State-By-State Medical Marijuana Laws:

How to Remove the Threat of Arrest

> "The federal government is not prosecuting marijuana users."
>
> —Former DEA Administrator Asa Hutchinson in the *Oakland Tribune*, 2/13/02

> "The one issue on which all the candidates agreed was the state's medical marijuana law, which all said they would fight to uphold."
>
> —"Candidates Make Their Case in California Debate," *The Washington Post*, 9/4/03, following the first debate among the five major gubernatorial candidates seeking to succeed Gray Davis in the 2003 recall election (Schwarzenegger did not attend, but had previously expressed his support for medical marijuana.)

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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 (Six of these laws have since expired or been repealed.)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, 30 states and the District of Columbia have laws on the books that recognize marijuana's medical value:
  - Eleven states that solely have "Therapeutic Research Program" laws are unable to give patients legal access to medical marijuana because of federal obstructionism.
  - Nine 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.
  - And, since 1996, nine states have enacted laws that effectively allow patients to use medical marijuana despite federal law. A tenth state, Maryland, has established an affirmative defense law that will protect medical marijuana patients from jail, but not arrest.
- The effective medical marijuana laws were enacted through ballot initiatives in Alaska, California, Colorado, Maine, Nevada, Oregon, and Washington. In Hawaii, an effective law was passed by the legislature and signed by the governor in June 2000. In Vermont, an effective law was passed by the legislature and allowed to become law without the governor's signature in May 2004.
- To be effective, a state law must remove criminal penalties for patients who use, possess, and grow medical marijuana with their doctors' approval or certification.
  - 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 can effectively protect 99 out of every 100 medical marijuana users who otherwise would have been prosecuted.
- Although the U.S. Supreme Court ruled in May 2001 that the medical necessity defense cannot be used to avoid a federal conviction for marijuana, a state government may still allow its residents to possess, grow, or distribute medical marijuana. The ruling does not nullify the nine effective state medical marijuana laws, nor does it prevent other states from enacting similar laws.
- Ultimately, federal law should be changed to treat marijuana like any other legal medication, available through pharmacies upon a doctor's prescription. However, the federal government currently refuses to budge. In the meantime, 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

"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 Hawaii legislature in June 2000."

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, nine states have found a way to help seriously ill people use medical marijuana with virtual impunity, despite federal law.[2]

(A tenth law, enacted in Maryland in May 2002, is weaker than the other nine laws because it only protects medical marijuana patients from jail—not arrest—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* (No. 00-151) that the medical necessity defense cannot be used to avoid a federal conviction for marijuana, a state may still allow its residents to possess, grow, or distribute medical marijuana. The ruling does not nullify the nine 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. "The federal government is not prosecuting marijuana users," according to former federal Drug Enforcement Administration (DEA) chief Asa Hutchinson, 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 patients legal access to medical marijuana. The most cost-effective way to allow patients to use medical marijuana is for state legislatures to pass bills similar to the law enacted by the Hawaii legislature in June 2000.

A model state medical marijuana law, which is based on the Hawaii 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.

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[1] See Appendix A.

[2] See Table I for details on the nine effective state laws.

[3] "Pot raids stir S.F. protests," Oakland Tribune, February 13, 2002.

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] A 2002 *Time* magazine poll found support for medical marijuana at 80%.

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.

State and local police made 697,082 marijuana arrests in the United States in 2002, 613,986 of which were for possession (not sale or manufacture).[7] Even if only one percent of those arrested were using marijuana for medical purposes, then there are more than 6,000 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 41 states and the District of Columbia.

Changing Federal Law

The federal Controlled Substances Act of 1970 establishes 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 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

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[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] See Appendix D for the results of major public opinion polls.

[7] FBI Uniform Crime Reports, *Crime in the United States: 2002*, published in October 2003.

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

[9] Appendix B provides more information about this litigation.

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 seven patients remain in the program.

All of these routes have been tried—and failed. Until a more sympathetic president and Congress is 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 1995[12]

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, did not enact its law until 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. To qualify, the law specifies that patients need a doctor to "recommend" marijuana. By avoiding the word "prescribe," doctors are not violating federal law in order to help their patients. (Of note, Arizona voters also passed a medical marijuana initiative in 1996, but it

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[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 9.

turned out to be only symbolic because it used the word "prescribe" rather than "recommend.")

"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."

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 it is a district, not a state, and is therefore subject to strict federal oversight.) Maine passed an initiative in 1999, while Colorado and Nevada followed suit in 2000. Each state approved its initiative by a wide margin; no state has ever rejected a medical marijuana initiative.

Hawaii broke new ground in 2000, when it became the first state to enact a law to remove criminal penalties for medical marijuana users via a state legislature. Governor Ben Cayetano (D), who submitted the original bill and signed the final measure into law on June 14, 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 Putman 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.

More than 59 million Americans—20% of the U.S. population—now live in the nine states where medical marijuana users are protected from both arrest and prison under state law.

The number of medical marijuana patients in each of the nine medical marijuana states is difficult to determine, especially for the states that do not have registry systems. There are unofficial estimates for the states that do not have registry systems, and documented numbers from those states that do have registry systems.

The number of medical marijuana users in California, Hawaii, Alaska, Oregon, and Colorado shows that an average of .09% of the population uses medical marijuana in the states that have available information on patient numbers.

And from all of the states' numbers, we can extrapolate that the percentage of people in a new medical marijuana state who would take advantage of the medical marijuana law would be between .007% and .20%.

What the New State Laws Do

The seven state initiative-created laws, the Vermont law, and the Hawaii law are similar in what they accomplish.[13]

Each of the nine 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. 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 which issue identification cards to registered patients and their caregivers.

Patients' marijuana possession and cultivation limits are generally restricted to a concrete number: 1-3 ounces of usable marijuana and 6-7 plants, three of which may be mature. Two states, Washington and California, have conceptual marijuana limits, respectively permitting a "sixty day supply" and enough "marijuana for the personal medical purposes of the patient."

(Modified by S.B. 420 in 2003, California's medical marijuana law additionally guarantees protection from arrest for patients who possess state-issued ID cards and possess less than eight ounces of usable marijuana and six mature plants or 12 immature plants. However, at the time that this report was printed, the state has not yet distributed 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 prosecution.

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

> "Joe" has AIDS. His doctor advised him to smoke marijuana in order to 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.
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> Luckily, Joe lives in one of the nine states with effective medical marijuana laws. Joe admits to 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. Joe takes another puff and finishes his dinner.

If Joe lived in one of the other 41 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 unlikely event that a patient is arrested for marijuana possession or cultivation in one of the nine

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

[14] Maryland's new law, which protects medical marijuana patients from criminal penalties, contains no explicit provision for cultivation.

states with effective laws, the patient is still allowed to argue at trial that his or her marijuana use was medically necessary.[15]

Is There A Conflict Between New State Laws and Federal Law?

In the eight years since California and other states began prosecuting 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.

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

The 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 can effectively protect 99 out of 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.

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 various states—commonly known as "cannabis buyers' clubs"—have been targeted by the federal government. This has been an issue only in California, which doesn't specifically allow for such buyer's clubs, as demonstrated by several federal raids in 2001 and 2002. (See Appendix S.)

Federal Court Rulings Have Clarified the Scope of State Laws

To date, there have only been two high-level federal cases that have been addressed by the U.S. Supreme Court: *Conant v. McCaffrey* (now, *Conant v. Walters*) and *U.S. v. Oakland Cannabis Buyers' Cooperative* (*OCBC*). (On June 28, 2004, the court agreed to hear the federal government's appeal of a third case, Raich v. Ashcroft.)[16] 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.

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

[16] See Appendix I.

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. Court of Appeals. On July 7, 2003, the federal government filed an appeal with the U.S. Supreme Court, which rejected the case on October 14, 2003.

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 state law, and it presents no foreseeable barriers to future state-level action.

In a related case, *Pearson v. McCaffrey*, the U.S. District Court for the District of Columbia granted former Drug Czar Barry McCaffrey's motion to dismiss. The plaintiffs unsuccessfully raised constitutional arguments against federal opposition to medical marijuana. The court said that "[e]ven though state law may allow for the prescription or recommendation of medical marijuana within its borders, to do so is still a violation of federal law under the [Controlled Substances Act]."

Presumably, this ruling could expose doctors to federal scrutiny, but the case, oddly, was brought and decided in a jurisdiction where no effective medical marijuana laws are on the books. No appeals are expected, and the role of physicians with regard to medical marijuana was settled by *Conant*.

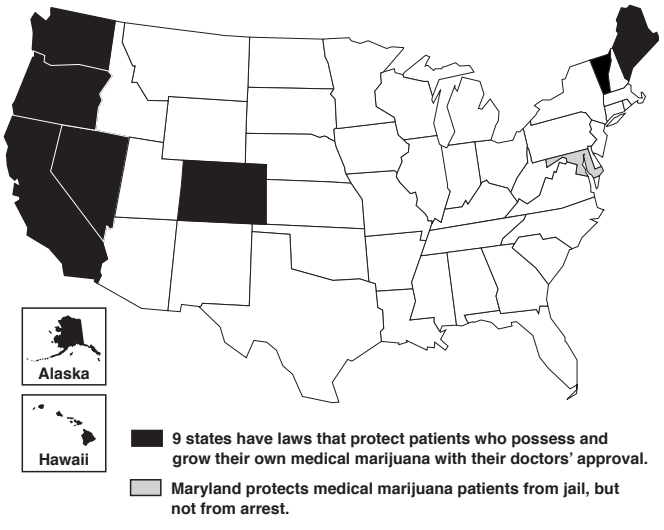
At the state level, there have been no serious challenges to the legality of medical marijuana laws. The only cases that have emerged have questioned whether individuals or organizations are in compliance with the state law. State-level cases have focused on whether individuals qualify as patients or caregivers, or whether they possess an amount of marijuana in excess of the specified legal limit. Thus, only the actions of individuals in relation to the law—not the law itself—have been litigated.[17]

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 six states have either expired or been repealed, but 30 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.)

States With Effective Medical Marijuana Laws



[17] See Appendix A for details on all state medical marijuana laws.

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. Nine states—Alaska, California, Colorado, Hawaii, Maine, Nevada, Oregon, Vermont, and Washington—have effective laws of this nature, all of which have been enacted since 1996.

"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."

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.

Therapeutic research programs[18]

The thirteen states listed in Appendix A, plus California 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. Seven states have laws that allow patients to possess marijuana if obtained directly from 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. 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 sub-

[18] See Appendix J for details on therapeutic research programs.

stance 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. States would also risk losing federal funding for operating state-run distribution systems. 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. Similar to "pseudo-prescriptive access" laws, it is unclear whether courts would interpret these laws as permitting a "medical necessity" defense.

Non-Binding Resolutions. At least six state legislatures—California, Michigan, Missouri, New Hampshire, New Mexico, and Washington—have passed non-binding resolutions urging the federal government to allow doctors to prescribe marijuana. Non-binding resolutions are passed by 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 30 states with current laws, Arkansas, Florida, North Carolina, and West Virginia have repealed their medical marijuana laws, while Michigan has let its medical marijuana law expire. 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, fourteen states have never had favorable medical marijuana laws.

States With Other Medical Marijuana Laws

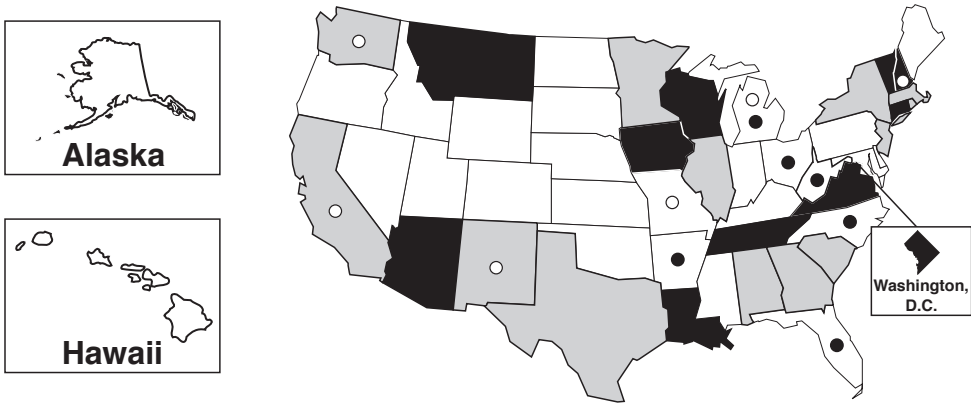


TABLE 1: Effective Medical Marijuana Laws in Nine States

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	...he or she may possess up to 8 ounces of dried marijuana and 6 mature or 12 immature marijuana plants without fear of arrest or prosecution.	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 prosecution if marijuana possession or cultivation is solely for the medical purposes of the patient	"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	S.B. 420 established a voluntary patient registry system; caregivers and patients with IDs will be verified through an 800 number.	S.B. 420 established that if a patient is in possession of an ID card, he or she may possess up to 8 ounces of marijuana without fear of arrest or prosecution. For cases without an ID card, there is no numerical limit, but "marijuana for the personal medical purposes of the patient."	the individual designated by the patient who has consistently assumed responsibility for the housing, health, or safety of that person	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	2 usable ounces and 6 plants; 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
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	7 plants, 3 of which may be mature, and 1 ounce per mature plant	one caregiver per patient, and a caregiver may serve only one patient at any given time	yes

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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?
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 1/2 ounces and 6 plants, 3 of which may be mature	one caregiver, who has consistently assumed responsibility for the housing, health, or safety of the patient or is a member of the same household and is named in a written individual instruction or power of attorney for health care	no
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	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	1 usable ounce and 7 plants, 3 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
Oregon Measure 67 (ballot initiative/55%) November 3, 1998 (modified by H.B. 3052, effective July 21, 1999)	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 Health Division	if not at a location where marijuana is produced, up to 1 usable ounce may be possessed; if at the location where marijuana is produced, up to 7 plants, 3 of which may be mature, and one usable ounce of marijuana per mature plant; 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
Vermont S. 76 (enacted by legislature) May 26, 2004	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	2 usable ounces and 3 plants, 1 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 Nine 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	exemption from prosecution if patient meets all criteria for status as a qualifying patient, possesses no more marijuana than is necessary for his or her personal medical use, and presents valid documentation to law enforcement who question medical use; affirmative defense available if in compliance with statute	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 only be changed or repealed 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.

Where Things Are Going From Here

The eight medical marijuana initiatives, seven 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 20% of the U.S. population, but they verified 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. State legislatures are increasingly supportive of medical marijuana. Twenty-three states have considered (or will consider[19]) medical marijuana bills during the 2003-2004 legislative sessions.

"The role of the 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."

Sixteen states have considered or will consider bills to remove 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. Vermont passed such a bill into law in 2004. California, Hawaii, Nevada, Oregon, and Washington considered bills to amend existing, effective medical marijuana laws. Maryland passed a bill that will protect medical marijuana patients from jail, but not arrest, and North Carolina considered a bill to research medical marijuana.[20]

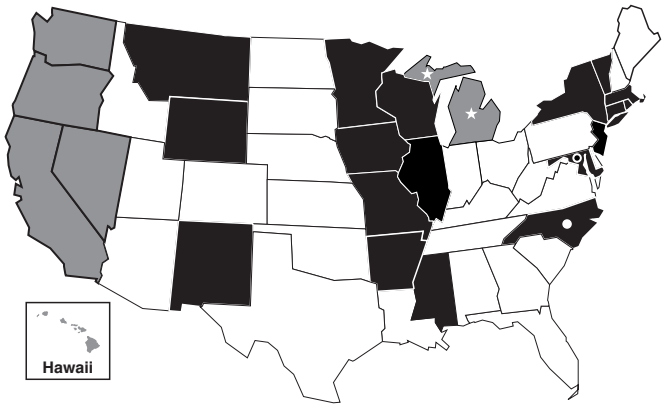
The volume of medical marijuana legislation increased by roughly 50 percent between the 1999-2000 and 2001-2002 legislative cycles, and it continues to increase. This trend demonstrates the growing appeal of medical marijuana not only in the general public, but also in statehouses across the nation.

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.

24 States Have Considered Medical Marijuana Legislation During the 2003-2004 Legislative Sessions



During the 2003-2004 legislative sessions:

- 16 states have considered or will consider bills to remove criminal penalties for medical marijuana.
- 5 states considered bills to amend existing, effective medical marijuana laws.
- Maryland passed an affirmative defense bill that will protect medical marijuana patients from jail, but not arrest.
- North Carolina considered a resolution to research medical marijuana.
- Michigan's House of Representatives passed a resolution opposing medical marijuana initiatives.

[19] Through discussions with legislators, MPP expects a medical marijuana bill to be introduced in New Jersey.

[20] See Appendix L for a list of all state medical marijuana bills and resolutions considered during the 2003-2004 legislative sessions.

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	9	1	1	13	13	2	10 plus D.C.	6
Grand Totals	9		2		26		12 plus D.C.		6

Thirty-six states have ever had favorable medical marijuana laws. Thirteen 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.

States with Effective Medical Marijuana Laws (Removal of Criminal Penalties)							
State	**MMJ Law Approved**	**Took Effect**	**Bill/Initiative#**	**Session Law**	**Citation for MMJ 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	§ 17.37	VIA	§ 11.71.160
Current Law:	Ballot Measure 8 removes 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 § 17.35) 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; 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."						

States with Effective Medical Marijuana Laws (Removal of Criminal Penalties)							
State	**MMJ Law Approved**	**Took Effect**	**Bill/Initiative#**	**Session Law**	**Citation for MMJ Law**	**Marijuana Schedule**	**Citation for Schedules**
CA	Nov. 5, 1996	Nov. 6, 1996	Ballot Initiative, Proposition 215 (modified by S.B. 420, effective January 1, 2004)	S.B. 420—Chapter 875, Statutes of 2003	H & S § 11362.5	I	H & S § 11054
Current Laws:	Proposition 215 removes 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. In addition, S.B. 847, which took effect Oct. 7, 1999 (session law Ch. 750), established the California Center for Medicinal Cannabis Research (H & S § 11362.9). A one-time $3 million appropriation was provided in the 2000-2001 state budget for the research, which is a three-year project coordinated by the San Diego and San Francisco campuses of the University of California. Research will focus on safety and efficacy of marijuana for treating a wide range of debilitating conditions. Marijuana used in the research will be obtained from the federal government. If the federal government fails to provide an adequate supply, the state "Attorney General shall provide an adequate supply." S.B. 420, which took effect on January 1, 2004, further defined California's 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. The law mandated the creation of a state registry and the distribution of state medical marijuana ID cards, which are optional for both patients and caregivers. The bill set a default limit of eight ounces of dried marijuana and six mature plants or 12 immature plants per patient, which counties and municipalities are permitted to raise, but cannot lower.						
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.						

States with Effective Medical Marijuana Laws (Removal of Criminal Penalties)							
State	**MMJ Law Approved**	**Took Effect**	**Bill/Initiative#**	**Session Law**	**Citation for MMJ Law**	**Marijuana Schedule**	**Citation for Schedules**
CO	Nov. 7, 2000	June 30, 2001	Ballot Initiative, Amendment 20	N/A	Constitutional Amendment 20	n/a	§ 18-18-203
Current Law:	Amendment 20 removes state-level criminal penalties for medical marijuana use, possession, and cultivation.						
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). Details of the program included administration by a Pharmacy and Therapeutics Committee (PTC) at the University of Colorado; the PTC could include other disease groups after review of pertinent data presented by a physician; apply to receive marijuana from the National Institute on Drug Abuse (NIDA); if unable to obtain marijuana from NIDA, investigate the feasibility of using seized marijuana that has been tested for impurities; $15,000 was appropriated. Amended by ch. 322 (1981) to say that other disease groups can be included after pertinent data are presented by a physician who has an IND (Investigational New Drug) number issued by FDA; apply to receive marijuana from federal government. The law was repealed by H.B. 95-1020 in 1995 (ch. 71).						
HI	June 14, 2000	June 14, 2000	S.B. 862	Act 228, SLH 2000	§ 329	I	§ 329-14
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 have 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.						

States with Effective Medical Marijuana Laws (Removal of Criminal Penalties)							
State	**MMJ Law Approved**	**Took Effect**	**Bill/Initiative#**	**Session Law**	**Citation for MMJ Law**	**Marijuana Schedule**	**Citation for Schedules**
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 § 2383-B	n/a	17-A § 1102
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.						
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 expired on Dec. 31, 1987, which 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. 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.						
NV	June 14, 2001	Oct. 1, 2001	Question 9, passed in 1998 and 2000; A.B. 453, passed the legislature in 2001	Statutes of Nevada 2001, Ch. 592	Title 40 of NRS, and Art. 4, Sec. 38 of the Nevada constitution	I	453.510 NAC
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.						
History:	A therapeutic research program—which was never operational—for glaucoma or 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).						
OR	Nov. 3, 1998	Dec. 3, 1998	Ballot Measure 67 (modified by H.B. 3052, effective July 21, 1999)	Oregon Laws 1999, Ch. 4 H.B. 3052—Oregon Laws 1999, Ch. 825	475.300-346	I	475.035 and OAR 855-80

States with Effective Medical Marijuana Laws (Removal of Criminal Penalties)							
State	**MMJ Law Approved**	**Took Effect**	**Bill/Initiative#**	**Session Law**	**Citation for MMJ Law**	**Marijuana Schedule**	**Citation for Schedules**
Current Law:	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, which 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; relieves police from the responsibility to maintain live marijuana plants while a case is pending.						
History:	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 was 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).						
VT	May 26, 2004	July 1, 2004	S. 76	Act No. 135 (2004)	18 VSA § 4471	n/a	n/a
Current Law:	S. 76 removes state-level penalties for medical marijuana use, possession, and cultivation for patients registered with the state. Registration is permitted only for AIDS, cancer, multiple sclerosis, and positive status for HIV. There are no legal protections provided to unregistered medical marijuana patients.						
History:	On April 27, 1981, the Vermont Legislaure 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. Administered by the Department of Health and called a "research program," H. 130 allowed physicians to prescribe marijuana; "[the] commissioner of health shall have the authority to obtain ... cannabis administered under this program."						
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

States with Effective Medical Marijuana Laws (Removal of Criminal Penalties)							
State	**MMJ Law Approved**	**Took Effect**	**Bill/Initiative#**	**Session Law**	**Citation for MMJ Law**	**Marijuana Schedule**	**Citation for Schedules**
Current Laws:	Measure 692 removes state-level criminal penalties for medical marijuana use, possession, and cultivation. 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." 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). On March 30, 1996, Washington State enacted the 1996 supplemental operating budget which allocated $130,000 for two medical marijuana-related projects: $70,000 to research a tamper-free means of cultivating marijuana for medicinal purposes, and $60,000 to research the therapeutic potential of marijuana. Research, however, was never conducted and the $60,000 appropriation expired.						

States with Workable Medical Marijuana Laws							
State	**MMJ Law Approved**	**Took Effect**	**Bill/Initiative#**	**Session Law**	**Citation for MMJ Law**	**Marijuana Schedule**	**Citation for Schedules**
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	**MMJ Law Approved**	**Took Effect**	**Bill/Initiative#**	**Session Law**	**Citation for MMJ Law**	**Marijuana Schedule**	**Citation for Schedules**
AL	July 30, 1979	July 30, 1979	S. 559	Act No. 79-472	§ 20-2-110	I	§ 20-2-23(3) and AAC Chap. 420-7-2
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 and Rules and Regulations Chapter 360-12	n/a	16-13-25
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.						

States with Medical Marijuana Research Laws (Therapeutic Research Programs)							
State	**MMJ Law Approved**	**Took Effect**	**Bill/Initiative#**	**Session Law**	**Citation for MMJ Law**	**Marijuana Schedule**	**Citation for Schedules**
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	n/a	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
Current Law:	For cancer only (THC only). THC is in Schedule I but is considered to be in Schedule II when used for medicinal purposes. 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.						

States with Medical Marijuana Research Laws (Therapeutic Research Programs)							
State	**MMJ Law Approved**	**Took Effect**	**Bill/Initiative#**	**Session Law**	**Citation for MMJ Law**	**Marijuana Schedule**	**Citation for Schedules**
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
Current Law:	For life- or sense-threatening diseases. The program has never been operational. 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.						
NM	Feb. 21, 1978	Feb. 21, 1978	H.B. 329	ch. 22 (1978)	26-2A	I*	30-31-3
Current Law:	For glaucoma and cancer chemotherapy (marijuana or THC); patients with other diseases must get approval from Patient Qualification Review Board. Administered by the Department of Health and Environment; the program was operational. Would have expired on July 1, 1979, but ch. 11 (1979) extended the program indefinitely. *State follows the federal government's scheduling of controlled substances as articulated in the Code of Federal Regulations [30-31-5; Board of Pharmacy, 505-841-9102]. Marijuana and THC are in Schedule I but are considered to be in Schedule II when used for medical purposes.						
NY	June 30, 1980	Sept. 1, 1980	S.B. 1123-6	ch. 810 (1980)	PHL § 3397 and PHL § 3328	I	PHL § 3306
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. 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).						
RI	May 19, 1980	May 19, 1980	H.B. 79.6072	ch. 375 (1980)	§ 21-28.4-1	I	§ 21-28-2.08
Current Law:	Patients must be involved in a life- or sense-threatening situation (original law specified cancer chemotherapy, glaucoma, and other disease groups); program—which has never been operational—administered by director of the Department of Health; director or director's designee authorized to review patients and physicians for participation in program (original law specified Patient Qualification Review Board). Amended by 86-H 7817 in 1986 (ch. 236) to instead say "life- or sense-threatening conditions," and deletes references to Patient Qualification Review Board.						

States with Medical Marijuana Research Laws (Therapeutic Research Programs)							
State	**MMJ Law Approved**	**Took Effect**	**Bill/Initiative#**	**Session Law**	**Citation for MMJ Law**	**Marijuana Schedule**	**Citation for Schedules**
SC	Feb. 28, 1980	Feb. 28, 1980	S. 350	Act No. 323 (1980)	§ 44-53-610	I	§ 44-53-160 and § 44-53-190
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; "Commissioner shall obtain marijuana through whatever means he deems most appropriate consistent with federal law." Minor amendments made by Act No. 181 (1993).						
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
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, after approval of Board of Health, may seek authorization to expand research program to include other diseases; get THC from federal government. 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. 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.						

States with Symbolic Medical Marijuana Laws								
State	**MMJ Law Approved**	**Took Effect**	**Measure**	**Session Law**	**Citation for MMJ 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
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. H.B. 2518 was signed by the governor on April 21, 1997, to repeal the medical marijuana provision of Prop. 200. H.B. 2518 requires the FDA to approve the medical use of marijuana before Arizona physicians can prescribe it. To prevent H.B. 2518 from taking effect, the sponsors of Prop. 200 qualified another ballot proposal (Prop. 300) that would allow the medical marijuana provision of Prop. 200 to remain in effect. On Nov. 3, 1998, Arizona voters voted "no" to the legislature's law by rejecting Prop. 300 (57% opposed, 43% in favor) and thus upholding the medical marijuana statute. 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.							
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. 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.							
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
Current Law:	For cancer chemotherapy and glaucoma. 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.							

States with Symbolic Medical Marijuana Laws

State	MMJ Law Approved	Took Effect	Measure	Session Law	Citation for MMJ Law	Description of Law	Marijuana Schedule	Citation for Schedules
DC	July 27, 2000	May 2001	Bill No. 13-240	Act 13-395 (2000)	§ 33-518	scheduling recognizes marijuana's therapeutic use	III	§ 33-516

Current Law: 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.

History: D.C. voters passed Ballot Initiative 59 on Nov. 3, 1998 (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.

DC 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 non-profit marijuana suppliers; and allowed a "sufficient quantity" of marijuana to treat illness.

States with Symbolic Medical Marijuana Laws

State	MMJ Law Approved	Took Effect	Measure	Session Law	Citation for MMJ 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 medicinal 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.							
LA	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.							
MT	March 26, 1979	March 26, 1979	H.B. 463	ch. 320 (1979)	50-32-222(7)	scheduling recognizes marijuana's therapeutic use	I	50-32-222

States with Symbolic Medical Marijuana Laws								
State	**MMJ Law Approved**	**Took Effect**	**Measure**	**Session Law**	**Citation for MMJ Law**	**Description of Law**	**Marijuana Schedule**	**Citation for Schedules**
Current Law:	Would automatically reschedule THC and marijuana to Schedule II if the federal government authorizes the prescription or administration of these substances.							
NH	April 23, 1981	June 22, 1981	S.B. 21	ch. 107 (1981)	318-B:9	physicians may prescribe	I*	318-B:1-a
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 only prescribe marijuana 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].							
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
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 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 medicinal 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.)							
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

States with Symbolic Medical Marijuana Laws								
State	**MMJ Law Approved**	**Took Effect**	**Measure**	**Session Law**	**Citation for MMJ Law**	**Description of Law**	**Marijuana Schedule**	**Citation for Schedules**
Current Law:	For cancer and glaucoma (marijuana or THC). Allows physicians to prescribe and pharmacists to dispense marijuana and THC for such purposes.							
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)
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	**MMJ Law Approved**	**Took Effect**	**Bill #**	**Session Law**	**Citation for MMJ 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

States in Which Medical Marijuana Laws Have Expired or Been Repealed									
State	**MMJ Law Approved**	**Took Effect**	**Bill #**	**Session Law**	**Citation for MMJ Law**	**Description of Law**	**Law Expired / Repealed**	**Marijuana Schedule**	**Citation for Schedules**
Current Law:	Marijuana and THC are listed in Schedule VI, but Schedule VI substances are defined similarly—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
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 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.								
MI	Oct. 22, 1979; Dec. 21, 1982	Oct. 22, 1979; Dec. 21, 1982	S.B. 185 (1979); S.B. 816 (1982)	Act No. 125 (1979); Act No. 352 (1982)	§ 333.7335	therapeutic research program	1979 law expired November 1, 1982; 1982 law does not apply after November 1, 1987	I	§ 333.7212; MAC 338.3114 and 338.3119a (1986 Annual Supplement); MAC 338.3113 (1988 Annual Supplement)
History:	For glaucoma and cancer chemotherapy (marijuana or THC); allowed patients with other diseases if patients have IND (Investigational New Drug) permit from FDA. Administered by the Department of Public Health, the program was operational; marijuana and THC considered to be in Schedule II when dispensed through the program; used federal marijuana; also authorized to use marijuana confiscated by state law-enforcement agencies (which almost certainly never happened). 1979 law expired on November 1, 1982, and then a nearly identical law was enacted a month later, which expired on November 1, 1987.								

States in Which Medical Marijuana Laws Have Expired or Been Repealed

State	MMJ Law Approved	Took Effect	Bill #	Session Law	Citation for MMJ Law	Description of Law	Law Expired / Repealed	Marijuana Schedule	Citation for Schedules
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
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."								
OH	March 21, 1980; 1995	June 20, 1980; July 1, 1996	S.B. 184; S.B. 2	Act No. 230 (1980); not available	§ 2925.11(I)	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:	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. 1996 law read 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.								

States in Which Medical Marijuana Laws Have Expired or Been Repealed

State	MMJ Law Approved	Took Effect	Bill #	Session Law	Citation for MMJ Law	Description of Law	Law Expired / Repealed	Marijuana Schedule	Citation for Schedules
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-2-204
History:	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 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.								

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	19-03.1-04
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	§ 35-7-1012 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
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) xx
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 medicinal purposes.

Medical Marijuana Briefing Paper – 2004

– 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 seven (7) 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 released that day was the result of two years of research that was funded by the White House drug policy office, which comprised a meta-analysis of all existing data on marijuana's therapeutic uses. *Please see <http://www.mpp.org/science.html>.*

Medicinal 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:

- Relief from nausea and increase of appetite;
- Reduction of intraocular ("within the eye") pressure;
- Reduction of muscle spasms;
- 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.
- **Glaucoma.** Marijuana can reduce intraocular pressure, thereby alleviating the pain and slowing—and sometimes stopping—the progress of the condition. (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 the chronic, often debilitating pain caused by myriad disorders and injuries.

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 **seven** people with special permission from the federal government, medical marijuana remains illegal!

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 from the ailment itself; or
2. Illegally obtain marijuana—and risk suffering consequences 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 medicinal 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 medicinal 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 medicinal 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 medicinal uses:

- Many scientists studied the health effects of marijuana and inadvertently discovered marijuana's astonishing medicinal history in the process.
- Many who used marijuana recreationally also suffered from diseases for which marijuana is beneficial. By fluke, they discovered its therapeutic usefulness.

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.

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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:

> "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. ..."
>
> (September 6, 1988)

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 still 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:

- Most patients would never consider the idea that an illegal drug might be their best medicine;
- Most patients fortunate enough to discover marijuana's medicinal value did not discover the IND program;
- Most of those who did learn of the program could not find doctors willing to take on the arduous task of enrolling in and working through the IND program.

In 1992, in response to a flood of new applications from AIDS patients, the Bush administration closed the program to all new applicants. On December 1, 1999, the Clinton administration restated that the IND program would not be reopened. Consequently, the IND program remains in operation only for the seven surviving previously approved patients.

Public Opinion

There is tremendous public support for ending the prohibition of medical marijuana:

- Since 1996, a majority of voters in Alaska, California, Colorado, the District of Columbia, Maine, 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. Recent polls have shown that public approval of these laws has increased since they went into effect.
- 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 broken the law by suggesting 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.]
- A Harris Interactive poll conducted October 23-24, 2004, and published in the November 4, 2002, issue of *Time* magazine found that 80% of Americans believe that "adults should be allowed to legally use marijuana for medical purposes if their doctor prescribes it. ..." (1,007 adults were interviewed for a 3.1% margin of error.) Over the last decade, polls have consistently shown between 60% and 80% support for legal access to marijuana.

Changing State Laws

The federal government has no legal authority to prevent state governments from changing their laws to remove state-level criminal penalties for medical marijuana use. Indeed, Hawaii enacted a medical marijuana law via its state legislature in June 2000. Vermont enacted a similar law in May 2004. 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, as the courts tend to defer to the DEA, which is aggressively working to keep marijuana illegal.

Efforts to obtain FDA approval of marijuana are similarly stalled. Though some small-scale studies of marijuana are now 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. Under the present circumstances, it is virtually impossible to do the sort of large-scale and 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 seven 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 http://bob.nap.edu/books/0309071550/html/

Appendix D: Surveys of Public Support for Medical Marijuana

Every scientifically conducted public opinion poll ever conducted has 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 percent 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. 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 *Time* magazine
Jan. 2002	70	N/A N/A	"Should medical marijuana be allowed?"	Center for Substance Abuse Research, Univ. of Maryland
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 *Wired* 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

Nationwide medical marijuana public opinion polling results				
Date	**Percent in favor**	**Margin of error / respondents**	**Wording**	**Polling firm/where reported**
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/*The New York Times*
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 Mobile Register
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	Feb. 2002	72	± 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
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	March 2002	73	± 4% 1,059 adults	"Do you favor changing the law to allow people with cancer, AIDS, and other serious illnesses to use and grow their own marijuana for medical purposes, if they have approval of their physician?"	Lucas Organization and Arlington Research Group, on behalf of MPP
District of Columbia	Nov. 1998	69	± 3.6% 763 voters leaving polling place	Favor medical marijuana	Fairbank, Maslin, Maullin & Associates, reported in *The People Have Spoken*
Florida	1997	63	± 4% 400 registered voters	Favor approving an amendment to the Florida Constitution legalizing "medicinal" marijuana	Florida Voter Poll of Ft. Lauderdale/The Miami Herald
Georgia	April 2001	69	± 4.5% 500 adults	Favor medical marijuana	Survey USA for KUSA (Denver), reported in *The People Have Spoken*
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	Mar. 14-17, 2002	67	± 3.9% 800 likely Illinois 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
Maine	Oct. 1999	68	± 4% 400	Support legalizing marijuana for medical use under a doctor's supervision	Bangor Daily News/WCSH 6 Poll, reported in *The People Have Spoken*

State-specific medical marijuana public opinion polling results					
state	**date**	**% in favor**	**margin of error/ respondents**	**wording**	**polling firm/where reported**
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
	1999	81	N/A 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. ... with the proper credentials could not be arrested or prosecuted for marijuana possession"	Fairbank, Maslin, Maullin & Associates on behalf of Americans for Medical Rights
Minnesota	Jan. 2001	59	± 4% 600 adults	Support "legalizing the use of marijuana for medical purposes"	Lazarus Strategic Services
Montana	Feb. 2002	66	± 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 grow their own medical marijuana with the support of their physicians"	Lucas Organization and Arlington Research Group, 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
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	Nov. 2003	84	± 4.5% 501 likely 2004 Democratic primary voters	"Do you strongly agree, somewhat agree, somewhat disagree, or strongly disagree that federal law should be changed so that people with cancer, AIDS, and other serious illnesses can use medical marijuana legally with the approval of their physician?"	Zogby International, on behalf of MPP
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 poll conducted by Mason-Dixon Polling & Research, "Poll: Voters Support Medical Pot" (Terrell, Steve) Santa Fe New Mexican, Oct. 5, 2002

State-specific medical marijuana public opinion polling results					
state	**date**	**% in favor**	**margin of error/ respondents**	**wording**	**polling firm/where reported**
New York	January 2003	66	± 3.5% 834 likely voters	Support allowing "people with cancer, AIDS, and other serious illnesses to use and grow their own marijuana for medical purposes, so long as their physician approves"	Zogby International, on behalf of MPP
North Dakota	Feb. 2002	63	± 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
Ohio	April 1998	71	± 6% 410 likely voters in Franklin County	Believe patients with glaucoma or undergoing chemotherapy "should be able to use [marijuana] legally"	Erney, Busher & Associates, Inc., sponsored by Columbus Institute for Contemporary Journalism, reported in The People Have Spoken, "Franklin County Voters Support Medical Marijuana," The Columbus Free Press, April 1998
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	Dec. 1978	83	N/A 1,008 respondents	Favor marijuana's prescriptive medical availability	National Center for Telephone Research
Rhode Island	March 19–22, 2004	69	± 4.5% 501 randomly selected voters	Support legislation " to allow people with cancer, AIDS, and other serious illnesses to use and grow their own marijuana for medical purposes, as long as their physician approves"	Zogby International, on behalf of MPP
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	April 2001	71	± 4.5% 500 adults	Favor medical marijuana	Survey USA for KUSA (Denver), reported in *The People Have Spoken*
Vermont	March 19–22, 2004	71	± 4.5% 502 randomly selected voters	Support pending legislation "to allow people with cancer, AIDS, and other serious illnesses to use and grow their own marijuana for medical purposes, as long as their physician approves"	Zogby International, 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**
Vermont	Mar. 19-22, 2004	71.2	± 4.5% 502 likely voters	Support a bill currently pending in the Vermont Legislature "that would allow people with cancer, AIDS, and other serious illnesses to use and grow their own marijuana for medical purposes, as long as their physician approves"	Zogby Poll, on behalf of MPP
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	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
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. 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 pain-killer, 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.

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 Nine Effective State Laws Are Working

Vermont

At the time that this report went to print, Vermont's medical marijuana law was not yet implemented, so there is no data on the law's effectiveness. 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. Although Gov. James Douglas (R) allowed S. 76 to become law without his signature on May 26, 2004, it did not take effect until July 1, 2004. The law gives the Vermont Department of Public Safety 120 days to implement a registry. Once the system is implemented, the department has 30 days to distribute registration cards to qualifying patients and their caregivers.

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 (AIDS, cancer, multiple sclerosis, or HIV positive status) 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 new medical marijuana law.

California

California's initiative was the first to be enacted and, as with all initial efforts, Proposition 215 did not address every aspect of medical marijuana policy. Most notably, California's law did not place a specific limit on the amount of marijuana that may be possessed by a patient, nor did it permit any state agency to establish guidelines for the law.

An estimated 75,000 patients are currently utilizing Proposition 215.[1] Patients throughout the state, with the help of their primary caregivers, are growing and using medical marijuana upon the recommendations of their physicians.

The major unresolved issue is supply. How much marijuana is sufficient for the "personal medical purposes" of a patient, as defined by Proposition 215? Without any specified numerical guidelines, law-enforcement officials sometimes err on the side of arresting—or at least hassling—patients if the quantity seems too large. One ruling in a state appeals court, *People v. Trippet* (1997), 56 Cal. App. 4th 1532, addressed the issue, but failed to provide much clarification. Commenting on the matter, Judge Paul Haerle said, "the rule should be that the quantity possessed should be reasonably related to the patient's current medical needs." (Of note, that same ruling also said that transportation of marijuana by patients and caregivers was implicitly included in Proposition 215.)

Another state appeals court ruling, *People v. Rigo* (1999), 69 Cal. App. 4th 409, determined that physician approval is necessary prior to arrest in order to assert an affirmative defense against a charge of marijuana possession.

On July 18, 2002, in a unanimous ruling, the California Supreme Court granted medical marijuana patients powerful legal protection against state prosecution for possession and cultivation of marijuana. The court ruled that Prop. 215 allows medical marijuana patients to move to dismiss attempts to prosecute them in a pretrial motion. In essence, Prop. 215 allows patients to avoid a jury trial if they are valid medical marijuana users.

As one would expect, without statewide regulations, enforcement of Proposition 215 varies widely. Some jurisdictions allow organized distribution, while some are hesitant to recognize a patient's

[1] Based on Oregon's mandatory medical marijuana registration, it can be estimated that all states will have approximately 0.2% of the population using medical marijuana.

right to use medical marijuana at all. A September 2000 ruling in San Diego Superior Court highlighted the discrepancies: In a case against five individuals connected to a medical marijuana clinic in Hillcrest, Judge William Mudd said that the defendants "took all steps necessary to comply with the statute," but the law is so "botched up" that what is legal in some parts of the state is illegal in San Diego.[2] Consequently, Mudd dismissed the charges, which could have put the defendants behind bars for six years if they had been convicted.

Attempting to address the questions left unanswered by Proposition 215, California Attorney General Bill Lockyer 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, the task force produced a number of recommendations that were added to a bill sponsored by Vasconcellos. The bill, Senate Bill 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 where medical marijuana may be authorized, and require that a patient's personal physician make the recommendation.

Although S.B. 848 was developed in a bipartisan atmosphere, it failed to pass the legislature in 1999 or 2000.

As a result, many of the state's medical marijuana rules remain open-ended, and the Department of Health Services has little responsibility to communicate with patients until a standardized policy is in place.

S.B. 187, a bill similar to S.B. 848, was introduced in 2001 and passed the House and Senate in slightly varying forms. Vasconcellos, the bill's sponsor, chose not to push for final passage in the Senate, fearing a veto from Gov. Gray Davis who has expressed no interest in working on the issue.[3]

In 2003, Sen. Vasconcellos again introduced a modified bill, S.B. 420, to implement the task force's recommendations. Governor Gray Davis (D) signed S.B. 420 on October 12, 2003. This is the first comprehensive law passed to clarify California's medical marijuana statutes since Proposition 215 in 1996. To help resolve the inconsistencies among jurisdictions in enforcing the medical marijuana law, S.B. 420 provided a statewide limit of eight ounces of marijuana and six mature or 12 immature plants per patient. Counties and localities may raise the limits, but are not permitted to lower them. Further, the new law mandated the creation of a voluntary statewide ID card and registry system so that medical marijuana patients' protection from arrest would be guaranteed throughout the state. Although the system was originally scheduled to start in January 2004, statewide ID cards had not been issued as this report went to print. Some counties are issuing temporary ID cards until the statewide cards become available.

Despite the inconsistencies among local jurisdictions, patients who possess and use small amounts of marijuana face very little threat of prosecution, even in the many jurisdictions in California that remain hostile to medical marijuana. Most of the medical marijuana arrests that have taken place involved two dozen plants or more, although there have been arrests for as few as six plants.

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[2] Of note, on February 4, 2003, the San Diego City Council voted 6-3 to enact guidelines that allow medical marijuana patients to possess up to one pound of marijuana and 20 plants.

[3] "Lawmaker puts pot bill on 'back burner'," *The Daily Review*, Sept. 27, 2001.

As the state that pioneered effective medical marijuana laws, California has been the site of two key federal lawsuits.[4] The first case, *Conant v. McCaffrey* (later known as *Conant v. Walters*), examined whether physicians have a right under federal law to discuss marijuana and recommend it to their patients. The second case, *U.S. v. Oakland Cannabis Buyers' Cooperative*, considered whether "medical necessity" is a valid defense against federal marijuana distribution charges. Please see Appendix I for detailed information on these cases.

Oregon Medical Marijuana Program		
Patient Characteristics	First Year (2000)	Third Year (2002)
Total Number	594	3,003
Average Age (range)	46 (14-87)	46 (18-87)
Male	415 (70%)	2,067 (68%)
Disease / Condition*		
Severe Pain	396 (67%)	1,760 (58%)
Spasms	243 (41%)	676 (23%)
Nausea	169 (29%)	154 (5%)
HIV	62 (10%)	98 (3%)
Cancer	54 (9%)	88 (3%)
Cachexia	44 (7%)	43 (1%)
Seizures	34 (6%)	71 (2%)
Glaucoma	16 (3%)	43 (1%)
Physicians participating	329	628
Counties with patients	31	34
Patients with a caregiver	60%	60%

* percentages may total more than 100% because many patients report multiple symptoms

Similar to the other seven effective medical marijuana laws, California's law does not 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—often referred to as "cannabis buyers' cooperatives" (CBCs) or "clubs"—emerged throughout the state. In fact, some had been in existence before the initiative became law. The CBCs essentially act as "caregivers" for the patients they serve. In many cases, patients are required to designate the CBC as their primary caregiver.

The most successful CBCs have been low-key and politically savvy, carefully orchestrating their operations every step of the way. Working above ground and with scrutiny, they have forged positive relationships with local governments, including law enforcement agencies. These CBCs carefully evaluate all applicants, maintain detailed inventories, and observe strict policies for on-site behavior. These steps allow local authorities to support the distributors' operations with the knowledge that only qualified patients receive marijuana and that no marijuana is diverted for illicit purposes.

Unfortunately, many CBCs were shut down either by state and local law enforcement or by federal legal action. The San Francisco CBC, for example, was targeted by the state attorney general's office. In that case, the California First District Court of Appeals ruled that a commercial enterprise that sells marijuana does not qualify as a primary caregiver.[5]

[4] See Appendix I for detailed information.

[5] *People ex rel. Lungren v. Peron* (1997), 59 Cal. App. 4th 1383.

The Oakland Cannabis Buyers' Cooperative (OCBC) 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.)

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.

Despite the occasional questions and controversies, California's medical marijuana law has increased in popularity since it was enacted. A statewide Field poll released in January 2004 found that 74 percent of California voters approved of legal protections for medical marijuana patients, compared to the 56 percent who approved Prop. 215 when it appeared on the 1996 ballot. ("Medical pot law gains acceptance, Prop. 215 polls better now than when it passed," San Francisco Chronicle, Jan, 30 2004)

Oregon

Oregon's medical marijuana registry program is the most popular in the nation, with more than 6,000 patients enrolled as of late 2003.

The volume of patients, however, overwhelmed the understaffed program in 2001, and an internal audit revealed numerous problems.

The program often failed to verify doctor signatures on applications, regularly missed deadlines for processing applications, and had no clear procedure for rejecting incomplete applications. In June 2001, the program had a backlog of almost 800 applications. Three registry cards (out of more than 2,000) had been issued to patients who had forged doctors' signatures. Those cards were revoked—and represented a mere fraction of the applications handled—but the oversights underscored the need for additional staff.

Originally, the program had been staffed by just one full-time employee and three part-time employees. Six full-time and one temporary employee now staff the program. As a result, the backlog of applications has been cleared and oversight has improved greatly. There have been no cards revoked in the last year, and six to eight cases of suspected fraud have been caught during the application-review process. The program continues to receive about 75 new applications per week.

Despite past administrative problems, the Oregon program has always compiled extensive data on the patients it registers. A comparison of patients in the program at the end of its first and third years is provided below.

In the program's first year, there were 1.8 patients participating in the program for every physician. That ratio has jumped to 4.8-to-one, because of a single physician—Dr. Phillip Leveque, a 77-year-old osteopath from Molalla—who has signed applications for nearly 2,000 patients.

Leveque's extensive list of recommendations led the Oregon program to adopt stricter rules for physicians. Under the new rules, doctors who sign program applications for patients must maintain an up-to-date medical file for each patient, perform a physical, and develop a treatment plan. The state program would also be allowed to examine a copy of the patient's file.

Leveque maintains that he was merely signing applications on behalf of legitimate patients whose own physicians were too timid to participate in the program. He believes the new rules will restrict patient participation. Program officials maintain that the rules are meant to ensure that patients and their physicians comply with the law.

The state medical board suspended Leveque for 30 days for failing to follow accepted standards of medical care when signing for medical marijuana patients. He was also fined $5,000 and placed on 10 years' probation.

Despite the publicity afforded Leveque, physician participation in Oregon has been relatively strong. In addition to individual physicians supporting the program, 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.

Although the program has had administrative problems, no substantial law-enforcement problems have yet materialized. A study conducted by the federal General Accounting Office (GAO) in 2002 on four states' (including Oregon's) medical marijuana programs found that "medical marijuana laws had had little impact on their law enforcement activities for a variety of reasons."[6] In addition, the federal government has not prosecuted a single medical marijuana patient or doctor in Oregon.

The system is not perfect, however. Patients, law enforcement, and state health officials agree that the greatest problem is the law's failure to provide for medical marijuana distribution. If a patient and his or her primary caregiver cannot cultivate their own marijuana, they must turn to the criminal market. Unfortunately, growing marijuana has been a problem for many patients. For some, the costs are prohibitive, while others may not have the space or horticultural skills necessary to cultivate a consistent supply. According to estimates by one patient advocate, as few as 25 percent of qualified patients have access to a steady supply of marijuana. To address these shortcomings, a new ballot initiative is being circulated with the goal of placing it on the November 2004 ballot.

The only clear flaw in the registry program is that the legislature has not provided any funds for its operation. As a result, the program is entirely supported by patient fees, which are $150 per application and must be renewed each year. This presents a financial hardship to the many patients who are too ill to work. Further, when this cost is coupled with the costs of cultivating marijuana, it could cost a patient $1,000 just to get started, and insurance does not cover any of this. Fortunately, the initiative that may appear on the November 2004 ballot (called the Oregon Medical Marijuana Act 2) would significantly lower the registration fee to only $20.

In tune with the information age, the program provides up-to-date information on its web site. Recent changes to the law and related administrative rules, application forms, and a frequently-asked-questions page are available at www.dhs.state.or.us/publichealth/mm/index.cfm.

In addition to administering the registry program, the Health Division 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, eight conditions were considered: agitation of Alzheimer's disease, anxiety, attention deficit disorder, bipolar disorder, insomnia, post-traumatic stress disorder, schizophrenia, and schizo-affective disorder. After review by an expert panel, three of the conditions (agitation of Alzheimer's disease, anxiety, and bipolar disorder) were recommended to the Health Division for final approval. The Division approved agitation of Alzheimer's disease, while rejecting the other two. The unapproved conditions may be reconsidered if additional supporting evidence can be offered.

In July 1999, less than nine months after the initiative 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

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

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. Also, cautious policies for seizing and destroying marijuana plants are provided for jurisdictions to consider.

In 2003, Oregon avoided passing a bill that would have made the medical marijuana program even more restrictive. Introduced by Rep. Jeff Kruse (R), H.B. 2939 would have disqualified any person previously convicted of a drug violation from accessing the medical marijuana program. In addition, it would have required medical marijuana patients to complete a "medical marijuana education course." H.B. 2939 passed the House, but the Senate did not bend to the pressure of this hostile legislator. The bill died in the Senate Health Policy Committee.

A major unresolved issue is whether a caregiver who serves multiple patients can have more than seven plants at a single location. One interpretation of the law says that if a caregiver serves three patients, then the caregiver could grow up to 21 plants, as each caregiver-patient pair is permitted to collectively possess seven plants. A competing interpretation says a caregiver cannot exceed the seven-plant limit, regardless of the number of patients under his or her care. This issue is also addressed in the attorney general's recommendations, which are available at www.doj.state.or.us/medmar.htm.

Another looming question is what constitutes a "mature" plant. The law says that only three of a patient's seven plants can be mature, which has led to some disagreements between patients and police. According to a local patient advocate, however, police are beginning to ignore the mature-immature distinction as long as patients have seven or fewer plants. In cases where registered or qualified patients possess more than seven plants, police are regularly destroying the plants in excess of the specified number, while leaving the permissible number intact, which was the preferred policy of the legislative working group that produced the 1999 amendments to the law.

Alaska

Alaska's medical marijuana history resembles Oregon's. Both states passed initiatives in 1998. Registry programs were established in both states, and each legislature amended the law within a year of its enactment. Differences, however, can be traced to the legislature's amendments, where Alaska lawmakers imposed far greater restrictions on their state's medical marijuana law.

Signed into law on June 1, 1999, Senate Bill 94 made Alaska's medical marijuana registration mandatory. No longer can residents assert a medical necessity defense if they adhere to the intent of the law but do not obtain a registry card.

Despite the state government's efforts to protect patient privacy, many Alaskans are reluctant to add their names to a list of individuals who have serious medical conditions and use medical marijuana. As a result, many patients do not register and thus have no legal protection.

Further, the legislature 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. Understandably, patients often complain that the plant limit is too low.

Related to the low plant limit, local advocates believe some patients are unable to maintain a con-

sistent 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.

Despite these restrictions, 180 patients registered with the program in the first 14 months of its existence. Seventy-seven physicians submitted documentation on behalf of those patients—a ratio of 2.3 patients for every physician, similar to Oregon's ratio. Although physician participation appears strong, patient advocates argue that many doctors refuse to sign statements on behalf of patients because of fear of federal retribution.

This problem may be uniquely compounded in Alaska, where many doctors are federal employees, working for either the Indian Health Service or the Department of Veterans Affairs. Outside of Washington, D.C., Alaska has the nation's largest per capita share of federal employees.

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

Since the program has opened, no registry cards have been revoked, and there have been no real test cases of the law. However, there are pending cases involving individuals who are on felony probation and have applied for and received medical marijuana registry cards. Under the terms of their probation, they are strictly prohibited from using any controlled substance, and the state contends they are not eligible for the medical marijuana exception.

Although the scope of the law has narrowed, 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, according to 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 jurisdiction to jurisdiction, 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

Similar to California's law, Washington's medical marijuana statute does not place a numerical limit on the amount of marijuana that may be possessed by a patient. Instead, the law allows patients to possess no more than a "sixty day supply." Further, the initiative does not designate any state agency to implement or oversee the law. As a result, Washington has no formal system for identifying patients, and there has been no clarification of a "sixty day supply."

Patient advocates estimate that there are at least 5,000 medical marijuana patients utilizing the state law. There could, however, be as many as 10,500 patients statewide, based on Oregon's mandatory registration system (which shows approximately 0.2% of the population using medical marijuana). Most patients grow their own medical marijuana, either by themselves or with the help of a caregiver. To assist those patients who cannot grow marijuana, a number of patient cooperatives exist. These

discreet organizations verify patients' credentials, distribute marijuana, and provide related services. They do not, however, meet the state's strict definition of a caregiver.

As a result, patient cooperatives have faced the threat of prosecution. The Green Cross Patient Co-op, located in West Seattle, stopped distributing medical marijuana after it received a "cease and desist" letter from the Seattle Police Department on July 27, 2001. Although Green Cross had been operating out of a Highland Park residence for years with the knowledge of many in the community, police asked it to shut down after receiving complaints from some neighbors. Green Cross served about 1,500 patients. It continues to provide some services, but patients are now referred elsewhere to obtain medical marijuana. Although police and prosecutors contend that Green Cross broke the law by serving multiple patients, they consciously worked to avoid dragging patients and their caregivers into court.

Supply—exactly how much patients and their caregivers may legally possess—remains the chief issue surrounding the law.

A recent appellate court decision, the first test of the law, 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.

The ruling, issued on March 12, 2002, by the state Court of Appeals in Spokane, suggested that physicians should determine how much a patient needs.

"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.[7]

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.

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. An appeal to the state Supreme Court is expected.

There have been attempts in the state legislature to clarify what constitutes a "sixty day supply" of medical marijuana, but bills have failed to become law in each of the last three sessions.

S.B. 5704 and S.B. 5176, considered in 1999-2000 and 2001-2002, respectively, would have authorized the state Department of Health to adopt administrative rules to implement the medical marijuana law. Although these bills had strong support in the Senate, neither had the force to get past the House. In 2003, Sen. Jeanne Kohl-Welles (D) sponsored a similar bill in the Senate for the third consecutive session. S.S.B. (Senate Substitute Bill) 5947, which would have allowed for clarifications and rules to implement the medical marijuana law, did not make it out of the Rules Committee.

In the absence of additional rules, local law enforcement has 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, but they

[7] "Appeals court backs strict reading of medical marijuana law," *Seattle Post-Intelligencer*, March 13, 2002.

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 claims that it 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. As an informational courtesy, the department 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 cause specific symptoms like nausea, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms, and spasticity, when these symptoms are unrelieved by standard treatments. The commission has rejected the inclusion of insomnia and post-traumatic stress disorder. According to Rob Killian, M.D., 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.

Maine

The Maine legislature broke new ground in 2002, becoming the first state to expand an existing medical marijuana law.

Signed into law on April 1, L.D. 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 system is in place.

Most 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 authorized the use of medical marijuana—quietly signed the bill into law, demonstrating that medical marijuana has not caused problems or controversy in Maine.

In fact, the legislature went so far as to consider having the state 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 OCBC case in 2001. Nonetheless, they were compelled to take action to improve the law that was approved by 61

percent of Mainers.

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]."[8]

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.

Geographical distribution of registered medical marijuana patients and their certifying physicians in Hawaii

	Registered Patients	Certifying Physicians
Big Island (Hawaii)	559	21
Kauai	267	13
Maui	127	17
Oahu	148	32
Totals	1,101	83

Data current as of November 20, 2003

According to Mainers for Medical Rights, the advocacy organization that sponsored the initiative, approximately 250 patients use medical marijuana. 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 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.

For example, two patients in separate cases—a 62-year-old man with muscular dystrophy and a 53-year-old man with muscle-hardening torticollis and a degenerative bone condition—were arrested for possessing 83 and 37 plants, respectively, in addition to at least one pound each of processed marijuana. These cases were reported in the Bangor Daily News on August 23, 2000, and the Portland Press Herald on September 23, 2000, respectively. There is little doubt about the validity of the patients' medical needs; however, they are in clear violation of the law. Despite this, they claim that the excessive amounts are necessary to maintain a medical marijuana supply throughout the year. But the law does not allow patients to assert an affirmative defense to argue that excessive amounts are medically necessary.

Although the 62-year-old defendant could have faced one year in jail and a $2,000 fine for the misdemeanor charge, he pleaded no contest and was fined $200 with no jail time.

Patients who feel compelled to exceed the plant limit in 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.

[8] "Bill clarifies medical marijuana guidelines," *Bangor Daily News*, March 6, 2002.

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 helping implement or administer the law. The bureau is not interested 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.

Hawaii

Although Hawaii's medical marijuana statute was signed into law on June 14, 2000, it did not take effect until December 28, 2000, when the Department of Public Safety issued administrative regulations and finalized designated 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, stating that they have debilitating conditions and the medical benefits of marijuana likely outweigh the risks.

In the registry program's first 15 months of operation, 540 patients signed up for the state program, and 44 physicians provided written certification for the participation of at least one patient. As of November 20, 2003, 83 physicians had recommended medical marijuana to 1,101 patients.

Data provided by the Hawaii Department of Public Safety, current through November 2003, shows the geographical breakdown of participating patients and physicians.

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. Copies of the booklet can be obtained from the DPFH Web site at www.dpfhi.org.

Although there were several failed attempts to curtail or undercut the medical marijuana law during the 2001-2002 legislative session, no bills were introduced in 2002 that would be harmful to patients; however, in 2003, a harmful bill was introduced in the legislature. The House Committee on Health deferred the bill (H.B. 1218), which would raise the fee ceiling for patients and provide penalties for physicians who violate the parameters of the medical marijuana law. The success in deferring this bill is indicative of legislative support for medical marijuana in Hawaii.

Colorado

On June 1, 2001, less than three weeks after the U.S. Supreme Court's negative ruling on medical marijuana distribution, the Colorado Department of Public Health and Environment (CDPHE) began issuing identification cards to patients and caregivers who qualify for legal protection under the state medical marijuana law approved by voters in November 2000.

After scrutiny from Colorado Governor Bill Owens (R) and Attorney General Ken Salazar (D)—both of whom oppose medical marijuana—no reason could be found to scrap the registry program. Following exhaustive research and vigorous debate by attorneys in their offices, Owens and Salazar jointly said "the Supreme Court's holding in the Oakland case was deliberately narrow enough to permit Colorado's medical registry to go forward."[9]

In the first year of the program, 149 applications from patients were received and approved. Only three applications were rejected, all for being incomplete. Severe pain is the most commonly reported ailment (58%) by registering patients, followed by muscle spasms (35%), nausea (27%), and ailments related to HIV/AIDS (12%).

Symptoms reported by patients in Nevada's medical marijuana registry program (as of June 1, 2002)

Disease or Condition	Number reported*
Severe Pain	109
Muscle Spasms	50
Severe Nausea	44
HIV / AIDS	27
Cachexia	24
Glaucoma	9
Cancer	8
Seizures	2

* Numbers total more than the 165 registered because many patients report multiple symptoms.

About half of registered patients have primary caregivers. The average patient age is 46, with a range of 20 to 92. There were no minors registered in the first year. Forty-five percent of the state's counties have at least one registered patient. Fifty-eight percent of patients come from rural areas, while 42 percent come from the Denver and Boulder areas. Seventy percent of applicants are male.

More than 117 physicians submitted supporting documentation for patients, giving Colorado the highest physician-to-patient ratio among the states with medical marijuana registry programs.

Colorado's high rate of physician participation may stem directly from information they receive from the program. Gail Kelsey, the program's administrator, tells physicians who are concerned about liability that Drug Enforcement Administration officials have informally told her that doctors are not breaking federal law by signing the program's registration forms.

Colorado's program also received a boost in legitimacy when, in July 2001, Kaiser Permanente gave its Colorado doctors permission to recommend medical marijuana. As of October 31, 2003, 202 physicians had signed forms recommending medical marijuana to 348 patients. 56% of patients have designated a primary caregiver.

"As with all medical decisions, we leave that up to the doctor to decide what type of therapy is best for the patient," said Steve Krizman, spokesman for Kaiser Permanente, regarding Kaiser's policy on medical marijuana.[10] Kaiser, one of the nation's largest health maintenance organizations, has 375,000 patients in Colorado.

Patients have expressed two main complaints regarding the state's law. First, many patients find the annual $140 registration fee to be a financial burden. Some patients, in fact, have failed to register

[9] "Owens' and Salazar's joint statement on medical marijuana," *Denver Rocky Mountain News*, May 31, 2001.

[10] "Kaiser to allow medical marijuana," *The Daily Times-Call*, July 7, 2001.

because they cannot afford it. 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, however, the program is working well. Although the program has 35 days to approve or reject applications, the average turnaround is one day. The program is staffed by one part-time employee, and it receives one to two new applications per week.

There have been only two publicized cases of a patient getting into trouble with police.

James Scruggs, a Crohn's disease patient from Cherry Creek, a Denver suburb, was accused of growing 22 marijuana plants, which police said were more than what one person would need for his or her own medical purposes.[11] Mr. Scruggs' case was dismissed due to insufficient evidence.

The state medical marijuana law restricts patients to growing six plants, three of which may be mature. The law, however, also allows patients to argue at trial that quantities in excess of that amount are medically necessary.

The district attorney's office felt confident that it could have won a conviction if it had been able to prove that Scruggs had 22 marijuana plants. Although district attorneys have prosecutorial discretion, the Scruggs case indicates that they may pursue patients who exceed the numerical limit of six plants.

The courts will decide on a case-by-case basis whether more than six plants is acceptable, but legitimate patients could face hardships if police and prosecutors are inflexible. Patients may see their supplies of medical marijuana seized and destroyed, and they may encounter substantial legal costs, whether or not they are convicted.

The second case involves Don Nord, a 57-year-old registered medical marijuana patient, who had his home raided by a local-federal drug task force. They 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 what rightfully belonged to him—his medicine.

The DEA decided to return his growing equipment, but still refused to return the marijuana to Mr. Nord. Judge Garrecht took another step toward the conflict of state and federal law, when he ordered the nine officials who participated in the raid of Mr. Nord's home to be held in contempt of court. Garrecht ordered a "show cause" hearing, where the nine officers will have to explain to the judge why they should not be held in contempt of court. As of March 2004, the "show cause" hearing had yet to be held.

Information and application forms for the Colorado registry program can be obtained from the CDPHE Web site at www.cdphe.state.co.us/hs/medicalmarijuana/marijuanafactsheet.asp.

Nevada

Nevada's medical marijuana registry program was launched in October 2001 with the enrollment of its first six patients. By early December of that year, nearly 60 were approved to use the drug legally.

As of April 2003, 181 physicians had recommended medical marijuana to 287 registered patients.

The program is running smoothly, with no signs of fraud or abuse. Even though the registry cards have a phone number printed on them that police can call if there are any questions, the program has received only a couple of calls from law-enforcement officers. No registry cards have been revoked.

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[11] "Defendant cites medical pot law," *Denver Post*, Dec. 12, 2001, and "Medical marijuana case takes interesting twist," *Denver Rocky Mountain News*, May 15, 2002.

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. More than two-thirds (67.6 percent) are male. The diseases and conditions reported by registered medical marijuana patients are provided in the chart to the right.

Nevada's registry program is the only one in the nation that does not charge patients an application or registry fee. Of note, the legislature and governor failed to provide any money for the program's operation. Currently, the program is operated using general funds from the state Department of Agriculture, which oversees the registry. Thus far, there have been no problems related to the program's lack of dedicated funding.

Nevada's law is arguably the 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.

Since the program's inception, about 1,200 information packets have been mailed to prospective patients. The 13-page packets include information on the program and the law, as well as application forms and physician certification forms.

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.

The medical marijuana registry program was put into place by a 2001 law passed by the Nevada legislature, which implemented the initiative that state voters approved on November 7, 2000. Assembly Bill 453, sponsored by Assemblywoman Chris Giunchigliani (D), 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.

Additionally, the Senate added an amendment to A.B. 453 that requires the state Department of Agriculture to work aggressively to obtain federal approval for a distribution program for marijuana and marijuana seeds. Another amendment 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 amendments.

Enacted after the U.S. Supreme Court's ruling on medical marijuana, the preamble of A.B. 453 says "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." There has been no federal action against Nevada or its citizens related to the state's medical marijuana law.

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 benefit from legal protection for using medical marijuana.

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

1. Exemption from 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 prosecution" prevents the state from 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 law in Alaska. 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 typically not arrested. Two states, Colorado and Oregon, allow individuals to use an affirmative defense to argue that an amount of marijuana in excess of the specified legal limit is medically necessary.

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 defense, 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]

[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.

The difference seems slight, but its effect is great. Patients in California are now 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.

The most recent medical marijuana law is unique in that it requires neither a prescription nor a recommendation, but rather a certification.

- Vermont law allows a person to register with the state as a medical marijuana patient if that patient possesses 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, Nevada, Virginia, Vermont, 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

Like a "recommendation," a "certification" is not a legal document. It is a diagnosis by a qualified physician in the context of a bona fide physician-patient relationship. By issuing a "certification," a physician is simply certifying 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.

A physician does not need to have a professional opinion on a patient's medical use of marijuana in order to issue a "certification." And because of this, medical marijuana law based on "certification" should fully eliminate physicians' concerns that they might face liability related to medical marijuana.

Appendix I: Federal Litigation and Other Federal Attempts to Thwart Effective State Medical Marijuana Laws

A *New York Times* article that covered the signing of Hawaii's medical marijuana bill into law on June 14, 2000, said, "the Justice Department is challenging those laws" that remove state-level criminal penalties for patients who cultivate, possess, and use medical marijuana. That is simply false. 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 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 "a problem" because there are not enough Drug Enforcement Administration (DEA) agents to enforce federal law 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

[1] Turner challenged the constitutionality of U.S. Rep. Bob Barr's 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 distriubtion of marijuana. This amendment had the effect of preventing the local 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.

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.

The Bush administration has maintained this stance against prosecuting patients who grow, possess, or use any amount of marijuana for their own medical purposes. Speaking in 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.

Thus it is highly unlikely that the federal government will ever be able to overturn state medical marijuana laws. 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. In select cases, however, the U.S. Department of Justice may take legal action against selected individuals and organizations for egregious violations of federal law.

Since 1996, there have been five key cases of federal litigation relating to medical marijuana: *Conant v. Walters, U.S. v. Oakland Cannabis Buyers' Cooperative, Wo/Men's Alliance for Medical Marijuana v. U.S., County of Santa Cruz v. Ashcroft*, and *Raich and Monson v. Ashcroft.*

Dr. Marcus Conant v. John L. Walters (No. 00-17222) — Originally *Dr. Marcus Conant v. McCaffrey* (No. C97-00139 WHA)

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 asserts 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 Justice Department sought to overturn Alsup's ruling. In a hearing before the Ninth Circuit Court 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 law. 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 an historic victory when the U.S. Supreme Court refused to hear *Conant*, letting stand the Ninth Circuit ruling from October 2002. This powerful ruling appears to have put a stop to the federal government's efforts 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. The case has since been remanded to district court as a result of a subsequent Ninth Circuit U.S. Court of Appeals ruling in *Raich* on June 18, 2004. The court ruled the federal government overstepped its bounds as delineated by the Commerce Clause in the U.S. Constitution when it enforced federal marijuana laws. The U.S. Department of Justice appealed the *Raich* decision to the Supreme Court, and on June 28, 2004, the court agreed to hear it.

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 Justice Department 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 the 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 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."

Whether an individual may assert a "medical necessity defense" to federal marijuana charges, however, may never be determined because the federal government has no history of prosecuting such cases—and there are no signs of that trend reversing, despite the ruling. Indeed, there has yet to be a federal prosecution of a simple medical marijuana possession case in any of the nine states that currently have effective medical marijuana laws.

Given the Supreme Court's narrow ruling, OCBC appealed the case again in the district court, raising constitutional and other issues.

OCBC argues 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 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 is appealing 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 Justice Department, affects OCBC, the Marin Alliance for Medical Marijuana in Fairfax, and a dispensary in Ukiah.

On June 18, 2004, the Ninth Circuit sent the case back to district court, arguing that "issues in

Raich may control the outcome in this case. Accordingly, this case is remanded for the district court to reconsider after the Supreme Court has completed its action in *Raich*."

On June 28, 2004, the Supreme Court agreed to hear Raich. See appendix I-6 for a further discussion of *Raich.*

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

Ruling: On August 28, 2003, U.S. District Court Judge Jeremy Fogel dismissed the lawsuit brought out by Santa Cruz County by ruling that federal laws trump California's medical marijuana law. The Ninth U.S. Circuit Court of Appeals reversed this decision and ordered a preliminary injunction barring the federal government from arresting or prosecuting plaintiffs. The case awaits U.S. Supreme Court action in *Raich*.

Background: This suit was prompted by a DEA raid that received national attention last September, when heavily armed federal agents stormed the Wo/Men's Alliance for Medical Marijuana (WAMM) cooperative and destroyed 167 marijuana plants. During this raid, they handcuffed several medical marijuana patients while destroying 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 seven plaintiffs who are also patients of the cooperative. The defendants in the case are U.S. Attorney General John Ashcroft, former DEA Administrator John Brown, and the director of the White House Office of National Drug Control Policy, John Walters. This is an 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, 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 167 plants. They were taken into custody but never 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. Ashcroft* focuses on constitutional issues related to the Commerce Clause; because no interstate trade or commercial activity is 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 denied the plaintiffs' motion for a preliminary injunction that would have barred the federal government from conducting raids while the case was tried. In light of a landmark decision by the Ninth Circuit in December of that year, the plaintiffs asked Judge Fogel to reconsider his decision.

In a case similar to *Santa Cruz, et al.*, *Raich v. Ashcroft*, the Ninth Circuit agreed with the plaintiffs' Commerce Clause argument and barred federal authorities from conducting raids. The court further ruled that the federal government lacked jurisdiction to interfere with the plaintiffs' activity under the Controlled Substances Act, which it ruled unconstitutional as it relates to medical marijuana. In *Raich*, the Ninth Circuit specifically criticized Judge Fogel's initial decision in the WAMM case, stating that the court had erred in its analysis.

In light of the precedent set by *Raich*, on April 21, 2004, Judge Fogel issued an historic preliminary injunction barring the Justice Department from raiding or prosecuting WAMM in Santa Cruz, California.

See page I-6 for a further discussion of *Raich.*

Wo/Men's Alliance for Medical Marijuana, Valerie Corral, and Michael Corral v. United States of America (No. 03-15062)

Ruling: As of November 2003, the Ninth U.S. Circuit Court of Appeals was still considering whether to overturn an earlier U.S. District Court ruling that denied the return of the 160 marijuana plants that were taken by Drug Enforcement Administration (DEA) agents during the September 2002 raid.

Background: This is the second suit that was filed by the Wo/Men's Alliance for Medical Marijuana (WAMM) following the DEA raid in 2002. WAMM cofounders Valerie and Michael Corral filed this lawsuit on the grounds that the federal government unlawfully seized property from them during the raid of the medical marijuana cooperative.

Although the plants were worth thousands of dollars, U.S. District Court Judge Jeremy Fogel denied the return of the plants, but the DEA did return a computer and other items that belonged to the Corrals.

Judge Fogel's ruling led WAMM to appeal the decision to the Ninth Circuit. According to the Corrals' lawyer, Ben Rice, "[The appeal] is to vindicate WAMM and get the Ninth Circuit to agree the feds were overstepping their authority" in the raid.[2]

The DEA has said that it will not return the marijuana plants.

Angel Raich and Diane Monson v. Ashcroft, et al. (No. 03-15481)

Ruling: On December 16, 2003, the Ninth U.S. Circuit Court of Appeals ruled in favor of two California medical marijuana patients and their caregivers, remanding the case to the U.S. District Court with instructions to issue an injunction barring the U.S. Department of Justice from raiding or arresting the plaintiffs. The Justice Department has appealed to the U.S. Supreme Court, which on June 28, 2004, agreed to hear the case.

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 allow her to function normally. Medical marijuana is the only medicine that allows her to function normally.

The lawsuit seeks to enjoin the U.S. 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."[3]

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[2] Brian Seals, "WAMM Set for Appeal to Return Seized Pot," *Santa Cruz Sentinel*, September 14, 2003.

[3] Taken from http://raich-v-ashcroft.com/page6.html

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

The appeals court heard oral arguments on October 7, 2003. On December 16, 2003, the court issued an opinion reversing the 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 court 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. This decision may also help to stave off further federal obstruction in states that have medical marijuana laws.

On February 26, 2004, the Ninth Circuit unanimously rejected the Justice Department's petition for an *en banc* review of the ruling.

The Justice Department has appealed to the U.S. Supreme Court. On June 28, 2004, the court agreed to hear the case.

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. (See www.mpp.org/guidelines.)

These new obstacles are not surprising, given NIDA's institutional mission. Its mission is 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, sought permission to conduct research on medical marijuana as part of the school's Medicinal Plant

Program. Prof. Craker was given elusive and contradictory information by the DEA several times, and was finally denied the permission to conduct research two years after applying. 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.

- Donald Abrams, M.D., a researcher at the University of California at San Francisco, 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." (Bruce Mirken, "Medical Marijuana: The State of the Research," AIDS Treatment News, no. 257, October 18, 1996.) He was only able to gain approval 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." (Mirken, above.)
- 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, 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. (Ethan Russo, "Marijuana for migraine study rejected by NIH, Revisited," posted on www.maps.org, March 1999)

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 November 2003, 14 research projects are currently under way, and one more is moving through the approval process. The focus of the research, however, is not to expand patient access to the drug, but to produce data on marijuana's safety and efficacy.[1] Most of the projects now underway are small pilot studies. The Center for Medicinal Cannabis Research (CMCR), as the program is known, is administered within the University of California system, rather than through a state health agency. More information is available at the Center's Web site at www.cmcr.ucsd.edu.

[1] Research teams are having difficulty recruiting and retaining patients because the marijuana supplied by NIDA is of low quality. These patients find they can obtain higher-quality, more effective marijuana from the criminal market. This underscores the need to end NIDA's monopoly on legally grown marijuana for research.

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. Oregon's medical marijuana law permits this defense for unregistered but documented patients, 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 elements 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 three states whose legislatures have passed bills to establish the medical necessity defense for medical marijuana offenses—Maine, Massachusetts, and Ohio. Ultimately, these efforts 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.

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]

States where courts have allowed the medical necessity defense in marijuana cases	
California	*People v. Trippet*, 56 Cal. App. 4th 1532, review denied (1997)
Florida	*Jenks v. Florida*, 582 So. 2d 676 (Ct. App. 1st Dist., Fl. 1991)
Florida	*Sowell v. State*, 738 So. 2d 333 (Ct. App. 1st Dist., Fl. 1998)
Hawaii	*State v. Bachman*, 595 P. 2d 287 (Haw. 1979)
Idaho	*Idaho v. Hastings*, 801 P. 2d 563 (Sup. Ct. Idaho 1990)
Iowa	*Iowa v. Allen Douglas Helmers* (Order No. FECR047575)
Washington	*Washington v. Diana*, 604 P. 2d 1312 (Ct. App. Wash. 1979)
Washington	*Washington v. Cole*, 874 P. 2d 878 (Ct. App. Wash. 1994)
District of Columbia	*United States v. Randall*, 104 Wash. Daily L. Rep. 2249 (D.C. Super. Ct. 1976)

[1] See Appendix I.

States where courts have refused to allow the medical necessity defense in marijuana cases		
Alabama	*Kauffman v. Alabama*, 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	*Spillers v. Georgia*, 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.
Maine	*Maine v. Donald Christen,* Som-96-129 (1997)	The Maine Supreme Court ruled that the "competing harms defense" applies only to conduct that the actor believes to be necessary to avoid imminent physical harm to himself or another, and that there be no reasonable alternative other than violating the law.
Massachusetts	*Massachusetts v. Hutchins,* 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	*Minnesota v. Hanson,* 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.
New Jersey	*New Jersey v. Tate,* 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	*South Dakota v. Matthew Ducheneaux,* 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.

Appendix L: State Medical Marijuana Legislation Considered (2003–2004)

State medical marijuana legislation considered during the 2003-2004 legislative sessions*

State	Bill Number	Intent	Good or Bad	Outcome
Arkansas (2003)	H.B. 1321	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana.	G	Died in committee.
California (2003)	S.B. 295	Eliminate the three-year limit on California's state-created medical marijuana research program at the University of California.	G	Passed House 49-27, Senate 24-12, and was signed into law by governor.
California (2003)	S.B. 420	Make clarifications to the medical marijuana law, including establishing a registry system with state ID cards; define qualifying conditions; and pave the way for patient growing cooperatives.	G	Passed House 42-32, Senate 24-14, and was signed into law by governor.
California (2004)	S.B. 1494	Make clarifications to medical marijuana law, specifying that the state guidelines for possession of medical marijuana and plants are minimum amounts for the counties to allow.	G	Passed Senate 21-3, in Assembly committee at time of publication.
Connecticut (2003)	H.B. 5100	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana.	G	Defeated on House floor, 79-64.
Connecticut (2004)	H.B. 5355	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana.	G	Passed House 75-71, but was sent to additional committee instead of Senate floor. After passing committee, died as session ended.
Hawaii (2003-2004)	H.B. 1218	Restrict medical marijuana law by removing the $25 cap on registry fees, restrict those in certain public-safety professions from qualifying as patients, and limit the locations where patients can grow their medicine.	B	Carried over to 2004 and died in committee.
Hawaii (2003-2004)	H.C.R. 212 (H.D. 1), H.R. 122	Request the Legislative Reference Bureau to study provisions of the medical marijuana law.	G	Carried over to 2004 and died in committee.
Hawaii (2003-2004)	S.B. 1389	Place numerous limitations on medical marijuana statute.	B	Carried over to 2004 and died in committee.
Hawaii (2004)	H.B. 2669, S.B. 3139	Allow tax-exempt organizations—including a church that includes marijuana use among its sacraments—to distribute medical marijuana and to use marijuana to treat crystal methamphetamine addiction.	G	Died in committee.

State medical marijuana legislation considered during the 2003-2004 legislative sessions*

State	Bill Number	Intent	Good or Bad	Outcome
Hawaii (2004)	H.C.R. 152 (H.D. 2)	Request the Legislative Reference Bureau to study how marijuana could be distributed to the state's medical marijuana patients	G	Passed both Houses, no executive action needed
Hawaii (2004)	H.R. 108-4	Request a plan to procure and distribute marijuana to the state's medical marijuana patients and request a study on treating crystal methamphetamine addiction with marijuana	G	Died in committee
Hawaii (2004)	S.B. 2029	Strip affirmative defense provision for medical marijuana from statutes	B	Died in committee
Hawaii (2004)	S.B. 2641 (S.D. 2)	Make numerous improvements to medical marijuana statute	G	Passed Senate 22-1, died in House committee
Hawaii (2004)	S.R. 32, S.C.R. 66	Request the Department of Health to report to the legislature on medical marijuana use	G	Died in committee
Illinois (2004)	H.B. 4868, S.B. 2440	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana	G	H.B. 4868 pending hearing in subcommittee
Iowa (2003-2004)	S.F. 234	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana	G	Died in subcommittee
Maryland (2003)	H.B. 702	Maximum $100 fine if patient demonstrates to judge that use was for medical purposes	G	Passed House 73-62, Senate 30-16, and signed into law by governor
Massachusetts (2003-2004)	H.B. 2965, S.B. 676	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana	G	Hearing held, died in committee
Michigan (2004)	H.R. 226	Non-binding House resolution opposing states' and cities' medical marijuana initiatives	B	Passed House 96-7, no further action needed
Minnesota (2003-2004)	H.F. 1440, S.F. 1328	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana	G	Died in committee
Mississippi (2003)	H.B. 1044	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana	G	Died in committee
Mississippi (2004)	H.B. 84	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana	G	Died in committee
Missouri (2003)	H.B. 644	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana	G	Died in committee

State medical marijuana legislation considered during the 2003-2004 legislative sessions*

State	Bill Number	Intent	Good or Bad	Outcome
Missouri (2004)	H.B. 1348	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana.	G	Died in committee.
Montana (2003)	H.B. 506	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana.	G	Defeated on House floor, 60-40.
Nevada (2003)	A.B. 130	Add osteopaths (D.O.s) to list of physicians qualified to recommend medical marijuana; establish guidelines for fees.	G	Passed House 41-0, Senate 21-0, and was signed into law by governor.
New Jersey (2004)		Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana.	G	Introduction expected.
New Mexico (2003)	H.B. 242	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana.	G	Passed three committees, failed on the floor, 46-20.
New York (2003-2004)	A. 5796, S. 4805	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana.	G	A. 5796 died in committee in 2003, carried over to 2004.
New York (2004)	A. 5796A	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana (amended from version introduced in 2003).	G	In committee at time of publication, further action expected.
New York (2004)	Senate version of A. 5796A	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana.	G	Introduction expected.
North Carolina (2003-2004)	H.J.R. 1038	Authorize the Legislative Research Commission to study the possession, cultivation, and use of marijuana for medical purposes.	G	Died in committee.
Oregon (2003)	H.B. 2939	Modify medical marijuana law by precluding any patient who has a prior drug conviction and require patients to attend and complete a "medical marijuana education course."	B	Died in committee.
Rhode Island (2003)	S.B. 725	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana.	G	Died in committee.
Rhode Island (2004)	H.B. 7588, S.B. 2357	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana.	G	Both bills had hearings and died in committee.
Vermont (2003-2004)	S. 76	Remove criminal penalties and threat of arrest for registered patients who grow, possess, and use medical marijuana.	G	Passed House 79-48, Senate 20-7, and became law without governor's signature.

State medical marijuana legislation considered during the 2003-2004 legislative sessions*

State	Bill Number	Intent	Good or Bad	Outcome
Washington (2003-2004)	S.S.B. 5947	Create a task force to study the implementation of the medical marijuana law	G	Died in committee
Wisconsin (2004)	H.B. 892	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana	G	Died in committee
Wyoming (2003)	S.F. 44	Remove criminal penalties and threat of arrest for patients who grow, possess, and use medical marijuana	G	Died on Senate General File

* 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: 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[1], that there are some circumstances in which smoking marijuana is a legitimate medical treatment[2]; 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 illegally[3]; 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 beneficial[4] and are already using it with their doctors' approval; and,

whereas, numerous organizations have endorsed the medical access to marijuana, including the AIDS Action Council, AIDS Project Rhode Island, American Academy of HIV Medicine (AAHIVM), American Anthropological Association, American Bar Association, American Nurses Association, American Preventive Medical 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, Life Extension Foundation, Lymphoma Foundation of America, Medical Society of the State of New York, 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), Progressive National Baptist Convention, Project Inform (national HIV/AIDS treatment education advocacy organization), Rhode Island Medical Society, Rhode Island State Nurses Association, Test Positive Aware Network (Illinois), Texas Democratic Party, The New England Journal of Medicine, Union of Reform Judiasm (formerly Union of American Hebrew Con-

gregations), Unitarian Universalist Association, United Church of Christ, United Methodist Church, United Nurses and Allied Professionals (Rhode Island), Wisconsin Nurses Association, and Wisconsin Public Health Association; 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 purpose;" and,

whereas, a scientific survey conducted in 2002 by Harris Interactive for *Time* magazine indicated that 80% of American adults "think that adults should be allowed to legally use marijuana for medical purposes if their doctor prescribes it";[5] and,

whereas, numerous other national public opinion polls have found substantial support for medical marijuana, including surveys conducted by ABC News, CBS News, the Family Research Council, and the Gallup Organization between 1997 and 1999; and,

whereas, since 1996, medical marijuana initiatives received a majority of votes in every state in which they appeared on the ballot—Alaska, Arizona, California, Colorado, the District of Columbia, Maine, Nevada, Oregon, and Washington state[7]; and,

whereas, on June 14, 2000, Governor Ben Cayetano of Hawaii signed into law the first medical marijuana bill enacted via a state legislature which permits the cultivation, possession, and use of medical marijuana; and,

whereas, the May 14, 2001, United States Supreme Court ruling on medical marijuana dealt exclusively with federal law, was essentially limited to distribution issues, and does not affect the ability of individual states to allow patients to grow, possess, and use medical marijuana under state law[8]; and,

whereas, the Ninth U.S. Circuit Court of Appeals, in the case of Walters v. Conant, 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 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 prescription[9]; 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 years[10]; 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 marijuana[11] and the resulting bureaucratic controls impede additional scientific research into marijuana's therapeutic potential[12], 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 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 criminal sanctions for using marijuana if the patient's physician has told the patient that such use is likely to be beneficial.

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

[2] From Principal Investigator Dr. John Benson's opening remarks at the Institute of Medicine's news conference releasing the report Marijuana and Medicine: Assessing the Science Base (March 17, 1999).

[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)

[5] Harris Interactive interviewed 1,007 adults (3.1% margin of error), selected at random, on behalf of Time magazine, which released its results in its November 4, 2002 issue.

[6] 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).

[7] **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; **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.

[8] U.S. v. Oakland Cannabis Buyers' Cooperative, No. 00-151.

[9] 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.

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

[11] Section 812(c) of Title 21, United States Code.

[12] 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.

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 which 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, Oregon, and Washington enacted statutory law. (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.

23* States and D.C. Have the Initiative Process				
	Statutory Law		Constitutional Amendment	
State	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.

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 on this page.)

Appendix O: Effective Arguments for Medical Marijuana Advocates

Effective Arguments for Medical Marijuana Advocates

by Chuck Thomas and Bruce Mirken

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, coordinating state legislative activities, 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 33 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 brochures for other activists. Additions or suggestions should be sent to MPP for inclusion in future editions of this paper.

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 tens 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 reported, "Nausea, appetite loss, pain, and anxiety are all afflictions of wasting, and all can be mitigated by marijuana. …"[1] Regarding marijuana's safety, the IOM also 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."[2] (The issue of smoking is dealt with in **Challenge #26**, below.)

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. …"[3]

Response C: A 1997 review found more than 70 modern studies published in peer-reviewed journals or by government agencies verifying that marijuana has medical value.[4] Many more have appeared since then.

[1]Institute of Medicine, *Marijuana and Medicine: Assessing the Science Base* (Washington, D.C.: National Academy Press, 1999), 159.
[2]Institute of Medicine, 5.
[3]"In the Matter of Marijuana Rescheduling Petition," DEA Docket No. 86-22, September 6, 1988.
[4]"Research Findings on Medicinal Properties of Marijuana," K. Zeese; Falls Church, VA: Common Sense for Drug Policy, 1997.

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Response D: In a detailed review published in May 2003, *The Lancet Neurology* evaluated current knowledge regarding marijuana's active components, called cannabinoids. This esteemed, peer-reviewed medical journal stated, "Cannabinoids inhibit pain in virtually every experimental pain paradigm. ... That we are only just beginning to appreciate the huge therapeutic potential of this family of compounds is clear ... some people suggest that cannabis [marijuana] could be the 'aspirin of the 21st century.'"[5]

Response E: There is extensive anecdotal evidence. However, this is in addition to the scientific evidence accepted by doctors and scientists, published in journals, and extensively peer-reviewed.

CHALLENGE #2: "Other drugs work better than marijuana. We should not make marijuana medically available unless it is shown to be the most effective drug for treating a particular condition."

Response A: No other drugs are required to be the **most** effective before they are made medically available—just **effective** (as well as safe enough). The reason is that 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.

Response B: 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."[6]
- "[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."[7]
- "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."[8]

CHALLENGE #3: "Why is marijuana needed when it is already available in pill form?"

Response A: THC, marijuana's main psychoactive ingredient, is sold in pill form as the prescription drug Marinol (with the generic name "dronabinol"). But people who use the pill find that it commonly takes an hour or more to work, while 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. As NIH panelist Avram Goldstein, M.D., explained on February 20, 1997: (1) "[T]he bioavailability is generally very good by the smoked route, and generally very predictable, whereas bioavailability by the oral route [pills] is both not good and not predictable in general," and (2) "[B]y the smoking route, the person can self-regulate or titrate the dosage. …"[9] *The Lancet Neurology* came to the same conclusion in May 2003, stating, "Oral administration is probably the least satisfactory route for cannabis."[5]

Response B: The price of the pill is 10-20 times that of the price of naturally grown marijuana. In an era of rapidly rising medical costs, we should be promoting the most economical alternatives.

Response C: NIH panelist Mark Kris, M.D., explained 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."[10]

Response D: Marijuana contains about 60 active cannabinoids in addition to THC.[11] Many of these compounds are believed to interact synergistically to produce therapeutic effects that THC alone does not. For example, cannabidiol seems to be primarily responsible for controlling spasticity,

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[5]Baker, David, *et al.*, "The Therapeutic Potential of Cannabis," *The Lancet Neurology 2* (May 2003), 291-298.
[6]Institute of Medicine, 159.
[7]Institute of Medicine, 3-4.
[8]Institute of Medicine, 159.
[9]"Report on the Possible Medical Uses of Marijuana," NIH medicinal marijuana expert group; Rockville, MD: National Institutes of Health, August 8, 1997; 81-82, 95.
[10]Ibid note 9, 89.
[11]*Marihuana, the Forbidden Medicine,* L. Grinspoon, M.D., and J. Bakalar; New Haven, CT: Yale University Press, 1993.

and it also moderates THC's effects so patients are less likely to get excessively "high."

Response E: 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 60 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. As the Institute of Medicine noted in 1999, "[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."[12]

Response B: Marijuana naturally contains all 60 cannabinoids in a combination that is safe and effective, and which has already given relief to millions of people. In contrast, it took years of research to develop the THC pill, which is still the only pharmaceutical cannabinoid available in the U.S. No other cannabinoids are even in advanced stages of testing in this country, meaning it will be years before we see any such drugs on 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, herbal medicine.

Response B: The availability of such delivery systems should not be used as an excuse to maintain the prohibition of the use of smokable 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.

Response C: [Use responses A and B to **Challenge #4**.]

CHALLENGE #6: "We should not subvert the FDA approval process by passing bills and initiatives."

Response A: 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. Indeed, the FDA has long permitted Americans to obtain (generally from overseas) and possess medicines—for their own personal use—that are not approved for U.S. sale. 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 B: There is already substantial evidence that marijuana is safe and effective for some patients. (See responses to **Challenge #1**.) However, the FDA's bureaucratic requirements mean that the specific types of studies that would be required for licensing, labeling, and marketing marijuana as a prescription drug would take many years—and would likely cost tens or even hundreds of millions of dollars. It is cruel and unfair to subject seriously ill patients to the threat of arrest and jail while we wait for this slow, cumbersome process. That is why *The New England Journal of Medicine* called the federal ban on the medical use of marijuana "misguided, heavy-handed and inhumane."[13]

Response C: 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 D: The decision to place marijuana in Schedule I of the 1970 Controlled Substances Act (the classification given to drugs deemed to have no accepted medical use) was not made by the FDA. It was a political decision, made by Congress. It is both appropriate and necessary to use political processes to correct a political mistake.

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[12]Institute of Medicine, 7.
[13]Kassirer, Jerome, "Federal Foolishness and Marijuana" (editorial), *The New England Journal of Medicine* (January 30, 1997), 366.

CHALLENGE #7: "Using marijuana for medicine is like using tobacco to facilitate weight loss."

Response: Many tobacco users do, in fact, use cigarettes as an appetite suppressant. But there are three major differences:

1. Medical marijuana is used to treat very serious ailments, not to maintain a trim figure. These therapeutic uses of marijuana are well-documented in the scientific literature. [Use any response to **Challenge #1**.]
2. Tobacco is a deadly drug, while research has shown that marijuana does not decrease life expectancy. A government-funded study conducted by the Kaiser Permanente Medical Care Program, published in the *American Journal of Public Health*, found no association between marijuana use and premature death in otherwise healthy people.[14]
3. Tobacco users are not arrested or sent to prison, regardless of the reason they are using it. Marijuana users—even those using it for medicine—are considered criminals.

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 California Student Survey (CSS), conducted by California's Office of the Attorney General, documented that marijuana use by California teens rose markedly until 1996—the year California's medical marijuana law, Proposition 215, passed—and dropped substantially afterwards. Among ninth graders, current marijuana use rates dropped by nearly half from 1996 to 2000.[15,16]

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."[17]

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: "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."[18] (See **Challenge #26** for a discussion of smoking.) In a 1998 editorial mainly focused on marijuana's recreational use, *The Lancet* stated, "[O]n the medical evidence available, moderate indulgence in cannabis has little ill-effect on health, and … decisions to ban or to legalize cannabis should be based on other considerations."[19]

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. The question is this: Do the benefits outweigh the risks for an individual patient? That decision should be made by a patient's doctor, 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 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,

[14]"Marijuana Use and Mortality," *American Journal of Public Health, 87(4)*, S. Sidney *et al.*, April 1997; 585-590.
[15]Skager, Rodney and Gregory Austin, Report to Attorney General Bill Lockyer. Eighth Biennial California Student Survey, 1999-2000, Major Findings: Alcohol and Other Drug Use, Grades 7, 9 and 11 (Los Alamitos, CA: WestEd, September 2000).
[16]Skager, Rodney and Gregory Austin, Report to Attorney General Bill Lockyer. Ninth Biennial California Student Survey, 2001-2002, Major Findings: Alcohol and Other Drug Use, Grades 7, 9 and 11 (Los Alamitos, CA: WestEd, August 2002).
[17]Skager, Rodney, Greg Austin, and Mamie M. Wong, "Marijuana Use and the Response to Proposition 215 Among California Youth, a Special Study From the California Student Substance Use Survey (Grades 7, 9, and 11) 1997-98," 8.
[18]Institute of Medicine, 5.
[19]"Dangerous Habits" (editorial), *The Lancet* 352 (November 14, 1998), 1565.

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."[20] You cannot provide a list of 10,000 negative studies, so please stop making this false statement.

CHALLENGE #10: "Isn't marijuana bad for the immune system?"

Response A: Scientific studies have not demonstrated any meaningful harm to the immune system that marijuana causes. 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."[21] 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."[22]

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 they also gained more weight than those taking a placebo. Patients using marijuana also showed greater reductions in the amount of HIV in their bloodstream.[23]

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.[24]

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."[25]

CHALLENGE #11: "Marijuana contains hundreds of compounds. Doesn't that make it too dangerous?"

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 #9**.]

CHALLENGE #12: "Marijuana's side effects—for instance, increased blood pressure—negate its effectiveness in fighting glaucoma."

Response A: NIH medical marijuana panelist Paul Palmberg, M.D., Ph.D., a glaucoma expert, said on February 20, 1997, "I don't think there's any doubt about its effectiveness, at least in some people with glaucoma."[25xx]

Response B: The federal government gives marijuana to at least three patients with glaucoma, and it has 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 #13: "What exactly do state medical marijuana laws do?"

Response: The laws of Alaska, California, Colorado, Hawaii, Maine, Nevada, Oregon, Vermont, and Washington remove state-level criminal penalties for using, obtaining, or cultivating marijuana strictly for medicinal 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. Unlike the laws of the nine other states, 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`.)

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[20]Letter from Beverly Urbanek, Research Associate of the University of Mississippi Research Institute of Pharmaceutical Sciences (601-232-5914), to Dr. G. Alan Robison, Drug Policy Forum of Texas, June 13, 1996.
[21]Institute of Medicine, 109.
[22]Institute of Medicine, 126.
[23]Abrams, D., *et al.*, "Short-Term Safety of Cannabinoids in HIV Patients," 8th Conference on Retroviruses and Opportunistic Infections, 2001; Feb. 5-9, abstract no. 744.
[24]Di Franco, M.J., *et al.*, "The Lack of Association of Marijuana and Other Recreational Drugs With Progression to AIDS in the San Francisco Men's Health Study," *Annals of Epidemiology, 6 (4)* (1996), 283-289.
[25]Romeyn, Mary, *Nutrition and HIV: A New Model for Treatment*, second edition (San Francisco: Jossey-Bass, 1998), 117-118.

Unfortunately, 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.

CHALLENGE #14: "Don't medical marijuana laws put the states in violation of federal law?"

Response: 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 grow their own.

CHALLENGE #15: "Aren't these medical marijuana bills and initiatives full of loopholes?"

Response A: The first successful medical marijuana initiative, California's Proposition 215, did contain some vague wording. However, California courts have issued clarifying rulings, and many cities and counties have enacted local laws and regulations aimed at eliminating ambiguities. 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. Newer medical marijuana laws in other states have been drafted much more precisely, eliminating many of the concerns raised by Proposition 215.

Response B: The medical marijuana laws adopted from 1998 on in Alaska, Colorado, Hawaii, Maine, Nevada, Oregon, Vermont, and Washington were all drafted very carefully to make sure that there are no loopholes, real or imagined. 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 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 #16: "These bills and initiatives basically legalize marijuana for everyone."

Response: That is dishonest, and anyone who says this knows it is not true. A person must have an ailment that a licensed medical doctor believes is best treated with marijuana. Without a physician's recommendation, marijuana users have absolutely no chance of avoiding arrest and prosecution. The General Accounting Office (the investigative arm of Congress) interviewed officials from 37 law-enforcement agencies in four states with medical marijuana laws. 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."[26]

CHALLENGE #17: "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 percent 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.

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 roughly as much money on its anti-drug ads (many of which demonize marijuana) in **one week** as Proposition 215 supporters spent during the entire campaign!

CHALLENGE #18: "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

[26]General Accounting Office, "Report to the Chairman, Subcommittee on Criminal Justice, Drug Policy and Human Resources, Committee on Government Reform, U.S. House of Representatives. Marijuana: Early Experiences With Four States' Laws that Allow Use for Medical Purposes" (Washington, D.C.: GAO, 2002), 32.

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.

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. Doctors who are willing to write such a recommendation on their letterheads or in the patients' records or to testify to it in court do not do so lightly or casually. They do it because they strongly believe that marijuana is an appropriate treatment.

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 #19: "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 #16**.]

CHALLENGE #20: "Cannabis buyers' clubs are totally out of control!"

Response A: Most buyers' clubs in California have now worked out cooperative arrangements with local law-enforcement and public-health officials. San Francisco District Attorney Terence Hallinan has written:

> "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."[27]

Response B: The few buyers' clubs that "push the envelope" will most likely end up in court, where judges and juries will decide if they were operating as the voters intended. "Out of control" clubs will be shut down and the operators will serve serious time in prison.

Response C: The best way to eliminate buyers' clubs is for Congress to pass federal legislation so that states can create a system whereby marijuana is sold through licensed pharmacies. Such a system is already in place in the Netherlands.

CHALLENGE #21: "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 the new medical marijuana bill/initiative. 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 journals and public-health organizations, including *The New England Journal of Medicine*, the American Academy of Family Physicians, the American Public Health Association, and the American Nurses Association. Do you really think these organizations are part of a conspiracy to legalize drugs?

CHALLENGE #22: "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 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. Bryan Epis of Chico, California, is now serving a 10-year federal prison sentence

[27]Hallinan, Terence, "Medical Marijuana: Feds Should Stop Their Attack," *Desert Post Weekly* (June 6, 2002).

for growing medical marijuana for himself and other seriously ill patients.

Response B: More than 12 million marijuana users have been arrested since 1965.[28] Unfortunately, the government does not keep track of how many were medical users. However, even if only 1% of those arrestees used marijuana for medicinal purposes, that is 120,000 patients arrested!

Response C: You insist that patients really don't 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 #23: "Do people really go to prison for medical marijuana offenses?"

Response A: Federal law and the laws of 40 states do not make any exceptions for medical marijuana. Federally, possession of even one joint carries a maximum penalty of 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 numerous examples. The following is a small sampling: Gordon Hanson served six months in a Minneapolis jail for growing his own marijuana to treat grand mal epilepsy. 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. Will Foster was sentenced to more than 90 years in Oklahoma for growing marijuana for chronic pain. Bryan Epis is now serving a 10-year federal prison sentence for growing medical marijuana for himself and other seriously ill patients.

Response C: There are an estimated 77,000 marijuana offenders in prisons and jails at any given time.[29] Even if only 1% of them are medical marijuana users, that is 770 patients in prison at this moment!

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 court costs, and possible loss of employment—all of which hurt the patient's ability to pay insurance, medical bills, rent, food bills, 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 #24: "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 there is every reason to believe that if the political pressure created by ballot initiatives and legislative proposals subsides, the feds will go back to their old, obstructionist ways.

Response B: The studies approved by the federal government thus far are small, pilot studies that will provide useful data, but they 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 cannabis 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 (the University of Massachusetts is interested in developing such a program), but without success thus far. The U.S. government remains the largest single obstacle to medical marijuana research.

Response C: Although research is beginning to move forward, it will take time. Should seriously ill patients have to

[28]Crime in the United States, FBI division of Uniform Crime Reports; Washington, D.C.: U.S. Government Printing Office, annual series from 1965 to 2002.
[29]MPP estimate, based on reports from the Bureau of Justice Statistics, U.S. Department of Justice.

risk arrest and jail in the meantime, for using a medicine that they and their doctors find beneficial?

CHALLENGE #25: "How would doctors control the dosages of medical marijuana?"

Response A: According to NIH medical marijuana panelist Avram Goldstein, M.D., "We know that there are no extreme immediate toxicity issues. It's a very safe drug, and therefore it would be perfectly safe medically to let the patient determine their own dose by the smoking route."[30]

Response B: In his book, *Understanding Marijuana*, University of Southern California 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."[31]

CHALLENGE #26: "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 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. Relatively simple devices called vaporizers give users access to the fast action of inhaled cannabinoids without most of those unwanted irritants.[32] Research is continuing on vaporizers, but they cannot be marketed openly because the federal 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."[33] 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![34]

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, and methamphetamine. Do you really think marijuana is more dangerous than those drugs?

CHALLENGE #27: "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 (e.g., the AMA) simply do not have positions in support of medical access to marijuana, but they do not have any policy statements opposing it, either. These groups are professional associations, and they avoid taking controversial positions early in the debate. However, many of these groups have chapters and journals that have endorsed medical marijuana.

Response B: None of these organizations state that seriously ill patients should be subject to arrest and imprisonment for using marijuana with their doctors' approval, so the current federal laws are not in step with these organizations' positions.

Response C: Numerous health and medical organizations and other prominent associations do have favorable medical marijuana positions, including: AIDS Action Council, AIDS Project Rhode Island, American Academy of HIV Medicine (AAHIVM), American Anthropological Association, American Bar Association, American Nurses Association, American Preventive Medical 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, Life Extension Foundation, Lymphoma Foundation of America, Medical Society of the State of New York, 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,

[30]Ibid note 9, 82.
[31]Earleywine, Mitch, *Understanding Marijuana* (New York: Oxford University Press, 2002), 171.
[32]Mirken, Bruce, "Vaporizers for Medical Marijuana," *AIDS Treatment News 327* (Sept. 17, 1999).
[33]Institute of Medicine, 119.
[34]Sidney, Stephen, *et al.*, "Marijuana use and cancer incidence (California, United States)," *Cancer Causes and Control 8*, (1997), 722-728.

Inc., Ninth District of the New York State Medical Society (Westchester, Rockland, Orange, Putnam, Dutchess, and Ulster counties), Progressive National Baptist Convention, Project Inform (national HIV/AIDS treatment education advocacy organization), Rhode Island Medical Society, Rhode Island State Nurses Association, Test Positive Aware Network (Illinois), Texas Democratic Party, The New England Journal of Medicine, Union of Reform Judiasm (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, and Wisconsin Public Health Association; and numerous other health and medical groups.[35]

CHALLENGE #28: "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 #27**, 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 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 #21**.]

CHALLENGE #29: "Very few oncologists support medical marijuana. Newer surveys negate the Doblin/Kleiman survey."

Response A: The Doblin/Kleiman (Harvard University) scientifically valid, random survey of oncologists conducted in 1990 found that 54% of those with an opinion favored the controlled medical availability of marijuana—and 44% had already advised at least one of their cancer patients to obtain marijuana illegally. This was published in the peer-reviewed *Journal of Clinical Oncology*.[36]

Response B: Critics of the Doblin/Kleiman study typically cite surveys by Schwartz/Beveridge and Schwartz/Voth, claiming that a very small number of oncologists support medical marijuana. In actuality, fully one-third of the oncologists who responded to the Schwartz surveys said that they "would prescribe" marijuana if it were legal.

In addition, a majority were not opposed to rescheduling marijuana to allow doctors to prescribe it (though many registered no opinion). Because Schwartz did not guarantee anonymity, it is reasonable to expect that the non-respondents had more favorable opinions than the respondents.[37]

Response C: Even if only a small percentage of all oncologists recommend medical marijuana, this translates to thousands of patients. Should these patients be subject to arrest and imprisonment?

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 and, therefore, may determine the standards for determining which schedule a substance belongs in. This catch-22 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 New England Journal of Medicine*, *The Lancet Neurology*, the Institute of Medicine, the American Academy of Family Physicians, the American Public Health 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 #27** for a more extensive list.)

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[35] "Partial List of Organizations with Favorable Medicinal Marijuana Positions," *State-By-State Report*, Marijuana Policy Project; 2004.
[36] "Marijuana as Antiemetic Medicine: A Survey of Oncologists' Experience and Attitudes," *Journal of Clinical Oncology* 9, R. Doblin & M. Kleiman, 1991; 1314-1319.
[37] "The Medical Use of Marijuana: The Case for Clinical Trials," *Journal of Addictive Diseases 14(1)*, R. Doblin & M. Kleiman, 1995; 5-14. (Refutes critics' surveys.)

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.

Response C: Walters' statement is hollow rhetoric. When science does not back his favorite policies, he ignores the science. For example, the D.A.R.E. program has been proven ineffective, but it still receives federal funds; needle exchanges have been shown to reduce HIV transmission without encouraging more drug use, but the government does not fund them.

CHALLENGE #32: "Isn't marijuana already available for some people?"

Response: Seven 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.

Nine states allow qualifying patients to use medical marijuana, but they 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: The Supreme Court is not a scientific body and did not evaluate the scientific data. It ruled that Congress, through the Controlled Substances Act, has decreed that marijuana is not a medicine. That is indeed what Congress said, but that doesn't make it true. If Congress passed a law declaring the world to be flat, would that make it so?

Response B: The Supreme Court's ruling—in a case involving a California medical marijuana dispensary—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 was unfortunate, but it was an extremely narrow ruling that did not in any way challenge 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.

Other Useful Sound Bites

- Which is worse for seriously ill people: marijuana or prison?
- Saying that the THC pill is medicine but marijuana is not is like saying that vitamin C pills are good for you but oranges are not.
- 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?
- Tens 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.

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.

Acknowledgments

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In July 2004, this paper was updated by MPP Assistant Director of State Policies, Larry Sandell.

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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 re-open the compassionate access program which operated from 1978 until 1992, when it was closed to all new applicants. (Only seven patients remain enrolled and 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 smoke 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, smokable marijuana. 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, smokable marijuana as a prescription medicine. These groups want patients to be allowed to smoke 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 that 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 which 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.)

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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
American Academy of HIV Medicine (AAHIVM)	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
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 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." other: Support rescheduling, "...to exclude marijuana from classification as a Schedule I drug."	ANA House of Delegates resolution
American Preventive Medical Association	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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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
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 exec. dir. supporting the efforts of Californians for Compassionate Use; plaintiff in Conant v. McCaffrey; signatory of 2000 letter to U.S. Dept. of Health and Human Services
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
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 Nurses Association	9/21/1995; 12/2000	✔	✔			prescriptive access: supported California bill AB 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	2/97; 11/29/99; 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
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
Life Extension Foundation	3/1997; 12/2000	✔	✔				complaint for declaratory judgment and injunctive relief, Pearson and Show v. McCaffrey; signatory of 2000 letter to U.S. Dept. of Health and Human Services

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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
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
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 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 Nurses Association	6/29/1995; 11/29/1999; 12/2000; 02/2004	✔	✔	✔			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
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

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Name of Group	Date	Legal/ Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
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
The New England Journal of Medicine	1/30/97	✔	✔			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
Union of Reform Judiasm (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
Virginia Nurses Association	10/7/1994; 12/2000	✔	✔				resolution; signatory of 2000 letter to U.S. Dept. of Health and Human Services

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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 ONDCP Director Barry McCaffrey
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
AIDS Project Rhode Island	3/24/04	✔				unanimous vote in favor of H.B. 7588 and S.B. 2357 (MPP's model bills); testified in favor of both bills	March 2004 letter
Alaska Nurses Association	9/1998	✔				access under a physician's supervision	ANA Resolution: September 1998
American Academy of Family Physicians	1989, 1995	✔				prescriptive access "under medical supervision and control for specific medical indications"	1996-1997 AAFP Reference Manual - Selected Policies on Health Issues
American Medical Student Association	3/1993	✔					AMSA House of Delegates Resolution #12
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
California Academy of Family Physicians	1994, 1996	✔				"Support efforts to expedite access to cannaboids [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 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; amicus curiae brief supporting right to distribute medical marijuana in California (U.S. v. Oakland Cannabis Buyers' Cooperative)
California Society of Addiction Medicine	5/1997	✔				prescriptive access: urges rescheduling	California Society of Addiction Medicine News, 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

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Colorado Nurses Association	1995	✔				prescriptive access: urges rescheduling	Colorado Nurses Association 1995 Convention Directory and Book of Reports, p. 28
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 CR 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
Iowa Democratic Party	2003	✔				Consumer Protection: "We support legalizing the medical use of marijuana ..."	2003 Party Plank 59
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
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 Attorneys General	6/25/1983	✔				prescriptive access (cancer or glaucoma)	resolution
National Nurses Society on Addictions	5/1/1995	✔		✔		has since modified its support of prescriptive access	"Position Paper: Access to Therapeutic Cannabis," approved by NNSA Board of Directors
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
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 Hospice and Palliative Care Association	2003	✔				"supports A. 5796/S. 4805"	"Memorandum of Support: Medical Use of Marijuana"

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Name of Group	Date	Legal / Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
New York StateWide 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"
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 US Congress, which would prevent federal raids on medical marijuana patients and providers who are in compliance with state law
Rhode Island Medical Society	3/15/2004	✔				supports H.B. 7588 (MPP's model bill) and plans to testify in favor of H.B. 7588. "[T]he RI Medical Society supports this legislation pertaining to the medical use of marijuana. We plan to testify in favor of your bill. ..."	letter to Rep. Thomas Slater, March 15, 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 GLMA and San Francisco Medical Society
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

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Partial List of Organizations Favoring Legal/Prescriptive Access to Medical Marijuana							
Name of Group	Date	Legal/ Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
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, proposed by the Commission on Social Wellness, and adopted by 2/3 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
United Nurses and Allied Professionals (Rhode Island)	5/2004	✔				sent legislative alerts to its members endorsing H.B. 7588 and S.B. 2357 (MPP's model bills)	May 2004 letters to Rhode Island Representative Thomas Slater and Rhode Island Senator Rhoda Perry
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 their June 1999 meeting

Partial List of Organizations Favoring Compassionate Access to Medical Marijuana							
Name of Group	Date	Legal/ Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
AIDS Foundation of Chicago	2/17/1999		✔				one of 17 organizations that signed letter to ONDCP Director Barry McCaffrey
AIDS National Interfaith Network	2/17/1999		✔				one of 17 organizations that signed letter to ONDCP Director Barry McCaffrey

Appendix P: Partial List of Organizations with Favorable Positions on Medical Marijuana

Partial List of Organizations Favoring Compassionate Access to Medical Marijuana

Name of Group	Date	Legal / Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
AIDS Project Arizona	2/17/1999		✔				one of 17 organizations that signed letter to ONDCP Director Barry McCaffrey
AIDS Project Los Angeles	2/17/1999		✔				one of 17 organizations that signed letter to ONDCP 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 Conant v. McCaffrey; 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 ONDCP 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 ONDCP Director Barry McCaffrey
Center for Women Policy Studies	2/2002		✔				Signatory of letter to President Bush
Colorado AIDS Project	2/17/1999		✔				one of 17 organizations that signed letter to ONDCP 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-Conmigo	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

Appendix P: Partial List of Organizations with Favorable Positions on Medical Marijuana

Partial List of Organizations Favoring Compassionate Access to Medical Marijuana							
Name of Group	Date	Legal / Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
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
Latino Commission on AIDS	2/17/1999		✔				one of 17 organizations that signed letter to ONDCP 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
Minnesota Nurses Association	2/2002		✔				Signatory of letter to President Bush
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 ONDCP 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 ONDCP Director Barry McCaffrey

Appendix P: Partial List of Organizations with Favorable Positions on Medical Marijuana

Partial List of Organizations Favoring Compassionate Access to Medical Marijuana

Name of Group	Date	Legal / Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
National Academy of Sciences' Institute of Medicine	3/17/1999		✔	✔			Marijuana and Medicine: Assessing the Science Base; see mpp.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
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 ONDCP Director Barry McCaffrey
National Native American AIDS Prevention Center	2/17/1999		✔				one of 17 organizations that signed letter to ONDCP 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 ONDCP 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 ONDCP 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
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

Appendix P: Partial List of Organizations with Favorable Positions on Medical Marijuana

Partial List of Organizations Favoring Compassionate Access to Medical Marijuana						
Name of Group	Date	Legal / Prescriptive Access	Compassionate Access	Research	Other	Comments	Reference
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 ONDCP 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	Feb. 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 ONDCP 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
Women and Men Against AIDS (Bronx, NY)	2/17/1999		✔				one of 17 organizations that signed letter to ONDCP 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 SB 535	letter to California State Sen. John Vasconcellos
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

Appendix P: Partial List of Organizations with Favorable Positions on Medical Marijuana

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 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 Psychiatric News, 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."	California Society of Addiction Medicine News, Spring 1997
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")	PA News article discusses BMA report, "The Therapeutic Uses of Cannabis"
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
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
The Lancet Neurology	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," The Lancet Neurology, Vol. 2, No. 5, May 1, 2003

Appendix Q: Model Bill

Be it enacted by the people of the state of _____:

SECTION 1. TITLE. Sections 1 through 10 of this Act shall be known as the _____ Medical Marijuana Act.

SECTION 2. PURPOSE.

(a) Modern medical research has discovered a beneficial use for marijuana in treating or alleviating the pain or other symptoms associated with certain debilitating medical conditions, as found by the National Academy of Sciences' Institute of Medicine in March 1999.

(b) According to the U.S. Sentencing Commission and the Federal Bureau of Investigation, 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 people who have a medical need to use marijuana.

(c) Although federal law currently prohibits the use of marijuana, the laws of Alaska, California, Colorado, Hawaii, Maine, Nevada, Oregon, Vermont, and Washington permit the medical use and cultivation of marijuana. _____ joins in this effort for the health and welfare of its citizens.

(d) 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.

(e) State law should make a distinction between the medical and non-medical use of marijuana. Hence, the purpose of this Act is to protect patients with debilitating medical conditions, and their physicians and primary caregivers, from arrest and prosecution, criminal and other penalties, and property forfeiture if such patients engage in the medical use of marijuana.

SECTION 3. DEFINITIONS. The following terms, as used in this Act, shall have the meanings set forth in this section:

(a) "Debilitating medical condition" means:

(1) cancer, glaucoma, positive status for human immunodeficiency virus, acquired immune deficiency syndrome, 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 or chronic pain; severe nausea; seizures, including but not limited to those characteristic of epilepsy; or severe or persistent muscle spasms, including but not limited to those characteristic of

multiple sclerosis or Crohn's disease; or

(3) any other medical condition or its treatment approved by the department, as provided for as follows: Not later than 90 days after the effective date of this Act, the department shall promulgate regulations governing the manner in which it will consider petitions from the public to add debilitating medical conditions to those included in this Act. In considering such petitions, the department shall include public notice of, and an opportunity to comment in a public hearing upon, such petitions. The department shall, after hearing, approve or deny such petitions within 180 days of submission. The approval or denial of such a petition shall be considered a final department action, subject to judicial review. Jurisdiction and venue for judicial review are vested in the _____ Court.

(b) "Department" means the _____ Department of Health or its successor agency.

(c) "Marijuana" has the meaning given that term in _____.

(d) "Medical use" means the acquisition, possession, cultivation, manufacture, use, delivery, transfer, or transportation of marijuana or paraphernalia relating to the consumption of marijuana to alleviate the symptoms or effects of a qualifying patient's debilitating medical condition.

(e) "Physician" means a person who is licensed under section _____, and is licensed with authority to prescribe drugs under section _____.

(f) "Primary caregiver" means a person who is at least eighteen years old, who has never been convicted of a felony drug offense, and who has agreed not to provide marijuana to any person other than qualifying patients. A qualifying patient may have only one primary caregiver at any one time.

(g) "Qualifying patient" means a person who has been diagnosed by a physician as having a debilitating medical condition.

(h) "Registry identification card" means a document issued by the department that identifies a person as a qualifying patient or primary caregiver.

(i) "Usable marijuana" means the dried leaves and flowers of marijuana, and any mixture or preparation thereof, and does not include the seeds, stalks, and roots of the plant.

(j) "Written certification" means the qualifying patient's medical records, or a statement signed by a physician, stating that in the physician's professional opinion, after having completed a full assessment of the qualifying patient's medical history and current medical condition made in the course of a bona fide physician-patient relationship, the qualifying patient has a debilitating medical condition and the potential benefits of the medical use of marijuana would likely outweigh the health risks for the qualifying patient.

SECTION 4. PROTECTIONS FOR THE MEDICAL USE OF MARIJUANA.

(a) A qualifying patient who has in his or her possession 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 professional licensing board or the department of labor and industry, for the medical use of marijuana, provided that the qualifying patient possesses an amount of marijuana which does not exceed six marijuana plants and one ounce of usable marijuana.

(b) Subsection (a) shall not apply to a qualifying patient under the age of 18 years, unless:

(1) The qualifying patient's physician has explained the potential risks and benefits of the medical use of marijuana to the qualifying patient and to a parent, guardian, or person having legal custody of the qualifying patient; and

(2) A parent, guardian, or person having legal custody consents in writing to:

(A) allow the qualifying patient's medical use of marijuana;

(B) serve as the qualifying patient's primary 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) A primary caregiver who has in his or her possession 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 professional licensing board or the department of labor and industry, for assisting the qualifying patient to whom he or she is connected through the Department's registration process with the medical use of marijuana, provided that the primary caregiver possesses an amount of marijuana which does not exceed six marijuana plants and one ounce of usable marijuana.

(d) There shall exist a presumption that a qualifying patient or primary caregiver is engaged in the medical use of marijuana if the qualifying patient or primary caregiver:

(1) is in possession of a registry identification card; and

(2) is in possession of an amount of marijuana which does not exceed the amount permitted under this Act. Such presumption may be rebutted by evidence that conduct related to marijuana was not for the purpose of alleviating the symptoms or effects of a qualifying patient's debilitating medical condition.

(e) A primary caregiver may receive reasonable compensation for

services provided to assist with a qualifying patient's medical use of marijuana.

(f) A physician 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 the department of labor and industry, for providing written certification for the medical use of marijuana to qualifying patients.

(g) Any interest in or right to property that is possessed, owned, or used in connection with the medical use of marijuana, or acts incidental to such use, shall not be forfeited.

(h) No person shall be subject to arrest or prosecution for "constructive possession," "conspiracy," or any other offense for simply being in the presence or vicinity of the medical use of marijuana as permitted under this Act.

(i) A registry identification card, or its equivalent, issued by another state government to permit the medical use of marijuana by a qualifying patient, or to permit a person to assist with a qualifying patient's medical use of marijuana, shall have the same force of effect as a registry identification card issued by the department.

SECTION 5. PROCEDURES AND REGULATIONS GOVERNING REGISTRATION.

(a) Not later than 90 days after the effective date of this Act, the department shall promulgate regulations governing the manner in which it will consider applications for and renewals of registry identification cards for qualifying patients and primary caregivers. The department's regulations shall establish application and renewal fees that generate revenues sufficient to offset all expenses of implementing and administering this Act. The department may vary the application and renewal fees along a sliding scale that accounts for a qualifying patient's income. The department may accept donations from private sources in order to reduce the application and renewal fees.

(b) The department shall issue registry identification cards to qualifying patients who submit the following, in accordance with the department's regulations:

(1) written certification that the person is a qualifying patient;

(2) application or renewal fee;

(3) name, address, and date of birth of the qualifying patient;

(4) name, address, and telephone number of the qualifying patient's physician; and

(5) name, address, and date of birth of the qualifying patient's primary caregiver, if any.

(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 receipt of the application or renewal. The department may deny an application or renewal only if the applicant did not provide the information required pursuant to this section, 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.

(d) The department shall issue a registry identification card to the primary caregiver who is named in a qualifying patient's approved application, so long as the primary caregiver signs a statement agreeing to provide marijuana only to qualifying patients who have named him or her as primary caregiver; provided, the department shall not issue a registry identification card to a proposed primary caregiver who has previously been convicted of a felony drug offense.

(e) The department shall issue registry identification cards within five days of approving an application or renewal, which shall expire one year after the date of issuance. Registry identification cards shall contain:

(1) name, address, and date of birth of the qualifying patient;

(2) name, address, and date of birth of the qualifying patient's primary caregiver, if any;

(3) the date of issuance and expiration date of the registry identification card; and

(4) other information that the department may specify in its regulations.

(f) A person who possesses a registry identification card shall notify the department of any change in the qualifying patient's name, address, physician, or primary caregiver, or change in status of the qualifying patient's debilitating medical condition, within 10 days of such change, or the registry identification card shall be deemed null and void.

(g) Possession of, or application for, a registry identification card shall not alone constitute probable cause to search the person or property of the person possessing or applying for the registry identification card, or otherwise subject the person or property of the person possessing the card to inspection by any governmental agency.

(h) 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:

(1) authorized employees of the department as necessary to perform official duties of the department; or

(2) authorized employees of state or local law enforcement agencies, only as necessary to verify that a person who is

engaged in the suspected or alleged medical use of marijuana is lawfully in possession of a registry identification card.

(i) The department shall report annually to the legislature on the number of applications for registry identification cards, the number of qualifying patients and primary caregivers approved, the nature of the debilitating medical conditions of the qualifying patients, the number of registry identification cards revoked, and the number of physicians providing written certification for qualifying patients. The department shall not provide any identifying information of qualifying patients, primary caregivers, or physicians.

(j) It shall be a crime, punishable by up to 180 days in jail and a $1,000 fine, for any person, including employees and officials of the department and other state and local governments or agencies, to provide any identifying information of qualifying patients or primary caregivers to a federal official or federal agency.

SECTION 6. SCOPE OF ACT.

(a) This Act shall not permit:

(1) any person to operate, navigate, or be in actual physical control of any motor vehicle, aircraft, or motorboat while under the influence of marijuana; and

(2) the smoking of marijuana:

(A) in a school bus or other form of public transportation;

(B) on any school grounds;

(C) in any correctional facility; or

(D) at any public park, public beach, public recreation center, or youth center.

(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; or

(2) an employer to accommodate the medical use of marijuana in any workplace.

(c) Notwithstanding any law to the contrary, 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 the non-medical use of marijuana.

SECTION 7. AFFIRMATIVE DEFENSE.

A person and a person's primary caregiver, if any, may assert the medical use of marijuana as a defense to any prosecution involving marijuana, and such defense shall be presumed valid where the evidence shows that:

(a) the person's medical records indicate, or a physician has stated that, in the physician's professional opinion, after having completed a full assessment of the person's medical history and current medical condition made in the course of a bona fide physician-patient relationship, the potential benefits of the medical use of marijuana would likely outweigh the health risks for the person; and

(b) the person and the person's primary 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 alleviating the symptoms or effects of the person's medical condition.

SECTION 8. REPEALER.

All laws and parts of laws in _____ that are in conflict with this Act are hereby repealed.

SECTION 9. 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 10. DATE OF EFFECT.

This Act shall take effect upon its approval.

Appendix R: Overview and Explanation of Model 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 seven states and by the Hawaii legislature 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 Hawaii law — because it is the only contemporary medical marijuana law that received 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 arrested by federal authorities for a small quantity of marijuana in the nine 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. 2(b) and 2(i));
2. provide legal protection for the primary caregivers of patients who are too ill to provide for their own medical use of marijuana (Sec. 3(c));
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. 3(a));
5. allow patients and primary caregivers who are arrested anyway to discuss the medical use of marijuana in court (Sec. 5); 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. 4).

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 potential benefits of the medical use of marijuana would likely outweigh the health risks," 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 requires qualified patients to possess 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.

Three optional provisions in the model bill

1. DEFINITION OF "ADEQUATE SUPPLY": The amount of marijuana a patient is permitted to possess is given conceptually ("not more than is reasonably necessary to ensure …") rather than as a specific numerical amount. This provides flexibility for all parties involved—patients, caregivers, police, prosecutors, and judges.
2. REGISTRY IDENTIFICATION CARDS ISSUED BY STATE HEALTH DEPARTMENT: It is recommended that this section of the bill be omitted when it is first introduced, as the ID card system is the primary offering that the sponsor of the bill can offer to other state legislators who feel the bill needs to be "tightened up" or "more restrictive."
3. STATE-SANCTIONED NON-PROFIT DISTRIBUTION OF MEDICAL MARIJUANA: One criticism that has been levied against the existing state medical marijuana laws is that they do not provide a way for patients to obtain a supply of marijuana beyond growing their own, obtaining the help of a caregiver, or purchasing marijuana from the criminal market. This provision authorizes non-profit organizations to distribute medical marijuana legally under state law without directly involving state and local officials in marijuana distribution.

Appendix S: What Do Federal Raids in California Mean for State Marijuana Laws?

Between October 2001 and September 2002, the DEA acted on its intention to target high-profile marijuana distributors by conducting a series of raids in California.

Even so, the DEA is still not targeting individual patients with arrest. Following a February 12, 2002, raid of the Sixth Street Harm Reduction Center, a medical marijuana provider in San Francisco, then-DEA Administrator Asa Hutchinson said that "The federal government is not prosecuting marijuana users."[1]

Further, DEA spokesman Richard Meyer said, "We did not target [the Harm Reduction Center] ... the investigation led us to the club."[2] The raids led to four arrests and the confiscation of 8,300 marijuana plants at eight locations. High-profile marijuana activist Ed Rosenthal was one of the four.

Rosenthal, who was deputized by the city of Oakland to grow marijuana, was supposed to have the same protection that narcotics officers are given. But he was put on trial and denied the right to discuss the medical aspects of his case. After much fanfare, Rosenthal was sentenced to one day (time served) and a $1,000 fine. This ruling highlighted the ongoing conflict between state and federal laws on medical marijuana.

Several other medical marijuana cooperatives, including the Oakland Cannabis Buyers' Cooperative (OCBC), have been forced out of business by the federal government by 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.

A few weeks after the September 11 terrorist attacks, the DEA raided a medical marijuana clinic in Los Angeles. In response to the raid, a U.S. Justice Department spokesperson said: "The recent enforcement is indicative that we have not lost our priorities in other areas since September 11," according to The New York Times on October 31, 2001.

On October 4, 2001, the DEA raided Lynn and Judy Osburn's Lockwood Valley ranch, where the Osburns have lived for 25 years.[3] Agents uprooted more than 200 plants intended for the 900 members of the Los Angeles Cannabis Resource Center (LACRC). According to LACRC President Scott Imler, the Osburns grew 30% to 40% of the center's annual supply.

On October 25, 2001, DEA agents raided and shut down the Los Angeles Cannabis Resource Center. No arrests were made, but the center's 900 members were no longer able to use that resource for medical marijuana. Scott Imler and two others involved with LACRC pleaded guilty to federal marijuana charges in 2003. In November 2003, all three of the LACRC members were sentenced to probation, while the ruling federal judge criticized the DEA and the Justice Department for spending funds and time prosecuting medical marijuana providers.

On May 29, 2002, two individuals were arrested in connection with a DEA raid of the Aiko Compassion Center in Santa Rosa. The center had served more than 100 patients.

On August 15, 2002, the DEA destroyed six marijuana plants in the garden of Diane Monson, a woman with a doctor's recommendation to smoke marijuana to treat chronic back spasms. This raid

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[1] "Pot raids stir S.F. protests," Oakland Tribune, Feb. 13, 2002.

[2] "Petaluman faces pot charges after two-nation bust: Suspect's marijuana club called front for drug dealing," *The Santa Rosa Press Democrat*, Feb. 14, 2002.

[3] The Osburns were first raided in August 2000 by a team of state and federal agents.

was carried out in defiance of a plea from Butte County District Attorney Mike Ramsey to leave Ms Monson's plants alone.[4]

Also on August 15, 2002, the DEA raided the Osburns' property for a third time, seizing 32 marijuana plants that were used to treat Lynn's severe back pain and Judy's constant muscle spasms.

On September 5, 2002, heavily armed DEA agents raided the Wo/Men's Alliance for Medical Marijuana (WAMM) cooperative and destroyed 167 plants. Federal agents handcuffed post-polio syndrome sufferer Suzanne Pfeil, forcing her to stand despite her leg braces and obvious difficulty moving. WAMM owners Mike and Valerie Corral had been dispensing marijuana, free of charge, to the club's 250 members before the DEA agents destroyed their crop.

On September 12, 2002, the DEA arrested Robert Schmidt and seized 3,454 marijuana plants intended for the more than 1,200 members of Genesis 1:29, a medical marijuana club in Petaluma.

Medical marijuana patient and provider Bryan Epis was arrested by federal agents in July 1997 for growing more than 1,000 marijuana plants, a crime that carries a mandatory minimum sentence of 10 years. On October 7, 2002, after a great deal of protest from supporters, Epis was sentenced to 10 years in federal prison.

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, the future for large-scale medical marijuana distribution remains bleak. Meanwhile, MPP seeks the passage of state medical marijuana laws to allow patients to grow marijuana themselves or establish distribution systems that will not trigger federal raids.

California passed a bill in late 2003 that further protects patients and their caregivers. S.B. 420, signed by Governor Gray Davis (D) just days after losing the gubernatorial recall election, recognizes the rights of patients and caregivers to associate collectively to cultivate medical marijuana. Other protective provisions include establishing a voluntary ID card system for patients and caregivers, which will be issued on the county level. This bill strengthens California's state medical marijuana law, and will make it even more difficult for the federal government to continue raiding medical marijuana patients.

[4] Medical marijuana patient Angel Raich and Ms Monson later charged the federal government, the DEA, and Attorney General John Ashcroft with violating the Fifth, Ninth, and Tenth Amendments to the U.S. Constitution for raids on medical marijuana cooperatives. On March 11, 2003, U.S. District Judge Martin Jenkins ruled against Raich and Monson, saying that federal law prevented him from issuing an injunction against the federal government. An appeal is pending.

Appendix T: Medical Conditions Approved for Treatment with Marijuana in the Nine States with Medical Marijuana Laws

Medical conditions approved for treatment with marijuana in the nine states with medical marijuana laws									
	California	Oregon	Alaska	Washington	Maine	Hawaii	Colorado	Nevada	Vermont
Specific Diseases									
Cancer	✔	✔	✔	✔	✔	✔	✔	✔	✔ [b]
Glaucoma	✔	✔	✔	✔	✔	✔	✔	✔	
AIDS or HIV	✔	✔	✔	✔	✔	✔	✔	✔	✔ [b]
Crohn's disease				✔ [b, c]		✔			
Hepatitis C				✔ [b, c]					
Multiple Sclerosis									✔ [b]
Debilitating medical conditions or symptoms produced by those conditions									
Cachexia, anorexia, or wasting syndrome	✔	✔	✔	✔ [b, c]		✔	✔	✔	
Severe or chronic pain	✔	✔	✔	✔ [b]		✔	✔		
severe or chronic nausea		✔	✔	✔	✔	✔	✔	✔	
seizure disorders (e.g., epilepsy)		✔	✔	✔	✔	✔	✔	✔	
muscle spasticity disorders (e.g., multiple sclerosis)	✔	✔	✔	✔		✔	✔	✔	
arthritis	✔								
migraines	✔								
agitation of Alzheimer's disease		✔ [c]							
Allows addition of diseases or conditions by state health agency	✔ [a]	✔	✔	✔		✔	✔	✔	

[a] In addition to the specific diseases and conditions listed, the law covers treatment of "any other illness for which marijuana provides relief."

[b] Requires that medications available by prescription have failed to provide relief

[c] Condition added by state agency