STATE-BY-STATE MEDICAL MARIJUANA LAWS:

How To Remove the Threat of Arrest

Marijuana Policy Project

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> **"I believe each state can choose that decision as they so choose."**
>
> — George W. Bush in "Bush Backs States' Rights on Marijuana: He Opposes Medical Use But Favors Local Control," *Dallas Morning News* (10/20/99)

Should these medical marijuana users be treated like criminals?

Marijuana can treat the symptoms of cancer, AIDS, multiple sclerosis, glaucoma, and other serious illnesses. Doctors often recommend it when other medicines have failed to help. More than *100,000 Americans* are already using medical marijuana.

Kenny and Barbra Jenks were **arrested** for using medical marijuana to treat AIDS wasting syndrome in Florida in 1990.

Jim Montgomery, who is paralyzed from the chest down, was **arrested** and imprisoned in Oklahoma in 1993 for using medical marijuana to treat pain and spasticity.

Renee Emry was **arrested** in September 1998 for smoking one marijuana cigarette in Washington, D.C., to treat multiple sclerosis.

Bill Anderson was **arrested** in 1997 for using marijuana in Michigan to treat the pain caused by massive head injuries.

"We concluded that there are some limited circumstances in which we recommend smoking marijuana for medical uses."

— National Academy of Sciences' Institute of Medicine, March 17, 1999

Hazel Rodgers legally used marijuana to treat glaucoma after California voters passed a medical marijuana ballot initiative in 1996.

Richard Brookhiser, senior editor of *National Review,* used medical marijuana during cancer chemotherapy in the early 1990s.

Jim Harden needs medical marijuana to treat the pain and muscle spasms caused by a broken back and other injuries.

Cheryl Miller was **arrested** in March 1998 for using marijuana in Washington, D.C., to treat multiple sclerosis.

Calvin Nokes uses marijuana to treat AIDS wasting syndrome.

Alaska, California, Colorado, Hawaii, Maine, Nevada, Oregon, and Washington all have effective medical marijuana laws. And every nationwide survey of voters shows at least 60% support. Yet most state governments continue to wage war on marijuana-using patients!

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Executive Summary

- Favorable medical marijuana laws have been enacted in 35 states since 1978. However, most of these laws are ineffectual, due to the federal government's overarching prohibition. (Five 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:
  - — Twelve states with "Therapeutic Research Program" laws are nevertheless unable to give patients legal access to medical marijuana because of federal obstructionism.
  - — Ten states and the District of Columbia have symbolic laws that recognize marijuana's medical value but fail to provide patients with protection from arrest.
  - — **And, since 1996, eight states have enacted laws that effectively allow patients to use medical marijuana despite federal law.**
- 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.
- To be effective, a state law must remove criminal penalties for patients who use, possess, and grow medical marijuana with their doctors' approval.
  - — Even though patients can still be penalized for violating federal marijuana laws, states are not required to have laws that are identical to federal law.
  - — 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.
- 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

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 35 states since 1978.[1]

Most of the favorable state laws are ineffectual, due to the federal government's overarching prohibition. Fortunately, since 1996, eight states have found a way to help seriously ill people use medical marijuana with virtual impunity despite federal law.[2]

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

This report analyzes the existing federal and state laws and describes what can be done to give patients legal access to medical marijuana. In the near future, 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.

Accordingly, MPP has prepared sample legislation which would effectively remove criminal penalties for the medical use of marijuana in any given state.

Marijuana's medical uses

Marijuana has a wide range of therapeutic applications, including:

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

Thousands of patients and their doctors have found marijuana to be beneficial in treating the symptoms of AIDS, cancer, multiple sclerosis, glaucoma, and other serious conditions.[3] 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."[4]

Accordingly, public opinion polls typically find that more than 60% of the American people support legal access to medical marijuana.[5]

Criminalizing patients

The federal marijuana penalties are 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 the laws are similar in most states.

State and local police make approximately 700,000 marijuana arrests in the United States each year, more than 600,000 of which are for possession (not sale or manufacture).[6] 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!

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[1] See Appendix A for a chart of all 50 state laws.

[2] See Table 1, page 8, for details on the eight effective state laws.

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

[4] See Appendix C for excerpts from the IOM report.

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

[6] FBI Uniform Crime Reports, *Crime in the United States: 1999*, published in October 2000.

Until a more sympathetic president or Congress is in power, there is little chance of changing federal law to give patients legal access to medical marijuana. Consequently, the greatest chance of success is in the states.

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.[7] 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 federal Drug Enforcement Administration (DEA) has the authority to move marijuana into a less restrictive schedule. After years of litigation, it has essentially been determined that DEA will not move a substance into a less restrictive schedule without an official determination of "safety and efficacy" by the Food and Drug Administration (FDA).[8]

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.[9] Since 1995, MPP has been helping scientists attempt to navigate the federal research obstacles, and it has become clear that it will take at least a decade—if ever—for FDA to approve the use of natural marijuana as a prescription medicine.

However, there are several other ways to change federal law to give patients legal access to medical marijuana[10]:

- Since FDA is part of the U.S. Department of Health and Human Services (HHS), the U.S. Secretary of Health can declare that marijuana meets sufficient standards of safety and efficacy to warrant rescheduling.
- Since 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 eight patients remain in the program.

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

Changing state laws: Past efforts

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.) Unfortunately, due to the overarching federal restrictions, most of these

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

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

[9] See "Suggested Revisions to the HHS Medical Marijuana Research Guidelines," which may be obtained by contacting MPP or viewing `http://www.mpp.org/guidelines`.

[10] Appendix B details some of these other routes.

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 would give a patient an official "prescription" for marijuana, the states did not account for the fact that it is a crime for pharmacies to distribute it, so patients would have no way to legally fill their marijuana prescriptions. (See "Overview of kinds of state laws" on page 5.)

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 specified that 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. (Of note, Arizona voters passed a medical marijuana initiative at the same time, but it turned out to be only symbolic because it used the word "prescribe" rather than "recommend.")

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. Maine passed an initiative in 1999, while Colorado and Nevada followed suit in 2000. Each state approved its initiative by a wide margin, and no state has rejected an initiative that solely addressed medical marijuana.

(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.)

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. Hawaii's governor, 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."

More than 51 million Americans—19% of the U.S. population—now live in the eight states where medical marijuana users are protected by state law.

What the new state laws do

The seven state initiative-created laws and the Hawaii law are similar in what they accomplish.[11]

Each of the eight states allows patients to grow, possess, and use medical marijuana if approved by a medical doctor. 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

[11] See Table 1 on page 8 for specifics on each state law. Also see Appendix F for how these laws are working in the real world.

To qualify, the law specified that 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.

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

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."

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

Luckily, Joe lives in one of the eight 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 42 states, he would be arrested, prosecuted, and possibly sent to prison.

In the unlikely event that a patient is arrested in one of the eight states with effective laws, the patient is still allowed to argue at trial that his or her marijuana use was medically necessary, if charged with unlawful marijuana possession or cultivation. 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, eliminating the need for a trial. Further, patients in some of the eight states have an exemption from prosecution, although this level of legal protection is usually reserved for those who are registered with the state.[12]

Conflict between new state laws and federal law

With the recent advent of state laws to protect patients who grow, possess, and use medical marijuana, many questions have surfaced regarding the status of those laws in relation to federal law. Some believe that the federal government can nullify those laws, or that the laws have no real value in the face of conflicting federal law. That is simply not the case.

Even though patients can be penalized 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.

The crucial distinction is frequently 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 any state looking for cancer patients growing a few marijuana plants.

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

Simply put, individual medical marijuana users generally are not on the federal government's radar screen.

(One drawback is that **distributors** are on the federal radar screen. Pharmacies do not sell marijuana anywhere in the United States, and numerous medical marijuana distribution centers that emerged in various states—commonly known as "cannabis buyers' clubs"—have been hampered by federal law.)

Court rulings have not overturned state laws

To date, there have only been two significant legal cases at the federal level which deal with medical marijuana policy: *Conant v. McCaffrey* and *U.S. v. Oakland Cannabis Buyers' Cooperative* (OCBC).[13] 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.

Conant considers whether the federal government can punish physicians for discussing or recommending medical marijuana, and a federal district court ruling says the federal government cannot.

The OCBC case examines whether a medical marijuana distributor can use a medical necessity defense against federal marijuana distribution charges. A federal appeals court said it could, but that ruling is pending before the U.S. Supreme Court. Regardless of the outcome of that case—which is expected to be resolved in the summer of 2001—medical marijuana patients afforded protection under state law will continue to have the right to the medical necessity defense (or other defenses allowed) against state marijuana charges.

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, it is the actions of individuals in relation to the law—not the law itself—that has been litigated.

Overview of kinds of state laws[14]

At various times since 1978, 35 states and the District of Columbia have had favorable medical marijuana laws. Laws in five states have either expired or have been repealed, but 30 states and D.C. currently have a law 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 35.)

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. Eight states—Alaska, California, Colorado, Hawaii, Maine, Nevada, Oregon, and Washington—have effective laws of this nature, all of which were enacted since 1996. (See preceding three sections of this report.)

Therapeutic research programs. [15] Fourteen states currently have laws that allow patients to legally use medical marijuana through a state-run therapeutic research program, and during the late 1970s and early 1980s at least seven states

[13] See Appendix J for details on these two cases.

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

[15] See Appendix K for details on therapeutic research programs.

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obtained all of the necessary federal permissions, received marijuana from the federal government, and distributed the substance to approved patients through pharmacies. None of these programs, however, has been operational since 1985.

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 a long and potentially fruitless application process. Additionally, many patient advocates oppose research programs as a primary mode of medical marijuana access because enrollment in research programs is highly restrictive.

In sum, therapeutic research program laws are no longer effective due to federal obstructionism.

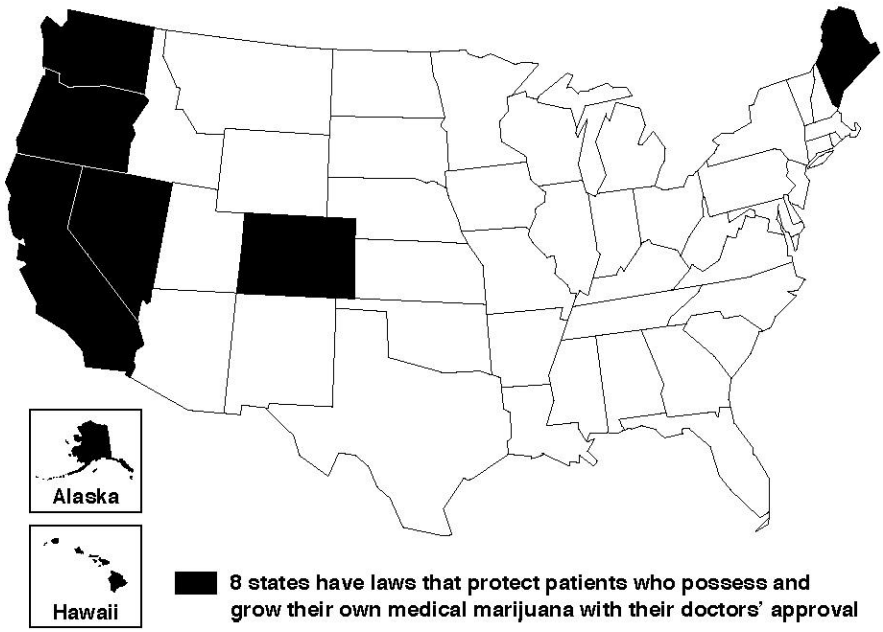
Symbolic measures. Pseudo-Prescriptive Access. Seven states have laws that allows patients to possess marijuana if obtained directly from a valid prescription. The problem is that there is no legal supply of marijuana to fill such a prescription. Federal law prohibits the distribution of marijuana and other Schedule I substances for anything other than research. Doctors cannot "prescribe" marijuana, and pharmacies cannot dispense it.

Laws of this nature 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, 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 states to look the other way while patients grow medical marijuana for themselves, but it's another thing for the state government itself to distribute a Schedule I substance for anything other than federally approved research. State officials would be highly vulnerable to federal prosecution for marijuana distribution, as they are more visible targets than individual patients. States would also risk losing federal funding for operating state-run distribution systems. Another concern is that confiscated marijuana may contain adulterants

States With Effective Medical Marijuana Laws



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 place substances in whatever schedules they see fit.

Four states—Alaska, Iowa, Montana, and Tennessee—and the District of Columbia currently have marijuana placed in a schedule that recognizes 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," 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 houses 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 policy on the state level and are unlikely to be of any practical help to patients.

The role of state legislatures in the movement to protect medical marijuana patients cannot be overstated. Only 24 states and the District of Columbia have the initiative process, which means that citizens in 26 states cannot directly enact their own laws.

Laws that have been repealed or expired. In addition to the 30 states with current laws, Arkansas, Florida, and North Carolina have repealed a medical marijuana law, while Michigan has had one expire. In Ohio, one law expired and a second law was repealed. Other states have had laws that have expired or have been repealed—but subsequently have enacted other medical marijuana laws. Further, 15 states have never had a favorable medical marijuana law.

States With Other Medical Marijuana Laws

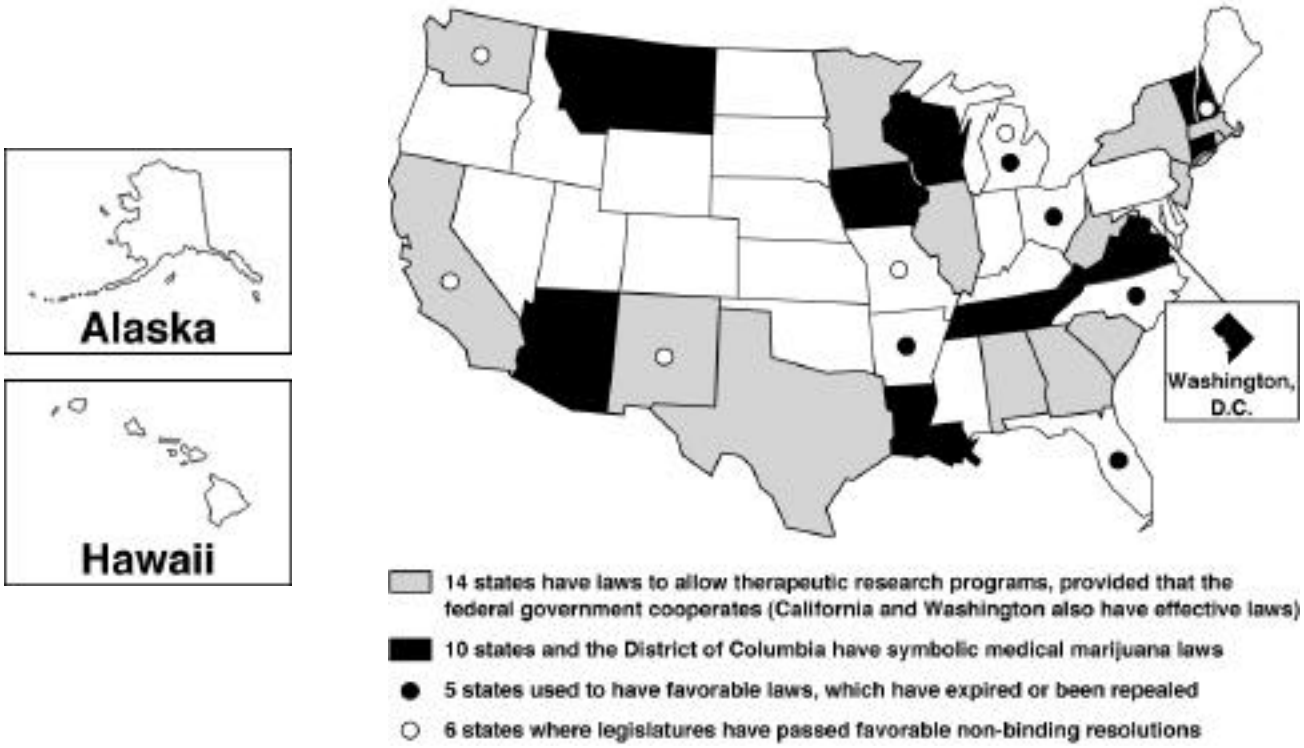


Table 1: Effective Medical Marijuana Laws In Eight States

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"	mandatory, with state Department of Health and Social Services	1 usable ounce and 6 plants, 3 of which may be mature	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	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	N/A	not a 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	optional, 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"	mandatory, 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
Maine Question 2 (ballot initiative/61%) November 2, 1999	statutory	provides a simple defense, which means the burden is on the state to prove that a patient's medical use or possession was not authorized by statute	an authenticated copy of pertinent medical records or written documentation from a physician showing that the patient has a qualifying condition; has discussed the risks and benefits of medical marijuana; and has been "advised" by the physician that he or she "might benefit" from medical marijuana	N/A	1 1/4 ounces and 6 plants, 3 of which may be mature	one caregiver, who has been consistently responsible for the patient's well-being and is named in a written individual instruction or power of attorney for health care	no
Nevada Question 9 (ballot initiative/65%) *59% in 1998 also* November 7, 2000	constitutional	exemption from prosecution	"advice required;" specifics to be determined by legislature	mandatory, with an agency not yet determined	to be determined by legislature	to be determined by legislature	yes

Table 1 (continued)

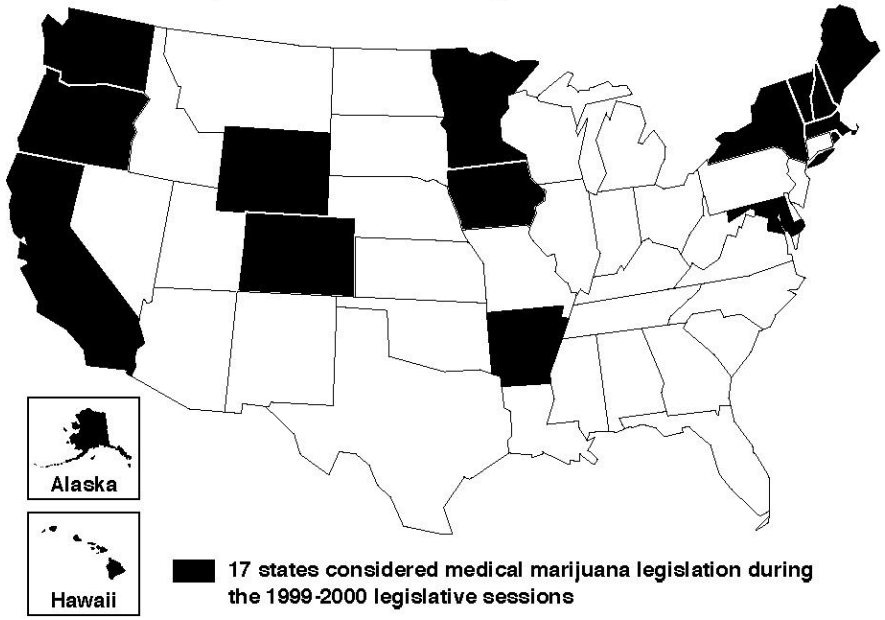
state; measure/% of vote; date enacted	statutory or constitutional[a]	how law protects patients (defenses provided) [b]	documentation required	registry system for patients and caregivers	marijuana quantity limits	caregiver provisions	can medical conditions be added?
Oregon Measure 67 (ballot initiative/55%) November 3, 1998 (modified by H.B. 3052, effective July 21, 1999)	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	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	optional, 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; affirmative defense may be used to argue that greater amount is medically necessary as determined by the patient's attending physician	one caregiver per patient, although caregivers can serve multiple patients simultaneously	yes
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.

States That Considered Medical Marijuana Legislation During the 1999-2000 Legislative Sessions



Where things are going from here

The nine 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 more than 18% 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 will enact effective laws to protect medical marijuana-using patients. State legislatures are increasingly supportive of medical marijuana. In the 1999-2000 legislative sessions, 17 states considered medical marijuana legislation. Seven states, including Hawaii, considered legislation to remove criminal penalties for medical marijuana. Six states considered legislation to amend existing medical marijuana laws, and four states—Colorado, New Hampshire, Vermont, and Wyoming—considered symbolic pieces of legislation.[16]

The role of state legislatures in the movement to protect medical marijuana patients cannot be overstated. Only 24 states and the District of Columbia have the initiative process, which means that citizens in 26 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.

State medical marijuana laws have the added benefit of putting political pressure on the federal government to change its laws.

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

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[16]See Appendix M for a listing of all state medical marijuana bills and resolutions considered during the 1999-2000 legislative sessions.

Table 2: Tally of State Medical Marijuana Laws

	Effective		Therapeutic Research Program		Symbolic		Non-Binding Resolution
State	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		✔	✔				

Table 2: Tally of State Medical Marijuana Laws (continued)

State	Effective		Therapeutic Research Program		Symbolic		Non-Binding Resolution
	Previously had	Currently has	Previously had	Currently has	Previously had	Currently has	
New Hampshire						✔	✔
New Jersey				✔			
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	1	8	12	14	2	10 plus D.C.	
Grand Totals	9		26		12 plus D.C.		6

At some point in time, 35 states have had a favorable medical marijuana law. Twelve of those 35 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	med. mj law approved	took effect	bill/initiative #	session law	citation for med. mj law	marijuana schedule	citation for schedules
AK	Nov. 3, 1998	March 4, 1999	Ballot Measure 8	Section 1, 1998 Ballot Measure 8	§ 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."						
CA	Nov. 5, 1996	Nov. 6, 1996	Ballot Initiative, Proposition 215	N/A	H & S § 11362.5	I	H & S § 11054
Current Laws:	Proposition 215 removes state-level criminal penalties for medical marijuana use, possession, and cultivation.						
	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."						
History:	From July 25, 1979 until June 30, 1989, a therapeutic research program — which was operational — for cancer and glaucoma existed (H & S § 11260 and H & S § 11480); enacted via S.B. 184, session law Ch. 300 (1979). The Research Advisory Panel coordinated research with marijuana and its derivatives; $100,000 was appropriated for the first year. Minor amendments by ch. 374 (1980) and ch. 101 (1983). H & S § 11260 would have expired on June 30, 1985, but the program was extended and modified slightly by ch. 417 (1984); the program finally expired on June 30, 1989; § 11480 remains on the books.						
CO	Nov. 7, 2000	June 30, 2001	Ballot Initiative, Amendment 20	N/A	Constitutional Amendment 20	N/A	§ 18-18-203
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.						

state	med. mj law approved	took effect	bill/initiative #	session law	citation for med. mj law	marijuana schedule	citation for schedules
ME	Nov. 2, 1999	Dec. 22, 1999	Referendum Election Ballot Question 2	Laws of Maine 1999, Initiated Bill Ch. 1	22 § 2383	N/A	17-A § 1102
Current Law:	Question 2 removes state-level criminal penalties for medical marijuana use, possession, and cultivation.						
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	Nov. 7, 2000	requires legislative implementation	Ballot Question 9	N/A	Constitutional Amendment	I	*453.510 NAC*
Current Law:	Question 9 removes state-level criminal penalties for medical marijuana use, possession, and cultivation.						
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	Oregon Laws 1999, Ch. 4	475.300-346	I	475.035 and *OAR 855-80*
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).						
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*
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 Medical Marijuana Research Laws (Therapeutic Research Programs)

state	med. mj law approved	took effect	bill #	session law	citation for med. mj 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.						
IL	Sept. 9, 1978	Sept. 9, 1978	H.B. 2625	80-1426	720 ILCS 550/11 and *77 IAC Ch. X, Sec. 2085*	N/A	720 ILCS 570/206 and *77 IAC Ch. X, Sec. 2070*
Remarks:	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.						
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.						
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.						

state	med. mj law approved	took effect	bill #	session law	citation for med. mj law	marijuana schedule	citation for schedules
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.						
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.						

state	med. mj law approved	took effect	bill #	session law	citation for med. mj law	marijuana schedule	citation for schedules
WV	March 10, 1979	June 8, 1979	S.B. 366	ch. 56 (1979)	§ 16-5A-7	I	§ 60A-2-204

Current Law: For cancer chemotherapy and glaucoma. The program has never been operational.

Program administered by director of the Department of Health and Patient Qualification Review Board; PQRB authorized to certify the participation of patients, physicians, and pharmacies for participation in the program; may include other disease groups if approved; director shall contract with federal government for supply of marijuana.

States with Symbolic Medical Marijuana Laws

state	med. mj law approved	took effect	measure	session law	citation for med. mj 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.

state	med. mj law approved	took effect	measure	session law	citation for med. mj law	description of law	marijuana schedule	citation for schedules
DC	July 27, 2000	projected to take effect 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. D.C. is the only jurisdiction where the federal government can prevent such laws from taking effect. Initiative 59 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. It is unclear whether Congress must block the initiative every year in order to prevent it from taking effect, or whether its November 1999 act permanently overturned the ballot initiative.							
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."							
	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.							
	The present law allows physicians with Schedule I licenses to prescribe marijuana in accordance with regulations promulgated by the Secretary of Health and Hospitals.							
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
Current Law:	Would automatically reschedule THC and marijuana to Schedule II if the federal government authorizes the prescription or administration of these substances.							

state	med. mj law approved	took effect	measure	session law	citation for med. mj law	description of law	marijuana schedule	citation for schedules
NH	April 23, 1981	June 22, 1981	S.B. 21	ch. 107 (1981)	318-B:9	physicians may prescribe	I*	318-B:1-a
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
Current Law:	For cancer and glaucoma (marijuana or THC). Allows physicians to prescribe and pharmacists to dispense marijuana and THC for such purposes.							
VT	April 27, 1981	April 27, 1981	H. 130	Act No. 49 (1981)	18 VSA § 4471	physicians may prescribe	N/A	N/A
Current Law:	For cancer and other medicinal uses as determined by the Commissioner of Health.							
	Administered by Department of Health; called a "research program" but really enables physicians to prescribe marijuana; "commissioner of health shall have the authority to obtain … cannabis administered under this program."							
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 Have Been REPEALED

state	med. mj law approved	took effect	bill #	session law	citation for med. mj law	description of law	law expired/repealed	marijuana schedule	citation for schedules
AR	Jan. 30, 1981	Jan. 30, 1981	H.B. 171	Act No. 8 (1981)	§ 82-1007 (numbering system has changed since law was repealed)	physicians may prescribe	repealed by Act No. 52 (1987)	VI	§ 5-64-215
Current Law:	Marijuana and THC are listed in Schedule VI, but Schedule VI substances are defined similarly — 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.								

state	med. mj law approved	took effect	bill #	session law	citation for med. mj 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 That Have NEVER HAD Medical Marijuana Laws

		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*
MD	I	27 § 279
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	res. 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 indicates 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 (trade name is Marinol) which is defined as THC “in sesame oil and encapsulated in a soft gelatin capsule in a U.S. Food and Drug Administration approved drug product.” 21 CFR Sec. 1308.13(g)(1)
6. Trivial amendments are not listed; bills that make minor, non-trivial amendments are listed.
7. Column with drug schedule: “N/A” simply means substance is not scheduled in state statutes or administrative code.
8. Statute citations for medical marijuana laws: The administrative code provisions for the therapeutic research programs are cited when possible but are not necessarily cited for all such states.
9. Many states have used a dual scheduling scheme for marijuana and/or THC. In these states, marijuana and THC are in Schedule I but are considered to be in Schedule II when used for medicinal purposes.

Medical Marijuana Briefing Paper – 2001

– 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 eight (8) 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 **eight** 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

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 the substance 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 felt the obligation to study the health effects of marijuana. They inadvertently discovered marijuana's astonishing medicinal history in the process.
- Many people who used marijuana recreationally were also suffering 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, because of marijuana's Schedule I status, doctors cannot prescribe it, and research approval and funding are severely curtailed.

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 suffers 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, members of the Bush administration closed the program to all new applicants. On December 1, 1999, the Clinton administration implemented its medical marijuana policy restating that the IND program would not be reopened. Consequently, the IND program remains in operation only for the eight 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.
- 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 nationwide Gallup poll taken on March 19-21, 1999, found that 73% of American adults are for "making marijuana legally available for doctors to prescribe in order to reduce pain and suffering." All other public opinion polls taken in the 1990s have shown between 60% and 80% support for making marijuana medically available.

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. 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 have exhausted the option of working through the judicial branch of the federal government. The courts ultimately defer to the judgment of the DEA, which creates its own regulations in order to keep medical marijuana illegal.

Efforts to obtain FDA approval of marijuana have similarly been thwarted by prohibitionist agencies. Instead of supplying marijuana to any FDA-approved researcher who requests it, the National Institute on Drug Abuse—the only legal source of marijuana for clinical research in the United States—uses unnecessary bureaucratic hurdles to justify denying researchers the marijuana they need.

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.**

"[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 eight 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 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 polling 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*, reports 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 reports that more than 60% of the public support 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
Mar. 19-21, 1999	73	±5% 1,018 randomly selected 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
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*, June 15, 1997
May 27, 1997	69	±4.5 % 517 adults	support "legalizing medical use of marijuana"	ABC News/Discovery News poll, conducted by Chilton Research, released May 29, 1997
Feb. 5-9, 1997	60	N/A 1,002 registered voters	favor allowing doctors to prescribe marijuana for medical purposes for seriously ill or terminal patients	Lake Research on behalf of The Lindesmith Center
Feb. 5-9, 1997	68	N/A 1,002 registered voters	the federal government should not penalize physicians who prescribe marijuana, regardless of whether state laws permit it	Lake Research on behalf of The Lindesmith Center
1997	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, of Washington, D.C., on behalf of the American Civil Liberties Union

Appendix D (continued)

State-specific medical marijuana public opinion polling results					
state	**date**	**% in favor**	**margin of error/ respondents**	**wording**	**polling firm/where reported**
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*, Sept. 23, 1997
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	1998	67	±3.5% 850 state residents	"doctors should be allowed to prescribe small amounts of marijuana for patients"	Center for Governmental Studies at Northern Ill. Univ./ *Daily Chronicle* (Dekalb/ Sycamore, Ill.) April 9, 1998
Maryland	1999	73	N/A 1,000 state residents	"physicians should be allowed to prescribe marijuana for medical use"	Center for Substance Abuse Research at the University of Maryland, College Park, results released on January 24, 2000
Massachusetts	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	March 10-12, 1999	68	±3.5% N/A	"If a patient has a debilitating illness and a doctor recommends marijuana as a medicine for that patient," the patient and doctor should "be protected from civil and criminal penalties"	Mason-Dixon political and media research firm
Nebraska	April 1979	83	N/A 1,040 respondents	favor marijuana's prescriptive medical availability	Joe B. Williams, Research Consultant, Elmwood, Nebraska
New York	April 26-28, 1999	80	±3.8% 700 registered voters	allow physicians "to prescribe marijuana for medical purposes to seriously and terminally ill patients, and to alleviate symptoms of diseases and the side effects associated with treatments"	Zogby International
Pennsylvania	Dec. 1978	83	N/A 1,008 respondents	favor marijuana's prescriptive medical availability	National Center for Telephone Research, Princeton, NJ
South Dakota	Dec. 26, 2000 - Jan. 9, 2001	81[1] 95[2]	N/A 505 registered voters	[1] "favor a change in South Dakota law so that seriously ill people — with a doctor's approval — can use medical marijuana legally without fearing the possibility of being arrested" [2] **do not** "think that patient should be arrested and sent to prison"	Creative Broadcast Systems, Inc.
Virginia	1999	77	±4.4 % 514 adults	"doctors should be allowed to prescribe marijuana for medical use when it reduces pain from cancer treatment or for other illnesses"	Center for Survey Research at Virginia Tech University (Quality of Life in Virginia Survey)

Appendix E: The 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 mainly 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 effective laws are currently working

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.

Estimates of the number of patients currently utilizing Proposition 215 range from 25,000 to more than 100,000. 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 sometimes err on the side of arresting — or at least hassling — patients if the quantity seems too large. One ruling in the state court of appeals, *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 in court against a charge of marijuana possession.

As one would expect, without statewide regulations, enforcement of Proposition 215 varies widely. Some jurisdictions allow distribution, while some are hesitant to recognize a patient's 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 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. 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 Senator John Vasconcellos and Santa Clara District Attorney George Kennedy, the task force produced a number of recommendations that were amended into 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 SB 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. As a related matter, the Department of Health Services feels little responsibility for communicating with patients about the law until a standardized policy is in place.

Despite this problem, patients who possess and use a small amount of marijuana face very

little threat of prosecution, despite the fact that many jurisdictions in California remain hostile to medical marijuana. Most medical marijuana arrests involve two dozen plants or more, although there have been arrests for as few as six plants.

As the pioneering state of effective medical marijuana laws, California has been the site of two key cases of federal litigation. The first case, *Conant v. McCaffrey*, examines whether physicians have a right under federal law to discuss marijuana and recommend it to their patients. (See Appendix J for detailed information.)

The second case, *U.S. v. Oakland Cannabis Buyers' Cooperative*, considers whether "medical necessity" is a valid defense against federal marijuana distribution charges.

Similar to most other medical marijuana initiatives, 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 a capable caregiver. In response to this unmet need, a number of medical marijuana distributors — often referred to as cannabis buyers' cooperatives or clubs (CBCs) — 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 CBCs, patients are required to designate the CBC as his or her primary caregiver.

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

Unfortunately, most of the 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 the San Francisco case, the California First District Court of Appeals ruled that a commercial enterprise that is selling marijuana does not qualify as a primary caregiver (*People ex rel. Lungren v. Peron* (1997), 59 Cal.App.4th 1383).

Distinct from a commercial enterprise, the Oakland Cannabis Buyers' Cooperative (OCBC) fought a January 1998 civil suit brought by the U.S. Department of Justice to stop the operation of OCBC and five other distribution centers in northern California. (See Appendix J for detailed information on this case.)

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

Oregon

Oregon may have the most functional medical marijuana law: There have been few complaints by either patients or law enforcement; the Health Division of the Department of Human Services has taken the most active role of any state health agency in the country; physicians have been broadly supportive; and only one registered patient out of the first 1,000 enrolled in the program has had a registry card revoked.

All of these elements have led law enforcement to ease its opposition to medical marijuana. When the initiative was passed, law enforcement was running to the legislature, fighting to have the law overturned. However, two years of enforcement have shown that there is no widespread abuse, and nearly all Oregonians utilizing the law are legitimate patients and caregivers.

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 —

suppliers are not permitted. 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 may not possess the horticultural skills necessary to cultivate a consistent supply. According to estimates by one patient advocate, as few as 25% of qualified patients have access to a steady supply.

Patients are also unable to travel out of state with their medicine, as the law protects them only in Oregon. Consequently, patients have suggested that Oregon develop reciprocity agreements with other states that allow medical marijuana. Under such an arrangement, patients could carry their medical marijuana with them when traveling between states that allow the possession and use of medical marijuana.

Amendments to and interpretations of the law

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

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

To address remaining ambiguities, the state attorney general's office convened a working group on medical marijuana 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 are provided for jurisdictions to consider.

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 on-line:
`http://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 limit intact, which was the preferred policy by the legislative working group that produced the 1999 amendments to the law.

The Oregon Medical Marijuana Program—Registration System

Though staffed by just one full-time individual, the Oregon Medical Marijuana Program—the state's registration program—has laid firm groundwork for a highly functional medical marijuana system. Beginning with its

inception in May 1999, the program registered just over 1,600 patients in its first 20 months of existence and consistently receives 5-10 new applications each day. The steady enrollment can be attributed to growing comfort levels for both patients and physicians with medical marijuana.

The program has compiled extensive data on the 594 patients who enrolled in the program during its first year of operation (May 1, 1999 - April 30, 2000). Seventy percent of registrants are male and the average age is 46—with a range of ages from 14 to 87. Sixty percent registered a primary caregiver. Many patients report multiple symptoms. Multiple sclerosis patients, for example, often report both muscle spasms and severe or chronic pain. The following table provides percentages for the diseases and symptoms reported by card-holders.

Symptoms reported by patients enrolled in Oregon's medical marijuana program

disease or condition	percentage reported*
severe or chronic pain	67
muscle spasms	41
nausea	29
HIV/AIDS	10
cancer	9
cachexia	7
seizures	6
glaucoma	3

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

In tune with the information age, the program provides up-to-date information via the Internet. Recent changes to the law and related administrative rules, application forms, and a frequently-asked-questions page, featuring contact information for patient network organizations that can assist those patients who are eligible to grow their own medical marijuana, are available at `http://www.ohd.hr.state.or.us/hclc/mm/welcome.htm` (the program's Web site). Oregon's Web site is unmatched by other states with medical marijuana laws, and Oregon is the only state to provide—as a courtesy—contact information for independent medical marijuana organizations.

In addition to its direct work with the patients, the program has a public education component. Though not compelled by statute, the program—more specifically its director—has spoken to countless groups across the state, including employers, attorneys, law enforcement, students, patient groups, other state agencies, and health care professionals. Through this outreach, the program has heightened awareness about the law and assured patients, physicians, law enforcement, and citizens alike that the state is committed to handling this issue in a sound manner.

Because of the outreach effort, all parties are increasingly comfortable with the law and its implementation. For example, Oregon has a surprisingly high rate of physician participation in the registry program. **Approximately 500 physicians have submitted documentation for patients seeking a registry card.** There is about one recommending physician for every 3.2 patients in the registry system, which shows that it is not just a handful of doctors who recognize the medical benefits of marijuana. Comparatively, patient networks in Washington state and California report that there is one recommending doctor for every 3.5 to 5.5 patients. 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.

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 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 to get started, and insurance does not cover any of this.

In addition to administering the registry program, the Health Division considers petitions to add 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.

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 lawmakers imposed far greater restrictions on Alaska's medical marijuana statute.

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'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 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 exception. 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 and too restrictive.

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

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, almost identical 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 Services or Veterans Administration. 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 a medical marijuana registry card. 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. The cases were still pending as of November 2000.

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 are often 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 qualified 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 a registry card. As enforcement practices vary from jurisdiction to jurisdiction, patients are not guaranteed the same treatment across Alaska.

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

Patient advocates have argued that the letter of the law permits nurse practitioners and physician assistants to sign the recommendation form. However, the Department of Health and Social Services obtained an opinion from the attorney general that only medical doctors and doctors of osteopathy meet the law's definition of "physician." Alaskans for Medical Rights is attempting to overturn this opinion.

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 did 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 what a "sixty day supply" of medical marijuana is.

Patient advocates such as Joanna McKee, director of Seattle's Green Cross Patient Cooperative, estimate that there are at least 3,000 medical marijuana patients utilizing the state law. 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. Although they do not meet the state's strict definition of a caregiver, many of the organizations—particularly the ones that provide identification cards or certificates—bolster the credibility of patients who are confronted by police. Nonetheless, disagreements and conflicts between patients and law enforcement remain common.

Not only do police lack clear guidance regarding what constitutes an appropriate supply, but they also complain that it is difficult to determine what is an appropriate doctor's recommendation. Although the law defines "valid documentation" more clearly than 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.

There have been several attempts to modify the law. A bill was introduced in both the 1999 and 2000 legislative sessions that would authorize the state Department of Health to adopt administrative rules to implement the medical marijuana law. Although the bill (S.B. 5704) passed the Senate in each session, it failed to move in the House. In Washington, it requires a two-thirds majority vote for the legislature to amend an initiative in the two years after it takes effect.

Beginning in 2001, it will only take a simple majority to amend the law via the legislature.

In the interim, 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 (3 mature, 3 immature, and 3 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, which said the police would not face any federal penalties for following in good faith the state's medical marijuana law.

To assist patients, the Health Department provides a toll-free phone number (800-525-0127) where patients can obtain information about the law. Although patient networks in Oregon maintain toll-free hotlines, Washington is the only state to provide this service through a state agency. As an informational courtesy, the department also 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.

Most patients who contact the Health Department know very little about the law and sometimes confuse it with the law in neighboring Oregon. Patients 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 a recommendation, 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 main 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, including nausea, vomiting, wasting, appetite loss, cramping, seizures, muscle spasms and/or 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 state has carefully listened to patient needs and has done the most of any state to expand the range of conditions that may be treated with medical marijuana.

Maine

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.

According to Mainers for Medical Rights, the advocacy organization that sponsored the initiative, there are approximately 250 patients in the state who use medical marijuana. Unfortunately, not all patients can afford to grow their medical marijuana indoors. The expensive lighting equipment necessary for growing indoors and the related energy costs are too great for some patients, many of whom have limited incomes and face other financial hardships due to their 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 reliable supply for the entire year. Not surprisingly, large grow operations, in excess of the law's specified

six-plant limit, have driven the state's few arrests related to the law.

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 their medical need. 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. The law does not, however, allow patients to assert an affirmative defense and argue that excessive amounts are medically necessary.

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 a caregiver capable of growing it for them. Some lack the horticultural skills needed to cultivate a reliable supply of marijuana. Time is another consideration, especially for cancer patients who need immediate chemotherapy treatment and an immediate supply; it takes several months for a marijuana plant to mature.

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

Although the plant limit is low with no exceptions, patients are afforded a "simple defense" to a charge of marijuana possession. With a simple defense, the defendant need only produce a relatively small amount of evidence at trial in support of the defense, with the state then having to disprove the existence of facts establishing the defense beyond a reasonable doubt. Maine is the only state where unregistered patients are afforded more than an "affirmative defense" at trial. An "affirmative defense" places the burden on the defendant to prove his or her medical necessity by a preponderance of the evidence. The "simple defense," on the other hand, makes it easier for a legitimate patient to avoid a conviction. Not surprisingly, law enforcement and prosecutors would like to see the simple defense tied to a state registry program. (California also does not have a registry program and the law provides an exemption from prosecution. However, the courts have interpreted the law as providing an affirmative defense at trial, for those patients who are prosecuted.)

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 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.

Access and enforcement issues drove the state to examine additional proposals for implementing the law. The state attorney general convened a broadly representative task force, which voted on three legislative recommendations following six meetings spread over five months (May to September 2000). Although the task force was unable to reach a consensus, a majority (15–10) voted in favor of a pilot project to establish a single non-profit center to sell medical marijuana to registered patients. A community oversight board would administer the center. There was also strong support for a bill to establish a state research program, and another bill to create a

registry program for patients and caregivers, as well as to allow patients to furnish marijuana to other patients on a one-to-one basis. Many supporters of the two latter bills favored various amendments. The results of the votes highlighted the task force's final report which was forwarded to the state legislature. The legislature will ultimately determine if further implementation takes place. The report is available on-line at the attorney general's Web site:

`http://www.state.me.us/ag/medicalmarijuana.htm`

Maine's Bureau of Health has expressed little interest in helping implement 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 medical marijuana task force member 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 its 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 a charge of marijuana possession if they have qualifying medical records or a signed statement by their physician stating that they have a debilitating condition and the medical benefits of marijuana likely outweigh the risks.

It is difficult to estimate how many patients will utilize the law. However, Oregon has a similar law and twice as many residents as Hawaii. Therefore, it may be assumed that 500 citizens of Hawaii will register in the first two years of the law's effectiveness.

Hawaii's law is well written with precisely defined terms, which may allow the state to avert much of the ambiguity and confusion experienced by other states with medical marijuana laws.

One concern, however, is that the state Health Department has declined to take an active role in the implementation of the law. In other states with formal systems, medical marijuana laws are administered by health officials rather than public safety officials. It remains to be seen whether physicians and patients will be less likely to utilize a program developed and maintained by law-enforcement officials.

Colorado

Colorado voters passed a medical marijuana initiative on November 7, 2000, with 53% of the vote. Similar to Nevada's, the Colorado initiative amends the state constitution, but it only required one vote.

Currently, the Colorado Department of Public Health and Environment is developing rules for a registry identification card program that will provide patients and their primary caregivers an exception from the state's marijuana laws. The registry program is expected to be effective by June 1, 2001. Until the registry is in place, Colorado patients have an affirmative defense to charges of unlawful marijuana possession or cultivation.

Nevada

Voters in Nevada enacted a medical marijuana law via initiative with 65% of the vote on November 7, 2000. (Because Nevada's law amends the state constitution, it required two votes. In 1998, Nevadans supported the proposal with 59% of the vote.) The new law requires the state legislature to provide for a system that allows qualified patients to use medical marijuana. Until the legislature acts, however, patients in Nevada have no legal protection for medical marijuana.

Medical conditions approved for treatment with marijuana in the eight states with medical marijuana laws

	California[a]	Oregon	Alaska	Washington	Maine	Hawaii	Colorado	Nevada
Specific diseases								
cancer	✔	✔	✔	✔	✔	✔	✔	✔
glaucoma	✔	✔	✔	✔	✔	✔	✔	✔
AIDS or HIV	✔	✔	✔	✔	✔	✔	✔	✔
Crohn's disease				✔[b, c]		✔		
Hepatitis C				✔[b, c]				
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.

Appendix G: Types of legal defenses afforded by effective state medical marijuana laws

i. Exemption from Prosecution

State governments are not required to enforce federal laws. 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.

ii. Simple Defense

With a simple defense to a charge of marijuana cultivation or possession, the defendant need only produce a relatively small amount of evidence at trial in support of the defense that the cultivation or possession was solely for a legitimate medical purpose. In order to win a conviction, the state must disprove the existence of facts establishing the defense beyond a reasonable doubt. Maine is the only state where unregistered patients are afforded a simple defense at trial.

In contrast to the affirmative defense, which places the burden on defendants to prove that their marijuana use or possession is medically necessary, a simple defense places the burden on prosecutors to prove that marijuana use or possession is not medically necessary for the defendant. As a result, it is difficult for prosecutors to win a conviction against legitimate patients afforded a simple defense in medical marijuana cases.

iii. 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.

iv. "Choice of Evils" Defense

In addition to providing one or more of the above specific defenses (exemption from prosecution, simple defense, or affirmative defense), the enactment of a medical marijuana law may allow defendants to raise a medical necessity defense, often referred to as a "choice of evils" defense. This defense is long recognized in common law and may be applied in states where a law or court decision defines or indicates circumstances where medical marijuana cultivation, possession, and use are permitted. See Appendix L 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 enact medical marijuana initiatives, 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 differences seem slight, but their effects are great. Patients in California are now protected under state law if they possess a valid recommendation 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 differences in legal protection for California and Arizona patients.

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; therefore, 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).

Six older state medical marijuana laws also use the word "prescribe," and are consequently also 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. See Appendix J for details.

Whereas patients do not receive meaningful legal protection via marijuana "prescriptions" because they cannot be lawfully obtained, those who have a physician's "recommendation" can meet their state's legal requirements for medical marijuana use.

States which followed California and Arizona in the initiative and legislative processes generally avoided both "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 physician concerns that they might face liability related to medical marijuana.

Appendix J: 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 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 does it plan on trying.

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 they concluded that such a challenge would fail.

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

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 Government Reform Subcommittee on Criminal Justice, Drug Policy and Human Resources of the U.S. House of Representatives, 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 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 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.

**Turner* challenged the constitutionality of U.S. Rep. Bob Barr's amendment to the fiscal year 1999 D.C. budget, which prohibited the District from spending any funds to conduct any initiative that would reduce the penalties for possession, use, or distribution of marijuana. The United States District Court for the District of Columbia ruled in Turner's favor, the votes were counted, and the medical marijuana initiative 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.

Thus it seems doubtful that the federal government will ever be able to overturn the state medical marijuana initiatives. That is, 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 **federal** marijuana offenses.

Since 1996, there have been two key cases of federal litigation relating to medical marijuana.

***Dr. Marcus Conant v. Barry R. McCaffrey* (Case No. C 97-00139 WHA)**

Ruling: A federal district court ruled that the federal government cannot punish physicians for discussing or recommending medical marijuana.

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 their 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, federal 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 a chronic, debilitating condition. 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 U.S. district court in August 2000. Plaintiffs argued that the threats amount to censorship. The federal government countered that there is a national standard for determining which medicines are accepted and that using 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 8, 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.”

Alsup further wrote that the ruling applies even if “the physician anticipates that the recommendation will, in turn, be used by the patient to obtain marijuana in violation of federal law.”

The U.S. Department of Justice has not yet appealed Judge Alsup’s ruling.

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

Ruling: A federal appeals court ruled that a medical marijuana distributor can use a medical necessity defense against federal marijuana distribution charges.

Background:

Large-scale distribution is the key unresolved issue surrounding state laws that remove criminal penalties for medical marijuana-using patients and the caregivers who assist them. In California, dozens of medical marijuana distribution centers received considerable media attention following the passage of Proposition 215. Many of them had been quietly operating for years before the law was enacted. State and local responses ranged from prosecution to uneasy tolerance to hearty endorsement.

In January 1998, the U.S. Department of Justice filed a civil suit to stop the operation of six distribution centers in northern California, including the Oakland Cannabis Buyers' Cooperative (OCBC). U.S. District Judge Charles Breyer issued a temporary injunction in May 1998 to shut down the distribution centers, pending the outcome of the case. OCBC, however, remained open, fighting the injunction for several months until Breyer ultimately rejected their arguments in October 1998 and ordered them to stop distributing marijuana. Six days later, OCBC complied—but immediately appealed the ruling.

Almost a year later, in September 1999, the Ninth U.S. Circuit Court of Appeals 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 level, where Breyer reconsidered arguments in July 2000 before ruling in favor of OCBC, which led him to modify his 1998 injunction. His new decision said OCBC could distribute marijuana to seriously ill people who meet the Ninth Circuit Court's medical necessity criteria.

The Justice Department immediately filed two appeals: (1) asking the U.S. Supreme Court to overturn the Ninth Circuit Court's decision establishing a federal "medical necessity defense" for marijuana distribution, and (2) asking the Ninth Circuit Court to overturn Judge Breyer's ruling specifically allowing OCBC to operate. The Justice Department also asked both courts for emergency injunctions to prevent medical marijuana distribution during the appeals process.

The Ninth Circuit Court refused to grant an emergency stay of Breyer's ruling, but on August 29, 2000, the U.S. Supreme Court granted the Justice Department's request, preventing OCBC from distributing medical marijuana in accordance with Breyer's order until appeals are heard. And, on November 27, the U.S. Supreme Court announced that it will hear the Justice Department's appeal of the Ninth Circuit Court's medical necessity decision.

Of note, the most recent stay applies only to OCBC. At least until the U.S. Supreme Court issues its final ruling in June 2001, medical marijuana distributors in the Ninth Circuit can still raise a medical necessity defense at trial against federal marijuana distribution charges during the appeals process of the OCBC case.

Furthermore, even if the U.S. Supreme Court rules against allowing a medical necessity defense, it will not affect the rights of California patients to grow, possess, and use medical marijuana under the **state** law created by Proposition 215. The case deals only with **federal** law, and only with the distribution of medical marijuana.

Appendix K: 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 receive special permission from the federal government, including 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 a federally approved source—currently, 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 from the federal government for the researchers.

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 the state's patient qualification review board, which resided within the department of health. If granted permission, they would receive marijuana from approved pharmacies. Patients were required to monitor their usage and its effects, which the state used to prepare reports for the FDA.

(Interestingly, 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 Resources—which oversees NIDA—issued new guidelines for research that 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 `http://www.mpp.org/guidelines`.)

Because of the excessively strict federal guidelines for research and the high cost of performing double-blind, placebo-controlled studies, it is unlikely that the therapeutic research laws will again distribute marijuana to patients on a meaningful scale in the near future. States are generally unwilling to devote their limited resources to a long and potentially fruitless application process for research. However, the laws establishing these programs currently remain on the books in 14 states.

The one exception may be California—a large and wealthy state—which appropriated $3 million for medical marijuana research in the state's fiscal year 2000-2001 budget. Research is expected to resume there in 2001, provided that federal approvals can be obtained. California's new research program is more scientifically modern than previous therapeutic research programs and is administered within the University of California system, rather than through a state health agency.

Appendix L: Medical necessity defense

The necessity defense, long recognized in common law, gives a defendant the chance to prove in court that his or her violation of the law was necessary to avert a greater evil. It is often referred to as the "defense of choice of evils."

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 an imminent harm. The threatened harm is so great that ordinary standards of intelligence and morality consider the desirability of avoiding the harm to be greater than the harm that is caused by violating the marijuana laws. Hence, it is the selection of the lesser harm.

Unlike "exemption from prosecution," a patient is still arrested and prosecuted for the crime; given that the 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 and the necessity defense, 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 (in addition to allowing an affirmative defense for unregistered but documented patients and an exemption 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 was 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 was more serious than the conduct to avoid it, i.e., cultivating marijuana.

In addition to Washington, D.C., courts in at least five states have allowed the medical necessity defense in medical marijuana cases, and in some cases those decisions have been reaffirmed.

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)
Washington	*Washington v. Diana*, 604 P.2d 1312 (Ct. App. Wash. 1979)
	Washington v. Cole, 874 P. 2d 878 (Ct. App. Wash. 1994)
Washington, D.C.	*United States v. Randall*, 104 Wash. Daily L. Rep. 2249 (D.C. Super. Ct. 1976)

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 a legal prescription 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 the schedule remains in place.

A different judge could have ruled that the 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—Minnesota and Alabama, for example—have made similar interpretations and have refused to allow this defense.

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 directly establishing 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 medical marijuana recognition by the state legislature precluded the court from allowing the medical necessity defense.
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 directly establishing 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 state 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.

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 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 purposes 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 typically 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 a simple defense or 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 where legislators have passed bills to establish the medical necessity defense for medical marijuana offenses—Maine, Massachusetts, and Ohio. Ultimately, the 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 Minnesota and Alabama, as noted above.

The U.S. Supreme Court has not yet recognized the necessity defense for medical marijuana. A decision from the U.S. Ninth Circuit Court of Appeals, however, has recognized medical necessity as a valid defense to federal marijuana charges. That case—*United States v. Oakland Cannabis Buyers' Cooperative*—is now pending before the U.S. Supreme Court. (See Appendix J.)

Appendix M: State medical marijuana legislation considered during the 1999-2000 legislative sessions

State	Bill Number	Intent	Good or Bad
Alaska	S.B. 94*	amend the law created by the medical marijuana initiative	B
Arkansas	H.B. 1043	remove criminal penalties for patients with state-issued ID cards who grow, possess, and use medical marijuana	G
California	S.B. 847*	establish a medical marijuana research program within the state university system	G
California	S.B. 848	implement the law created by the medical marijuana initiative, based on recommendations of the attorney general's task force	B
California	S.B. 2089	narrow the scope of the law created by the medical marijuana initiative by establishing a mandatory registration system and limiting a patient's use to less than one year, among other provisions	B
Colorado	H.J.R. 00-1033**	non-binding resolution opposing Amendment 20, the medical marijuana initiative	B
Hawaii	S.B. 862*	remove criminal penalties for patients who grow, possess, and use medical marijuana	G
Iowa	S.F. 2076	remove criminal penalties for patients who grow, possess, and use medical marijuana; establish a medical necessity defense; and establish a therapeutic research program	G
Maine	S.P. 1012/ L.D. 2580*	implement the law created by the medical marijuana initiative by requiring the Department of Public Safety to distribute confiscated marijuana to registered patients; bill was converted into a resolution creating a task force to examine broad implementation issues	G
Maryland	H.B. 308	remove criminal penalties for patients who grow, possess, and use medical marijuana	G
Massachusetts	H.B. 2128	expand therapeutic research program to include additional disease groups	G
Minnesota	S.F. 780/ H.F. 936	remove criminal penalties for patients who grow, possess, and use medical marijuana (introduced in 1999)	G
Minnesota	S.F. 3326/ H.F. 3669	establish a medical necessity defense for patients who possess small amounts of marijuana (introduced in 2000)	G
New Hampshire	H.B. 202	remove criminal penalties for patients who grow, possess, and use medical marijuana with a prescription (symbolic)	G
New York	A.B. 8082	remove criminal penalties for patients who grow, possess, and use medical marijuana, and permit distribution of medical marijuana	G
Oregon	H.B. 3052*	amend the law created by the medical marijuana initiative	B
Rhode Island	S.B. 2390/ H.B. 7398	remove criminal penalties for patients who grow, possess, and use medical marijuana	G
Vermont	J.R.H. 72	implement a symbolic 1981 law that permits physicians to "prescribe" marijuana to patients	G
Washington	S.B. 5704	implement the law created by the medical marijuana initiative, giving the Department of Health the authority to adopt rules	G
Washington	S.B. 5771	narrow the scope of the law created by the medical marijuana initiative, designating parameters of valid documentation, requiring physicians to determine specific dosage and maximum quantity limits that may be legally possessed	B
Wyoming	S.F. 20	move marijuana from Schedule I to Schedule II under state law should the federal government do the same (symbolic)	G

*passed and signed into law (Maine's resolution does not create statutory law, but it did appropriate funds for the task force)

**passed, but as a non-binding resolution does not require governor's signature

Appendix N

Resolutions demonstrate an organization's support for a particular policy and can encourage public officials to take action. MPP encourages activists to urge local and state organizations—especially health and medical groups—to pass this resolution, then forward a copy to MPP.

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 medical access to marijuana, including the AIDS Action Council, American Academy of Family Physicians, American Bar Association, American Medical Student Association, American Preventive Medical Association, American Public Health Association, California Academy of Family Physicians, California Legislative Council for Older Americans, California Medical Association, California Nurses Association, California-Pacific Annual Conference of the United Methodist Church, California Pharmacists Association, California Society of Addiction Medicine, Florida Medical Association, Gray Panthers, Lymphoma Foundation of America, Multiple Sclerosis California Action Network, National Association for Public Health Policy, National Association of Attorneys General, National Association of People with AIDS, National Black Police Association, National Women's Health Network, New York State Nurses Association, Public Citizen, Virginia Nurses Association, Whitman-Walker Clinic (Washington, D.C.), Women of Reform Judaism; and,

whereas, a scientific survey conducted in 1995 by Belden & Russonello (a Washington, D.C.-based polling firm) indicated that 79% of U.S. voters support the idea of "legaliz[ing] marijuana to relieve pain and for other medical uses if prescribed by a doctor"[5]; and,

whereas, national public opinion polls conducted by ABC News, CBS News, the Family Research Council, and the Gallup Organization between 1997 and 1999 found substantial support for medical marijuana[6]; 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, 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[8]; 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[9]; 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[10] and the resulting bureaucratic controls impede additional scientific research into marijuana's therapeutic potential[11], 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]Belden & Russonello interviewed 1,001 registered voters, selected by a national random digit dial survey, on behalf of the American Civil Liberties Union, which released the results via its Department of Public Education on November 27, 1995.

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

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

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

[11]The U.S. Department of Health and Human Services (HHS) issued written guidelines for medical marijuana research, effective December 1, 1999. The guidelines drew criticism from a coalition of medical groups, scientists, members of Congress, celebrities, and concerned citizens. The coalition called the guidelines "too cumbersome" and urged their modification in a letter to HHS Secretary Donna Shalala, dated November 29, 1999. Signatories of the letter included 33 members of Congress, former Surgeon General Joycelyn Elders, and hundreds of patients, doctors, and medical organizations.

Appendix O: Initiative states

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

Colorado's and Nevada's initiatives amended the state constitution, while measures in Alaska, Arizona, California, Maine, Oregon, and Washington enacted statutory law. (The initiative that appeared on the ballot in the District of Columbia was also a statutory law.)

The initiative process is not a panacea, however. Twenty-six states do not have it, which means voters in more than half of the states cannot enact favorable medical marijuana laws via the ballot; rather, they must rely on their elected representatives to change the medical marijuana laws. Moreover, legislation is much more cost-effective than 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 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 amendment or statute on the ballot for voter approval or rejection.

States with 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
Illinois	N	N	Y	N
Maine	N	Y	N	N
Massachusetts	N	Y	N	Y
Michigan	N	Y	Y	N
Mississippi	N	N	N	Y

	Statutory Law		Constitutional Amendment	
State	Direct	Indirect	Direct	Indirect
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				

Responses to Anti-Medical Marijuana Arguments

The issue at hand is the removal of criminal penalties for patients who use medical marijuana. It is crucial to avoid getting lost in side arguments. Federal law and 42 state laws subject seriously ill people to arrest and imprisonment for using marijuana. It is important to ask opponents, "Should seriously ill people be arrested and sent to prison for using marijuana with their doctors' approval?"

The key issue is not making 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.

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 arrests, fines, court costs, property forfeiture, incarceration, probation, and criminal records.

This paper provides the Marijuana Policy Project's (MPP's) answers to the following common challenging questions:

Challenge #1: "There is no reliable evidence that marijuana has medical value."

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."

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

Challenge #4: "Why not isolate the other useful cannabinoids and make them available in a pure, synthetic form?"

Challenge #5: "Why not make THC and other cannabinoids available in inhalers, suppositories, and so forth?"

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

Challenge #7: "Doesn't medical marijuana send the wrong message to children?"

Challenge #8: "Marijuana is too dangerous to be used as a medicine. Over 10,000 scientific studies have shown that marijuana is harmful and addictive."

Challenge #9: "Isn't marijuana bad for the immune system?"

Challenge #10: "Marijuana contains hundreds of compounds. Doesn't that make it too dangerous?"

Challenge #11: "Marijuana's side effects—for instance, increased blood pressure—negate its effectiveness in fighting glaucoma."

Challenge #12: "What exactly do all of the medical marijuana ballot initiatives do?"

Challenge #13: "Don't state-level medical marijuana laws put the states in violation of federal law?"

Challenge #14: "Aren't these medical marijuana bills and initiatives full of loopholes?"

Challenge #15: "Weren't the initiatives passed because of well-funded campaigns that hoodwinked the voters?"

Challenge #16: "This bill/initiative doesn't even require a doctor's prescription!"

Challenge #17: "These bills and initiatives are confusing to law-enforcement officials."

Challenge #18: "Cannabis buyers' clubs are totally out of control!"

Challenge #19: "If the U.S. Supreme Court rules against the buyers' clubs, will state-level medical marijuana laws be effectively overturned or negated?"

Challenge #20: "Isn't the medical marijuana issue just a sneaky step toward legalization?"

Challenge #21: "Are people really arrested for medical marijuana?"

Challenge #22: "Do people really go to prison for medical marijuana offenses?"

Challenge #23: "Is the federal government allowing medical marijuana research?"

Challenge #24: "How would doctors control the dosages of medical marijuana?"

Challenge #25: "Why make marijuana medically available when no other medicines are smoked? How can you call something a medicine when you have to smoke it? Smoke is not a medicine, and smoking is not a safe delivery system!"

Challenge #26: "Medical marijuana is opposed by all major health and medical organizations."

Challenge #27: "Medical marijuana is advocated by the same people who support drug legalization!"

Challenge #28: "Very few oncologists support medical marijuana. Newer surveys negate the Doblin/Kleiman survey."

Challenge #29: "In 1994, the U.S. Court of Appeals overruled DEA Administrative Law Judge Francis Young's decision, so his ruling in favor of medical marijuana is irrelevant."

Challenge #30: "Drug policy should be based on 'science, not ideology'."

Challenge #31: "Doesn't the federal government already allow some people to use medical marijuana?"

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CHALLENGE #1: "There is no reliable evidence that marijuana has medical value."

Response: In March 1999, the National Academy of Sciences' Institute of Medicine concluded that "there are some limited circumstances in which we recommend smoking marijuana for medical purposes." The report noted that "nausea, appetite loss, pain and anxiety … all can be mitigated by marijuana." (See http://www.mpp.org/science.html .)

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: In March 1999, the National Academy of Sciences' Institute of Medicine concluded, "Although some medications are more effective than marijuana … they are not equally effective in all patients."

Everyone knows 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. Treatment decisions should be made in doctors' offices, not by federal bureaucrats.

Response B: A 1997 National Institutes of Health medical marijuana report noted, "There was considerable discussion and debate as to whether smoked marijuana … would need to demonstrate clear superiority or some unique benefit compared with other medications currently available for these conditions. The Expert Group concluded that smoked marijuana should be held to standards equivalent to other medications for efficacy and safety considerations." [Emphasis added.][1]

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

Response A: Marijuana contains about 60 active cannabinoids in addition to THC. Many of these compounds produce therapeutic effects that THC alone does not. For example, cannabidiol seems to be primarily responsible for controlling spasticity.

Response B: In March 1999, the National Academy of Sciences' Institute of Medicine noted, "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."

CHALLENGE #4: "Why not isolate the other useful cannabinoids and make them available in a pure, synthetic form?"

Response: It took many years of research before THC was approved in pill form, and no other cannabinoids have since been made available. What pharmaceutical company is going to spend millions of dollars on research when natural marijuana is currently widely available? How many decades would it take to synthesize, approve, and market 60 different compounds? Why make patients wait that long when the natural substance already exists? Should patients who use marijuana be arrested and put in prison in the meantime?

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 of smokable marijuana that is necessary for FDA approval of the natural, whole marijuana.

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.

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

Response: There is already enough scientific evidence to establish that marijuana is a safe and effective medicine for some people. More research is needed simply to satisfy rigid FDA requirements for marketing, labeling, and distributing the substance in pharmacies. But the current federal research guidelines make it nearly impossible to do the research required by the FDA to approve natural, smokable marijuana as a prescription medicine. Even if the research were allowed to proceed, it could still take several years before marijuana is approved by the FDA.

Should the thousands of seriously ill people already using medical marijuana be arrested and sent to prison in the meantime? Of course not. Therefore, the only immediate solution is to change federal and state laws—through legislation and ballot initiatives—to exempt patients from criminal prosecution for using and obtaining marijuana, as long as their doctors agree that it is medically beneficial.

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1. "Report on the Possible Medical Uses of Marijuana," NIH medical marijuana expert group; Rockville, MD: National Institutes of Health, August 8, 1997; page 5.

CHALLENGE #7: "Doesn't medical marijuana send the wrong message to children?"

Response A: The federal government's annual National Household Survey on Drug Abuse has found that marijuana use has not increased among young people in California since the passage of Proposition 215 in 1996. In fact, the marijuana usage rates among California teenagers is currently lower than the national average.

Response B: Children can and should be taught the difference between medicine and drug abuse. There are no legal medications 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 C: 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 people might de-glamorize it for children. The message is, "Marijuana is for sick people."

Response D: Under federal law, cocaine and morphine are currently legal as medicines. This means that federal law defines cocaine and morphine as being better for you—in that they have more therapeutic value and are less dangerous—than marijuana. What kind of message does current federal law send to children?

CHALLENGE #8: "Marijuana is too dangerous to be used as a medicine. Over 10,000 scientific studies have shown that marijuana is harmful and addictive."

Response A: 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 B: 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 C: The medical marijuana opponents' popular "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 canon of marijuana literature. The Institute notes: "Many of the studies cited in the bibliography are clinical, but the total number also includes papers on the chemistry and botany of the Cannabis plant, cultivation, epidemiological surveys, legal aspects, eradication studies, detection, storage, economic aspects and a whole spectrum of others that do not mention positive or negative effects. … However, we have never broken down that figure into positive/negative papers, and I would not even venture a guess as to what that number would be."[2]

CHALLENGE #9: "Isn't marijuana bad for the immune system?"

Response A: No studies have conclusively established that marijuana's effects on the immune system exacerbate the condition of AIDS or cancer patients, according to the Journal of the American Medical Association.[3]

Response B: According to Marijuana Myths, Marijuana Facts, there is no evidence that marijuana users are more susceptible to infections than non-users. Early studies that showed decreased immune function in cells taken from marijuana users have since been disproved.[4] Indeed, not a single case of marijuana-induced immune impairment has ever been observed in humans.

CHALLENGE #10: "Marijuana contains hundreds of compounds. Doesn't that make it too dangerous?"

Response: 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.

CHALLENGE #11: "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."[5]

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2. 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.

3. *Journal of the American Medical Association*, 267(19), May 20, 1992; page 2573.

4. *Marijuana Myths, Marijuana Facts*, L. Zimmer, Ph.D., and J. Morgan, M.D.; New York, NY: The Lindesmith Center, 1997; page 106.

5. Ibid note xx formerly "1", pages 96-97.

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 a particular patient's circumstances?

Response D: Even if the benefits of using marijuana to treat glaucoma did not outweigh the risks, that would not negate the medical utility of marijuana for treating all of the other conditions that marijuana helps treat. Should a cancer patient be arrested for using marijuana if it is not particularly helpful for glaucoma patients?

CHALLENGE #12: "What exactly do all of the medical marijuana ballot initiatives do?"

Response: In short, they 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.

Unfortunately, federal laws still apply to patients. Luckily, the federal government does not have the resources to arrest and incarcerate a significant number of small-scale medical marijuana users and growers. Therefore, seriously ill people in the eight states that have passed effective medical marijuana laws are essentially free to grow and use marijuana if their doctors deem it appropriate.

CHALLENGE #13: "Don't state-level medical marijuana laws put the states in violation of federal law?"

Response: No. There is no federal law that mandates that states must enforce federal laws against marijuana possession or cultivation. States are free to determine their own penalties—or lack thereof—for drug offenses. State governments cannot directly violate federal law by giving marijuana to patients, but states can refuse to arrest patients who grow their own.

CHALLENGE #14: "Aren't these medical marijuana bills and initiatives full of loopholes?"

Response A: The voters intended to allow seriously ill people to use marijuana without being arrested. While some of the wording of the California initiative may have been sloppy, the judicial system is clearing up the gray areas. The courts are making sure that the new laws are being implemented as the voters intended and making sure that healthy people do not have a green light to use marijuana for fun. In California, there are still no reports of people getting away with using marijuana recreationally by using the initiative falsely as a defense. Judges and juries are able to decide who is a patient and who is not.

Response B: More recent bills and initiatives were drafted very carefully to ensure 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 writing initiatives that 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 #15: "Weren't the initiatives passed because of well-funded campaigns that hoodwinked the voters?"

Response A: No. Independent polls conducted before any money was spent on these campaigns indicated solid support for the initiatives. Furthermore, opponents used tax dollars, government officials (such as Drug Czar Barry McCaffrey), and statements from three former presidents to oppose the initiatives.

Response B: Proposition 215 was the culmination of more than three years of legislative activity in Sacramento. The California legislature passed one medical marijuana resolution and two bills in 1993, 1994, and 1995. The 1995 bill—which Governor Pete Wilson vetoed—became the basis for Proposition 215.

Response C: Ninety-five percent of California voters were aware that marijuana is sometimes used for medical purposes, according to a June 1996 poll conducted for the campaign. In fact, 32% of the voters said that they knew someone who had used medical marijuana.

Response D: The budget for Proposition 215 (less than $2 million) was peanuts compared to California campaign standards. The campaign budgets for Governor Pete Wilson and U.S. Senator Dianne Feinstein, for example, were each about $20 to $30 million in 1994. Interestingly, the entire Proposition 215 budget was less than half of what the so-called Partnership for a Drug-Free America spends each week on its advertising campaign.

CHALLENGE #16: "This bill/initiative doesn't even require a doctor's prescription!"

Response A: The federal government prohibits doctors from "prescribing" marijuana for any reason. A prescription is a legal document ordering a pharmacy to release a

controlled substance. Currently, the federal government does not allow this for marijuana.

However, there needs to be some way for state criminal justice systems to determine which marijuana users have a legitimate medical need. So the initiatives and bills require a physician to document that a patient has a debilitating medical condition whereby the potential benefits of the medical use of marijuana would likely outweigh the health risks for the qualifying patient.

The recommendation for marijuana must be written, or a physician must be willing to testify in court that he or she orally recommended marijuana. Doctors do not risk their reputations and livelihoods unless they very strongly believe that their patients need marijuana.

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? Opponents simply do not want patients to use medical marijuana, and they'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? What is the big difference, in practical terms?

CHALLENGE #17: "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: Law enforcement officials are just playing dumb in order to scare the public into opposing medical marijuana bills and initiatives. Why? Because they have a vested financial interest in being able to arrest as many people as possible.

CHALLENGE #18: "Cannabis buyers' clubs are totally out of control!"

Response: Most medical marijuana distribution centers (also known as cannabis buyers' clubs) in California worked out arrangements with local governments and law-enforcement officials. They were subject to strict guidelines, and they verified patients' diagnoses and recommendations from physicians. Photo IDs were issued in most cases. The marijuana was checked for quality control. The buyers' clubs were run above ground and would not risk the consequences of providing marijuana to healthy people.

Unfortunately, federal and overzealous state law-enforcement officials shut down almost all of the centers, including those that were the most tightly run—driving many patients back to the streets to buy their medicine. Nevertheless, even without buyers' clubs, the initiatives are still effective, in that they protect patients from being arrested regardless of how they obtain their medical marijuana.

CHALLENGE #19: "If the U.S. Supreme Court rules against the buyers' clubs, will state-level medical marijuana laws be effectively overturned or negated?

Response: Absolutely not. Contrary to common belief, the pending U.S. Supreme Court opinion on medical marijuana—which is expected to be issued in June 2001—will rule only on whether distribution (and presumably use) of medical marijuana is legal under federal law. The validity or nature of state medical marijuana laws is not in question. Consequently, state legislators should not use the upcoming Court decision as an excuse for inaction during the 2001 legislative session, because the upcoming Court ruling will not impact one way or the other on a state's ability to change state law in order to protect patients and primary caregivers from arrest. (If the Court rules that medical marijuana distribution is legal under federal law, state legislatures will still need to pass bills to protect patients under state law. If, on the other hand, the Court rules that medical marijuana distribution is prohibited under federal law, that is the assumption that most patients, physicians, and state governments have been working under all along, so this would not change the need to pass state medical marijuana bills.)

CHALLENGE #20: "Isn't the medical marijuana issue just a sneaky step toward legalization?"

Response A: How? Exactly how does allowing seriously ill people 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 people be subject to arrest and imprisonment for using marijuana with their doctors' approval? If not, then people should support the new medical marijuana bills and initiatives. Should healthy people be sent to prison for using marijuana for fun? If so, then we should keep all non-medical uses of marijuana illegal. There's no magic tunnel between the two.

CHALLENGE #21: "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 in 1996. There have been many other publicized and not-so-publicized cases across the United States.

Response B: More than 12 million marijuana users have been arrested since 1970.[6] Unfortunately, the government does not keep track of how many were medical users. However, even if only 1% of those arrestees used marijuana for medical purposes, that is 120,000 patients arrested!

Response C: The threat of arrest is itself a terrible punishment for seriously ill people. 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 #22: "Do people really go to prison for medical marijuana offenses?"

Response A: Federal law and the laws of most states do not make any exceptions for medical marijuana. On the federal level, possession of even one joint carries a maximum penalty of one year in prison. And cultivation of even one plant is a felony, with a maximum sentence of five years. Most state 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.

Response C: There are an estimated 60,000 marijuana offenders in prisons and jails at any given time.[7] Even if only 1% of them are medical marijuana users, that is 600 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 for by the patient and the taxpayers. Probation—which means urine tests for a couple of years, which means that the patient must go without his or her medical marijuana. Huge fines and possible loss of employment, 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 that 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 #23: "Is the federal government allowing medical marijuana research?"

Response: The 1999 federal medical marijuana research guidelines still make it nearly impossible to do research that would generate the necessary data to enable the FDA to approve natural, smokable marijuana as a prescription medicine. (See http://www.mpp.org/guidelines .)

Two things that would make it much easier to conduct research would be (1) moving marijuana from Schedule I to Schedule II of the federal Controlled Substances Act, and (2) ending the National Institute on Drug Abuse's monopoly on the supply of marijuana for research.

CHALLENGE #24: "How would doctors control the dosages of medical marijuana?"

Response: 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."[9]

CHALLENGE #25: "Why make marijuana medically available when no other medicines are smoked? How can you call something a medicine when you have to smoke it? Smoke is not a medicine, and smoking is not a safe delivery system!"

Response A: While there are health hazards associated with smoking, medicines do not have to be completely safe to be approved. They must be safe relative to other approved medicines. Considering that cocaine, morphine, and methamphetamine are legal medicines, it is absurd to prohibit medical marijuana.

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6. Crime in the United States, FBI Uniform Crime Reports; Washington, D.C.: U.S. Government Printing Office, annual series from 1970 to 1998.

xx7. "Marijuana Arrests and Incarceration in the United States: Preliminary Report," C. Thomas; Washington, D.C.: Marijuana Policy Project, 1998.

8. Ibid note xx, page 82.

Response B: Most medical marijuana users do not need to smoke so much that they are put at risk. For example, AIDS and cancer patients generally need just a couple of puffs just before a meal. And the hazards of smoking can be reduced by (1) using higher potency marijuana, (2) using vaporization devices, or (3) eating the marijuana.

Response C: Many medical practices that seemed absurd at one time are now generally accepted; for example, acupuncture, massage therapy, hypnotherapy, guided visualizations, and herbal medicines.

Response D: Smoked medicine is not unprecedented. For example, stramonium cigarettes were used to treat asthma in the 20th century.

CHALLENGE #26: "Medical marijuana is opposed by all major health and medical organizations."

Response A: No medical organizations state that seriously ill people 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 B: Numerous health and medical organizations and other prominent associations do have favorable medical marijuana positions, including AIDS Action Council, American Academy of Family Physicians, American Bar Association, American Medical Student Association, American Preventive Medical Association, American Public Health Association, California Academy of Family Physicians, California Legislative Council for Older Americans, California Medical Association, California Nurses Association, California-Pacific Annual Conference of the United Methodist Church, California Pharmacists Association, California Society of Addiction Medicine, Florida Medical Association, Gray Panthers, Lymphoma Foundation of America, Multiple Sclerosis California Action Network, National Association for Public Health Policy, National Association of Attorneys General, National Association of People with AIDS, National Black Police Association, National Women's Health Network, New York State Nurses Association, Public Citizen, Virginia Nurses Association, Whitman-Walker Clinic (Washington, D.C.), Women of Reform Judaism, and numerous other organizations.[9]

CHALLENGE #27: "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.

Response B: Surely you're not suggesting that patients should be punished just to spite people who believe that healthy people should not go to prison for using marijuana.

CHALLENGE #28: "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 suggested to at least one of their cancer patients that they obtain marijuana illegally. This was published in the peer-reviewed Journal of Clinical Oncology.[10]

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, a substantial minority of oncologists (one-third) who responded to the Schwartz surveys said 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 even more favorable opinions than the respondents.[11]

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?

9. "Partial List of Organizations With Favorable Positions on Medical Marijuana," Marijuana Policy Project; 2001.

10. "Marijuana as Antiemetic Medicine: A Survey of Oncologists' Experience and Attitudes," *Journal of Clinical Oncology*, 9, R. Doblin & M. Kleiman, 1991; pages 1314-1319.

11. "The Medical Use of Marijuana: The Case for Clinical Trials," *Journal of Addictive Diseases 14*(1), R. Doblin & M. Kleiman, 1995; pages 5-14. (Refutes critics' surveys.)

CHALLENGE #29: **"In 1994, the U.S. Court of Appeals overruled DEA Administrative Law Judge Francis Young's decision, so his ruling in favor of medical marijuana 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 create 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 opposed to making marijuana medically available, and the courts are willing to allow this tyrannical behavior.

CHALLENGE #30: **"Drug policy should be based on 'science, not ideology'."**

Response A: While science is important, mercy and compassion are essential. Even if there were no scientific evidence supporting the medical use of marijuana, it would be immoral to punish patients for doing something with the intent of treating their pain. Fortunately, there is considerable scientific evidence supporting marijuana's therapeutic benefits.

Response B: What is the "scientific" basis for arresting medical marijuana users? What peer-reviewed research has found that prison is healthier than marijuana? The opponents of medical marijuana have 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: Former Drug Czar Barry McCaffrey's statement about "science, not ideology" is hollow rhetoric. When science did not back his favorite policies, he ignored 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 federal government does not fund them; the Institute of Medicine (IOM) once wrote "evidence of effectiveness" of community-based drug abuse prevention programs "is relatively weak," yet the federal government enacted a law in 1997 to spend more than $140 million over five years to fund such programs; IOM also wrote, "Prevention intervention research should focus more attention on the transition from use to abuse and dependence," yet most programs and studies focus on the unrealistic goal of preventing experimental use; and finally, every comprehensive, objective government commission that has examined the marijuana phenomenon during the past 100 years has recommended that adults should not be criminalized for using marijuana—yet simple possession of marijuana remains a criminal offense in 40 states and on the federal level.

CHALLENGE #31: **"Doesn't the federal government already allow some people to use medical marijuana?"**

Response: Only eight 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.

Other Important Points to Make When Advocating Legal Access to Medical Marijuana:

- 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.
- We're 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. 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.
- If there must be a war against marijuana users, can't we at least remove the sick and wounded from the battlefield?

revised 2/2001

Appendix Q: 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." If federal and state laws were changed accordingly, marijuana would be as available through pharmacies as other tightly controlled prescription drugs, e.g., morphine. 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 it was closed to all new applicants in 1992. (Only eight 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 will 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 a "research" position differ from the White House Office of National Drug Control Policy and numerous other drug war hawks that **claim** to support research. Groups that claim to be in favor of research 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. (The groups listed as supporting research at worst remain silent on the issue of criminal penalties—and many, in fact, concurrently endorse legal/prescriptive access and/or compassionate access.)

Partial List of Organizations With Favorable Positions on 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
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 Bar Association	2/1984; 5/4/1998	✔	✔				resolution; letter to U.S. House Judiciary Committee opposing an anti-medical marijuana resolution
Americans for Democratic Action	1/1997	✔	✔	✔			resolution approved at annual meeting, Jan. 19-20, 1997; signatory of 2000 letter to U.S. Dept. of Health and Human Services
American Medical Student Association	3/1993	✔					AMSA House of Delegates Resolution #12
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
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 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

Partial List of Organizations With Favorable Positions on Medical Marijuana

Name of Group	Date	legal/ prescriptive access	compassionate access	research	other	Comments	Reference
California Legislative Council for Older Americans	12/1/1993; 11/29/1999; 12/2000	✔	✔	✔		prescriptive access: urges rescheduling	adopted at 23rd Annual Action Conference; signatory of 1999 and 2000 letters to U.S. Dept. of Health and Human Services
California Medical Association	1997; 1/11/2000	✔		✔	✔	other: letter opposes federal threats against doctors for discussing risks and benefits of marijuana	March 14, 1997 letter; May 21, 1997 endorsement of CA research bill; amicus curiae brief supporting right to distribute medical marijuana in California (*U.S. v. Oakland Cannabis Buyers' Cooperative*)
California Nurses Association	9/21/1995; 12/2000	✔	✔			prescriptive access: supported California bill AB 1529 to remove penalties for medical use	letter to California Governor Pete Wilson; signatory of 2000 letter to U.S. Dept. of Health and Human Services
California-Pacific Annual Conference of the United Methodist Church	6/1996	✔				prescriptive access: via resolution (also specifically endorsed Proposition 215)	Resolution 104 of the California-Pacific Annual Conference of the United Methodist Church, June 12-16, 1996
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
California Society of Addiction Medicine	5/1997	✔				prescriptive access: urges rescheduling	*California Society of Addiction Medicine News*, Spring 1997
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	✔					67th Convention of the Episcopal Church (B-004)a

Partial List of Organizations With Favorable Positions on Medical Marijuana

Name of Group	Date	legal/ prescriptive access	compassionate access	research	other	Comments	Reference
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
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
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 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
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 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 Nurses Association	6/29/1995; 11/29/1999; 12/2000	✔	✔	✔			signatory of 1999 and 2000 letters to U.S. Dept. of Health and Human Services
North Carolina Nurses Association	10/15/1996	✔		✔			"Position Statement of Therapeutic Use of Cannabis"

Partial List of Organizations With Favorable Positions on Medical Marijuana

Name of Group	Date	legal/ prescriptive access	compassionate access	research	other	Comments	Reference
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
Virginia Nurses Association	10/7/1994; 12/2000	✔	✔				resolution; signatory of 2000 letter to U.S. Dept. of Health and Human Services
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 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
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 Treatment Initiatives (Atlanta)	12/2000		✔				signatory of 2000 letter to U.S. Dept. of Health and Human Services
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

Partial List of Organizations With Favorable Positions on Medical Marijuana

Name of Group	Date	legal/ prescriptive access	compassionate access	research	other	Comments	Reference
The Center for AIDS Services (Oakland)	2/17/1999		✔				one of 17 organizations that signed letter to ONDCP Director Barry McCaffrey
Colorado AIDS Project	2/17/1999		✔				one of 17 organizations that signed letter to ONDCP Director Barry McCaffrey
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
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; signatory of 1999 and 2000 letters to U.S. Dept. of Health and Human Services
Gray Panthers	12/2000		✔				signatory of 2000 letter 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
Latino Commission on AIDS	2/17/1999		✔				one of 17 organizations that signed letter to ONDCP Director Barry McCaffrey
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

Partial List of Organizations With Favorable Positions on Medical Marijuana

Name of Group	Date	legal/ prescriptive access	compassionate access	research	other	Comments	Reference
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
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
National Academy of Sciences' Institute of Medicine	3/17/1999		✔	✔			*Marijuana and Medicine: Assessing the Science Base*; see http://www.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 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
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

Partial List of Organizations With Favorable Positions on Medical Marijuana

Name of Group	Date	legal/ prescriptive access	compassionate access	research	other	Comments	Reference
People of Color Against AIDS Network (Seattle)	2/17/1999		✔				one of 17 organizations that signed letter to ONDCP Director Barry McCaffrey
Public Citizen	12/2000		✔				signatory of 2000 letter to U.S. Dept. of Health and Human Services
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
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
American Cancer Society	7/24/1997			✔		supported California research bill SB 535	letter to California Senator 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
American Nurses Assoociation	1996			✔	✔	Congress of Nursing Practice passed a motion to "support the education for RN's regarding current evidence based therapeutic uses of cannabis" and to "support investigation of therapeutic efficacy of cannabis in controlled trials."	

Partial List of Organizations With Favorable Positions on Medical Marijuana

Name of Group	Date	legal/ prescriptive access	compassionate access	research	other	Comments	Reference
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
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
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

MPP's model state medical marijuana bill based on Hawaii law enacted on June 14, 2000

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TITLE: An Act to Protect Seriously Ill People from Prosecution and Prison for Using Medical Marijuana Under a Medical Doctor's Supervision

SECTION 1: Findings

(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) The legislature admits that it would prefer for the federal government to permit marijuana to be prescribed by physicians and to be dispensed at pharmacies. However, the legislature finds that the federal government has shown no indication that it will change federal policy with regard to medical marijuana, as evidenced by the federal government's reluctance to allow even FDA-approved clinical trials to move forward.

(c) According to the U.S. Sentencing Commission and the Federal Bureau of Investigation, more than 99 out of every 100 marijuana arrests are made under state law, rather than under federal law. Consequently, the legislature finds that 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.

(d) Although federal law expressly prohibits the use of marijuana, the legislature recognizes that the laws of Alaska, California, Colorado, Hawaii, Maine, Nevada, Oregon, and Washington permit the medical use and cultivation of marijuana. The legislature intends to join in this effort for the health and welfare of its citizens. However, the legislature does not intend to make marijuana legally available for other than medical purposes.

(e) The legislature finds that the state is 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 in violation of federal law.

(f) The legislature finds that state law should make a distinction between the medical and non-medical use of marijuana. Hence, the purpose of this act is to ensure that physicians are not penalized for discussing marijuana as a treatment option with their patients, and seriously ill people who engage in the medical use of marijuana upon their physicians' advice are not arrested and incarcerated for using marijuana for medical purposes.

SECTION 2: Definitions

(a) "Adequate supply" means an amount of marijuana collectively possessed between the qualifying patient and the qualifying patient's primary caregivers that is not more than is reasonably necessary to ensure the uninterrupted availability of marijuana for the purpose of alleviating the symptoms or effects of a qualifying patient's debilitating medical condition; [ADDING THE FOLLOWING IS OPTIONAL … provided that an "adequate supply" shall not exceed three mature marijuana plants, four immature marijuana plants, and one ounce of usable marijuana per each mature plant. "Usable marijuana" means the dried leaves and flowers of marijuana, and any mixture or preparation thereof, that are appropriate for the medical use of marijuana, and does not include the seeds, stalks, and roots of the plant.]

(b) "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 pain; severe nausea; seizures, including those characteristic of epilepsy; or severe and persistent muscle spasms, including 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 agency action, subject to judicial review.

(c) "Department" means state department of health.

(d) "Marijuana" shall have the same meaning as "marijuana" and "marijuana concentrate" as provided in sections _____ and _____.

(e) "Medical use" means the acquisition, possession, cultivation, use, transfer, or transportation of marijuana or paraphernalia relating to the administration of marijuana to alleviate the symptoms or effects of a qualifying patient's debilitating medical condition. For the purposes of "medical use," the term "transfer" is limited to the transfer of marijuana and paraphernalia between primary caregivers and qualifying patients.

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

(g) "Primary caregiver" means a person who is at least 18 years old and who has agreed to undertake responsibility for managing the well-being of a person with respect to the medical use of marijuana.

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

(i) "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 3: Exemption from criminal and civil penalties for the medical use of marijuana

(a) A qualifying patient who has in his or her possession written certification shall not be subject to arrest, prosecution, or penalty in any manner for the medical use of marijuana, provided the quantity of marijuana does not exceed an adequate supply.

(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) When the acquisition, possession, cultivation, transportation, or administration of marijuana by a qualifying patient is not practicable, the legal protections established by this act for a qualifying patient shall extend to the qualifying patient's primary caregivers, provided that the primary caregivers' actions are necessary for the qualifying patient's medical use of marijuana.

(d) A physician shall not be subject to arrest or prosecution, penalized in any manner, or denied any right or privilege for providing written certification for the medical use of marijuana to qualifying patients.

(e) Any property interest that is possessed, owned, or used in connection with the medical use of marijuana, or acts incidental to such use, shall not be harmed, neglected, injured, or destroyed while in the possession of state or local law enforcement officials, provided that law enforcement agencies seizing live plants as evidence shall not be responsible for the care and maintenance of marijuana plants. Any such property interest shall not be forfeited under any provision of state or local law providing for the forfeiture of property other than as a sentence imposed after conviction of a criminal offense or entry of a plea of guilty to a criminal offense. Marijuana, paraphernalia, or other property seized from a qualifying patient or primary caregivers in connection with the claimed medical use of marijuana shall be returned immediately upon the determination by a court or prosecutor that the qualifying patient or primary caregivers are entitled to the protections of this act, as may be evidenced by a decision not to prosecute, the dismissal of charges, or an acquittal.

(f) 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.

SECTION 4: Prohibitions, restrictions, and limitations regarding the medical use of marijuana

(a) The authorization for the medical use of marijuana in this act shall not apply to:

(1) The medical use of marijuana that endangers the health or well-being of another person, such as driving or operating heavy machinery while under the influence of marijuana;

(2) The smoking of marijuana:

(A) in a school bus, public bus, or other public vehicle;

(B) in the workplace of one's employment;

(C) on any school grounds;

(D) in any correctional facility; or

(E) at any public park, public beach, public recreation center, or youth center; and

(3) The use of marijuana by a qualifying patient, primary caregiver, or any other person for purposes other than medical use permitted by this act.

(b) Insurance companies shall not be required to cover the medical use of marijuana.

(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 a petty misdemeanor and subject

to a fine of $500. This penalty shall be in addition to any other penalties that may apply for the non-medical use of marijuana.

SECTION 5: Establishing a defense in court for patients and primary caregivers

A person and a person's primary caregivers 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 caregivers 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 6: Severability of this act

If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

SECTION 7: Implementation of this act

This act shall take effect upon its approval.

SECTION __: Registry identification cards issued by state health department

[OPTIONAL: This section can be removed without affecting any other section of the bill; a registry identification card section appeared in the Hawaii law.]

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

(b) A qualifying patient or primary caregiver shall qualify for the legal protections of Section 3 only if the qualifying patient or primary caregiver is in possession of a registry identification card.

(c) 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 registry identification cards, and for renewing registry identification cards, for qualifying patients and primary caregivers.

(d) The department shall issue registry identification cards to qualifying patients, and to qualifying patients' primary caregivers, if any, who submit the following, in accordance with the department's regulations:

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

(2) registration fee, not to exceed $25 per qualifying patient;

(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 caregivers, if the qualifying patient has designated any primary caregivers at the time of application.

(e) The department shall verify the information contained in an application submitted pursuant to this section, and shall approve or deny an application within 30 days of receipt of the application. The department may deny an application 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. Any person whose application has been denied may not reapply for six months from the date of the denial, unless so authorized by the department or a court of competent jurisdiction.

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

(1) the name, address, and date of birth of the qualifying patient and primary caregivers, if any;

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

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

(g) A person who possesses a registry identification card shall notify the department of any change in the person's name, address, qualifying patient's physician, qualifying patient's 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.

(h) 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 card, or otherwise subject the person or property of the person possessing the card to inspection by any governmental agency.

(i) The department shall maintain a confidential list of the persons to whom the department has issued registry identification cards. Individual names on the list shall be confidential 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 for the purpose of verifying that a person who is engaged in the suspected or alleged medical use of marijuana is lawfully in possession of a registry identification card.

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SECTION __: State-sanctioned non-profit distribution of medical marijuana

[OPTIONAL: This section can be removed without affecting any other section of the bill; this section does not appear in the Hawaii law.]

(a) A "registered organization" is a non-profit corporation registered with the state under section _____ and organized for the purpose of lawfully selling, administering, delivering, dispensing, distributing, cultivating, or possessing marijuana, cultivation equipment, related supplies and educational materials, or marijuana seeds for medical use.

(b) Prior to selling, administering, delivering, dispensing, distributing, cultivating, or possessing marijuana for medical use, a registered organization shall file a registration statement with the department, and thereafter shall file an annual registration statement with the department, in accordance with department regulations which shall provide for the form and content of the registration statement.

(c) Not later than 90 days after the effective date of this act, the department shall promulgate regulations that include procedures for the oversight of registered organizations, specifications for the membership of the staff and the boards of directors of registered organizations, appropriate protections for people associated with registered organizations, a registration system for qualifying patients and

primary caregivers who use the services of registered organizations, record-keeping and reporting requirements for registered organizations, the potential transference or sale of seized cultivation equipment and related supplies from law enforcement agencies to registered organizations, and procedures for suspending or terminating the registration of registered organizations.

(d) It shall be lawful to sell, administer, deliver, dispense, distribute, cultivate, or possess marijuana where it is:

(1) by a registered organization to a qualifying patient or primary caregiver; or

(2) by any federal, state, or local law enforcement agency to a registered organization.

(e) The registered organization is prohibited from:

(1) obtaining marijuana from outside the state in violation of federal law;

(2) employing or utilizing the services of any person who has a criminal record involving a controlled substance offense; and

(3) selling, administering, delivering, dispensing, or distributing marijuana to qualifying patients or primary caregivers without first verifying the validity of the qualifying patient's written certification by:

(A) contacting the office of the qualifying patient's physician; and

(B) contacting the appropriate state medical board or association to determine that the physician is licensed to practice medicine under section _____.