these rates have remained unchanged over the past ten years;[5] and

Remembering that from 1985 to 1990, many different industries were recorded on silicosis death certificates, the most common being coal and metal mining (combined) (13.8 percent of cases), steelmaking (6.9 percent), miscellaneous non-mineral and stone products (6.1 percent), and iron foundries (5.4 percent);[5] and

Noting that the Mine Safety and Health Administration (MSHA) and the Occupational Safety and Health Administration (OSHA) have both the mandate and the authority to regulate workers' exposure to silica; and

Recognizing that 26.9 percent of MSHA samples of mine air for respirable dust in 1991 exceeded the permissible exposure limit (PEL) and that this exposure limit is twice the value recommended by NIOSH (100 v. 50 micrograms per cubic meter);[5] and

Acknowledging that silicosis is entirely preventable with known, effective, and conventional public health methods such as medical surveillance leading to secondary prevention and exposure surveillance leading to primary prevention; and

Noting that feasible and effective dust control methods include, from most to least adequate, use of less hazardous materials, dust suppression with water or enclosure of drill bits,[6] local exhaust ventilation, or use of respirators that have been fit-tested and worn by informed and trained workers who are physically able to wear them; and

Recognizing that several countries in Europe (Sweden, United Kingdom, Germany) prohibit or restrict the use of sand in abrasive blasting;[7] therefore

1. Urges OSHA and MSHA to improve regulations and their enforcement for preventing silicosis by requiring exposure and medical monitoring, including surveillance for tuberculosis; improving exposure limits; restricting the use of silica; and enforcing these regulations vigorously;

2. Urges OSHA and MSHA to adopt the exposure limits recommended by NIOSH;

3. Suggests that OSHA and MSHA should require medical and exposure monitoring of workers exposed to silica and should prohibit the use of silica in abrasive blasting;

4. Urges OSHA and other agencies to investigate the use of safe alternative materials in foundries and to promote research that would identify substitute materials for abrasive blasting and sand casting, with additional funds being made available to these agencies if necessary;

5. Recommends that NIOSH continue and expand its efforts to identify cases through surveillance, investigating death certificates, and other means; and

6. Recommends health education of workers and families about prevention and treatment of silicosis.

References

1. Balaan MR, Banks DR. Silicosis. In Rom WN, ed., *Environmental and Occupational Medicine,* 2d ed. Boston: Little, Brown and Co., 1992;345-358.
2. National Institute for Occupational Safety and Health. *Alert–Request for Assistance in Preventing Silicosis and Deaths among Rock Drillers.* Cincinnati: U.S. Department of Health and Human Services, Public Health Service, 1992. DHHS (NIOSH) Publication No. 92-107.
3. National Institute for Occupational Safety and Health. *Alert–Request for Assistance in Preventing Silicosis and Deaths from Sandblasting.* Cincinnati: U.S. Department of Health and Human Services, Public Health Service, 1992. DHHS (NIOSH) Publication No. 92-102.
4. Morris J. Worked to Death. *Houston Chronicle,* Fall, 1994.
5. National Institute for Occupational Safety and Health, Division of Respiratory Disease Surveillance. *Work-Related Lung Disease Surveillance Report, 1994.* Cincinnati: U.S. Department of Health and Human Service, Public Health Service, 1994. DHHS (NIOSH) Publication No. 94-120.
6. National Institute for Occupational Safety and Health. *Industrial Health and Safety Criteria for Abrasive Blast Cleaning Operations.* Washington, DC: U.S. Department of Health, Education, and Welfare (DHEW) (NIOSH) Pub. No 75-122.
7. PEI Associates, Inc. Investigation of Quartz Dust Sources and Control Mechanisms on Surface Coal Mine Operations. Vol. I, Results, Analysis, and Conclusions. A mining research contract report, Contract No. J03348032. Pittsburgh: U.S. Department of the Interior, Bureau of Mines. March 1986.

9513: Access to Therapeutic Marijuana/Cannabis

The American Public Health Association,

Being aware that cannabis/marijuana has been used medicinally for centuries and that cannabis products were widely prescribed by physicians in the United States until 1937;[1,2] and

Being aware that "marijuana" prohibition began with the Marihuana Tax Act of 1937 under false claims despite disagreeing testimony from the AMA's representative;[3,4] and

Being further aware that the Controlled Substances Act of 1970 completely prohibited all medicinal use of marijuana by placing it in the most restrictive category of Schedule I, whereby drugs must meet three criteria for placement in this category: 1) have no therapeutic value, 2) are not safe for medical use, and 3) have a high abuse potential;[5] and

Being cognizant that the Drug Enforcement Administration's own administrative law judge ruled in 1988 that marijuana must be removed from Schedule I and made available for physicians to prescribe;[6–8] and

Knowing that 36 states have passed legislation recognizing marijuana's therapeutic value;[9,10] and

Also knowing that the only available access to legal marijuana which was through the Food and Drug Administration's Investigational New Drug Program has been closed by the Secretary of Health and Human Services since 1992;[11] and

Understanding that while synthetic Tetrahydrocannibinol (THC) is available in pill form, it is only one of approximately 60 cannabinoids which may have medicinal value individually or in some combination; and

Understanding that marijuana has an extremely wide acute margin of safety for use under medical supervision and cannot cause lethal reactions;[6,32,34] and

Understanding that marijuana has been reported to be effective in: a) reducing intraocular pressure in glaucoma;[12,13] b) reducing nausea and vomiting associated with chemotherapy;[14–16] c) stimulating the appetite for patients living with AIDS (acquired immunodeficiency syndrome) and suffering from the wasting syndrome;[17–19] d) controlling spasticity associated with spinal cord injury and multiple sclerosis;[20–25] e) decreasing the suffering from chronic pain;[26–28] and f) controlling seizures associated with seizure disorders;[29–31] and

Understanding that marijuana seems to work differently from many conventional medications for the above problems, making it a possible option for persons resistant to the conventional medications;[32,33] and

Being concerned that desperate patients and their families are choosing to break the law to obtain this medicine when conventional medicines or treatments have not been effective for them or are too toxic;[34,35] and

Realizing that this places ill persons at

risk for criminal charges and at risk for obtaining contaminated medicine because of the lack of quality control; and

Realizing that thousands of patients not helped by conventional medications and treatments may find relief from their suffering with the use of marijuana if their primary care providers were able to prescribe this medicine; and

Concluding that cannabis/marijuana was wrongfully placed in Schedule I of the Controlled Substances Act depriving patients of its therapeutic potential; and

Recognizing that APHA adopted a resolution (7014) on Marijuana and the Law which urged federal and state drug laws to exclude marijuana from classification as a narcotic drug;[36] and

Concluding that greater harm is caused by the legal consequences of its prohibition than possible risks of medicinal use; therefore

1. Encourages research of the therapeutic properties of various cannabinoids and combinations of cannabinoids;

2. Encourages research on alternative methods of administration to decrease the harmful effects related to smoking; and

3. Urges the Administration and Congress to move expeditiously to make cannabis available as a legal medicine where shown to be safe and effective and to immediately allow access to therapeutic cannabis through the Investigational New Drug Program.

References

1. Abel EA. *Marihuana: The First Twelve Thousand Years.* New York: McGraw-Hill Book Company, 1982.
2. Mikuriya TH, ed. *Marijuana: Medical Papers 1839-1972.* Oakland, CA: MediComp Press, 1973.
3. Bonnie RJ, Whitebread II CH. *The Marihuana Conviction: A History of Marihuana Prohibition in the United States.* Charlottesville, VA: University Press of Virginia, 1974.
4. National Commission on Marihuana and Drug Abuse (RP Shafer, Chairman). *Marihuana: A Signal of Misunderstanding.* New York: The New American Library, Inc., 1972.
5. Controlled Substances Act of 1970 (Pub.L. 91-513, October 27, 1970, 21USC801 et seq.).
6. In the Matter of Marihuana Rescheduling Petition, Docket 86-22, Opinion, Recommended Ruling, Findings of Fact, Conclusions of Law, and Decision of Administrative Law Judge, September 6, 1988. Washington, DC: Drug Enforcement Agency, 1988.
7. Randall RC. *Marijuana, Medicine and the Law.* Washington, DC: Galen Press, 1988.
8. Randall RC. *Marijuana, Medicine and the Law,* Vol. II. Washington, DC: Galen Press, 1989.
9. Alliance for Cannabis Therapeutics. No accepted medical value?? *ACT News.* Spring, 1995;4.
10. Grinspoon L, Bakalar JB. Marihuana as medicine: A plea for reconsideration. *JAMA.* 1995;273(23):1875-1876.
11. Government extinguishes marijuana access, advocates smell politics. *JAMA.* May 20, 1992;267(19):2673-2674.
12. Colasanti BK. Review: Ocular hypotensive effect of marihuana cannabinoids: Correlate of central action or separate phenomenon. *J Ocular Pharmacol.* 1986;2(3):295-304.
13. Hepler RS, Frank IM. Marihuana smoking and intraocular pressure. *JAMA.* 1971;217:1392.
14. Sallan SE, Zinberg NE, Frei III E. Antiemetic effect of delta-9-tetrahydrocannabinol in patients receiving cancer chemotherapy. *New Engl J Med.* 1975;293(16):795-797.
15. Sallan SE, Cronin C, Zelen M, Zinberg NE. Antiemetics in patients receiving chemotherapy for cancer. *New Engl J Med.* 1980;302:135-138.
16. Vinciguerra V, Moore T, Brennan, E. Inhalation marijuana as an antiemetic for cancer chemotherapy. *NY State J Med.* 1988;88:525-527.
17. Nelson K, Walsh D, Deeter P, et al. A phase II study of delta-9-tetrahydrocannabinol for appetite stimulation in cancer-associated anorexia. *J Palliative Care.* 1994;10(1):14-18.
18. Regelson W, Butler JR, Schultz J, et al. Delta-9-THC as an effective antidepressant and appetite stimulating agent in advanced cancer patients. In *Int Conf Pharmacol Cannabis,* S Szara, MC Braude, eds. Savannah: Raven, 1975.
19. Foltin RW, Fischman MW, Byrne MF. Effects of smoked marijuana on food intake and body weight of humans living in a residential laboratory. *Appetite.* 1988;11:1-14.
20. Clifford DB. Tetrahydrocannabinol for tremor in multiple sclerosis. *Ann Neurol.* 1983;13:669-671.
21. Malec J, Harvey RF, Cayner JJ. Cannabis effect on spasticity in spinal cord injury. *Arch Phys Med Rehab.* 1982;35:198.
22. Meinck H, Schonle PW, Conrad B. Effect of cannabinoids on spasticity and ataxia in multiple sclerosis. *J Neurol.* 1989;236:120-122.
23. Petro D. Marihuana as a therapeutic agent for muscle spasm or spasticity. *Psychosomatics.* 1980;21:81-85.
24. Petro D, Ellenberger C. Treatment of human spasticity with delta-9-tetrahydrocannabinol. *J Clin Pharmacol.* 1981;21:413S-416S.
25. Ungerleider JT, Andyrsiak T, Fairbanks L, et al. Delta-9-THC in the treatment of spasticity associated with multiple sclerosis.
26. Johnson MR, Melvin LS, Althius TH, et al. Selective and potent analgesics derived from cannabinoids. *J Clin Pharmacol.* 1981;21:271S-282S.
27. Maurer M, Henn V, Dittrich A, et al. Delta-9-tetrahydrocannabinol shows antispastic and analgesic effects in a single case double-blind trial. *Eur Arch Psychiatry Clin Neurosci.* 1990;240:1-4.
28. Noyes Jr. R, Brunk SF, Avery DH, et al. The analgesic properties of delta-9-tetrahydrocannabinol and codeine. *Clin Pharmacol Ther.* 1975;18(1):84-89.
29. Cunha JM, Carlini EA, Pereira AE, et al. Chronic administration of cannabidiol to healthy volunteers and epileptic patients. *Pharmacology.* 1980;21:175-185.
30. Feeney D. Marihuana use among epileptics. *JAMA.* 1976;235:1105.
31. Karler R, Turkanis SA. The cannabinoids as potential antiepileptics. *J Clin Pharmacol.* 1981;21:437S-448S.
32. Institute of Medicine. *Marijuana and Health.* Washington, DC: National Academy Press, 1982.
33. Mechoulam R, ed. *Cannabinoids as Therapeutic Agents.* Boca Raton, FL: CRC Press, 1986.
34. Cannabis clubs open for medicinal business. *USA Today,* October 1, 1993:B1, B5.
35. Berger J. Mother's homemade marijuana: A plan to aid her son leads to arrest and push for change. *The New York Times,* October 11, 1993.
36. American Public Health Association. Resolution No. 7014: Marijuana and the Law. APHA Public Policy Statements, 1948–present, cumulative. Washington, DC: APHA, current volume.

9514: Reducing Youth Tobacco Use through Increased Excise Taxes

The American Public Health Association,

Recognizing that smoking is the leading preventable cause of morbidity and mortality in the United States;[1] and