

STATE-BY-STATE MEDICAL MARIJUANA LAWS

HOW TO REMOVE THE THREAT OF ARREST

2008

“ For now, federal law is blind to the wisdom of a future day when the right to use medical marijuana to alleviate excruciating pain may be deemed fundamental. Although that day has not yet dawned, considering that during the last ten years eleven states have legalized the use of medical marijuana, that day may be upon us sooner than expected.”

— Ninth Circuit Court of Appeals, *Raich v. Gonzales*, March 2007



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Executive Summary

- Favorable medical marijuana laws have been enacted in 36 states since 1978. However, most of these laws are ineffectual, due to their reliance on the federal government's directly providing or authorizing a legal supply of medical marijuana. (Six of these laws have since expired or been repealed.)
- Currently, 31 states and the District of Columbia have laws on the books that recognize marijuana's medical value:
 - Since 1996, 13 states have enacted laws that effectively allow patients to use medical marijuana despite federal law. To be effective, a state law must remove criminal penalties for patients who use and possess medical marijuana with their doctors' approval or certification. Effective laws must also allow patients to grow their own marijuana or allow a provider to do so for the patient.
 - A 14th state, Maryland, has established an affirmative defense law that protects patients who possess marijuana from jail sentences but not fines. Maryland's law also does not allow cultivation.
 - Nine states solely have "Therapeutic Research Program" laws that fail to give patients legal access to medical marijuana because of federal obstructionism.
 - Eight states and the District of Columbia solely have symbolic laws that recognize marijuana's medical value but fail to provide patients with protection from arrest.
- Nine of the 13 effective medical marijuana laws were enacted through the ballot initiative process — in Alaska, California, Colorado, Maine, Michigan, Montana, Nevada, Oregon, and Washington. The other four effective laws were passed by the state legislatures of Hawaii, New Mexico, Rhode Island, and Vermont. Hawaii and New Mexico's laws were enacted with the governors' signatures. The Rhode Island law was enacted over the governor's veto, and Vermont's governor allowed the medical marijuana legislation to become law without his signature.
- The federal government cannot force states to have laws that are identical to federal law, nor can the federal government force state and local police to enforce federal laws.
- Because 99% of all marijuana arrests in the nation are made by state and local (not federal) officials, properly worded state laws effectively protect at least 99 out of every 100 medical marijuana users who otherwise would have been prosecuted. Indeed, there aren't any known cases in which the federal government has prosecuted patients for small amounts of marijuana in the 13 states that have enacted medical marijuana laws since 1996.
- Since 2001, federal courts have handed down decisions on three significant medical marijuana cases — *U.S. v. Oakland Cannabis Buyers' Cooperative (OCBC)*, *Gonzales v. Raich*, and *Conant v. Walters*. The U.S. Supreme Court issued opinions on the first two of these cases and declined to hear the third.
 - In *OCBC*, the court determined that the medical necessity defense cannot be used to avoid a federal conviction for marijuana distribution; in *Raich*, the court held that the federal government can arrest and prosecute patients in states where medical marijuana is legal under state law. Despite issuing unfavorable decisions in both cases, the U.S. Supreme Court did not in any way nullify the 13 effective state medical marijuana laws, nor did it prevent additional states from enacting similar laws.
 - The U.S. Supreme Court also sent the *Raich* case back to the Ninth U.S. Circuit Court of Appeals to consider additional legal issues. The Ninth Circuit ruled that there is not yet a constitutional right to use marijuana to preserve one's life. It also held that the "medical necessity" criminal defense cannot be

used in a civil suit to prevent a federal prosecution.

- In deciding *Conant*, the Ninth U.S. Circuit Court of Appeals held that doctors cannot be prosecuted for recommending that their patients use medical marijuana. By choosing not to hear *Conant*, the U.S. Supreme Court effectively let this protection stand.
- Ultimately, the federal executive branch should allow marijuana to move through the FDA approval process so that marijuana can be approved as a prescription medicine and sold through pharmacies; or, barring that, Congress and the president should enact legislation giving states the right to make marijuana medically available in any way they choose without federal interference. However, because the federal government refuses to budge on either of these two fronts, the only way to protect marijuana-using patients from arrest is through legislation in the states.
- This report describes all favorable medical marijuana laws ever enacted in the United States, details the differences between effective and ineffective state laws, and explains what must be done to give patients immediate legal access to medical marijuana. Accordingly, a model bill and a compilation of resources for effective advocacy are provided.

Overview

Despite marijuana's widely recognized therapeutic value, the medical use of marijuana remains a criminal offense under federal law. Nevertheless, favorable medical marijuana laws have been enacted in 36 states since 1978.¹

Most of the favorable state laws are ineffectual, due to their reliance on the federal government's directly providing or authorizing a legal supply of medical marijuana. Fortunately, since 1996, 13 states have found a way to help seriously ill people use medical marijuana with virtual impunity, despite federal law.²

(A 14th law, enacted in Maryland in May 2003, is weaker than the 13 other laws because it protects medical marijuana patients only from jail sentences — not fines — and it forces patients to obtain their supply of medical marijuana from drug dealers. The Maryland law should not be used as a model for other states.)

Although the U.S. Supreme Court ruled in *U.S. v. Oakland Cannabis Buyers' Cooperative (OCBC)* (No. 00-151) that the medical necessity defense cannot be used to avoid a federal conviction for marijuana distribution, a state may still allow its citizens to possess, grow, or distribute medical marijuana. Furthermore, a 2007 Ninth Circuit Court of Appeals decision — *Gonzales v. Raich* — left open the possibility that a patient may be able to raise a medical necessity defense to prevent a federal criminal conviction. The *OCBC* ruling does not nullify the 13 effective state medical marijuana laws, nor does it prevent other states from enacting similar laws.

This is important because the overwhelming majority of marijuana arrests are made at the state and local level, not the federal level.

The few marijuana arrests made at the federal level almost always involve large-scale distribution. "We do not target sick and dying people," according to federal Drug Enforcement Administration (DEA) chief Karen Tandy, who insists that the federal government is interested in only those who traffic in large amounts of the drug.³

This report analyzes the existing federal and state laws and describes what can be done to give

1 See Appendix A.

2 See Table 1 for details on the 13 effective state laws.

3 "Justices Rule U.S. Can Ban Medical Pot," *Los Angeles Times*, June 7, 2005.

patients legal access to medical marijuana. The most effective way to allow patients to use medical marijuana is for state legislatures to pass bills similar to the law enacted by the Rhode Island General Assembly in June 2007.

A model state medical marijuana law, which is based on the Rhode Island law, can be found in Appendix Q.

Marijuana's Medical Uses

Marijuana has a wide range of therapeutic applications, including:

- relieving nausea and increasing appetite;
- reducing muscle spasms and spasticity;
- relieving chronic pain; and
- reducing intraocular (“within the eye”) pressure.

Thousands of patients and their doctors have found marijuana to be beneficial in treating the symptoms of AIDS, cancer, multiple sclerosis, glaucoma, and other serious conditions.⁴ For many people, marijuana is the only medicine with a suitable degree of safety and efficacy.

In March 1999, the National Academy of Sciences' Institute of Medicine (IOM) released its landmark study, *Marijuana and Medicine: Assessing the Science Base*. The scientists who wrote the report concluded that “there are some limited circumstances in which we recommend smoking marijuana for medical uses.”⁵

Accordingly, public opinion polls find that most Americans support legal access to medical marijuana.⁶

Criminalizing Patients

Federal marijuana penalties assign up to a year in prison for as little as one marijuana cigarette — and up to five years for growing even one plant. There is no exception for medical use, and many states mirror federal law.

There were 829,627 marijuana arrests in the United States in 2006, 89% of which were for possession (not sale or manufacture).⁷ Even if only 1% of those arrested were using marijuana for medical purposes, then there are more than 7,000 medical marijuana arrests every year!

In addition, untold thousands of patients are choosing to suffer by not taking a treatment that could very well cause them to be arrested in 37 states and the District of Columbia.

4 See Appendix B for a more detailed briefing paper about marijuana's medical uses.

5 See Appendix C for excerpts from the IOM report.

6 A 2005 national Gallup poll found support for medical marijuana at 78%. See Appendix D for the results of major public opinion polls.

7 FBI Uniform Crime Reports, *Crime in the United States: 2005-6*, published in September 2007.

Changing Federal Law

The federal Controlled Substances Act of 1970 established a series of five “schedules” (categories) into which all illicit and prescription substances are placed. Marijuana is currently in Schedule I, defining the substance as having a high potential for abuse and no currently accepted medical use in treatment in the United States.⁸ The federal government does not allow Schedule I substances to be prescribed by doctors or sold in pharmacies. Schedule II substances, on the other hand, are defined as having accepted medical use “with severe restrictions.” Schedules III, IV, and V are progressively less restrictive.

The DEA has the authority to move marijuana into a less restrictive schedule. After years of litigation, it has essentially been determined that the DEA will not move a substance into a less restrictive schedule without an official determination of “safety and efficacy” by the U.S. Food and Drug Administration (FDA).⁹

Unfortunately, current federal research guidelines make it nearly impossible to do sufficient research to meet the FDA’s exceedingly high standard of medical efficacy for marijuana.¹⁰ Since 1995, MPP has been helping scientists attempt to navigate federal research obstacles, and it has become clear that it will take at least a decade — if ever — for the FDA to approve the use of natural marijuana as a prescription medicine — and this assumes that a privately funded company is willing to spend the tens of millions of dollars that will be necessary to do the research.

However, there are several other ways to change federal law to give patients legal access to medical marijuana:¹¹

- Because the FDA is part of the U.S. Department of Health and Human Services (HHS), the U.S. Secretary of Health and Human Services can declare that marijuana meets sufficient standards of safety and efficacy to warrant rescheduling.
- Because Congress created the Controlled Substances Act (CSA), Congress can change it. Some possibilities include: passing a bill to move marijuana into a less restrictive schedule; moving marijuana out of the CSA entirely; or even replacing the entire CSA with something completely different. In addition, Congress can remove criminal penalties for the medical use of marijuana regardless of what schedule it is in.
- HHS can allow patients to apply for special permission to use marijuana on a case-by-case basis. In 1978, the Investigational New Drug (IND) compassionate access program was established, enabling dozens of patients to apply for and receive marijuana from the federal government. Unfortunately, the program was closed to all new applicants in 1992, and only three are still receiving medical marijuana through the program.

All of these routes have been tried — and failed. Until a more sympathetic president and Congress are in power, there is little chance of changing federal policies to give patients legal access to medical marijuana. Consequently, the greatest chance of success is in the states.

Changing State Laws: From 1978 to 1995¹²

States have been trying to give patients legal access to marijuana since 1978. By 1991, favorable laws had been passed in 34 states and the District of Columbia. (The 35th state, Hawaii, enacted its law in

8 See Appendix E for more details on the federal Controlled Substances Act.

9 Appendix B provides more information about this litigation.

10 See Appendix B for details on the difficulties involved with marijuana research.

11 Appendix B details some of these other routes.

12 See “Overview of Kinds of State Laws” on page 10.

2000, and Maryland, the 36th state, enacted its law in 2003.) Unfortunately, because of numerous federal restrictions, most of these laws have been largely symbolic, with little or no practical effect.

For example, several states passed laws stating that doctors may “prescribe” marijuana. However, federal law prohibits doctors from writing “prescriptions” for marijuana, so doctors are unwilling to risk federal sanctions for doing so. Furthermore, even if a doctor were to give a patient an official “prescription” for marijuana, the states did not account for the fact that it is a federal crime for pharmacies to distribute it, so patients would have no way to legally fill their marijuana prescriptions.

Changing State Laws: Since 1996

The tide began to turn in 1996 with the passage of a California ballot initiative. California became the first state to effectively remove criminal penalties for qualifying patients who grow, possess, and use medical marijuana. The law specifies that qualifying patients need a doctor to “recommend” marijuana. By avoiding issuing a prescription, doctors are not violating federal law in order to certify their patients. (Of note, Arizona voters also passed a medical marijuana initiative in 1996, but it turned out to be only symbolic because it required a prescription — an order to dispense a medication — rather than a recommendation — a statement of a doctor’s professional opinion.)

Over the next four years, seven states and the District of Columbia followed in California’s footsteps. Alaska, Oregon, Washington, and the District of Columbia passed similar initiatives in 1998. (Congress was able to prevent the D.C. initiative from taking effect because D.C. is a district, not a state, and is therefore subject to strict federal oversight.) Maine passed an initiative in 1999, and Colorado and Nevada followed suit in 2000.

Also in 2000, Hawaii broke new ground, when it became the first state to enact a law to remove criminal penalties for medical marijuana users via a state legislature. Gov. Ben Cayetano (D), who submitted the original bill in 1999 and signed the final measure into law on June 14, 2000, said, “The idea of using marijuana for medical purposes is one that’s going to sweep the country.”

On May 22, 2003, Gov. Robert Ehrlich of Maryland became the first Republican governor to sign workable medical marijuana legislation into law. Gov. Ehrlich signed H.B. 702, the Darrell Putnam Compassionate Use Act, in the face of staunch opposition from White House drug czar John Walters. The law removes criminal penalties for medical marijuana patients who can prove a medical necessity in court. Unfortunately, these patients still face arrest, a fine of \$100, and possible related court costs.

Vermont became the ninth state to pass an effective medical marijuana law on May 26, 2004, when Gov. James Douglas (R) allowed S. 76, An Act Relating to Marijuana Use by Persons with Severe Illness, to become law without his signature. Gov. Douglas, too, was pressured by the White House drug czar to reject the bill, but due to the high profile of the medical marijuana bill in the media and overwhelming public support by Vermonters, he decided against a veto.

In November of 2004, Montana voters approved an initiative to allow qualified patients to use and cultivate marijuana for their medical use. The proposal received 62% of the vote.

Rhode Island became the 11th state to pass an effective medical marijuana law in 2006 – and the first state to enact a medical marijuana law since the U.S. Supreme Court’s decision in *Gonzales v. Raich*. When the state legislature passed the Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act on June 28, 2005, and sent the bill to Gov. Donald Carcieri’s (R) desk for his signature, the governor vetoed the legislation the very next day. On January 3, 2006, the Rhode Island Legislature overwhelmingly overrode the governor’s veto – so patients in Rhode Island could use, possess, and grow their own medical marijuana without the fear of arrest. The initial law had a built-in sunset clause, but it was made permanent over Gov. Carcieri’s veto on June 21, 2007. Significantly, Rhode Island’s law is the first state medical marijuana law to be enacted over the veto of a governor.

In 2007, Gov. Bill Richardson (D) became the first governor in history to enact a medical marijuana law while running for the presidency by signing SB523, making New Mexico the 12th state to protect medical marijuana patients from arrest. New Mexico's medical marijuana law is the only one of the 13 effective state medical marijuana laws that directs the state to develop a system for the distribution of medical marijuana to qualifying patients. The department has held public meetings regarding this issue and is expected to make recommendations for enacting this provision of the law sometime in the near future.

Sixty-three percent of Michigan voters approved a medical marijuana initiative on November 4, 2008. That made Michigan the 13th state with an effective medical marijuana law, and the first in the Midwest.

More than 71 million Americans — about 24% of the U.S. population — now live in the 13 states where medical marijuana users are protected from both arrest and prison under state law.

The number of state-legal medical marijuana patients is available for nine of the medical marijuana states, where patients have to register to be protected from arrest. Unofficial estimates are available for the Maine and Washington, which have no registry, and for California, where most patients do not register. Michigan's law is so new that the registry is not yet up and running.

The number of registered medical marijuana users in Alaska, Colorado, Hawaii, Montana, Nevada, New Mexico, Oregon, Rhode Island, and Vermont shows that an average of 0.17% of the population uses medical marijuana in the states that have available information on patient numbers.

And from those states' numbers, we can extrapolate that the percentage of people in a new medical marijuana state who would take advantage of a medical marijuana law similar to MPP's model bill would be between 0.016% and 0.531%. See the chart in Appendix F for details about the number of registered patients in each state.

What the New State Laws Do

The nine state initiative-created laws, and the four laws created by state legislatures are similar in what they accomplish.¹³

Each of the 13 states allows patients to grow, possess, and use medical marijuana if approved by a medical doctor.¹⁴ Patients may also be assisted by a caregiver, who is authorized to help the patient grow, acquire, or consume medical marijuana. Further, physicians are immune from liability for discussing or recommending medical marijuana in accordance with the law.

To qualify for protection under the law, patients must have documentation verifying they have been diagnosed with a specified serious illness. The conditions are not specified in California, although in most states there is a defined list of medical conditions.

“Patients need a doctor to ‘recommend’ marijuana. By avoiding the word ‘prescribe,’ doctors do not need to violate federal law in order to help their patients.”

¹³ See Table 1 for specifics on each state law. Also see Appendix F for how these laws are working in the real world.

¹⁴ Maryland's law, which protects medical marijuana patients from criminal penalties, contains no explicit provision for cultivation. The text of New Mexico's law does not specify that patients can cultivate marijuana; it provides for state-regulated distribution and allows the department to determine how much marijuana patients and their caregivers can possess. The New Mexico Department of Health enacted rules allowing the amount of marijuana patients can possess to include plants. At the time of this writing, the state-regulated distribution system is not yet in effect.

“Some believe that the federal government can nullify state laws, or that the laws have no real value in the face of federal law. That is simply not the case.”

Most states require a statement of approval signed by the patient’s physician, but some permit a patient’s pertinent medical records to serve as valid documentation. To help law enforcement identify qualifying patients, some states have implemented formal state registry programs that issue identification cards to registered patients and their caregivers.

Patients’ marijuana possession and cultivation limits are generally restricted to a concrete number: one to 24 ounces of usable marijuana and six to 24 plants, sometimes limiting the number that can be mature. One state, Washington, has a conceptual marijuana limit, permitting a “60-day supply,” which is being further defined by the state’s health department. (California’s 1996 medical marijuana law permits enough marijuana “for the personal medical purposes of the patient.” A 2003 addition to the law, S.B. 420, guarantees protection from arrest for patients who possess state-issued ID cards and possess up to eight ounces of usable marijuana and six mature plants or 12 immature plants. However, at the time this report was published, 18 of California’s 58 counties are not yet distributing statewide medical marijuana ID cards.)

Regardless of whether patients grow their own, get it from a caregiver, or buy it from the criminal market, a patient in possession of an allowable quantity of marijuana and otherwise in compliance with the law is protected from arrest and/or conviction.

To illustrate how the law works, consider the following prototypical vignette:

“Joe” has AIDS. His doctor advised him that marijuana could boost his appetite, so he has three marijuana plants growing in the closet of his apartment, and he smokes four puffs of marijuana every day before dinner. One day, Joe’s neighbor smells the marijuana smoke and calls the police. The officer knocks on Joe’s door, and when Joe opens it, the officer sees the marijuana pipe on the table.

Luckily, Joe lives in one of the 13 states with effective medical marijuana laws. Joe acknowledges growing and using marijuana, but then shows the officer a note on his doctor’s letterhead, which says, “I am treating Joe for AIDS, and in my professional medical opinion I believe that the benefits of Joe’s medical marijuana use outweigh any possible health risks.” The officer documents or verifies Joe’s information, gives Joe his best wishes, and goes on his way.

If Joe lived in one of the 37 other states, he would be arrested, prosecuted, and possibly sent to prison.

As a matter of practice, police often do not arrest and prosecutors often do not prosecute individuals who can readily show that they are qualified patients, thus eliminating the need for a trial. In the event that a patient is arrested for marijuana possession or cultivation in one of the 13 states with effective laws, the patient is still allowed to argue at trial that his or her marijuana use was medically necessary.¹⁵

¹⁵ See Appendix G for more detailed definitions of these defenses.

Is There Conflict Between New State Laws and Federal Law?

In the 12 years since California and other states began protecting medical marijuana patients from arrest, many questions have surfaced regarding the status of those laws in relation to federal law. Some believe that the federal government can nullify state laws, or that state laws have no real value in the face of conflicting federal law. That is simply not the case.

Even though patients can be penalized by federal authorities for violating federal marijuana laws, a state government is not required to have identical laws. Therefore, a state may still allow its residents to possess, grow, or distribute marijuana for medical purposes.

This crucial distinction is often misunderstood: It is true that the federal government can enforce federal laws anywhere in the United States, even within the boundaries of a state that rejects those laws. Nevertheless, the federal government cannot force states to have laws that are identical to federal law, nor can the federal government force state and local police to enforce federal laws.

This division of power is extremely advantageous to patients who need to use marijuana: Because 99% of all marijuana arrests in the nation are made by state and local — not federal — officials, favorable state laws effectively protect 99 out of every 100 medical marijuana users who otherwise would have been prosecuted. Federal drug enforcement agents simply do not have the resources or the mandate to patrol the streets of a state to look for cancer patients growing a few marijuana plants.¹⁶

In fact, the federal government has declared its intention not to pursue patients who possess or use small amounts of marijuana for medical use. But distributors of medical marijuana are on the federal radar screen. Pharmacies do not sell marijuana anywhere in the United States. But numerous medical marijuana distribution centers that emerged in California and several other states — commonly known as dispensaries — have been targeted by the federal government. This has been an issue mostly in California, where the federal government has raided several large-scale distribution centers and grow operations, especially since 2001. (See Appendix S.)

Federal Court Rulings Have Clarified the Scope of State Laws

To date, there have been only two medical marijuana cases heard by the U.S. Supreme Court: *U.S. v. Oakland Cannabis Buyers' Cooperative (OCBC)* and *Gonzales v. Raich*.¹⁷ (A third case, *Conant v. Walters*, was appealed to the U.S. Supreme Court, but the court chose not to hear the case.) These cases do not challenge the legitimacy of the state medical marijuana laws and therefore do not affect the ability of states to protect medical marijuana patients under state law. Instead, they focus solely on federal issues.

In the *OCBC* case, the U.S. Supreme Court unanimously ruled (8–0) that medical marijuana distributors cannot assert a “medical necessity” defense against federal marijuana distribution charges. The ruling, issued on May 14, 2001, does not overturn state laws allowing seriously ill people to possess and grow their own medical marijuana.

OCBC dealt exclusively with federal law and was essentially limited to distribution issues. The case did not question a state’s ability to allow patients to grow, possess, and use medical marijuana under

¹⁶ See *FBI Uniform Crime Reports 2002*. (U.S. Government Printing Office, 2003) p. 223, Table 4.1 and p. 224, Table 29 and *Compendium of Federal Justice Statistics 2002*. (Bureau of Justice Statistics, 2004), p. 13, Figure 1.1. Calculations derived from the two cited Uniform Crime Reports tables show that there were a total of 697,082 marijuana arrests nationwide during 2002. The *Compendium of Federal Justice Statistics* table states that there were 7,464 arrests for federal marijuana offenses in the 12-month period ending on September 30, 2002. Thus, the arrests for federal marijuana charges are 1.07% of the total marijuana arrests. Note, however, that the actual number of persons arrested by federal agents on federal charges is even lower than 7,464 — 5% of persons arrested on federal charges were arrested by state and local agencies.

¹⁷ See Appendix I.

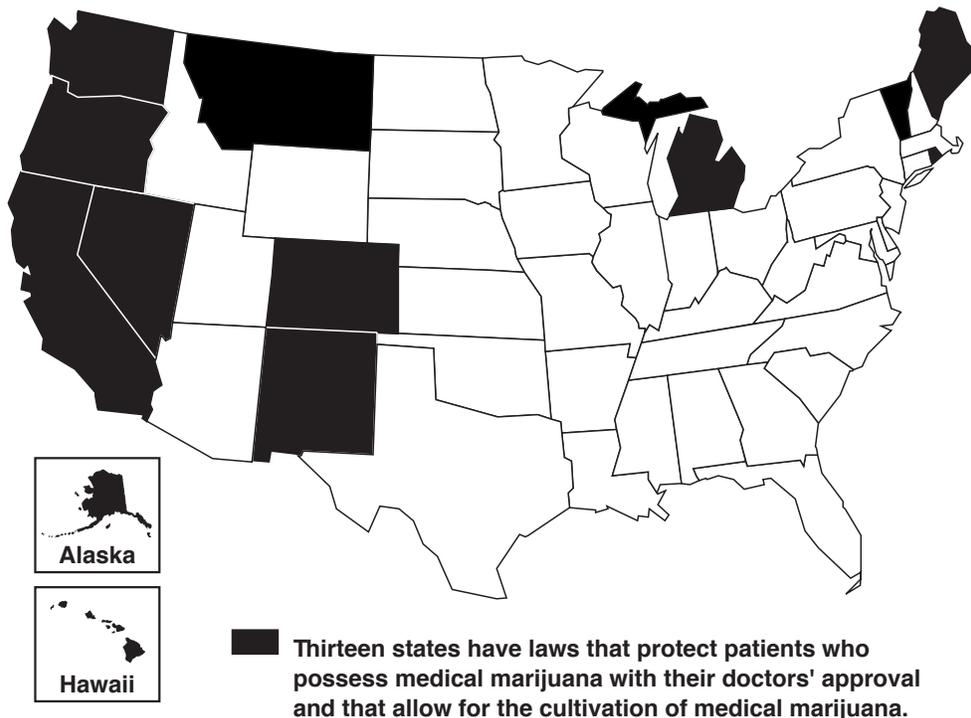
state law, and it presents no foreseeable barriers to additional state-level protections.

At issue in *Gonzales v. Raich* was whether the federal government has the constitutional authority to arrest and prosecute patients who are using medical marijuana in compliance with state laws. On June 6, 2005, the U.S. Supreme Court ruled 6-3 that the federal government can continue arresting patients who use medical marijuana legally under their state laws. However, the court did not overturn state medical marijuana laws or in any way interfere with their continued operation.

Gonzales v. Raich does not affect states' ability to pass medical marijuana laws — and it does not overturn the laws now protecting the right of more than 71 million Americans living in Alaska, California, Colorado, Hawaii, Maine, Michigan, Montana, Nevada, New Mexico, Oregon, Rhode Island, Vermont, and Washington to use medical marijuana legally under state laws.

Conant considered whether the federal government can punish physicians for discussing or recommending medical marijuana. The U.S. District Court for the Northern District of California ruled in September 2000 that the federal government cannot gag doctors in this fashion; the ruling was upheld in an October 2002 opinion from the Ninth U.S. Circuit Court of Appeals. On July 7, 2003, the federal government filed an appeal with the U.S. Supreme Court, which chose to not hear the case on October 14, 2003. This is the only appellate court decision on the issue of physicians recommending medical marijuana, and it is controlling law in the seven medical marijuana states in the Ninth Circuit. This unanimous decision in the Ninth Circuit is solidly grounded in the First Amendment, and physicians who evaluate the risks and benefits of the medical uses of marijuana

13 States Have Effective Medical Marijuana Laws



outside the Ninth Circuit should also have nothing to fear.

There are other important federal cases that have not (yet) made it up to the U.S. Supreme Court; these are reviewed in Appendix I.

At the state level, the vast majority of cases that have emerged have questioned whether individuals or organizations are in compliance with state law. Generally, state-level cases have focused on whether individuals qualify as patients or caregivers or whether they possess an amount of marijuana in excess of the specified legal limit.¹⁸ So far, the only case challenging a state medical marijuana law has failed. Three California counties — San Diego, San Bernardino, and Merced counties — that did not want to implement the state’s medical marijuana ID card program filed suit. The counties claimed that the ID cards and much of the rest of California’s medical marijuana law were invalid because of federal law and treaties. The counties lost in the superior court in December 2006. Merced then dropped out of the case, and the two remaining counties lost a unanimous ruling in July 2008. As of publication, San Diego County plans to appeal the case to the state supreme court, but San Bernardino has not decided whether to join in the appeal. The case is expected to lose.¹⁹

“The only laws that currently provide meaningful protection for patients are ones that remove state-level criminal penalties for cultivation, possession, and use of medical marijuana.”

Overview of Kinds of State Laws

At various times since 1978, 36 states and the District of Columbia have had favorable medical marijuana laws.

Laws in five states have either expired or been repealed, but 31 states and D.C. currently have laws on the books. Although well-intentioned, most of these laws do not provide effective protection for patients who need to use medical marijuana.

(Because some states have enacted more than one type of law, the totals for the following subsections add up to more than 36.)

Effective laws

The only laws that currently provide meaningful protection for patients are ones that remove state-level criminal penalties for cultivation, possession, and use of medical marijuana. Thirteen states — Alaska, California, Colorado, Hawaii, Maine, Michigan, Montana, Nevada, New Mexico, Oregon, Rhode Island, Vermont, and Washington — have effective laws of this nature, all of which have been enacted since 1996.

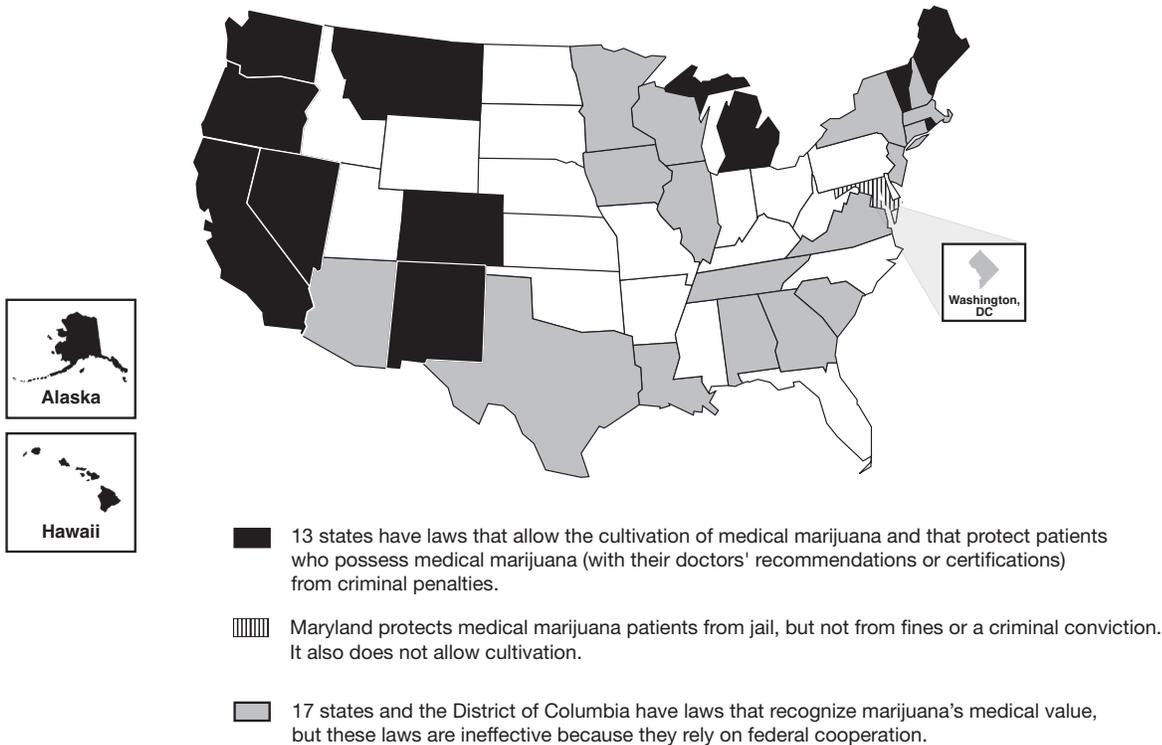
Workable laws

Maryland is the only state that has what MPP considers a “workable law.” Maryland protects patients from jail time for possession of marijuana, but the law does not specifically address cultivation. For patients who can prove in court that their use of marijuana was a medical necessity, the maximum penalty is a \$100 fine.

¹⁸ See Appendix A for details on all state medical marijuana laws.

¹⁹ *County of San Diego v. San Diego NORML*, No. GIC860665 (San Diego Superior Court 2006).

31 STATES WITH MEDICAL MARIJUANA LAWS, 2008



Therapeutic research programs²⁰

The nine states listed under this title in Appendix A, plus California, New Mexico, Rhode Island, and Washington, currently have laws that allow patients to legally use medical marijuana through state-run therapeutic research programs. During the late 1970s and early 1980s, at least seven states obtained all of the necessary federal permissions, received marijuana from the federal government, and distributed the marijuana to approved patients through pharmacies.

The federal approval process for medical marijuana research is excessively cumbersome. As a result, state health departments are generally unwilling to devote their limited resources to the long and potentially fruitless application process, nor are they willing to spend taxpayer money administering the program. Additionally, many patient advocates oppose research programs as the primary mode of access to medical marijuana because enrollment in such programs is highly restrictive.

In sum, therapeutic research program laws are no longer effective because of federal obstructionism.

Symbolic measures

Pseudo-prescriptive access. Eight states have laws that allow patients to possess marijuana if obtained directly through a valid prescription. The problem is that there is no legal supply of marijuana to fill such a prescription. Federal law prohibits the distribution of marijuana and other Schedule I substances for any reason other than research. Doctors cannot "prescribe" marijuana, and pharmacies cannot dispense it.

Prescriptive-access laws demonstrate a state's recognition of marijuana's therapeutic use, but they are not effective as written without a change in federal policy.

Establishing provisions for the state government to distribute confiscated marijuana.

²⁰ See Appendix J for details on therapeutic research programs.

Before it was repealed in 1987, an Oregon law allowed physicians to prescribe confiscated marijuana. Several other states have considered similar legislation, although it does not appear that confiscated marijuana has ever been distributed in any state.

It is one thing for state governments to look the other way while patients grow medical marijuana for themselves, but it's another thing for the state government itself to distribute a Schedule I substance for anything other than federally approved research. State officials would be highly vulnerable to federal prosecution for marijuana distribution, as they are more visible targets than individual patients. Another concern is that confiscated marijuana may contain adulterants and would require screening, which could be prohibitively expensive.

Rescheduling marijuana. States have their own controlled substance schedules, which typically mirror the federal government's. However, states are free to schedule substances as they see fit.

Four states — Alaska, Iowa, Montana, and Tennessee — and the District of Columbia currently place marijuana in schedules that recognize its therapeutic use.

However, there is little or no practical significance to rescheduling marijuana on the state level, because the federal schedules supersede state schedules and the federal government does not permit marijuana prescriptions. As with “pseudo-prescriptive access” laws, it is unclear whether courts would interpret these laws as permitting a “medical necessity” defense.

Non-binding resolutions. At least seven state legislatures — California, Michigan, Missouri, New Hampshire, New Mexico, Rhode Island, and Washington — have passed non-binding resolutions urging the federal government to allow doctors to prescribe marijuana. Non-binding resolutions are passed by one or both chambers of a state's legislature and do not require the governor's signature. The resolutions send a message, officially proclaiming the legislatures' positions, but do not change state policy and are unlikely to be of any practical help to patients.

Laws that have expired or been repealed

In addition to the 31 states with current laws, Arkansas, Florida, North Carolina, and West Virginia have repealed their medical marijuana laws. In Ohio, one law expired and a second law was repealed. A few other states have had laws that have expired or been repealed — but subsequently enacted other medical marijuana laws that are still on the books.

And, finally, 14 states have never had favorable medical marijuana laws.

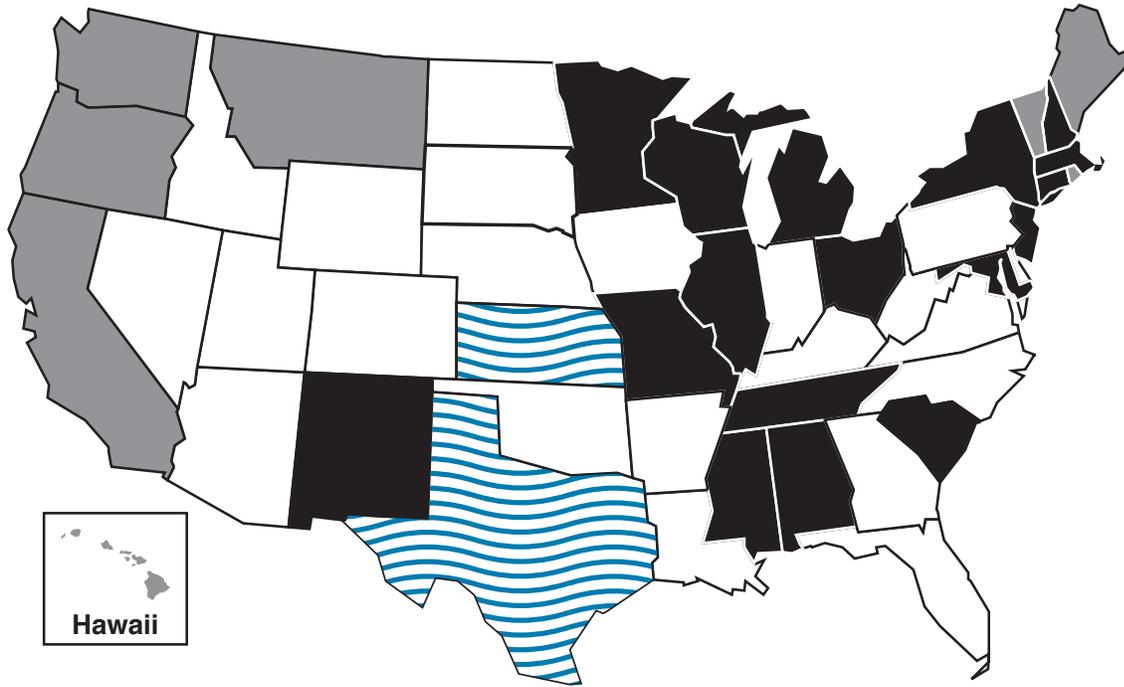
Where Things Are Going From Here

The 10 statewide medical marijuana initiatives that voters approved, nine of which resulted in effective state laws, have been described as the first wave of activity to protect medical marijuana patients nationwide. Not only do they provide legal protection for patients in states that collectively contain about 24% of the U.S. population, they also verify Americans' strong support for favorable medical marijuana laws.

In turn, Hawaii's success has been called the beginning of the second wave, whereby state legislatures are enacting effective laws to protect medical marijuana patients.

In the 2007-2008 legislative sessions, 17 state legislatures have considered bills to remove arrest and criminal penalties for medical marijuana, attempting to establish laws similar to those in the states that have already effectively allowed patients to use medical marijuana. Two additional state legislatures considered bills that would remove the chance of conviction, but not arrest from medical marijuana. Vermont, Rhode Island, and New Mexico passed such bills into law in 2004, 2006, and 2007, respectively. In 2007, Vermont expanded the conditions covered by its medical marijuana

27 States Considered Medical Marijuana Legislation During the 2007 or 2008 Legislative Sessions



During the 2007 and 2008 legislative sessions:

-  17 states considered bills to protect medical marijuana patients and caregivers from arrest and criminal penalties.
-  8 states considered bills to amend existing, effective medical marijuana laws.
-  Texas and Kansas considered bills that would protect medical marijuana patients from being convicted, but not arrested.

For more information about these bills, including their status, please see Appendix L.

law, and Rhode Island modified and made permanent its law. California, Hawaii, Maine, Montana, Oregon, and Washington considered expanding their effective laws.²¹

The role of state legislatures in the movement to protect medical marijuana patients cannot be overstated. Only 23 states and the District of Columbia have the initiative process, which means that citizens in 27 states cannot directly enact their own laws. They must rely on their state legislatures to enact favorable medical marijuana laws, and the number of future legislative victories will depend on how many people effectively lobby their state officials. Moreover, legislation is much more cost-effective than ballot initiatives, which can be very expensive endeavors.

The passage of additional state medical marijuana laws will have the added benefit of pressuring the federal government to change its laws.

The third and final wave will be a change in federal law.

²¹ See Appendix L for a list of all state medical marijuana bills and resolutions considered during 2007.

TABLE 1: Effective Medical Marijuana Laws in 13 States

State; Measure/% of vote; Date enacted	Statutory or constitutional ^a	How law protects patients (defenses provided) ^b	Documentation required	Registry system for patients and caregivers	Marijuana quantity limits	Caregiver provisions	Can medical conditions be added?
Alaska Measure 8 (ballot initiative/58%) November 3, 1998 (modified by S.B. 94, effective June 2, 1999)	statutory	affirmative defense provided only for those registered with the state ^c	signed physician statement that the patient was examined in the context of a bona fide physician- patient relationship, the patient has been diagnosed with a debilitating medical condition, and other approved medications were “considered”	with state Department of Health and Social Services	one ounce of marijuana in usable form and six marijuana plants, with no more than three mature and flowering plants producing usable marijuana at any one time	one primary and one alternate caregiver who may serve only one patient at a time, with limited exceptions	yes
California Proposition 215 (ballot initiative/56%) November 5, 1996 (modified by S.B. 420, effective January 1, 2004)	statutory	exemption from arrest for those with voluntary ID cards; affirmative defense or dismissal for those with only written recommendations	“written or oral recommendation or approval of a physician” who has determined that the patient’s health “would benefit from medical marijuana” in the treatment of a qualifying condition	voluntary patient registry system; caregivers and patients with IDs are verified through the California Medical Marijuana Program Web site	the state initiative, which cannot be amended by legislation, did not include limits; the legislature later enacted quantity guidelines, which are being challenged in court as unconstitutional caps, see Appendix F for details	the individual designated by the patient who has consistently assumed responsibility for the housing, health, or safety of that person; this may include a person who was designated by more than one patient if they all reside in the same city or county	N/A
Colorado Amendment 20 (ballot initiative/54%) November 7, 2000	constitutional	exemption from prosecution if in lawful possession of a registry card; affirmative defense if not registered but in compliance with the law	diagnosed by a physician (prior to arrest) as having a debilitating condition and “advised” by the physician, in the context of a bona fide physician-patient relationship, that the patient “might benefit” from medical marijuana	with state Department of Public Health and Environment	two usable ounces and six plants, three of which may be mature; patients may use affirmative defense to argue that greater amounts are medically necessary	an individual who has significant responsibility for managing the well- being of the patient	yes

TABLE 1: Effective Medical Marijuana Laws in 13 States

State; Measure/% of vote; Date enacted	Statutory or constitutional ^a	How law protects patients (defenses provided) ^b	Documentation required	Registry system for patients and caregivers	Marijuana quantity limits	Caregiver provisions	Can medical conditions be added?
Hawaii S.B. 862 HD1 (enacted by legislature) June 14, 2000	statutory	exemption from prosecution if in lawful possession of a registry card; "choice of evils" defense also on the books, independent of this statute	patient's medical records or a statement signed by the patient's physician, stating that in the physician's professional opinion, the patient has a debilitating condition and the "potential benefits of the medical use of marijuana would likely outweigh the health risks"	with state Department of Public Safety	seven plants, three of which may be mature, and one ounce per mature plant	one caregiver per patient, and a caregiver may serve only one patient at any given time	yes
Maine Question 2 (ballot initiative/61%) November 2, 1999 (modified by L.D. 611, effective April 1, 2002)	statutory	exemption from prosecution if in possession of a "usable amount" of medical marijuana and has available an authenticated copy of an appropriate medical record or written documentation from a physician; affirmative defense if in compliance with statute	an authenticated copy of pertinent medical records or written documentation from a physician showing that the patient has a qualifying condition; the physician has discussed the risks and benefits of medical marijuana; and the patient has been "advised" by the physician that he or she "might benefit" from medical marijuana	N/A	2.5 ounces and six plants, three of which may be mature	one caregiver, who has consistently assumed responsibility for the housing, health, or safety of the patient or who is a member of the same household and is named in a written individual instruction or power of attorney for health care	no
Michigan Proposal 1 (ballot initiative/63%) November 4, 2008	statutory	exemption from prosecution if in lawful possession of a registry card; affirmative defense if not registered but meet certain conditions	valid, written documentation from the person's physician stating that the person has been diagnosed with a debilitating medical condition and that "the patient is likely to receive therapeutic or palliative benefit from the medical use of marihuana"	with the state Department of Community Health	2.5 usable ounces and 12 plants	one caregiver per patient	yes

TABLE 1: Effective Medical Marijuana Laws in 13 States

State; Measure/% of vote; Date enacted	Statutory or constitutional ^a	How law protects patients (defenses provided) ^b	Documentation required	Registry system for patients and caregivers	Marijuana quantity limits	Caregiver provisions	Can medical conditions be added?
Montana Initiative 148 (ballot initiative)/62% November 2, 2004	statutory	exemption from prosecution if in lawful possession of a registry card; affirmative defense if not registered but in compliance with the law	valid, written documentation from the person's physician stating that the person has been diagnosed with a debilitating medical condition and that "potential benefits of the medical use of marijuana would likely outweigh the health risks for the qualifying patient"	with state Department of Public Health and Human Services	one usable ounce and six plants	one caregiver per patient	yes
Nevada A.B. 453 (enacted by the legislature; implements ballot initiative Question 9, which passed with 59% of the vote in 1998 and again with 65% on November 7, 2000) June 14, 2001 (modified by A.B. 519, effective July 1, 2005)	constitutional and statutory	exemption from prosecution if in lawful possession of a registry card; affirmative defense if not registered but in compliance with the law	diagnosed within 12 months prior to arrest with a qualifying condition; advised by attending physician that marijuana "may mitigate the symptoms or effects" of the debilitating condition	with a joint system operated by the state Departments of Motor Vehicles and Agriculture	one usable ounce and seven plants, three of which may be mature; patients may use affirmative defense to argue that greater amounts are medically necessary	one caregiver per patient, although caregivers can serve multiple patients simultaneously	yes
New Mexico SB 523 (enacted by legislature) July 1, 2007	statutory	exemption from prosecution if in lawful possession of a registry identification card and in possession of no more than an "adequate supply" of medical marijuana	written certification that, in the practitioner's opinion, patient has a debilitating medical condition and that the benefits of medical marijuana would likely outweigh the risks	Department of Health held meetings in October 2007 and September 2008 to discuss patient registry system and ID cards, which are being issued temporarily until official rules are adopted	an "adequate supply" not to exceed six ounces of usable marijuana, four mature plants, and 12 seedlings, or a three-month supply of topical treatment	a caregiver may have up to four patients and possess up to six ounces of usable cannabis, four mature plants, and three seedlings for each patient	yes

TABLE 1: Effective Medical Marijuana Laws in 13 States

State; Measure/% of vote; Date enacted	Statutory or constitutional ^a	How law protects patients (defenses provided) ^b	Documentation required	Registry system for patients and caregivers	Marijuana quantity limits	Caregiver provisions	Can medical conditions be added?
Oregon Measure 67 (ballot initiative/55%) November 3, 1998 (modified by H.B. 3052, effective July 21, 1999, and S.B. 1085, effective January 1, 2006)	statutory	exemption from prosecution if in lawful possession of a registry card; affirmative defense if not registered but in compliance with the law; "choice of evils" defense also authorized by statute	valid, written documentation from the person's attending physicians stating that the person has been diagnosed with a debilitating medical condition and that the medical use of marijuana may mitigate the symptoms or effects of the person's debilitating condition	with state Department of Human Services	24 ounces of usable marijuana, six mature marijuana plants, and 18 seedlings per patient jointly with his or her caregiver; patients no longer have an affirmative defense to argue that greater amounts are medically necessary	one caregiver per patient, although caregivers can serve multiple patients simultaneously	yes
Rhode Island H 6052 and S 710 (enacted by legislature in 2006); H 6005 and S 791 (enacted by legislature in 2007) January 3, 2006, made permanent June 21, 2007	statutory	exemption from prosecution if in lawful possession of a registry card; affirmative defense if not registered but in compliance with the law	medical records and valid, written documentation from the person's medical practitioner stating that the person has been diagnosed with a debilitating medical condition and that "potential benefits of the medical use of marijuana would likely outweigh the health risks for the qualifying patient"	with state Department of Health	2.5 usable ounces and 12 plants	two caregivers per patient	yes
Vermont S. 76 (enacted by legislature) May 26, 2004 (modified by S.7, effective July 1, 2007)	statutory	exemption from arrest and prosecution if in lawful possession of registry card	signed application by the patient, along with medical record sufficient to establish qualifying medical condition; physician then contacted to verify existence of bona fide physician-patient relationship and medical condition	with state Department of Public Safety	two usable ounces and nine plants, two of which may be mature	one caregiver per patient, and a caregiver may serve only one patient at a time; a caregiver cannot have a drug- related conviction and must be registered with the state	no

TABLE 1: Effective Medical Marijuana Laws in 13 States

State; Measure/% of vote; Date enacted	Statutory or constitutional ^a	How law protects patients (defenses provided) ^b	Documentation required	Registry system for patients and caregivers	Marijuana quantity limits	Caregiver provisions	Can medical conditions be added?
Washington Measure 692 (ballot initiative)/59% November 3, 1998	statutory	affirmative defense available if in compliance with the statute ^d	statement signed by patient's physician, or a copy of the patient's pertinent medical records, which states that in the physician's professional opinion, the "potential benefits" of medical marijuana "would likely outweigh the health risks"	N/A	"sixty-day supply"	one caregiver per patient, and a caregiver may serve only one patient at any given time	yes

a There is no difference in the functionality of medical marijuana laws that are enacted by "statute" versus "constitutional amendment." The only difference is that a constitutional amendment cannot be changed by statutory law; it may be changed or repealed only by another constitutional amendment. Therefore, constitutional amendments are more entrenched than statutory law, which can be more easily changed or repealed by the legislature.

b See Appendix G for definitions of "affirmative defense," "exemption from prosecution," and "choice of evils."

c In practice, Alaska considers an individual in possession of a valid registry card and otherwise in compliance with the law to be exempt from prosecution.

d In practice, Washington law enforcement rarely arrest or prosecute patients and caregivers who have their doctors' written certifications and small amounts of marijuana. For example, the Seattle Police Department's policy is generally not to arrest patients with their doctors' certifications if they have less than two ounces of marijuana and nine plants.

TABLE 2: Tally of State Medical Marijuana Laws

TABLE 2: Tally of State Medical Marijuana Laws									
State	Effective		Workable		Therapeutic Research Program		Symbolic		Non-Binding Resolution
	Previously had	Currently has	Previously had	Currently has	Previously had	Currently has	Previously had	Currently has	
Alabama						✓			
Alaska		✓			✓				
Arizona					✓			✓	
Arkansas							✓		
California		✓				✓			✓
Colorado		✓			✓				
Connecticut								✓	
Delaware									
District of Columbia								✓	
Florida					✓				
Georgia						✓			
Hawaii		✓							
Idaho									
Illinois						✓			
Indiana									
Iowa					✓			✓	
Kansas									
Kentucky									
Louisiana					✓			✓	
Maine		✓			✓				
Maryland				✓					
Massachusetts						✓			
Michigan		✓			✓				✓
Minnesota						✓			
Mississippi									
Missouri									✓
Montana		✓							
Nebraska									
Nevada		✓			✓				
New Hampshire								✓	✓
New Jersey						✓			

TABLE 2: Tally of State Medical Marijuana Laws

State	Effective		Workable		Therapeutic Research Program		Symbolic		Non-Binding Resolution
	Previously had	Currently has	Previously had	Currently has	Previously had	Currently has	Previously had	Currently has	
New Mexico		✓				✓			✓
New York						✓			
North Carolina							✓		
North Dakota									
Ohio			✓		✓				
Oklahoma									
Oregon		✓			✓				
Pennsylvania									
Rhode Island		✓				✓			✓
South Carolina						✓			
South Dakota									
Tennessee					✓			✓	
Texas						✓			
Utah									
Vermont		✓							
Virginia								✓	
Washington		✓				✓			✓
West Virginia					✓				
Wisconsin								✓	
Wyoming									
Totals	0	13	1	1	13	13	2	8 plus D.C.	7
Grand Totals	13		2		26		10 plus D.C.		7

Thirty-six states have had favorable medical marijuana laws at one point or another. Fourteen of those 36 states have had more than one type of medical marijuana law. California, for example, currently has both an effective law and a research law, while Arizona previously had a research law and currently has a symbolic law.

Appendix A: State Medical Marijuana Laws

States with Effective Medical Marijuana Laws (Removal of Criminal Penalties)							
State	Medical Marijuana Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Medical Marijuana Law	Marijuana Schedule	Citation for Schedules
AK	Nov. 3, 1998	March 4, 1999	Ballot Measure 8 (modified by S.B. 94, effective June 2, 1999)	S.B. 94 — Chapter 37, SLA 1999	§ 1737	VIA	§ 11.71.160
Current Law:	Ballot Measure 8 removed state-level criminal penalties for medical marijuana use, possession, and cultivation. However, S.B. 94, which took effect June 2, 1999, made the state's medical marijuana registry program mandatory and removed the affirmative defense for patients (or their caregivers) who possess more marijuana than is permitted by the law.						
History:	A therapeutic research program — which was never operational — for cancer chemotherapy and radiology and glaucoma (statute § 1735) was enacted in 1982 (session law § 5 Ch. 45). The law was repealed by Ch. 146 (1986). Details of the program included administration by the Board of Pharmacy and patient certification by a Patient Qualification Review Committee; the Board of Pharmacy was also permitted to include other disease groups if a physician presented pertinent medical data. As a Schedule VIA drug, marijuana has the “lowest degree of danger or probable danger to a person or the public.”						
CA	Nov. 5, 1996	Nov. 6, 1996	Ballot Initiative, Proposition 215 (added to by S.B. 420, effective January 1, 2004)	S.B. 420 — Chapter 875, Statutes of 2003	Cal. Health & Safety Code § 11362.5, et seq.	I	Cal. Health & Safety Code § 11054
Current Law:	Proposition 215 removed state-level criminal penalties for medical marijuana use, possession, and cultivation. S.B. 420, which was passed in 2003, made several positive clarifications to the medical marijuana law. It specifically allowed nonprofit cooperative and collective patient gardens as well as the exchange of money for incurred expenses and services performed by caregivers. It also created an ID card program, which is optional for both patients and caregivers, but which provides protection from arrest. It also set threshold amounts of marijuana that patients are allowed to possess. In addition, S.B. 847, which took effect in 1999, established the California Center for Medicinal Cannabis Research to research marijuana's safety and efficacy, using federal marijuana.						
History:	From July 25, 1979, until June 30, 1989, a therapeutic research program—which was operational—for cancer and glaucoma existed (H & S § 11260 and H & S § 11480); enacted via S.B. 184, session law Ch. 300 (1979). The Research Advisory Panel coordinated research with marijuana and its derivatives; \$100,000 was appropriated for the first year. Minor amendments by ch. 374 (1980) and ch. 101 (1983). H & S § 11260 would have expired on June 30, 1985, but the program was extended and modified slightly by ch. 417 (1984); the program finally expired on June 30, 1989; § 11480 remains on the books.						
CO	Nov. 7, 2000	June 30, 2001	Ballot Initiative, Amendment 20	N/A	Constitutional Amendment 20	N/A	§ 18-18-203

States with Effective Medical Marijuana Laws (Removal of Criminal Penalties)

State	Medical Marijuana Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Medical Marijuana Law	Marijuana Schedule	Citation for Schedules
	<p>Current Law: Amendment 20 removes state-level criminal penalties for medical marijuana use, possession, and cultivation.</p> <p>History: A therapeutic research program — which was never operational — for cancer and glaucoma (§ 25-5-901 to -907) was enacted and took effect on June 21, 1979 (H.B. 1042, Ch. 265). The program was administered by the Chancellor for Health Affairs at the University of Colorado Medical Center. The Pharmacy and Therapeutics Committee (PTC) of the medical board of Colorado General Hospital was charged with reviewing applicants and their practitioners and certifying their participation in the program. Additionally, the PTC could include other disease groups after reviewing pertinent data presented by a “practitioner,” who was authorized to prescribe and administer drugs, and the chancellor would apply to receive marijuana from the National Institute on Drug Abuse (NIDA). If unable to obtain marijuana from NIDA, the chancellor would investigate the feasibility of using marijuana acquired from other sources, including seized marijuana that had been tested for impurities; \$15,000 was appropriated for the program. In 1981, the program was amended by H.B. 1224 (Ch. 322), which stipulated that other disease groups could be included after pertinent data was presented by a “clinical researcher” who was licensed to experiment with, study, or test any dangerous drug within the state and who had an IND (Investigational New Drug) number issued by the FDA. The amendment also provided that the chancellor would apply to receive marijuana from the “federal government” rather than NIDA. The law was repealed by H.B. 95-1020 in 1995 (Ch. 71).</p>						
HI	June 14, 2000	June 14, 2000	S.B. 862	Act 228, SLH 2000	§ 329-121	I	§ 329-14
	<p>Current Law: S.B. 862 removes state-level criminal penalties for medical marijuana use, possession, and cultivation. This is the first law of this nature to be enacted by a state legislature, rather than by a ballot initiative. (Other state legislatures had enacted medical marijuana research laws and symbolic laws relating to marijuana scheduling or prescriptive access.) This is Hawaii’s first medical marijuana law of any kind.</p>						
ME	Nov. 2, 1999	Dec. 22, 1999	Referendum Election Ballot Question 2 (Modified by L.D. 611, effective April 1, 2002)	Laws of Maine 1999, Initiated Bill Ch. 1 L.D. 611 — Laws of Maine 2001, Chapter 580	22 MRSA § 2383-B	Z	17-A MRSA § 1102

States with Effective Medical Marijuana Laws (Removal of Criminal Penalties)

State	Medical Marijuana Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Medical Marijuana Law	Marijuana Schedule	Citation for Schedules
<p>Current Law: Question 2 removes state-level criminal penalties for medical marijuana use, possession, and cultivation. L.D. 611, effective April 1, 2002, clarified protections for patients and caregivers and increased the amount of usable marijuana a patient may possess.</p> <p>History: A therapeutic research program — which was never operational — for glaucoma and cancer chemotherapy (22 § 2401-2410) was enacted on Sept. 14, 1979 (H.B. 665, Ch. 457). The program expired in 1981, but an almost identical law reinstated the program on Sept. 23, 1983 (H.B. 1025, Ch. 423, 22 § 2411-2420). That law, which expired on Dec. 31, 1987, had authorized a research program within the Department of Human Services to use federal marijuana or, if necessary, marijuana confiscated by state law enforcement agencies; a Participation Review Board would approve physicians.</p> <p>Controlled substances are in Schedules W, X, Y, and Z, which determine the severity of penalties for possession, manufacture, and distribution of these substances. The schedules make no statement as to the medical value of the controlled substances.</p>	Nov. 4, 2008	Will be in effect by Dec. 4, 2008	Ballot initiative, Proposal 1	N/A	Not Yet Codified	I	333.7212; MAC 338.3114 and 338.3119a (1986 Annual Supplement); MAC 338.3113 (1988 Annual Supplement)
<p>Current Law: The Michigan Medical Marihuana Act removes state-level criminal penalties for medical marijuana use, possession, and cultivation.</p> <p>History: On Oct. 22, 1979, a law was enacted to allow patients with glaucoma and cancer chemotherapy to use medical marijuana. It also allowed patients with other diseases to use THC or marijuana if they had an IND (Investigational New Drug) permit from the FDA. It also authorized patients to use marijuana confiscated by state law enforcement agencies (which almost certainly never happened). The program was operational and used federal marijuana and was administered by the Department of Public Health. The law expired on November 1, 1982. A month later, a nearly identical law was enacted, which expired on November 1, 1987.</p>							

States with Effective Medical Marijuana Laws (Removal of Criminal Penalties)

State	Medical Marijuana Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Medical Marijuana Law	Marijuana Schedule	Citation for Schedules
MT	Nov. 2, 2004	Nov. 2, 2004	Ballot Initiative	N/A	MCA Title 50, Chapter 46; MCA Title 37, Chapter 1, Section 136 and Title 45, Chapter 9, Sections 101 to 110	I	MCA § 50-32-222
Current Law:	Initiative 148 removes state-level criminal penalties for medical marijuana use, possession, and cultivation.						
History:	Montana's symbolic law — §50-32-222(7) — was enacted on March 26, 1979. It would automatically reschedule THC and marijuana to Schedule II if the federal government authorizes the prescription or administration of these substances.						
NM	April 2, 2007	July 1, 2007	SB 523	Ch. 210 (2007)	Lynn and Erin Compassionate Use Act — yet to be codified in NMSA	I (II for purposes of the Lynn and Erin Compassionate Use Act)	§ 30-31-6, 7 NMSA
Current Law:	SB 523 removes the possibility of “arrest, prosecution or penalty in any manner for the possession of or the medical use of cannabis if the quantity of cannabis does not exceed an adequate supply.” The Department of Health has subsequently defined an adequate supply as six ounces of usable marijuana, four mature plants, and three seedlings. SB 523 permits patients with the following conditions to qualify for a registry identification card: cancer; glaucoma; multiple sclerosis; damage to the nervous tissue of the spinal cord, with objective neurological indication of intractable spasticity; epilepsy; positive status for human immunodeficiency virus or acquired immune deficiency syndrome; admitted into hospice care in accordance with rules promulgated by the department; or any other medical condition, medical treatment, or disease as approved by the department.						

States with Effective Medical Marijuana Laws (Removal of Criminal Penalties)

State	Medical Marijuana Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Medical Marijuana Law	Marijuana Schedule	Citation for Schedules
NV	June 14, 2001	Oct. 1, 2001	Question 9 passed in 1998 and 2000; A.B. 453 passed the legislature in 2001 (modified by A.B. 519, effective July 1, 2005)	Statutes of Nevada 2001, Ch. 592	Title 40-Ch. 453A of NRS, and Art. 4, Sec. 38 of the Nevada Constitution	I	453-510 NAC
	<p>Current Law: A.B. 453 removes state-level criminal penalties for medical marijuana use, possession, and cultivation. Question 9, an initiative on the ballot in 1998 and 2000, amended the state constitution to require the legislature to implement a medical marijuana law. A.B. 519, passed in 2005, allows the Department of Agriculture to revoke the registry identification card of a participant in the state's medical marijuana program who has been convicted of drug trafficking or has intentionally provided false information on his or her application.</p> <p>History: A therapeutic research program — which was never operational — for glaucoma, cancer chemotherapy, or other approved conditions (453-740 - 453-810 and 453-740 NAC) was enacted on June 2, 1979 (S.B. 470, Ch. 610). Administered by Health Division of Department of Human Services and a Board of Review for Patients. The law was repealed by A.B. 695 in 1987 (Ch. 417).</p>						
OR	Nov. 3, 1998	Dec. 3, 1998	Ballot Measure 67 (modified by H.B. 3052, effective July 21, 1999, and S.B. 1085, effective January 1, 2006)	Oregon Laws 1999, Ch. 4 H.B. 3052 — Oregon Laws 1999, Ch. 825	475.300	I	475.035 and OAR 855-80

States with Effective Medical Marijuana Laws (Removal of Criminal Penalties)

State	Medical Marijuana Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Medical Marijuana Law	Marijuana Schedule	Citation for Schedules
Current Law:	<p>Measure 67 removes state-level criminal penalties for medical marijuana use, possession, and cultivation. Minor amendments were made via H.B. 3052, which took effect July 21, 1999. It mandates that patients may not use medical marijuana in a correctional facility; limits patients and caregivers to growing marijuana at one location each; requires that a patient be diagnosed within 12 months prior to arrest to assert an affirmative defense; and relieves police from the responsibility to maintain live marijuana plants while a case is pending. S.B. 1085, passed by the legislature in 2005, increases the limits to 24 plants — six of which may be mature — and 24 ounces of dried marijuana per patient or caregiver. However, the bill eliminates the affirmative defense for going over these limits.</p>						
History:	<p>A law to allow physicians to prescribe marijuana for cancer chemotherapy and glaucoma (§ 475.505) was enacted on June 18, 1979 (H.B. 2267, Ch. 253). Oregon State Police could make confiscated marijuana available to the Health Division to test it for contaminants; if marijuana were found to be free of contaminants, Health Division could make marijuana available to physicians upon written request; patients who are prescribed such marijuana could possess less than an ounce. In 1980, the Health Division received federal permission to distribute marijuana, pursuant to the statute, and a federal supply of marijuana; however, it is unlikely that distribution ever occurred. The law was repealed by S.B. 160 in 1987 (Ch. 75).</p>						
RI	Jan. 3, 2006 and June 21, 2007	Jan. 3, 2006 and June 21, 2007	H 6052 and S 710 (2006); H 6005 and S 791 (2007)	Ch. 72 & 475, Laws of 2007	RISA § 21-28.6-1 et seq.	I	RISA § 21-28-2.08
Current Law:	<p>The Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act removes state-level penalties for medical marijuana use, possession, and cultivation for patients and their caregivers who are registered with the state.</p>						
History:	<p>A therapeutic research program — which was never operational — for patients with life- or sense-threatening conditions was enacted in 1980 by H.B. 79.6072 (Ch. 375) and amended in 1986 (by 86-H 7817, Ch. 236) to expand the law from patients with specified disease groups to patients with “life- or sense-threatening conditions” and to delete references to Patient Qualification Review Board. The program would have been administered by the director of the Department of Health.</p>						
VT	May 26, 2004	July 1, 2004	S. 76 (modified by S.7 effective July 1, 2007)	Act No. 135 (2004)	18 VSA § 4471 et seq.	N/A	N/A

States with Effective Medical Marijuana Laws (Removal of Criminal Penalties)

State	Medical Marijuana Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Medical Marijuana Law	Marijuana Schedule	Citation for Schedules
<p>Current Law: S.76 removes state-level penalties for medical marijuana use, possession, and cultivation for patients and their caregivers who are registered with the state. Initially, registration was permitted only for people diagnosed with AIDS, cancer, multiple sclerosis, or HIV. S.7, effective July 1, 2007, expanded the definition of “debilitating medical condition” by adding conditions and treatments that cause cachexia or wasting, severe pain, severe nausea, or seizures. S.7 also increased the number of plants a patient or caregiver can possess and allowed doctors licensed to practice in New Hampshire, Massachusetts, and New York to recommend marijuana to their Vermont patients. There are no legal protections provided to unregistered medical marijuana patients.</p> <p>History: On April 27, 1981, the Vermont Legislature passed H. 130 (Act No. 49, session law 18 VSA § 4471), which allowed physicians to prescribe marijuana for cancer and other medical uses as determined by the commissioner of health. The program was administered by the Department of Health. Called a “research program,” H. 130 allowed physicians to prescribe marijuana and provided that “[the] commissioner of health shall have the authority to obtain ... cannabis administered under this program.”</p>							
WA	Nov. 3, 1998	Nov. 3, 1998	Initiative Measure No. 692	1999 c 2 § 1	RCW 69.51A	I	69.50.204 and WAC 246-887-100
<p>Current Laws: Measure 692 removes state-level criminal penalties for medical marijuana use, possession, and cultivation.</p> <p>In 2007, SB 6032 passed, directing the Department of Health to hold hearings in order to determine what constitutes a 60-day supply of medical marijuana. SB 6032 also added the following qualifying conditions to RCW 69.51A, which had previously been approved by the Washington State Medical Quality Assurance Commission, but never codified: Crohn’s disease, hepatitis C, and diseases that cause nausea, vomiting, wasting, appetite loss, cramping, seizures, and muscle spasms.</p> <p>In addition, a therapeutic research program — which was operational — for cancer chemotherapy and radiology, glaucoma, and other disease groups (RCW 69.51) was enacted on March 27, 1979 (H.B. 259, Ch. 136), and remains on the books. Program administered by Board of Pharmacy and Patient Qualification Review Committee; “Board shall obtain marijuana through whatever means it deems most appropriate and consistent with regulations promulgated by federal government”; “board may use marijuana which has been confiscated by local or state law enforcement agencies and has been determined to be free from contamination.”</p> <p>There was dual scheduling for marijuana and every compound (including THC — tetrahydrocannabinol, the primary active ingredient) in the marijuana plant; amendment in 1986 (Ch. 124) removed the dual scheduling of marijuana and THC; minor amendments made in 1989 (Ch. 9).</p> <p>On March 30, 1996, Washington state enacted a 1996 supplemental operating budget allocating \$130,000 for two medical marijuana-related projects: \$70,000 to research a tamper-free means of cultivating marijuana for medical purposes, and \$60,000 to research the therapeutic potential of marijuana. Research, however, was never conducted, and the \$60,000 appropriation expired.</p>							

Appendix A: State Medical Marijuana Laws

States with Workable Medical Marijuana Laws						
State	Medical Marijuana Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Medical Marijuana Law	Citation for Marijuana Schedule
MD	May 22, 2003	Oct. 1, 2003	H.B. 702	2003 session, Ch. 442	§ 25-601c, 5-619c	I Art. 27 § 277-5-402
Current Law: Allows individuals to prove a medical necessity during court sentencing. If medical necessity is proven, the maximum penalty is a fine of \$100.						

States with Medical Marijuana Research Laws (Therapeutic Research Programs)						
State	Medical Marijuana Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Medical Marijuana Law	Citation for Marijuana Schedule
AL	July 30, 1979	July 30, 1979	S. 559	Act No. 79-472	§ 20-2-110 et seq.	I § 20-2-23(3) and AAC Ch. 420-72
Current Law: For cancer chemotherapy and glaucoma. State Board of Medical Examiners is authorized to create review committee to administer program — which has never been operational. S. 163 (Act. No. 81-506) made minor changes.						
GA	Feb. 22, 1980	Feb. 22, 1980	H.B. 1077	No. 710 (1980)	§ 43-34-120 et seq. and Rules and Regulations Chapter 360-12	N/A O.C.G.A. § 16-13-25

States with Medical Marijuana Research Laws (Therapeutic Research Programs)

State	Medical Marijuana Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Medical Marijuana Law	Marijuana Schedule	Citation for Schedules
Current Law:	For cancer and glaucoma (marijuana or THC). Composite State Board of Medical Examiners has authority to appoint a Patient Qualification Review Board, which can approve patients, physicians, and pharmacies for participation in the program — which was operational; no other ailments allowed.						
IL	Sept. 9, 1978	Sept. 9, 1978	H.B. 2625	80-1426	720 ILCS 550/11, 550/15 and 77 IAC Ch. X, Sec. 2085	N/A	720 ILCS 570/206 and 77 IAC Ch. X, Sec. 2070
Current Law:	For glaucoma and cancer chemotherapy and radiology or other procedures. The program has never been operational. Allows persons “engaged in research” to use marijuana when authorized by physician; must be approved by Department of Mental Health and Developmental Disabilities. The law also encourages research on cannabis to “establish methods to assess accurately the effect of cannabis,” and to create related research programs.						
MA	Dec. 31, 1991	Dec. 31, 1991	S. 1582	Ch. 480 (1991)	94D § 1 et seq.	D	94C § 31
Current Law:	For cancer chemotherapy and radiology, glaucoma, and asthma (marijuana or THC). The program has never been operational. On August 8, 1996, Massachusetts passed a second medical marijuana bill (H. 2170), which mandated that within 180 days the state’s public health department must establish the rules and regulations necessary to get its therapeutic research program running and to allow a defense of medical necessity for enrolled patients. Rules were established, but federal permission for research was never obtained. Controlled substances are in Classes A, B, C, and D, which determine the severity of penalties for possession, manufacture, and distribution of these substances. The classes make no statement as to the medical value of the controlled substances.						
MN	April 24, 1980	April 25, 1980	H.F. 2476	Ch. 614 (1980)	§ 152.21	I	§ 152.02 and MR 6800.4200

States with Medical Marijuana Research Laws (Therapeutic Research Programs)

State	Medical Marijuana Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Medical Marijuana Law	Marijuana Schedule	Citation for Schedules
	<p>Current Law: For cancer only (THC only). THC is in Schedule I but is considered to be in Schedule II when used for medical purposes.</p> <p>The 1980 bill originally appropriated \$100,000 to the THC Therapeutic Research Act, but this line-item was vetoed by the governor. The program has never been operational.</p>						
NJ	March 23, 1981	March 23, 1981	A.B. 819	Ch. 72 (1981)	26:2L	I	24:21-5 and 8:65-10 New Jersey Administrative Code
	<p>Current Law: For life- or sense-threatening diseases. The program has never been operational.</p> <p>Pertains to any Schedule I substance (not specific to marijuana); administered by Department of Health; only for patients participating in research programs conducted by FDA; patients and physicians certified by Therapeutic Research Qualification Board; get substances from NIDA.</p>						
NY	June 30, 1980	Sept. 1, 1980	S.B. 1123-6	Ch. 810 (1980)	Pub Health § 3397-a et seq. and Pub Health § 3328	I	Pub Health § 3306
	<p>Current Law: For cancer, glaucoma, and other life- and sense-threatening diseases approved by the commissioner. Administered by Department of Health and Patient Qualification Review Board; the program was operational; confiscated marijuana may be used if necessary.</p> <p>In 1981, the name of the “controlled substances therapeutic research program” was changed to the “Antonio G. Olivieri controlled substances therapeutic research program” by Ch. 208 (1981).</p>						
SC	Feb. 28, 1980	Feb. 28, 1980	S. 350	Act No. 323 (1980)	§ 44-53-610 et seq.	I	§ 44-53-160 and § 44-53-190

States with Medical Marijuana Research Laws (Therapeutic Research Programs)

State	Medical Marijuana Law Approved	Took Effect	Bill/Initiative #	Session Law	Citation for Medical Marijuana Law	Marijuana Schedule	Citation for Schedules
	<p>Current Law: For glaucoma, cancer chemotherapy and radiology, and other disease groups (marijuana and THC). The program has never been operational. Administered by commissioner of Department of Health and Environmental Control and Patient Qualification Review Advisory Board; "The director shall obtain marijuana through whatever means he deems most appropriate consistent with federal law."</p> <p>Minor amendments made by Act No. 181 (1993).</p>						
TX	June 14, 1979	January 1, 1980	S.B. 877	Ch. 826 (1979)	H & S § 481.111 and § 481.201-205	I	H & S § 481.032 and § 481.038 and 37 TAC § 13.1
	<p>Current Law: For cancer and glaucoma (THC or its derivatives). The program has never been operational. Administered by Board of Health and Research Program Review Board (RPRB), which, after approval of Board of Health, may seek authorization to expand research program to include other diseases; get THC from federal government.</p> <p>Minor amendments made by S.B. 688 in 1983 (Ch. 566). H.B. 2136 in 1989 (Ch. 678) moved the therapeutic research program law from Civil Statutes Health Art. 4476-15 to H & S § 481.201-205.</p> <p>H.B. 2213, signed into law by Texas Governor George W. Bush on June 18, 1997, prohibits local governments in Texas from adopting policies of not fully enforcing existing state drug laws. The bill was inspired by the voter initiative in San Marcos — rejected by voters on May 3, 1997 — which would have allowed police to overlook the medical use of marijuana. This law does not affect the existing therapeutic research program law.</p>						

Appendix A: State Medical Marijuana Laws

States with Symbolic Medical Marijuana Laws								
State	Medical Marijuana Law Approved	Took Effect	Measure	Session Law	Citation for Medical Marijuana Law	Description of Law	Marijuana Schedule	Citation for Schedules
AZ	Nov. 5, 1996	Dec. 6, 1996	Proposition 200	N/A	§ 13-3412.01	physicians may prescribe	I	§ 36-2512
<p>Current Law: Similar to other state medical marijuana initiatives, but uses the word “prescribe” rather than “recommend.” Because of this narrow language, patients do not have legal protection. Prescriptive authority is controlled by the federal government, which does not permit marijuana prescriptions. Therefore, a valid prescription cannot be obtained.</p> <p>On April 21, 1997, the governor signed H.B. 2518, an act to repeal the medical marijuana provision of Prop. 200. H.B. 2518 added a condition to Prop. 200 that would have prohibited Arizona physicians from prescribing medical marijuana until the FDA approved its medical use. Subsequently, the sponsors of Prop. 200 submitted Prop. 300 — a referendum question on H.B. 2518. A “no” vote would have rejected H.B. 2518 and preserved the medical marijuana provision of Prop. 200. On Nov. 3, 1998, 57% of Arizona voters voted “no” on Prop. 300.</p> <p>The medical marijuana provisions of Proposition 200 were only a small part of this more comprehensive drug policy reform initiative, which is effectively keeping many low-level, nonviolent drug offenders out of prison.</p> <p>History: A medical marijuana (and THC) research law — which was never operational — for cancer and glaucoma research (§ 36-2601), enacted on April 22, 1980 (H.B. 2020; Ch. 122), expired on June 30, 1985. Director of the Department of Health Services authorized to appoint a Patient Qualification Review Board; PQRB was authorized to review patients and doctors for participation in the program; University of Arizona was to obtain marijuana or THC from NIDA. S.B. 1023 in 1981 (Ch. 264) moved the therapeutic research program provisions from § 36-1031 to § 36-2601.</p> <p>Had a dual scheduling scheme for marijuana, but the provisional Schedule II marijuana provision was ultimately replaced with a permanent Schedule II provision for THC.</p>								
CT	not available	July 1, 1981	Sub. H.B. 5217	Public Act No. 81-440	§ 21a-246 and § 21a-253	physicians may prescribe	I	§ 21a-243 and § 21a-243-7 Reg. of Conn. State Agencies

States with Symbolic Medical Marijuana Laws

State	Medical Marijuana Law Approved	Took Effect	Measure	Session Law	Citation for Medical Marijuana Law	Description of Law	Marijuana Schedule	Citation for Schedules
<p>Current Law: For cancer chemotherapy and glaucoma.</p> <p>Law formerly set out as § 19-453 and § 19-460a, but sections were transferred in 1983; allows physicians licensed by the Commissioner of Consumer Protection to provide marijuana; allows patients to possess marijuana obtained from a prescription; makes no provision for the source of the marijuana supply.</p>								
DC	July 27, 2000	June 8, 2001	Bill No. 13-240 (became Law 13-300)	Act 13-395 (2000)	§ 33-518	scheduling recognizes marijuana's therapeutic use	III	§ 33-516
<p>Current Law: Washington, D.C., moved marijuana from Schedule V to Schedule III in 2000, which means "the substance has currently accepted medical use in treatment in the United States or the District of Columbia." D.C. instituted a scheduling system in 1981 (Bill No. 4-123, Law 429 (1981), enacted on June 9, 1981, took effect on August 5, 1981) that listed marijuana ("cannabis") among the substances in Schedule V, the least restrictive schedule.</p>								
<p>History: On Nov. 3, 1998, D.C. voters passed Ballot Initiative 59 (69% in favor, 31% opposed), which is similar to other state initiatives and removes criminal penalties for medical marijuana use. The U.S. Congress, however, nullified the election results in November 1999 and again in December 2000, thwarting the will of the voters. In September 2002, Initiative 63, the Medical Marijuana Initiative of 2002, had enough valid signatures to qualify for the November ballot. But three days after the initiative had qualified for the ballot, the U.S. Court of Appeals for the D.C. Circuit prevented the D.C. Board of Elections and Ethics from printing the initiative on the 2002 ballot. The Court of Appeals decision reinstated the Barr Amendment, previously ruled unconstitutional by a U.S. District Court judge. The Barr Amendment, named after its sponsor, former U.S. Rep. Bob Barr (R-Ga.), prohibits the D.C. government from spending any money to "enact or carry out" any local law that would reduce penalties associated with the possession, use, or distribution of any Schedule I controlled substances, including marijuana. However, Initiative 63 can appear on the ballot in the next city-wide election after the Barr Amendment is repealed. When the Barr Amendment will be repealed is unclear.</p> <p>D.C. is the only jurisdiction where the federal government can prevent such laws from taking effect. Initiatives 59 and 63 would have permitted patients to have up to four caregivers; permitted nonprofit marijuana suppliers; and allowed a "sufficient quantity" of marijuana to treat illness.</p>								

Appendix A: State Medical Marijuana Laws

States with Symbolic Medical Marijuana Laws								
State	Medical Marijuana Law Approved	Took Effect	Measure	Session Law	Citation for Medical Marijuana Law	Description of Law	Marijuana Schedule	Citation for Schedules
IA	June 1, 1979	July 1, 1979	S.F. 487	Ch. 9 (1979)	§ 124.204 and § 124.206	scheduling recognizes marijuana's therapeutic use	I*	§ 124.204 and § 124.206
Current Law:	*The bill implemented a dual scheduling scheme for marijuana and THC, which are in Schedule I but are considered to be in Schedule II when used for medical purposes.							
History:	The bill appropriated \$247,000 to the Board of Pharmacy Examiners, which was contingent upon the Board of Pharmacy Examiners' establishing a therapeutic research program within 90 days of the effective date of the act (July 1, 1979); the board was mandated to organize a Physicians Advisory Group to advise the board on the structure of the program — which was never operational.							
	Scheduling information was originally located at § 204.204 but was moved to § 124.204 in 1993 by the Iowa Code Editor. No disease groups were specified in the bill.							
	The dual scheduling scheme still exists in the statutes, but the language for the therapeutic research program — Administrative Code 620-12 — was active from October 1, 1979, to June 30, 1981, and was removed on January 20, 1987.							
IA	July 17, 1978; July 23, 1991	August 14, 1978; August 21, 1991	S.B. 245 (1978); H.B. 1187 (1991)	Act No. 725 (1978); Act No. 874 (1991)	§ 40:1021	physicians may prescribe	I	§ 40:964
Current Law:	For glaucoma, cancer chemotherapy, and "spastic quadriplegia."							
	The present law allows physicians with Schedule I licenses to prescribe marijuana in accordance with regulations promulgated by the Secretary of Health and Hospitals.							
History:	A previous law, 40:1021 - 40:1026, had been repealed by H.B. 1224 in 1989 (Act No. 662). The previous law was a therapeutic research program that addressed only glaucoma and cancer.							

States with Symbolic Medical Marijuana Laws

State	Medical Marijuana Law Approved	Took Effect	Measure	Session Law	Citation for Medical Marijuana Law	Description of Law	Marijuana Schedule	Citation for Schedules
NH	April 23, 1981	June 22, 1981	S.B. 21	Ch. 107 (1981)	318-B:9	physicians may prescribe	I*	318-B:1-a
<p>Current Law: For cancer chemotherapy and radiology. Amended by H.B. 1563 (enacted June 8, 1998; took effect Jan. 1, 1999), which says doctors may prescribe marijuana only if it is approved by the FDA; previously doctors could prescribe it without FDA approval, but the absence of a legal supply made the law ineffective. *State follows the federal government's scheduling of controlled substances as articulated in the Code of Federal Regulations [318-B:1-a; June 11, 1996, phone conversation with John McCormick at New Hampshire State Library, 603-271-2239].</p>								
TN	April 2, 1981	April 2, 1981	H.B. 314	Ch. 114 (1981)	§ 68-52-101	scheduling recognizes marijuana's therapeutic use	VI*	§ 39-17-408
<p>Current Law: Only the scheduling provision of the therapeutic research program remains on the books. History: The bill created a therapeutic research program — which was operational — for cancer chemotherapy or radiology or glaucoma (marijuana or THC); administered by Patient Qualification Review Board (PQRB) created within Board of Pharmacy; PQRB was authorized to contract with federal government for marijuana. Therapeutic research program was repealed by S.B. 1818 in 1992 (Ch. 537), but dual scheduling scheme still remains. *Marijuana and THC are in Schedule VI but are considered to be in Schedule II when used for medical purposes. (Schedule VI includes controlled substances that "should not be included in Schedules I through V." Schedules I through V have the typical definitions used in other states.)</p>								
VA	March 27, 1979	Spring 1979	S. 913	Ch. 435 (1979)	§ 18.2-250.1 and § 18.2-251.1	physicians may prescribe	N/A	§ 54-1-3443
<p>Current Law: For cancer and glaucoma (marijuana or THC). Allows physicians to prescribe and pharmacists to dispense marijuana and THC for such purposes.</p>								
WI	not available; April 20, 1988	April 20, 1982; April 28, 1988	A.B. 697; A.B. 662	Ch. 193 (1981); Act 339 (1987)	46.60	physicians may prescribe	I	161.13; 161.41(3r)

Appendix A: State Medical Marijuana Laws

States with Symbolic Medical Marijuana Laws								
State	Medical Marijuana Law Approved	Took Effect	Measure	Session Law	Citation for Medical Marijuana Law	Description of Law	Marijuana Schedule	Citation for Schedules
Current Law:	No disease groups specified (marijuana or THC). Allows medical marijuana prescriptions in accordance with federal IND (Investigational New Drug) permits; gives controlled substances board the authority to set up regulations. A.B. 662 in 1987 (Act 339), enacted in 1988, allows for the possession of THC if obtained directly from a valid prescription.							

States in Which Medical Marijuana Laws Have Expired or Been Repealed									
State	Medical Marijuana Law Approved	Took Effect	Bill #	Session Law	Citation for Medical Marijuana Law	Description of Law	Law Expired / Repealed	Marijuana Schedule	Citation for Schedules
AR	Jan. 30, 1981	Jan. 30, 1981	H.B. 171	Act No. 8 (1981)	§ 82-1007 (numbering system has changed since law was repealed)	physicians may prescribe	repealed by Act No. 52 (1987)	VI	§ 5-64-215
Current Law:	Marijuana and THC are listed in Schedule VI, but Schedule VI substances are defined similarly to — yet even more restrictively than — Schedule I substances.								
History:	For cancer (lawfully obtained THC).								
FL	June 26, 1978	July 1, 1978	H.B. 1237	c. 78-413 (1978)	§ 402.36	therapeutic research program	repealed by c. 84-115 (1984)	I	§ 893.03

States in Which Medical Marijuana Laws Have Expired or Been Repealed

State	Medical Marijuana Law Approved	Took Effect	Bill #	Session Law	Citation for Medical Marijuana Law	Description of Law	Law Expired/ Repealed	Marijuana Schedule	Citation for Schedules
<p>History: For cancer and glaucoma (marijuana or THC). Therapeutic Research Program — which was never operational — administered by secretary of Department of Health and Rehabilitative Services (HRS), who would delegate to Patient Qualification Review Board (PQRB) the authority to approve cancer and glaucoma patients; PQRB authorized to include other disease groups after pertinent data have been presented by physician; secretary of HRS was mandated to apply to federal government for marijuana and transfer marijuana to certified state-operated pharmacies for distribution to certified patients upon written prescription of certified physicians. Minor modifications: c. 79-209 (1979); c. 81-279 (1981); interesting modification with c. 82-12 (1982), which changed name from “controlled substances therapeutic research” to “cancer therapeutic research” to allow for “unconventional therapies” that are not yet approved by the federal government.</p>									
NC	June 5, 1979	June 5, 1979	H.B. 1065	Ch. 781 (1979)	§ 90-101	physicians may prescribe	de facto repealed by H.B. 878 in 1987 (Ch. 412), which allows physicians to administer only dronabinol (synthetic THC) for cancer chemotherapy	VI	§ 90-90
<p>History: “A physician ... may possess, dispense or administer tetrahydrocannabinols in duly constituted pharmaceutical form for human administration for treatment purposes pursuant to rules adopted by the [North Carolina Drug] Commission.” Schedule VI (§ 90-94) is specific to marijuana: “no currently accepted medical use in the United States, or a relatively low potential for abuse in terms of risk to public health and potential to produce psychic or physiological dependence liability based upon present medical knowledge, or a need for further and continuing study to develop scientific evidence of its pharmacological effects.”</p>									

Appendix A: State Medical Marijuana Laws

States in Which Medical Marijuana Laws Have Expired or Been Repealed									
State	Medical Marijuana Law Approved	Took Effect	Bill #	Session Law	Citation for Medical Marijuana Law	Description of Law	Law Expired/ Repealed	Marijuana Schedule	Citation for Schedules
OH	March 21, 1980; 1996	June 20, 1980; July 1, 1996	S.B. 184; S.B. 2	Act No. 230 (1980); not available	§ 2925.11(l)	therapeutic research program; medical necessity defense	first law expired in 1984; medical necessity defense repealed by S.B. 2 in 1997	I	§ 3719.41
History:	<p>The 1980 law, which expired on June 20, 1984, was a therapeutic research program — which was never operational — to be administered by the Director of Health; marijuana and THC; Patient Review Board; glaucoma, cancer chemotherapy or radiology, or other medical conditions; law appeared at § 3719.85.</p> <p>The 1996 law reads as follows: “It is an affirmative defense ... to a charge of possessing marijuana under this section that the offender, pursuant to the prior written recommendation of a licensed physician, possessed the marijuana solely for medicinal purposes.” Coincidentally, the enacting (1996) and repealing laws (1997) had the same number: S.B. 2.</p>								
WV	March 10, 1979	June 8, 1979	S.B. 366	Ch. 56 (1979)	§ 16-5A-7	therapeutic research program	repealed by H.B. 2161, Ch. 61 (1997)	I	§ 60A-2-2.04
History:	<p>This 1979 law established a therapeutic research program for cancer chemotherapy and glaucoma. It was to be administered by the director of the Department of Health and Patient Qualification Review Board (PQRB), which was authorized to certify patients, physicians, and pharmacies for participation in the program; it may have included other disease groups if approved; the director would contract with the federal government for a supply of marijuana. This program was never operational, and it was repealed in 1997.</p>								

States That Have Never Had Medical Marijuana Laws		
State	Schedule	Citation for Schedules
DE	I	16 § 4713
ID	I	37-2705
IN	I	35-48-2
KS	I	65-4105
KY	I	218A and 902 KAR 55:020
MO	I	195.017
MS	I	§ 41-29-113
ND	I	19-031-04
NE	I	§ 28-405
OK	I	63 § 2-204
PA	I	35 § 780-104 and 28 § 25.72 Penn. Code
SD	n/a	§ 34-20B-11
UT	I	58-37-4
WY	I	§ 35-71012 and 024 059 101 Wyoming Rules

States That Have Passed Non-Binding Resolutions Urging the Federal Government to Make Marijuana Medically Available

State	Resolution Passed	Resolution #
CA	Sept. 2, 1993	Sen. Joint Res. No. 8
MI	March 17, 1982	Sen. Conc. Res. No. 473
MO	Spring 1994	Sen. Conc. Res. 14
NH	not available	not available
NM	Spring 1982	Sen. Memorial 42
RI	Spring 2005	Sen. Res. 1158 *This resolution urges the federal government to defund the federal prosecution of medical marijuana patients and caregivers.
WA	not available	not available

NOTES:

1. Some states use the spelling “marihuana” in their statutes — “marijuana” is used in this report.
2. Italics for a citation indicate that it is in the state’s administrative code (developed by state agencies in the executive branch), not the state’s statutes (laws passed by the state legislature).
3. The definitions of Schedule I and Schedule II in state controlled substances acts are always similar to the federal definitions — which can be found in Appendix E of this report — unless noted otherwise. When marijuana is not in Schedule I or Schedule II, a clarifying description is noted.
4. THC is an abbreviation for tetrahydrocannabinol, the only active ingredient in dronabinol and the primary active ingredient in marijuana.
5. Dronabinol is an FDA-approved prescription drug (its trade name is Marinol), and is defined as THC “in sesame oil and encapsulated in a soft gelatin capsule in a U.S. Food and Drug Administration approved drug product.” 21 CFR Sec. 1308.13(g)(1)
6. Trivial amendments are not listed; bills that make minor, non-trivial amendments are listed.
7. Column with drug schedule: “N/A” simply means substance is not scheduled in state statutes or administrative code.
8. Statute citations for medical marijuana laws: The administrative code provisions for the therapeutic research programs are cited when possible but are not necessarily cited for all such states.
9. Many states have used a dual scheduling scheme for marijuana and/or THC. In these states, marijuana and THC are in Schedule I but are considered to be in Schedule II when used for medical purposes.

MEDICAL MARIJUANA BRIEFING PAPER

The Need to Change State and Federal Law

For thousands of years, marijuana has been used to treat a wide variety of ailments. Until 1937, marijuana (*Cannabis sativa L.*) was legal in the United States for all purposes. Presently, federal law allows only three Americans to use marijuana as a medicine.

On March 17, 1999, the National Academy of Sciences' Institute of Medicine (IOM) concluded that "there are some limited circumstances in which we recommend smoking marijuana for medical uses." The IOM report, the result of two years of research that was funded by the White House drug policy office, analyzed all existing data on marijuana's therapeutic uses. Please see <http://www.mpp.org/SCIENCE>.

MEDICAL VALUE

Marijuana is one of the safest therapeutically active substances known. No one has ever died from an overdose, and it has a wide variety of therapeutic applications, including:

- Relief from nausea and appetite loss;
- Reduction of intraocular (within the eye) pressure;
- Reduction of muscle spasms; and
- Relief from chronic pain.

Marijuana is frequently beneficial in the treatment of the following conditions:

AIDS. Marijuana can reduce the nausea, vomiting, and loss of appetite caused by the ailment itself and by various AIDS medications. Observational research has found that by relieving these side effects, medical marijuana increases the ability of patients to stay on life-extending treatment. (See also **CHRONIC PAIN** below)

HEPATITIS C. As with AIDS, marijuana can relieve the nausea and vomiting caused by treatments for hepatitis C. In a study published in the September 2006 *European Journal of Gastroenterology & Hepatology*, patients using marijuana were better able to complete their medication regimens, leading to a 300% improvement in treatment success.

GLAUCOMA. Marijuana can reduce intraocular pressure, alleviating the pain and slowing — and sometimes stopping — damage to the eyes. (Glaucoma is the leading cause of blindness in the United States. It damages vision by increasing eye pressure over time.)

CANCER. Marijuana can stimulate the appetite and alleviate nausea and vomiting, which are common side effects of chemotherapy treatment.

MULTIPLE SCLEROSIS. Marijuana can limit the muscle pain and spasticity caused by the disease, as well as relieving tremor and unsteadiness of gait. (Multiple sclerosis is the leading cause of neurological disability among young and middle-aged adults in the United States.)

EPILEPSY. Marijuana can prevent epileptic seizures in some patients.

CHRONIC PAIN. Marijuana can alleviate chronic, often debilitating pain caused by myriad disorders and

injuries. Since 2007, three published clinical trials have found that marijuana effectively relieves neuropathic pain (pain cause by nerve injury), a particularly hard to treat type of pain that afflicts millions suffering from diabetes, HIV/AIDS, multiple sclerosis, and other illnesses.

Each of these applications has been deemed legitimate by at least one court, legislature, and/or government agency in the United States.

Many patients also report that marijuana is useful for treating arthritis, migraine, menstrual cramps, alcohol and opiate addiction, and depression and other debilitating mood disorders.

Marijuana could be helpful for millions of patients in the United States. Nevertheless, other than for the three people with special permission from the federal government, medical marijuana remains illegal under federal law!

People currently suffering from any of the conditions mentioned above, for whom the legal medical options have proven unsafe or ineffective, have two options:

1. Continue to suffer without effective treatment; or
2. Illegally obtain marijuana — and risk suffering consequences directly related to its illegality, such as:
 - an insufficient supply due to the prohibition-inflated price or scarcity; impure, contaminated, or chemically adulterated marijuana;
 - arrests, fines, court costs, property forfeiture, incarceration, probation, and criminal records.

BACKGROUND

Prior to 1937, at least 27 medicines containing marijuana were legally available in the United States. Many were made by well-known pharmaceutical firms that still exist today, such as Squibb (now Bristol-Myers Squibb) and Eli Lilly. The Marijuana Tax Act of 1937 federally prohibited marijuana. Dr. William C. Woodward of the American Medical Association opposed the Act, testifying that prohibition would ultimately prevent the medical uses of marijuana.

The Controlled Substances Act of 1970 placed all illicit and prescription drugs into five “schedules” (categories). **Marijuana was placed in Schedule I, defining it as having a high potential for abuse, no currently accepted medical use in treatment in the United States, and a lack of accepted safety for use under medical supervision.**

This definition simply does not apply to marijuana. Of course, at the time of the Controlled Substances Act, marijuana had been prohibited for more than three decades. Its medical uses forgotten, marijuana was considered a dangerous and addictive narcotic.

A substantial increase in the number of recreational users in the 1970s contributed to the rediscovery of marijuana’s medical uses:

- Many scientists studied the health effects of marijuana and inadvertently discovered marijuana’s medical uses in the process.
- Many who used marijuana recreationally also suffered from diseases for which marijuana is beneficial. By accident, they discovered its therapeutic value.

As the word spread, more and more patients started self-medicating with marijuana. However, marijuana’s Schedule I status bars doctors from prescribing it and severely curtails research.

THE STRUGGLE IN COURT

In 1972, a petition was submitted to the Bureau of Narcotics and Dangerous Drugs — now the Drug Enforcement Administration (DEA) — to reschedule marijuana to make it available by prescription.

After 16 years of court battles, the DEA's chief administrative law judge, Francis L. Young, ruled on September 6, 1988:

“Marijuana, in its natural form, is one of the safest therapeutically active substances known. ...”

“... [T]he provisions of the [Controlled Substances] Act permit and require the transfer of marijuana from Schedule I to Schedule II.”

“It would be unreasonable, arbitrary and capricious for DEA to continue to stand between those sufferers and the benefits of this substance. ...”

Marijuana's placement in Schedule II would enable doctors to prescribe it to their patients. **But top DEA bureaucrats rejected Judge Young's ruling and refused to reschedule marijuana.** Two appeals later, petitioners experienced their first defeat in the 22-year-old lawsuit. On February 18, 1994, the U.S. Court of Appeals (D.C. Circuit) ruled that the DEA is allowed to reject its judge's ruling and set its own criteria — enabling the DEA to keep marijuana in Schedule I.

However, Congress has the power to reschedule marijuana via legislation, regardless of the DEA's wishes.

TEMPORARY COMPASSION

In 1975, Robert Randall, who suffered from glaucoma, was arrested for cultivating his own marijuana. He won his case by using the “medical necessity defense,” forcing the government to find a way to provide him with his medicine. As a result, the Investigational New Drug (IND) compassionate access program was established, enabling some patients to receive marijuana from the government.

The program was grossly inadequate at helping the potentially millions of people who need medical marijuana. Many patients would never consider the idea that an illegal drug might be their best medicine, and most who were fortunate enough to discover marijuana's medical value did not discover the IND program. Those who did often could not find doctors willing to take on the program's arduous, bureaucratic requirements.

In 1992, in response to a flood of new applications from AIDS patients, the George H.W. Bush administration closed the program to new applicants, and pleas to reopen it were ignored by subsequent administrations. The IND program remains in operation only for the three surviving, previously approved patients.

PUBLIC AND PROFESSIONAL OPINION

There is wide support for ending the prohibition of medical marijuana among both the public and the medical community:

- Since 1996, a majority of voters in Alaska, California, Colorado, the District of Columbia, Maine, Michigan, Montana, Nevada, Oregon, and Washington state have voted in favor of ballot initiatives to remove criminal penalties for seriously ill people who grow or possess medical marijuana.

- A national Gallup poll released November 1, 2005, found that 78% of Americans support “making marijuana legally available for doctors to prescribe in order to reduce pain and suffering.” For over a decade, polls have consistently shown between 60% and 80% support for legal access to medical marijuana. Polls conducted in the 11 states with medical marijuana laws during 2006 found support for the laws was high and steady, or (in nearly all cases) increasing.
- Organizations supporting some form of physician-supervised access to medical marijuana include the American Academy of Family Physicians, American Nurses Association, American Public Health Association, American Academy of HIV Medicine, and many others.
- A 1990 scientific survey of oncologists (cancer specialists) found that 54% of those with an opinion favored the controlled medical availability of marijuana and 44% had already suggested at least once that a patient obtain marijuana illegally. [R. Doblin & M. Kleiman, “Marijuana as Antiemetic Medicine,” *Journal of Clinical Oncology* 9 (1991): 1314-1319.]

CHANGING STATE LAWS

The federal government has no legal authority to prevent state governments from changing their laws to remove state-level penalties for medical marijuana use. Thirteen states have already done so: Hawaii, Rhode Island, New Mexico, and Vermont through their legislatures, and the others by ballot initiatives. State legislatures have the authority and moral responsibility to change state law to:

- exempt seriously ill patients from state-level prosecution for medical marijuana possession and cultivation; and
- exempt doctors who recommend medical marijuana from prosecution or the denial of any right or privilege.

Even within the confines of federal law, states can enact reforms that have the practical effect of removing the fear of patients being arrested and prosecuted under state law — as well as the symbolic effect of pushing the federal government to allow doctors to prescribe marijuana.

U.S. CONGRESS: THE FINAL BATTLEGROUND

State governments that want to allow marijuana to be sold in pharmacies have been stymied by the federal government’s overriding prohibition of marijuana.

Patients’ efforts to bring change through the federal courts have made little progress thus far. The U.S. Supreme Court’s June 2005 decision in *Gonzales v. Raich* preserved state medical marijuana laws but allowed continued federal attacks on patients, even in states with such laws.

Efforts to obtain FDA approval of marijuana also remain stalled. Though some small studies of marijuana have been published or are underway, the National Institute on Drug Abuse — the only legal source of marijuana for clinical research in the U.S. — has consistently made it difficult (and often nearly impossible) for researchers to obtain marijuana for their studies. At present, it is effectively impossible to do the sort of large-scale, extremely costly trials required for FDA approval.

In the meantime, patients continue to suffer. **Congress has the power and the responsibility to change federal law so that seriously ill people nationwide can use medical marijuana without fear of arrest and imprisonment.**

Appendix C: Excerpts from the Institute of Medicine 1999 Report

“[W]e concluded that there are some limited circumstances in which we recommend smoking marijuana for medical uses.”

— from principal investigator Dr. John Benson’s opening remarks at IOM’s 3/17/99 news conference

Questions about medical marijuana answered by the Institute of Medicine’s report Marijuana and Medicine: Assessing the Science Base*

Excerpts compiled by the Marijuana Policy Project

What conditions can marijuana treat?

“The accumulated data indicate a potential therapeutic value for cannabinoid drugs, particularly for symptoms such as pain relief, control of nausea and vomiting, and appetite stimulation.” [p. 3]

“[B]asic biology indicates a role for cannabinoids in pain and control of movement, which is consistent with a possible therapeutic role in these areas. The evidence is relatively strong for the treatment of pain and, intriguing although less well established, for movement disorders.” [p. 70]

“For patients such as those with AIDS or who are undergoing chemotherapy and who suffer simultaneously from severe pain, nausea, and appetite loss, cannabinoid drugs might offer broad-spectrum relief not found in any other single medication. The data are weaker for muscle spasticity but moderately promising.” [p. 177]

“The most encouraging clinical data on the effects of cannabinoids on chronic pain are from three studies of cancer pain.” [p. 142]

Why can’t patients use medicines that are already legal?

“[T]here will likely always be a subpopulation of patients who do not respond well to other medications.” [Pp. 3, 4]

“The critical issue is not whether marijuana or cannabinoid drugs might be superior to the new drugs, but whether some group of patients might obtain added or better relief from marijuana or cannabinoid drugs.” [p. 153]

“The profile of cannabinoid drug effects suggests that they are promising for treating wasting syndrome in AIDS patients. Nausea, appetite loss, pain, and anxiety are all afflictions of wasting, and all can be mitigated by marijuana. Although some medications are more effective than marijuana for these problems, they are not equally effective in all patients.” [p. 159]

What about Marinol®, the major active ingredient in marijuana in pill form?

“It is well recognized that Marinol’s oral route of administration hampers its effectiveness because of slow absorption and patients’ desire for more control over dosing.” [Pp. 205, 206]

Why not wait for more research before making marijuana legally available as a medicine?

“[R]esearch funds are limited, and there is a daunting thicket of regulations to be negotiated at the federal level (those of the Food and Drug Administration, FDA, and the Drug Enforcement Administration, DEA) and state levels.” [p. 137]

“Some drugs, such as marijuana, are labeled Schedule I in the Controlled Substance Act, and this adds considerable complexity and expense to their clinical evaluation.” [p. 194]

“[O]nly about one in five drugs initially tested in humans successfully secures FDA approval for marketing through a new drug application.” [p. 195]

“From a scientific point of view, research is difficult because of the rigors of obtaining an adequate supply of legal, standardized marijuana for study.” [p. 217]

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“In short, development of the marijuana plant is beset by substantial scientific, regulatory, and commercial obstacles and uncertainties.” [p. 218]

“[D]espite the legal, social, and health problems associated with smoking marijuana, it is widely used by certain patient groups.” [p. 7]

Do the existing laws really hurt patients?

“G.S. spoke at the IOM workshop in Louisiana about his use of marijuana first to combat AIDS wasting syndrome and later for relief from the side effects of AIDS medications. ... [He said,] ‘Every day I risk arrest, property forfeiture, fines, and imprisonment.’” [Pp. 27, 28]

Why shouldn't we wait for new drugs based on marijuana's components to be developed, rather than allowing patients to eat or smoke natural marijuana right now?

“Although most scientists who study cannabinoids agree that the pathways to cannabinoid drug development are clearly marked, there is no guarantee that the fruits of scientific research will be made available to the public for medical use.” [p. 4]

“[I]t will likely be many years before a safe and effective cannabinoid delivery system, such as an inhaler, is available for patients. In the meantime there are patients with debilitating symptoms for whom smoked marijuana might provide relief.” [p. 7]

“[W]hat seems to be clear from the dearth of products in development and the small size of the companies sponsoring them is that cannabinoid development is seen as especially risky.” [Pp. 211, 212] [*IOM later notes that it could take more than five years and cost \$200-300 million to get new cannabinoid drugs approved—if ever.*]

“Cannabinoids in the plant are automatically placed in the most restrictive schedule of the Controlled Substances Act, and this is a substantial deterrent to development.” [p. 219]

Isn't marijuana too dangerous to be used as a medicine?

“[E]xcept for the harms associated with smoking, the adverse effects of marijuana use are within the range of effects tolerated for other medications.” [p. 5]

“Until the development of rapid onset antiemetic drug delivery systems, there will likely remain a subpopulation of patients for whom standard antiemetic therapy is ineffective and who suffer from debilitating emesis. It is possible that the harmful effects of smoking marijuana for a limited period of time

might be outweighed by the antiemetic benefits of marijuana, at least for patients for whom standard antiemetic therapy is ineffective and who suffer from debilitating emesis. Such patients should be evaluated on a case-by-case basis and treated under close medical supervision.” [p. 154]

“Terminal cancer patients pose different issues. For those patients the medical harm associated with smoking is of little consequence. For terminal patients suffering debilitating pain or nausea and for whom all indicated medications have failed to provide relief, the medical benefits of smoked marijuana might outweigh the harm.” [p. 159]

What should be done to help the patients who already benefit from medical marijuana, prior to the development of new drugs and delivery devices?

“Patients who are currently suffering from debilitating conditions unrelieved by legally available drugs, and who might find relief with smoked marijuana, will find little comfort in a promise of a better drug 10 years from now. In terms of good medicine, marijuana should rarely be recommended unless all reasonable options have been eliminated. But then what? It is conceivable that the medical and scientific opinion might find itself in conflict with drug regulations. This presents a policy issue that must weigh—at least temporarily—the needs of individual patients against broader social issues. Our assessment of the scientific data on the medical value of marijuana and its constituent cannabinoids is but one component of attaining that balance.” [p. 178]

“Also, although a drug is normally approved for medical use only on proof of its ‘safety and efficacy,’ patients with life-threatening conditions are sometimes (under protocols for ‘compassionate use’) allowed access to unapproved drugs whose benefits and risks are uncertain.” [p. 14]

“Until a nonsmoked rapid-onset cannabinoid drug delivery system becomes available, we acknowledge that there is no clear alternative for people suffering from *chronic* conditions that might be relieved by smoking marijuana, such as pain or AIDS wasting. One possible approach is to treat patients as *n-of-1* clinical trials (single-patient trials), in which patients are fully informed of their status as experimental subjects using a harmful drug delivery system and in which their condition is closely monitored and documented under medical supervision. ...” [p. 8] [*The federal government's “compassionate use” program, which currently provides marijuana to three patients nationwide, is an example of an n-of-1 study.*]

The IOM report doesn't explicitly endorse state bills and initiatives to simply remove criminal penalties for bona fide medical marijuana users. Does that mean that we should keep the laws exactly as they are and keep arresting patients?

"This report analyzes science, not the law. As in any policy debate, the value of scientific analysis is that it can provide a foundation for further discussion. Distilling scientific evidence does not in itself solve a policy problem." [p. 14]

If patients were allowed to use medical marijuana, wouldn't overall use increase?

"Finally, there is a broad social concern that sanctioning the medical use of marijuana might increase its use among the general population. At this point there are no convincing data to support this concern. The existing data are consistent with the idea that this would not be a problem if the medical use of marijuana were as closely regulated as other medications with abuse potential. ... [T]his question is beyond the issues normally considered for medical uses of drugs and should not be a factor in evaluating the therapeutic potential of marijuana or cannabinoids." [Pp. 6, 7]

"No evidence suggests that the use of opiates or cocaine for medical purposes has increased the perception that their illicit use is safe or acceptable." [p. 102]

"Thus, there is little evidence that decriminalization of marijuana use necessarily leads to a substantial increase in marijuana use." [p. 104]
[Decriminalization is defined as the removal of criminal penalties for all uses, even recreational.]

Doesn't the medical marijuana debate send children the wrong message about marijuana?

"[T]he perceived risk of marijuana use did not change among California youth between 1996 and 1997. In summary, there is no evidence that the medical marijuana debate has altered adolescents' perceptions of the risks associated with marijuana use." [p. 104]

"Even if there were evidence that the medical use of marijuana would decrease the perception that it can be a harmful substance, this is beyond the scope of laws regulating the approval of therapeutic drugs. Those laws concern scientific data related to the safety and efficacy of drugs for individual use; they do not address perceptions or beliefs of the general population." [p. 126]

Isn't marijuana too addictive to be used as a medicine?

"Some controlled substances that are approved medications produce dependence after long-term use; this, however, is a normal part of patient management and does not generally present undue risk to the patient." [p. 98]

"Animal research has shown that the potential for cannabinoid dependence exists, and cannabinoid withdrawal symptoms can be observed. However, both appear to be mild compared to dependence and withdrawal seen with other drugs." [p. 35]

"A distinctive marijuana and THC withdrawal syndrome has been identified, but it is mild and subtle compared with the profound physical syndrome of alcohol or heroin withdrawal." [Pp. 89, 90]

Drug Category	Proportion Of Users That Ever Became Dependent (%)
Alcohol	15
Marijuana (including hashish)	9 [p. 95]

"Compared to most other drugs ... dependence among marijuana users is relatively rare." [p. 94]

"In summary, although few marijuana users develop dependence, some do. But they appear to be less likely to do so than users of other drugs (including alcohol and nicotine), and marijuana dependence appears to be less severe than dependence on other drugs." [p. 98]

Doesn't the use of marijuana cause people to use more dangerous drugs?

"[I]t does not appear to be a gateway drug to the extent that it is the *cause* or even that it is the most significant predictor of serious drug abuse; that is, care must be taken not to attribute cause to association." [p. 101]

"There is no evidence that marijuana serves as a stepping stone on the basis of its particular physiological effect." [p. 99]

"Instead, the legal status of marijuana makes it a gateway drug." [p. 99]

Shouldn't medical marijuana remain illegal because it is bad for the immune system?

"The short-term immunosuppressive effects are not well established; if they exist at all, they are probably not great enough to preclude a legitimate medical use. The acute side effects of marijuana use are within the risks tolerated for many medications." [p. 126]

Doesn't marijuana cause brain damage?

"Earlier studies purporting to show structural changes in the brains of heavy marijuana users have not been replicated with more sophisticated techniques." [p. 106]

Doesn't marijuana cause amotivational syndrome?

"When heavy marijuana use accompanies these symptoms, the drug is often cited as the cause, but no convincing data demonstrate a causal relationship between marijuana smoking and these behavioral characteristics." [Pp. 107, 108]

Doesn't marijuana cause health problems that shorten the life span?

"[E]pidemiological data indicate that in the general population marijuana use is not associated with increased mortality." [p. 109]

Isn't marijuana too dangerous for the respiratory system?

"Given a cigarette of comparable weight, as much as four times the amount of tar can be deposited in the lungs of marijuana smokers as in the lungs of tobacco smokers." [p. 111]

"However, a marijuana cigarette smoked recreationally typically is not packed as tightly as a tobacco cigarette, and the smokable substance is about half that in a tobacco cigarette. In addition, tobacco smokers generally smoke considerably more cigarettes per day than do marijuana smokers." [Pp. 111, 112]

"There is no conclusive evidence that marijuana causes cancer in humans, including cancers usually related to tobacco use. ... More definitive evidence that habitual marijuana smoking leads or does not lead to respiratory cancer awaits the results of well-designed case control epidemiological studies." [p. 119]

Don't the euphoric side effects diminish marijuana's value as a medicine?

"The high associated with marijuana is not generally claimed to be integral to its therapeutic value. But mood enhancement, anxiety reduction, and mild sedation can be desirable qualities in medications—particularly for patients suffering pain and anxiety. Thus, although the psychological effects of marijuana are merely side effects in the treatment of some symptoms, they might contribute directly to relief of other symptoms." [p. 84]

What other therapeutic potential does marijuana have?

"One of the most prominent new applications of cannabinoids is for 'neuroprotection,' the rescue of neurons from cell death associated with trauma, ischemia, and neurological diseases." [p. 211]

"There are numerous anecdotal reports that marijuana can relieve the spasticity associated with multiple sclerosis or spinal cord injury, and animal studies have shown that cannabinoids affect motor areas in the brain—areas that might influence spasticity." [p. 160]

"High intraocular pressure (IOP) is a known risk factor for glaucoma and can, indeed, be reduced by cannabinoids and marijuana. However, the effect is too and [sic] short lived and requires too high doses, and there are too many side effects to recommend lifelong use in the treatment of glaucoma. The potential harmful effects of chronic marijuana smoking outweigh its modest benefits in the treatment of glaucoma. Clinical studies on the effects of smoked marijuana are unlikely to result in improved treatment for glaucoma." [p. 177] *[Note that IOM found that marijuana does work for glaucoma, but was uncomfortable with the amount that a person needs to smoke. Presumably, it would be an acceptable treatment for glaucoma patients to eat marijuana. Additionally, MPP believes that IOM would not support arresting patients who choose to smoke marijuana to treat glaucoma.]*

Do the American people really support legal access to medical marijuana, or were voters simply tricked into passing medical marijuana ballot initiatives?

"Public support for patient access to marijuana for medical use appears substantial; public opinion polls taken during 1997 and 1998 generally report 60-70 percent of respondents in favor of allowing medical uses of marijuana." [p. 18]

But shouldn't we keep medical marijuana illegal because some advocates want to "legalize" marijuana for all uses?

"[I]t is not relevant to scientific validity whether an argument is put forth by someone who believes that all marijuana use should be legal or by someone who believes that any marijuana use is highly damaging to individual users and to society as a whole." [p. 14]

The full report by the National Academy of Sciences can be viewed on-line at
www.nap.edu/openbook.php?record_id=6376

Appendix D: Surveys of Public Support for Medical Marijuana

Scientifically conducted public opinion polls have consistently found a majority of support for making marijuana medically available to seriously ill patients.

In addition to the following tables, which break down nationwide and state-specific public opinion poll results, there have been two reports that have analyzed nationwide polls on medical marijuana over time:

Meta-analysis of nationwide polls

1997–1998: The Institute of Medicine (IOM), in its 1999 report, *Marijuana and Medicine: Assessing the Science Base*, reported that “public support for patient access to marijuana for medical use appears substantial; public opinion polls taken during 1997 and 1998 generally reported 60-70% of respondents in favor of allowing medical uses of marijuana” (p. 18).

1978–1997: A study by the Harvard School of Public Health — published on March 18, 1998, in the *Journal of the American Medical Association* — analyzed the results of 47 national drug policy surveys conducted between 1978 and 1997. The study reported that more than 60% of the public supports the “legalized use of marijuana for medical purposes.”

Nationwide Medical Marijuana Public Opinion Polling Results				
Date	Percent in favor	Margin of error/ respondents	Wording	Polling firm/where reported
Nov. 2005	78	+/- 2% 2,034 adults	“Do you support making marijuana legally available for doctors to prescribe in order to reduce pain and suffering?”	Gallup
2005	41.2	22,587 chiefs of police and sheriffs	“Should marijuana be legalized in the United States for those who have a legitimate medical need for the drug?”	National Association of Chiefs of Police
Nov. 2004	72	+/- 2.37% 1,706 adults aged 45 and older	“I think that adults should be allowed to legally use marijuana for medical purposes if a physician recommends it.”	International Communications Research, on behalf of <i>AARP The Magazine</i>
Nov. 2002	80	+/- 3.1% 1,007 adults	“Do you think adults should be allowed to legally use marijuana for medical purposes if their doctor prescribes it?”	Harris Interactive for <i>Time</i> magazine
Jan. 2002	70	N/A	“Should medical marijuana be allowed?”	Center for Substance Abuse Research, Univ. of Maryland

Nationwide Medical Marijuana Public Opinion Polling Results				
Date	Percent in favor	Margin of error/ respondents	Wording	Polling firm/where reported
March 2001	73	+/- 3% 1,513 adults	“Regardless of what you think about the personal non-medical use of marijuana, do you think doctors should or should not be allowed to prescribe marijuana for medical purposes to treat their patients?”	Pew Research Center
Mar. 19-21, 1999	73	+/- 5% 1,018 adults	Support “making marijuana legally available for doctors to prescribe in order to reduce pain and suffering”	Gallup
Sept. 7-21, 1997	62	N/A N/A	Favor legalizing marijuana “strictly for medical use”	The Luntz Research Companies for Merrill Lynch and <i>Wired</i> magazine
May 27, 1997	69	+/- 4.5 % 517 adults	Support “legalizing medical use of marijuana”	Chilton Research, on behalf of ABC News/Discovery News
Feb. 5-9, 1997	60	N/A 1,002 registered voters	“Do you favor allowing doctors to prescribe marijuana for medical purposes for seriously ill or terminal patients?”	Lake Research on behalf of The Lindesmith Center
Feb. 5-9, 1997	68	N/A 1,002 registered voters	“The federal government should not penalize physicians who prescribe marijuana, regardless of whether state laws permit it.”	Lake Research on behalf of The Lindesmith Center
1997	66 - Independents 64 - Democrats 57 - Republicans	N/A responses divided among party affiliations	“Doctors should be allowed to prescribe small amounts of marijuana for patients suffering serious illnesses.”	CBS News/ <i>The New York Times</i>
1997	74	+/- 2.8 % 1,000 registered voters	“People who find that marijuana is effective for their medical condition should be able to use it legally.”	Commissioned by the Family Research Council
1995	79	+/- 3.1% 1,001 registered voters	“It would be a good idea ... to legalize marijuana to relieve pain and for other medical uses if prescribed by a doctor.”	Belden & Russonello on behalf of the American Civil Liberties Union

State-Specific Medical Marijuana Public Opinion Polling Results					
State	Date	% in favor	Margin of error/ respondents	Wording	Polling firm/ where reported
Alabama	released on July 4, 2004	75	312 respondents	“Would you approve or disapprove of allowing doctors to prescribe marijuana for medical purposes?”	University of South Alabama, commissioned by the <i>Mobile Register</i>
Alaska	March 2006	74 (54% strongly favor, 20% somewhat favor)	+/- 4.3% 500 adults	“Under present Alaska state law, it is legal for people who have cancer, AIDS, and other serious illnesses to use and grow marijuana for medical purposes, as long as their physician approves. Overall, do you strongly favor, somewhat favor, somewhat oppose, or strongly oppose this law?”	Goodwin Simon Strategic Research, on behalf of MPP
Alaska	Feb. 2002	74	+/- 2.6% to 3.1% between 1,004 and 1,464 adults	“What is your level of support for the current medical marijuana law?”	Lucas Organization and Arlington Research Group, on behalf of MPP
Arizona	March 2007	68	400 registered voters	Support an initiative to “allow Arizona residents with cancer, AIDS, multiple sclerosis, and other serious illnesses to grow and use marijuana for medical purposes, as long as their physician approves. It would also permit the establishment of medical marijuana dispensaries to allow patients to purchase medical marijuana legally.”	Goodwin Simon Victoria Research, on behalf of MPP
Arkansas	Nov. 6-8, 2002	62	+/- 4.1% 600 voters (exit poll)	Support “a law that would allow people with cancer and other debilitating medical conditions to register in a state-regulated program permitting them to grow and use a limited amount of marijuana for medical purposes”	Zogby International poll commissioned by the Arkansas Alliance for Medical Marijuana

State-Specific Medical Marijuana Public Opinion Polling Results					
State	Date	% in favor	Margin of error/ respondents	Wording	Polling firm/ where reported
California	Jan. 2004	74	+/- 4.5% 500 registered voters	"Do you favor or oppose implementation of Proposition 215, to allow for the medical use of marijuana in California?"	Field Research poll
Colorado	Feb. 2002	77	+/- 2.6% to 3.1% between 1,004 and 1,464 adults	"What is your level of support for the current medical marijuana law?"	Lucas Organization and Arlington Research Group, on behalf of MPP
Connecticut	June 2004	83	+/- 4.4% 501 adult Connecticut residents	Think "adults should be able to legally use marijuana for medical purposes if their doctor prescribes it"	Center for Research and Survey Analysis at the University of Connecticut
District of Columbia	Nov. 1998	69	+/- 3.6% 763 voters leaving polling place	Favor medical marijuana	Fairbank, Maslin, Maullin & Associates, reported in <i>The People Have Spoken</i>
Florida	1997	63	+/- 4% 400 registered voters	Favor approving an amendment to the Florida Constitution legalizing "medicinal" marijuana	Florida Voter Poll of Ft. Lauderdale/ <i>The Miami Herald</i>
Georgia	April 2001	69	+/- 4.5% 500 adults	Favor medical marijuana	Survey USA for KUSA (Denver), reported in <i>The People Have Spoken</i>
Hawaii	Feb. 3-12, 2000	77	+/- 3.7% 703 registered voters	Favor "the Hawaii State Legislature passing a law in Hawaii to allow seriously or terminally ill patients to use marijuana for medical purposes if supported by their medical doctor"	QMark Research & Polling on behalf of the Drug Policy Forum of Hawaii
Illinois	Feb. 9-16, 2008	68	+/- 4% 625 registered voters	"Do you support allowing seriously and terminally ill patients to use and grow medical marijuana for personal use if their doctors recommend it?"	Mason-Dixon Polling & Reporting, Inc., on behalf of MPP
Illinois	Mar. 14-17, 2002	67	+/- 3.9% 800 likely voters	"Would you favor or oppose a new law that would allow physicians to prescribe marijuana for the medical purpose of relieving pain and suffering?"	McCulloch Research & Polling

State-Specific Medical Marijuana Public Opinion Polling Results					
State	Date	% in favor	Margin of error/ respondents	Wording	Polling firm/ where reported
Maine	October 2006	67	+/- 4% 625 likely voters	Support “present Maine state law, [which allows] for people who have cancer, AIDS, or other serious illnesses to use and grow marijuana for medical purposes, as long as their physician approves”	Mason-Dixon Polling & Research, Inc. on behalf of MPP
Maryland	May 2001	66	+/- 3.5% 836 registered voters	“Do you believe that doctors should be able to prescribe marijuana to AIDS and cancer patients, or should possession of marijuana remain a criminal offense in all cases?”	Gonzales/Arscott Research
Massachusetts	1999	81	N/A	Would definitely (62%) or probably (19%) support “an initiative that would allow the medical use of marijuana by patients with certain diseases, who have a doctor’s recommendation.	Fairbank, Maslin, Maullin & Associates on behalf of Americans for Medical Rights
Michigan	March 2008	67	+/- 4.1% 600 registered voters	Would you vote to “allow under state law the medical use of marijuana?”	Marketing Resource Group
Minnesota	May 1, 2008	64	+/- 4.3% 500 registered voters	“Think marijuana should be legal when used for medicinal purposes”	SurveyUSA
Montana	October 2006	62	+/- 4% 625 likely voters	Support “present Montana state law, [which allows] for people who have cancer, AIDS, or other serious illnesses to use and grow marijuana for medical purposes, as long as their physician approves”	Mason-Dixon Polling & Research, Inc., on behalf of MPP
Nebraska	Feb. 2002	64	+/- 2.6% to 3.1% between 1,004 and 1,464 adults	Support an initiative that “would remove the threat of arrest and all other penalties for seriously ill patients who use and grow their own medical marijuana with the approval of their physicians”	Lucas Organization and Arlington Research Group, on behalf of MPP

State-Specific Medical Marijuana Public Opinion Polling Results					
State	Date	% in favor	Margin of error/ respondents	Wording	Polling firm/ where reported
Nevada	Feb. 2002	79	+/- 2.6% to 3.1% between 1,004 and 1,464 adults	“What is your level of support for the current medical marijuana law?”	Lucas Organization and Arlington Research Group, on behalf of MPP
New Hampshire	April 7-8, 2008	71	+/- 4% 625 registered voters	“changing the law in New Hampshire to allow seriously and terminally ill patients to use and grow medical marijuana for personal use if their doctors recommend it”	Mason-Dixon Polling & Research, Inc., on behalf of MPP
New Jersey	May 23-25, 2006	86	+/- 3.7% 700 registered voters	“seriously ill patients should have access to marijuana for medical purposes if a physician recommends it”	The Polling Company, Inc.
New Mexico	Sept. 24-26, 2002	72	+/- 5% 421 registered and likely voters	Favor “legalizing marijuana use by those who have serious medical conditions, to alleviate pain and other symptoms”	New Mexican/KOB-TV poll conducted by Mason-Dixon Polling & Research, “Poll: Voters Support Medical Pot,” (Terrell, Steve) <i>Santa Fe New Mexican</i> , October 5, 2002
New York	July 16-17, 2007	55	+/- 4.5% 500 registered Conservative Party voters	Support “allowing seriously and terminally ill patients to use and grow a limited amount of medical marijuana if their doctors recommend it”	Mason-Dixon Polling & Research, Inc.
New York	June 2005	76	+/- 3.9% 622 registered voters	Support allowing “people with cancer, MS, and other serious illnesses to use marijuana for medical purposes, as long as it is under the supervision of a physician who has prescribed it.”	Siena Research Institute
North Dakota	August 2003	57	+/- 3.6% 800 registered voters	Support an initiative that would allow seriously ill patients who have approval from their doctors to receive an ID card from the state health department, which would allow them to possess up to one ounce of marijuana and grow up to six plants	The Southwest Group, on behalf of MPP

State-Specific Medical Marijuana Public Opinion Polling Results					
State	Date	% in favor	Margin of error/ respondents	Wording	Polling firm/ where reported
Ohio	December 18-21, 2006	61	+/-4.3% 500 registered voters	Support “a law in Ohio to allow people with cancer, AIDS, multiple sclerosis, and other serious illnesses to grow and use marijuana for medical purposes, as long as their physician approves”	Goodwin Simon Victoria Research, on behalf of MPP
Oregon	Feb. 2002	77	+/- 2.6% to 3.1% between 1,004 and 1,464 adults	“What is your level of support for the current medical marijuana law?”	Lucas Organization and Arlington Research Group, on behalf of MPP
Pennsylvania	April 27- May 1, 2006	61	+/- 4.1% 578 registered voters	Favor “allowing adults to legally use marijuana for medical purposes if a doctor recommends it”	Keystone Poll
Rhode Island	Sept. 25- 28, 2006	79	+/- 4.0% 625 likely voters	Support Rhode Island’s law allowing “people who have cancer, AIDS, or other serious illnesses to use and grow marijuana for medical purposes, as long as their physician approves”	Mason-Dixon Polling & Research, Inc.
South Dakota	Feb. 2002	64	+/- 2.6% to 3.1% between 1,004 and 1,464 adults	Support an initiative that “would remove the threat of arrest and all other penalties for seriously ill patients who use and grow their own medical marijuana with the approval of their physicians”	Lucas Organization and Arlington Research Group, on behalf of MPP
Texas	October 2004	75	+/- 3.3% 900 adults	“Would you favor or oppose a bill in the Texas Legislature that would allow people with cancer and other serious illnesses to use their own marijuana for medical purposes, as long as their physician approves?”	Scripps Research Center
Vermont	October 2006	74	+/- 4% 625 registered voters	Support “present Vermont state law, [which allows] for people who have cancer, AIDS, or other serious illnesses to use and grow marijuana for medical purposes, as long as their physician approves”	Mason-Dixon Polling & Research, Inc., on behalf of MPP

State-Specific Medical Marijuana Public Opinion Polling Results					
State	Date	% in favor	Margin of error/ respondents	Wording	Polling firm/ where reported
Virginia	June 2001	75	+/- 3% 686 adults	“Do you agree that doctors should be allowed to prescribe marijuana for medical use when it reduces pain from cancer treatment or other illnesses?”	Virginia Tech Center for Survey Research
Wisconsin	July 11-22, 2005	75.7	+/-4% 600 residents	Support a bill that would “allow people with cancer, multiple sclerosis, or other serious illnesses to use marijuana for medical purposes, as long as their physician approves”	Chamberlain Research Consultants, on behalf of MPP
Wisconsin	Feb. 2002	80	+/- 4% 600 registered voters	Support for “the Wisconsin state legislature passing a law to allow seriously ill or terminally ill patients to use marijuana for medical purposes if supported by their physician”	Chamberlain Research Consultants
Wyoming	Feb. 2002	65	+/- 2.6% to 3.1% between 1,004 and 1,464 adults	Support an initiative that “would remove the threat of arrest and all other penalties for seriously ill patients who use and grow their own medical marijuana with the approval of their physicians”	Lucas Organization and Arlington Research Group, on behalf of MPP

Appendix E: The Federal Controlled Substances Act (and Drug Schedules)

The federal Controlled Substances Act of 1970 created a series of five schedules establishing varying degrees of control over certain substances. Marijuana and its primary active ingredient — tetrahydrocannabinol (THC) — are presently in Schedule I. As such, doctors may not prescribe marijuana under any circumstances.

Although the DEA has not rescheduled marijuana, it has made the drug “dronabinol” available by prescription. Dronabinol — marketed as “Marinol” — is synthetic THC in sesame oil in a gelatin capsule. Unfortunately, evidence indicates that it is less effective than marijuana for many patients. Dronabinol is currently in Schedule III.

Most states mirror the scheduling criteria established by the federal government. However, marijuana has been assigned to Schedule II or lower in a few states that have recognized its medicinal value and/or relative safety.¹ Rescheduling on the state level is largely symbolic at this time — doctors may not prescribe marijuana in those states because the federal schedules supersede state law.

The criteria for each of the schedules, listed in Title 21 of the U.S. Code, Section 812(b) (21 U.S.C. 812(b)), and a few example substances from Title 21 of the Code of Federal Regulations, Section 1308, are:

Schedule I (includes heroin, LSD, and marijuana)

- 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.

Schedule II (includes morphine, used as a painkiller, and cocaine, used as a topical anesthetic)

- 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 substance may lead to severe psychological or physical dependence.

Schedule III (includes anabolic steroids and Marinol)

- A. The drug or other substance has a potential for abuse less than the drugs or other substances in Schedules I and II.
- B. The drug or other substance has a currently accepted medical use in treatment in the United States.
- C. Abuse of the drug or other substance may lead to moderate or low physical dependence or high psychological dependence.

¹ See Appendix A.

Schedule IV (includes Valium and other tranquilizers)

- A. The drug or other substance has a low potential for abuse relative to the drugs or other substances in Schedule III.
- B. The drug or other substance has a currently accepted medical use in treatment in the United States.
- C. Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in Schedule III.

Schedule V (includes codeine-containing analgesics)

- A. The drug or other substance has a low potential for abuse relative to the drugs or other substances in Schedule IV.
- B. The drug or other substance has a currently accepted medical use in treatment in the United States.
- C. Abuse of the drug or other substance may lead to limited physical dependence or psychological dependence relative to the drugs or other substances in Schedule IV.

Appendix F: How the 13 Effective State Laws Are Working

Key Figures for State Medical Marijuana Programs ¹										
	AK	CA	CO	HI	MT	NV	NM	OR	RI	VT
Number of doctors who recommended/registered with the program	N/A	N/A	500+	125	162	263	140	2,970	N/A	N/A
Number of patients enrolled in the program	175	7,359 ²	3,302	4,118	1,144	860	162	19,646	483	99
Registration fee	\$25	\$66/ card plus a county fee ³	\$90	\$25	\$50	\$242+	N/A ⁵	\$100 ⁶	\$75 ⁷	\$50
Number of registered caregivers	47	1,034	N/A ⁴	398	386	80	N/A	9,672	393	20
Number of cards revoked/suspended	2	N/A	7	N/A	3	N/A	N/A	N/A	2	0
<p>1. Maine and Washington are not listed because they do not offer registry identification cards. Michigan is not listed because its law was enacted immediately prior to the publication of this report, and it has four months to set up a registry identification program.</p> <p>2. These figures are the number of cards issued during the 2007/2008 fiscal year. The number is significantly lower than the actual number of patients because California's medical marijuana registry program is voluntary for patients and caregivers and has not yet been implemented in some counties. Based on the number of people utilizing Oregon's program, MPP estimates that 190,000 patients are protected by California's medical marijuana law.</p> <p>3. Patients enrolled in Medi-Cal pay half price.</p> <p>4. As of June 14, 2004, caregivers are no longer issued cards.</p> <p>5. Currently, there is no registration fee because there is not yet an official registration process with the state of New Mexico.</p> <p>6. Those who are on the Oregon Health Plan (OHP), receive monthly Supplemental Security Income (SSI) benefits, or receive Food Stamp benefits can obtain a card at a reduced rate of \$20.</p> <p>7. Patients who can show that they receive Supplemental Security Income or Medicaid can obtain cards at a reduced rate of \$10.</p>										

Michigan

On Tuesday, November 4, 63% of Michigan voters approved Proposal 1, the Michigan Medical Marijuana Act, making their state the first in the Midwest to approve an effective medical marijuana law. Michigan is the 13th state to enact an effective medical marijuana law.

Michigan's new law allows patients with debilitating medical conditions to register with the state to use marijuana according to their doctors' recommendations. The Department of Community Health has until early April 2009 to begin accepting applications for the program. Patients will be allowed to possess up to 2.5 ounces of usable marijuana without facing arrest. They will also be allowed to grow up to 12 plants in an indoor, locked facility, or to designate a caregiver to cultivate for them.

The law creates an additional penalty for diversion of medical marijuana. Any registered patient or

caregiver who sells marijuana to someone for non-medical use faces an additional penalty of up to two years in jail and a \$2,000 fine.

The law also includes an affirmative defense, which will be in effect by December 4, 2008. Unregistered patients will be allowed to raise this defense in court. The defense also protects patients whose serious medical conditions are not enumerated in the bill, as well as patients who have a medical need to possess more than 12 plants and 2.5 ounces. Michigan's law is one of three that protects patients from other medical marijuana states and their caregivers. Once an out-of-state patient has been a resident of Michigan for 30 days, he or she would have to get a state ID card for protection from arrest.

New Mexico

In 2007, Gov. Bill Richardson (D) became the first governor in history to enact a medical marijuana law while running for the presidency by signing SB523, making New Mexico the 12th state to protect medical marijuana patients from arrest. Shortly thereafter, the Department of Health set possession limits at six ounces of usable marijuana, four mature plants, and three seedlings. New Mexico's medical marijuana law is the only one of the 13 effective state medical marijuana laws that directs the state to develop a system for the distribution of medical marijuana to qualifying patients. The department has held public meetings regarding this issue and is expected to make recommendations regarding enactment of this provision of the law sometime in the near future.

Rhode Island

In June 2005, Gov. Donald Carcieri (R) became the first governor to veto effective medical marijuana legislation, and six months later the Rhode Island General Assembly became the first state legislature to override a medical marijuana veto. Eighty-two percent of voting members in each chamber voted to override the veto of MPP's medical marijuana bill, while only 60% of their votes were needed to enact it.

The law included a sunset clause, which would have caused it to expire on June 30, 2007. However, the state legislature enacted a bill to make the law permanent and slightly modify it. Gov. Carcieri vetoed that bill too, and an even higher percent of the state legislature overrode his veto on June 21 and June 22, 2007.

The Edward O. Hawkins and Thomas C. Slater Medical Marijuana Act — named in honor of Senate sponsor Rhoda Perry's nephew, who succumbed to AIDS, and House sponsor Thomas Slater, who suffers from cancer — went into effect upon its passage on January 3, 2006. The Department of Health issued the first medical marijuana ID cards in May 2006. Patients with medical marijuana ID cards are protected from arrest, prosecution, and other statewide civil and criminal penalties if they possess no more than 2.5 ounces of marijuana and 12 plants. They are also allowed to have one or two caregivers cultivate marijuana for their medical use.

To qualify, patients must have one of the listed debilitating conditions — cancer; glaucoma; AIDS; hepatitis C; wasting syndrome; severe, chronic, debilitating pain; severe nausea; or severe or persistent muscle spasms — and the patient's doctor must certify that "the potential benefits of the medical use of marijuana would likely outweigh health risks for the qualifying patient." Rhode Island gives medical marijuana identification cards issued by other states the same force and effect as a Rhode Island registry identification card.

The 2007 law extended the time medical marijuana ID cards are valid for, from one year to two years. It also capped the amount of marijuana that caregivers for multiple patients can possess at 24 plants and five ounces. Caregivers assisting one patient can possess no more than 12 plants and 2.5 ounces.

In 2008, Rep. Slater and Sen. Perry proposed a bill to improve access for patients, some of whom are

unable to grow their own medicine or find reliable caregivers. Their bills would have allowed up to three state-regulated, nonprofit compassion centers to distribute medical marijuana to registered patients. The Senate passed Sen. Perry's bill, 29-5. The House modified its bill to create a study commission on the issue, which easily passed both chambers. Gov. Carcieri vetoed the study commission resolution, and as of publication the legislature has not returned for overrides.

Montana

In November 2004, Montana voters enacted a medical marijuana initiative — Initiative 148 — by the largest margin of any effective statewide medical marijuana initiative, 62% to 38%. The law, which MPP drafted and campaigned for, went into effect upon its passage. Patients could immediately raise their medical need for marijuana in court if they were arrested on marijuana charges.

Protection from arrest quickly followed. The Department of Public Health and Human Services (DPHHS) began accepting applications for registry ID cards by December 21, 2004. Registered patients and their caregivers may each possess up to an ounce of marijuana and six plants for the patient's medical use. To register, a patient must have one of the listed debilitating conditions — cancer, glaucoma, AIDS, wasting syndrome, severe or chronic pain, severe nausea, or severe or persistent muscle spasms — and the patient's doctor must certify that "the potential benefits of the medical use of marijuana would likely outweigh the health risks for the qualifying patient."

Unlike most other states' medical marijuana laws, Montana gives medical marijuana cards issued by other states the same force and effect as a Montana registry ID card.

During the 2007 legislative session, Rep. Ron Erickson (D) introduced H.B. 311. This bill would have improved Montana's medical marijuana law by allowing physician assistants and nurse practitioners to recommend marijuana to their patients (as opposed to just physicians), legally protecting those people who transport marijuana from a registered caregiver to a registered patient, and increasing the allowable possession quantities for patients and caregivers. The House Judiciary Committee heard testimony on H.B. 311, but voted to table the bill without any further discussion.

Vermont

Vermont's medical marijuana law — S. 76 — is the first effective medical marijuana law to be passed by a state legislature in spite of the public objections of a governor. After MPP organized a robust campaign, Gov. James Douglas (R) allowed S. 76 to become law without his signature on May 26, 2004. The law went into effect on July 1, 2004, and the Vermont Department of Public Safety (DPS) began accepting applications for registry ID cards on October 28, 2004.

Vermont's law is unique in that physicians are not required to "recommend" the medical use of marijuana. A physician must only "certify" that his or her patient has a qualifying condition in order for that patient to register with the Department of Public Safety. Unfortunately, unregistered medical marijuana patients — including medical marijuana patients who suffer from illnesses outside of the narrow purview of qualifying conditions — are offered no legal protections under the law.

In May 2005, a 54-year-old former construction worker who had been impaled by a metal rod 30 years earlier was convicted of cultivating 49 plants for his medical use. Although he did not qualify under Vermont's medical marijuana law, the jury acquitted him of possession of marijuana, finding that his marijuana use was medically necessary.

During the 2007 legislative session, the Vermont Legislature passed S. 7, which improved the medical marijuana law by expanding the qualifying conditions for the program. As he did in 2004, Gov. Douglas allowed the bill to become law without his signature. The new medical marijuana law took effect on July 1, 2007. It allows seriously ill patients suffering from conditions that cause

nausea, wasting, chronic pain, or seizures to apply for the program. It also increases the number of plants patients and caregivers are allowed to grow, to two mature plants and seven immature plants. Additionally, the new law reduces the nonrefundable annual application fee from \$100 to \$50. And licensed physicians in New York, Massachusetts, and New Hampshire are now allowed to certify that Vermont patients have a qualifying condition.

Hawaii

Hawaii's medical marijuana statute was signed into law on June 14, 2000 — making Hawaii the first state to enact such a law through the state legislature — and took effect on December 28, 2000, when the Department of Public Safety issued administrative regulations and finalized forms allowing patients to register with the state.

In addition to the registry, patients have a “choice of evils” defense to charges of marijuana possession if they have qualifying medical records or signed statements from their physicians attesting that they have debilitating conditions and that the medical benefits of marijuana likely outweigh the risks.

Patient interest in the Hawaii law has been strong since its enactment. The major problem patients face, however, is the difficulty of finding physicians willing to provide written certification in support of their medical use of marijuana.

To help patients and physicians better understand the law, the Drug Policy Forum of Hawaii (DPFH) published a 15-page booklet in October 2001. The booklet, which details the legal protections afforded and the process of registering patients, was mailed to more than 2,400 registered physicians and distributed to clients of certain nonprofit health organizations.

There were several failed attempts to curtail or undercut the medical marijuana law during the 2001-2002 legislative session. In 2003, HB1218 sought to raise the fee ceiling for patients and impose additional penalties on physicians who violated the parameters of the medical marijuana law, but it was tabled and went nowhere.

In 2005, the legislature took up SB128, which sought to raise possession limits, to allow for the addition of qualifying conditions, and perhaps most importantly, to transfer administration of the medical marijuana program from the Department of Public Safety's Narcotics Enforcement Division to the Department of Health. Many participants in the medical marijuana program find it both inappropriate and intimidating that the Narcotics Enforcement Division oversees the program. While SB128 passed the Senate and several committees in the House, it died in the House Finance Committee after failing to make a deadline.

The legislature, however, did pass Senate Concurrent Resolution 197 on May 5, 2005, to convene a working group to make recommendations to the Department of Public Safety to improve Hawaii's medical marijuana program. The working group met in late 2005 and included representatives from the Department of Public Safety, the Department of Health, the Drug Policy Forum of Hawaii, and a qualifying patient. Although SCR197 requested the group “to make recommendations to improve Hawaii's Medical Marijuana Program,” the scope of the work as performed was narrowly defined to: (1) a discussion of the contents of the Narcotics Enforcement Division's Web page and (2) a discussion on which department should administer the program. The group found that transferring the program from the Department of Public Safety's Narcotics Enforcement Division to the Department of Health “would have substantial cost implications, including but not limited to, added personnel and operating costs” and that the Narcotics Division should upgrade its computer systems. An official report was submitted to the state legislature during the 2006 session.

In June 2005, the U.S. attorney for Hawaii, Ed Kubo, created a great deal of controversy following the U.S. Supreme Court's decision in *Gonzales v. Raich*, when he said that *Raich* signaled the “death knell” of medical marijuana in Hawaii and threatened to begin investigating doctors who recommend

marijuana to patients. The Hawaii attorney general was quick to assure patients that *Raich* would not change the way the state enforced its medical marijuana laws, and Kubo later retreated from his statements, saying that doctors who merely certify patients to use marijuana would not be prosecuted unless there are extenuating circumstances.

A second major controversy occurred in June 2008, when the Department of Public Safety's Narcotics Enforcement Division mistakenly released the names and personal information of 4,200 registered medical marijuana patients to the *Hawaii Tribune-Herald*. Although the department was quick to recover the names (they maintain the only people to see the names were the reporter working on the story and the editor) and issue an apology, this serious mishandling of sensitive patient information further eroded patients' faith in the ability of a narcotics department to handle a health care program. Although several bills have been introduced over the years that sought to move the medical marijuana program from the Narcotics Enforcement Division to the Department of Health, none have passed.

In 2008, several bills were introduced to improve Hawaii's medical marijuana program, or to study improvements to it. Only one, HB2675, made it to Gov. Linda Lingle's desk. In July 2008, patients suffered another disappointment when Gov. Lingle (R) vetoed the bill, which would have established a temporary task force comprised of state officials, physicians, and patients to examine critical issues affecting Hawaii's medical marijuana program. Although the Senate voted overwhelmingly (21-1) to override Gov. Lingle's veto, the House failed to follow suit, which means that questions regarding adequate supply, growing facilities, and the inter-island transport of medical marijuana will remain unanswered for at least another year.

Colorado

Colorado voters passed a ballot initiative on November 7, 2000, to remove state-level criminal penalties for medical marijuana use, possession, and cultivation. On June 1, 2001, less than three weeks after the U.S. Supreme Court's negative ruling on medical marijuana distribution in *U.S. v. Oakland Cannabis Buyers' Cooperative*, the Colorado Department of Public Health and Environment (CDPHE) implemented the Medical Marijuana Registry program and began issuing identification cards to patients and caregivers who qualify for legal protection under state law.

After scrutiny from Gov. Bill Owens (R) and then-Attorney General Ken Salazar (D) — both of whom oppose medical marijuana — no reason could be found to scrap the Medical Marijuana Registry program. Following exhaustive research and vigorous debate by attorneys in their offices, Owens and Salazar jointly said that “the Supreme Court's holding in the Oakland case was deliberately narrow enough to permit Colorado's medical registry to go forward.”¹

Colorado's program received a boost in legitimacy when, in July 2001, Kaiser Permanente gave its Colorado doctors permission to recommend medical marijuana.² Kaiser, one of the nation's largest health maintenance organizations, has over 400,000 patients in Colorado.

Since the program's inception, several patients and caregivers have encountered trouble with local and state law enforcement, sometimes working in conjunction with or as part of a program funded by federal agencies. Colorado law enforcement choosing to ignore state law most often cite federal law or a simple aversion to the concept of medical marijuana as the reason for harassing and sometimes arresting patients and caregivers, many of whom are properly registered with the department of health and in compliance with Colorado's medical marijuana law.

In 2002, James Scruggs — a Crohn's disease patient from Cherry Creek — was accused of growing

¹ “Owens' and Salazar's joint statement on medical marijuana,” *Denver Rocky Mountain News*, May 31, 2001.

² “Kaiser to allow medical marijuana,” *Daily Times-Call*, July 7, 2001.

³ “Defendant cites medical pot law,” *Denver Post*, Dec. 12, 2001, and “Medical marijuana case takes interesting twist,” *Denver Rocky Mountain News*, May 15, 2002.

22 marijuana plants, which police said were more than what one person would need for his or her own medical purposes.³ While the law restricts patients to growing six plants, three of which may be mature, it permits patients to argue at trial that quantities in excess of that amount are medically necessary. Although Mr. Scruggs' case was dismissed due to insufficient evidence, it signaled the intention of law enforcement to interfere with registered patients in need of more medicine than could be produced by six plants. Two years later, Scruggs was sentenced to six years in prison for growing several hundred marijuana plants.

In 2003, Don Nord — a disabled, wheelchair-bound, state-registered medical marijuana patient suffering from kidney cancer, diabetes, lung disease, and a neck injury — was raided by a local-federal drug task force, which seized his marijuana and charged him with marijuana possession and possession of drug paraphernalia. Routt County Judge James Garrecht dismissed the charges against Mr. Nord and ordered the federal authorities to return the marijuana that rightfully belonged to him.

The DEA returned his growing equipment but refused to return the marijuana. Judge Garrecht ordered the officials who participated in the raid of Mr. Nord's home to be held in contempt of court. Garrecht planned a "show cause" hearing, where the officers would have had to explain to the judge why they should not have been held in contempt of court.

The U.S. Attorney's office had the case transferred to federal court, where U.S. District Judge Walker Miller heard arguments in 2004. In July 2005, Miller dismissed the contempt citation, concluding that the agents were protected by federal immunity and were therefore not required to return the marijuana that they confiscated from Nord. Nord has not been prosecuted on federal charges.

Several other patients and caregivers that have been in complete or substantial compliance with state law have been raided, had their equipment and marijuana confiscated, and in many instances, returned after a court determined that the marijuana was intended for medical use and being grown legally under state law. Larisa Lawrence, for example, who is a caregiver and member of the Colorado Compassion Club — a Denver-area medical marijuana organization that helps serve the needs of registered patients — had marijuana confiscated and later returned by police on separate occasions in 2004 and 2006.

In 2004, the Two Rivers Drug Enforcement Team (TRIDENT), a federally funded High Intensity Drug Trafficking Area (HIDTA) program run by the Office of National Drug Control Policy (ONDCP), arrested four people for collectively growing 131 plants. By January 2006, all charges had been dropped except with regard to one defendant, who pled guilty to cultivation charges and received probation. The charges against the other three defendants were dismissed due to their status as registered patients and/or caregivers, being in compliance with state law, or evidence against them being destroyed by police in violation of state law.

In August 2006, state narcotics officers raided Fort Collins patients/caregivers James and Lisa Masters and seized their marijuana plants, as well as thousands of dollars worth of growing equipment. In June 2007, the charges were dropped. A Larimer County District Court judge subsequently ordered the Fort Collins police department to return the Masters' growing equipment and marijuana plants. Because the police violated state law, which requires them to maintain seized medical marijuana, and refused the Masters' offer to settle for monetary damages, the Masters plan to sue the police department for the value of their lost medicine.

In 2007, Huerfano County patient/caregiver Mike Stetler — a Navy veteran suffering from chronic pain — was raided by sheriff's deputies, who landed a helicopter on his land, destroyed personal property, and ransacked his trailer in order to seize 44 marijuana plants. At the time, Stetler was a caregiver for eight registered patients. To date, no charges have been filed against Stetler, who plans to sue the police for the value of the marijuana plants destroyed during the raid.

Chris Crumbliss, a father of two and caregiver for 40 patients in Larimer County, has been raided

twice in two years, most recently in August 2008 when Larimer and Boulder County sheriff's deputies executed a multi-jurisdictional, predawn SWAT-team raid of his home. He and his wife, who have always been open about their status as caregivers, have been charged with multiple felonies that could land them in prison for nearly a decade.

Despite some problems with local law enforcement, several officials and Colorado state courts have been more understanding and have shown a willingness to recognize Colorado's medical marijuana law.

In 2005, following the U.S. Supreme Court's decision in *Gonzales v. Raich*, Colorado Attorney General John Suthers stated that Colorado's medical marijuana program would remain intact and unchanged notwithstanding the decision.⁴

In November 2007, Senior Denver District Judge Larry Naves overturned the Colorado Department of Health and Environment's policy limiting the number of patients a caregiver can assist. A limit of five patients per caregiver was adopted by the department during a closed meeting in 2004, during which no health care professionals, patients, caregivers, or horticulturists were consulted. In his ruling, Judge Naves criticized the department's policy as completely lacking in scientific evidence and labeled it "arbitrary and capricious" in nature.⁵

In 2008, Jeff Sweetin, head of Denver's branch of the federal Drug Enforcement Administration, called Colorado's passage of Amendment 20 "a mistake." Even so, when Colorado police ask for his help regarding the court-ordered return of marijuana or growing equipment, he said he refuses 99 out of 100 times, stating that "it is not the position of the DEA to rescue everybody from their state's legislation."⁶

Besides some local law enforcement officers' reluctance to abide by state law, patients have expressed two other concerns regarding the medical marijuana program. First, some patients find the annual \$90 registration fee to be a financial burden. The fee was lowered to \$110 from \$140 on June 1, 2004, and then to \$90 in June 2007, but some patients, especially disabled patients on a fixed income, say they still cannot afford to register. Second, patients complain that no authorized distribution system exists; many would prefer not to grow their own marijuana or obtain it on the illegal market. For those who can grow their own medical marijuana or have access to a reliable caregiver, however, the program is working well.

Severe pain is the ailment most commonly reported by registered patients (85%), followed by muscle spasms (21%) and severe nausea (21%), seizures (5%), cancer (4%), cachexia (3%), glaucoma (2%), and symptoms related to HIV/AIDS (2%). (The total adds up to more than 100%, since some patients report using medical marijuana for more than one debilitating medical condition.) CDPHE accepts and reviews petitions to add conditions to the current list of debilitating medical conditions and symptoms. To date, four petitions have been received, one for Parkinson's disease, one for asthma, one for anxiety, and another for bipolar disorder. All petitions were subsequently denied "due to lack of scientific evidence that treatment with marijuana might have a beneficial effect."

Approximately three-quarters (77%) of registered patients have designated primary caregivers. On June 14, 2004, CDPHE stopped issuing cards to caregivers, after determining that the law does not allow for caregiver identification cards. Caregivers are still legally protected, however, provided they are designated by registered patients in their applications to the department. The average patient age is 42. 78% of the state's counties have at least one registered patient. 63% of patients come from rural

4 "AG Says Ruling Doesn't Directly Affect Colorado Medical Marijuana Program," Associated Press-Denver, July 1, 2005.

5 "Denver Judge Increases Safe Access to Medical Marijuana for Patients," *Rocky Mountain News*, Nov. 20, 2007.

6 "Marijuana, a Growing Battle," *The Denver Post*, Sept. 14, 2008.

areas, while 37% come from the Denver and Boulder areas. Denver, El Paso, and Jefferson counties account for 36% of the state's registered patients, each with 12% of the state's medical marijuana patient population.

More than 500 physicians have submitted supporting documentation for patients, giving Colorado one of the highest physician-to-patient ratios among the states with medical marijuana registry programs. This high rate of physician participation may stem directly from information they receive from the program and the fact that program administrators have told physicians concerned about liability that Drug Enforcement Administration officials have indicated that doctors are not breaking federal law by signing the program's registration forms.

Nevada

Nevada voters twice approved a constitutional amendment allowing the use of medical marijuana, most recently in November 2000 (with 65% of the vote). The amendment required the legislature to create implementing legislation for licensing patients and caregivers, which the legislature did in 2001 with A.B. 453, which established the state's medical marijuana registry program. A.B. 453 originally intended for the state to grow and distribute medical marijuana to patients who are either unable or unwilling to grow their own. That provision was dropped, however, and the bill was amended to resemble Oregon's law.

Enacted after the U.S. Supreme Court's May 2001 ruling on medical marijuana in *U.S. v. Oakland Cannabis Buyers' Cooperative*, the preamble of A.B. 453 says that "the State of Nevada as a sovereign state has the duty to carry out the will of the people of this state and to regulate the health, medical practices and well-being of those people in a manner that respects their personal decisions concerning the relief of suffering through the medical use of marijuana."

Nevada's law is arguably the nation's strictest, with a requirement that patients undergo a background check to ensure that they have no prior convictions for distributing drugs. The program requires that patients provide a fingerprint card to aid in the background check.

Once patients are approved, they are issued a 30-day temporary certificate, which affords them legal protection and allows them to obtain a one-year photo identification card from one of five Department of Motor Vehicles offices across the state. Patients who fail to register with the program — but are otherwise in compliance with the law — are allowed to argue at trial that they had a medical need to use marijuana.

A.B. 453 also requires the state Department of Agriculture to work aggressively to obtain federal approval for a distribution program for marijuana and marijuana seeds and requires the University of Nevada School of Medicine to seek, in conjunction with the state Agriculture Department, federal approval for a research project into the medical uses of marijuana. Apparently, no work has been done to carry out either of these directives.

In 2003, the legislature passed a bill that slightly amended the medical marijuana law. A.B. 130, introduced on behalf of the Nevada Department of Agriculture, allows osteopathic physicians to qualify as "attending physicians" for the medical marijuana program. This is good for patients in Nevada because it expands the scope of those who may receive legal protection for using medical marijuana. In 2005, the legislature passed a bill that would allow the Department of Agriculture to revoke the registry identification card of a participant in the state's medical marijuana program who has been convicted of drug trafficking or who has provided false information on his or her application.

The program is running smoothly, with no signs of fraud or abuse. The registry cards show a phone number that police can call if they have any questions, and the program has received only a couple of calls from law enforcement officers. No registry cards have been revoked.

Demographically, Nevada's medical marijuana patients resemble those in other states. The average

age of registered patients is 49, with a range of ages from 20 to 86 years old. The diseases and conditions reported by registered medical marijuana patients are provided in the chart at the end of this section.

Although Nevada's registry program was once the only one in the nation that did not charge patients an application or registry fee, it is now the most expensive, with totals reaching as high as \$242.

Maine

Maine, which in 1999 became the fifth state to enact a modern medical marijuana law, broke new ground in 2002, when its legislature made it the first state to expand an existing medical marijuana law.

Signed into law on April 1, 2002, LD 611 doubled the amount of usable marijuana a patient may possess, from 1.25 ounces to 2.5 ounces. The bill also clarified protections for patients and caregivers, explicitly providing them with an "affirmative defense" against charges of unlawfully growing, possessing, or using marijuana.

As originally written, the medical marijuana law did not sufficiently outline legal protections for caregivers. The original law did, however, provide a "simple defense" for patients, which meant the burden was on the prosecution to prove that patients did not have a medical need for marijuana. By contrast, the new law now puts the burden on patients to prove their medical need under an "affirmative defense." This is comparable to how medical marijuana laws work in other states where protections exist but no registry ID card systems are in place.

Notably, the bill passed the legislature with little fanfare, gaining approval in the Senate by a voice vote rather than a roll-call vote. Gov. Angus King (I) — who opposed the 1999 initiative that originally authorized the use of medical marijuana — quietly signed the bill into law, demonstrating that medical marijuana has not caused problems or controversy in Maine.

Most legislators did not find federal law a hindrance to changing Maine law. According to Rep. Robert Nutting (R), the medical marijuana law is "workable under federal law ... It's kind of like driving five miles an hour above the speed limit — no one's going to [enforce that]."⁷

In fact, the legislature went so far as to consider having the state government distribute medical marijuana to qualifying patients through a pilot project. That idea was the result of a task force convened by the attorney general's office in 2000 to address access and enforcement issues related to the law. Legislators abandoned the distribution project following the U.S. Supreme Court's ruling in the *Oakland Cannabis Buyers' Cooperative* case in 2001.

According to the state attorney general's office, Maine's medical marijuana law is best suited for patients to grow their marijuana supply indoors. Indeed, for patients who can produce a consistent supply with six indoor plants, the law seems to be working well. Arrests have been few, and complaints have been minimal.

Unfortunately, not all patients can afford to grow their marijuana indoors. The expensive lighting equipment necessary for growing indoors and the related energy costs are too high for some patients, many of whom have limited incomes and face other financial hardships due to their medical conditions.

As an alternative, some patients have chosen to grow their medical marijuana outdoors. While this is not a crime, Maine's short growing season almost necessitates that many plants be grown

⁷ "Bill clarifies medical marijuana guidelines," *Bangor Daily News*, March 6, 2002.

simultaneously if the goal is to produce a supply for the entire year. Not surprisingly, it is these large grow operations, in excess of the law's specified six-plant limit, that have spurred the state's few medical marijuana-related arrests.

Patients who feel compelled to exceed the plant limit with outdoor grows are not the only ones who find access to medical marijuana a problem. Some patients live in apartments and do not have the space to grow marijuana. Others are too sick to grow for themselves and do not have caregivers capable of growing for them. Some lack the horticultural skills needed to cultivate a reliable supply of marijuana. Time is another consideration, especially for cancer patients who may need an immediate supply; it takes several months for a marijuana plant to mature.

In addition to access and distribution issues, other questions about the law have surfaced. With no formal registry system, law enforcement maintains that it cannot readily identify legitimate patients. The law simply says that a patient's documentation must be "available." As a result, police can be unnecessarily harsh when individuals possess marijuana and claim to have appropriate medical documentation but are not in possession of the documentation.

Attempting to address law enforcement questions, the attorney general's office released a "Patrol Officer's Guide to the Medicinal Marijuana Law," which appeared in the *Maine Law Officer's Bulletin* on December 18, 1999, four days before the law took effect. The guide tells officers to conduct thorough investigations and to exercise discretion. Of particular note, officers are encouraged to accompany suspects, when reasonable, to the location where medical documentation exists if the suspect does not have it on hand.

Maine's Bureau of Health has expressed little interest in conducting research, maintaining a registry, or monitoring medical marijuana distribution by patient cooperatives. In fact, the bureau's director, Dr. Dora Mills, was the only member of the attorney general's task force who voted against all three legislative proposals that were considered.

At least one patient has taken his concerns directly to the legislature. Maine law allows residents to request that their legislators introduce legislation on their behalf, and in 2005, medical marijuana improvement bill S.B. 533 was introduced on a patient's behalf. The bill would have established a registry ID card program, allowed patients to grow a larger quantity of medical marijuana, and provided that a parent's medical use of marijuana cannot negatively affect a child custody or other child welfare proceeding. The Health and Human Services Committee heard testimony on the bill from patients and their advocates but ultimately voted down the bill.

In 2007, Sen. Ethan Strimling (D) and eight co-sponsors introduced LD 1418, An Act to Provide Patients With Their Medication. This bill would have improved the medical marijuana law by establishing a registry ID card program, creating a dispensary system, and increasing the amount of marijuana patients are allowed to possess. It received a public hearing in the Joint Committee on Health and Human Services and was recommended "Ought Not to Pass." It was then amended to remove everything except the provision to increase the possession limit to 3.5 ounces. However, the bill wasn't brought for a vote on the House floor. Another bill, LD 770, would have expanded the qualifying conditions by adding Crohn's disease and Alzheimer's. This bill was introduced by Rep. Charles Harlow by request from a constituent. However, it was later withdrawn by the sponsor because its provisions were in LD 1418.

Oregon

The Oregon Medical Marijuana Program (OMMP) — enacted by a 1998 ballot initiative — is the most popular in the nation, with a current enrollment of more than 10,000 patients. Like other effective medical marijuana laws, Oregon's protects patients from state-level criminal penalties for the use, possession, and cultivation of medical marijuana. The OMMP, run through the Oregon

Department of Human Services, issues registry ID cards to qualified patients and caregivers.

In addition to administering the registry program, the Department of Human Services considers petitions to add new medical conditions to the list of qualifying conditions, diseases, and symptoms covered by the law. In the first year of the program, an expert panel considered eight conditions — agitation of Alzheimer’s disease, anxiety, attention deficit disorder, bipolar disorder, insomnia, post-traumatic stress disorder, schizophrenia, and schizo-affective disorder — and recommended three of them — agitation of Alzheimer’s disease, anxiety, and bipolar disorder — for final approval. The department approved agitation of Alzheimer’s disease, while rejecting the other two. The unapproved conditions may be reconsidered if additional supporting evidence can be offered, but no new medical conditions have since been approved.

In July 1999, less than nine months after the law was passed, the state amended the Medical Marijuana Act when Gov. John Kitzhaber (D) signed H.B. 3052 into law. The changes included:

- Mandating that patients may not use marijuana for medical purposes in correctional facilities;
- Limiting a given patient and primary caregiver to growing marijuana at one location each;
- Requiring that people arrested for marijuana who want to raise the medical necessity defense in court must have been diagnosed with a debilitating medical condition within 12 months prior to the arrest; and
- Specifying that a law enforcement agency that seizes marijuana plants from a person who claims to be a medical user has no responsibility to maintain the live marijuana plants while the case is pending.

To address remaining ambiguities in the medical marijuana law, the state attorney general’s office convened a working group to develop recommendations on how state and local authorities should enforce the law. Issued on December 15, 1999, the recommendations elaborate on the range of defenses provided by the law and when they are applicable and offer cautious policies for seizing and destroying marijuana plants for jurisdictions to consider.

In 2001, with the volume of patients overwhelming the understaffed program, an internal audit revealed numerous problems: The program had a backlog of almost 800 applications, often failed to verify doctor signatures on applications, regularly missed deadlines for processing applications, and had no clear procedure for rejecting incomplete applications. Three registry cards (out of more than 2,000) had been issued to patients who had forged doctors’ signatures. In response, the OMMP dramatically increased its staffing, which allowed it to clear the application backlog and greatly improve oversight. In its total history, the OMMP has had to suspend only two cards — in addition to the three cards it revoked in 2001 — and it continues to receive 200 applications per week for new cards and renewals.

The program has also adopted stricter rules for physicians, requiring that doctors who sign patients’ applications maintain an up-to-date medical file for each patient, perform a physical, and develop a treatment plan. The state program may also examine a copy of the patient’s file.

In 2003, Oregon avoided passing a bill to further restrict the program. H.B. 2939 would have disqualified any person previously convicted of a drug violation from accessing the medical marijuana program and required medical marijuana patients to complete a “medical marijuana education course.” H.B. 2939 passed the House but died in the Senate Health Policy Committee.

In 2004, in response to concerns that patients who cannot cultivate their own marijuana must turn to the criminal market to obtain it, some activists attempted to pass Measure 33, a ballot initiative that would have created state-regulated nonprofit dispensaries where qualified patients could buy medical marijuana. The measure also proposed increasing the amount of medical marijuana a patient may have on hand, to one pound of usable medical marijuana — six pounds if the patient were to choose

to grow once a year. Measure 33 lost by 58% to 42%.

In 2005, the Oregon Legislature considered two key medical marijuana bills. S.B. 1085, which was passed in August 2005, increased the amount of marijuana that a patient could possess from seven plants, three of which could be mature, and one ounce of usable marijuana per mature plant to 24 ounces of usable marijuana, six mature plants, and 18 seedlings. H.B. 2693, which died, would have given employers much more room to discriminate against medical marijuana patients in the workplace.

The intent of H.B. 2693 seemed to be to overrule *Washburn v. Columbia Forest Products, Inc.*, 104 P3d 609 (2005), which held that an employee's use of medical marijuana in the home does not constitute the medical use of marijuana in the workplace. However, this was accomplished judicially when the Oregon Supreme Court reversed *Washburn* in May of 2006 (CC 0012-12516; CAA116664; SC S52254). The Oregon Supreme Court held that Robert Washburn's employer, Columbia Forest Products, did not have to accommodate Washburn's after-hours use of marijuana to quell spasms in his legs that kept him from sleeping at night.

The court reasoned that Washburn is not "disabled" under Oregon disability law because he is able to control the spasms in his legs with a range of medications, including marijuana. Thus, the court held that — because other drugs would deal with the symptoms — Columbia Forest Products could deny Washburn the right to use medical marijuana, even if marijuana is the most effective relief. While this is a blow to the employment rights of medical marijuana patients, the court left open the issue of whether a patient would have the right to an accommodation if marijuana is the only medication that provides relief.

In 2007, a bill was introduced that would have allowed employers to discriminate against medical marijuana patients. S.B. 465 would have allowed employers to fire patients for using medical marijuana, regardless of when or where patients used their medicine, or if they were medicated while working. Interestingly, Oregon Revised Statute 659.840 requires an employer to have reasonable grounds before administering a Breathalyzer test to an employee they believe to be under the influence of alcohol. S.B. 465 would have actually allowed an employer to test an employee for marijuana with less evidence of wrongdoing than is required for the same employer to test the same employee for alcohol. S.B. 465 passed the Senate, but died in the House Elections, Ethics and Rules Committee.

Meanwhile, the program has proved a financial boon to the state government. The OMMP is entirely supported by patient fees, which were originally set at \$150 per application and renewal. Due to the popularity of the program, the OMMP was able to create significant cash reserves and lower the rate to \$100, with a further reduced rate of \$20 for those who could demonstrate financial need. In 2005, the legislature shifted \$900,000 worth of accumulated funds from the OMMP to an underfunded Department of Health — demonstrating not only that medical marijuana programs need not cost the state, but that they can actually produce revenues.

No substantial law enforcement problems have materialized around the program. A study conducted by the federal General Accounting Office (GAO) in 2002 on Oregon's and three other states' medical marijuana programs found that "medical marijuana laws had had little impact on their law enforcement activities."⁸

The federal government has not taken an interest in Oregon's medical marijuana program with the intensity it has in California's, and only a couple of patients have faced federal prosecution in the last seven years.

In 2005, in the days following the U.S. Supreme Court's decision in *Gonzales v. Raich*, Dr. Grant Higginson — the public health officer who oversees the OMMP — said that the OMMP would stop

⁸ United States General Accounting Office, *Marijuana: Early Experiences with Four States' Laws That Allow Use for Medical Purposes*, Washington: GAO, 2002.

issuing registry cards until the Oregon attorney general issued an opinion on the impact of the *Raich* decision. After a tremendous public outcry and threats of litigation, the Oregon attorney general issued an opinion on June 17, stating that the *Raich* decision had no impact on the state's administration of the OMMF. It immediately resumed issuing cards and cleared the backlogged applications in a matter of weeks.

Physician participation in Oregon has remained strong, with 2,970 physicians participating. In addition, Kaiser Permanente, one of the nation's largest health maintenance organizations, developed a standardized recommendation letter for its Oregon physicians to use in conjunction with the registry process.

Alaska

Alaska voters passed a ballot initiative in 1998 to protect seriously ill state residents from arrest for possessing, using, and cultivating medical marijuana.

In 1999, S.B. 94 made it mandatory for medical marijuana patients to participate in a state registration program in order to assert a medical necessity defense. Because many Alaskans are reluctant to add their names to a list of individuals who have serious medical conditions and use medical marijuana, many patients do not register and thus have no legal protection.

The legislature also limited the amount of marijuana that a patient may legally possess to one ounce and six plants, with no exceptions. Previously, patients who exceeded the numerical limit could argue at trial that a greater amount was medically necessary. Patients now often complain that the plant limit is too low.

Additionally, local advocates believe some patients are unable to maintain a consistent supply of medical marijuana. With the nation's shortest growing season, Alaskans generally have no choice but to grow indoors, which often presents a financial hardship. Not only does the state not permit medical marijuana distribution, but the Department of Health and Social Services rejected an idea to allow the registry program to provide patients with a list of independent groups that could provide them with the assistance necessary to grow marijuana on their own.

Because of these factors, there are only 175 registered medical marijuana patients in the state, five less than the 180 patients that registered with the program during the first 14 months of its existence. However, in addition to the problems mentioned above, low registration rates may also be due to the fact that Alaska courts have held that the Alaska Constitution's privacy clause protects the adult possession of limited amounts of marijuana in the home, thereby lessening the need to register with the state for protection for patients who do not possess marijuana outside the home.

Alaska has no breakdown of its registrants' conditions and symptoms because the physician statement forms do not require the naming of the specific ailments, in order to protect patient confidentiality.

Although the scope of the law has narrowed since it was first passed, police and prosecutors typically exercise discretion and maintain the spirit of the law when conducting medical marijuana investigations, according to the state attorney general's office. Unregistered patients often are either not charged or are charged with a lesser crime if they can clearly demonstrate their medical need to the investigating officer.

In one case reported by the Alaska attorney general's office, an unregistered wife and husband — who possessed plants in excess of the specified limit — were initially charged with felonies. After obtaining evidence that the woman had a qualifying medical need, the charges against her were dropped, and the husband was allowed to plead guilty to a lesser charge. Although not wholly absolved, the couple avoided prosecution for serious charges. At the same time, this example stresses the value of obtaining registry cards. As enforcement practices vary from town to town, patients are not guaranteed the same

treatment across Alaska.

Overall, patients have made few complaints regarding the law to either the health department or attorney general's office. State officials interpret this to mean that those patients with true medical needs are generally satisfied.

Washington

Of the states that passed medical marijuana initiatives in 1998, Washington was the only one not to place a numerical limit on the amount of marijuana that may be possessed or grown by a patient. Instead, the law allows patients to possess no more than a "sixty-day supply."

In 2007, the legislature passed SB 6032, which directed the Department of Health to determine what constitutes a "sixty-day supply" by July 1, 2008. In June, about one month before their recommendation was statutorily due, the department suggested that a 60-day supply be defined as 35 ounces and a 100-square-foot canopy; however Gov. Christine Gregoire (D) felt law enforcement and prosecutors were underrepresented and pressured the department to reconsider. Although there were four public hearings held across the state by the department in 2007, and law enforcement did in fact comment, with the DEA even showing up at one point, the department acquiesced, recanted its original recommendation of 35 ounces and a 100-square-foot canopy, and came back with a recommendation of 24 ounces and 24 plants. The recommended 24 ounce/24 plant limit would be a presumptive limit, and could "be overcome by documentation from the patient's physician stating the amount that is medically necessary for the qualifying patient."

Washington is also the only one of the 13 states with an effective medical marijuana law without some sort of registry system in place. The number of patients utilizing the state law has been estimated to be as high as 25,000 to 30,000 patients. The 25,000 estimate comes from a patient advocate, while the 30,000 patients estimate is calculated based on Oregon's mandatory registration system (which shows approximately 0.5% of the entire population using medical marijuana).

Most patients grow their own medical marijuana, either alone or with the help of a designated provider. To assist those patients who cannot grow marijuana, a handful of patient cooperatives exist to verify patients' credentials, distribute marijuana, and provide related services. Although designated providers are limited to serving one patient at a time, statutory law is silent as to cooperatives and designated providers growing in groups. While some cooperatives and designated providers continue to operate without interference from law enforcement, others have been targeted by police and sometimes raided. This situation is a result of different law enforcement agencies having different policies regarding acceptable plant limits, coupled with a lack of statutory guidance.

How much marijuana patients and their designated providers may legally possess will remain the chief issue surrounding the medical marijuana law until the Department of Health makes an official recommendation and adopts rules, as directed to by statute. In *State v. Shepard* in 2002, a Washington state appellate court determined that caregivers must prove at trial that the amount of marijuana they grow or possess does not exceed a "sixty-day supply" for the patients they serve and suggested that physicians should determine how much a patient needs. The defendant in the case grew only 15 plants, but he did not prove at trial that he was growing only an amount that met the "sixty-day supply" requirement of the patient he served.

"While nothing in the act requires doctors to disclose the patient's particular illness, there must, nonetheless, be some statement as to how much he or she needs," wrote Judge Dennis Sweeney for the court.⁹

Frank Cikutovich, defense counsel in the case, worries that doctors may be reluctant to accept any greater role in the law's administration for fear of federal reprisals. The state appealed the decision to the Washington Supreme Court, which denied the appeal in October 2002. Subsequent cases have touched on the subject but have added little clarity to the issue. Until the Department of Health is able to decide what constitutes a "sixty-day supply," patients and law enforcement will not have much more guidance than has already been provided.

In the absence of additional rules, local law enforcement have taken steps to limit the scope of the law. The Seattle Police Department, for example, developed directives to streamline how medical marijuana

investigations are conducted. Attempting to address the supply issue, Seattle police consider “suspicious” the possession of more than two usable ounces of marijuana and more than nine marijuana plants (three mature, three immature, and three starter plants). However, this is only a benchmark and not an absolute standard; each case is reviewed on an individual basis. The Seattle police also obtained advice from the U.S. Attorney for Western Washington, who said the police would not face any federal penalties for following the state’s medical marijuana law in good faith.

Not only do police lack clear guidance regarding what constitutes an appropriate supply, they also complain that it is difficult to determine what is an appropriate doctor’s recommendation. Although the law defines “valid documentation” more clearly than it defines supply, law enforcement claim that they must guess at both issues. As a result, enforcement practices vary throughout the state, and several patients have been arrested or have had their marijuana seized because police and patients have differing interpretations of the law.

To assist patients, the Washington Department of Health provides a toll-free phone number (800-525-0127), where patients can obtain information about the law, and distributes copies of the statute, a fact sheet on the law, and a guide to the law (produced by Washington Citizens for Medical Rights and the ACLU), which includes a physician’s recommendation form developed by the Washington State Medical Association.

Patients who contact the Department of Health most often ask about how they can obtain marijuana, if they can be referred to a physician, and what their status is under federal law. The department does not refer patients to physicians who can provide recommendations, nor does it refer them to patient networks that can provide medical marijuana. With no formal role in the administration of the law, the department’s primary advice for patients is to read the law carefully.

The only state agency with any administrative authority over the law is the Medical Quality Assurance Commission. It can expand the list of terminal or debilitating conditions that may be treated with marijuana under state law. During the law’s first two years of effectiveness, the commission added Crohn’s disease and hepatitis C, as well as diseases that have specific symptoms like nausea, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms, and spasticity, when these symptoms are unrelieved by standard treatments. In 2007, SB 6032 codified these conditions and symptoms as “qualifying conditions” under the medical marijuana statute. The commission has rejected the inclusion of insomnia, post-traumatic stress disorder, depression, and severe anxiety. However, according to Dr. Rob Killian, who has frequently petitioned the commission, Washington has carefully listened to patients’ needs and has done more than any state to expand the range of conditions that may be treated with medical marijuana.

California

California’s law — which passed in November 1996 — was the first effective medical marijuana law to be enacted and, as with all initial efforts, Proposition 215 did not address every aspect of medical marijuana policy. Most notably, the law — called the Compassionate Use Act (CUA) — did not specify the amount of marijuana that may be possessed by a patient, nor did it permit any state agency to establish guidelines for the law.

One major unresolved issue has been supply. How much marijuana is sufficient for the “personal medical purposes” of a patient, as defined by the CUA? Without any specified numerical guidelines, law enforcement officials sometimes err on the side of prosecuting — or at least hassling — patients if the quantity seems too large.

Unlike most of the later state medical marijuana laws, the CUA has not been interpreted as providing protection from arrest. On July 18, 2002, in a unanimous ruling, the California Supreme Court interpreted the CUA as allowing CUA patients to move to dismiss attempts to prosecute them in a pretrial motion.¹⁰ In essence, the CUA allows patients to avoid a jury trial if they are valid medical marijuana users.

Similar to all of the other effective medical marijuana laws except New Mexico’s, the CUA did not

¹⁰ *People v. Mower*, (Cal. 2002) 49 P3d 1067.

explicitly permit distribution beyond individual caregivers assisting individual patients. Unfortunately, many patients are not capable of growing their own marijuana, nor do they have capable caregivers. In response to this unmet need, a number of medical marijuana distributors — in earlier years referred to as “cannabis buyers’ cooperatives” or “clubs” (CBCs) and now called “dispensaries” or “collectives” — emerged throughout the state. In fact, some had been in existence before the initiative became law.

The dispensaries act as the “qualified primary caregiver” for the patients they serve. However, at least one court held that an organization did not meet the definition, which required that the caregiver be a person who has consistently assumed responsibility for the patient’s housing, health, or safety.¹¹ In that 1997 decision, the San Francisco CBC was successfully targeted by the state attorney general’s office. The California First District Court of Appeals ruled that a commercial enterprise that sells marijuana does not qualify as a primary caregiver.

Attempting to address the questions left unanswered by the CUA, then-California Attorney General Bill Lockyer (D) formed a task force in 1999 to develop recommendations for implementing the law.

Co-chaired by state Sen. John Vasconcellos (D) and Santa Clara District Attorney George Kennedy (R), the task force produced a number of recommendations that were added to a bill sponsored by Vasconcellos. The bill, S.B. 848, contained four major provisions:

- Establish a registry program within the Department of Health Services;
- Allow the Department of Health Services to determine what constitutes an appropriate medical marijuana supply;
- Permit regulated operation of cooperative cultivation projects; and
- Clarify those instances when medical marijuana may be authorized, and require that a patient’s personal physician make the recommendation.

After years of attempts, a modified version of the legislation was enacted in 2003, and signed into law by Gov. Gray Davis (D). To help resolve the inconsistencies among jurisdictions in enforcing the medical marijuana law, S.B. 420 provided that patients and caregivers may possess at least eight ounces of marijuana and six mature or 12 immature plants per patient. Counties and localities may raise those amounts but are not permitted to lower them. In addition, a patient can possess a greater amount with a doctor’s recommendation stating that the limit would be insufficient. Further, the new law, called the Medical Marijuana Program (MMP), mandated the creation of a voluntary statewide ID card and registry system, which provided the patients and caregivers who choose to participate with additional protection — protection from arrest. County health departments are required to verify information in the applications, approve and deny the applications, and issue the cards. The California Department of Health Services maintains a Web site for law enforcement to verify ID cards’ validity.

Some counties have stalled or resisted implementing the ID card program. As of publication, 18 of California’s 58 counties are still not offering ID cards¹². Three of those 18 counties have voted to issue cards and are expected to begin issuing them within the coming months.

The most important provision of the MMP is that it makes California the first state to expressly allow cooperatives under state law. The provision states, “Qualified patients, persons with valid identification cards, and the designated primary caregivers of qualified patients and persons with identification cards, who associate within the State of California in order collectively or cooperatively to cultivate marijuana for medical purposes, shall not solely on the basis of that fact be subject to state

11 *People ex rel. Lungren v. Peron* (App. 1 Dist. 1997) 70 Cal.Rptr.2d 20, 59 Cal.App.4th 1383, review denied.

12 A current list of active county programs is available at <http://www.cdph.ca.gov/services/Pages/MMPCounties.aspx>

criminal sanctions.” It also provides that caregivers cannot be prosecuted solely for being compensated for their actual expenses and their services. The MMP also said that it does not authorize for-profit marijuana distribution.

The MMP also modified the language defining a primary caregiver, stating that the definition includes “an individual who has been designated as a primary caregiver by more than one qualified patient or person with an identification card, if every qualified patient or person with an identification card who has designated that individual as a primary caregiver resides in the same city or county as the primary caregiver.”¹³

In a 2005 ruling, *People v. Urziceanu*, the Third Appellate District Court of Appeal of California found that the MMP provides a defense for distribution by collectives and cooperatives, including for conduct that occurred before the law passed. It found that S.B. 420’s “specific itemization of marijuana sales indicates it contemplates the formation and operation of medical marijuana cooperatives that would receive reimbursement for marijuana and the services provided in conjunction with the provision of marijuana.” In the ruling, that court also found that the CUA did not allow collective medical marijuana distribution.

There are estimated to be more than 400 dispensaries serving patients in California. However, even after the passage of the MMP, many dispensaries have been shut down either by state and local law enforcement or by federal legal action.

The Oakland Cannabis Buyers’ Cooperative (OCBC) unsuccessfully fought a January 1998 civil suit brought by the U.S. Department of Justice, which sought to stop the operation of OCBC and five other distribution centers in Northern California. (See Appendix I for detailed information on this case.)

More recently, the DEA sent threatening letters to more than 160 landlords who allegedly leased to dispensaries in several areas of the state. In July 2007, it notified the landlords that they could face federal prosecution or forfeiture if they continued leasing to medical marijuana collectives.¹⁴ In Santa Barbara, these letters were followed up with in-person threats to landlords of fines, forfeiture, and even prosecution if they do not evict the dispensaries.¹⁵ Since the enactment of the CUA, federal agents have also raided more than 190 medical marijuana locations, mostly dispensaries, homes related to them, and large gardens. Several dozen people have been federally prosecuted for medical marijuana, usually for involvement in dispensing collectives or large gardens.

The MMP’s provisions allowing for dispensing collectives are vague, and some local officials – such as San Diego County District Attorney Bonnie Dumanis – have claimed they are not allowed. In San Diego and some other areas, local and federal officials have cooperated to raid dispensaries.¹⁶ In one case, a county sheriff requested a federal raid against a city-licensed dispensary. The operator, Charles Lynch, was convicted of five federal charges on August 5, 2008, because perfect compliance with a state’s medical marijuana law is no defense to federal charges.¹⁷

In 2008, San Diego Assemblymember Lori Saldaña introduced legislation to stop the use of state and local resources to subvert the state’s medical marijuana law. The bill, A.B. 2743, was sponsored by MPP and would prevent state and local officials from assisting in federal raids. For its first year, the legislation made significant progress. It passed two committees and had more supporters than

13 Ca. Health & Safety Code 11362.7 (d)(2).

14 See Welch, William, “DEA Targets Landlords in Pot Battle,” *USA Today*, July 26, 2007.

15 “Shakedown From Feds Imperils Medicinal Marijuana,” *Santa Barbara Independent*, August 12, 2008.

16 See Office of the San Diego County District Attorney 2007 Annual Report. “Our prosecutors effectively shut down all of these so-called medical marijuana clinics.”

17 See “Ex-Morro Bay pot dispensary owner to seek new trial after conviction,” *San Luis Obispo Tribune*, August 7, 2008.

opponents in the Assembly. However, a majority of all members – not just voting members – is required in California, and the bill was not called to a floor vote.

Another relatively recent development is city ordinances prohibiting dispensaries or putting a hold, or moratorium, on new dispensaries. The sheriff's office in one county, Butte, is even raiding private patient collectives, including forcing the uprooting of 29 of 41 plants for a seven-patient collective. Butte's policy, as well as dispensary bans in Fresno, Concord, Pasadena, and Susanville, are being challenged in court by ASA, which is arguing that they violate the MMP. Other cities are seeking to ensure safe access while making sure dispensaries are good neighbors. More than three dozen cities and counties across California — including San Francisco — have passed ordinances regulating medical marijuana dispensaries. These ordinances usually contain security requirements, such as limiting the hours of operation, requiring plenty of outdoor lighting, or requiring security guards. They also may require the dispensaries to prevent loitering. Some of the cities that have temporary moratoriums, such as Los Angeles, have done so to give themselves time to develop and issue regulations.

Regardless of how these matters involving distribution centers are resolved, individual patients and their primary caregivers will continue to be allowed to acquire or grow medical marijuana under state law.

In 2007 and 2008, legislation was introduced to address another problem dispensaries face. Sen. Carole Migden (D-San Francisco) introduced bills to remove liability for back sales taxes that older medical marijuana dispensaries faced. The dispensaries had little reason to believe they owed sales taxes on prior years, since they were not allowed to obtain sellers permits until 2005. Most dispensaries were only notified that they were liable for any sales taxes in February 2007. The legislation did not make it out of committee either year.

Meanwhile, in January 2006, three of California's 58 counties — San Diego, San Bernardino, and Merced — refused to issue medical marijuana ID cards and filed a lawsuit claiming that the MMP and parts of the CUA are preempted by federal law. In December 2006, San Diego Superior Court Judge William R. Nevitt Jr., ruled against the counties and upheld California's medical marijuana laws. Merced County dropped out of the lawsuit and began issuing medical marijuana cards. San Diego and San Bernardino filed an appeal. In 2008, the Fourth District Court of Appeals unanimously found that the counties only had legal standing to challenge the part of law requiring them to issue of ID cards, and it unanimously ruled against the two counties.¹⁸ The two counties decided to appeal to the state supreme court.

Four other important court decisions also came down in late 2007 or 2008. Many California patients have had their medical marijuana seized by state or local officials who refused to return it. On November 28, 2007, the Fourth District Court of Appeals unanimously upheld a ruling requiring the City of Garden Grove to return seized marijuana to patient Felix Kha. The state supreme court refused to hear the city's appeal.¹⁹

The state supreme court ruled on January 24, 2008, that patients can be fired or not hired for testing positive for having marijuana in their systems.²⁰ The 5-2 ruling did note that the legislature could explicitly choose to protect patients from employment discrimination, and Assemblyman Mark Leno introduced A.B. 2279, a bill sponsored by Americans for Safe Access (ASA) that would do just that. As of publication, the bill has passed both the state Assembly and Senate but has not yet received an approval from the governor.

18 *County of San Diego et al. v San Diego NORML et al.*, (CA.App 4th Dist. 2008) 2008 WL 2930117.

19 *City of Garden Grove v. Superior Court*, 68 Cal.Rptr.3d 656 (CA.App 4th Dist. 2007), review denied.

20 *Ross v. Ragingwire Telecommunications, Inc.*, (Cal. 2008) 179 P3d 200.

The validity of the MMP guidelines have been called into question in two other cases. In California, state legislation cannot amend initiatives. The CUA did not include any caps on how much marijuana can be possessed, so subsequent legislation cannot do so either. Unfortunately, the wording of the guideline amounts in the MMP indicate that they are caps; though they were intended to be safe harbors.²¹

In 2005, patient Patrick Kelly was arrested and charged for about 12 ounces of marijuana and either seven or 14 plants. In his criminal trial, the prosecutor argued that Kelly could not possess more than eight ounces and six plants under the MMP. The judge allowed this argument to be made, and Kelly was convicted. On May 22, 2008, the state's Second District Court of Appeal overturned Kelly's conviction, saying that the amounts in the MMP were unconstitutional caps.²² The court then severed the part of the MMP that contains the limits. Many advocates believe that the amounts should remain, not as caps but as safe harbors that patients will not be able to be convicted for. On August 15, 2008, the California Supreme Court agreed to review the case.

Also in August 2008, California Attorney General Jerry Brown issued long-awaited medical marijuana guidelines, which the attorney general was instructed to issue by the MMP.²³ The "Guidelines for the Security and Non-Diversion of Marijuana Grown for Medical Use" seek to clarify the state's medical marijuana law for patients, caregivers, dispensing collectives, and law enforcement personnel.

They note that, under existing law, collectives and cooperatives of patients and caregivers are allowed, but that they may not operate for profit. They also include recordkeeping guidelines and provide that marijuana cannot be obtained from sources other than patients and caregivers who are part of the collective. The attorney general also made recommendations that should help prevent the arrest of bona fide patients, including a recommendation that state and local law enforcement officers "not arrest individuals or seize marijuana under federal law" if they determine that the activity is protected by state law.

Despite the occasional questions and controversies, California's medical marijuana law has increased in popularity since it was enacted. A statewide Field Research poll released in January 2004 found that 74% of California voters approved of legal protections for medical marijuana patients, compared to the 56% who approved the CUA when it appeared on the 1996 ballot.²⁴ The law is protecting an estimated 190,000 patients, who are allowed to use medical marijuana with the approval of physicians.²⁵

21 In 2004, Sen. Vasconcellos introduced a bill — S.B. 1494 — to clarify that the MMP's limits did not overrule the CUAs limits. It stated both that a patient or caregiver may "possess any amount of marijuana consistent with the medical needs of that qualified patient" and that patients and caregivers cannot be arrested for possessing up to eight ounces and six mature or 12 immature plants. S.B. 1494 passed both chambers by wide majorities, but it was vetoed by Gov. Arnold Schwarzenegger (R).

22 *People v. Kelly*, (CA.App 2nd Dist 2008), 77 Cal.Rptr.3d 390.

23 The guidelines are available at http://ag.ca.gov/cms__attachments/press/pdfs/n1601__medicalmarijuanaguidelines.pdf.

24 "Medical pot law gains acceptance, Prop. 215 polls better now than when it passed," *San Francisco Chronicle*, January 30, 2004.

25 Based on Oregon's medical marijuana registration, which began two years after California's law went into effect, it can be estimated that approximately 0.58% of California's population uses medical marijuana.

Appendix G: Types of Legal Defenses Afforded by Effective State Medical Marijuana Laws

1. Exemption from Arrest and Prosecution

A state may establish that it is no longer a state-level crime for patients to possess or cultivate marijuana for medicinal purposes. Federal laws would be broken by individual patients, but an “exemption from arrest and prosecution” prevents the state from arresting and prosecuting qualified patients. Most exemptions are tied to a state registry program, which allows patients’ credentials to be easily verified.

2. Affirmative Defense

Several state medical marijuana laws allow individuals to assert an affirmative defense to charges of unlawful marijuana cultivation or possession. To establish the affirmative defense, individuals must prove at trial — by a preponderance of the evidence — that they are in compliance with the medical marijuana statute. The affirmative defense is the only defense afforded individuals by the medical marijuana laws in Alaska and Washington. Although this defense does not prevent patients from being arrested, as a matter of practice, individuals who are clearly in compliance with the law are often not arrested. Colorado, Michigan, Montana, and Nevada allow individuals to use an affirmative defense to argue that an amount of marijuana in excess of the specified legal limit is medically necessary. California, Michigan, Montana, Nevada, Oregon, and Rhode Island allow unregistered patients to raise an affirmative defense.

3. “Choice of Evils” Defense

In addition to being exempt from prosecution or providing an affirmative defense, medical marijuana patients may raise a medical necessity defense¹, often referred to as a “choice of evils” defense. This is brought up to show that violation of the law (such as using marijuana) was necessary to prevent a greater evil (such as exacerbation of an illness).

¹ See Appendix K for more information on the medical necessity defense.

Appendix H: Types of Physician Documentation Required to Cultivate, Possess, or Use Medical Marijuana

California and Arizona, the first two states to pass medical marijuana initiatives in 1996, used slightly different wording in their enacting statutes:

- California law allows patients to use medical marijuana if they possess a recommendation from a physician.
- Arizona law allows patients to use medical marijuana if they possess a prescription from a physician.

The difference seems slight, but its effect is great. Patients in California are protected under state law if they possess valid recommendations for medical marijuana. In Arizona, however, patients do not enjoy state-level legal protection because it is impossible to obtain a prescription for medical marijuana.

Definitions of “prescription” and “recommendation,” as they apply to medical marijuana, explain the difference in legal protections for California and Arizona patients.

Vermont’s medical marijuana law is unique in that it doesn’t require physicians to prescribe or recommend medical marijuana; rather, a physician must simply certify that a patient has a qualifying illness.

- Vermont law allows a person to register with the state as a medical marijuana patient if that patient possesses such a certification from his or her physician.

Prescription

A prescription is a legal document from a licensed physician, ordering a pharmacy to release a controlled substance to a patient. Prescription licenses are granted by the federal government, and it is a violation of federal law to “prescribe” marijuana, regardless of state law. Furthermore, it is illegal for pharmacies to dispense marijuana (unless as part of a federally sanctioned research program).

In addition to Arizona, the medical marijuana laws of Connecticut, Louisiana, Virginia, and Wisconsin also use the word “prescribe” and are therefore ineffective.

Recommendation

A recommendation is not a legal document, but a professional opinion provided by a qualified physician in the context of a bona fide physician-patient relationship. The term “recommendation” skillfully circumvents the federal prohibition on marijuana prescriptions, and federal court rulings have affirmed a physician’s right to discuss medical marijuana with patients, as well as to recommend it. A “recommendation” is constitutionally protected speech.¹

Whereas patients do not receive meaningful legal protection via marijuana “prescriptions” because they cannot be lawfully obtained, patients who have physicians’ “recommendations” can meet their state’s legal requirements for medical marijuana use.

The states that have enacted medical marijuana laws since 1996 have generally avoided using the words “prescription” and “recommendation.” Instead, they require physicians to discuss, in the context of a bona fide physician-patient relationship, the risks and benefits of medical marijuana use and advise patients that the medical benefits of marijuana would likely outweigh the health risks. Not only does this circumvent the federal prohibition on marijuana, but it minimizes physicians’ concerns that they might face liability related to medical marijuana.

¹ See Appendix I for details.

Certification

The states that have enacted medical marijuana laws since 1996 have generally avoided using the words “prescription” and “recommendation.” Instead, they generally protect patients who submit written certifications to a health department. Like a “recommendation,” a “certification” is not a legal document. In issuing a “certification,” a physician simply signs a written statement. In most states, the statement must affirm that the physician discussed, in the context of a bona fide physician-patient relationship, the risks and benefits of medical marijuana use and advised the patient that the medical benefits of marijuana would likely outweigh the health risks.

However, in Vermont, the physician needs only to certify that the patient has a medical condition that the state has approved as a qualifying condition for the medical use of marijuana. This circumvents the federal prohibition on marijuana. And because of this, a medical marijuana law based on this type of “certification” should fully eliminate physicians’ concerns that they might face liability related to medical marijuana.

Appendix I: Federal Litigation Related to Effective State Medical Marijuana Laws

The federal government's position on medical marijuana

The federal government has not tried to overturn any state medical marijuana law, nor is it planning to do so.

In fact, high-ranking members of the U.S. Department of Justice evaluated the legal prospects of a court challenge to the medical marijuana initiatives and concluded that such a challenge would fail.

This was stated on the record by David Anderson of the U.S. Department of Justice during a hearing in *Wayne Turner v. D.C. Board of Elections and Ethics, et al.* (Civil Action No. 98-2634 RWR, September 17, 1999).¹

Anderson's comments are supported by Footnote 5 in the federal court's *Turner* opinion: "In addition, whatever else Initiative 59 purports to do, it proposes making local penalties for drug possession narrower than the comparable federal ones. Nothing in the Constitution prohibits such an action."

Testifying at a June 16, 1999, hearing of the U.S. House Government Reform Subcommittee on Criminal Justice, Drug Policy, and Human Resources, then-drug czar Barry McCaffrey also admitted that "these [medical marijuana] statutes were deemed to not be in conflict with federal law."

Further, McCaffrey said that the federal government has "the problem" because there are not enough Drug Enforcement Administration (DEA) agents to enforce federal laws against personal use, possession, and cultivation in the states that have removed criminal penalties for medical marijuana.

Speaking directly to that point, Kristina Pflaumer, U.S. attorney for Western Washington, informed the Seattle Police Department that her office did not intend to prosecute cases relating to the state's medical marijuana law. Specifically, Pflaumer wrote:

Speaking for this office, we do not intend to alter our declination policies on marijuana, which preclude our charging any federal offense for the quantities legalized by the new "medical marijuana" initiative. (I am assuming an authorized 60 day supply would be fewer than 250 plants.) Given our limited funding and overwhelming responsibilities to enforce an ever larger number of federal offenses, we simply cannot afford to devote prosecutive resources to cases of this magnitude. In short, we anticipate maintaining our present declination standards.

We therefore have no interest in the Seattle Police Department investigating or forwarding such cases to us. We can also assure you in advance we will also decline to prosecute a police officer who merely returns to its owner marijuana he believes to meet the 'medical marijuana' standards.

Further, Pflaumer said the U.S. attorney's office did not expect that the Seattle Police Department would jeopardize any of its federal funding for complying with the state's medical marijuana law. Pflaumer's statements were made to Seattle Police Department Vice and Narcotics Section Commander Tom Grabicki in a letter dated August 11, 1999, in response to Grabicki's letter of July 22, 1999.

Although Bush administration drug czar John Walters has vehemently opposed the use of medical marijuana — equating it to "medicinal crack" — the Justice Department has generally maintained its stance against prosecuting small-scale growers, possessors, or users of medical marijuana. Speaking in

¹ Turner challenged the constitutionality of U.S. Rep. Bob Barr's (R-GA) amendment to the fiscal year 1999 budget, which prohibited the District from spending any funds to conduct any initiative that would reduce the penalties for possession, use, or distribution of marijuana. This amendment had the effect of preventing the local Washington, D.C., government from tallying the votes on the local medical marijuana ballot initiative in November 1998. The U.S. District Court for the District of Columbia ruled in Turner's favor—albeit not on constitutional grounds—the votes were counted, and the medical marijuana initiative was found to have passed; however, Congress subsequently prevented it from taking effect. This occurred only because D.C. is a district, not a state, and therefore is legally subject to greater federal oversight and control.

San Francisco on February 12, 2002, then-DEA chief Asa Hutchinson said, “The federal government is not prosecuting marijuana users.” He insisted that the federal government is interested only in those who traffic in large amounts of the drug. More recently, in the wake of the *Raich* decision (see below), DEA Administrator Karen Tandy said, “We don’t target sick and dying people.”

The federal government cannot force states to have laws that are identical to federal law, nor can the federal government force state and local police to enforce federal laws. However, the U.S. Department of Justice may take legal action against individuals and organizations for violations of federal law.

Medical marijuana litigation in federal court

Since 1996, there have been four key federal cases relating to medical marijuana: *Conant v. Walters*, *U.S. v. Oakland Cannabis Buyers’ Cooperative*, *County of Santa Cruz v. Ashcroft*, and *Gonzales v. Raich*.

***Dr. Marcus Conant v. John L. Walters* (No. 00-17222)**

Ruling: A federal district court ruled that the federal government cannot punish physicians for discussing or recommending medical marijuana. After this ruling was upheld by the Ninth U.S. Circuit Court of Appeals, it was appealed to the U.S. Supreme Court, which declined to take the case, letting the ruling stand.

Background: Shortly after California voters approved Proposition 215 in 1996, the federal government threatened to punish—even criminally prosecute—physicians who recommend medical marijuana. Specifically, the federal government wanted to take away physician authority to write prescriptions for any controlled substances. In response to those threats, a group of California physicians and patients filed suit in federal court on January 14, 1997, claiming that the federal government had violated their constitutional rights.

The lawsuit asserted that physicians and patients have the right—protected by the First Amendment to the U.S. Constitution—to communicate in the context of a bona fide physician-patient relationship, without government interference or threats of punishment, about the potential benefits and risks of the medical use of marijuana.

On April 30, 1997, U.S. District Court Judge Fern Smith issued a preliminary injunction prohibiting federal officials from threatening or punishing physicians for recommending medical marijuana to patients suffering from HIV/AIDS, cancer, glaucoma, and/or seizures or muscle spasms associated with chronic, debilitating conditions. According to Judge Smith, “[t]he First Amendment allows physicians to discuss and advocate medical marijuana, even though use of marijuana itself is illegal.”

The case was finally heard in the U.S. District Court for the Northern District of California in August 2000. Plaintiffs argued that the threats amounted to censorship. The federal government countered that there is a national standard for determining which medicines are accepted and that the use of marijuana should not be decided by individual physicians. In response to that argument, Judge William Alsup stated, “Who better to decide the health of a patient than a doctor?”

Alsup ruled on September 7, 2000, that the federal government cannot penalize California doctors who recommend medical marijuana under state law. Specifically, he said the U.S. Department of Justice is permanently barred from revoking licenses to dispense medication “merely because the doctor recommends medical marijuana to a patient based on a sincere medical judgment and from initiating any investigations solely on that ground.”

The U.S. Department of Justice sought to overturn Alsup’s ruling. In a hearing before the Ninth Circuit on April 8, 2002, judges questioned Justice Department attorneys who were appealing an injunction against sanctioning these doctors.

“Why on earth does an administration that’s committed to the concept of federalism . . . want to go to this length to put doctors in jail for doing something that’s perfectly legal under state law?” asked Judge Alex Kozinski at the hearing.

U.S. Attorney Mark Stern argued that the government should be allowed to investigate doctors whose advice “will make it easier to obtain marijuana.” But he had difficulty convincing judges that there was a distinction between discussing marijuana and recommending it.

On October 29, 2002, the Ninth Circuit upheld the *Conant v. McCaffrey* ruling, which affirms that doctors may recommend marijuana to their patients, regardless of federal laws prohibiting medical marijuana. The government’s attempt to bar doctors from recommending medical marijuana “does . . . strike at core First Amendment interests of doctors and patients. . . . Physicians must be able to speak frankly and openly to patients,” Chief Judge Mary Schroeder wrote in the 3–0 opinion.

On October 14, 2003, medical marijuana patients and doctors achieved a historic victory when the U.S. Supreme Court refused to hear the Justice Department’s appeal of *Conant*, letting stand the Ninth Circuit ruling from October 2002. This powerful ruling has put a stop to the federal government’s campaign to punish physicians who recommend medical marijuana to patients.

***United States of America v. Oakland Cannabis Buyers’ Cooperative* (No. 98-16950)**

Ruling: The U.S. Supreme Court ruled that people who are arrested on federal marijuana distribution charges may not raise a “medical necessity” defense in federal court to avoid conviction.

Background: In California, dozens of medical marijuana distribution centers received considerable media attention following the passage of Proposition 215. Yet many of them had been quietly operating for years before the law was enacted. State and local responses ranged from prosecution to uneasy tolerance to hearty endorsement.

In January 1998, the U.S. Department of Justice filed a civil suit to stop the operation of six distribution centers in Northern California, including the Oakland Cannabis Buyers’ Cooperative (OCBC).

The U.S. District Court issued an injunction in May 1998 to stop the distributors’ actions and rejected, in October 1998, OCBC’s motion to modify the injunction to allow medically necessary distributions of marijuana. In September 1999, the Ninth Circuit ruled 3–0 that “medical necessity” is a valid defense against federal marijuana distribution charges, provided that a distributor can prove in a trial court that the patients it serves are seriously ill, face imminent harm without marijuana, and have no effective legal alternatives.

The case then went back to U.S. District Court, where the 1998 injunction was modified, allowing OCBC to distribute marijuana to seriously ill people who meet the Ninth Circuit’s medical necessity criteria. The Justice Department then filed an appeal, asking the U.S. Supreme Court to overturn the Ninth Circuit’s decision establishing a federal “medical necessity defense” for marijuana distribution.

Writing for a unanimous court (8–0), Justice Clarence Thomas affirmed what medical marijuana patients, providers, and advocates have long known: The U.S. Congress has not recognized marijuana’s medical benefits, as evidenced by the drug’s placement in the most restrictive schedule of the federal Controlled Substances Act.

Specifically, Thomas wrote: “In the case of the Controlled Substances Act, the statute reflects a determination that marijuana has no medical benefits worthy of an exception (outside the confines of a Government-approved research project).”

“Unable . . . to override a legislative determination manifest in statute” that there is no exception at all for any medical use of marijuana, the court held that the “medical necessity defense” is unavailable

to medical marijuana distributors like OCBC.

The ruling does not affect the ability of states to remove criminal penalties for medical marijuana. It merely asserts that similar protections do not currently exist at the federal level. Of note, the case did not challenge the viability of Proposition 215, the California law that allows patients to legally use medical marijuana.

The ruling will likely prevent large-scale medical marijuana distribution in all 50 states because such operations are visible targets for federal authorities, as demonstrated in this case.

Unclear, however, is whether individual patients can assert a “medical necessity defense” to federal marijuana charges.

Footnote 7 of the opinion says nothing in the court’s analysis “suggests that a distinction should be made between prohibitions on manufacturing and distributing and other prohibitions in the Controlled Substances Act.”

In a concurring opinion, Justice John Paul Stevens criticized Footnote 7, writing that “the Court reaches beyond its holding, and beyond the facts of the case, by suggesting that the defense of necessity is unavailable for anyone under the Controlled Substances Act.”

Given the U.S. Supreme Court’s narrow ruling, OCBC appealed the case again in U.S. District Court, raising constitutional and other issues.

OCBC argued that the federal injunction against it exceeds federal authority over interstate commerce. The organization also argued that barring marijuana distribution would violate its members’ fundamental rights to relieve pain and the life-threatening side effects of some treatments for conditions like AIDS and cancer.

Ruling for the U.S. District Court on May 3, 2002, Judge Charles Breyer said OCBC has no constitutional right to distribute medical marijuana to sick patients. Breyer also said the federal government has the constitutional authority to regulate drug activity, even if it takes place entirely within a state’s boundaries. OCBC appealed the ruling to the Ninth Circuit.

On June 12, 2003, Judge Breyer issued a permanent injunction prohibiting OCBC and two other organizations from distributing medical marijuana. The order, requested by the U.S. Department of Justice, affects OCBC, the Marin Alliance for Medical Marijuana in Fairfax, and a dispensary in Ukiah.

***Gonzales v. Raich* (No. 03-1454)**

Ruling: On June 6, 2005, the U.S. Supreme Court ruled 6-3 that the federal government has the power under the Commerce Clause of the U.S. Constitution to prohibit purely intrastate cultivation and possession of marijuana authorized by state medical marijuana laws.

The Supreme Court also sent *Raich* back to the Ninth Circuit to consider legal issues that had not been argued. On March 14, 2007, the Ninth Circuit ruled that there is not yet a constitutional due process right to use marijuana to preserve one’s life. It also held that the criminal defense “medical necessity” cannot be used in a civil suit to prevent a federal prosecution.

Background: On October 9, 2002, two seriously ill medical marijuana patients sued the federal government for violating the Fifth, Ninth, and Tenth Amendments to the U.S. Constitution in its attacks on patients and providers.

Angel Raich, who suffers from life-threatening wasting syndrome, nausea, a brain tumor, endometriosis, scoliosis, and other disorders that cause her chronic pain and seizures, uses marijuana because of her adverse reaction to most pharmaceutical drugs.

Diane Monson, a medical marijuana patient suffering from severe chronic back pain and spasms, was raided by the Drug Enforcement Administration (DEA) on August 15, 2002. Ms. Monson has tried several pharmaceutical drugs, but none of them allows her to function normally; only medical marijuana does.

The lawsuit sought to prevent the federal government from arresting or prosecuting the plaintiffs for their medical use of marijuana. According to the complaint, U.S. Attorney General John Ashcroft and former DEA Administrator Asa Hutchinson were overstepping their authority by seizing marijuana plants that were grown under the state's medical marijuana law. The plaintiffs argued that the federal government has no constitutional jurisdiction over their activities, which are entirely noncommercial and do not cross state lines.

On March 5, 2003, the U.S. District Court denied the preliminary injunction, despite finding that “the equitable factors tip in plaintiff’s favor.”

A week later, on March 12, 2003, Angel Raich and Diane Monson filed an appeal with the Ninth U.S. Circuit Court of Appeals.

The appeals court heard oral arguments on October 7, 2003. On December 16, 2003, the court issued an opinion reversing the U.S. District Court decision and remanding *Raich* to the district court with instructions to enter a preliminary injunction, as sought by the patients and caregivers. The Ninth Circuit found that “the appellants have demonstrated a strong likelihood of success on their claim that, as applied to them, the CSA [Controlled Substances Act of 1970] is an unconstitutional exercise of Congress’ Commerce Clause authority.”

This decision stated that federal interference in state medical marijuana laws is unconstitutional. This was a huge victory for medical marijuana patients—and for the states that have these laws, establishing clearly that the federal Controlled Substances Act does not apply to noncommercial medical marijuana activities that do not cross state lines.

On February 26, 2004, the Ninth Circuit unanimously rejected the U.S. Department of Justice’s petition for an *en banc* review of the ruling. The Justice Department appealed to the U.S. Supreme Court, which on June 28, 2004, agreed to hear the case.

On June 6, 2005, the U.S. Supreme Court ruled 6-3 that the federal government has the power under the Commerce Clause of the U.S. Constitution to prohibit purely intrastate cultivation and possession of marijuana authorized by state medical marijuana laws. Justices Sandra Day O’Connor and Clarence Thomas and Chief Justice William Rehnquist argued in dissent that prohibiting this activity is beyond the scope of the Commerce Clause. This ruling in no way invalidates existing state medical marijuana laws, nor does it prevent states from enacting medical marijuana laws. It merely upholds the status quo: that federal authorities can continue to arrest medical marijuana users.

The Supreme Court remanded the case to the Ninth Circuit for further proceedings to determine whether an injunction is warranted based on due process, medical necessity, or Tenth Amendment claims. The Ninth Circuit had not addressed these claims in earlier proceedings since the Court of Appeals held that an injunction was warranted based solely on the Commerce Clause argument. On March 27, 2006, the Ninth Circuit heard oral arguments on these issues, with Diane Monson no longer a party to the case.

On March 14, 2007, the three-judge panel unanimously ruled against Raich’s remaining arguments for an injunction to prevent federal prosecution.

The court found that there is not a due process right “to use marijuana to preserve bodily integrity, avoid pain, and preserve [one’s] life.” The majority decision, authored by Judge Harry Pregerson and signed by Judge Richard Paez, suggested that there is a possibility that under emerging standards of fundamental rights the medical use of marijuana could eventually be recognized as a fundamental

right. The opinion said, “For now, federal law is blind to the wisdom of a future day when the right to use medical marijuana to alleviate excruciating pain may be deemed fundamental. Although that day has not yet dawned, considering that during the last ten years eleven states have legalized the use of medical marijuana, that day may be upon us sooner than expected.”

The Ninth Circuit also unanimously ruled that Raich could not use a medical necessity defense to obtain a civil injunction barring a federal prosecution. The ruling noted that it did not decide whether Raich could successfully raise the defense if she were criminally prosecuted. The majority evaluated the three prongs that must be proven in a necessity defense and said, “Raich appears to satisfy the threshold requirements for asserting a necessity defense under our case law.” The opinion also said that the issue of whether the Supreme Court’s OCBC ruling and the Controlled Substances Act foreclose the possibility of patients like Raich asserting marijuana necessity defenses is an unanswered question.

The third judge, C. Arlen Beam, issued an opinion that concurred with the decision to uphold the district court’s denial of an injunction. However, he dissented “from the court’s expansive consideration” of whether Raich met the prongs of a necessity defense. He argued that because *Gonzales v. Raich* was a civil case that followed civil rules of evidence and procedure, the court could not make a determination about whether Raich could meet the requirements for a necessity defense to a criminal prosecution. He did, however, “acknowledge that [Raich] certainly may be eligible to advance such a defense to criminal liability in the context of an actual prosecution.”

Although the Ninth Circuit’s ruling on remand did not provide any immediate protection to Raich, it was not entirely negative. It left open the possibility that the seriously ill might eventually have a due process right to use medical marijuana if states continue enacting effective medical marijuana laws. It also left open the possibility that the seriously ill could avoid criminal liability under federal law by raising the medical necessity defense.

***County of Santa Cruz, et al. v. Mukasey, et al.* (C-03-1802 JF)**

Ruling: On April 21, 2004, U.S. District Court Judge Jeremy Fogel issued a historic preliminary injunction barring the U.S. Department of Justice from raiding or prosecuting Wo/Men’s Alliance for Medical Marijuana (WAMM) in Santa Cruz, California. The Ninth Circuit reversed the injunction following the U.S. Supreme Court decision *Gonzales v. Raich*, but the case is still alive. The plaintiffs raised additional claims for declaratory relief and an injunction, and Judge Fogel ruled against the defendants’ motion to dismiss the claims based on medical necessity and the Tenth Amendment. As of publication, Judge Fogel has not issued a final decision.

Background: This suit was prompted by a DEA raid that received national attention in September 2002, when heavily armed federal agents stormed the Wo/Men’s Alliance for Medical Marijuana cooperative. During this raid, they handcuffed several medical marijuana patients while cutting down the plants that Valerie and Michael Corral had been dispensing free of charge.

The lawsuit — which aims to end the Bush administration’s active interference with state medical marijuana laws — was filed by eight plaintiffs who are patients of the cooperative. Four of them have passed away. The defendants in the case are the U.S. attorney general, the DEA administrator, the director of the White House Office of National Drug Control Policy, and the DEA agents who conducted the raid. This is a historic lawsuit because it is the first time that a public entity has sued the federal government on behalf of medical marijuana patients.

On September 24, 2002, 20 to 30 DEA agents raided WAMM, a collective of medical marijuana patients and their caregivers. While holding the founders of the collective, Valerie and Mike Corral, at gunpoint, they confiscated 160 plants. The Corrals were taken into custody but have not been charged with a crime. Following the raid, WAMM and the City and County of Santa Cruz jointly sued the federal government, challenging the authority of the federal government to conduct medical

marijuana raids. *County of Santa Cruz, et al. v. Mukasey* initially focused on constitutional issues related to the Commerce Clause; because no interstate trade or commercial activity was involved, plaintiffs argued that the federal raid was unconstitutional in that it went beyond the scope of the Commerce Clause.

On August 28, 2003, Judge Fogel of the U.S. District Court for Northern California denied the plaintiffs' motion for a preliminary injunction that would have barred the federal government from conducting raids while the case was tried. Later that year, in light of the Ninth Circuit's landmark decision in *Raich* — which specifically criticized Judge Fogel's decision in this case — the plaintiffs asked the judge to reconsider his decision. On April 21, 2004, Judge Fogel issued a historic preliminary injunction barring the U.S. Department of Justice from raiding or prosecuting WAMM in Santa Cruz, California.

On September 20, 2005, after the U.S. Supreme Court decision overturning and remanding the Ninth Circuit's *Raich* decision, the Ninth Circuit reversed the order for a preliminary injunction. The County of Santa Cruz, et al. raised additional legal theories requesting declaratory relief and an injunction. Those included claims based on the Tenth Amendment, medical necessity, and due process. On June 23, 2006, the court heard a motion to dismiss, filed by the defendants. The court waited to decide until after the Ninth Circuit ruled on *Raich v. Gonzales* on remand (*Raich II*). In the wake of *Raich II*, both parties filed supplemental briefings, and Judge Fogel heard oral arguments on July 13, 2007. The defendants argued that *Raich II* controlled and that the claims should be dismissed.

The County of Santa Cruz, et al. argued that the medical necessity claims are distinguishable from those raised in *Raich II* because they are in the context of part of a criminal prosecution, since charges could still be filed against the members of WAMM. They also maintained that the due process claims are valid because the court in *Raich II* did not consider the right to control the circumstances of one's death. The plaintiffs also claimed that the Tenth Amendment claims are distinguishable from those raised in *Raich II* because they are raised by local governments. They argued that the federal government cannot interfere in the states' affairs.

On August 20, 2007, Judge Fogel granted federal motion to dismiss all of the claims except medical necessity. He also allowed County of Santa Cruz, et al. to submit an amended complaint on the Tenth Amendment issue. In their amended complaint, County of Santa Cruz, et al. argued that the federal government engaged in a plan to try to force California and other states to repeal their medical marijuana laws. This conduct included threatening to punish doctors who recommend medical marijuana, threatening officials who issue medical marijuana cards, interfering with zoning plans, and raiding and arresting providers who work closely with municipalities.

On August 19, 2008, Fogel ruled against the federal government's motion to dismiss the Tenth Amendment claims. The court found, "If Plaintiffs can prove that Defendants are enforcing the CSA in the manner alleged ... they may be able to show that Defendants deliberately are seeking to frustrate the state's ability to determine whether an individual's use of marijuana is permissible under California law. A working system of recommendations, identification cards and medicinal providers is essential to the administration of California's medical marijuana law. The effect of a concerted effort to disrupt that system at least arguably would be to require state officials to enforce the terms of the CSA."

Appendix J: Therapeutic Research Programs

The federal government allows one exception to its prohibition of the cultivation, distribution, and use of Schedule I controlled substances: research. Doctors who wish to conduct research on Schedule I substances such as marijuana must obtain a special license from the DEA to handle the substance, FDA approval of the research protocol (if experimenting with human subjects), and a legal supply of the substance from the only federally approved source — the National Institute on Drug Abuse (NIDA).

An individual doctor may conduct research if all of the necessary permissions have been granted. In addition, a state may run a large-scale program involving many doctor-patient teams if the state secures the necessary permission for the researchers from the federal government.

Beginning in the late 1970s, a number of state governments sought to give large numbers of patients legal access to medical marijuana through federally approved research programs.

While 26 states passed laws creating therapeutic research programs, only seven obtained all of the necessary federal permissions, received marijuana and/or THC (tetrahydrocannabinol, the primary active ingredient in marijuana) from the federal government, and distributed the substances to approved patients through approved pharmacies. Those seven states were California, Georgia, Michigan, New Mexico, New York, Tennessee, and Washington.

Typically, patients were referred to the program by their personal physicians. These patients, who had not been responding well to conventional treatments, underwent medical and psychological screening processes. Then the patients applied to their state patient qualification review boards, which resided within the state health department. If granted permission, they would receive marijuana from approved pharmacies. Patients were required to monitor their usage and marijuana's effects, which the state used to prepare reports for the FDA.

(Interestingly, former Vice President Al Gore's sister received medical marijuana through the Tennessee program while undergoing chemotherapy for cancer in the early 1980s.)

These programs were designed to enable patients to use marijuana. The research was not intended to generate data that could lead to FDA approval of marijuana as a prescription medicine. For example, the protocols did not involve double-blind assignment to research and control groups, nor did they involve the use of placebos.

Since the programs ceased operating in the mid-1980s, the federal government has made it more difficult to obtain marijuana for research, preferring to approve only those studies that are well-controlled clinical trials designed to yield essential scientific data.

Outlining its position on medical marijuana research, the U.S. Department of Health and Human Services — in which NIDA resides — issued new research guidelines, which became effective on December 1, 1999. The guidelines were widely criticized as being too cumbersome to enable research to move forward as expeditiously as possible.

These new obstacles are not surprising, given NIDA's institutional mission: to sponsor research into the understanding and treatment of the harmful consequences of the use of illegal drugs and to conduct educational activities to reduce the demand for and use of these illegal drugs. This mission makes NIDA singularly inappropriate for expediting scientific research into the potential medical uses of marijuana.

Three recent cases demonstrate the federal barricade to medical marijuana research:

- Lyle Craker, Ph.D., a researcher at the University of Massachusetts at Amherst, has been denied permission to cultivate research-grade medical marijuana to be used in government-approved medical studies by himself and other scientists. Prof. Craker was given elusive and

contradictory information by the DEA several times, which finally denied the permission to conduct research. His application was denied because of a lack of “credible evidence” supporting his claim that researchers were not adequately served by NIDA’s marijuana. NIDA produces marijuana at only one location, the University of Mississippi. The DEA has not prohibited any other Schedule I drug — even cocaine — from being produced by DEA-licensed private labs for research. Six years into his efforts, Drug Enforcement Administration Administrative Law Judge Mary Ellen Bittner issued a ruling in his favor, concluding “that there is currently an inadequate supply of marijuana available for research purposes.” Scientists testified in his favor that NIDA denied their requests for marijuana to be used in FDA-approved research protocol. However, the decision is non-binding, and the DEA has so far shown no sign of complying with the ruling.

- Donald Abrams, M.D., a researcher at the University of California at San Francisco (UCSF), tried for five years to gain approval to conduct a study on marijuana’s benefits for AIDS patients with wasting syndrome. Despite approval by the FDA and UCSF’s Institutional Review Board, Abrams’ proposal was turned down twice by NIDA, in an experience he described as “an endless labyrinth of closed doors.” He was able to gain approval only after redesigning the study so that it focused on the potential risks of marijuana in AIDS patients rather than its benefits. “The science,” Abrams said at the time, “is barely surviving the politics.”¹
- Neurologist Ethan Russo, M.D., finally gave up trying to secure approval for a study of marijuana to treat migraine headaches — a condition afflicting 35 million Americans, nearly one-third of whom do not respond to “gold standard” treatments. When his first proposal was rejected by the National Institutes of Health (NIH), he sought guidance from his “program official” as to how to revise the design, but the official failed to respond and later denied receiving his e-mails. Russo rewrote the protocol according to recommendations made by the 1997 NIH Consensus Panel on Medical Marijuana. The second rejection complained that the evidence for marijuana’s efficacy was only “anecdotal” — but failed to address how better evidence could be obtained if formal trials are not approved. Only after this second rejection did Russo learn that not a single headache specialist was included on the 20-member review panel.²

Because of these excessively strict federal guidelines for research and the high cost of conducting clinical trials, it is unlikely that the therapeutic-research laws will again distribute marijuana to patients on a meaningful scale. States are generally unwilling to devote their limited resources to the long and potentially fruitless research application process; however, the laws establishing these programs currently remain on the books in 13 states.

California is the only state where medical marijuana research is taking place, thanks to a \$3 million appropriation granted by S.B. 847, which was passed by the California Legislature. S.B. 847, introduced by state Sen. John Vasconcellos (D), created a three-year program for medical research, which started in 2001.

The California Legislature passed a bill in 2003 that continued the research created by S.B. 847. On October 10, 2003, Gov. Gray Davis (D) signed S.B. 295 (also introduced by Sen. Vasconcellos), eliminating the original three-year limit.

As of September 2008, 19 research projects have been approved. Eleven of the studies were completed, and six were discontinued. Three additional studies are either under review or active.

1 Bruce Mirken, “Medical Marijuana: The State of the Research,” *AIDS Treatment News*, no. 257, October 18, 1996.

2 Ethan Russo, “Marijuana for migraine study rejected by NIH, Revisited,” posted on www.maps.org, March 1999.

Appendix K: Medical Necessity Defense

The necessity defense, long recognized in common law, gives defendants the chance to prove in court that their violation of the law was necessary to avert a greater evil. It is often referred to as the “choice of evils defense.”

If allowed in a medical marijuana case, the medical necessity defense may lead to an acquittal, even if the evidence proves that the patient did indeed possess or cultivate marijuana. This defense generally holds that the act committed (marijuana cultivation or possession, in this case) was an emergency measure to avoid imminent harm.

Unlike “exemption from prosecution,” a patient is still arrested and prosecuted for the crime, because a judge and/or jury may decide that the evidence was insufficient to establish medical necessity.

The necessity defense is not allowed as a defense to any and all charges. Typically, courts look to prior court decisions or legislative actions that indicate circumstances where a necessity defense may be applicable. Regarding medical marijuana, for example, a court’s decision on whether to permit the defense may depend on whether the legislature has enacted a law that recognizes marijuana’s medical benefits.

This defense is typically established by decisions in state courts of appeals. Additionally, a state legislature may codify a medical necessity defense into law. Several state medical marijuana laws — including Montana’s and Oregon’s — permit a variation of this defense for unregistered patients whose doctors recommend medical marijuana, in addition to an exemption from prosecution for registered patients.

The first successful use of the medical necessity defense in a marijuana cultivation case led to the 1976 acquittal of Robert Randall, a glaucoma patient in Washington, D.C.

In the Randall case, the court determined that the defense is available if (1) the defendant did not cause the compelling circumstances leading to the violation of the law, (2) a less offensive alternative was not available, and (3) the harm avoided (loss of vision) was more serious than the harm that was caused (such as cultivating marijuana).

It is also possible for a judge to allow an individual to raise a medical necessity defense based on the state having a symbolic medical marijuana law. For example, an Iowa judge ruled (in *Iowa v. Allen Douglas Helmers*) that a medical marijuana user’s probation could not be revoked for using marijuana because the Iowa Legislature has defined marijuana as a Schedule II drug with a “currently accepted medical use.”

There is presently no way for patients to obtain legal prescriptions for marijuana in Iowa, however, because of federal law. Nevertheless, the Iowa judge ruled that the legislature’s recognition of marijuana’s medical value protects Allen Helmers from being sent to prison for a probation violation for using marijuana.

Of note, Iowa moved marijuana into Schedule II in 1979, when it enacted a therapeutic research program. The research program expired in 1981, but marijuana’s schedule remains in place.

A different judge could have ruled that the Iowa Legislature intended for marijuana to be used solely in connection with the research program and, without the program, the medical necessity defense should not be available. In fact, some state courts — in Alabama and Minnesota, for example — have made similar interpretations and have refused to allow this defense.

These cases demonstrate that although it is up to the courts to decide whether to allow the medical necessity defense, the activities of a state legislature may significantly impact this decision.

Some states have statutes that authorize a necessity defense generally and have specified the ele-

ments of proof needed to succeed. But this does not guarantee that the courts will recognize a medical necessity defense for marijuana. It depends on how the courts interpret the legislature's intent. If the defense is not recognized, the case proceeds as if the defendant possessed marijuana for recreational use or distribution. If found guilty, the offender is subject to prison time in most states.

The medical necessity defense is a very limited measure. Though a legislature may codify the defense into law, this is not the best course of action for a state legislature to pursue.

Preferably, a state would have a law that (1) exempts from prosecution qualified patients who cultivate and/or possess medical marijuana, and (2) allows patients to use an affirmative defense if they are arrested and prosecuted anyway. An ideal statute would allow the defense for personal-use cultivation, as well as possession.

MPP has identified only four states whose legislatures have passed bills to establish the medical necessity defense for medical marijuana offenses — Maine, Maryland, Massachusetts, and Ohio. Ultimately, all of these efforts but Maryland's were short-lived, if not unsuccessful.

Maine's legislature passed a bill in 1992, but it was vetoed by the governor. An Ohio bill that included a medical necessity defense provision became law in 1996, only to be repealed a year later. Massachusetts enacted a law in 1996 to allow patients to use the defense, but only if they are "certified to participate" in the state's therapeutic research program. Unfortunately, the state has never opened its research program. As a result, Massachusetts patients are likely to be denied the necessity defense, similar to patients in Alabama and Minnesota, as noted above. Maryland's medical necessity law was enacted in 2003. It does not prevent a conviction. Rather, it can be raised at sentencing to reduce the penalty to a fine of up to \$100.

At the federal level, the U.S. Supreme Court ruled in May 2001 that people who are arrested on federal marijuana distribution charges may not raise a medical necessity defense in federal court to avoid conviction.¹

¹ See Appendix I.

States Where Courts Have Allowed the Medical Necessity Defense in Marijuana Cases	
Florida	<i>Jenks v. Florida</i> , 582 So. 2d 676 (Ct. App. 1st Dist., Fl. 1991)
Florida	<i>Sowell v. State</i> , 738 So. 2d 333 (Ct. App. 1st Dist., Fl. 1998)
Hawaii	<i>State v. Bachman</i> , 595 P. 2d 287 (Haw. 1979)
Idaho	<i>Idaho v. Hastings</i> , 801 P. 2d 563 (Sup. Ct. Idaho 1990)
Iowa	<i>Iowa v. Allen Douglas Helmers</i> (Order No. FECR047575)
Texas	<i>Texas v. Stevens</i> , unpublished (2008) A Potter County jury acquitted an HIV patient charged with possessing four grams of marijuana based on a medical necessity defense.
Vermont	Addison County District Court acquitted Steven Bryant of possession of marijuana in May 2005 based on medical necessity. See: Flowers, John, "Bryant Claims Marijuana Was Medically Necessary," <i>Addison County Independent</i> , May 2, 2005.
Washington	<i>Washington v. Diana</i> , 604 P. 2d 1312 (Ct. App. Wash. 1979)
Washington	<i>Washington v. Cole</i> , 874 P. 2d 878 (Ct. App. Wash. 1994)
District of Columbia	<i>United States v. Randall</i> , 104 Wash. Daily L. Rep. 2249 (D.C. Super. Ct. 1976)

States Where Courts Have Refused to Allow the Medical Necessity Defense in Marijuana Cases		
Alabama	<i>Kauffman v. Alabama</i> , 620 So. 2d 90 (1993)	The state Court of Appeals refused to allow a patient to use the medical necessity defense because the legislature had already expressed its intent by placing marijuana in Schedule I — and by establishing a therapeutic research program, thereby defining the very limited circumstances under which marijuana may be used.
Georgia	<i>Spillers v. Georgia</i> , 245 S.E. 2d 54, 55 (1978)	The state Court of Appeals ruled that the lack of any recognition of marijuana's medical uses by the state legislature precluded the court from allowing the medical necessity defense.
Massachusetts	<i>Massachusetts v. Hutchins</i> , 575 N.E. 2d 741, 742 (1991)	The state Supreme Judicial Court ruled that the societal harm of allowing the medical necessity defense would be greater than the harm done to a patient denied the opportunity to offer the medical necessity defense.
Minnesota	<i>Minnesota v. Hanson</i> , 468 N.W. 2d 77, 78 (1991)	The state Court of Appeals refused to allow a patient to use the medical necessity defense because the legislature had already expressed its intent by placing marijuana in Schedule I — and by establishing a therapeutic research program, thereby defining the very limited circumstances under which marijuana may be used.

Missouri	<i>Missouri v. Cox</i> , 248 S.W.3d 1 (2008)	The state Court of Appeals affirmed a lower court's rejection of a patient's medical necessity defense because the legislature had already expressed its intent by placing marijuana in Schedule 1, even though statute allowed the dispensing of Schedule I substances by certain professionals.
New Jersey	<i>New Jersey v. Tate</i> , 505 A. 2d 941 (1986)	The state Supreme Court ruled that the legislature — by placing marijuana in Schedule I — had already indicated its legislative intent to prohibit the medical use of marijuana. In addition, the court claimed that the criteria of “necessity” could not be met because there were research program options that could have been pursued instead.
South Dakota	<i>South Dakota v. Matthew Ducheneaux</i> , SD 131 (2003)	The state Supreme Court ruled that Mr. Ducheneaux — who was convicted of marijuana possession in 2000 — could not rely on a state necessity defense law that allows illegal conduct when a person is being threatened by unlawful force. The court stated that it would strain the language of the law if it could be used to show that a health problem amounts to unlawful force against a person.
Virginia	<i>Murphy v. Com.</i> 31 Va. App. 70, 521 S.E. 2d 301 Va. App., 1999	The Court of Appeals ruled that the necessity defense was unavailable to a migraine sufferer because the legislature limited the medical use of marijuana (symbolically only) to patients whose doctors prescribe it to relieve cancer or glaucoma.

Appendix L: State Medical Marijuana Legislation Considered (2007 - 2008)

State medical marijuana legislation considered in 2007-2008 *				
State	Bill Number	Intent	Good or Bad	Outcome
Alabama (2007)	HB 206	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana.	G	Died in House Judiciary subcommittee on civil justice.
Alabama (2008)	HB 679	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana	G	Died in the House Judiciary Committee
California (2008)	A.B. 2279	Protect employment rights for medical marijuana patients.	G	Passed Assembly (41-35) and Senate (21-15), governor has not acted as of publication
California (2008)	A.B. 2743	Create a policy of non-assistance to federal medical marijuana raids.	G	Moved to inactive file on Assembly floor; passed two committees but did not receive floor vote.
California (2008)	S.B.1098	Provide amnesty for back taxes for medical marijuana dispensaries from before October 2005	G	Died in the Senate Revenue and Taxation Committee.
California (2008)	SJR 20	Call for a change in federal policies against medical marijuana.	G	Passed Senate floor (24-15); died in Assembly.
Connecticut (2007)	HB 6715	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana.	G	Passed House and Senate, but Gov. M. Jodi Rell (R) vetoed it.
Connecticut (2007)	HB 6328	Prohibit the medical use of "crude marijuana" that has not been tested and approved for such use by the federal Food and Drug Administration.	B	Died in the Joint Committee on Public Health.

State medical marijuana legislation considered in 2007-2008 *				
State	Bill Number	Intent	Good or Bad	Outcome
Hawaii (2007)	SB 905; HB 300	Clarify certain aspects regarding employment, provide better protection to physicians, increase plant/weight limits, make patient application forms available on the web, but double registration fees and fails to improve patient/caregiver ratio after amendment.	G	Passed Senate unanimously but died after assignment to three House committees; died after re-referral to three House committees.
Hawaii (2008)	SB2547; HB2067	Establish a committee that may add other medical conditions to the definition of "debilitating medical condition" for the purpose of medical marijuana use	G	Died in Senate Health Committee; died in House Health, Public Safety and Military Affairs, Judiciary, and Finance committees
Hawaii (2008)	HB2674	Increase the amount of medical marijuana a qualifying patient may possess to the number of marijuana plants capable of being cultivated in a ten-foot-by-ten-foot garden area and 48 ounces of dried usable marijuana	G	Died in House Health and Judiciary committees
Hawaii (2008)	HB2675	Establish task force to examine issues regarding adequate supply, growing facilities, and the inter-island transport of medical marijuana	G	Passed both chambers, governor vetoes, Senate overrides veto, but House does not
Hawaii (2008)	HB2678	Authorize the establishment of a secure growing facility for the production of medical marijuana for not more than 14 qualified patients	G	Died in House Health, Public Safety and Military Affairs, Judiciary, and Finance committees
Hawaii (2008)	HB2673	Afford drug testing protections for public employees holding medical marijuana registration certificates.	G	Died in House Labor and Public Employment, Health, and Judiciary committees

State medical marijuana legislation considered in 2007-2008 *				
State	Bill Number	Intent	Good or Bad	Outcome
Hawaii (2008)	HB2871	Appropriate funds for the University of Hawaii to study the medical efficacy of marijuana	G	Died in House Health, Higher Education, and Judiciary committees
Illinois (2007)	SB 650	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana.	G	Defeated on Senate floor, 22-29.
Illinois (2008-2009)	SB 2865; HB 5938	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana	G	Passed the Senate Public Health Committee 6-4 and is now awaiting a vote on the Senate floor, which must take place by January 13, 2009, per legislative rule; re-referred back to the rules committee
Kansas (2008)	SB 556	Provide affirmative defense to medical marijuana patients holding a recommendation from their physician	G	Died in Senate Health Care Strategies Committee
Maine (2007)	LD 1418	Establish a registry ID card program, create a dispensary system, and increase the amount of marijuana patients are allowed to possess.	G	Joint Committee on Health and Human Services recommended it "Ought Not to Pass;" died without vote on House floor.
Maryland (2007)	HB 1040, SB 757	Remove criminal penalties and threat of arrest for patients who grow, acquire, possess, and use medical marijuana.	G	HB 1040 died in House Judiciary Committee; SB 757 died in Senate Judicial Proceedings Committee.
Massachusetts (2007-2008)	House, No. 2247, Senate, No. 944	Would remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana.	G	Both bills sent to study by committee (died).

State medical marijuana legislation considered in 2007-2008 *				
State	Bill Number	Intent	Good or Bad	Outcome
Michigan (2007-2008)	H.B. 4038	Would remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana.	G	Currently pending in the House Committee on Judiciary.
Minnesota (2007-2008)	H.F. 655, S.F. 345	H.F. 655 and S.F. 345 would remove criminal penalties and threat of arrest for patients and caregivers who acquire, possess, and use medical marijuana. These bills would also establish licensed nonprofit dispensaries to distribute medical marijuana to qualified patients and their caregivers.	G	S.F. 345 passed the Senate in 2007. H.F. 655 passed five House committees, but died because it was not called for a vote on the House floor before the 2008 session ended
Mississippi (2007)	HB 421	Protect seriously ill patients who use marijuana with a doctor's recommendation from arrest, prosecution, and imprisonment.	G	Died in House Judiciary Committee.
Missouri (2007)	HB 1138	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana.	G	Died without committee assignment.
Missouri (2008)	HB 1830	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana	G	Died in the House Crime Prevention and Public Safety Committee
Montana (2007)	H.B. 311	Allow physician assistants and nurse practitioners to recommend marijuana to their patients; protect people who transport marijuana from a registered caregiver to a registered patient; increase the allowable possession quantities for patients and caregivers.	G	Died in House Judiciary Committee.

State medical marijuana legislation considered in 2007-2008 *				
State	Bill Number	Intent	Good or Bad	Outcome
New Hampshire (2007)	HB 774	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana.	G	Defeated on House floor, 186-177.
New Jersey (2008-2009)	S119, A804	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana.	G	S119 is currently in the Senate Health, Human Services and Senior Citizens Committee; A804 is currently in the Assembly Health and Senior Services Committee.
New Mexico (2007)	SB 523	Protect seriously ill patients who use marijuana with a doctor's recommendation from arrest, prosecution, and imprisonment.	G	Passed both chambers, signed by governor, and became effective July 1, 2007.
New York (2007-2008)	A. 4867	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana.	G	In 2007, A. 4867-A passed the Assembly (95-52). In 2008, A. 4867-B passed the Assembly floor (89-52) and died in the Senate.
New York (2007-2008)	S. 6303	Allows patients to use and possess medical marijuana from state-licensed distributors; state must have exclusive control over area where marijuana is grown.	Flawed	Did not receive a vote before adjournment.
New York (2007-2008)	S. 4768	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana.	G	Died in Senate Health Committee.
North Carolina (2008)	H. 2405	Allows the legislature's Legislative Research Commission to study the issue of enacting a medical marijuana law in North Carolina.	G	Died in the House Science and Technology Committee without a vote

State medical marijuana legislation considered in 2007-2008 *				
State	Bill Number	Intent	Good or Bad	Outcome
Ohio (2008)	S.B. 343	Removes criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana	G	Pending in House Judiciary Committee
Oregon (2007)	SB 161	Clarifies patient's responsibility to notify caregiver/grower upon changes in the patient's status and rules regarding grow sites, but makes it harder for patients to renew cards and gives courts the power to revoke cards.	Both	Passed both chambers, signed by governor, became effective on January 1, 2008.
Oregon (2007)	SB 294	Allow workplace discrimination of medical marijuana patients.	B	Died in Senate Business, Transportation and Workforce Development Committee.
Oregon (2007)	SB 423	Prohibit workplace discrimination of medical marijuana patients	G	Died in Senate Commerce Committee.
Oregon (2007)	SB 465; HB 2808	Allow workplace discrimination of medical marijuana patients	B	Passed Senate and died in House Elections, Ethics and Rules committee; died in House Elections, Ethics and Rules Committee.
Oregon (2007)	SB 767	Authorize the Department of Human Services to launch a medical marijuana dispensary program	G	Died in Senate Health and Human Services Committee.
Oregon (2007)	HB 3174	Prohibit use of medical marijuana by law enforcement officer	B	Died in Senate Health and Human Services Committee.
Oregon (2007)	HB 3299	Clarify terms, provide "choice of evils" defense to registered patients, recognize patients registered in other medical marijuana states, require state research on medical marijuana	G	Died in House Judiciary Committee.

State medical marijuana legislation considered in 2007-2008 *				
State	Bill Number	Intent	Good or Bad	Outcome
Rhode Island (2007)	H 6005, S 791	Made permanent the law removing criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana; made relatively minor changes to the law, including doubling the time medical marijuana ID cards are valid	G	Enacted by legislature's override of governor's veto.
Rhode Island	H 7888	Initially to allow for the pharmacy-like distribution of medical marijuana to qualifying patients; modified to create a study commission.	G	Passed House (54-2) and Senate (29-0) as study commission bill, vetoed by governor.
Rhode Island (2008)	S 2693	Allow for the pharmacy-like distribution of medical marijuana to qualifying patients from a compassion center.	G	Passed Senate (29-6), died in House without receiving a vote.
Rhode Island (2008)	S 2687	Provide police with names and addresses of patients and caregivers to monitor them; provide that medical marijuana cannot be smoked in cars or where people would be exposed to secondhand smoke.	B	Died in committee.
South Carolina (2007-2008)	S 220	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana	G	Died in Senate Committee on Medical Affairs

Appendix L: State Medical Marijuana Legislation Considered (2007-2008)

State medical marijuana legislation considered in 2007-2008 *				
State	Bill Number	Intent	Good or Bad	Outcome
Texas (2007)	SB 641; HB 486	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana	G	Died in Senate General Welfare, Health and Human Services Committee; Assigned to House Health and Human Resources Committee, which held a study session in November and heard testimony from patients, physicians, and activists, but no further action was taken and it died.
Texas (2007)	HB 1534	Provide an “affirmative defense” for patients who use medical marijuana	G	Died in House Health Committee.
Vermont (2007)	S.7	Allow medical marijuana to be used for more debilitating conditions; increase number of plants patients and caregivers are allowed to grow and possess; allow doctors from New Hampshire, Massachusetts, and New York to certify their Vermont patients for the registry; and reduce the registry fee.	G	Passed by House and Senate. Gov. Jim Douglas allowed it to become law without his signature.
Washington (2007)	SB 6032	Codifies certain qualifying conditions approved by Washington State Medical Quality Assurance Commission, directs Department of Health to define “sixty-day supply” by July 2008, and opens the discussion of a state-regulated system of delivering medical marijuana to patients.	G	Passed both chambers, signed by governor, and became effective on July 22, 2007.

State medical marijuana legislation considered in 2007-2008 *				
State	Bill Number	Intent	Good or Bad	Outcome
Wisconsin (2007)	Assembly Bill 550	Removes criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana	G	Assigned to Assembly Committee on Health and Healthcare Reform in 2007, carried over to 2008 and died
*In some states that have two-year legislative cycles, bills that are not passed or defeated in the first year can be considered in the second year. In other states with two-year cycles, bills that are not passed or defeated do not carry over to the following year.				

Appendix M: Model Resolution of Support

Resolution to Protect Seriously Ill People from Arrest and Imprisonment for Using Medical Marijuana

Whereas, the National Academy of Sciences' Institute of Medicine concluded, after reviewing relevant scientific literature – including dozens of works documenting marijuana's therapeutic value – that "Nausea, appetite loss, pain, and anxiety are all afflictions of wasting, and all can be mitigated by marijuana" and that "there will likely always be a subpopulation of patients who do not respond well to other medications"¹; and,

whereas, subsequent studies since the 1999 Institute of Medicine report continue to show the therapeutic value of marijuana in treating a wide array of debilitating medical conditions, including relieving medication side effects and thus improving the likelihood that patients will adhere to life-prolonging treatments for HIV/AIDS and hepatitis C and alleviating HIV/AIDS neuropathy, a painful condition for which there are no FDA-approved treatments²; and,

whereas, a scientific survey conducted in 1990 by Harvard University researchers found that 54% of oncologists with an opinion favored the controlled medical availability of marijuana, and 44% had already suggested at least once that a patient obtain marijuana illegally³; and,

whereas, tens of thousands of patients nationwide – people with AIDS, cancer, glaucoma, chronic pain, and multiple sclerosis – have found marijuana in its natural form to be therapeutically beneficial⁴ and are already using it with their doctors' approval; and,

whereas, numerous organizations support allowing medical access to marijuana, including the American Academy of HIV Medicine, the American Anthropological Association, the American Bar Association, the American Nurses Association, the American Public Health Association, the Community HIV/AIDS Mobilization Project (CHAMP), the Episcopal Church,

1 *Marijuana and Medicine: Assessing the Science Base*, Institute of Medicine (Washington: National Academy Press, 1999); Chapter 4, "The Medical Value of Marijuana and Related Substances," lists 198 references in its analysis of marijuana's medical uses.

2 B.C. deJong, et al., "Marijuana Use and its Association With Adherence to Antiretroviral Therapy Among HIV-Infected Persons With Moderate to Severe Nausea," *Journal of Acquired Immune Deficiency Syndromes*, January 1, 2005; D.L. Sylvestre, B.J. Clements, and Y. Malibu, "Cannabis Use Improves Retention and Virological Outcomes in Patients Treated for Hepatitis C," *European Journal of Gastroenterology & Hepatology*, September 2006; D. Abrams, et al., "Cannabis in Painful HIV-Associated Sensory Neuropathy," *Neurology*, February 13, 2007.

3 R. Doblin and M. Kleiman, "Marijuana as Antiemetic Medicine," *Journal of Clinical Oncology* 9 (1991): 1314-1319.

4 The therapeutic value of marijuana is supported by existing research and experience. For example, the following statement appeared in the American Medical Association's "Council on Scientific Affairs Report 10 — Medicinal Marijuana," adopted by the AMA House of Delegates on December 9, 1997:

- "Smoked marijuana was comparable to or more effective than oral THC, and considerably more effective than prochlorperazine or other previous antiemetics in reducing nausea and emesis." (page 10)
- "Anecdotal, survey, and clinical data support the view that smoked marijuana and oral THC provide symptomatic relief in some patients with spasticity associated with multiple sclerosis (MS) or trauma." (page 13)
- "Smoked marijuana may benefit individual patients suffering from intermittent or chronic pain." (page 15)

the Leukemia & Lymphoma Society, the Lymphoma Foundation of America, National Association of People With AIDS, the Presbyterian Church (USA), the Progressive National Baptist Convention, the Union of Reform Judaism, the Unitarian Universalist Association, the United Church of Christ, the United Methodist Church, the state medical societies of New York and Rhode Island, and numerous state nurses associations; and,

whereas, a national CNN/*Time* magazine poll published November 4, 2002, found that 80% of U.S. adults “think adults should be able to use marijuana legally for medical purposes”; and,

whereas, a national Gallup poll released in November 2005 found that 78% of Americans support “making marijuana legally available for doctors to prescribe in order to reduce pain and suffering”; and,

whereas, numerous other national public opinion polls have found substantial support for medical marijuana, including surveys conducted by AARP, ABC News, CBS News, the Family Research Council, and the Gallup Organization since 1997;⁵ and,

whereas, since 1996, medical marijuana initiatives received a majority of votes in the District of Columbia and 10 states – Alaska, Arizona, California, Colorado, Maine, Michigan, Montana, Nevada, Oregon, and Washington state⁶; and,

whereas, since 2000, Hawaii, New Mexico, Rhode Island, and Vermont’s state legislatures have enacted effective medical marijuana laws; and,

whereas, the May 14, 2001, and June 6, 2005, United States Supreme Court rulings on medical marijuana dealt exclusively with federal law and do not affect the ability of individual states to allow patients to grow, possess, and use medical marijuana under state law⁷; and,

whereas, the Ninth U.S. Circuit Court of Appeals, in the case of *Conant v. Walters*, upheld the right of physicians to recommend medical marijuana to patients without federal government interference, and the United States Supreme Court declined to hear the federal government’s appeal of this ruling; and,

whereas, on September 6, 1988, after reviewing all available

5 AARP (72% of Americans aged 45 and older support medical marijuana, November 2005); ABC News/Discovery News (69% support medical marijuana, poll conducted May 27, 1997, by Chilton Research); CBS News (66% of Independent respondents, 64% of Democrat respondents, and 57% of Republican respondents support medical marijuana, poll reported in *The New York Times*, June 15, 1997); Family Research Council (74% support medical marijuana, poll conducted Spring 1997); Gallup (73% support medical marijuana, poll conducted March 19-21, 1999).

6 Alaska, Measure 8, Nov. 1998, received 58% of the vote; Arizona, Proposition 200, Nov. 1996, received 65% of the vote; Arizona, Proposition 300, Nov. 1998, rejected by 57% of the vote (by rejecting Proposition 300, voters upheld the medical marijuana provision in 1996’s Proposition 200); California, Proposition 215, Nov. 1996, received 56% of the vote; Colorado, Amendment 20, Nov. 2000, received 54% of the vote; District of Columbia, Initiative 59, Nov. 1998, received 69% of the vote; Maine, Question 2, Nov. 1999, received 61% of the vote; Michigan, Proposal 1, Nov. 2008, received 63% of the vote; Montana, Initiative 148, Nov. 2004, received 62% of the vote; Nevada, Question 9, Nov. 2000, received 65% of the vote; Oregon, Measure 67, Nov. 1998, received 55% of the vote; Washington, Initiative 692, Nov. 1998, received 59% of the vote.

7 *U.S. v. Oakland Cannabis Buyers’ Cooperative*, No. 00-151; *Gonzales v. Raich*, No. 03-1454.

medical data, the Drug Enforcement Administration's chief administrative law judge, Francis L. Young, declared that marijuana is "one of the safest therapeutically active substances known" and recommended making marijuana available by prescription⁸; and,

whereas, the federal penalty for possessing one marijuana cigarette – even for medical use – is up to one year in prison, and the penalty for growing one plant is up to five years⁹; and,

whereas, the penalties are similar in most states, where medical marijuana users must live in fear of being arrested; and,

whereas, the present federal classification of marijuana¹⁰ and the resulting bureaucratic controls impede additional scientific research into marijuana's therapeutic potential¹¹, thereby making it nearly impossible for the Food and Drug Administration to evaluate and approve marijuana through standard procedural channels; and,

whereas, seriously ill people should not be punished for acting in accordance with the opinion of their physicians in a bona fide attempt to relieve suffering; therefore,

Be it resolved that licensed medical practitioners should not be punished for recommending the medical use of marijuana to seriously ill patients, and seriously ill patients should not be subject to criminal sanctions for using marijuana if the patients' medical practitioners have told them that such use is likely to be beneficial.

8 U.S. Department of Justice, Drug Enforcement Administration. "In The Matter Of Marijuana Rescheduling Petition, Docket No. 86-22, Opinion and Recommended Ruling, Findings of Fact, Conclusions of Law and Decision of Administrative Law Judge," Francis L. Young, Administrative Law Judge, September 6, 1988.

9 Section 844(a) and Section 841(b)(1)(D), respectively, of Title 21, United States Code.

10 Section 812(c) of Title 21, United States Code.

11 The U.S. Department of Health and Human Services (HHS) issued written guidelines for medical marijuana research, effective December 1, 1999. The guidelines drew criticism from a coalition of medical groups, scientists, members of Congress, celebrities, and concerned citizens. The coalition called the guidelines "too cumbersome" and urged their modification in a letter to HHS Secretary Donna Shalala, dated November 29, 1999. Signatories of the letter included 33 members of Congress, former Surgeon General Joycelyn Elders, and hundreds of patients, doctors, and medical organizations. In addition, Drug Enforcement Administration (DEA) Administrative Law Judge Mary Ellen Bittner issued a February 2007 ruling concluding "that there is currently an inadequate supply of marijuana available for research purposes" and recommending that the DEA grant Dr. Lyle Craker a license to cultivate research-grade marijuana, but the DEA has failed to do so.

Appendix N: States That Have the Initiative Process

The initiative process allows citizens to vote on proposed laws, as well as amendments, to the state constitution. There is no national initiative process, but 23 states and the District of Columbia have the initiative process in some form.

Some states allow citizens to propose laws that are placed directly on a ballot for voters to decide. The legislature has no role in this process, known as the “direct initiative process.”

Other states have an “indirect initiative process,” where laws or constitutional amendments proposed by the people must first be submitted to the state legislature. If the legislature fails to approve the law or constitutional amendment, the proposal appears on the ballot for voters to decide. Maine’s medical marijuana law, for example, was enacted via an indirect initiative process; all other state medical marijuana initiatives have been direct.

Colorado’s and Nevada’s medical marijuana initiatives amended their state constitutions, while the medical marijuana initiatives in Alaska, California, Maine, Michigan, Montana, Oregon, and Washington enacted statutory laws. (The initiative that appeared on the ballot in the District of Columbia was also a statutory initiative, but Congress has not yet allowed it to become law.)

The initiative process is not a panacea, however. Twenty-seven states do not have it, which means voters in these states cannot themselves propose and enact medical marijuana laws; rather, they must rely on their elected representatives to enact such laws. Moreover, passing legislation is much more cost-effective than passing ballot initiatives, which can be very expensive endeavors.

In contrast to initiatives, referenda deal with matters not originated by the voters. There are two types of referenda. A popular referendum is the power of the people to refer to the ballot, through a petition, specific legislation that was enacted by the legislature, for the voters’ approval or rejection. A legislative referendum is when a state legislature places a proposed constitutional amendment or statute on the ballot for voter approval or rejection.

There are three states that have a referendum process but not an initiative process — Kentucky, Maryland, and New Mexico. (A listing of the three states with the referendum process is *not* provided in the chart in this section.)

23* States and D.C. Have the Initiative Process				
State	Statutory Law		Constitutional Amendment	
	Direct	Indirect	Direct	Indirect
Alaska	Y	N	N	N
Arizona	Y	N	Y	N
Arkansas	Y	N	Y	N
California	Y	N	Y	N
Colorado	Y	N	Y	N
District of Columbia	Y	N	N	N
Florida	N	N	Y	N
Idaho	Y	N	N	N
Maine	N	Y	N	N
Massachusetts	N	Y	N	Y
Michigan	N	Y	Y	N
Mississippi	N	N	N	Y
Missouri	Y	N	Y	N
Montana	Y	N	Y	N
Nebraska	Y	N	Y	N
Nevada	N	Y	Y	N
North Dakota	Y	N	Y	N
Ohio	N	Y	Y	N
Oklahoma	Y	N	Y	N
Oregon	Y	N	Y	N
South Dakota	Y	N	Y	N
Utah	Y	Y	N	N
Washington	Y	Y	N	N
Wyoming	Y	N	N	N
Y – has the process; N – does not have the process				
* MPP does not consider Illinois to be an initiative state because voters cannot place marijuana-related questions on the ballot. Rather, only initiatives that change the structure or function of government can be placed on the ballot.				

Appendix O: Effective Arguments for Medical Marijuana Advocates

Effective Arguments for Medical Marijuana Advocates

by Bruce Mirken, MPP director of communications

INTRODUCTION

Medical marijuana advocates are frequently confronted with challenging questions and arguments. Media interviews, debates, and correspondence with government officials require meticulous preparation. Reformers' responses to these challenges will significantly affect the future of the medical marijuana movement.

Since its inception in January 1995, the Marijuana Policy Project (MPP) has devoted substantial time and energy to changing the medical marijuana laws. Whether lobbying Congress or state legislatures, campaigning for ballot initiatives, networking with health and medical associations, attending drug warriors' conferences, or talking to reporters, reformers continue to encounter the same questions and arguments.

MPP's responses to these challenges have been developed through experience, advice from colleagues, observations of debates and news coverage, and an extensive review of poll results and publications by prohibitionists and reformers alike.

This paper provides medical marijuana advocates with responses to the 34 most common challenges.

MPP encourages all reform advocates to read this paper. Keep it handy when giving media interviews, writing to elected officials, testifying before legislative committees, or debating the medical marijuana issue. Feel free to copy responses verbatim or to use this paper to prepare materials for other activists. Additions or suggestions should be sent to MPP for inclusion in future editions.

OVERARCHING RESPONSE TO MEDICAL MARIJUANA QUESTIONS AND CHALLENGES

Always stress that the core issue is protecting seriously ill patients from arrest and jail. It is crucial to avoid getting lost in side arguments. Whenever possible, remind your audience that federal and most state laws subject seriously ill patients to arrest and imprisonment for using marijuana. Most of the following responses can be enhanced by ending with the question, "Should seriously ill patients be arrested and sent to prison for using marijuana with their doctors' approval?"

The key issue is not that patients and advocates are trying to make a "new drug" available. Rather, the goal is to protect from arrest and imprisonment the hundreds of thousands of patients who are already using marijuana, as well as the doctors who are recommending such use. Always bring the discussion back to the issue of arrest and imprisonment.

Remember: Patients for whom the standard, legal drugs are not safe or effective are left with two terrible choices: (1) continue to suffer, or (2) obtain marijuana illegally and risk suffering such consequences as:

- an insufficient supply of marijuana due to prohibition-inflated prices or scarcity;
- impure, contaminated, or chemically adulterated marijuana purchased from the criminal market; and
- arrests, fines, court costs, property forfeiture, incarceration, probation, and criminal records.

CHALLENGE #1:

“There is no reliable evidence that marijuana has medical value. Existing evidence is either anecdotal, unscientific, or not replicated.”

Response A: There is abundant scientific evidence that marijuana is a safe, effective medicine for some people. In 1999, the National Academy of Sciences’ Institute of Medicine (IOM) reported, “Nausea, appetite loss, pain, and anxiety are all afflictions of wasting, and all can be mitigated by marijuana.”¹

Since then, extensive new research has confirmed marijuana’s medical benefits. Three University of California studies published since February 2007 have found that marijuana relieved neuropathic pain (pain caused by damage to nerves), a type of pain that commonly afflicts patients with multiple sclerosis, HIV/AIDS, diabetes, and a variety of other conditions, and for which conventional pain drugs are notoriously inadequate — and did so with only minor side effects.^{2,3,4} An observational study reported in the *European Journal of Gastroenterology & Hepatology* found that hepatitis C patients using marijuana had three times the cure rate of those not using marijuana, apparently because marijuana successfully relieved the noxious side effects of anti-hepatitis C drugs, allowing patients to successfully complete treatment.⁵

Response B: On September 6, 1988, after hearing two years of testimony, the Drug Enforcement Administration’s chief administrative law judge, Francis Young, ruled: “Marijuana, in its natural form, is one of the safest therapeutically active substances known ... It would be unreasonable, arbitrary, and capricious for DEA to continue to stand between those sufferers and the benefits of this substance.”⁶ Newer research (see **Response A** above) has confirmed that finding many times over.

Response C: Numerous medical organizations have examined the evidence and concluded that marijuana can be a safe, effective medicine for some patients. These include the American College of Physicians, American Public Health Association, American Nurses Association, and many others (for a full list, see **Challenge #28**). For example, the American College of Physicians has stated, “Evidence not only supports the use of medical marijuana in certain conditions, but also suggests numerous indications for cannabinoids.”⁷

CHALLENGE #2:

“Medical marijuana is unnecessary. We already have drugs that work better than marijuana for the conditions it’s used to treat.”

Response A: That’s not true. For example, neuropathic pain — pain caused by damage to the nerves — often is not helped by existing drugs, but marijuana has been shown to provide effective relief. (See **Challenge #1, Response A**.) This is a type of pain that affects millions of Americans with multiple sclerosis, diabetes, HIV/AIDS, and other illnesses.

Response B: Different people respond differently to different medicines. The most effective drug for one person might not work at all for another person. That is why there are different drugs on the market to treat the same ailment. Treatment decisions should be made in doctors’ offices, not by federal bureaucrats. Doctors need to have numerous substances available in their therapeutic arsenals in order to meet the needs of a variety of patients. That’s why the *Physicians’ Desk Reference* comprises 3,000 pages of prescription drugs, rather than just one drug per symptom.

Response C: Consider all of the over-the-counter pain medications: aspirin, acetaminophen, ibuprofen, etc. We do not just determine which is “best” and then ban all of the rest. Because patients are different, doctors must have the freedom to choose what works best for a particular patient. Why use a double standard for marijuana?

Response D: The 1999 Institute of Medicine report explained:

- “Although some medications are more effective than marijuana for these problems, they are not equally effective in all patients.”⁸
- “[T]here will likely always be a subpopulation of patients who do not respond well to other medications. The combination of cannabinoid drug effects (anxiety reduction, appetite stimulation, nausea reduction, and pain relief) suggests that cannabinoids would be moderately well suited for certain conditions, such as chemotherapy-induced nausea and vomiting and AIDS wasting.”⁹
- “The critical issue is not whether marijuana or cannabinoid drugs might be superior to the new drugs, but whether some group of patients might obtain added or better relief from marijuana or cannabinoid drugs.”¹⁰

CHALLENGE #3:

“Why is marijuana needed when it is already available in pill form?”

Response A: Marijuana is not available in pill form. THC, the component responsible for marijuana’s “high,” is sold as the prescription pill Marinol (with the generic name “dronabinol”). But people who use the pill find that it commonly takes an hour or more to work, while vaporized or smoked marijuana takes effect almost instantaneously. They also find that the dose of THC they have absorbed (in the pill form) is often either too much or too little. Because slow and uneven absorption makes oral dosing of THC so difficult, *The Lancet Neurology* wrote in May 2003, “Oral administration is probably the least satisfactory route for cannabis.”¹¹ In its 2008 position paper on medical marijuana, the American College of Physicians noted, “Oral THC is slow in onset of action but produces more pronounced, and often unfavorable, psychoactive effects than those experienced with smoking.”⁷

Response B: As Mark Kris, M.D., one member of an expert panel convened by the National Institutes of Health in 1997 to review the scientific data on medical marijuana, explained during the group’s discussion on February 20, 1997: “[T]he last thing that [patients] want is a pill when they are already nauseated or are in the act of throwing up.”¹²

Response C: Marijuana contains at least 66 active cannabinoids in addition to THC.¹³ Research has shown that these other compounds contribute significantly to marijuana’s therapeutic effects. For example, cannabidiol (CBD) has been shown to have anti-nausea, anti-anxiety, and anti-inflammatory actions, as well as the ability to protect nerve cells from many kinds of damage.¹⁴ CBD also moderates THC’s effects so patients are less likely to get excessively “high.” Other cannabinoids naturally contained in marijuana have also shown significant therapeutic promise.

Response D: Thousands of patients continue to break the law to obtain marijuana, even though they could legally use the THC pill. Why would they risk arrest and prison to use something that doesn’t work?

CHALLENGE #4:

“Why not isolate the other useful cannabinoids and make them available in a pure, synthetic form?”

Response A: Marijuana contains at least 66 naturally occurring cannabinoids. While spending time and money testing and producing pharmaceutical versions of these chemicals may someday produce useful drugs, it does nothing to help patients now. The Institute of Medicine urged such research in 1999, but added, “In the meantime there are patients with debilitating symptoms for whom smoked marijuana might provide relief.”¹⁵

Response B: Marijuana naturally contains all 66 cannabinoids in a combination that is safe and effective, and which has already given relief to millions of people. Given the current state of research, it will be years before any new cannabinoid drugs reach pharmacy shelves. Why should seriously ill patients have to risk arrest and jail for

years while awaiting new pharmaceuticals which may or may not ever be available?

Response C: If spending time and money isolating the different cannabinoids would help patients, then we support such research. But such research should not be a stall tactic to keep medical marijuana illegal. Patients should be allowed to use a drug they and their doctors know works in the meantime — in many cases, that drug is marijuana.

CHALLENGE #5:

“Why not make THC and other cannabinoids available in inhalers, suppositories, and so forth?”

Response A: If these delivery systems would help patients, then they should be made available. However, the development of these systems should not substitute for the research into marijuana that is necessary for FDA approval of this natural medicine. A safe, effective delivery system for whole marijuana already exists: vaporization (discussed in **Response A to Challenge #27**).

Response B: The availability of such delivery systems should not be used as an excuse to maintain the prohibition of the use of natural marijuana. As long as there are patients and doctors who prefer the natural substance, they should not be criminalized for using or recommending it, no matter what alternatives are available. Doctors and patients should be able to choose the form that’s best for their particular situation.

Response C: [Use **Responses A and B to Challenge #4**. See also **Challenge #6**.]

CHALLENGE #6:

“Doesn’t Sativex, the new marijuana-based spray, make use of the crude plant unnecessary?”

Response A: In fact, Sativex, a liquid extract of natural marijuana, proves that marijuana is a medicine. Sativex is to marijuana as a cup of coffee is to coffee beans. If Sativex is safe and effective, marijuana is safe and effective. But for now, Sativex is legally available only in Canada. The company that makes it, GW Pharmaceuticals, only recently started the process of seeking U.S. approval, which is likely to take years.

Response B: Natural marijuana has significant advantages over Sativex. For one thing, Sativex acts much more slowly than marijuana that is vaporized or smoked. Peak blood levels are reached in one and a half to four hours, as opposed to a matter of minutes with inhalation.¹⁶ Because patients have found that different strains of marijuana provide the best relief for different conditions, Sativex is unlikely to help every patient who benefits (or could benefit) from whole marijuana. It’s simply another form of medical marijuana, and patients and doctors should be able to choose what works best for each individual.

CHALLENGE #7:

“The FDA says that marijuana is not a medicine and that medical marijuana laws subvert the FDA drug approval process.”

Response A: The FDA issued its April 2006 statement without conducting any studies or even reviewing studies done by others, under political pressure from rabidly anti-medical marijuana politicians such as Congressman Mark Souder(R-Ind.). The FDA simply ignored evidence that contradicts federal policy, such as the 1999 Institute of Medicine report. That’s why IOM co-author Dr. John A. Benson told *The New York Times* that the government “loves to ignore our report ... They would rather it never happened.”¹⁷ The FDA statement was immediately denounced by health experts and newspaper editorial boards around the country as being political and unscientific.

Response B: State medical marijuana laws have absolutely nothing to do with the FDA drug approval process. The FDA does not arrest people for using unapproved treatments. The FDA does not bar Americans from growing, using, and possessing a wide variety of medical herbs that it has not approved as prescription drugs, including echinacea, ginseng, St. John’s Wort, and many others. State medical marijuana laws don’t conflict with the FDA in the slightest. They simply protect medical marijuana patients from arrest and jail under state law.

Response C: There is already substantial evidence that marijuana is safe and effective for some patients, including new studies published after the FDA’s statement. (See responses to **Challenge #1.**) However, the federal government has blocked researchers from doing the specific types of studies that would be required for licensing, labeling, and marketing marijuana as a prescription drug. They’ve created a perfect Catch-22: Federal officials say “Marijuana isn’t a medicine because the FDA hasn’t approved it,” while making sure that the studies needed for FDA approval never happen. (See also **Response C** to **Challenge #25.**)

Response D: Marijuana was already on the market (in some two dozen preparations, many marketed by well-known pharmaceutical companies) before the 1938 Food, Drug, and Cosmetics Act was passed, creating the FDA. Under the terms of the Act, marijuana should not be considered a “new” drug, subject to the FDA drug-approval requirements that new drugs must meet. Many older drugs, including aspirin and morphine, were “grandfathered in” under this provision, without ever being submitted for new-drug approval by the FDA.

Response E: Half of current prescriptions have **never** been declared safe and effective by the FDA. Between 40-60% of all drug prescriptions in this country are “off-label” — i.e. for drugs **not** approved by the FDA for the condition they’re being prescribed for. We know much more about marijuana’s safety and efficacy in cancer, AIDS, MS, and many other conditions than we know about most off-label prescriptions.

Response F: The FDA is not infallible. For instance, FDA-approved Vioxx is estimated to have caused between 26,000 and 55,000 needless deaths before it was taken off the market. And David Graham, associate director of the FDA’s Office of Drug Safety, has told Congress that the FDA is “virtually defenseless” against another Vioxx-type disaster. In contrast, 5,000 years of real world experience with marijuana show that it is safe and effective for many patients.

CHALLENGE #8:

“Doesn’t medical marijuana send the wrong message to children?”

Response A: Experience in states with medical marijuana laws shows that they do not increase teen marijuana use. For example, the state-sponsored California Student Survey (CSS) documented that marijuana use by California teens rose markedly until 1996 — the year California’s medical marijuana law, Proposition 215, passed — and then dropped dramatically afterwards — by nearly half in some age groups.¹⁸

State surveys of students in the other medical marijuana states have consistently reported declines in teen marijuana use since those laws were passed.¹⁹

The state of California commissioned an independent study examining the effects of Proposition 215, as part of the 1997-98 CSS. Researchers concluded, “There is no evidence supporting that the passage of Proposition 215 increased marijuana use during this period.”²⁰

Response B: Harsh, uncompassionate laws — like those which criminalize patients for using their medicine — send the wrong message to children. Dishonesty sends the wrong message to children. Arguing that sick people should continue to suffer in order to protect children sends the wrong message to children.

Response C: Children can and should be taught the difference between medicine and drug abuse. There are no substances in the entire *Physicians’ Desk Reference* that children should use for fun. In fact, doctors can

prescribe cocaine, morphine, and methamphetamine. Children are not taught that these drugs are good to use recreationally just because they are used as medicines.

Response D: It is absurd to think that children will want to be as “cool” as a dying cancer patient. If anything, the use of marijuana by seriously ill patients might de-glamorize it for children. The message is, “Marijuana is for sick people.”

CHALLENGE #9:

“It’s dangerous to allow patients to grow marijuana, especially when children might be around. Not only does it expose kids to an illegal drug, it puts them in danger of criminal activity: Patients may sell their marijuana on the illicit market or thieves could break into the home to rob them of it.”

Response A: There are already laws against drug dealing. If someone is selling marijuana to non-patients, they’re breaking the law and subject to arrest. And state and county child protective services agencies already have the power to protect children whose parents are engaged in criminal activity. A medical marijuana law changes none of this.

Response B: What do you think is more dangerous: a bottle of liquid morphine sitting next to a dying patient’s bed (or a bottle of OxyContin in the medicine cabinet), or a marijuana plant growing in the basement? All medicines need to be handled with appropriate care and kept out of easy reach of children. Marijuana is no different.

Response C: Criminals break into homes every day to steal valuable items — jewelry, high-end electronics, and even prescription drugs. We don’t ban possession of these items because the owners might be victims of crime. By your logic, parents shouldn’t be allowed to drive 1995 Honda Civics (the most-stolen vehicle in 2007, according to the National Insurance Crime Bureau).

CHALLENGE #10:

“Marijuana is too dangerous to be used as a medicine. More than 10,000 scientific studies have shown that marijuana is harmful and addictive.”

Response A: A large and growing body of scientific evidence demonstrates that the health risks associated with marijuana are actually relatively minor. The 1999 Institute of Medicine report noted, “[E]xcept for the harms associated with smoking, the adverse effects of marijuana use are within the range of effects tolerated for other medications. “(See **Challenge #26** for a discussion of smoking.)²¹ In 2008, the American College of Physicians agreed, citing marijuana’s “relatively low toxicity.”¹⁷

A government-funded study, conducted by researchers at the Kaiser Permanente HMO, found no association between marijuana use and premature death in otherwise healthy people.²²

Response B: Doctors are allowed to prescribe cocaine, morphine, and methamphetamine. Can anyone say with a straight face that marijuana is more dangerous than these substances?

Response C: All medicines have some negative side effects. For example, Tylenol (acetaminophen) has been estimated to kill nearly 500 Americans per year by causing acute liver failure,²³ while no one has ever died from marijuana poisoning. But no one would seriously suggest banning Tylenol because it’s too dangerous. In contrast, recent medical marijuana studies have found no significant side effects. (See responses to **Challenge #1**.) The question is this: Do the benefits outweigh the risks for an individual patient? Such decisions should be made by doctors and patients, not the criminal justice system. Patients should not be criminalized if their doctors believe that the benefits of using medical marijuana outweigh the risks.

Response D: The “10,000 studies” claim is simply not true. The University of Mississippi Research Institute of Pharmaceutical Sciences maintains a 12,000-citation bibliography on the entire body of marijuana literature. The institute notes: “Many of the studies cited in the bibliography are clinical, but the total number also includes papers on the chemistry and botany of the Cannabis plant, cultivation, epidemiological surveys, legal aspects, eradication studies, detection, storage, economic aspects and a whole spectrum of others that do not mention positive or negative effects ... However, we have never broken down that figure into positive/negative papers, and I would not even venture a guess as to what that number would be.”²⁴ You cannot provide a list of 10,000 negative studies, so please stop making this false statement.

**CHALLENGE #11:
“Isn’t marijuana bad for the immune system?”**

Response A: Scientific studies have not demonstrated any meaningful harm to the immune system from marijuana. The Institute of Medicine reported, “Despite the many claims that marijuana suppresses the human immune system, the health effects of marijuana-induced immunomodulation are still unclear.”²⁵

The IOM also noted, “The short-term immunosuppressive effects [of marijuana] are not well established; if they exist at all, they are probably not great enough to preclude a legitimate medical use.”²⁶

Response B: Extensive research in HIV/AIDS patients — whose immune systems are particularly vulnerable — shows no sign of marijuana-related harm. University of California at San Francisco researcher Donald Abrams, M.D., has studied marijuana and Marinol in AIDS patients taking anti-HIV combination therapy. Not only was there no sign of immune system damage, but the patients gained T-lymphocytes, the critical immune system cells lost in AIDS, and also gained more weight than those taking a placebo. Patients using marijuana also showed greater reductions in the amount of HIV in their bloodstream.²⁷ Long-term studies of HIV/AIDS patients have shown that marijuana use (including social or recreational use) does not worsen the course of their disease. For example, in a six-year study of HIV patients conducted by Harvard University researchers, marijuana users showed no increased risk of developing AIDS-related illness.²⁸ In her book *Nutrition and HIV*, internationally known AIDS specialist Mary Romeyn, M.D., noted, “The early, well-publicized studies on marijuana in the 1970s, which purported to show a negative effect on immune status, used amounts far in excess of what recreational smokers, or wasting patients with prescribed medication, would actually use ... Looking at marijuana medically rather than sociopolitically, this is a good drug for people with HIV.”²⁹

**CHALLENGE #12:
“Marijuana contains over 400 chemicals, including most of the harmful compounds found in tobacco smoke.”**

Response A: Coffee, mother’s milk, broccoli, and most foods also contain hundreds of different chemical compounds. This number doesn’t mean anything. Marijuana is a relatively safe medicine, regardless of the number of chemical compounds found therein.

Response B: [Use **Response A, B, or C** to **Challenge #10.**]

Response C: [Use **Response A, B, or C** to **Challenge #27.**]

**CHALLENGE #13:
“Marijuana’s side effects — for instance, increased blood pressure — negate its effectiveness in fighting glaucoma.”**

Response A: Paul Palmberg, M.D., one member of an expert panel convened by the National Institutes of Health in 1997 to review the scientific data on medical marijuana, explained during the group’s discussion on

February 20, 1997, “I don’t think there’s any doubt about its effectiveness, at least in some people with glaucoma.”³⁰

Response B: The federal government has given marijuana to at least three patients with glaucoma, and it preserved their vision for years after they were expected to go blind.

Response C: So should someone who uses marijuana to treat glaucoma be arrested? Shouldn’t we trust a patient and a doctor to make the right decision regarding that patient’s circumstances?

CHALLENGE #14:

“How exactly do state medical marijuana laws help patients?”

Response: The laws of Alaska, California, Colorado, Hawaii, Maine, Michigan, Montana, Nevada, New Mexico, Oregon, Rhode Island, Vermont, and Washington remove state-level criminal penalties for using, obtaining, or cultivating marijuana strictly for medical purposes. To verify a legitimate medical need, a doctor’s recommendation is required. Doctors may not be punished by the state for making such recommendations.

Maryland’s law, enacted in 2003, provides for reduced penalties for patients who present evidence that their marijuana use was necessary for medical purposes. Unfortunately, Maryland’s law does not protect patients from arrest. (For a detailed analysis of these laws, see MPP’s report at www.mpp.org/statelaw.)

Federal laws still apply to patients. While the federal government does not have the resources to arrest, try, and incarcerate a significant number of small-scale medical marijuana users and growers, the federal government has raided some large-scale medical marijuana distributors in California. However, because 99 out of 100 marijuana arrests are made at the state or local level, state medical marijuana laws give patients 99% protection.

CHALLENGE #15:

“Don’t medical marijuana laws put the states in violation of federal law?”

Response: No. There is no federal law that mandates that states must enforce federal laws against marijuana possession or cultivation. States are free to determine their own penalties — or lack thereof — for drug offenses. State governments cannot directly violate federal law by giving marijuana to patients, but states can refuse to arrest patients who possess or grow their own. The 2005 Supreme Court decision in *Gonzales v. Raich* (discussed in detail under **Challenge #33**) did not overturn state medical marijuana laws or block other states from adopting similar measures.

CHALLENGE #16:

“Aren’t these medical marijuana bills and initiatives full of loopholes?”

Response A: The medical marijuana laws adopted from 1998 on in Alaska, Colorado, Hawaii, Maine, Michigan, Montana, Nevada, New Mexico, Oregon, Rhode Island, Vermont, and Washington were all drafted very carefully to make sure that there are no loopholes, real or imagined. These laws are not at all like the comparatively open-ended law in California (see **Response B**). Read them carefully and you’ll see. Medical marijuana advocates have nothing to gain and everything to lose by wording the initiatives so as to enable recreational marijuana use.

Response B: The first successful medical marijuana initiative, California’s Proposition 215, did contain some vague wording, which has resulted in some reported abuse. However, California courts have issued clarifying rulings, and the state legislature, as well as many cities and counties, has enacted laws and regulations aimed at eliminating ambiguities. In 2008, California Attorney General Jerry Brown issued guidelines that have also helped provide clarity. Despite these concerns, there is broad consensus in California that the law is generally working well and doing what the voters intended — protecting seriously ill medical marijuana patients from the

risk of arrest — and recent polls have shown voter support for the law running at roughly 3-1. Newer medical marijuana laws in other states have been drafted much more precisely, eliminating many of the concerns raised by Proposition 215.

Response C: If the bills and initiatives are not perfect, they are the best attempt to protect patients and physicians from punishment for using or recommending medical marijuana. The real problem is that the federal government's overriding prohibition of medical marijuana leaves state bills and initiatives as the only option to help patients at this point. As soon as federal law changes, this process will no longer be needed.

CHALLENGE #17:

“These bills and initiatives basically legalize marijuana for everyone.”

Response: That is simply not true. A person must have an ailment that a licensed medical doctor believes is best treated with marijuana. The General Accounting Office (the investigative arm of Congress, recently renamed the Government Accountability Office) interviewed officials from 37 law enforcement agencies in four states with medical marijuana laws. A key issue they examined was whether medical marijuana laws had interfered with enforcement of laws regarding non-medical use. According to the GAO's November 2002 report, the majority of these officials “indicated that medical marijuana laws had had little impact on their law enforcement activities.”³¹ In California, the number of marijuana arrests has increased since passage of Prop. 215, totaling over 65,000 in 2004.³² That hardly sounds like legalization, does it?

CHALLENGE #18:

“Didn't these medical marijuana initiatives pass because of well-funded campaigns that hoodwinked the voters?”

Response A: Actually, the public has never needed to be persuaded — much less “hoodwinked” — to support legal protection for medical marijuana patients.

State, local, and national public opinion polls have consistently shown overwhelming public support. A CNN/*Time* magazine national poll, published November 4, 2002, found 80% support for legal access to medical marijuana. During the 1996 campaign for California's Proposition 215, independent polls showed the measure ahead months before any ads ran. Just as important, polling in states that have had medical marijuana laws for years shows support just as high as or — in most cases — higher than when they were on the ballot,³³ so voters clearly don't think they were hoodwinked.

Response B: The medical marijuana initiative drives have actually been low-budget campaigns by modern standards. In California, where statewide campaign expenditures commonly run into the tens of millions of dollars, the Proposition 215 campaign spent slightly more than \$2 million.

In contrast, federal officials, including the last two White House drug czars, have used their offices and budgets to oppose medical marijuana initiatives, campaigning with a virtually unlimited supply of taxpayer dollars. The Office of National Drug Control Policy spends nearly as much money on its anti-drug ads (many of which demonize marijuana) in **two weeks** as Proposition 215 supporters spent during the entire campaign!

CHALLENGE #19:

“This bill/initiative doesn't even require a doctor's ‘prescription,’ just a ‘recommendation’!”

Response A: The federal government prohibits doctors from “prescribing” marijuana for any reason. A prescription is a legal document ordering a pharmacy to release a controlled substance. Currently, the federal government does not allow this for marijuana.

However, there needs to be some way for state criminal justice systems to determine which marijuana users have a legitimate medical need. So state medical marijuana laws require doctors' recommendations. Doctors recommend many things: exercise, rest, chicken soup, vitamins, cranberry juice for bladder infections, and so on. The right of physicians to recommend marijuana when appropriate for a patient's condition has been upheld by the federal courts.

Nothing in these laws requires the courts or law enforcement to simply take it on faith that a person has a legitimate physician's recommendation for marijuana. They can and do ask for documentation. The vast majority of doctors who are willing to write such a recommendation do not do so lightly or casually, but state medical boards do investigate and discipline physicians who fail to follow appropriate standards of care.

Response B: If you would trust a doctor to write a prescription for marijuana, why not trust a doctor to write a professional opinion on his or her letterhead instead? Admit it: You simply do not want patients to use medical marijuana, and you're just nit-picking for an excuse to attack the bill/initiative. What advantage would there be to a prescription instead of a written, signed recommendation on a physician's letterhead? Please explain the big difference in practical terms.

Response C: [Best for a live debate format:] Oh, so you agree that doctors should be allowed to prescribe marijuana?

CHALLENGE #20:

"These bills and initiatives are confusing to law enforcement officials."

Response A: What's so confusing? If a person is growing or using marijuana and has a written recommendation from a physician, do not arrest the patient or caregiver. If the person does not have suitable documentation, either call the person's doctor or arrest the person and let the courts decide.

It should be no more confusing than determining if someone drinking alcohol is underage or on probation, if someone is the legal owner of a piece of property, or if a person is a legal immigrant or not.

Response B: [Use the GAO statement in the response to **Challenge #17**.]

CHALLENGE #21:

"Cannabis buyers' clubs are totally out of control!"

Response A: That's an exaggeration, but to the degree that it's true, it's true only in California, whose medical marijuana law was the first and most loosely worded. The much tighter wording in the other 12 states has effectively prevented such problems.

Response B: Many dispensaries or buyers' clubs in California (the only state whose law currently allows for such entities) have now worked out cooperative arrangements with local law enforcement and public health officials. Former San Francisco District Attorney Terence Hallinan explained:

"Our Department of Public Health has established a system of identification cards that protects patient confidentiality while helping law enforcement identify documented medical marijuana patients. Nonprofit medical marijuana dispensaries have become an important part of this system, providing a safe, quality-controlled supply of medicinal cannabis to seriously ill people and working closely with local law enforcement and public health officials."³⁴

Response C: Many cities have developed or are in the process of developing regulations to ensure that medical marijuana dispensaries operate in a safe, healthful, and law-abiding manner, and California's attorney general recently issued guidelines to assist in that process. State and local officials have the ability to prosecute

dispensary operators who do not obey the law. “Out of control” clubs will be shut down, and the operators will serve serious time in prison. The biggest obstacle to effective local regulation of dispensaries is federal law that irrationally treats anyone providing medical marijuana to a cancer or AIDS patient as a common drug dealer, making no distinction between good guys and bad guys. States and cities will have no trouble effectively regulating dispensaries if the federal government will let them.

Response D: Any problems with dispensaries could be eliminated if Congress passed federal legislation allowing states to create a system whereby medical marijuana is sold through licensed pharmacies. Such a system is already in place in the Netherlands.

CHALLENGE #22:

“Isn’t the medical marijuana issue just a sneaky step toward legalization?”

Response A: How? Exactly how does allowing seriously ill patients to use marijuana lead to the end of the prohibition of marijuana for recreational use? Doctors are allowed to prescribe cocaine and morphine, and these drugs are not even close to becoming legal for recreational use.

Response B: Each law should be judged on its own merits. Should seriously ill patients be subject to arrest and imprisonment for using marijuana with their doctors’ approval?

If not, then support medical marijuana access. Should healthy people be sent to prison for using marijuana for fun? If so, then keep all non-medical uses illegal. There’s no magic tunnel between the two.

Response C: Supporters of medical marijuana include some of the most respected medical and public-health organizations, including the American College of Physicians, American Public Health Association, American Nurses Association, American Academy of HIV Medicine, and the state medical societies of New York, California, and Rhode Island. Do you really think these organizations are part of a conspiracy to legalize drugs?

CHALLENGE #23:

“Are people really arrested for medical marijuana?”

Response A: There were dozens of known medical marijuana users arrested in California in the 1990s, which is what prompted people to launch the medical marijuana initiative there. There have been many other publicized and not-so-publicized cases across the United States. Even after Proposition 215 passed in November 1996, the federal government has continued to raid, arrest, and jail medical marijuana patients and caregivers. (See also **Response B to Challenge #24.**)

Response B: Roughly 17 million marijuana users have been arrested since 1970.³⁵

Unfortunately, the government does not keep track of how many were medical users. However, even if only 1% of those arrestees used marijuana for medical purposes, that is approximately 170,000 patients arrested!

Response C: You insist that patients don’t really get arrested for using medical marijuana. If that is the case, then the bill/initiative doesn’t change anything. Why are you so strongly opposed to it?

Response D: The possibility of arrest is itself a terrible punishment for seriously ill patients. Imagine the stress of knowing that you can be arrested and taken to jail at any moment. Stress and anxiety are proven detriments to health and the immune system. Should patients have to jump out of bed every time they hear a bump in the night, worrying that the police are finally coming to take them away?

CHALLENGE #24:

“Do people really go to prison for medical marijuana offenses?”

Response A: Federal law and the laws of 37 states do not make any exceptions for medical marijuana. Federally, possession of even one joint carries a penalty of up to one year in prison. Cultivation of even one plant is a felony, with a maximum sentence of five years. Most states' laws are in this same ballpark. With no medical necessity defense available, medical marijuana users are treated the same as recreational users. Many are sent to prison.

Response B: There are too many examples to list. Here are just a few: Rancher and Vietnam veteran Larry Rathbun was arrested in December 1999 for cultivating medical marijuana to relieve his degenerative multiple sclerosis. When he was arrested in 1999, he could still walk, which he attributes to the medical use of marijuana. After serving 19 months, Rathbun came out of Montana State Prison confined to a wheelchair. Byron Stamate spent three months in a California jail for growing marijuana for his disabled girlfriend (who killed herself so that she would not have to testify against Byron). Gordon Farrell Ethridge spent 60 days in an Oregon jail for growing marijuana to treat the pain from his terminal cancer. Oklahoman Will Foster served over four years in prison (of an original sentence of 93 years) for growing marijuana for chronic pain. Quadriplegic Jonathan Magbie, who used marijuana to ease the constant pain from the childhood injury that left him paralyzed, died in a Washington, D.C., jail in September 2004 while serving a 10-day sentence for marijuana possession.

Response C: Estimates vary, but all sources agree that there are at minimum tens of thousands of marijuana offenders in prisons and jails at any given time. Even if only 1% of them are medical marijuana users, that is hundreds of patients behind bars right now!

Response D: Even if a patient is not sent to prison, consider the trauma of the arrest. A door kicked in, a house ransacked by police, a patient handcuffed and put into a police car. Perhaps a night or two in jail. Court costs and attorney fees paid by the patient and the taxpayers. Probation — which means urine tests for a couple of years, which means that the patient must go without his or her medical marijuana. Huge fines and possible loss of employment — which hurt the patient's ability to pay insurance, medical bills, rent, food, home-care expenses, and so on. Then there's the stigma of being a "druggie." Doctors might be too afraid to prescribe pain medication to someone whom the system considers a "drug addict." Should any of this happen to seriously ill people for using what they and their doctors believe is a beneficial medicine?

CHALLENGE #25:

“Isn't the government making it easier to do medical marijuana research? Since they are becoming more flexible, shouldn't we wait for that research before we proceed?”

Response A: As a Schedule I drug, marijuana can be researched as a medicine only with federal approval. Until California voters passed Proposition 215 in 1996, federal authorities blocked all efforts to study marijuana's medical benefits. Since then, federal restrictions have been loosened somewhat, and a small number of studies have gone forward, but that happened because the passage of ballot initiatives forced the government to acknowledge the need for research. The federal government remains intensely hostile to medical marijuana, and if the political pressure created by ballot initiatives and legislative proposals subsides, the feds will surely go back to their old, obstructionist ways. The federal government has been supplying medical marijuana to a small group of patients for over 20 years, in what is officially deemed a research program, but has refused to study even its own patients!

Response B: Some studies have indeed been completed, and they've all shown medical marijuana to be safe and effective. More research is always desirable, but we know enough right now to know that there is no justification for arresting patients using medical marijuana under their doctor's care.

Response C: The studies approved by the federal government thus far are small, pilot studies that are providing useful data, but are not large enough to bring about FDA approval of marijuana as a prescription drug.

And all medical marijuana research must be done with marijuana supplied by the National Institute on Drug Abuse. NIDA's product is poor-quality, low-grade marijuana that is likely to show less efficacy and greater side effects than the marijuana available through medical marijuana dispensaries in California and elsewhere — but it remains illegal to use this higher-quality marijuana for research! Scientists and activists have appealed to the Drug Enforcement Administration to allow other sources of marijuana to be used, and in 2007, DEA Administrative Law Judge Mary Ellen Bittner ruled that a proposed University of Massachusetts project to grow and study marijuana for medical purposes should be allowed to proceed. But the DEA does not have to obey Bittner's ruling and has given no indication that it intends to do so. The U.S. government remains the largest single obstacle to medical marijuana research.

CHALLENGE #26:

“Modern medicine no longer uses crude plant products like marijuana, so this would be a return to the dark ages. Aspirin is made from willow bark, but we take it in pill form, not by chewing — or smoking — willow bark. You can't control the dosage of a crude plant product.”

Response A: If you're suggesting that medical marijuana be treated just like willow bark, then you're endorsing our position. Yes, most people prefer their aspirin in pill form, but we don't arrest and jail patients for possession of willow bark. And in this case, there is plenty of evidence that the whole plant works better than the pharmaceutical alternatives now available. (See responses to **Challenges #3** and **4**.)

Response B: Marijuana is so safe that patients can easily find the proper dose themselves with no danger of overdose. As University of Washington researcher Dr. Gregory Carter and colleagues noted in a recent journal article, “THC (and other cannabinoids) has relatively low toxicity and lethal doses in humans have not been described ... It has been estimated that approximately 628 kilograms of cannabis would have to be smoked in 15 minutes to induce a lethal effect.”³⁶

Response C: In his book, *Understanding Marijuana*, State University of New York psychology professor Mitch Earleywine explains, “Smoked marijuana may also have fewer side effects than oral THC and other drugs. Patients can smoke a small amount, notice effects in a few minutes, and alter their dosages to keep adverse reactions to a minimum.”³⁷

Response D: The Canadian government-approved prescribing information for Sativex, the natural marijuana extract now sold by prescription in Canada (discussed in **Challenge #6**), gives patients complete freedom to adjust their dose as needed. The official pamphlet provided to patients specifies: “The dose you require is determined by you. You can determine the dose that best suits you according to the pain relief you experience.”³⁸ Patients using whole marijuana can do just the same — and more easily, because the action of vaporized or smoked marijuana is much faster than Sativex.

CHALLENGE #27:

“How can you call something a medicine when you have to smoke it? Smoke is not a medicine, and marijuana smoke contains more carcinogens than tobacco smoke.”

Response A: Patients don't need to smoke marijuana. Marijuana can be vaporized, eaten, or made into extracts and tinctures. (Such products were sold in pharmacies prior to marijuana prohibition in 1937.) The tars and other unwanted irritants in smoke have nothing to do with marijuana's therapeutically active components, called cannabinoids. Vaporizers are simple devices that give users the fast action of inhaled cannabinoids without most of those unwanted irritants.^{39, 40} Research on vaporizers has proceeded more slowly than it should have because of federal obstructionism, and they cannot be marketed openly because the government considers them

illegal “drug paraphernalia.”

Response B: While heavy marijuana smokers do face some health risks associated with smoke — for example, an increased risk of bronchitis — those risks do not include higher rates of lung cancer. The Institute of Medicine reported, “There is no conclusive evidence that marijuana causes cancer in humans, including cancers usually related to tobacco use.”⁴¹

In a huge study that followed 65,000 California HMO patients for 10 years, tobacco use, as expected, resulted in rates of lung cancer as much as 11 times that of nonsmokers. But marijuana smokers who did not use tobacco actually had a slightly lower rate of lung cancer than nonsmokers.⁴² A major, federally-funded study conducted at UCLA also found no lung cancer risk connected to marijuana smoking — and even suggestions of a “possible protective effect of marijuana” against lung cancer.⁴³

Response C: All medicines have risks and side effects, and part of a physician’s job is to evaluate those risks in relation to the potential benefits for the individual patient. Doctors are allowed to prescribe morphine, cocaine, OxyContin, and methamphetamine. Do you really think marijuana is more dangerous than those drugs?

CHALLENGE #28:

“Medical marijuana is opposed by the American Medical Association, the American Cancer Society, and all other major health and medical organizations.”

Response A: Most of these organizations simply do not have positions in support of medical access to marijuana, but neither do they advocate arresting and jailing patients who use medical marijuana, which is what our current laws do. And many, including both the AMA and ACS, have acknowledged that marijuana contains medically useful components. So effectively, their position is closer to neutrality than to active opposition to medical marijuana. Such large professional associations often avoid taking what they perceive as controversial positions early in the debate, even though many of them have chapters and journals that have endorsed medical marijuana. And a huge number of medical organizations support medical marijuana. (See **Response C** below.)

Response B: As former U.S. Surgeon General Dr. Joycelyn Elders put it in a 2004 newspaper column, “I know of no medical group that believes that jailing sick and dying people is good for them.”⁴⁴

Response C: Numerous health and medical organizations and other prominent associations have favorable medical marijuana positions, including: AIDS Action Council; AIDS Foundation of Chicago; AIDS Project Rhode Island; American Academy of HIV Medicine (AAHIVM); American Anthropological Association; American Association for Social Psychiatry; American Bar Association; American College of Physicians; American Nurses Association; American Public Health Association; Americans for Democratic Action; Associated Medical Schools of New York; Being Alive: People With HIV/AIDS Action Committee (San Diego); California Democratic Council; California Legislative Council for Older Americans; California Nurses Association; California Pharmacists Association; California Society of Addiction Medicine; California-Pacific Annual Conference of the United Methodist Church; Colorado Nurses Association; *Consumer Reports* magazine; Episcopal Church; Gray Panthers; Hawaii Nurses Association; Iowa Democratic Party; Leukemia & Lymphoma Society; Life Extension Foundation; Lymphoma Foundation of America; Medical Society of the State of New York; Medical Student Section of the American Medical Association; National Association of People With AIDS; New Mexico Nurses Association; New York County Medical Society; New York State AIDS Advisory Council; New York State Association of County Health Officials; New York State Hospice and Palliative Care Association; New York State Nurses Association; New York StateWide Senior Action Council, Inc.; Ninth District of the New York State Medical Society (Westchester; Rockland; Orange; Putnam; Dutchess; and Ulster counties); Presbyterian Church (USA); Progressive National Baptist Convention; Project Inform (national HIV/AIDS treatment education

advocacy organization); Rhode Island Medical Society; Rhode Island State Nurses Association; Society for the Study of Social Problems; Test Positive Aware Network (Illinois); Texas Democratic Party; Union of Reform Judaism (formerly Union of American Hebrew Congregations); Unitarian Universalist Association; United Church of Christ; United Methodist Church; United Nurses and Allied Professionals (Rhode Island); Wisconsin Nurses Association; Wisconsin Public Health Association; and numerous other health and medical groups.⁴⁵

Response D: Surveys of physicians also show strong support for medical marijuana. For example, a 2005 national survey of physicians conducted by HCD Research and the Muhlenberg College Institute of Public Opinion found that 73% of doctors supported use of marijuana to treat nausea, pain, and other symptoms associated with AIDS, cancer, and glaucoma. 56% would recommend medical marijuana to patients if permitted by state law, even if it remained illegal under federal law.⁴⁶

CHALLENGE #29:

“Medical marijuana is advocated by the same people who support drug legalization!”

Response A: Many health and medical associations support medical access to marijuana but do not advocate broader reform of the drug laws. (See **Challenge #28, Response C.**) In fact, poll results consistently show that half of the people who support medical marijuana actually oppose the full legalization of marijuana.

Response B: Some organizations believe that nobody, sick or not, should be sent to prison simply for growing or using their own marijuana. Why is it surprising or scandalous that those organizations think that patients should not go to prison? Should those organizations take the position that healthy marijuana users should not go to prison but medical marijuana users should?

Response C: Surely you’re not suggesting that patients should be punished just to spite me for believing that healthy people shouldn’t go to prison for using marijuana.

Response D: [Use Responses B & C to Challenge #22.]

CHALLENGE #30:

“In 1994, the U.S. Court of Appeals overruled DEA Administrative Law Judge Francis Young’s decision, so his ruling is irrelevant.”

Response: The U.S. Court of Appeals simply ruled that the DEA has the authority to ignore the administrative law judge’s ruling— in effect, that the DEA can substitute its own prejudices for the facts established by the administrative law judge’s investigation. This bolsters the argument that medical marijuana laws should be changed by legislation or ballot initiatives. The DEA has proven itself to be completely intransigent, and the courts are willing to allow this tyrannical behavior.

CHALLENGE #31:

“Drug czar John Walters says that drug policy should be based on ‘science, not ideology.’”

Response A: It is Walters who is putting ideology ahead of science. He has no scientific training, yet he calls medical marijuana “absurd” and comparable to “medicinal crack” — ignoring the real experts, including the American College of Physicians, the editor of *The New England Journal of Medicine*, the Institute of Medicine, the American Public Health Association, the American Nurses Association, and literally thousands of other organizations and individuals with real scientific expertise who have found marijuana to have therapeutic value. (See **Response C to Challenge #28** for a more extensive list.)

Response B: What is the “scientific” basis for arresting medical marijuana users? What peer-reviewed research has found that prison is healthier for patients than marijuana? Walters has it backwards: In a free society, the burden of proof should be on the government to prove that marijuana is so worthless and dangerous that patients should be criminalized for using it.

CHALLENGE #32:

“Isn’t marijuana already available for some people?”

Response: Three patients in the United States legally receive marijuana from the federal government. These patients are in an experimental program that was closed to all new applicants in 1992. Thousands of Americans used marijuana through experimental state programs in the late 1970s and early 1980s, but none of these programs are presently operating.

Thirteen states allow qualifying patients to use medical marijuana, but patients there can still be arrested by the federal government.

CHALLENGE #33:

“The Supreme Court ruled that marijuana is not medicine and that states can’t legalize medical marijuana.”

Response A: That is not true. In fact, the majority opinion in the Supreme Court’s June 2005 decision in *Gonzales v. Raich* stated unequivocally that “marijuana does have valid therapeutic purposes.” The ruling did not overturn state medical marijuana laws or prevent states from enacting new ones. It simply preserved the status quo as it has been since California passed Proposition 215 in 1996: States can stop arresting medical marijuana patients under state law, but these laws don’t create immunity from federal prosecution.

Response B: The Supreme Court’s other ruling related to medical marijuana — in a 2001 case involving a California medical marijuana dispensary — also did not overturn state medical marijuana laws. It simply declared that under federal law, those distributing medical marijuana cannot use a “medical necessity” defense in federal court. This extremely narrow ruling did not in any way curb the rights of states to protect patients under state law. Indeed, the U.S. Department of Justice has never even tried to challenge the rights of states to enact such laws. Notably, in both cases the court went out of its way to leave open the possibility that individual patients could successfully present a “medical necessity” claim.

CHALLENGE #34:

“Marijuana use can increase the risk of serious mental illness, including schizophrenia.”

Response: There remains no convincing evidence that marijuana causes psychosis in otherwise healthy individuals. Epidemiological data show no correlation between rates of marijuana use and rates of psychosis or schizophrenia: Countries with high rates of marijuana use don’t have higher rates of these illnesses than countries where marijuana use is rarer, and increased rates of marijuana use in the U.S. and Australia during the 1970s and ‘80s did not lead to increased incidence of schizophrenia. Overall, the evidence suggests that marijuana can precipitate schizophrenia in vulnerable individuals but is unlikely to cause the illness in otherwise normal persons.⁴⁷ As with all medications, the physician needs to consider what is an appropriate medication in light of the individual patient’s situation, and may well suggest avoiding marijuana or cannabinoids in patients with a family or personal history of psychosis. This is the sort of risk/benefit assessment that physicians are trained to make.

OTHER USEFUL SOUND BITES

- Which is worse for seriously ill people: marijuana or prison?
- Saying that the THC pill is medicine but marijuana must stay illegal is like saying, “You can have a vitamin C pill, but we’ll throw you in jail for eating an orange.”
- I’m very concerned about the message that’s sent to children when government officials deny marijuana’s medicinal value. They’re destroying the credibility of drug education.
- The central issue is not research, and it’s not the FDA. The issue is arresting patients.
- How many more studies do we need to determine that seriously ill people should not be arrested for using their medicine?
- Hundreds of thousands of patients are already using medical marijuana. Should they be arrested and sent to prison? If so, then the laws should remain exactly as they are.
- Arrest suffering, not patients.
- As long as we have a war on drugs, let’s remove the sick and wounded from the battlefield.

FOR FURTHER INFORMATION

Please refer reporters and elected officials to MPP for information. MPP will provide further documentation upon request for any of the points made in this paper.

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Appendix P: Partial List of Organizations with Favorable Positions on Medical Marijuana

Definitions

Legal/prescriptive access: This category encompasses the strongest of all favorable medical marijuana positions. Although the exact wording varies, organizations advocating “legal/prescriptive access” assert that marijuana should be legally available upon a doctor’s official approval. Some groups say that marijuana should be “rescheduled” and/or moved into a specified schedule (e.g., Schedule II) of the federal Controlled Substances Act; others say that doctors should be allowed to “prescribe” marijuana or that it should be available “under medical supervision.” These organizations support changing the law so that marijuana would be as available through pharmacies as other tightly controlled prescription drugs, like morphine or cocaine. This category also includes endorsements of specific efforts to remove state-level criminal penalties for medical marijuana use with a doctor’s approval.

Compassionate access: Organizations with positions in this category assert that patients should have the opportunity to apply to the government for special permission to use medical marijuana on a case-by-case basis. Most groups in this category explicitly urge the federal government to reopen the compassionate access program that operated from 1978 until 1992, when it was closed to all new applicants. (Only three patients still receive free marijuana from the federal government.) “Compassionate access” is a fairly strong position, as it acknowledges that at least some patients should be allowed to administer natural, whole marijuana right now. However, access to marijuana would be more restrictive than access to legally available prescription drugs, as patients would have to jump through various bureaucratic hoops to receive special permission.

Research: This category includes positions urging the government to make it easier for scientists to conduct research into the medical efficacy of natural marijuana that can be vaporized or smoked. Many of these groups have recognized that the federal government’s current medical marijuana research guidelines are unnecessarily burdensome. Modifying the guidelines would increase the likelihood that the FDA could eventually approve natural, whole marijuana as a prescription medicine. These groups want patients to be allowed to administer marijuana as research subjects and — if the results are favorable — to eventually qualify marijuana as an FDA-approved prescription drug. Groups listed with “research” positions differ from the White House Office of National Drug Control Policy and numerous other drug war hawks who claim to support research. Such groups are not listed if they (1) oppose research that has a realistic chance of leading to FDA approval of natural marijuana, or (2) actively support the laws that criminalize patients currently using medical marijuana. (At worst, some of the groups listed as supporting research are silent on the issue of criminal penalties — but many, in fact, concurrently endorse legal/prescriptive access and/or compassionate access.)

Appendix P: Partial List of Organizations with Favorable Positions on Medical Marijuana

Partial List of Organizations Favoring Legal/Prescriptive Access to Medical Marijuana							
Name of Group	Date	Legal/Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
AIDS Action Council	12/14/1996; 11/29/1999	✓	✓	✓		prescriptive access (for HIV/AIDS)	resolution; signatory of 1999 letter to U.S. Dept. of Health and Human Services
AIDS Foundation of Chicago	4/30/2007	✓	✓	✓		“New research has shown that medical marijuana can be both helpful and safe for many people living with HIV,” said John Peller, director of state affairs for the AIDS Foundation of Chicago. “A University of California study found that marijuana relieves a type of incapacitating nerve pain that causes great suffering to people debilitated by AIDS, while other research has shown that vaporization allows patients to use medical marijuana without the risks of smoking. It’s time for Illinois to act so that the sick and suffering don’t have to face arrest and jail.”	
AIDS Project Rhode Island	3/24/2004	✓				unanimous vote in favor of 2004 medical marijuana bills; testified in favor of them and the 2005 bills, which became law (H.B. 6052 and S.B. 710)	March 2004 letter
Alaska Nurses Association	9/1998	✓				access under a physician’s supervision	ANA Resolution: September 1998
American Academy of HIV Medicine (AAHIWM)	11/11/2003	✓	✓		✓	“We support state and federal legislation not only to remove criminal penalties associated with medical marijuana, but further to exclude marijuana/cannabis from classification as a Schedule I drug.” other: support incorporating a medical marijuana distribution program into state and local delivery systems of care	letter to New York Assemblyman Richard Gottfried, Chair of the Assembly Health Committee, in support of the New York Assembly medical marijuana bill, A.5796

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Name of Group	Date	Legal/Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
American Anthropological Association	9/2003	✓	✓		✓	"We seek to repeal laws which penalize or prohibit the peaceful, personal, religious, scientific, medical, agricultural, spiritual, artistic, historical, and/or industrial uses of Cannabis, Marijuana, Hemp. We favor laws which permit such beneficial uses."	resolution from 2003 Annual Meeting
American Bar Association	2/1984; 5/4/1998	✓	✓				resolution; letter to U.S. House Judiciary Committee opposing an anti-medical marijuana resolution
American Medical Student Association	3/1993	✓					AMSA House of Delegates Resolution #12
American Nurses Association	6/2003	✓	✓	✓		legal/prescriptive access, compassionate access: "Support the right of patients to have safe access to ... marijuana under appropriate prescriber supervision ... Support the ability of health care providers to discuss and/or recommend the medicinal use of marijuana without the threat of intimidation or penalization." Also supports rescheduling "to exclude marijuana from classification as a Schedule I drug."	ANA House of Delegates resolution
American Preventive Medical Association (now "American Association for Health Freedom")	12/8/1997; 12/2000	✓	✓				"Medicinal Use of Marijuana" policy statement; signatory of 2000 letter to U.S. Dept. of Health and Human Services
American Public Health Association	1995; 12/2000	✓	✓	✓		prescriptive access: "marijuana was wrongfully placed in Schedule I of the Controlled Substances Act"; "greater harm is caused by the legal consequences of its prohibition than possible risks of medicinal use"	position # 9513; Access to Therapeutic Marijuana/Cannabis; signatory of 2000 letter to U.S. Dept. of Health and Human Services

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Name of Group	Date	Legal/Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
Americans for Democratic Action	1/1997; 12/2000	✓	✓	✓			resolution approved at annual meeting, Jan. 19-20, 1997; signatory of 2000 letter to U.S. Dept. of Health and Human Services
Associated Medical Schools of New York	4/14/2004	✓				“supports Assembly Bill A. 5796”	letter to New York Assemblyman Richard Gottfried, chair of the Assembly Health Committee, in support of the New York Assembly medical marijuana bill, A. 5796
Being Alive: People With HIV/AIDS Action Committee (San Diego)	1/3/1996; 1/1997; 12/2000	✓	✓		✓	legal access under a physician's supervision and prescriptive access other: endorsement of a physician's right to discuss marijuana therapy with a patient	letter from executive director supporting the efforts of Californians for Compassionate Use; plaintiff in <i>Conant v. McCaffrey</i> ; signatory of 2000 letter to U.S. Dept. of Health and Human Services
California Academy of Family Physicians	1994; 1996	✓				“Support efforts to expedite access to cannabinoids [sic] for use under the direction of a physician”; endorsed 1996 California Ballot Proposition 215	February 1994 statement adopted by Academy's Congress of Delegates; 1996 endorsement, reported via the Business Wire Service, Oct. 29, 1996
California Democratic Council	8/3/2003	✓	✓			“We call upon our elected officials to ... [r]eform federal laws to allow for the legal cultivation of medical cannabis and its provision in a safe and orderly manner.”	resolution approved at annual meeting

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Name of Group	Date	Legal/ Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
California Legislative Council for Older Americans	12/1/1993; 11/29/1999; 12/2000	✓	✓	✓		prescriptive access: urges rescheduling	adopted at 23rd Annual Action Conference; signatory of 1999 and 2000 letters to U.S. Dept. of Health and Human Services
California Medical Association	1997; 1/11/2000	✓		✓	✓	other: letter opposes federal threats against doctors for discussing risks and benefits of marijuana	March 14, 1997, letter; May 21, 1997, endorsement of CA research bill; <i>amicus curiae</i> brief supporting right to distribute medical marijuana in California (<i>U.S. v. Oakland Cannabis Buyers' Cooperative</i>)
California Nurses Association	9/21/1995; 12/2000	✓	✓			prescriptive access: supported California bill A.B. 1529 to remove penalties for medical use	letter to California Gov. Pete Wilson; signatory of 2000 letter to U.S. Dept. of Health and Human Services
California Pharmacists Association	2/1997; 11/29/1999; 12/2000	✓	✓	✓		prescriptive access: according to Associated Press, the CPA "passed a resolution supporting pharmacy participation in the legal distribution of medical marijuana"	AP Financial News, 5/26/97; signatory of 1999 and 2000 letters to U.S. Dept. of Health and Human Services
California Society of Addiction Medicine	5/1997	✓				prescriptive access: urges rescheduling	<i>California Society of Addiction Medicine News</i> , Spring 1997
California-Pacific Annual Conference of the United Methodist Church	6/1996	✓				prescriptive access: via resolution (also endorsed California 1996 ballot Proposition 215)	Resolution 104 of the California-Pacific Annual Conference of the United Methodist Church, June 12-16, 1996
Colorado Nurses Association	1995	✓				prescriptive access: urges rescheduling	Colorado Nurses Association 1995 Convention Directory and Book of Reports, p. 28

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Name of Group	Date	Legal/Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
Community HIV/AIDS Mobilization Project (CHAMP)	10/ 2007	✓		✓		supports legal/prescriptive access, allowing pharmacy-like distribution, and research, including private production of marijuana for research; "Licensed medical doctors should not be punished for recommending medical use of marijuana to seriously ill people, who should not be subject to criminal sanctions for using marijuana if the patients' physicians have told the patients that such use is likely to be beneficial"	letter from executive director, Julie Davids
Consumer Reports magazine	5/1997	✓				prescriptive access: "Federal laws should be relaxed in favor of states' rights to allow physicians to administer marijuana to their patients on a caring and compassionate basis."	May 1997 <i>Consumer Reports</i> article, "Marijuana as medicine: How strong is the science?" Pp. 62-63
Episcopal Church	1982	✓				"The Episcopal Church urges the adoption by Congress and all states of statutes providing that the use of marijuana be permitted when deemed medically appropriate by duly licensed medical practitioners."	67th Convention of the Episcopal Church (B-004)a
Gray Panthers	12/2000	✓	✓			legal access: "we strongly support ... efforts to reform state and federal law so that patients may use marijuana when their doctors believe it would be beneficial to them"; urges rescheduling	signatory of 2000 letter to U.S. Dept. of Health and Human Services
Hawaii Nurses Association	10/21/1999; 12/2000	✓	✓			"support legislation to remove state level criminal penalties for both bona fide medical marijuana patients and their healthcare providers"	resolution; signatory of 2000 letter to U.S. Dept. of Health and Human Services

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Name of Group	Date	Legal/Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
Illinois Nurses Association	12/2004 4/30/2007	✓	✓	✓	✓	"The Illinois Nurses Association supports the position of the ANA and will be counted among the organizations that support the right of patients to access legally and safely therapeutic cannabis, and the right of providers to prescribe, without recrimination, therapeutic cannabis for their patients."	"Position Paper on Providing Patients Safe Access to Therapeutic Marijuana/Cannabis," December 2004; signatory of 2000 letter to U.S. Dept. of Health and Human Services
International Nurses Society on Addictions	5/1/1995	✓		✓		has since modified its support of prescriptive access	"Position Paper: Access to Therapeutic Cannabis," approved by IntNSA Board of Directors
Iowa Democratic Party	2003	✓				Consumer Protection: "We support legalizing the medical use of marijuana ..."	2003 Party Plank 59
Leukemia & Lymphoma Society	July 2007	✓				"supports legislation to remove criminal and civil sanctions for the doctor-advised, medical use of marijuana by patients with serious physical medical conditions"	resolution approved July 2007
Life Extension Foundation	3/1997; 12/2000	✓	✓				complaint for declaratory judgment and injunctive relief, <i>Pearson and Show v. McCaffrey</i> ; signatory of 2000 letter to U.S. Dept. of Health and Human Services
Lymphoma Foundation of America	1/1997; 11/29/1999	✓	✓	✓		prescriptive access: urges rescheduling	resolution; signatory of 1999 letter to U.S. Dept. of Health and Human Services

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Name of Group	Date	Legal/ Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
Medical Society of the State of New York	5/3/2004	✓				"supports [A. 5796-A, amended medical marijuana legislation in New York] and urges its passage"	letter to New York Assemblyman Richard Gottfried, chair of the Assembly Health Committee, in support of the New York Assembly medical marijuana bill, A. 5796
Michigan Democratic Party	2/27/2007	✓				"licensed medical doctors should not be criminally punished for recommending the medical use of marijuana to seriously ill people, and seriously ill people should not be subject to criminal sanctions for using marijuana if the patient's physician has told the patient that such use is likely to be beneficial"	resolution approved by annual state convention in Detroit, February 2007
Michigan Nurses Association	10/2/2008	✓				"Medical marijuana has proven to be an effective treatment for many patients suffering from illnesses like cancer, HIV/AIDS, multiple sclerosis and other conditions, and that's why the Michigan Nurses Association endorses Proposal 1."	10/2/08 press release, "Michigan Nurses Association endorses medical marijuana ballot proposal"
Minnesota AIDS Project	4/1/2005	✓				"supports the passage of S.F. 1973 and H.F. 2151," MPP's model medical marijuana bill	letter to Minnesota State Sen. Steve Kelley, medical marijuana bill sponsor
Minnesota Nurses Association	2/2002; 2/7/2006	✓				regarding prescriptive access: "Along with our national association and many other state nurses associations, the Minnesota Nurses Association wants to offer our support for the passage of S.F. 1973 and H.F. 2151," MPP's model medical marijuana bill	signatory of letter to President Bush; letter to Minnesota State Sen. Steve Kelley, medical marijuana bill sponsor
Minnesota Public Health Association	2/28/2006	✓				"supports the passage of S.F. 1973 and H.F. 2151," MPP's model medical marijuana bill	letter to Minnesota State Sen. Steve Kelley, medical marijuana bill sponsor
Minnesota Senior Foundation	3/1/2006	✓				"supports the passage of S.F. 1973 and H.F. 2151," MPP's model medical marijuana bill	letter to Minnesota State Sen. Steve Kelley, medical marijuana bill sponsor

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Name of Group	Date	Legal/Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
Multiple Sclerosis California Action Network	1996	✓				prescriptive access: "the decision as to whether or not marijuana constitutes an appropriate treatment is one best left to physician and patient on a case-by-case basis"	Government Issues Action (GIA) Report, page 2, January/February 1996
National Association of People With AIDS	1992; 11/29/1999; 12/2000	✓	✓	✓			signatory of 1999 and 2000 letters to U.S. Dept. of Health and Human Services
<i>The New England Journal of Medicine</i>	1/30/1997	✓	✓			prescriptive access: urges rescheduling "[A] federal policy that prohibits physicians from alleviating suffering by prescribing marijuana for seriously ill patients is misguided, heavy-handed, and inhumane."	Editorial, Dr. Jerome P. Kassirer, Volume 336, Number 5, Jan. 30, 1997
New Jersey State Nurses Association	3/20/1999	✓				"recognizes the therapeutic value and safety of medically recommended marijuana; recognizes the effect of secondhand smoke on those in the immediate therapeutic environment; supports legal access to medically recommended marijuana for patients in New Jersey who are under the care of a licensed health care provider; and urges the Governor of New Jersey and the New Jersey State Legislature to move expeditiously to make medical marijuana legally available to New Jersey residents who can benefit from it"	Resolution Concerning Therapeutic Marijuana, 2002 New Jersey Nursing Convention
New Mexico Nurses Association	7/28/1997; 12/2000	✓	✓			"endorse the concept of allowing for the therapeutic use of marijuana in a variety of disease states ... when conventional treatments are ineffective"	letter to Bryan A. Krumm, RN, BSN; signatory of 2000 letter to U.S. Dept. of Health and Human Services
New York County Medical Society	10/29/2003	✓				"adopt a position of support"	letter to New York Assemblyman Richard Gottfried, chair of the Assembly Health Committee, in support of the New York Assembly medical marijuana bill, A. 5796

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New York State AIDS Advisory Council	12/16/2003	✓				“supports A. 5796, ‘An act to amend the public health law, in relation to medical use of marijuana.’”	letter to New York Assemblyman Richard Gottfried, chair of the Assembly Health Committee, in support of the New York Assembly medical marijuana bill, A. 5796
New York State Association of County Health Officials	6/5/2003	✓	✓			“Marijuana has proven to be effective in the treatment of people with HIV/AIDS, multiple sclerosis, cancer, and those suffering from severe pain or nausea.”	press release in support of the New York Assembly’s medical marijuana bill, A. 5796
New York State Hospice and Palliative Care Association	2003	✓				“supports A. 5796/ S. 4805”	“Memorandum of Support: Medical Use of Marijuana”
New York State Nurses Association	6/29/1995; 11/29/1999; 12/2000; 2/2004	✓	✓	✓			signatory of 1999 and 2000 letters to U.S. Dept. of Health and Human Services; resolution in support of the New York Assembly’s medical marijuana bill, A. 5796
New York State Wide Senior Action Council, Inc.	6/17/2003	✓				supports A. 5796 and S. 4805, to “authorize medical treatment with inhaled marijuana for patients with conditions where other treatments have proven ineffective and marijuana is effective. The bill contains safeguards against diversion of marijuana into illegal use.”	memorandum in support of medical marijuana bills, A. 5796 and S. 4805
Ninth District of the New York State Medical Society (Westchester, Rockland, Orange, Putnam, Dutchess, and Ulster counties)	1/2004	✓				“supports bills in the New York State Legislature to allow the medical use of marijuana”	resolution with the New York County Medical Society 2004
North Carolina Nurses Association	10/15/1996	✓		✓			“Position Statement of Therapeutic Use of Cannabis”

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Name of Group	Date	Legal/Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
Progressive National Baptist Convention	5/2004	✓				"Licensed medical doctors should not be punished for recommending the medical use of marijuana to seriously ill people, and seriously ill people should not be subject to sanctions for using marijuana if the patient's physician has told the patient that such use is likely to be beneficial."	signed statement of principle
Project Inform (national HIV/AIDS treatment education advocacy organization)	6/19/2004	✓				"Licensed medical doctors should not be punished for recommending the medical use of marijuana to seriously ill people, and seriously ill people should not be subject to sanctions for using marijuana if the patient's physician has told the patient that such use is likely to be beneficial."	resolution in support of the Hinchey-Rohrabacher Amendment to the Commerce-State-Justice Appropriations bill in U.S. Congress, which would prevent federal raids on medical marijuana patients and providers who are in compliance with state law
Rhode Island chapter of the Leukemia & Lymphoma Society	2/2008	✓		✓		supports legal/prescriptive access, allowing pharmacy-like distribution, and research, including private production of marijuana for research	Resolution, Medical Marijuana Use and Research
Rhode Island Medical Society	3/15/2004	✓				supports Rhode Island's medical marijuana law (based on MPP's model bill) and testified in favor of it; "[T]he RI Medical Society supports this legislation pertaining to the medical use of marijuana."	letter to Rep. Thomas Slater, March 15, 2004
Rhode Island Office of the Public Defender	4/2008	✓				supports legal/prescriptive access and allowing pharmacy-like distribution, "seriously ill patients whose doctors have told them that the medical use of marijuana is likely to be beneficial should not be arrested for its use and should have safe access to medical marijuana from a non-profit distribution facility"	Resolution signed by executive director John Harriman, "Medical Marijuana Use & Access," 4/2008

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Rhode Island Public Health Association	4/2008	✓				“seriously ill patients whose doctors have told them that the medical use of marijuana is likely to be beneficial should not be arrested for its use and should have safe access to medical marijuana from pharmacy-like non-profit establishments”	“Resolution Supporting Rhode Island’s Medical Marijuana Law And Efforts to Improve Legal Access to Medical Marijuana”		
Rhode Island State Council of Churches	3/2008	✓				“seriously ill patients whose doctors have told them that the medical use of marijuana is likely to be beneficial should not be arrested for its use and should have safe access to medical marijuana from a non-profit Compassion Center”	Resolution, “Medical Marijuana Use & Access”		
Rhode Island State Nurses Association	3/29/2004	✓	✓	✓	✓	“The Rhode Island State Nurses Association is supportive of providing patients safe access to therapeutic Marijuana/Cannabis. Our position is consistent with the American Nurses Association (ANA).”	letter to Tom Angell, March 29, 2004		
San Francisco Medical Society	8/8/1996; 2/1997	✓		✓	✓	“The SFMS takes a support position on the California Medical Marijuana Initiative” (Proposition 215) other: endorsement of a physician’s right to discuss marijuana therapy with a patient	motion passed by SFMS Board of Directors; “Medical Marijuana: A Plea for Science and Compassion,” issued jointly by Gay and Lesbian Medical Association and San Francisco Medical Society		
Senior Agenda Coalition	March 2007	✓		✓		“supports making Rhode Island’s medical marijuana law permanent, so that no seriously ill patient will be subject to criminal or civil sanction under [the] state’s laws for the doctor-advised, medical use of marijuana” and resolved that state-approved medical marijuana patients “should not be subject to federal criminal penalties for such medical use”	director issued resolution, March 2007		

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Name of Group	Date	Legal / Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
Test Positive Aware Network (Illinois)	1/26/2004	✓				endorses legislation "... to protect the right of medical marijuana use for people with AIDS/HIV and other life threatening and long-term chronic health conditions"	letter from Matt Sharp, director of treatment education
Texas Democratic Party	6/2004	✓	✓	✓	✓	"RESOLVED that the Democratic Party supports and/or encourages the following: ... Research in controlled investigational trials ... The right of patients to have safe access to therapeutic marijuana/cannabis under appropriate medical supervision ... The ability of health care providers to discuss and/or recommend the medicinal use of marijuana ... Legislation to remove criminal penalties including arrest and imprisonment for bona fide patients and providers ... Federal and state legislation to exclude marijuana/cannabis from classification as a Schedule I drug ... The education of medical professionals regarding current, evidence-based therapeutic use of marijuana/cannabis."	adopted at 2004 Texas Democratic Convention
Texas League of Women Voters	1/2006	✓				"Laws regarding drug abuse and drug addiction should include no criminal penalties for cannabis (marihuana) possession when recommended by a physician."	position adopted by TLWV state board at January 2006 meeting
Texas Nurses Association	1/2005	✓				"Licensed health care providers should not be punished for recommending the medical use of marijuana to seriously ill people, and seriously ill people should not be subjected to criminal sanctions for using medical marijuana if their health care provider has told the patient that such use is likely to be beneficial."	statement of principle adopted by TNA state board at January 2005 meeting

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Union of Reform Judaism (formerly Union of American Hebrew Congregations)	11/2003; 6/2004	✓	✓	✓		resolves to "support federal legislation and regulation to allow the medicinal use of marijuana ... urge the Food and Drug Administration to expand the scope of allowable Investigational New Drug applications ... call for further medical research ... advocate for the necessary changes in local, state and federal law to permit the medicinal use of marijuana and ensure its accessibility for that purpose"; "Licensed medical doctors should not be punished for recommending the medical use of marijuana to seriously ill people, and seriously ill people should not be subject to sanctions for using marijuana if the patient's physician has told the patient that such use is likely to be beneficial."	resolution adopted at the 67th General Assembly; signed statement of principle
Unitarian Universalist Association	6/22/2002	✓		✓		"Make all drugs legally available with a prescription by a licensed physician, subject to professional oversight. End the practice of punishing an individual for obtaining, possessing, or using an otherwise illegal substance to treat a medical condition."	from "Alternatives to the War on Drugs: Statement of Conscience" resolution, passed by the General Assembly with a two-thirds majority of delegates
United Church of Christ	2002	✓				"We believe that seriously ill people should not be subject to arrest and imprisonment for using medical marijuana with their doctors' approval."	Ministry for Criminal Justice & Human Rights signed on to MPP's Coalition for Compassionate Access in 2002
United Methodist Church	5/2004	✓				"Licensed medical doctors should not be punished for recommending the medical use of marijuana to seriously ill people, and seriously ill people should not be subject to sanctions for using marijuana if the patient's physician has told the patient that such use is likely to be beneficial."	statement of principle signed by United Methodist Church General Board of Church and Society after quadrennial convention

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Name of Group	Date	Legal/Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
United Nurses and Allied Professionals (Rhode Island)	5/2004	✓				sent legislative alerts to its members endorsing MPP's model bills	May 2004 letters to Rhode Island Rep. Thomas Slater and Rhode Island Sen. Rhoda Perry
Veterans for Peace	8/18/2007	✓		✓	✓	“supports legislation that eliminates criminal and civil penalties for the doctor-advised, medical use of marijuana by patients with serious physical medical conditions” and “urges the Veterans Administration and its doctors not to withhold treatments from a patient under their care simply because they test positive for marijuana”	resolution approved at annual meeting, August 2007
Virginia Nurses Association	10/7/1994; 12/2000	✓	✓				resolution; signatory of 2000 letter to U.S. Dept. of Health and Human Services
Wisconsin Nurses Association	10/29/1999; 12/2000	✓	✓			“urges the Governor of Wisconsin and the Wisconsin Legislature to move expeditiously to make cannabis available as a legally prescribed medicine where shown to be safe and effective”	resolution adopted by WNA; one of the 17 organizations that signed letter to former Office of National Drug Control Policy Director Barry McCaffrey
Wisconsin Public Health Association	6/1999	✓				“urges the Governor of Wisconsin and the Wisconsin Legislature to move expeditiously to make cannabis available as a legally prescribed medicine where shown to be safe and effective”	WPHA resolution from its June 1999 meeting
Women of Reform Judaism	12/1999; 12/2000	✓	✓	✓			Health Issues Resolution, adopted at the 1999 Orlando Assembly; signatory of 2000 letter to U.S. Dept. of Health and Human Services

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AIDS National Interfaith Network	2/17/1999		✓				one of 17 organizations that signed letter to former Office of National Drug Control Policy Director Barry McCaffrey
AIDS Project Arizona	2/17/1999		✓				one of 17 organizations that signed letter to former Office of National Drug Control Policy Director Barry McCaffrey
AIDS Project Los Angeles	2/17/1999		✓				one of 17 organizations that signed letter to former Office of National Drug Control Policy Director Barry McCaffrey
AIDS Survival Project (Atlanta)	2/2002		✓				signatory of letter to President Bush
AIDS Treatment Initiatives (Atlanta)	12/2000		✓				signatory of 2000 letter to U.S. Dept. of Health and Human Services
AIDS Treatment News	2/2002		✓				signatory of letter to President Bush
American Civil Liberties Union	2/2002		✓				signatory of letter to President Bush
Bay Area Physicians for Human Rights	1/1997; 12/2000		✓		✓	other: endorsement of a physician's right to discuss marijuana therapy with a patient	plaintiff in <i>Conant v. McCaffrey</i> ; signatory of 2000 letter to U.S. Dept. of Health and Human Services
Boulder County AIDS Project (Colorado)	2/17/1999; 12/2000		✓				one of 17 organizations that signed letter to former Office of National Drug Control Policy Director Barry McCaffrey; signatory of 2000 letter to U.S. Dept. of Health and Human Services
Center for AIDS Services (Oakland)	2/17/1999		✓				one of 17 organizations that signed letter to former Office of National Drug Control Policy Director Barry McCaffrey
Center for Women Policy Studies	2/2002		✓				signatory of letter to President Bush

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Name of Group	Date	Legal/ Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
Colorado AIDS Project	2/17/1999		✓				one of 17 organizations that signed letter to former Office of National Drug Control Policy Director Barry McCaffrey
Commission on Social Action of Reform Judaism	2/2002		✓				signatory of letter to President Bush
Connecticut Peace Coalition/ New Haven	2/2002		✓				signatory of letter to President Bush
Contigo-Commigo	12/2000		✓				signatory of 2000 letter to U.S. Dept. of Health and Human Services
Embrace Life (Santa Cruz)	12/2000		✓				signatory of 2000 letter to U.S. Dept. of Health and Human Services
Florida Medical Association	6/1/1997		✓	✓			resolution #97-61
Gay and Lesbian Medical Association	5/1995; 2/1997; 11/29/1999; 12/2000		✓	✓	✓	other: endorsement of a physician's right to discuss marijuana therapy with a patient	GLMA Policy Statement #066-95-104; "Medical Marijuana: A Plea for Science and Compassion," issued jointly by GLMA and San Francisco Medical Society in 1997; signatory of 1999 and 2000 letters to U.S. Dept. of Health and Human Services
Harm Reduction Coalition	12/2000		✓				signatory of 2000 letter to U.S. Dept. of Health and Human Services
Hepatitis C Action & Advocacy Coalition	1/2001		✓				signatory of letter to President Bush
Institute for Policy Studies, Drug Policy Project	2/2002		✓				signatory of letter to President Bush
Justice Policy Institute	2/2002		✓				signatory of letter to President Bush

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Latino Commission on AIDS	2/17/1999		✓				one of 17 organizations that signed letter to former Office of National Drug Control Policy Director Barry McCaffrey
Libertarian Party	2/2002		✓				signatory of letter to President Bush
Life Foundation	12/2000		✓				signatory of 2000 letter to U.S. Dept. of Health and Human Services
Maine AIDS Alliance	12/2000		✓				signatory of 2000 letter to U.S. Dept. of Health and Human Services
Mississippi Nurses Association	12/2000		✓				signatory of 2000 letter to U.S. Dept. of Health and Human Services
Mobilization Against AIDS (San Francisco)	2/17/1999		✓				one of 17 organizations that signed letter to former Office of National Drug Control Policy Director Barry McCaffrey
Moderation Management	1/2001		✓				signatory of letter to President Bush
Mothers Against Misuse and Abuse	12/2000		✓				signatory of 2000 letter to U.S. Dept. of Health and Human Services
Mothers' Voices to End AIDS	2/17/1999		✓				one of 17 organizations that signed letter to former Office of National Drug Control Policy Director Barry McCaffrey
National Academy of Sciences' Institute of Medicine	3/17/1999		✓	✓			<i>Marijuana and Medicine: Assessing the Science Base</i> ; see www.mppp.org/science.html
National Association for Public Health Policy	11/29/1999; 12/2000		✓	✓			signatory of 1999 and 2000 letters to U.S. Dept. of Health and Human Services
National Black Police Association	11/29/1999; 12/2000		✓	✓			signatory of 1999 and 2000 letters to U.S. Dept. of Health and Human Services

Partial List of Organizations Favoring Compassionate Access to Medical Marijuana

Name of Group	Date	Legal/ Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
National Center on Institutions and Alternatives	2/2002		✓				signatory of letter to President Bush
National Latina/o Lesbian, Gay, Bisexual and Transgender Organization	2/17/1999		✓				one of 17 organizations that signed letter to former Office of National Drug Control Policy Director Barry McCaffrey
National Native American AIDS Prevention Center	2/17/1999		✓				one of 17 organizations that signed letter to former Office of National Drug Control Policy Director Barry McCaffrey
National Women's Health Network	12/2000		✓				signatory of 2000 letter to U.S. Dept. of Health and Human Services
Nebraska AIDS Project	2/2002		✓				signatory of letter to President Bush
New York City AIDS Housing Network	2/2002		✓				signatory of letter to President Bush
Northwest AIDS Foundation (Seattle)	2/17/1999		✓				one of 17 organizations that signed letter to former Office of National Drug Control Policy Director Barry McCaffrey
Okaloosa AIDS Support and Information Services (Ft. Walton Beach, Florida)	12/2000		✓				signatory of 2000 letter to U.S. Dept. of Health and Human Services
People of Color Against AIDS Network (Seattle)	2/17/1999		✓				one of 17 organizations that signed letter to former Office of National Drug Control Policy Director Barry McCaffrey
Physicians for Social Responsibility (Oregon)	2/2002		✓				signatory of letter to President Bush
POZ magazine	2/2002		✓				signatory of letter to President Bush

Appendix P: Partial List of Organizations with Favorable Positions on Medical Marijuana

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Partial List of Organizations Favoring Compassionate Access to Medical Marijuana							
Name of Group	Date	Legal/ Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
Project Safe	1/2001		✓				signatory of letter to President Bush
Public Citizen	12/2000		✓				signatory of 2000 letter to U.S. Dept. of Health and Human Services
Radio Bilingue	2/2002		✓				signatory of letter to President Bush
San Francisco AIDS Foundation	2/17/1999; 12/2000		✓				one of 17 organizations that signed letter to former Office of National Drug Control Policy Director Barry McCaffrey; signatory of 2000 letter to U.S. Dept. of Health and Human Services
The Regas Institute	2/2002		✓				signatory of letter to President Bush
The Village Well: Lesbian, Gay, Bisexual, and Transgender Initiative of the Harlem Community AIDS Center	2/2002		✓				signatory of letter to President Bush
Tri-County AIDS Consortium (Provincetown, MA)	2/2002		✓				signatory of letter to President Bush
Whitman-Walker Clinic (Washington, D.C.)	2/17/1999; 11/29/1999; 12/2000		✓	✓			one of 17 organizations that signed letter to former Office of National Drug Control Policy Director Barry McCaffrey; signatory of 1999 and 2000 letters to U.S. Dept. of Health and Human Services
Wisconsin Nurses Association	12/2000		✓				signatory of 2000 letter to U.S. Dept. of Health and Human Services

Partial List of Organizations Favoring Compassionate Access to Medical Marijuana

Name of Group	Date	Legal/Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
Women and Men Against AIDS (Bronx, NY)	2/17/1999		✓				one of 17 organizations that signed letter to former Office of National Drug Control Policy Director Barry McCaffrey

Partial List of Organizations With Favorable Positions on Research and/or Other Uses of Medical Marijuana

Name of Group	Date	Legal/Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
American Cancer Society	7/24/1997			✓		supported California research bill S.B. 535	letter to California State Sen. John Vasconcellos
American College of Physicians	2/2008			✓	✓	The ACP “urges an evidence-based review of marijuana’s status as a Schedule I controlled substance to determine whether it should be reclassified to a different schedule.” It also “strongly urges protection from criminal or civil penalties for patients who use medical marijuana as permitted under state laws.”	February 2008 position paper, with July 2008 addendum
American Medical Association	12/1997			✓	✓	other: endorsement of a physician’s right to discuss marijuana therapy with a patient	Council on Scientific Affairs Report #10: Medical Marijuana, as amended and passed by AMA House of Delegates
American Psychiatric Association	1998				✓	other: “effective patient care requires the free and unfettered exchange of information on treatment alternatives; discussion of these alternatives between physicians and patients should not subject either party to any criminal penalties”	approved by the APA Board of Trustees in response to federal threats against physicians following the passage of Calif. Prop. 215, reported in <i>Psychiatric News</i> , 9/4/1998
American Society of Addiction Medicine	4/16/1997			✓	✓	other: “Physicians should be free to discuss the risks and benefits of medical use of marijuana, as they are free to discuss any other health-related matters.”	<i>California Society of Addiction Medicine News</i> , Spring 1997

Appendix P: Partial List of Organizations with Favorable Positions on Medical Marijuana

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Partial List of Organizations With Favorable Positions on Research and/or Other Uses of Medical Marijuana							
Name of Group	Date	Legal/Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
British Medical Association	11/18/1997			✓	✓	research to develop cannabinoid pharmaceuticals; other: leniency for medical marijuana-using patients in the meantime (“therapeutic use should not be confused with recreational misuse”)	BMA report: “Therapeutic Uses of Cannabis,” 1997
Congress of Nursing Practice	5/31/1996			✓	✓	other: instructing RNs on medical marijuana	motion passed by CNP
Federation of American Scientists	11/1994			✓			FAS Petition on Medical Marijuana
Human Rights Campaign	1/15/1997			✓			resolution
Kaiser Permanente	1997				✓	other: May/June 1997 edition of their Health Education Services’ “HIV Newsletter” includes marijuana as a treatment option for AIDS wasting syndrome; developed form letter for California and Washington doctors to acknowledge patients’ medical marijuana use	on file
<i>The Lancet Neurology</i>	5/1/03				✓	other: Marijuana can “inhibit pain in virtually every experimental pain paradigm.” Also suggested that marijuana could be “the aspirin of the 21st century.”	“The therapeutic potential of cannabis,” <i>The Lancet Neurology</i> , Vol. 2, No. 5, May 1, 2003
National Multiple Sclerosis Society	7/2008			✓		“Because inhaled smoked cannabis has more favorable pharmacokinetics than administration via oral or other routes, research should focus on the development of an inhaled mode of administration that gives results as close to smoked cannabis as possible. ... There are sufficient data available to suggest that cannabinoids may have neuroprotective effects that studies in this area should be aggressively pursued.”	“Recommendations Regarding the Use of Cannabis in Multiple Sclerosis,” Expert Opinion Paper, July 2008

Partial List of Organizations With Favorable Positions on Research and/or Other Uses of Medical Marijuana

Name of Group	Date	Legal/ Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
Texas Medical Association	5/14/2004			✓	✓	"The Texas Medical Association supports (1) the physician's right to discuss with his/her patients any and all possible treatment options related to the patients' health and clinical care, including the use of marijuana, without the threat to the physician or patient of regulatory, disciplinary, or criminal sanctions; and (2) further well-controlled studies of the use of marijuana with seriously ill patients who may benefit from such alternative treatment."	adopted as association policy at the May 2004 annual convention

Appendix Q: Model Bill

MPP's model medical marijuana legislation can be used in your efforts to lobby your state legislature. The model bill is based on laws that have been passed by voters in nine states and by the Hawaii, New Mexico, Rhode Island, and Vermont legislatures. It incorporates the lessons learned about the laws by patients, their advocates, physicians, lawyers, and government studies of those laws -- including reports by the Vermont Medical Marijuana Study Commission and the U.S. General Accounting Office.

Because 99 percent of all marijuana arrests are made by state and local -- not federal -- officials, this bill can effectively protect 99 out of every 100 medical marijuana users who would otherwise face prosecution at the state level.

Be it enacted by the people of the state of _____:

Section 1. Title.

Sections 1 through 12 of this act shall be known as the _____ Medical Marijuana Act.

Section 2. Findings.

(a) Modern medical research has discovered beneficial uses for marijuana in treating or alleviating the pain, nausea, and other symptoms associated with a variety of debilitating medical conditions, as found by the National Academy of Sciences' Institute of Medicine in March 1999.

(b) Subsequent studies since the 1999 National Academy of Sciences' Institute of Medicine report continue to show the therapeutic value of marijuana in treating a wide array of debilitating medical conditions, including increasing the chances of patients finishing their treatments for HIV/AIDS and hepatitis C.

(c) Data from the Federal Bureau of Investigation's Uniform Crime Reports and the Compendium of Federal Justice Statistics show that approximately 99 out of every 100 marijuana arrests in the U.S. are made under state law, rather than under federal law. Consequently, changing state law will have the practical effect of protecting from arrest the vast majority of seriously ill patients who have a medical need to use marijuana.

(d) Although federal law currently prohibits any use of marijuana except under very limited circumstances, Alaska, California, Colorado, Hawaii, Maine, Michigan, Montana, Nevada, New Mexico, Oregon, Vermont, Rhode Island, and Washington have removed state-level criminal penalties from the medical use and cultivation of marijuana. _____ joins in this effort for the health and welfare of its citizens.

(e) States are not required to enforce federal law or prosecute people for engaging in activities prohibited by federal law. Therefore, compliance with this act does not put the state of _____ in violation of federal law.

(f) State law should make a distinction between the medical

and non-medical uses of marijuana. Hence, the purpose of this act is to protect patients with debilitating medical conditions, as well as their practitioners and providers, from arrest and prosecution, criminal and other penalties, and property forfeiture if such patients engage in the medical use of marijuana.

(g) The people of the state of _____ declare that they enact this act pursuant to the police power to protect the health of its citizens that is reserved to the state of _____ and its people under the 10th Amendment to the United States Constitution.

Section 3. Definitions.

The following terms, as used in this act, shall have the meanings set forth in this section:

(a) "Cardholder" means a qualifying patient, a designated caregiver, or a principal officer, board member, employee, volunteer, or agent of a compassion center who has been issued and possesses a valid registry identification card.

(b) "Compassion center staffer" means a principal officer, board member, employee, volunteer, or agent of a compassion center who has been issued and possesses a valid registry identification card.

(c) "Debilitating medical condition" means one or more of the following:

(1) cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, hepatitis C, amyotrophic lateral sclerosis, Crohn's disease, agitation of Alzheimer's disease, nail patella, or the treatment of these conditions;

(2) a chronic or debilitating disease or medical condition or its treatment that produces one or more of the following: cachexia or wasting syndrome; severe pain; severe nausea; seizures, including but not limited to those characteristic of epilepsy; or severe and persistent muscle spasms, including but not limited to those characteristic of multiple sclerosis; or

(3) any other medical condition or its treatment approved by the department, as provided for in Section 6(a).

(d) "Department" means the _____ Department of Health or its successor agency.

(e) "Designated caregiver" means a person who is at least 21 years of age, who has agreed to assist with a patient's medical use of marijuana, and who has never been convicted of an excluded felony offense. A designated caregiver may assist no more than five qualifying patients with their medical use of marijuana.

(f) "Enclosed, locked facility" means a closet, room, greenhouse, or other enclosed area equipped with locks or other security devices that permit access only by a

cardholder.

(g) "Excluded felony offense" means:

(1) a violent crime defined in Section _____, that was classified as a felony in the jurisdiction where the person was convicted; or

(2) a violation of a state or federal controlled substance law that was classified as a felony in the jurisdiction where the person was convicted. It does not include:

(A) an offense for which the sentence, including any term of probation, incarceration, or supervised release, was completed 10 or more years earlier; or

(B) an offense that consisted of conduct for which this act would likely have prevented a conviction, but the conduct either occurred prior to the enactment of this act or was prosecuted by an authority other than the state of _____

(h) "Marijuana" has the meaning given that term in _____.

(i) "Medical use" means the acquisition, possession, cultivation, manufacture, use, delivery, sale, transfer, or transportation of marijuana or paraphernalia relating to the administration of marijuana to treat or alleviate a registered qualifying patient's debilitating medical condition or symptoms associated with the patient's debilitating medical condition.

(j) "Practitioner" means a person who is licensed with authority to prescribe drugs to humans under Section _____ except that in relation to a visiting qualifying patient, "practitioner" means a person who is licensed with authority to prescribe drugs to humans in the state of the patient's residence.

(k) "Qualifying patient" means a person who has been diagnosed by a practitioner as having a debilitating medical condition.

(l) "Registered compassion center" means a not-for-profit entity registered pursuant to Section 5 that acquires, possesses, cultivates, manufactures, delivers, transfers, transports, supplies, or dispenses marijuana or related supplies and educational materials to cardholders. A registered compassion center may receive compensation for all expenses incurred in its operation.

(m) "Registry identification card" means a document issued by the department that identifies a person as a registered qualifying patient, registered designated caregiver, or a registered principal officer, board member, employee, volunteer, or agent of a registered compassion center.

(n) "Unusable marijuana" means marijuana seeds, stalks, seedlings, and unusable roots. "Seedling" means a marijuana plant that has no flowers and is less than twelve (12) inches in height and less than twelve (12) inches in diameter. A seedling must meet all three (3) criteria set forth above.

(o) "Usable marijuana" means the dried leaves and flowers of the marijuana plant and any mixture or preparation thereof, but does not include the seeds, stalks, and roots of the plant and does not include the weight of any non-marijuana ingredients combined with marijuana and prepared for consumption as food or drink.

(p) "Verification system" means a secure, password-protected, Web-based system that is operational 24 hours each day that law enforcement personnel and compassion center staffers shall use to verify registry identification cards and that shall be established and maintained by the department pursuant to Section 7(h) (4).

(q) "Visiting qualifying patient" means a patient with a debilitating medical condition who is not a resident of _____ or who has been a resident of _____ less than 30 days.

(r) "Written certification" means a document signed by a practitioner, stating that in the practitioner's professional opinion the patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the patient's debilitating medical condition or symptoms associated with the debilitating medical condition. A written certification shall be made only in the course of a bona fide practitioner-patient relationship after the practitioner has completed a full assessment of the qualifying patient's medical history. The written certification shall specify the qualifying patient's debilitating medical condition.

Section 4. Protections for the Medical Use of Marijuana.

(a) A qualifying patient who has been issued and possesses a registry identification card shall not be subject to arrest, prosecution, or penalty in any manner, or denied any right or privilege, including but not limited to civil penalty or disciplinary action by a court or occupational or professional licensing board or bureau, for the medical use of marijuana in accordance with this act, provided that the qualifying patient possess an amount of marijuana that does not exceed 12 marijuana plants and six ounces of usable marijuana. Said plants shall be kept in an enclosed, locked facility, unless they are being transported because the qualifying patient is moving or if they are being transported to the qualifying patient's or designated caregiver's property. This subsection shall not apply to matters and entities that are covered by subsections (f) or (g).

(b) A designated caregiver who has been issued and possesses a registry identification card shall not be subject to arrest, prosecution, or penalty in any manner, or denied any right or privilege, including but not limited to civil penalty or disciplinary action by a court or occupational or professional licensing board or bureau, for assisting a qualifying patient to whom he or she is connected through the department's registration process with the medical use

of marijuana in accordance with this act, provided that the designated caregiver possess an amount of marijuana that does not exceed 12 marijuana plants and six ounces of usable marijuana for each qualifying patient to whom he or she is connected through the department's registration process. Said plants shall be kept in an enclosed, locked facility, unless they are being transported because the designated caregiver is moving or if they are being transported to a designated caregiver's or a qualifying patient's property. This subsection shall not apply to matters and entities that are covered by subsections (f) or (g).

(c) Registered designated caregivers and registered qualifying patients shall be allowed to possess a reasonable amount of unusable marijuana, including up to 12 seedlings, which shall not be counted toward the limits in this section.

(d) (1) There shall be a presumption that a qualifying patient or designated caregiver is engaged in the medical use of marijuana in accordance with this act if the qualifying patient or designated caregiver:

- (A) is in possession of a registry identification card; and
- (B) is in possession of an amount of marijuana that does not exceed the amount allowed under this act.

(2) The presumption may be rebutted by evidence that conduct related to marijuana was not for the purpose of treating or alleviating the qualifying patient's debilitating medical condition or symptoms associated with the debilitating medical condition, in accordance with this act.

(e) A registered qualifying patient or designated primary caregiver shall not be subject to arrest, prosecution, or penalty in any manner, or denied any right or privilege, including but not limited to civil penalty or disciplinary action by a court or occupational or professional licensing board or bureau, for giving marijuana to a registered qualifying patient or a registered designated caregiver for the registered qualifying patient's medical use where nothing of value is transferred in return, or for offering to do the same, provided that the person giving the marijuana does not knowingly cause the recipient to possess more marijuana than is permitted by Section 4.

(f) (1) No school or landlord may refuse to enroll or lease to, or otherwise penalize, a person solely for his or her status as a registered qualifying patient or a registered designated caregiver, unless failing to do so would put the school or landlord in violation of federal law or regulations.

(2) For the purposes of medical care, including organ transplants, a registered qualifying patient's authorized use of marijuana in accordance with this act shall be considered the equivalent of the authorized use of any other medication used at the direction of a physician, and shall not constitute the use of an illicit substance.

(3) Unless a failure to do so would put an employer in violation of federal law or federal regulations, an employer may not discriminate against a person in hiring, termination, or any term or condition of employment, or otherwise penalize a person, if the discrimination is based upon either of the following:

(A) The person's status as a registered qualifying patient or registered designated caregiver; or

(B) A registered qualifying patient's positive drug test for marijuana components or metabolites, unless the patient used, possessed, or was impaired by marijuana on the premises of the place of employment or during the hours of employment.

(g) A person shall not be denied custody of or visitation or parenting time with a minor and there shall be no presumption of neglect or child endangerment for conduct allowed under this act, unless the person's behavior is such that it creates an unreasonable danger to the safety of the minor as established by clear and convincing evidence.

(h) A registered designated caregiver may receive compensation for costs associated with assisting a registered qualifying patient's medical use of marijuana, provided that registered designated caregiver is connected to the registered qualifying patient through the department's registration process. Any such compensation shall not constitute the sale of controlled substances.

(i) A practitioner shall not be subject to arrest, prosecution, or penalty in any manner, or denied any right or privilege, including but not limited to civil penalty or disciplinary action by the _____ Medical Board or by any other occupational or professional licensing board or bureau, solely for providing written certifications or for otherwise stating that, in the practitioner's professional opinion, a patient is likely to receive therapeutic benefit from the medical use of marijuana to treat or alleviate the patient's serious or debilitating medical condition or symptoms associated with the serious or debilitating medical condition, provided that nothing shall prevent a professional licensing board from sanctioning a practitioner for failing to properly evaluate a patient's medical condition or otherwise violating the standard of care for evaluating medical conditions.

(j) A person shall not be subject to arrest, prosecution, or penalty in any manner, or denied any right or privilege, including but not limited to civil penalty or disciplinary action by a court or occupational or professional licensing board or bureau, for providing a registered qualifying patient or a registered designated caregiver with marijuana paraphernalia for purposes of a qualifying patient's medical use of marijuana.

(k) Any marijuana, marijuana paraphernalia, licit property, or interest in licit property that is possessed, owned, or used in connection with the medical use of marijuana as

allowed under this act, or acts incidental to such use, shall not be seized or forfeited. This act shall not prevent the seizure or forfeiture of marijuana exceeding the amounts allowed under this act.

(l) A person shall not be subject to arrest, prosecution, or penalty in any manner, or denied any right or privilege, including but not limited to civil penalty or disciplinary action by a court or occupational or professional licensing board or bureau, simply for being in the presence or vicinity of the medical use of marijuana as allowed under this act, or for assisting a registered qualifying patient with using or administering marijuana.

(m) A registry identification card, or its equivalent, that is issued under the laws of another state, district, territory, commonwealth, or insular possession of the United States that allows, in the jurisdiction of issuance, a visiting qualifying patient to possess marijuana for medical purposes, shall have the same force and effect as a registry identification card issued by the department.

Section 5. Compassion Centers.

(a) Registration requirements.

The following provisions govern the registration of compassion centers.

(1) The department shall register a compassion center and issue a registration certificate, with a random 20-digit alphanumeric identification number, within 90 days of receiving an application for a compassion center, provided that the following conditions are met:

(A) The prospective compassion center provided the following, in accordance with the department's regulations:

(i) An application or renewal fee;

(ii) The legal name of the compassion center;

(iii) The physical address of the compassion center and the physical address of one additional location, if any, where marijuana will be cultivated, neither of which may be within 500 feet of a preexisting public or private school;

(iv) The name, address, and date of birth of each principal officer and board member of the compassion center;

(v) The name, address, and date of birth of any person who is an agent of or employed by the compassion center;

(vi) Operating regulations that include procedures for the oversight of the compassion center and procedures to ensure accurate record-keeping and security measures, that are in accordance with the regulations issued by the department under Section 6(c); and

(vii) If the city or county in which the compassion center would be located has enacted reasonable zoning restrictions, a sworn and truthful statement that the registered

compassion center would be in compliance with those restrictions; and

(B) Issuing the compassion center a registration would not be in violation of a reasonable limitation on the number of registered compassion centers that can operate in the jurisdiction in which it would operate; and

(C) None of the principal officers or board members has been convicted of an offense that was classified as a felony in the jurisdiction where the person was convicted, unless the offense consisted of conduct for which this act would likely have prevented a conviction, but the conduct either occurred prior to the enactment of this act or was prosecuted by an authority other than the state of _____ ; and

(D) None of the prospective principal officers or board members has served as a principal officer or board member for a registered compassion center that has had its registration certificate revoked; and

(E) None of the principal officers or board members is younger than 21 years of age.

(2) Except as provided in Section 5(a)(3), the department shall issue each compassion center staffer a registry identification card and log-in information for the verification system within 10 days of receipt of the person's name, address, date of birth, and a fee in an amount established by the department. Each card shall specify that the cardholder is a principal officer, board member, agent, volunteer, or employee of a registered compassion center and shall contain the following:

(A) the name, address, and date of birth of the compassion center staffer;

(B) the legal name of the registered compassion center with which the compassion center staffer is affiliated;

(C) a random 20-digit alphanumeric identification number that is unique to the cardholder;

(D) the date of issuance and expiration date of the registry identification card;

(E) a photograph, if the department decides to require one; and

(F) a statement signed by the prospective principal officer, board member, agent, volunteer, or employee pledging not to divert marijuana to anyone who is not allowed to possess marijuana pursuant to this act.

(3) (A) The department shall not issue a registry identification card to any compassion center staffer who has been convicted of an offense that was classified as a felony in the jurisdiction where the person was convicted, unless the offense consisted of conduct for which this act would likely have prevented a conviction, but the conduct either occurred prior to the enactment of this act or was prosecuted by an authority other than the state of _____ . The department may conduct a background check

of each compassion center staffer in order to carry out this provision. The department shall notify the registered compassion center in writing of the reason for denying the registry identification card.

(B) The department shall not issue a registry identification card to any principal officer, board member, agent, volunteer, or employee of a registered compassion center who is younger than 21 years of age.

(C) The department may refuse to issue a registry identification card to a compassion center staffer who has had a card revoked for violating this act.

(b) Expiration.

(1) A registered compassion center's registration certificate and the registry identification card for each compassion center staffer shall expire one year after the date of issuance. The department shall issue a renewal compassion center registration certificate within 10 days to any registered compassion center that submits a renewal fee, provided that its registration is not suspended and has not been revoked. The department shall issue a renewal registry identification card within 10 days to any compassion center staffer who submits a renewal fee, except as provided by Section 5(a)(3).

(2) A registry identification card of a compassion center staffer shall expire and the person's log-in information to the verification system shall be deactivated upon notification by a registered compassion center that such person ceases to work at the registered compassion center.

(c) Inspection. Registered compassion centers are subject to reasonable inspection by the department. The department shall give at least 24 hours notice of an inspection under this paragraph.

(d) Registered compassion center requirements.

(1) A registered compassion center may not be located within 500 feet of the property line of a preexisting public or private school.

(2) A registered compassion center shall be operated on a not-for-profit basis for the mutual benefit of its members and patrons. The by-laws of a registered compassion center or its contracts with patrons shall contain such provisions relative to the disposition of revenues and receipts as may be necessary and appropriate to establish and maintain its nonprofit character. A registered compassion center need not be recognized as tax-exempt by the Internal Revenue Service and is not required to incorporate pursuant to ____.

(3) A registered compassion center shall notify the department within 10 days of when a compassion center staffer ceases to work at the registered compassion center.

(4) A registered compassion center shall notify the department in writing of the name, address, and date of birth of any new compassion center staffer and shall submit

a fee in an amount established by the department for a new registry identification card before a new compassion center staffer begins working at the registered compassion center.

(5) A registered compassion center shall implement appropriate security measures to deter and prevent unauthorized entrance into areas containing marijuana and the theft of marijuana.

(6) The operating documents of a registered compassion center shall include procedures for the oversight of the registered compassion center and procedures to ensure accurate recordkeeping.

(7) A registered compassion center is prohibited from acquiring, possessing, cultivating, manufacturing, delivering, transferring, transporting, supplying, or dispensing marijuana for any purpose except to assist registered qualifying patients with the medical use of marijuana directly or through the qualifying patients' designated caregivers.

(8) All principal officers and board members of a registered compassion center must be residents of the state of _____.

(9) All cultivation of marijuana must take place in an enclosed, locked facility, which can only be accessed by principal officers, board members, agents, volunteers, or employees of the registered compassion center who are cardholders.

(10) County and city governments may enact reasonable limits on the number of registered compassion centers that can operate in their jurisdictions, and may enact zoning regulations that reasonably limit registered compassion centers to certain areas of their jurisdictions.

(e) Dispensing restrictions.

(1) Before marijuana may be dispensed to a designated caregiver or a registered qualifying patient, a compassion center staffer must look up the registered qualifying patient for whom the marijuana is intended, and the designated caregiver transporting the marijuana to the patient, if any, in the verification system and must verify each of the following:

(A) that the registry identification card presented to the registered compassion center is valid;

(B) that the person presenting the card is the person identified on the registry identification card presented to the compassion center staffer; and

(C) that the amount to be dispensed would not cause the registered qualifying patient to exceed his or her limit of obtaining six ounces of marijuana during any 30-day period.

(2) After verifying the information in subsection (e)(1), but before dispensing marijuana to a registered qualifying patient or a registered designated caregiver on a registered qualifying patient's behalf, a compassion center staffer must make an entry in the verification system, specifying

how much marijuana is being dispensed to the registered qualifying patient and whether it was dispensed directly to the registered qualifying patient or to the registered qualifying patient's registered designated caregiver. The entry must include the date and time the marijuana was dispensed.

(f) Immunity.

(1) A registered compassion center shall not be subject to prosecution; search, except by the department pursuant to Section 5(c); seizure; or penalty in any manner or be denied any right or privilege, including but not limited to civil penalty or disciplinary action by a court or business licensing board or entity, solely for acting in accordance with this act and department regulations to acquire, possess, cultivate, manufacture, deliver, transfer, transport, supply, or dispense marijuana or related supplies and educational materials to registered qualifying patients, to registered designated caregivers on behalf of registered qualifying patients, or to other registered compassion centers.

(2) No compassion center staffers shall be subject to arrest, prosecution, search, seizure, or penalty in any manner or denied any right or privilege, including but not limited to civil penalty or disciplinary action by a court or occupational or professional licensing board or entity, solely for working for a registered compassion center in accordance with this act and department regulations to acquire, possess, cultivate, manufacture, deliver, transfer, transport, supply, or dispense marijuana or related supplies and educational materials to registered qualifying patients, to registered designated caregivers on behalf of registered qualifying patients, or to other registered compassion centers.

(g) Prohibitions.

(1) A registered qualifying patient shall not directly, or through his or her designated caregiver, obtain more than six ounces of marijuana from registered compassion centers in any 30-day period.

(2) A registered compassion center may not dispense, deliver, or otherwise transfer marijuana to a person other than another registered compassion center, a registered qualifying patient, or a registered qualifying patient's registered designated caregiver.

(3) A registered compassion center may not obtain marijuana from outside the state of _____.

(4) Except as provided in Section 5(a)(3), no person who has been convicted of an offense that was classified as a felony in the jurisdiction where the person was convicted may be a compassion center staffer. A person who works as an agent, volunteer, employee, principal officer, or board member of a registered compassion center in violation of this section is subject to a civil violation punishable by a penalty of up

to \$1,000. A subsequent violation of this section is a gross misdemeanor.

(5) A registered compassion center may not acquire usable marijuana or mature marijuana plants from any person other than another registered compassion center, a registered qualifying patient, or a registered designated caregiver. A registered compassion center is only allowed to acquire usable marijuana or marijuana plants from a registered qualifying patient or a registered designated caregiver if the registered qualifying patient or registered designated caregiver receives no compensation for the marijuana.

(6) A person who violates paragraph (2) or (5) of this subsection may not be a compassion center staffer, and such person's registry identification card shall be immediately revoked. The department may suspend or revoke a compassion center staffer's registry identification card for violating this act.

(7) A registered compassion center that violates paragraph (2) or (5) of this subsection shall immediately have its registration revoked, and its board members and principal officers may not serve as the board members or principal officers for any other registered compassion centers.

Section 6. Department to Issue Regulations.

(a) Not later than 120 days after the effective date of this act, the department shall promulgate regulations governing the manner in which the department shall consider petitions from the public to add debilitating medical conditions or treatments to the list of debilitating medical conditions set forth in Section 3(c) of this act. In considering such petitions, the department shall include public notice of, and an opportunity to comment in a public hearing upon, the petitions. The department shall, after hearing, approve or deny a petition within 180 days of its submission. The approval or denial of a petition is a final department action, subject to judicial review. Jurisdiction and venue for judicial review are vested in the _____ Court.

(b) Not later than 120 days after the effective date of this act, the department shall promulgate regulations governing the manner in which it shall consider applications for and renewals of registry identification cards.

(c) (1) Not later than 120 days after the effective date of this act, the department shall promulgate regulations governing the manner in which it shall consider applications for and renewals of registration certificates for registered compassion centers, including reasonable rules governing:

(A) The form and content of registration and renewal applications;

(B) Minimum oversight requirements for registered compassion centers;

(C) Minimum recordkeeping requirements for registered

compassion centers;

(D) Minimum security requirements for registered compassion centers, which shall include that each registered compassion center location must be protected by a fully operational security alarm system; and

(E) Procedures for suspending or terminating the registration of registered compassion centers that violate the provisions of this act or the regulations promulgated pursuant to this section.

(2) The department shall design rules with the goal of protecting against diversion and theft, without imposing an undue burden on the registered compassion centers or compromising the confidentiality of registered qualifying patients and their registered designated caregivers. Any dispensing records that a registered compassion center is required to keep shall track transactions according to registered qualifying patients', registered designated caregivers', and registered compassion centers' registry identification numbers, rather than their names, to protect their confidentiality.

(d) Not later than 120 days after the effective date of this act, the department shall issue regulations establishing application and renewal fees for registry identification cards and registered compassion center registration certificates. The fees shall be in accordance with the following parameters:

(1) the total fees collected must generate revenues sufficient to offset all expenses of implementing and administering this act;

(2) compassion center application fees may not exceed \$5,000;

(3) compassion center renewal fees may not exceed \$1,000;

(4) the total revenue from compassion center application and renewal fees and registry identification card fees for compassion center staffers must be sufficient to offset all expenses of implementing and administering the compassion center aspects of this act, including the verification system;

(5) the department may establish a sliding scale of patient application and renewal fees based upon a qualifying patient's family income; and

(6) the department may accept donations from private sources in order to reduce the application and renewal fees.

Section 7. Administering the Department's Regulations.

(a) The department shall issue registry identification cards to qualifying patients who submit the following, in accordance with the department's regulations:

(1) written certification;

(2) application or renewal fee;

(3) name, address, and date of birth of the qualifying patient, except that if the applicant is homeless, no address is required;

(4) name, address, and telephone number of the qualifying patient's practitioner; and

(5) name, address, and date of birth of the designated caregiver designated, if any, by the qualifying patient;

(6) a statement signed by the qualifying patient, pledging not to divert marijuana to anyone who is not allowed to possess marijuana pursuant to this act; and

(7) a signed statement from the designated caregiver, if any, agreeing to be designated as the patient's designated caregiver and pledging not to divert marijuana to anyone who is not allowed to possess marijuana pursuant to this act.

(b) The department shall not issue a registry identification card to a qualifying patient who is younger than 18 years of age unless:

(1) The qualifying patient's practitioner has explained the potential risks and benefits of the medical use of marijuana to the custodial parent or legal guardian with responsibility for health care decisions for the qualifying patient; and

(2) The custodial parent or legal guardian with responsibility for health care decisions for the qualifying patient consents in writing to:

(A) allow the qualifying patient's medical use of marijuana;

(B) serve as the qualifying patient's designated caregiver; and

(C) control the acquisition of the marijuana, the dosage, and the frequency of the medical use of marijuana by the qualifying patient.

(c) The department shall verify the information contained in an application or renewal submitted pursuant to this section, and shall approve or deny an application or renewal within 15 days of receiving it. The department may deny an application or renewal only if the applicant did not provide the information required pursuant to this section, the applicant previously had a registry identification card revoked for violating this act, or if the department determines that the information provided was falsified. Rejection of an application or renewal is considered a final department action, subject to judicial review. Jurisdiction and venue for judicial review are vested in the ____ Court.

(d) The department shall issue a registry identification card to the designated caregiver, if any, who is named in a qualifying patient's approved application, up to a maximum of one designated caregiver per qualifying patient, provided that the designated caregiver meets the requirements of Section 3(e). The department shall notify the qualifying patient who has designated someone to serve as his or her designated caregiver if a registry identification card

will not be issued to the designated person. A designated caregiver shall be issued a registry identification card each time the designated caregiver is designated by a qualifying patient.

(e) The department shall issue registry identification cards to qualifying patients and to designated caregivers within five days of approving an application or renewal. Each registry identification card shall expire one year after the date of issuance, unless the practitioner states in the written certification that he or she believes the qualifying patient would benefit from medical marijuana only until a specified earlier or later date, then the registry identification card shall expire on that date. Registry identification cards shall contain all of the following:

- (1) Name, address, and date of birth of the qualifying patient;
- (2) Name, address, and date of birth of the designated caregiver, if any, of the qualifying patient;
- (3) The date of issuance and expiration date of the registry identification card;
- (4) A random 20-digit alphanumeric identification number, containing at least four numbers and at least four letters, that is unique to the cardholder;
- (5) If the cardholder is a designated caregiver, the random identification number of the registered qualifying patient the designated caregiver is assisting; and
- (6) A photograph, if the department decides to require one.

(f) The following notifications and department responses are required:

- (1) A registered qualifying patient shall notify the department of any change in his or her name, address, or designated caregiver, or if the registered qualifying patient ceases to have his or her debilitating medical condition, within 10 days of such change.
- (2) A registered qualifying patient who fails to notify the department of any of these changes is subject to a civil infraction, punishable by a penalty of no more than \$150. If the registered qualifying patient's certifying practitioner notifies the department in writing that either the registered qualifying patient has ceased to suffer from a debilitating medical condition or that the practitioner no longer believes the patient would receive therapeutic or palliative benefit from the medical use of marijuana, the card is null and void upon notification by the department to the qualifying patient.
- (3) Any registered designated caregiver or compassion center staffer must notify the department of any change in his or her name or address within 10 days of such change. A registered designated caregiver or compassion center staffer who fails to notify the department of any of these changes is subject to a civil infraction, punishable by a penalty of

no more than \$150.

(4) When a cardholder notifies the department of any changes listed in this paragraph, the department shall issue the cardholder a new registry identification card with new random 20-digit alphanumeric identification numbers within 10 days of receiving the updated information and a \$10 fee. If the person notifying the department is a registered qualifying patient, the department shall also issue his or her registered designated caregiver, if any, a new registry identification card within 10 days of receiving the updated information.

(5) When a registered qualifying patient ceases to be a registered qualifying patient or changes his or her registered designated caregiver, the department shall notify the designated caregiver within 10 days. The registered designated caregiver's protections under this act as to that qualifying patient shall expire 10 days after notification by the department.

(6) If a cardholder loses his or her registry identification card, he or she shall notify the department and submit a \$10 fee within 10 days of losing the card. Within five days after such notification, the department shall issue a new registry identification card with a new random identification number to the cardholder and, if the cardholder is a registered qualifying patient, to the registered qualifying patient's registered designated caregiver, if any.

(g) Mere possession of, or application for, a registry identification card shall not constitute probable cause or reasonable suspicion, nor shall it be used to support the search of the person or property of the person possessing or applying for the registry identification card. The possession of, or application for, a registry identification card shall not preclude the existence of probable cause if probable cause exists on other grounds.

(h) The following confidentiality rules shall apply:

(1) Applications and supporting information submitted by qualifying patients and designated caregivers, including information regarding their designated caregivers and practitioners, are confidential.

(2) Applications and supporting information submitted by compassion centers and compassion center personnel operating in compliance with this act, including the physical addresses of compassion centers, are confidential.

(3) The department shall maintain a confidential list of the persons to whom the department has issued registry identification cards. Individual names and other identifying information on the list shall be confidential, exempt from the _____ Freedom of Information Act, and not subject to disclosure, except to authorized employees of the department as necessary to perform official duties of the department and as provided in paragraph (4) of this subsection.

(4) Within 120 days of the effective date of this act, the department shall establish a secure, password-protected, Web-based verification system that is operational 24 hours each day, which law enforcement personnel and compassion center staffers can use to verify registry identification cards. The verification system must allow law enforcement personnel and compassion center staffers to enter in a registry identification number to determine whether or not the number corresponds with a current, valid ID card. The system shall disclose the name and photograph of the cardholder, but shall not disclose the cardholder's address. The system shall also display the amount and quantity of marijuana that each registered qualifying patient received from compassion centers during the past 60 days. The system shall allow compassion center staffers to add the amount of marijuana dispensed to registered qualifying patients, directly or through their designated caregivers, and the date and time the marijuana was dispensed. The verification system must include the following data security features:

(A) Any time an authorized user enters five invalid registry identification numbers within five minutes, that user cannot log in to the system again for 10 minutes; and

(B) The server must reject any log-in request that is not over an encrypted connection.

(4) Any hard drives containing cardholder information must be destroyed once they are no longer in use, and the department shall retain a signed statement from a department employee confirming the destruction.

(5) (A) It shall be a crime, punishable by up to 180 days in jail and a \$1,000 fine, for any person, including an employee or official of the department or another state agency or local government, to breach the confidentiality of information obtained pursuant to this act.

(B) Notwithstanding this provision, this section shall not prevent the following notifications:

(i) Department employees may notify law enforcement about falsified or fraudulent information submitted to the department, so long as the employee who suspects that falsified or fraudulent information has been submitted confers with his or her supervisor (or at least one other employee of the department) and both agree that circumstances exist that warrant reporting;

(ii) The department may notify state or local law enforcement about apparent criminal violations of this act, provided that the employee who suspects the offense confers with his or her supervisor and both agree that circumstances exist that warrant reporting; and

(iii) Compassion center staffers may notify the department of a suspected violation or attempted violation of this act or the regulations issued pursuant to it.

(i) Any cardholder who sells marijuana to a person who is not allowed to possess marijuana for medical purposes under

this act shall have his or her registry identification card revoked, and shall be subject to other penalties for the unauthorized sale of marijuana. The department may revoke the registry identification card of any cardholder who violates this act, and the cardholder shall be subject to any other penalties for the violation.

(j) The department shall submit to the legislature an annual report that does not disclose any identifying information about cardholders, compassion centers, or practitioners, but does contain, at a minimum, all of the following information:

- (1) The number of applications and renewals filed for registry identification cards;
- (2) The number of qualifying patients and designated caregivers approved in each county;
- (3) The nature of the debilitating medical conditions of the qualifying patients;
- (4) The number of registry identification cards revoked;
- (5) The number of practitioners providing written certifications for qualifying patients;
- (6) The number of registered compassion centers; and
- (7) The number of compassion center staffers.

(k) Where a state-funded or locally funded law enforcement agency encounters an individual who, during the course of the investigation, credibly asserts that he or she is a registered cardholder or an entity whose personnel credibly assert that it is a compassion center, the law enforcement agency shall not provide any information from any marijuana-related investigation of the person to any law enforcement authority that does not recognize the protection of this act and any prosecution of the individual, individuals, or entity for a violation of this act shall be conducted pursuant to the laws of this state.

(l) The application for qualifying patients' registry identification cards shall include a question asking whether the patient would like the department to notify him or her of any clinical studies regarding marijuana's risk or efficacy that seek human subjects. The department shall inform those patients who answer in the affirmative of any such studies it is notified of that will be conducted in the United States.

Section 8. Affirmative Defense and Dismissal for Medical Marijuana.

(a) Except as provided in Section 9, a patient may assert the medical purpose for using marijuana as a defense to any prosecution of an offense involving marijuana intended for the patient's medical use, and this defense shall be presumed valid where the evidence shows that:

- (1) A practitioner has stated that, in the practitioner's

professional opinion, after having completed a full assessment of the patient's medical history and current medical condition made in the course of a bona fide practitioner-patient relationship, the patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the patient's serious or debilitating medical condition or symptoms associated with the patient's serious or debilitating medical condition; and

(2) The patient and the patient's designated caregiver, if any, were collectively in possession of a quantity of marijuana that was not more than was reasonably necessary to ensure the uninterrupted availability of marijuana for the purpose of treating or alleviating the patient's serious or debilitating medical condition or symptoms associated with the patient's serious or debilitating medical condition; and

(3) The patient was engaged in the acquisition, possession, cultivation, manufacture, use, or transportation of marijuana, paraphernalia, or both, relating to the administration of marijuana solely to treat or alleviate the patient's serious or debilitating medical condition or symptoms associated with the patient's serious or debilitating medical condition.

(b) A person may assert the medical purpose for using marijuana in a motion to dismiss, and the charges shall be dismissed following an evidentiary hearing where the person shows the elements listed in subsection (a).

(c) If a patient demonstrates the patient's medical purpose for using marijuana pursuant to this section, except as provided in Section 9, the patient and the patient's designated caregiver shall not be subject to the following for the patient's use of marijuana for medical purposes:

(1) disciplinary action by an occupational or professional licensing board or bureau; or

(2) forfeiture of any interest in or right to non-marijuana, licit property.

Section 9. Scope of Act.

(a) This act shall not permit any person to do any of the following, nor shall it prevent the imposition of any civil, criminal, or other penalties for any such actions:

(1) Undertake any task under the influence of marijuana, when doing so would constitute negligence or professional malpractice;

(2) Possess marijuana, or otherwise engage in the medical use of marijuana:

(A) in a school bus;

(B) on the grounds of any preschool or primary or secondary school; or

(C) in any correctional facility.

(3) Smoke marijuana:

(A) on any form of public transportation; or

(B) in any public place.

(4) Operate, navigate, or be in actual physical control of any motor vehicle, aircraft, or motorboat while under the influence of marijuana. However, a registered qualifying patient shall not be considered to be under the influence of marijuana solely because of the presence of metabolites or components of marijuana that appear in insufficient concentration to cause impairment.

(5) Use marijuana if that person does not have a serious or debilitating medical condition.

(b) Nothing in this act shall be construed to require:

(1) A government medical assistance program or private health insurer to reimburse a person for costs associated with the medical use of marijuana;

(2) Any person or establishment in lawful possession of property to allow a guest, client, customer, or other visitor to use marijuana on or in that property. This act shall not limit a person or entity in lawful possession of property, or an agent of such person or entity, from expelling a person who uses marijuana without permission from their property and from seeking civil and criminal penalties for the unauthorized use of marijuana on their property; or

(3) An employer to accommodate the ingestion of marijuana in any workplace or any employee working while under the influence of marijuana, provided that a qualifying patient shall not be considered to be under influence of marijuana solely because of the presence of metabolites or components of marijuana that appear in insufficient concentration to cause impairment. This act shall in no way limit an employer's ability to discipline an employee for ingesting marijuana in the workplace or working while under the influence of marijuana.

(c) Fraudulent representation to a law enforcement official of any fact or circumstance relating to the medical use of marijuana to avoid arrest or prosecution shall be punishable by a fine of \$500, which shall be in addition to any other penalties that may apply for making a false statement or for the use of marijuana other than use undertaken pursuant to this act.

Section 10. Enforcement of this Act.

(a) If the department fails to adopt regulations to implement this act within 120 days of the effective date of this act, a qualifying patient or a prospective board member or prospective principal officer of a compassion center may commence an action in ____ court to compel the department to

perform the actions mandated pursuant to the provisions of this act.

(b) If the department fails to issue a valid registry identification card in response to a valid application or renewal submitted pursuant to this act within 20 days of its submission, the registry identification card shall be deemed granted, and a copy of the registry identification application or renewal shall be deemed a valid registry identification card.

(c) If at any time after the 140 days following the effective date of this act the department is not accepting applications, including if it has not created regulations allowing qualifying patients to submit applications, a notarized statement by a qualifying patient containing the information required in an application, pursuant to Section 7(a) (2-5) together with a written certification shall be deemed a valid registry identification card.

Section 11. Severability.

Any section of this act being held invalid as to any person or circumstances shall not affect the application of any other section of this act that can be given full effect without the invalid section or application.

Section 12. Date of Effect.

This act shall take effect upon its approval.

Appendix R: Overview and Explanation of MPP's Model State Medical Marijuana Bill

The relationship of the model bill and state law to federal law

Although the Supreme Court ruled (*U.S. v. Oakland Cannabis Buyers' Cooperative*) on May 14, 2001, that the medical necessity defense cannot be used to avoid a federal conviction for distributing marijuana, the Court did not question a state's ability to allow patients to grow, possess, and use medical marijuana under state law.

Indeed, the medical marijuana laws that have been passed by voter initiatives in nine states and by the Hawaii, Rhode Island, New Mexico, and Vermont legislatures continue to provide effective legal protection for patients and their primary caregivers because they are carefully worded. MPP's model bill is based on those laws, primarily the Rhode Island law — because it is the most recently enacted medical marijuana law to receive majority support among state legislators, rather than at the ballot box.

Of course, the model bill only provides protection against arrest and prosecution by state or local authorities. State laws cannot offer protection against the possibility of arrest and prosecution by federal authorities. Even so, because 99 percent of all marijuana arrests are made by state and local — not federal — officials, properly worded state laws can effectively protect 99 out of every 100 medical marijuana users who would otherwise face prosecution at the state level.

In truth, changing state law is the key to protecting medical marijuana patients from arrest, as there has not been one documented case where a patient has been prosecuted by federal authorities for a small quantity of marijuana in the 13 states that have effective medical marijuana laws.

Six key principles for effective state medical marijuana laws

In order for a state law to provide effective protection for seriously ill people who engage in the medical use of marijuana, a state law must:

1. define what is a legitimate medical use of marijuana by requiring a person who seeks legal protection to (1) have a medical condition that is sufficiently serious or debilitating, and (2) have the approval of his or her physician (Sec. 3(c) and 3(r));
2. provide legal protection for the primary caregivers of patients who are too ill to provide for their own medical use of marijuana (Sec. 4(b));
3. avoid provisions that would require physicians or government employees to violate federal law in order for patients to legally use medical marijuana;
4. provide a means of obtaining marijuana, which can only be done in the following four ways: permit patients to cultivate their own marijuana; permit primary caregivers to cultivate marijuana on behalf of patients; permit patients or primary caregivers to purchase marijuana from the criminal market (which patients already do illegally); and/or authorize non-governmental organizations to cultivate and distribute marijuana to patients and their primary caregivers (Sec. 4(a) and (b), Sec. 5);
5. allow patients who are arrested to discuss the medical use of marijuana in court (Sec. 8); and
6. implement a series of sensible restrictions, such as prohibiting patients and primary caregivers from possessing large quantities of marijuana, prohibiting driving while under the influence of marijuana, and so forth (Sec. 9).

The importance of precisely worded state laws

Because the medical use of marijuana is prohibited by federal law, state medical marijuana legislation must be worded precisely in order to provide patients and primary caregivers with legal protection under state law. Even changing just one or two words in the model bill can make it symbolic, rather than truly effective.

For example, it is essential to avoid use of the word “**prescribe**,” since federal law prohibits doctors from prescribing marijuana. Doctors risk losing their federally-controlled license to prescribe all medications if they “prescribe” marijuana — which would be useless anyway because pharmacies are governed by the same regulations and cannot fill marijuana prescriptions.

Physicians are, however, permitted under federal law to “**recommend**” marijuana. Thus, to establish a patient’s legitimate medical marijuana use, the state law must contain language accepting a physician’s statement that the patient is “likely to receive therapeutic or palliative benefit from the medical use of marijuana,” or similar language.

The importance of this seemingly trivial distinction is made clear by the case of Arizona, which passed a ballot initiative (Proposition 200) by 65% of the vote in November 1996. Arizona’s law is dependent upon patients possessing marijuana “prescriptions.” As a result, no patients in Arizona have legal protection for using medical marijuana.

There are numerous other important technical nuances which are impossible to anticipate without having spent several years working on medical marijuana bills and initiatives nationwide. Consequently, it is crucial to discuss ideas and concerns with MPP before changing even one word of the model bill. MPP can also provide a more complete written technical analysis of the model bill.

Two versions of the model bill

MPP has two versions of its model bill. The version included in this report allows for the state-sanctioned nonprofit delivery of marijuana. Another version is available, which allows for patients and caregivers to cultivate a supply, but does not allow for regulated distribution. That version of the bill is available at mpp.org/modelbill2.

Appendix S: What Do Federal Raids in California Mean for State Marijuana Laws?

California is home to an estimated 190,000 state-legal medical marijuana patients and hundreds of dispensing collectives.¹ California's dispensing collectives often operate out of storefronts, as pharmacies do. This is unique among medical marijuana states: Most states do not have any dispensing collectives and instead only provide for patients or caregivers to grow patients' medical marijuana.² The other states that have dispensaries, such as Colorado, are only known to have a very small number of them.

Since California's enactment of its medical marijuana law in 1996, federal agents have conducted raids on more than 190 medical marijuana locations in California, and a handful of medical marijuana raids outside of California.³ The vast majority of these raids have targeted medical marijuana dispensaries, homes or storage spaces associated with them, and large gardens serving multiple patients.⁴ Some, but not all, of these raids have resulted in prosecutions in federal court, where compliance with state law is no defense. Federal agents have not, however, generally targeted individual patients for arrest, nor are they known to have prosecuted individual patients for small amounts of marijuana.⁵

California's state law allowing dispensing collectives is vague. Until the 2003 enactment of SB 420, California's medical marijuana law did not include any explicit protection for collectives. Since then, the state has allowed patients to collectively and cooperatively grow and distribute marijuana. Providers are allowed to receive "reasonable compensation" for their services, but cannot operate "for profit."⁶

In addition, dozens of cities and counties — such as San Francisco and Los Angeles County — have enacted ordinances permitting and regulating dispensaries. Meanwhile, even more have imposed moratoria or outright bans on dispensaries, though the bans are being challenged in courts.⁷

In some cases, the ambiguities in California's medical marijuana laws have been seized upon by federal agents, who often claim that those who are raided are actually in violation of state law.⁸ However, because these cases are always tried in federal court, defendants never have an opportunity to raise state law as a defense.

In addition, local law enforcement have at times assisted with federal raids and even requested raids.⁹ One of the places where this has shut down most organized access is San Diego County. More than 10 locations were raided by both federal and local agents in late 2005 and again on July 6, 2006.¹⁰ After the second wave of raids, U.S. Attorney Carol Lam and San Diego District Attorney Bonnie Dumanis warned all dispensaries to shut down or face closure and arrest of the operators.¹¹ By the end of 2007, Dumanis said that all dispensaries in the city had been shut down.¹² Three additional collectives in the county were raided on August 6, 2008, by local-federal task forces.¹³

Local participation in federal raids is particularly detrimental to patients' access. It gives a veneer of legitimacy to federal raids, but deprives providers of a chance to prove their innocence in court. Because of this, San Diego Assemblymember Lori Saldaña (D) proposed MPP-sponsored legislation in 2008 to stop the use of state and local funds to assist in federal raids. That way, if a collective were accused of violating state law, it would be able to litigate the issue in state court — where compliance with state law is a defense — rather than federal court, where it isn't. The legislation made it to the Assembly floor, where it had more supporters than opponents, but it did not receive a vote because the author felt that it wouldn't have received the necessary 41 votes to pass.

In addition to raids and prosecutions, the DEA has shut down some dispensaries, including the Oakland Cannabis Buyers' Cooperative (OCBC) with civil injunctions. Following the U.S. Supreme Court's May 2001 ruling in the OCBC case — which found that defendants could not use a "medical necessity" defense to federal charges — the federal government took more aggressive actions against

large-scale medical marijuana providers.

Beginning in July 2007, the DEA began a new tactic to try to shut down medical marijuana distribution. It sent letters to more than 160 landlords of medical marijuana cooperatives, stating that knowingly allowing medical marijuana dispensaries could result in property forfeiture or even prosecution.¹⁴ In at least one of the areas where the letters went, Santa Barbara, the letters have been followed up by threatening meetings with landlords and federal agents. There is widespread concern that the city's dispensaries — which are licensed and regulated by the city — will face eviction.¹⁵

The federal government has thus far remained opposed to changing federal law to allow medical marijuana patients to obtain their medicine from distribution centers. And until a change in government leadership occurs, large-scale medical marijuana distribution will likely continue to carry high risks of raids, prosecution, and property forfeiture for those who undertake it. In addition, federal raids, prosecutions, and threats can shut down medical marijuana distributors in at least some areas of a state.

For this reason, it is important that state laws allow patients and caregivers to cultivate their own medical marijuana, without relying on organized distribution alone. Regardless of what federal officials and lawmakers do, patients' welfare is massively improved if they live in states where medical marijuana is allowed. With 99% of all marijuana arrests at the state and local — not federal — level, removing states' criminal penalties almost eliminates the chances that an individual patient will be incarcerated for modest amounts of medical marijuana.

After the June 2005 U.S. Supreme Court decision that the federal government can prosecute medical marijuana patients, *Raich v. Gonzales*, there was some fear that it would do so. However, numerous federal officials — including DEA head Karen Tandy — reiterated that the federal government would not prosecute the sick and dying.¹⁶ Top officials in every medical marijuana state at the time — including attorneys general for Oregon, Montana, and California — stressed that state laws are still valid.¹⁷

In April 2007, New Mexico Gov. Bill Richardson (D) signed a medical marijuana bill into law, providing for state-regulated distribution of medical marijuana. The state would issue regulations for providers and would designate areas where marijuana could be dispensed. So far, the state is only allowing cultivation by individual patients and caregivers. Initially, the Health Department refused to issue regulations for organized production and distribution, due to fear that employees could be subject to federal prosecution.¹⁸ However, Gov. Richardson directed the department to resume drafting regulations, saying that a decision about whether to implement the distribution would be made later.¹⁹ In September 2008, the Health Department held a hearing on draft rules that would allow non-profits to cultivate up to 95 plants for patients, in addition to individual patient cultivation.

If the New Mexico law is fully implemented, it will be closely watched to see how the federal government reacts to organized distribution by providers that are individually licensed and regulated by the state government.

Although the federal raids have interrupted access for some very ill patients and have resulted in the arrest and incarceration of providers, numerous medical marijuana collectives are operating in almost all major California cities, and many smaller towns also have collectives. Patients in California and 12 other states have a dramatically reduced chance of being prosecuted for growing and possessing modest amounts of the medicine their doctors recommend — marijuana.

- 1: The patient estimate is based on the number of patients per capita in Oregon. A report prepared by California NORML and cited by the California Board of Equalization estimated that there are more than 400 medical marijuana dispensaries. << <http://www.boe.ca.gov/legdiv/sutleg/pdf/sbo529-2sw.pdf>>
- 2: Rhode Island's law allows caregivers to provide for no more than five patients; Oregon and New Mexico restrict caregivers to four patients. Washington, Hawaii, Nevada, and Vermont only allow caregivers to assist one patient; and Alaska usually restricts caregivers to one patient. Colorado and Montana do not limit the number of patients a caregiver can assist, and they are believed to have no more than a few dispensing collectives. In Maine, caregivers must have "consistently assumed responsibility for the housing, health or safety of a person," so it's unlikely they would meet this qualification for large numbers of patients.
- 3: Locations raided outside of California include patient Travis Paulsen of Oregon's garden, where 104 plants were seized in 2003; a 12-plant, three-patient garden raided in Oregon on Sept. 23, 2003; and Leonard French, a New Mexico quadriplegic whose small garden was raided by a task force that said they did not know he was state-registered.
- 4: Although most federal medical marijuana raids have focused on larger targets, federal agents have occasionally uprooted small patient gardens. For example, patient Diane Monson's six-plant garden was uprooted by federal agents despite the objections of her county officials. She was not prosecuted. Monson and another patient, Angel Raich, later charged the federal government with violating the U.S. Constitution for medical marijuana raids. The U.S. Supreme Court ruled against the patients on their Commerce Clause argument, and, on remand, the Ninth Circuit ruled against their remaining constitutional claims.
- 5: There is no numerical limit on how much marijuana patients can possess in California; they are allowed to possess marijuana for personal medical use. In some cases, such as the case of David Davidson and Cynthia Blake, county officials have claimed that patients had "too much" marijuana and began prosecution only to hand it over to federal authorities, where compliance with state law is no defense. "Feds Bust Medical Pot Patients In Courtroom," *AlterNet*, January 17, 2004.
- 6: Calif Health & Safety Code 11362.775.
- 7: Americans for Safe Access has a list of cities and counties with regulations, moratoria, and bans at <http://www.safeaccessnow.org/article.php?id=3165>.
- 8 See, i.e., "Feds raid pot dispensary second time in a month: SALES IN QUESTION: An affidavit says the organization was selling marijuana for profit." *Press-Enterprise*, November 2, 2006.
- 9 One example is Charles Lynch, who operated a city-licensed dispensary. Lynch was raided and prosecuted by federal officials. Discovery in Lynch's cases showed that the sheriff of San Luis Obispo explicitly requested the DEA's intervention, without the knowledge or consent of the city. See "Sheriff skirted state marijuana law, claim says," *The Tribune*, October 27, 2007.
- 10 "Agents Raid 13 Medical Pot Dispensaries in S.D. County," *San Diego Union-Tribune*, Dec. 13, 2005. "Authorities Raid Eleven SD Marijuana Dispensaries," KGTV 10 News, July 6, 2006.
- 11 "Agents Make 'Visits' to Pot Shops," *San Diego Union-Tribune*, July 22, 2006.
- 12 Office of the San Diego County District Attorney 2007 Annual Report. "Our prosecutors effectively shut down all of these so-called medical marijuana clinics."
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Appendix T: Medical Conditions Approved for Treatment with Marijuana in the 13 States with Medical Marijuana Laws

Medical conditions approved for treatment with marijuana in the 13 states with medical marijuana laws													
	California	Oregon	Alaska	Washington	Maine	Hawaii	Colorado	Nevada	Vermont	Montana	Rhode Island	New Mexico	Michigan
Specific Diseases													
Cancer	√	√	√	√	√	√	√	√	√ ³	√	√	√	√
Glaucoma	√	√	√	√	√	√	√	√		√	√	√	√
AIDS or HIV	√	√	√	√	√	√	√	√	√ ³	√	√	√	√
Crohn's disease				√		√				√			√
Hepatitis C				√							√		√
Multiple sclerosis									√ ³	√		√	
Debilitating medical conditions or symptoms produced by those conditions													
Cachexia, anorexia, or wasting syndrome	√	√	√	√		√	√	√	√ ³	√	√		√
Severe or chronic pain	√	√	√	√		√	√	√	√ ³	√	√ ⁴		√
Severe or chronic nausea		√	√	√		√	√	√	√ ³	√	√		√
Seizure disorders (e.g., epilepsy)	√	√	√	√	√	√	√	√	√ ³	√	√	√	√
Muscle spasticity disorders (e.g., multiple sclerosis)	√	√	√	√	√	√	√	√		√	√	√	√
Arthritis	√												
Migraines	√												
Agitation of Alzheimer's disease		√ ²									√		√
Allows addition of diseases or conditions by state health agency	√ ¹	√	√	√		√	√	√		√	√	√ ⁵	√ ⁶
Medical defense, but no protection from arrest, available for other medical conditions			√	√				√		√			√
<p>1 In addition to the specific diseases and conditions listed, the law covers treatment of "any other illness for which marijuana provides relief."</p> <p>2 Condition added by state agency</p> <p>3 Requires that reasonable medical efforts have been made over a reasonable amount of time without success to relieve the symptoms</p> <p>4 Allows medical marijuana to treat "severe, debilitating, chronic pain"</p> <p>5 In addition to the specific diseases and conditions listed, the law covers patients with damage to the nervous tissue of the spinal cord or those "admitted into hospice care in accordance with rules promulgated by the department."</p> <p>6 In addition, the law explicitly covers patients with amyotrophic lateral sclerosis or nail patella.</p>													