpreted broadly. Often, an employer’s animus is not aimed directly at a disability. Instead, an employer’s adverse action may be directed at something related to the disability, such as the inconvenience of accommodating a disabled person. As a result,

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<sup>115</sup> *Id.* at 770.

<sup>116</sup> *Id.*

<sup>117</sup> *Id.* at 771-72.

<sup>118</sup> *Id.* at 772.

<sup>119</sup> *Id.*

<sup>120</sup> *Id.*

<sup>121</sup> See *supra* notes 33-35 and accompanying text; see also *Marijuana*, NAT’L INST. ON DRUG ABUSE, <http://www.nida.nih.gov/DrugPages/Marijuana.html> (last visited Jan. 17, 2011).

<sup>122</sup> See *supra* note 14 and accompanying text.

<sup>123</sup> EEOC DISABILITY-RELATED INQUIRIES, *supra* note 107.

some courts and the EEOC have interpreted “on the basis of disability” broadly.

Several cases related to methadone treatment facilities provide an example of the tendency to read “on the basis of disability” broadly. Methadone is a restricted drug that is used primarily for drug addiction treatment programs.<sup>124</sup> Because of this use, both Methadone clinics and users have often been looked upon with suspicion.<sup>125</sup> Much of the jurisprudence is focused on “regarded as” claims,<sup>126</sup> but a Third Circuit zoning decision provided guidance that highlights the boundaries of discrimination. In *New Directions Treatment Services v. City of Reading*, a Pennsylvania statute restricted the location of methadone clinics.<sup>127</sup> The clinic and its patients brought suit based on the Equal Protection Clause and the ADA. The court stated that the statute “facially singles out methadone clinics, and thereby methadone patients, for different treatment, thereby rendering the statute facially discriminatory.”<sup>128</sup> The case may be distinguishable from the plight of employees using medical marijuana in two ways: (1) the claim is based upon zoning discrimination and not employment discrimination, and (2) the statute was enacted because of residents’ fears about the recovering addicts who would use the methadone clinic in their neighborhood. But, importantly, the court viewed discrimination directed at a particular *treatment program* as discrimination against disabled persons. Treating a person with a disability differently because of their chosen treatment program constitutes “different treatment” that is actionable under the ADA.

The Tenth Circuit’s understanding of conduct related to a disability also sheds light on the type of discriminatory behavior that the

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<sup>124</sup> *Methadone*, NAT’L CTR. FOR BIOTECHNOLOGY INFO., U.S. NAT’L LIBRARY OF MED., <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000591#a682134-why> (last updated Feb. 1, 2009).

<sup>125</sup> Julie Manganis, *Methadone Clinic Appeals Denial of Permit*, SALEM NEWS (Jan. 15, 2011), <http://www.salemnews.com/local/x233316319/Methadone-clinic-appeals-denial-of-permit> (zoning board “found that the clinic would create ‘substantial detriment’ to the surrounding community . . . .”); Scott Taylor, *Site for Methadone Clinic Wrong, Neighbors Say*, SUN JOURNAL (Jan. 14, 2011), <http://www.sunjournal.com/city/story/970513> (the owner of a daycare near a proposed methadone clinic commented, “You can bring us in and educate us about what you do. But can you bring all the parents in here? The ones who will stop coming when they find out how close you are to our door?”).

<sup>126</sup> 42 U.S.C. § 12102(2)(C) (2006), amended by ADA Amendments Act of 2008, Pub. L. No. 110-325, sec. 4, § 12102, 122 Stat. 3555 (codified as amended at 42 U.S.C. § 12102(1)(C)).

<sup>127</sup> *New Directions Treatment Services v. City of Reading*, 490 F.3d 293, 298 (3d Cir. 2007).

<sup>128</sup> *Id.* at 304.

ADA prohibits. In both *Den Hartog v. Wasatch Academy*<sup>129</sup> and *Nielsen v. Moroni Feed Company*,<sup>130</sup> the Tenth Circuit rejected a “stark dichotomy” between a disability and disability-caused misconduct. The employees who brought the claims did not prevail in either case, but the court did clarify how conduct related to a disability ought to be understood. In *Nielsen*, the court explained that abnormal behavior that an employer treated as “misconduct” could be protected by the ADA because it was caused by mental illness.<sup>131</sup> Normally, conduct caused by a disability should be afforded the same protection as the disability itself.<sup>132</sup> Again, medical marijuana use may be distinguishable: it is not a symptom of the underlying disability in the way that abnormal behavior is a symptom of mental illness. But, the Tenth Circuit’s approach may be relevant to the issue of medical marijuana use because the court framed the issue in broader terms—the ADA can apply to behavior or “misconduct” that is related to, or caused by, a disability.

As long as an employee can perform the essential functions of the job, an employer ought to tolerate behavior that is caused by, or directly related to, a disability. For example, “an employer must make an exception to a general policy requiring employees to be neat and courteous in order to accommodate a mentally disabled employee whose job does not involve interaction with customers or co-workers.”<sup>133</sup> Similarly, an employer ought to make an exception to a general policy prohibiting the use of marijuana to accommodate an employee whose disability is best treated with medical marijuana.

Moreover, EEOC guidance reflects the Third and Tenth Circuit approach and supports the idea that a course of treatment (or, from the employer’s perspective, misconduct) should be handled the same as the disability itself. One EEOC example, contained in the guidance, states that employee misconduct stemming from the side effects of a medication should be accommodated unless it creates an undue hardship.<sup>134</sup> Similarly, medical marijuana use is directly related to, and caused by, the underlying disability. The need for treatment is a direct result of the disability. Many employers regard medical marijuana use as misconduct. If that misconduct—which, in reality, is simply

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<sup>129</sup> *Den Hartog v. Wasatch Acad.*, 129 F.3d 1076, 1088 (10th Cir. 1997).

<sup>130</sup> *Nielsen v. Moroni Feed Co.*, 162 F.3d 604, 608 (10th Cir. 1998).

<sup>131</sup> *Id.*

<sup>132</sup> *Id.*

<sup>133</sup> *Id.* (citing EEOC, NOTICE NO. 915.002, EEOC ENFORCEMENT GUIDANCE ON THE AMERICANS WITH DISABILITIES ACT & PSYCHIATRIC DISABILITIES (Mar. 25, 1997) [hereinafter EEOC ENFORCEMENT GUIDANCE ON THE ADA], available at 1997 WL 34622315, at \*15).

<sup>134</sup> EEOC ENFORCEMENT GUIDANCE ON THE ADA, *supra* note 133, at \*15.

prescription drug use—is caused by the disability, the employer discriminates by refusing to accommodate it.

### C. *Recommendations for Employers*

How should employers change their policies and practices in states where medical marijuana is legal? Employer policies and actions should be founded on two inquiries. First, is the employee's use of marijuana permitted by state law and supervised by a licensed medical professional? Second, how will medical marijuana use affect the employee and the workplace? If the employee chooses to bring a reasonable accommodation claim, the employer must show that permitting medical marijuana use will constitute an undue hardship.<sup>135</sup> If the employee chooses to challenge the policy, as tending to screen out disabled persons, the employer must show that the policy is job-related and consistent with business necessity.<sup>136</sup>

Employers may still test for the presence of illegal drugs, including marijuana. If an employee tests positive for marijuana in a state where medical use is legal, the employer should provide the employee with an opportunity to produce documentation that the marijuana is lawfully prescribed. If an employer wishes to take adverse action because of medical marijuana use, it must bear the burden of demonstrating that accommodation creates an undue hardship or that the decision is job-related and consistent with business necessity. The employer ought to engage in a dialogue with the employee to ensure that any decision is based on an individualized analysis of the facts.

## III. STATUTORY SOLUTIONS

This Note contends that there is reason to believe that the ADA protects disabled employees who use medical marijuana. However, the path to relief could be made clearer if certain changes were made to federal law. While I disagree with the unreported decision of the district court in *James v. City of Costa Mesa*, the court highlighted what could be a recurring theme for plaintiffs:

The record and arguments in this case stimulate thoughts on many other questions concerning medical marijuana, the rights of the seriously ill, and the interplay between federal, state, and municipal law. Were our federal statutes written differently, the Court

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<sup>135</sup> 42 U.S.C. § 12112(b)(5)(A) (2006).

<sup>136</sup> *Id.* § 12112(b)(6).

would have the chance to contribute to the growing body of scholarship on these questions.<sup>137</sup>

Below are suggestions as to how to write those statutes differently.

#### A. ADA Revision

The ADA, in its current form, does not provide a clear enough directive regarding what constitutes the illegal use of drugs. More specifically, the status of disabled persons lawfully using medical marijuana under state law is unacceptably uncertain with regard to federal protection against discrimination. The ADA definition of “illegal use of drugs” should be revised to protect individuals who use marijuana in compliance with state law and under a doctor’s supervision.

The revision ought to provide a general rule similar to the first sentence of the current definition. The definition then ought to enumerate exceptions to that general rule. The revised definition could read as follows:

The term “illegal use of drugs” means the use of drugs, the possession or distribution of which is unlawful under the Controlled Substances Act. However, the following are excluded from the term “illegal use of drugs”: (1) uses authorized by the Controlled Substances Act; (2) uses authorized by other provisions of federal law; (3) uses authorized by state law and supervised by a licensed health care professional.

This would provide much-needed protection for disabled employees and job-seekers who rely on medical marijuana for treatment.

The proposed change would clearly demonstrate that the ADA drug provision does not simply mirror the CSA. It would reinforce that the purpose of the ADA is to protect the rights of disabled individuals, and not to serve as an enforcement arm of federal criminal law. People like Joseph Casias and Jane Roe might be taking their chances with regard to federal drug prosecution, but at least they would gain the opportunity to prove that they were subjected to unlawful discrimination. The proposed change does not guarantee victory for medical marijuana users; it simply affords disabled individuals for whom medical marijuana is an effective treatment the same rights that other disabled individuals have.

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<sup>137</sup> James v. City of Costa Mesa, No. SACV 10-0402 AG (MLGx), 2010 WL 1848157, at \*1 (C.D. Cal. Apr. 30, 2010).

## B. CSA Rescheduling

Unfortunately, revising the ADA will not protect medical marijuana users against possible federal criminal prosecution, and it leaves the ADA and CSA with conflicting messages. Disabled persons who are protected by the ADA in the workplace should not have to fear becoming a casualty of the war on drugs. Senator Helms feared that the war on drugs would be lost unless drug users were excluded from ADA protection.<sup>138</sup> Unfortunately, the war on drugs has now put disabled individuals at risk. Currently, marijuana is in the most highly restricted category of controlled substances.<sup>139</sup> Changing that status would further protect disabled individuals and harmonize the impacts of the ADA and the CSA.

### 1. Scheduling Criteria

Congress states in the findings and declarations of the CSA that “[m]any of the drugs included within this subchapter have a useful and legitimate medical purpose and are necessary to maintain the health and general welfare of the American people.”<sup>140</sup> Increasingly, marijuana fits that description. However, it is currently a Schedule I drug, and no medical use is permitted under the CSA.<sup>141</sup> Controlled substances are organized into five schedules, Schedule I being the most severely restricted. Schedule I substances require the following findings: “(A) The drug or other substance has a high potential for abuse. (B) The drug or other substance has no currently accepted medical use in treatment in the United States. (C) There is a lack of accepted safety for use of the drug or other substance under medical supervision.”<sup>142</sup>

Current research regarding medical marijuana,<sup>143</sup> coupled with the fact that approximately 270,000 Americans are currently using medi-

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<sup>138</sup> See *supra* notes 90-91 and accompanying text.

<sup>139</sup> 21 U.S.C. § 812(c)(10) (2006); 21 C.F.R. § 1308.11 (2011).

<sup>140</sup> 21 U.S.C. § 801(1) (2006).

<sup>141</sup> *Id.* § 812(c)(10); see also 21 C.F.R. § 1308.11 (2011); The CSA did create a program that has allowed a handful of individuals over the years to use medical marijuana for research purposes. *Gonzales v. Raich*, 545 U.S. 1, 14 (2005) (“By classifying marijuana as a Schedule I drug, as opposed to listing it on a lesser schedule, the manufacture, distribution, or possession of marijuana became a criminal offense, with the sole exception being use of the drug as part of a Food and Drug Administration preapproved research study.”).

<sup>142</sup> § 812(b)(1)(A)-(C).

<sup>143</sup> See *supra* Part I.A-B.

cal marijuana,<sup>144</sup> indicates that marijuana's Schedule I status is inappropriate. With further study, marijuana could prove to be effective for a wide range of ailments. There are side effects, just as there are with any prescription drug, but not to the point where it is unsafe when used under proper supervision. There are other drugs which present a greater risk of dependence and abuse than marijuana, such as cocaine and methamphetamine,<sup>145</sup> but those drugs have not been relegated to Schedule I.<sup>146</sup>

Marijuana would be more appropriately categorized as a Schedule II drug, which requires the following findings:

(A) The drug or other substance has a high potential for abuse. (B) The drug or other substance has a currently accepted medical use in treatment in the United States or a currently accepted medical use with severe restrictions. (C) Abuse of the drug or other substances may lead to severe psychological or physical dependence.”<sup>147</sup>

This would reflect the known medicinal value of marijuana while acknowledging the importance of proper medical supervision and accepting that more research is necessary into the side effects and possible dangers of medical marijuana use.

The U.S. Attorney General has authority under the CSA to reschedule a drug if the proper findings are made.<sup>148</sup> Prior to rescheduling, the Attorney General must request a scientific and medical evaluation of the proposed change from the Secretary of Health and Human Services. The recommendation of the Secretary is binding on the Attorney General.<sup>149</sup> The statute lists eight factors for consideration: (1) actual or relative potential for abuse, (2) evidence of pharmacological effect, (3) current scientific knowledge, (4) history and pattern of abuse, (5) scope, duration, and significance of abuse, (6) risk to public health, (7) psychic or physiological dependence liability, and (8) whether the substance is an immediate precursor of a substance already controlled under the statute.<sup>150</sup> Marijuana does have potential

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<sup>144</sup> See *supra* note 3.

<sup>145</sup> David Nutt et al., *Development of a Rational Scale to Assess the Harm of Drugs of Potential Misuse*, 369 THE LANCET 1047, 1051 (2007).

<sup>146</sup> 21 C.F.R. § 1308.12 (2011).

<sup>147</sup> 21 U.S.C. § 812(b)(2)(A)-(C) (2011).

<sup>148</sup> *Id.* § 811(a).

<sup>149</sup> *Id.* § 811(b).

<sup>150</sup> *Id.* § 811(c)(1)-(8).

for abuse. But levels of dependence are relatively low compared to other drugs in both Schedule I and II.<sup>151</sup> Current scientific knowledge and medical practice make clear that marijuana has significant medicinal value.<sup>152</sup>

In fact, on November 30, 2011, the governors of Washington and Rhode Island (where medical marijuana is legal under state law) petitioned the federal government to reschedule marijuana as a Schedule II drug. Governor Christine Gregoire of Washington stated that, “[W]e have patients who really either feel like they’re criminals or may be engaged in some criminal activity, and really are legitimate patients who want medicinal marijuana.”<sup>153</sup> More to the point, the governors’ petition argued that

(1) cannabis for medical purposes has a relatively low potential for abuse, especially in comparison with other Schedule II drugs; (2) the medical community has concluded that cannabis has accepted medical use in treatment in the United States; and (3) cannabis has accepted safety for use under medical supervision and pharmacy based access.<sup>154</sup>

The petition pointed out that marijuana use has never resulted in a lethal overdose, and it is safer and has milder side effects than many Schedule II drugs.<sup>155</sup> In addition, current scientific evidence shows marijuana to be medically effective for a variety of conditions.<sup>156</sup> Medical marijuana has progressed to the point that—the governors insist—“it can be considered to have a ‘currently accepted medical use’ as required by 21 U.S.C. 812(b)(2)(B).”<sup>157</sup> As a result, marijuana ought to be rescheduled, so that there is a path for lawful use and

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<sup>151</sup> See *supra* notes 145-46.

<sup>152</sup> See *supra* Part I.A-B.

<sup>153</sup> Michael Cooper, *2 Governors Asking U.S. to Ease Rules on Marijuana to Allow for Its Medical Use*, N.Y. TIMES (Nov. 30, 2011), <http://www.nytimes.com/2011/12/01/us/federal-marijuana-classification-should-change-gregoire-and-chafee-say.html>.

<sup>154</sup> Letter from Lincoln D. Chafee, Governor of Rhode Island & Christine O. Gregoire, Governor of Washington, to Michele Leonhardt, Administrator, U.S. Drug Enforcement Administration 2 (Nov. 30, 2011), *available at* [http://www.governor.wa.gov/priorities/healthcare/petition/combined\\_document.pdf](http://www.governor.wa.gov/priorities/healthcare/petition/combined_document.pdf).

<sup>155</sup> *Id.*, Exh. B, at 7-10.

<sup>156</sup> *Id.*, Exh. B, at 10-13.

<sup>157</sup> *Id.*, Exh. B, at 16.

those who need it for treatment do not have to risk federal prosecution.

## 2. *The DOJ Approach*

Shortly after President Obama took office, the U.S. Department of Justice (DOJ) took action indicating that it acknowledged the problem with marijuana's Schedule I status. On October 19, 2009, the DOJ issued a memo to U.S. Attorneys to "provide[] clarification and guidance" regarding medical marijuana use.<sup>158</sup> The memo emphasized the Justice Department's commitment to enforcing the CSA, and reiterated the dangerous nature of illegal distribution and sale of marijuana.<sup>159</sup> However, in the interest of properly utilizing "limited investigative and prosecutorial resources," the memo also instructed U.S. Attorneys to "not focus federal 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."<sup>160</sup>

The DOJ memo carefully circumscribed a new, more relaxed standard. U.S. Attorneys were advised to be aware of certain characteristics that might indicate that marijuana was not being used pursuant to state law.<sup>161</sup> The memo enumerated the following indications of illegal activity:

- unlawful possession or unlawful use of firearms;
- violence;
- sales to minors;
- financial and marketing activities inconsistent with the terms, conditions, or purposes of state law, including evidence of money laundering activity and/or financial gains or excessive amounts of cash inconsistent with purported compliance with state or local law;
- amounts of marijuana inconsistent with purported compliance with state or local law;
- illegal possession or sale of other controlled substances; or

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<sup>158</sup> Memorandum from David W. Ogden, Deputy Att'y Gen., U.S. Dep't of Justice to Selected U.S. Att'ys, et al., Investigations and Prosecutions in States Authorizing the Medical Use of Marijuana 1 (Oct. 19, 2009), available at <http://www.justice.gov/opa/documents/medical-marijuana.pdf>.

<sup>159</sup> *Id.*

<sup>160</sup> *Id.* at 1-2.

<sup>161</sup> *Id.* at 2.

- ties to other criminal enterprises.<sup>162</sup>

The DOJ also reaffirmed its power to prosecute marijuana use.<sup>163</sup> The guidance was not intended to legalize medical marijuana use or create a defense to criminal prosecution.<sup>164</sup>

Essentially, the memo imposed something of a moratorium on prosecuting medical marijuana use in states that have legalized it, but emphasized the DOJ's right to act contrary to that moratorium at any time. While this was a move in the right direction, it obviously created a great deal of uncertainty for those using medical marijuana. This deferential policy might change, and a future administration could prosecute actions taken now in reliance on the current policy. In fact, the atmosphere of uncertainty has worsened as a result of recent events.

On October 7, 2011, four U.S. Attorneys in California announced that they would be cracking down on medical marijuana dispensaries that were simply “[l]arge commercial operations [that] cloak their money-making activities in the guise of helping sick people . . . . Our interest is in enforcing federal criminal law, not prosecuting seriously ill sick people and those who are caring for them.”<sup>165</sup> In theory, those who are legitimately in need of medical marijuana should not be affected, but it may be difficult for the DOJ to appropriately draw the line between legitimate and nonlegitimate medical marijuana providers. State officials have already expressed frustration with the increased federal intervention and fear that legitimate activity may be driven underground.<sup>166</sup> California's Attorney General Kamala Harris complained that the DOJ's newfound aggressiveness “has only increased uncertainty about how Californians can legitimately comply with state law.”<sup>167</sup>

The DOJ seems to realize that marijuana does not belong in Schedule I, but it so far remains unwilling to take steps to reschedule, perhaps for pragmatic political considerations. For decades now, most politicians and administrations have been terrified of being

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<sup>162</sup> *Id.*

<sup>163</sup> *Id.*

<sup>164</sup> *Id.*

<sup>165</sup> Jennifer Medina, *U.S. Attorneys in California Set Crackdown on Marijuana*, N.Y. TIMES (Oct. 7, 2011), <http://www.nytimes.com/2011/10/08/us/california-to-crack-down-on-medical-marijuana.html>.

<sup>166</sup> Erik Eckholm, *Medical Marijuana Industry is Unnerved by U.S. Crackdown*, N.Y. TIMES (Nov. 23, 2011), <http://www.nytimes.com/2011/11/24/us/medical-marijuana-target-of-us-prosecutors.html>.

<sup>167</sup> *Id.*

branded as “soft on crime.”<sup>168</sup> But, with popular support for medical marijuana around 75 percent, that fear seems unfounded.<sup>169</sup> The DOJ has the authority to initiate a schedule change and should do so in the interest of complying with the statutory criteria, and providing more certainty and stability for disabled individuals who need medical marijuana.

### C. Policy Concerns

The current Schedule I status of marijuana puts ADA protections at risk. Disabled employees who find marijuana to be the only treatment that alleviates their suffering should not be punished by the government. The uncertain status of marijuana under the ADA and the fear of criminal liability could quite possibly have a chilling effect on individuals otherwise eligible to bring ADA claims related to medical marijuana. Employers need to know how they should treat employees who use medical marijuana. Employees need to know that they can pursue treatment for their disabilities without fear of losing their jobs or being subject to criminal sanctions.

Opponents of medical marijuana fear that rescheduling and ADA protection would create a litany of public policy concerns related to productivity, safety, and employer liability.<sup>170</sup> The perception is that employees using medical marijuana are seriously affected by it and therefore miss more work and make more mistakes than co-workers.<sup>171</sup> Employers fear negative financial consequences (due to employee mistakes, absenteeism, or decreased productivity) and perhaps even reputational harm.<sup>172</sup> One author asserts that marijuana users are characterized by “absenteeism, shiftlessness, or malfeasance.”<sup>173</sup> Furthermore, employers would have to put up with “impairment of short-term memory, attention, motor skills, reaction time, and the organization and integration of complex information,” not to

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<sup>168</sup> See, e.g., Albert R. Hunt, *A Country of Inmates*, N.Y. TIMES (Nov. 20, 2011), <http://www.nytimes.com/2011/11/21/us/21iht-letter21.html>; Kate Zernike, *Old Clemency May Be Issue for Huckabee*, N.Y. TIMES (Nov. 30, 2009), <http://www.nytimes.com/2009/12/01/us/politics/01huckabee.html>; Michelle Norris, *Opposition Research: Know Thy Enemies*, NPR (Feb. 6, 2007), <http://www.npr.org/templates/story/story.php?storyId=7226716>.

<sup>169</sup> See *supra* note 2 and accompanying text.

<sup>170</sup> Deborah J. La Fetra, *Medical Marijuana and the Limits of the Compassionate Use Act: Ross v. RagingWire Telecommunications*, 12 CHAP. L. REV. 71, 73-74 (2008).

<sup>171</sup> *Id.* at 73.

<sup>172</sup> *Id.* at 74.

<sup>173</sup> *Id.* at 75.

mention “apathy, lowered motivation, and impaired cognitive performance.”<sup>174</sup>

However, the ADA is designed to manage the sorts of fears expressed above. Employers can still fire employees for failing to do their jobs. They can refuse to accommodate an employee’s treatment choice when it would present an undue hardship. They can impose prescription drug policies that are job-related and consistent with business necessity. To the extent that legitimate concerns do exist, there are adequate employer protections built into the ADA framework.

### CONCLUSION

Individuals with disabilities should not have to choose between effective treatment and gainful employment. Medical research has demonstrated the effectiveness of marijuana for certain applications, and doctors have prescribed it in numerous circumstances. Many individuals rely on marijuana to treat their disabilities. It enables them to work, to care for themselves, and to be self-reliant. These individuals should not be excluded from ADA protection or from the workplace on the basis of their treatment. Justice Breyer succinctly summarized what the ADA secures for disabled individuals:

The statute seeks to diminish or to eliminate the stereotypical thought processes, the thoughtless actions, and the hostile reactions that far too often bar those with disabilities from participating fully in the Nation’s life, including the workplace . . . . These objectives demand unprejudiced thought and reasonable responsive reaction on the part of employers and fellow workers alike.<sup>175</sup>

Medical marijuana users should not be automatically excluded from ADA protection. The ADA framework is fully capable of protecting employers while living up to its ideal of eliminating discrimination against individuals with disabilities.

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<sup>174</sup> *Id.* (quoting AMA COUNCIL ON SCIENTIFIC AFFAIRS, FEATURED REPORT: MEDICAL MARIJUANA (A-01) (2001), available at <http://web.archive.org/web/20080210055322/http://www.ama-assn.org/ama/pub/category/13625.html>).

<sup>175</sup> *U.S. Airways, Inc. v. Barnett*, 535 U.S. 391, 401 (2002).