



# State Medical Marijuana Initiatives: A Justification and Analysis

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# State Medical Marijuana Initiatives: A Justification and Analysis

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JULIUS ROBERTS — INITIATIVE

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## I. Introduction

In 1996, California and Arizona passed medical marijuana initiatives with 55.6% and 65.4% of the votes respectively. The elections stunned federal, state and local leaders, who convened in an emergency session of the Senate Judiciary Committee to determine what had happened. These leaders maintained that the Arizona and California voters had been duped by pro drug legalization advocates masquerading as compassionate groups seeking to comfort the sick and dying. Government leaders maintained that systems were in place to deal with medicines and that misguided voters should not subvert these safeguards.

The government leaders failed to recognize that in the case of Schedule I drugs, these systems had failed. The current political, legal, and administrative system in the United States does not provide a method to determine whether Schedule I substances are medically beneficial. Modern science does not accept anecdotal evidence; it requires rigorous and exhaustive testing before a drug is deemed safe and effective. Yet the federal government has thwarted any attempt to perform this necessary scientific testing. Therefore, according to the scientific standards in the United States, nobody knows whether marijuana possesses medically beneficial properties that outweigh its risks.<sup>3</sup> On the other hand, for the same reasons, nobody knows whether marijuana is not medically beneficial. For the past twenty five years, the federal government has refused to allow this question to be answered.

<sup>1</sup>California Secretary of State web site, 1996 Election Results, <<http://Vote96.ss.ca.gov/Vote96/html/vote/prop/page.961218083528.html>> (January 14, 1998).

<sup>2</sup>Arizona Secretary of State web site, Unofficial Election Results, <<http://sosaz.com/results/1996general/>> (January 14, 1998).

<sup>3</sup>Marinol, a drug approved by the FDA is a synthetic form of THC, the primary active substance in marijuana. Logic dictates that if Marinol has medical benefits, marijuana would have medical benefits. The debate then centers on whether the risks associated with raw marijuana outweigh the benefits.

In this paper, I take the position that according to contemporary scientific standards in the United States, marijuana has not been shown to be medically beneficial. I also takes the position that even if marijuana has medically beneficial properties, the current system in the United States offers no method for proving such a fact in a scientifically acceptable manner. Therefore, patients, physicians, and other advocates who believe that marijuana is medically effective, have no alternative but to pursue alternative methods, such as state voter initiatives, to achieve their goal. This strategy has proven effective in pressuring the federal government to relent and allow scientific testing of marijuana to finally answer the question of whether marijuana has medical benefits. The ultimate goal, for the purposes of this paper, is to answer the medical marijuana question in a definitive manner. If marijuana is shown to be beneficial, it should be absorbed into the proper systems regulated by the Food and Drug Administration.

This paper briefly chronicles the efforts of marijuana activists at the federal level. Then it analyzes the text, implementation and subsequent developments of the California and Arizona initiatives passed by the voters in 1996, with the goal of helping future initiative drafters learn from the failures and successes of these initiatives. Finally, this paper critically analyzes medical marijuana initiatives currently being pursued throughout the country.

#### H. Relevant Federal Legislation

In order to understand marijuana's recent history, as well as the nuances of the state initiatives, it is necessary to have at least a cursory understanding of the Food Drug and Cosmetics Act (FDCA) and the Controlled Substances Act (CSA), and how the two interact when a drug classified as a controlled substance is involved. Understanding how the two acts fit together is not an easy task. The interrelationship between the two Acts is far from clear.<sup>4</sup>

<sup>4</sup>National Organization For the Reform of Marijuana Laws (NORML) v. DEA, 559 F.2d 735.

750 note 65, 118 U.S. App. D.C. 114 (D.C. Cir. 1977).

A. The Food Drug and Cosmetics Act (FDCA)

The Food Drug and Cosmetics Act (FDCA) is a sweeping legislation that regulates just about any substance that goes on or into the bodies of humans and animals.<sup>5</sup> As it relates to drugs, the FDCA is directed mainly at keeping unsafe drugs out of interstate commerce. Because it is more like a consumer protection statute than a criminal statute, the FDCA focuses primarily on issues of distribution as opposed to possession. It does not prohibit the possession of unapproved drugs.

The FDCA's regulation of drugs begins with its definition of a drug. A drug is (a) any article recognized by an official compendium<sup>6</sup> such as the United States Pharmacopoeia; (b) any article intended to diagnose, cure, mitigate, treat, or prevent disease in humans or animals; (c) any article (other than food) that is intended to affect the structure or function of the body; and (d) components of any article in the first three categories.<sup>7</sup> No new drug may be introduced or delivered into interstate commerce without the approval of the Food and Drug Administration

(FDA).<sup>8</sup>

<sup>5</sup>This discussion is intended to give a brief sketch of the drug approval process and give the reader a feel for how the FDA gets its authority to regulate drugs. For a more in-depth discussion of the FDA approval process, see Veronica Henry, Problems with Pharmaceutical regulation in the United States, 14 *Journal of Legal Medicine* 617 (1993).

<sup>6</sup>21 U.S.C.A. §33216).

<sup>7</sup>21 U.S.C.A. §321(g).

<sup>8</sup>21 U.S.C.A. §§331(d), 355(a).

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While nobody would question the fact that marijuana is a drug according to this definition,<sup>9</sup> one may wonder why marijuana would fall into the new drug category considering it has been used as medicine for centuries.<sup>10</sup> The term new drug is defined as any drug that does not meet one of the following two exemptions. First, drugs that are generally recognized by experts as safe and effective for the use described in the labeling are exempted. Second, drugs subject to the Food and Drug Act of June 30, 1962 are not considered new drugs if their labels have not changed with respect to uses of the drug.<sup>12</sup> Some experts argue that marijuana is safe and effective,<sup>13</sup> but Congress has determined that it lacks an accepted medical use or level of safety by virtue of its designation as a Schedule I substance.<sup>14</sup>

In order to receive approval by the FDA of a new drug, one must first perform rigorous clinical trials of the drug. The process begins with the submission of an Investigational New Drug Application (IND) to the FDA, which must occur before clinical testing can begin.<sup>15</sup> Because the FDCA prohibits the introduction into interstate commerce of unapproved new drugs, and one cannot realistically perform clinical trials on a drug without violating the prohibition, the FDCA creates an exemption for new drugs intended for investigational use.<sup>16</sup>

<sup>9</sup>At least for medical uses, marijuana is intended to be used as a drug.

<sup>10</sup>Robert C. Clarke & David W. Pate, Medical Marijuana, in Hemp Today 303, 306 (Ed Rosenthal ed., 1994).

<sup>11</sup>21 U.S.C.A. §321(p).

<sup>12</sup>21 U.S.C.A. §321(p)(1).

<sup>13</sup>Ed Rosenthal, Introduction, in Hemp Today, and Robert C. Clarke & David W. Pate, Medical Marijuana in Hemp Today 299-309 (Ed Rosenthal ed., 1994).

<sup>14</sup>21 C.F.R. §3 12.20.

<sup>15</sup>21 U.S.C.A. §355(i).



The new drug sponsor must then perform three stages of human clinical evaluations for safety and efficacy.<sup>17</sup> These three phases last approximately six years.<sup>18</sup> After the clinical trials, the sponsor submits a New Drug Application (NDA), which must contain reports of all investigations and all other information pertinent to the drug, to the FDA.<sup>19</sup> When the FDA approves a NDA, it classifies it as either a prescription drug or a non prescription drug.<sup>20</sup>

Once a drug's NDA is approved, the FDCA no longer prohibits its distribution. However, the FDCA still regulates all drugs (both approved new drugs and exempted old drugs), as well as food and cosmetics, through restrictions on misbranded and adulterated substances.<sup>21</sup> While the terms misbranded and adulterated seem narrow, these two words provide the basis for an entire regulatory structure. For example, a prescription drug dispensed without a valid prescription is deemed to be misbranded. In fact, a manufacturer, who markets its drug for a use other than that for which the FDA approved it, misbrands the drug.<sup>22</sup> Furthermore, any distribution of material distributed by the manufacturer that describes the use of a drug is deemed labeling by the FDCA.<sup>23</sup> Therefore, falsehoods in such materials would constitute misbranding.<sup>24</sup>

<sup>17</sup>See Veronica Henry, Problems with Pharmaceutical Regulation in the United States, 14 Journal of Legal Medicine 617, 621 (1993).

<sup>18</sup>Veronica Henry, Problems with Pharmaceutical Regulation in the United States, 14 Journal of Legal Medicine 617, 621 (1993).

<sup>19</sup>21 C.F.R. §3 14.50.

<sup>20</sup>21 U.S.C.A. §353(b)(1)(B); *National Nutritional Foods Association v. Weinberger*, 512 F.2d 688, 699 (2nd Cir. 1975) (ruling that the FDA has the power to determine which products are prescription drugs).

<sup>21</sup>21 U.S.C.A. §331(a)-(c).

<sup>22</sup>See Richard A. Merrill, The Architecture of Government Regulation of Medical Products, 82 Virginia Law Review 1753, 1853-4 (1996).

<sup>23</sup>21 U.S.C.A. § 321(m)-(n); *Kordel v. United States* 335 U.S. 345, 349-50 (1948) (ruling that pamphlets and other materials describing a drug constitute labeling regardless of whether they are

The FDA has used this misbranding restriction to institute a comprehensive set of guidelines on manufacturer advertising.<sup>25</sup>

When an individual distributes an unapproved new drug, or a drug deemed misbranded or adulterated, federal courts have the authority to enjoin such distribution.<sup>26</sup> Furthermore, the person who distributes the drug is subject to imprisonment for up to one year and fines up to \$1,000 for a first offense and three years and \$10,000 for a subsequent offense.<sup>27</sup>

B. The Controlled Substances Act (CSA)

The Comprehensive Drug Abuse Prevention and Control Act of 1970, better known as the Controlled Substances Act (CSA) categorizes substances that pose a danger of abuse and dependence into five schedules, according to the level of danger for abuse and dependence the substance poses.<sup>28</sup> A substance placed in any of the schedules is considered to be a controlled substance. Marijuana is a Schedule I drug, which means that it has a high potential for abuse, no currently accepted medical use in treatment in the United States, and is not accepted as safe, even under medical supervision.<sup>29</sup> Examples of other Schedule I drugs include peyote, PCP, heroin, and LSD.<sup>30</sup> A Schedule II drug has a high potential for abuse, has a currently accepted medical use in the United States with severe restrictions, and poses a danger of severe

physically attached to the product).

2421 U.S.C.A. § 33 1(a).

2521 C.F.R. § 202.1.

2621 U.S.C.A. §332(a).

2721 U.S.C.A. §333(a).

2821 U.S.C.A. §812(b)(1).

2921 U.S.C.A. §812(b)(1); 21 C.F.R. §1308.11 Schedule I (d)(19)

~21 C.F.R. §1308.11 Schedule I.

psychological or physical dependence.<sup>31</sup> Examples of Schedule H drugs include cocaine and opium.<sup>32</sup> A Schedule II drug has a lower potential for abuse compared to Schedule I and H drugs, a currently accepted medical use in the United States, and a moderate to low risk of physical dependence or a high risk of psychological dependence.<sup>33</sup> Examples of Schedule III drugs include anabolic steroids and certain diluted mixtures of codeine.<sup>34</sup> A Schedule IV drug has a relatively low potential for abuse compared to Schedule III drugs, a currently accepted medical use in the United States, and a potential for limited physical or psychological dependence compared to Schedule III drugs.<sup>35</sup> Examples of Schedule IV drugs include both components of the diet drug Phen fen (phen-termine and fenfluramine).<sup>36</sup> A Schedule V drug has a low potential for abuse and physical or psychological dependence relative to Schedule IV drugs, and an accepted medical use in the United States.<sup>37</sup> Examples of Schedule V drugs include further diluted mixtures of codeine.<sup>38</sup>

The Controlled Substances Act authorizes the Attorney General to either reschedule a drug or remove it from scheduling after taking into account its potential for abuse, its potential for dependency, and scientific knowledge of the drug.<sup>39</sup> The Attorney General has delegated all

~21 U.S.C.A. § 812(b)(2).

3221 C.F.R. §1308.12 Schedule II.

~21 C.F.R. §1308.13 Schedule III.

3621 C.F.R. § 1308.14 Schedule IV.

3821 C.F.R. §1308.15 Schedule V.

~21 U.S.C.A. §811(c).

authority derived from the CSA to the Administrator of the Drug Enforcement Administration (DEA),<sup>40</sup> who may delegate its authority to subordinates in the DEA.<sup>41</sup> Therefore, the DEA has the legal authority to reschedule or deschedule a drug. While the DEA has the formal legal authority to schedule a drug, the FDA retains significant power over the drug scheduling process. The Attorney General, Secretary of Health and Human Services, or an interested party may file a petition to reschedule a controlled substance.<sup>42</sup> Once a petition is filed, the DEA must request scientific and medical evaluations from the Secretary of Health and Human Services (Secretary), along with the Secretary's recommendation as to how the drug should be scheduled and hold a public hearing on the matter.<sup>43</sup> The Secretary has delegated this responsibility to the FDA. These scientific and medical evaluations are binding on the DEA.<sup>45</sup> Because a Schedule I drug by definition does not have an acceptable medical use in the United States, if the FDA recognizes an acceptable medical use, the DEA may no longer keep a drug in Schedule I. Furthermore, the DEA may not control a drug at all if the FDA recommends that the drug not be controlled. In effect, unless the FDA does not make a recommendation, the DEA merely has authority to determine in which schedule to place a drug, consistent with the FDA's scientific and medical evaluations.

<sup>40</sup>28 C.F.R. 0.100.

<sup>41</sup>28 C.F.R. 0.104.

<sup>42</sup>21 U.S.C.A. 811(a).

<sup>43</sup>21 U.S.C.A. 811(b).

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

This preceding explanation is a bit simplistic and possibly misleading because if an international treaty or obligation, to which the United States has adhered, requires control of a certain drug, 21 U.S.C.A. §811(d) states that the Attorney General (who's authority is delegated to the DEA) shall schedule the drug as she deems fit, without regard to the recommendations of the FDA. Since most substances covered by the CSA are controlled by treaties, a literal reading would effectively void the power Congress gave to the Secretary. In National Organization For the Reform of Marijuana Laws (NORML) v. DEA<sup>46</sup> the court found that Congress never intended to bestow such discretion on the DEA. Instead, the court found, the DEA may overrule the FDA only to the extent necessary to satisfy the treaty obligations of the United States.<sup>47</sup> Although the Secretary of Health and Human Services and the FDA maintain significant power.

The question then becomes, how does one access a Schedule I drug, not yet approved by the FDA, to perform the clinical testing necessary for FDA approval of a New Drug Application? To distribute a Schedule I or II controlled substance, one must obtain DEA registration.<sup>48</sup> The DEA has broad discretion in terms of whose registration application it approves.<sup>49</sup> For clinical research, one must first receive approval of an Investigational New Drug Application (IND) by the FDA.<sup>50</sup> Then the researcher must submit the approved ND to the DEA along with a statement of security provisions the researcher intends to implement.<sup>51</sup> The CSA requires the DEA to forward the application and protocol to the Secretary of Health and Human Services,

46559 F.2d 735, 746, 182 U.S. App. D.C. 114 (D.C. Cir. 1977).

<sup>47</sup>Id.

4821 C.F.R. 1301.11.

<sup>49</sup>21 U.S.C.A. 823(b)

5021 C.F.R. 1301.18(b); 21 C.F.R. 312.20 (requirements for IND).

<sup>51</sup>21 C.F.R. 1301.18(b).

who has ultimate authority to approve or reject the protocol. This requirement is moot because the Secretary has delegated this authority to the FDA, which has already approved the protocol.<sup>52</sup> The FDA should, however, defer to the DEA for issues of adequate safeguards to prevent diversion of the drug.<sup>53</sup> Once the FDA has approved the ND and the DEA has approved the research protocol application, thus registering the applicant as an approved Schedule I or II distributor under 21 U.S.C.A. 823, the researcher may proceed as with any other new drug clinical trial. With a Schedule I drug, however, the researcher still has a problem of access to the drug. Unless the researchers wish to manufacture (or grow) the drug themselves (an endeavor that also requires DEA approval<sup>54</sup>), finding a domestic source of the drug may prove difficult.<sup>55</sup> Another alternative is to import the drug, which requires DEA approval.<sup>56</sup> Although not impossible to perform, experiments involving Schedule I drugs pose greater obstacles to researchers than experiments involving drugs in other schedules. In the case of approving imports, the DEA retains sole authority to approve or reject the application.

C. Physician Liability Under the CSA and FDCA

The two biggest issues for medical marijuana and the two Acts are how the law applies to a patient using marijuana and how the law applies to a physician who prescribes it. The FDCA is primarily aimed at commerce involving misbranded, adulterated, and unapproved new drugs. A

5221 C.F.R. 510(a)(8-10).

~21 C.F.R. § 1301.32(a).

~21 C.F.R. §1301.1 8(a)(2)(vii).

For example, the only legal source for marijuana in the United States is the National Institute on Drug Abuse. Chemist is USA's Guardian of Grass USA Today, February 10, 1997, 3A.

5621 C.F.R. 1312.11, 1312.12, 1312.13.

See Grinspoon v. DEA, 828 F. 2d 881, 896 (1st Cir. 1987).

drug marketed intrastate could theoretically be sold without FDA approval.<sup>58</sup> It is not an attempt to restrict possession of a substance, or regulate physicians or the practice of medicine.<sup>59</sup> In other words, it regulates the availability of drugs that a physician may prescribe, as opposed to regulating a physician's ability to prescribe drugs. Attempts have occasionally been made to prosecute physicians for prescribing drugs absent a legitimate patient-doctor relationship; however, most of these prosecutions involve a physician personally distributing a drug, as opposed to merely prescribing it.<sup>60</sup>

Case law and FDA policy, however, both indicate that the FDCA may not regulate physicians prescribing habits within a legitimate doctor-patient relationship. For a number of years, the FDA has facilitated a personal use importation exemption that allows patients to import limited amounts of unapproved drugs, if done so under the supervision of a physician.<sup>61</sup> Implicit in this program is the act of a physician prescribing, or at least supervising the use of, an unapproved new drug. Additionally, the FDA allows, and possibly does not have the authority to prevent, physicians writing off-label prescriptions.<sup>62</sup> An off-label prescription is one where a physician prescribes a drug for an ailment, or in a manner, that the FDA has not approved. Such

<sup>58</sup>See *Grinspoon v. DEA* at 887.

<sup>59</sup>*U.S. v. Evers*, 643 F.2d 1043, 1048 (5th Cir. 1981).

<sup>60</sup>Most prosecutions were for distribution of drugs by a physician, as opposed to drug prescription. These cases became moot after the passage of the Controlled Substances Act of 1970. See *DeFreese v. United States*, 270 F.2d 730 (5th Cir. 1959); *Brown v United States*, 250 F.2d 745 (5th Cir. 1958). Physicians, however, have been prosecuted for prescribing drugs outside of a doctor-patient relationship. *Doe v. United States*, 801 F.2d 1164 (9th Cir. 1986).

<sup>61</sup> e.g. Eric Lindemann, Importing Aids Drugs: Food and Drug Administration Policy and its Limitations, 28 *Geo. Wash. J. of Int'l. L. & Econ.* 133 140-142 and fn 8, 1994.

<sup>62</sup>37 Fed. Reg. 16,503 (1972). See also, Lars Noah, Constraints on the Off-Label Uses of Prescription Drugs, 16 *J. Prods. & Toxics Liab.* 139 (1994).

activity is not only common, but frequently represent[s] acceptable, sometimes even essential, clinical practice.<sup>63</sup> The FDA draws a clear distinction between prescribing, and promoting or distributing drugs.<sup>64</sup> It recognizes that it is powerless to sanction a physician for prescription practices, and is limited in its statutory mandate to controlling the actual drug through restricting its movement in interstate commerce.<sup>65</sup>

Conversely, a physician who prescribes a Schedule I drug without permission from the DEA is subject to prosecution. First time offenders are subject to one year in prison and a \$25,000 fine.<sup>66</sup> Furthermore, the physicians may lose their registrations permitting them to prescribe any controlled substances.<sup>67</sup>

While most people understand that the CSA prohibits the possession and distribution of certain kinds of drugs, it is important to understand how the statute affects drugs in the medical realm and where the DEA derives its authority to impose sanctions on physicians for their prescribing practices. The CSA generally restricts possession of a controlled substance without a prescription.<sup>68</sup> It does not, however, authorize prescriptions for Schedule I drugs.<sup>69</sup> For a real life example—in the context of marijuana, a patient who wishes to lawfully use marijuana for medical

Richard A. Merrill, The Architecture of Government Regulation of Medical Products, 82 Va. L. Rev. 1753, 1854.

See id. at fn 318.

<sup>65</sup>J~ 37 Fed. Reg. 16503 (1972), the FDA proposed regulation that would have allowed the FDA to change a drug's labeling, restrict its distribution, or revoke approval if off-label prescribing became a problem. The FDA recognized that it could not regulate the physicians and had to effect change through regulating the products.

6621 U.S.C.A. §842(c)(2).

6721 U.S.C.A. §824(a)(2).

6821 U.S.C.A. §844(a).

6921 U.S.C.A. §829.



purposes needs a prescription; however, physicians are not permitted to issue prescriptions for marijuana. Therefore, notwithstanding state laws to the contrary, a patient who possesses marijuana, regardless of purpose, is in violation of federal law. The only exception to this prohibition would be possession in connection with DEA approved clinical research.<sup>70</sup>

Furthermore, under the Act, a physician may not dispense or prescribe<sup>71</sup> a controlled substance unless registered by the Attorney General to do so.<sup>72</sup> Physicians who prescribe marijuana to their patients are subject to prosecution and loss of registration to prescribe controlled substances. The DEA has also taken the position that it may revoke the registration of physicians who recommend Schedule I drugs to their patients. Although recommending would not violate a law, the DEA claims that 21 U.S.C.A. §824(a)(4) allows it to reject registrations for acts that violate the public interest.<sup>74</sup> Rescinding a physician's registration, however, for acts that do not constitute a crime and involve communication with a patient may violate the physician's First Amendment right to speech. The line between acts against public interest and free speech is unclear. A recent district court decision indicates that recommending may be covered by the First Amendment.<sup>75</sup>

<sup>70</sup>21 C.F.R. §1301.18.

<sup>71</sup>The Act considers prescribing a drug to be the equivalent of dispensing.  
21 U.S.C.A.

802(10).

<sup>72</sup>21 U.S.C.A. §§823(f), 844(a).

<sup>73</sup>Conant v. McCaffrey, 172 F.R.D. 681, 699 (N.D. CA 1997).

<sup>74</sup>Id.

<sup>75</sup>Id.

If the Attorney General revokes a physician's license to prescribe controlled substances, the Attorney General has effectively revoked a physician's ability to prescribe drugs, because a large number of commonly prescribed drugs are controlled substances.<sup>76</sup> This power the DEA wields significantly impacts any state laws aimed at making marijuana available for medical purposes because these laws cannot utilize the prescription process to make marijuana available to patients while restricting it from recreational users.

### III. History of Efforts at the Federal Level to gain Access to Marijuana for Patients Who May Benefit

Soon after the CSA passed, marijuana advocates began a campaign to gain access to marijuana for patients. Due to marijuana's unique situation, this group could not follow the traditional avenue taken by pharmaceutical companies seeking FDA approval for their drugs. Efforts to obtain FDA approval for a new drug take years and cost millions of dollars. To compensate these companies for their time and expense, the government grants them the exclusive right to sell their drugs for a certain number of years. In order to recoup these costs, pharmaceutical companies sell their drugs at inflated prices. Without the exclusive right to sell the drug, competitors unburdened by these millions of dollars in sunk costs could sell the drugs at lower prices, becoming free riders on the original company's research.

Just as with any other drug, efforts to gain FDA approval for marijuana would take a number of years and cost millions of dollars. Because marijuana is a plant that can grow just about anywhere, if the FDA were to approve it as a drug, patients would have little incentive to purchase it at inflated prices from pharmacies when they could grow their own. Consequently, pharmaceutical companies have little incentive to incur the costs of securing FDA approval for marijuana, especially when its approval may take market share away from drugs that they

<sup>76</sup> Cal. Att'y. Gen. Office, Proposition 215: An Analysis, (December 20, 1996), 5.

currently market. Medical marijuana advocates recognized this problem and focused their original efforts at rescheduling marijuana to a Schedule that allowed doctors to prescribe it to their patients on an individual basis. They also attempted to allow patients access to marijuana while it remained a Schedule I drug on a case by case basis. When they realized that marijuana would not be rescheduled, they began to seek FDA approval. By 1996, they had failed on all three fronts.

A.            NORML v. DEA

In 1972, the National Organization for the Reform of Marijuana Laws (NORMIL) petitioned the DEA's predecessor, the Bureau of Narcotics and Dangerous Drugs (BNDD) to reschedule marijuana and found itself locked in litigation with an intransigent DEA for twenty-two years. NORMIL originally requested the government to either remove marijuana from scheduling or alternatively reschedule it to Schedule V. Under 21 U.S.C.A. 811, the BNDD was required to refer the petition to the Secretary of Health, Education and Welfare (HEW), the predecessor to the Department of Health and Human Services (HHS), for scientific evaluation. The BNDD refused to accept the petition or refer it to HEW, claiming that it had sole authority for scheduling drugs covered by international treaties to which the United States was a party.<sup>77</sup>

NORMIL sought appellate review of BNDD's refusal to even accept their petition for rescheduling and the court of appeals ruled that the treaty obligations did not prevent the BNDD (now the DEA) from reviewing the petition, even if just to determine what the United States treaty obligations really were.<sup>78</sup> The court remanded the case, requiring the DEA to determine

7737 Fed. Reg. 18097 (1972). See also NORMI v. Ingersol, 497 F.2d 654, 656 (D.C. Cir. 1974).

<sup>78</sup>NORMIL v. Ingersol at 661.

whether international treaties allowed the DEA to place marijuana in any other Schedules. It also ordered the DEA to seek evaluations and recommendations from HEW.<sup>79</sup>

The DEA held a hearing before Administrative Law Judge Parker to determine the extent of the treaty obligations. He ruled that the DEA had the authority to reschedule cannabis (flowers and tops) and cannabis resin to Schedule II, cannabis leaves to Schedule V, and it could deschedule synthetic THC. He also ruled that the DEA should follow normal procedures relating to rescheduling, including abiding by HEW's recommendations.<sup>80</sup>

The DEA Administrator rejected Judge Parker's conclusions, ruled that marijuana would remain in Schedule I, and refused to refer the petition to HEW for recommendations.<sup>81</sup> He maintained that 21 U.S.C.A. 201(d) gave him sole discretion to schedule controlled substances and he did not have to seek recommendations from HEW.<sup>82</sup> He argued that even if he did have to refer the petition for rescheduling to HEW, a letter the DEA had received from the Acting Assistant Secretary of Health that stated there is currently no accepted medical use of marijuana in the United States, met that requirement.<sup>83</sup>

NORMIL appealed for the second time and the court of appeals ruled that the DEA was bound to follow HEW's recommendations up to the point at which they would cause a violation of an international treaty and ordered it to refer NORMIL's rescheduling petition to HEW.<sup>84</sup> By this time, five years had passed since NORMIL filed its petition and the DEA had yet to take

<sup>79</sup>NORMIL v. Ingersol at 661.

<sup>80</sup>NORMIL v. DEA, 559 F.2d 735, 742 (D.C. Cir. 1977).

814Q Fed. Reg. 44164, 44168 (1975).

<sup>82</sup>407 F.2d 735, 743 (D.C. Cir. 1977).

<sup>83</sup>NORMIL v. DEA, 559 F.2d 735, 742 (D.C. Cir. 1977).

<sup>84</sup>NORMIL v. DEA, 559 F.2d 735, 746-7 (D.C. Cir. 1977).

action on its merits or refer it to HEW. The court ordered the DEA to obtain separate recommendations from HEW for cannabis and cannabis resin, leaves, seeds capable of germination, and synthetic THC.<sup>85</sup> It chastised the DEA for relying on the letter, and, noting a HEW report on potential therapeutic aspects of marijuana, ordered the DEA to hold a formal hearing on the question of marijuana's medical potential.<sup>86</sup> Contrary to the court's order, however, HEW did not make separate evaluations and merely recommended that marijuana remain in Schedule 1.87

NORML appealed for the third time, and for the third time the DEA Administrator was reversed. The court chastised the DEA and HEW for not following its order to evaluate the four separate classifications of marijuana and implied that the DEA had attempted to skirt the spirit of its previous decision.<sup>88</sup> The Court again ordered the DEA to refer the petition to HEW's successor HHS for scientific and medical findings for each of the four classifications.<sup>89</sup>

The FDA, under its authority from I{HS, reviewed NOR.ML's petition and concluded that all portions of marijuana should remain in Schedule 17' After the FDA's recommendation, notwithstanding the CSA's requirement for a public hearing, the DEA did not hold a hearing on

<sup>85</sup>NORMIL v. DEA, 559 F.2d 735, 749 (D.C. Cir. 1977).

<sup>86</sup>NORMIL v. DEA, 559 F.2d 735, 757 (D.C. Cir. 1977).

<sup>87</sup>In the Matter of Marijuana Rescheduling Petition, Opinion and Recommended Ruling, Findings of Fact, Conclusions of Law and Decision of Administrative Law Judge Francis L. Young, September 6, 1988, No. 86-22, accessed at <<http://mojo.calyx.notl-olsen/MEDICAL/YOUNG/young.1.html>> (January 10, 1998).

<sup>88</sup>NORMIL v. DEA No. 79.1660, unpublished D.C. Circuit order filed October 16, 1980. cited in In the Matter of Marijuana Rescheduling Petition at 3.

<sup>89</sup>NORMIL v. DEA No. 79.1660, unpublished D.C. Circuit order filed October 16, 1980. cited in In the Matter of Marijuana Rescheduling Petition at 3.

<sup>87</sup>47 Fed. Reg. 28141 (1982).

the petition for six years. By this time, NORML had modified its petition, seeking only that marijuana be moved to schedule II. The Administrative Law Judge presiding over the hearing, Francis L. Young, found that a respectable minority of doctors accepted marijuana as having a medical use in treating cancer patients, multiple sclerosis, and hyperparathyroidism.<sup>91</sup> He cited copious examples of marijuana's usefulness in treatment and concluded that any decision claiming that marijuana had no acceptable medical use in the United States would be unreasonable, arbitrary, and capricious.<sup>92</sup> He concluded that marijuana was medically beneficial and recommended that the DEA reschedule marijuana to Schedule H.<sup>93</sup>

The DEA administrator, for the second time, rejected the findings of an administrative law judge, in this case claiming that the anecdotal evidence Judge Young relied on did not meet the requirements of scientific evidence.<sup>94</sup> He applied an eight part test previously developed by

<sup>91</sup>In the Matter of Marijuana Rescheduling Petition at 29, 34, 54-5.

In the Matter of Marijuana Rescheduling Petition at 34.

<sup>93</sup>In the Matter of Marijuana Rescheduling Petition at 67.  
9454 Fed. Reg. 53767 (1989)

the DEA to determine whether marijuana had an accepted medical use in the United States,<sup>95</sup> and on the basis of that test denied NORML's petition.

NORMiL appealed for the fourth time and the court for the fourth time reversed the DEA, calling its eight part test arbitrary and capricious.<sup>96</sup> It noted that at least three of the eight factors in the DEA's test could not possibly be met by a Schedule I drug, creating a catch 22 where no Schedule I substance could ever be rescheduled because it would fail the test by virtue of its classification as a schedule I drug.<sup>97</sup> The DEA Administrator issued a new five part test that omitted the three impossible factors, and ruled that because marijuana did not meet this test either, it would remain in Schedule I.<sup>98</sup> He also noted that in the future, anecdotal evidence of

<sup>95</sup>The eight part test required a drug to meet the following requirements to be considered to

have an accepted medical use in treatment in the United States:

1. Scientifically determined and accepted knowledge of its chemistry;
2. The toxicology and pharmacology of the substance in animals;
3. Establishment of its effectiveness in humans through scientifically designed clinical trials;
4. General availability of the substance and information regarding the substance and its use;
5. Recognition of its clinical use in generally accepted pharmacopeia, medical references, journals or textbooks;
6. specific indications for the treatment of recognized disorders;
7. Recognition of the use of the substance by organizations or associations of physicians;
8. Recognition and use of the substance by a substantial segment of the medical practitioners in the United States. 54 Fed. Reg. 53767, 53783 (1989).

<sup>96</sup>Alliance for Cannabis Therapeutics et al. v. DEA, 930 F.2d 936, 940 (1991).

<sup>97</sup>Numbers 4, 5 and 8 were deemed impossible for a Schedule I drug to meet. Alliance for Cannabis Therapeutics et al. v. DEA, 930 F.2d 936, 940 (1991).

<sup>98</sup>The five part test includes the following factors:

1. The drug's chemistry must be known and reproducible;
2. There must be adequate Safety Studies;
3. There must be adequate and well-controlled studies proving efficacy;
4. The drug must be accepted by qualified experts
5. The scientific evidence must be widely available.

effectiveness and opinions of practitioners would not be considered by the DEA in evaluating rescheduling petitions.<sup>7</sup> NORML appealed for the fifth time and lost.<sup>8</sup>

NORMIL spent twenty-two years attempting to reschedule marijuana. The DEA spent sixteen years avoiding the petition before it ever held a hearing on its merits; then it rejected the administrative law judge's recommendations. Four times, the DEA was overturned by appellate courts, sometimes with criticism for acting in bad faith. This experience led marijuana advocates to conclude that at the federal level politics and medicine were inseparable and the politics would prevail.

#### B. The Compassionate ND Program

During these years, marijuana advocates also pursued other avenues to allow patients and physicians to obtain marijuana on a case by case basis for treatment. In the late 1970's, they succeeded in persuading the FDA to create a single patient ND program also known as the compassionate ND program, which allowed approved physicians to receive and dispense marijuana to their patients. The FDA administered the program and evaluated the applications, and the National Institute on Drug Abuse (NIDA) provided the marijuana.<sup>9</sup><sup>10</sup> To comply with the

<sup>7</sup>57 Fed. Reg. 10499, 10506 (1992).

<sup>8</sup>57 Fed. Reg. 10499, 10506 (1992).

<sup>9</sup>00Alliance for Cannabis Therapeutics et al. v. DEA, 15 F.3d 1131 (1994).

Lester Grinspoon, M.D. & James B. Bakalar, ID, Marihuana as Medicine: A Plea for Reconsideration JAMA, June 1995, revised at the Schaffer Library of Drug Policy web site <<http://www.druglibrary.org/schaffer/hemp/medical/grinjama.htm>> (January 10, 1998).

<sup>10</sup>2Declaration of Daniel A. Spyker, Ph.D., M.D., Huffman v. FDA, No. 93-0237 NHJ (June 13, 1993), accessed at <<http://mojo.calyxnetkolsen/M1EDICAL/spyker.html>> (January 10).



Controlled Substances Act, the physicians also had to obtain DEA registration before they could obtain the marijuana from NIDA.<sup>03</sup>

As the AIDS epidemic increased, more patients began applying to the program. In response, the federal government discontinued the program, citing its opposition to illegal drugs and the lack of persuasive research to indicate the program's value.<sup>04</sup> NIDA would continue to supply patients already receiving marijuana, but patients who had been approved by the FDA but not yet by the DEA were excluded.<sup>05</sup> Due to attrition, the program currently provides marijuana to eight patients. 06

By 1992, the compassionate ND program had been discontinued and the futility of NORMIL's petition to reschedule marijuana was becoming apparent. Marijuana would remain forbidden unless its advocates could obtain FDA approval. On the other hand, the AIDS epidemic coupled with evidence that marijuana could help alleviate the nausea and weight loss associated with AIDS had increased the support for access to marijuana. These factors led to renewed attempts at clinical testing.

<sup>03</sup>Id.

<sup>04</sup>Lester Grinspoon, M.D. & James B. Bakalar, ID, Marihuana as Medicine: A Plea for Reconsideration JAMA, June 1995 ~ at the Schaffer Library of Drug Policy web site <<http://www.druglibrary.org/schaffer/hemp/medical/grinjama.htm>> (January 10, 1998); Peter Gwynne, Trials of Marijuana's Medical Potential Languish as Government Just S The Scientist Vol:9, No.23, November 27, 1995, 3, accessed at The Scientist web site <[http://www.the-scientist.library.upenn.edu/y1995/nov/smoke\\_95112.html](http://www.the-scientist.library.upenn.edu/y1995/nov/smoke_95112.html)> (April 29, 1998).

<sup>05</sup>Declaration of Daniel A. Spyker, Ph.D., M.D., Huffman v. FDA, No. 93-0237 NHJ (June 13, 1993), accessed at <<http://mojo.calyxnet/~olsen/MEDICAL/spyker.html>> (January 10, 1998).

<sup>06</sup>Lester Grinspoon, M.D. & James B. Bakalar, ID, Marihuana as Medicine: A Plea for Reconsideration JAMA, June 1995 accessed at the Schaffer Library of Drug Policy web site <<http://www.druglibrary.org/schaffer/hemp/medical/grinjama.htm>> (January 10, 1998).

### Roadblocks to Clinical Testing

Dr. Donald Abrams, an AIDS researcher, worked with the FDA to develop a suitable protocol for a study of marijuana's effects on AIDS wasting syndrome. The FDA approved ND No. 43,542 allowing Abrams to proceed. Abrams encountered difficulty, however, in obtaining the marijuana to perform the study. The only legal access to Schedule I drugs is by importing it with the approval of the DEA or obtaining it from a DEA registered domestic producer.<sup>107</sup> The DEA refused to allow Dr. Abrams to import marijuana and the only registered domestic producer in the United States, NIDA, refused to provide a supply.<sup>108</sup> Researchers in the United States were left with a Catch 22. The DEA refused to reschedule marijuana until legitimate scientific research showed that it had medical benefits; however, the federal government was preventing researchers from performing FDA approved research.

In 1996, marijuana advocates' assertions that politics, not science, was driving the government's resistance to marijuana and that the DEA had intentionally thwarted Dr. Abrams study were substantiated. After the DEA refused a Freedom of Information Act request, Public Citizen sued the DEA and obtained a letter written by the DEA to the FDA accusing it of approving an illegitimate study and informing it that the DEA would not cooperate.<sup>109</sup> In the letter, the DEA expressed its intention to prevent Dr. Abrams from importing marijuana and to reject his request for registration to dispense a Schedule I drug unless the FDA changed the study

t0721 C.F.R. 1301.18(a).

<sup>108</sup>Lester Grinspoon, M.C. & James Bakalar, Marijuana. The AIDS Wasting Syndrome. and the U.S. Government, New England Journal of Medicine, September 7, 1995, accessed at MAPS web site <<http://www.maps.org/mmj/nejm.htm>> (January 10, 1998).

<sup>109</sup>Letter from Gene R. Haislip, Deputy Assistant Administrator, Drug Enforcement

Administration to David A. Kessler, M.D., Commissioner, Food and Drug Administration (June

8, 1994) accessed at The Marijuana Policy Project web site <<http://www.mpp.org/deal.html>> (April 14, 1998).

to fit the DEA's criteria.<sup>0</sup> The most distressing aspect of the letter is that it indicated an effort by a law enforcement agency to force the agency responsible for scientific evaluation of medicines in the United States to alter its scientific procedures.

In the early 1990's, marijuana advocates were faced with a problem. In 1992, the government discontinued the compassionate ND program. Then in 1994, NORML lost its final appeal to reschedule marijuana to Schedule II. Finally, in 1995, NIDA and the DEA refused to allow an FDA approved study on marijuana's efficacy to proceed. The advocates were left with conundrums and Catch 22's, but without options.

Shortly thereafter, the movement turned its attention away from the federal avenues that had proven futile after twenty three years of effort, and directed its efforts towards the states. This movement to the states was a reasonable and natural progression of their efforts. Advocates felt that while federal politics opposed medical marijuana, the people did not. They were right. In 1996 voters in California and Arizona passed initiatives that would legalize marijuana, at the state level, for medical purposes.

IV. Analysis of What Drafts of Future Medical Marijuana Initiatives Can Learn from the Arizona and California Initiatives.

Now that medical marijuana activists have moved away from the traditional routes of

change, they need to define their ultimate goals. Marijuana advocates have diverse ultimate goals; some see medical marijuana as the first step in legalizing either marijuana or all drugs, others care only about the issue of medical access to marijuana, and others joined the movement because they disagree with government influence in personal choices generally, and they see medical marijuana prohibition as such interference. Activists who see medical marijuana legalization as a step in a broader ultimate plan may prefer a different approach than those

<sup>0</sup>1d.

focused strictly on obtaining medicine for the sick. For example, if marijuana is approved by the FDA and rescheduled, it still may not be distributed without a prescription, and physicians and pharmacists must comply with strict record keeping requirements.<sup>7</sup> Activists with strong libertarian leanings want the government completely uninvolved with medical marijuana and see the issue as one of personal privacy. These activists may disapprove of such stringent controls of marijuana, especially if they seek to legalize marijuana completely as the next step. They might prefer a system that hindered law enforcement officers by making it difficult for them to quickly distinguish medical marijuana from black market recreational marijuana.

This paper does not attempt to divine medical marijuana activist's motivations and assumes that the ultimate goal is to achieve FDA approval of marijuana and treatment by federal and state governments equivalent to any other medical drug, unaffected by politics.

A.

Notwithstanding the varied ultimate goals of medical marijuana initiative drafters, pursuing state medical marijuana initiatives involves three more basic goals or strategies that drafters must keep in mind: drafting an initiative that the voters will pass, exerting pressure on the federal government to change its policy, and creating a statute that works after the federal government does change its policy. First, drafters must create an initiative that is politically palatable to more than half of the voters so it will pass. An initiative that allows anybody to get marijuana for any condition anytime without restriction would certainly fail. Activists often feel

<sup>7</sup>21 C.F.R. 1306.05.

that any concessions to placate their opponents constitutes capitulation or selling out and they need to remain true to the cause regardless of the cost. The failure of medical marijuana initiatives throughout the country, however, would damage the movement and give opponents more credibility. In this case, it is not better to have tried and failed than to never have tried at all. Therefore, drafters must consider how the public will perceive the text and more importantly, in what ways the text lends itself to negative spins by opponents.

Second, pressuring the federal government flows naturally from the first goal. A primary reason for passing an initiative is to pressure the federal government, either to permit the research necessary to obtain FDA approval, or to back off and acquiesce to the way states wish to regulate medical marijuana use. Such policy changes would occur due to the political message state voters who pass initiatives send to the federal government. They also come from the increased responsibility the federal government must shoulder if certain types of drug violations no longer violate state law. The federal government is simply not equipped to investigate, arrest, and prosecute every dime bag dealer operating in even one large state, let alone several.<sup>12</sup>

Third, when the federal government does back off, either through a change of policy or lack of resources, the state needs to have a workable system. When the federal government changes its policy, it will not merely legalize marijuana, nor will it acquiesce to the states forever. It will defer to the states until definitive information on the risks and benefits can be ascertained, whereupon it will adjust its policy accordingly. During this time, the state law will

<sup>2</sup>The DEA rarely prosecutes possession for quantities anywhere near an amount that would constitute personal possession. The average weight of marijuana for DEA conviction cases is over 300 pounds and the U.S. Attorney's threshold policy for prosecution in Los Angeles and Orange County, California is 200 kilograms of marijuana or 200 plants. Hearings on the Arizona and California Medical Drug Use Initiative (December 2, 1996) (Statements of Tom Constantine, Administrator of the Drug Enforcement Agency and Brad Gates, Sheriff, Orange County, CA), available in LEXIS Legis Library. Fednew File.

govern medical marijuana use in the state. If the initiative is unworkable, patients will suffer. In many states, the legislatures cannot alter voter initiatives. The only way to fix the system would be to place a new initiative on the ballot, which is not an attractive option. Therefore, drafters must balance the need to draft a politically feasible initiative with the need to create a workable one.

Writing initiatives while balancing these multiple goals is a complex undertaking. One not only needs to create a workable initiative, but one that voters will approve. Some aspects of an initiative, however, may be desirable in developing a good statute, but are not politically acceptable. Other aspects are not necessary to the effectiveness of the statute, but are politically popular and can help an initiative gain needed votes. Other aspects may be politically damaging, but are essential to a workable statute and must be included regardless of the fodder it provides opponents.

The California, and to a lesser degree, Arizona initiatives provide an opportunity to examine what aspects of an initiative can create political liabilities, which cause unforeseen problems, and which are necessary to a properly functioning medical marijuana statute. In this section, I will first describe some of the general criticisms directed at state initiatives. Then I will describe the Arizona and California initiatives and what has occurred since they passed. Finally I will discuss the lessons medical marijuana advocates can glean from the experiences associated with these initiatives.

#### B. Criticisms Leveled Against State Medical Marijuana Initiatives

Some criticisms opponents level at medical marijuana initiatives apply to all initiatives. They argue that marijuana is not FDA approved, legalizing marijuana as a medicine sends the wrong message to children, and these initiatives are attempts at backdoor legalization, evidenced

by the fact that patients do not even need a doctor's prescription to use marijuana. These criticisms are really a product of the situation and drafters cannot avoid them through changes to the texts. Nevertheless, the fundamental flaw in these criticisms suggest the possibility that opponents, many of whom hold government positions, are willing to use disingenuous arguments and untruths to defeat these initiatives.

1. Argument That Marijuana Is Not FDA Approved

Opponents argue that the FDA's purpose is to protect consumers from unsafe drugs, and drugs therefore, should not be available without FDA approval.<sup>3</sup> They argue that marijuana should be subject to the same approval process as any other drug. General McCaffrey argued:

[A]llowing any potential medication to bypass [the FDA] process establishes a loophole that threatens to undermine the imperative for rigorous science as the basis for determining what constitutes good medicine."<sup>4</sup>

These opponents fail to note two problems with their argument. First, no market incentive exists for anybody to obtain FDA approval for marijuana.<sup>5</sup> Second, as discussed in Section HI, the federal government has thwarted attempts by researchers to do the studies necessary for FDA approval. Given the federal government's history of blocking studies on the potential medical benefits of marijuana, it is disingenuous for its representatives such as Orin

<sup>3</sup>James P. Fox, Michael J. Meyers, M.D., & Sharon Rose, Argument Against Proposition 215, 1996 California Election Pamphlet, reprinted in Cal. Att'y General's Office, Proposition

215: An Analysis (Dec. 20, 1996) Appendix I.

<sup>4</sup>Hearings On Medical Marijuana Referenda in America Before the Subcomm. on Crime of the House 105th Cong. (October 1, 1997) (Statement of General Barry R. McCaffrey, Director, Office of National Drug Control Policy), <http://www.whitehousedrugpolicy.gov/news/testimony/> (April 23, 1998).

<sup>5</sup> See Section HI, discussion on the lack of incentives to seek FDA approval for marijuana

Hatch and Barry McCaffrey to argue that marijuana should not be used for medical purposes until the FDA approves it.<sup>6</sup>

**2. Argument that legalizing marijuana for medical uses sends the wrong message to children**

The second argument opponents make against medical marijuana initiatives, and the movement in general, is that approving marijuana for medical purposes would send the wrong message to children.<sup>7</sup> The opponents, however, fail to note that both cocaine and opium are Schedule II drugs under the Controlled Substances Act. Both cocaine and opium have accepted medical uses in the United States. Cocaine, for example, is used as a local anesthetic.<sup>8</sup> Yet the opponents do not seem to fear that cocaine's status as a medicine sends a message to children that it is safe for recreational use. Opponents take a disingenuous position when they argue that treating marijuana equivalent to cocaine and opium sends the wrong message to children. If the marijuana activists had succeeded in creating parity in scheduling between marijuana and cocaine, they probably would not have tuned to the state initiative movement because researchers would have had less restricted access to marijuana to pursue FDA testing and physicians could have prescribed it on an individual basis.

<sup>6</sup>Hearings on the Arizona and California Medical Drug Use Initiatives Before the Senate Comm. on the Judiciary, (December 2, 1996), available in LEXIS Legis Library, Fednew File.

<sup>7</sup>Hearings on the Arizona and California Medical Drug Use Initiatives Before the Senate Comm. on the Judiciary, (December 2, 1996)(statement by Brad Gates, Sheriff, Orange County California), available in LEXIS Legis Library, Fednew File; Hearings On Medical Marijuana Referenda in America Before the Subcomm. on Crime of the House Comm. on the Judiciary, 105th Cong. (October 1, 1997) (Statement of General Barry R. McCaffrey, Director, Office of National Drug Control Policy), accessed at <http://www.whitehousedrugpolicy.gov/news/testimony/medical.html> (April 23, 1998).

<sup>8</sup>Stedman's Medical Dictionary 337 (2 1st ed. 1966).



3. Patients do not even need a doctor's prescription to use marijuana

The third general argument opponents make is that the initiatives are attempts at backdoor legalization evidenced by the fact that patients do not even need a doctor's prescription to use marijuana. ~ As discussed in Section IIC, physicians who prescribe Schedule I drugs risk criminal prosecution and the loss of their licenses to prescribe controlled substances. The initiatives seek to protect physicians by allowing them to merely recommend marijuana to patients. The opponents understand this conundrum,<sup>20</sup> yet disingenuously seize it as an opportunity to accuse the initiative drafters of attempting to surreptitiously legalize marijuana.

C. Arizona

Arizona's Proposition 200 is a broad drug and crime bill that goes beyond the medical marijuana issue and attempts to restructure the way Arizona deals with drugs. It sought to redefine the drug issue as a medical as opposed to punishment minded one. Some of these issues go beyond the scope of this paper. I will highlight them, but only go into detail on the issues surrounding medical marijuana.

"James P. Fox, Michael J. Meyers, M.D., & Sharon Rose, Argument Against Proposition 215, 1996 California Election Pamphlet, reprinted in Cal. Att'y General's Office, Proposition

215: An Analysis (Dec. 20, 1996) Appendix I; Leon Worden, Marijuana Initiative is Bad Medicine, The Signal, (Oct. 2, 1996), reprinted in

<<http://www.scvleon.com/signal/lwl00296.htm>> (Feb. 5, 1997).

<sup>20</sup>Cal. Att'y General's Office, Proposition 215: An Analysis (Dec. 20, 1996) at 5.

## 1. Summary

a. General Provisions

Proposition 200 creates a nine member Parents Commission on Drug Education and Prevention appointed by the governor, consisting of parents, law enforcement officials, educators, and drug treatment experts.<sup>21</sup> This commission's mandate is to fund programs to increase and enhance parent involvement and education on alcohol and drug problems.<sup>22</sup> The initiative provides for the commission's funding through increased taxes on alcohol and tobacco.<sup>23</sup>

Proposition 200 also requires people convicted of violent crimes while under the influence of a controlled substance to serve 100% of their sentences without parole.<sup>24</sup> The initiative also provides that individuals in prison for personal possession of drug charges be immediately eligible for parole.<sup>25</sup> As a condition of their parole, they are required to participate in a drug treatment plan.<sup>26</sup> Furthermore, after the proposition takes effect, new individuals convicted of personal possession charges will be given probation and required to participate in a drug treatment program as a condition of such probation.<sup>27</sup> Individuals convicted of simple

<sup>21</sup>Arizona Proposition 200 §4(1).

<sup>22</sup>1d.

<sup>23</sup>pj §§4, 12.

<sup>24</sup> §5.

<sup>25</sup> §8.

<sup>26</sup> §9.

<sup>27</sup>J4 §10.

possession charges for the third time would then be sentenced to prison under the standard sentencing provisions.<sup>128</sup>

b. Provisions Relating to Marijuana

Proposition 200 allows seriously and terminally ill patients to possess controlled substances, including those in Schedule I, when prescribed by a physician.<sup>129</sup> When prescribing schedule I drugs, doctors must comply with professional medical standards and document that scientific research exists to support its use.<sup>130</sup> The doctor must also obtain a written second opinion by a second medical doctor stating that the prescription is appropriate.<sup>131</sup> Finally, the doctor must obtain written consent from the patient.<sup>132</sup> Any failure to meet these requirements will result in discipline by the board of medical examiners. As an additional safeguard, the initiative declares any information given in an effort to unlawfully obtain a Schedule I drug will not be privileged doctor-patient communication.<sup>134</sup>

Proposition 200 not only exempts patients from prosecution, but it creates a distribution system by exempting participants in the legitimate drug distribution channel, from the doctor to the pharmacist and common carrier, from drug prohibition laws when acting within guidelines of the statute.<sup>135</sup> Such guidelines include a requirement that doctors and pharmacists act in good

<sup>128</sup>J § 10(7).

<sup>129</sup> §6(9).

<sup>130</sup>pj §7(1)-(2).

<sup>131</sup> §7(2).

<sup>132</sup>k §7(2).

<sup>133</sup>k §7(3).

<sup>134</sup>p~j §6(9)(3).

<sup>135</sup>pj §6.

faith and in accordance with acceptable medical standards.<sup>36</sup> Allowing for distribution as well as possession avoids the problems associated with the California Proposition 215, which only exempts patients and primary caregivers from prosecution. In that system, patients may possess marijuana, but they cannot obtain the marijuana without causing another person to break the law.<sup>37</sup>

## 2. Subsequent Developments

Proposition 200 does not offer observers a chance to study its implementation. Although it passed with 65.4% of the vote, the Arizona legislature effectively gutted the initiative. In Arizona, the legislature may amend initiatives passed by the voters as if they were any other statute. Taking advantage of this loophole, the Arizona state legislature passed Ariz. H.B. 2518, which does not allow the two sections of the initiative that relate to marijuana (§§ 6, 7) to take

effect until Congress authorizes the medical use of marijuana or... the federal food and drug administration authorizes the medical use of marijuana and the drug enforcement administration reschedules marijuana to a schedule other than schedule I. Arizona for Drug Policy Reform, The group that supported Proposition 200, has since renamed itself The People Have Spoken, and is supporting a state initiative to overturn this legislation.<sup>40</sup>

<sup>36</sup>H §6(2).

<sup>37</sup>Even patients who grow their own marijuana must obtain the seeds on the black market.

<sup>38</sup>Arizona Secretary of State web site, Unofficial Election Results, <<http://www.sosaz.com/Results/1996g>> (January 14, 1998).

<sup>39</sup>Ariz. H.B. 2518 (1997). See also Ariz. Stat. §13-3412.01.

<sup>40</sup>National Organization for the Reform of Marijuana Laws (NORML), Press Release. accessed at <<http://www.pdxnorml.org/050897.txt>> (April 18, 1998).

#### D California

Because the Arizona legislature thwarted Proposition 200, California's Proposition 215 is the first and only medical marijuana initiative passed and implemented. Therefore, it is the only tested guide for future medical marijuana initiative drafters. Future drafters should avoid reinventing the wheel and learn from the issues and problems generated both during the election and implementation process.

Proposition 215 is relatively simple and straightforward. It states the drafters' intentions, and implements them in two sentences. Its simplicity is both a virtue and a hindrance. It is easy to understand and did not confuse the voters with technicalities. On the other hand, its lack of precision opened it to attack both during the election and in its implementation. The California experience has demonstrated the importance of technical precision in the text.

##### 1. Summary

The California initiative entitled the Compassionate Use Act of 1996, added Section 11362.5 to the California Health and Safety Code. The initiative has two main sections. The first section, 11362.5(b), expresses the intent of the drafters. This expression of intent provides necessary definitions and guidance for interpreting the statute. The second section, 11362.5(c)-(d), provides the affirmative defenses to marijuana laws, or implements the intent expressed in 11362.5(b). The initiative also contains a severability clause protecting the remainder of the initiative if a court declares a portion of it invalid.<sup>41</sup>

<sup>41</sup>Cal. Proposition 215 §2.

The initiative exempts patients and primary caregivers from marijuana cultivation and possession laws when they use marijuana for medical purposes based upon the written or oral recommendation or approval of a physician.<sup>142</sup> It also protects physicians from punishment or discipline for recommending marijuana for medical purposes to patients.<sup>143</sup> These two exemptions summarize the heart of the law: to protect patients, primary caregivers, and physicians who wish to include marijuana in a patient's treatment. The initiative expressly withholds a defense for conduct endangering others or for diverting marijuana to nonmedical uses.<sup>144</sup>

The statute has two express definitions. First, a patient may use marijuana for the following medical conditions: cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief.<sup>145</sup> Second, primary caregiver means the individual designated by the [patient] who has consistently assumed responsibility for the housing, health, or safety of that person.<sup>146</sup>

## 2. Subsequent Developments

When proposition 215 passed in November 1996, it initially provoked strong, negative responses from both federal and California government leaders. On the other hand, passage of proposition 215 prompted numerous positive developments from the point of view of the medical

<sup>142</sup>Cal. Proposition 215 §1; Cal. Health & Safety Code § 11362.5(d).

<sup>143</sup>Cal. Proposition 125 §1; Cal. Health & Safety Code §11362.5(c)

<sup>144</sup>Cal. Proposition 125 §1; Cal. Health & Safety Code §11362.5(b)(2)

<sup>145</sup>Cal. Proposition 125 §1; Cal. Health & Safety Code §1 *1362.5(b)(A)*

<sup>146</sup>Cal. Proposition 125 §1; Cal. Health & Safety Code §11362.5(e)

marijuana movement. Examining these subsequent developments offers drafters an opportunity

to observe how the initiative and its accompanying case law has developed.

a. Federal Response

Both California and Arizona passed initiatives that legalized marijuana for medical uses, so the federal response was generally directed at both initiatives. The initial federal response involved taking a bipartisan tough stance, harshly criticizing the initiatives, and threatening to enforce federal law against physicians and patients involved in medical marijuana.

Senator Orin Hatch convened a meeting of the Senate Judiciary Committee in which, among others, General Barry McCaffrey, the Director of the Office of National Drug Control Policy, and Tom Constantine, the Administrator of the DEA spoke.<sup>47</sup> The committee attempted to determine the ramifications of the initiative and develop a plan for handling the situation. Senator Hatch, General McCaffrey, and Mr. Constantine all used the dearth of scientific studies and the lack of FDA approval to justify their stance opposing the state initiatives.<sup>48</sup> In his remarks, General McCaffrey said that the initiative was a hoax proposition and called it a Cheech and Chong show.<sup>49</sup> Many speakers voiced fear, pointing out unforeseeable consequences of the initiatives such as marijuana smoking school bus drivers and people using marijuana for corns on their feet, with no possibility for law enforcement agencies to stop such actions. ISO

<sup>47</sup> Hearings on the Arizona and California Medical Drug Use Initiatives Before the Senate Comm. on t  
(December 2, 1996), available in LEXIS Legis Library, Fednew File.

<sup>48</sup>Id

<sup>49</sup>Id.

<sup>50</sup>Id.

Both Mr. Constantine and Senator Hatch expressed concern as to whether state and local law enforcement officials had the authority to make an arrest for violations of federal law in situations where neither the state or federal government had no immediate plans to prosecute.<sup>151</sup> Mr. Constantine concluded that the Controlled Substances Act did not provide such authority to local agencies.<sup>1</sup> They also expressed concern that federal agencies were not equipped to handle the load of drug cases that could potentially be shifted from state to federal responsibility.<sup>153</sup> Nevertheless, Mr. Constantine committed to prosecute significant drug traffickers including physicians.

Four weeks later, the government was ready to address the issue with the public. On December 30, 1996 General McCaffrey; Donna Shalala, Secretary of Health and Human Services; and Attorney General Janet Reno issued a document and briefed the public on how it intended to handle the situation)<sup>54</sup> Attorney General Reno indicated that the government would consider prosecuting or revoking the registration of any physician who recommended marijuana to patients.<sup>155</sup> She said that the government would not turn a blind eye toward [its] responsibility to enforce federal law and preserve the integrity of the medical and scientific process to determine if drugs have medical value before allowing them to be used.<sup>156</sup> The written statement, on a stronger note, warned physicians that the DEA would take action to

<sup>151</sup>Id.

<sup>1</sup>Id.

<sup>54</sup>News Conference With Drug Control Policy Director General Barry McCaffrey, Attorney General Janet Reno, and Donna Shalala, Secretary of Health and Human Services, White House Briefing, December 30, 1996, available in LEXIS Legis Library, Fednew File; 62 F.R. 6164.

<sup>155</sup>Id.



revoke the registrations of physicians who prescribe or recommend marijuana, and the Department of Health and Human Services (HHS) would exclude them from participating in Medicare and Medicaid programs.' HHS and the Department of Justice (DOJ) backed off of their position a bit and clarified their stance in a joint letter stating that it did not intend to institute a gag rule and a physician could discuss the risks and benefits of marijuana with a patient, but 'physicians may not intentionally provide their patients with oral or written statements in order to enable them to obtain controlled substances in violation of federal law. Physicians who do so risk revocation of their DEA prescription authority, criminal prosecution, and exclusion from participation in the Medicare and Medicaid programs.<sup>58</sup>

In response to the Administration's hard line against physicians, a group of California physicians and patients attempted to work out a compromise with the federal government to prevent the abuses that the government feared. They sought an agreement where the federal government would not prosecute a physician who discusses or recommends medical marijuana in the physician's best medical judgment and in the context of a bona fide physician-patient relationship.<sup>59</sup> McCaffrey and the Justice Department refused to the proposed agreement, again asserting its ability to criminally prosecute physicians who recommend marijuana to a patient. In response, the group filed a class action claiming that the government's threats to discipline physicians who recommend marijuana to their patients caused a chilling of First Amendment

<sup>57</sup> 62 F.R. 6164.

<sup>58</sup> *Conant v. McCaffrey*, 172 F.R.D. 681, 688, 1997 U.S. Dist. LEXIS 8749 (U.S.D.C. Northern Dist. CA 1997).

<sup>59</sup> Eric Brazil, *Drug Czar Won't Budge: McCaffrey Rejects Doctors' Settlement on Medical Pot*, The San Francisco Examiner, February 9, 1997, C-2.

speech rights.<sup>60</sup> The government countered with the argument that recommending marijuana crossed the line to assisting with a violation of the law.<sup>61</sup> On April 30, 1997 the court issued a preliminary injunction against the government from imposing or threatening to impose criminal or civil sanctions on physicians for actions that do not rise to the level of a criminal offense.<sup>62</sup> The court recognized that what constitutes a criminal offense is not exactly clear,<sup>63</sup> but the case nonetheless gave physicians leverage in the dispute and stopped the federal government from threatening physicians and patients.

The Justice Department then turned its attention to the buyers clubs, seeking injunctions against six buyers clubs to force them to close.<sup>64</sup> It is interesting to note that Justice did not target clients of the buyers clubs and chose to file civil suits against the clubs and their operators instead of seeking criminal charges. The Justice Department admitted that political considerations influenced their decision. The action against the buyers clubs indicates that the federal government has moved away from its initial harsh, uncompromising rhetoric.<sup>65</sup>

<sup>60</sup>Complaint, *Conant v. McCaffrey*, January 14, 1997. ~~~diI <<http://www.lindesmith.org/mmjsuitIco>> (April 15, 1998).

Hearing Transcript of April 11, 1997 Plaintiffs' Motion for Preliminary Injunction and Defendant's Motion to Dismiss, United States District Court for the Northern District of California, accessed at <<http://www.lindesmith.org/mmjsuitItranscrl.html>> (April 15, 1998).

<sup>62</sup>*Conant v. McCaffrey*, 172 F.R.D. 681, 700, 1997 U.S. Dist. LEXIS 8749 (U.S.D.C. Northern Dist. CA 1997).

<sup>63</sup>*Id*

<sup>64</sup>Kate Rix, Feds Jump into Marijuana Club Prosecutions, *The Recorder*, January 12, 1998. News 2.

In addition to Senator Hatch and the Senate Judiciary Committee, both houses of Congress have tackled the issue of the state initiatives. Although many bills and resolutions die in committee, a House vote is scheduled for late April on a Resolution declaring the House of Representatives's opposition to the medical use of marijuana.<sup>66</sup> Other anti-medical marijuana bills have been introduced in Congress, but remain in committee.<sup>67</sup> Judging from the text, they appear to be knee jerk reactions with little chance of passing or being effective. One bill has been introduced in Congress that would reschedule marijuana to Schedule II, allow its use for medical purposes in states that permit such use, and require the National Institute on Drug Abuse to provide marijuana for Investigative New Drug Studies approved by the FDA.<sup>68</sup> This bill has ten co-sponsors and was introduced to the Committee on Commerce on June 4, 1997 and to the Subcommittee on Health and Environment on June 18, 1997. Otherwise it has remained inactive.

Not all responses from the federal government, however, have been negative. The federal government has also responded to the state initiatives in California and Arizona with increased openness toward scientific testing of marijuana. In January of 1997, General McCaffrey and the White House Office of National Drug Control Policy commissioned a study by the Institute of Medicine (IOM) of the National Academy of Science (NAS) to conduct a comprehensive

<sup>66</sup>H. Res. 372, 2nd Sess. 105th Cong. 1998.

<sup>67</sup>H.R. 1265 (restricting certain benefits for individuals convicted of state offenses when the state does not prohibit marijuana for medical purposes); H.R. 1310 (requiring the Attorney General to revoke physicians' controlled substance registration if they recommend an illegal substance); H.R. 3184 (reiterating federal supremacy of Controlled Substances Act over state law).

<sup>68</sup>H.R. 1782, 1st Sess. 105th Cong. 1987.

review of the known health effects and potential medical use of smoked marijuana.<sup>169</sup> Medical marijuana advocates were initially skeptical of such a study, and felt that it was an attempt to give medical marijuana opponents a token study to show that the government was addressing the issue, while avoiding new studies of marijuana.<sup>170</sup> Some activists, however, have changed their position, noting that the IOM group is looking beyond the existing, decades-old research to the anecdotal evidence and is seeking public comment on the issues.<sup>171</sup>

Additionally, in February 1997, the National Institutes of Health (NIH) held a two day conference where it brought together an ad hoc group of experts to study the medical marijuana issue.<sup>172</sup> The group found that the existing studies did not provide definitive answers; however, based on promising preliminary evidence, it recommended new controlled studies.<sup>173</sup> It also recommended that NIDA should supply marijuana to studies that meet U.S. regulatory standards.<sup>174</sup> Subsequently, in September 1997, NIDA not only agreed to provide the marijuana

<sup>169</sup>Statement by General Barry R. McCaffrey, Director, Office of National Drug Control Policy, Submitted for the Record to the House Judiciary, Committee, Subcommittee on Crime, Medical Marijuana Referenda in America, October 1, 1997, accessed at

<<http://www.whitehousedrugpolicy.gov/news/testimony/medical.html>> (April 23, 1998).

<sup>170</sup> Telephone interview with Paul Wolf, ACT UP (January 17, 1998).

<sup>171</sup> Telephone interview with Dave Fratello, Spokesperson, Americans For medical Rights (April 2, 1998). ~ Teri Sforza, Pot useful or bad medicine? The Orange County Register, December 14, 1997, A-i

<sup>172</sup>Workshop on the Medical Utility of Marijuana, Report to the Director, National Institutes of Health, by the Ad Hoc Group of Experts (February 1997) accessed at <<http://www.nih.gov/news/medmarijuana1MedicalMarijuana.htm>> (April 5, 1998).

<sup>173</sup>Id.

<sup>174</sup>Defined as FDA protocol approval and DEA controlled substances registration. Id. This definition is problematic because FDA approval of a protocol does not guarantee the DEA will approve the controlled substance registration. Letter to David A. Kessler, M.D., Commissioner. FDA, from Gene R. Haislip, Deputy Assistant Administrator, DEA, June 8, 1994. (refusing to grant controlled substance registration to researcher with approved ND, citing insufficient FDA assurance of scientific integrity).

for Dr. Abrams's study on AIDS wasting, but it gave Dr. Abrams a \$978,000 grant for the study.<sup>175</sup> The two-year study will be the first FDA-approved study of the use of smoked marijuana in a patient population in about fifteen years.<sup>176</sup> Ironically, had the federal government taken these steps toward allowing research two years earlier, it may have never had to deal with the problems spawned by the state initiative movements.

b. State Response

On the state level, the response by leaders was critical, albeit a bit unsteady. Attorney General Dan Lungren called Proposition 215's passage a disaster.<sup>177</sup> His office expressed concern at the legal anarchy the initiative created, but admitted no plans to challenge the new law, noting that it would not have standing.<sup>178</sup> Close to a year after the initiative passed, Lungren softened his stance on the idea of clinical testing. While he maintained that Proposition 215 was a dumb idea, he expressed support for a state Senate bill that would provide for testing of marijuana's medical value and agreed to provide the marijuana if the federal government refused.<sup>179</sup>

<sup>175</sup>Multidisciplinary Association For Psychedelic Studies, Medical Marijuana Research in the 90's : The struggle to begin a medical marijuana research project (updated April 1998), [accessed at <http://www.maps.org/mmj/index.html>](http://www.maps.org/mmj/index.html) (April 15, 1998). ~ Section III C discussing Dr. Abrams's study.

<sup>176</sup>Multidisciplinary Association For Psychedelic Studies, Medical Marijuana Research in the

90's : The struggle to begin a medical marijuana research project (updated April 1998), [accessed at <http://www.maps.org/mmj/index.html>](http://www.maps.org/mmj/index.html) (April 15, 1998).

<sup>177</sup>Jon Mathews, Voters favor medical marijuana, San Francisco Bee, November 6, 1996, A15.

<sup>178</sup>Eric Brazil, Medicinal Marijuana Vote Stymies Lungren, The San Francisco Examiner, November 7, 1996, A-8.

<sup>179</sup>Robert B. Gunnison, Lungren Backs Medical Pot Study, The San Francisco Chronicle, August 27, 1997, A18.

Lungren has also actively opposed the buyers clubs. The buyers club concept and their involvement in distributing medical marijuana predates Proposition 215. After Proposition 215, more buyers clubs began forming throughout the state. The state and federal governments, however, did not turn the expected blind eye and are seeking to close them. Because Proposition 215 does not contain a provision for distribution, the buyers clubs turned to the primary caregiver clause for protection. Purporting to fit a buyers club into the primary caregiver definition of an individual designated by the [patient] who has consistently assumed responsibility for the housing, health, or safety of [the patient].<sup>80</sup> is a stretch, but it is the only avenue. Denis Peron, the operator of the Cannabis Cultivators Club, the largest and most famous club in California serving over 9,000 clients,<sup>81</sup> asserted that he was a primary caregiver to his clients after the California Attorney General's office sued to enjoin his operation.<sup>82</sup> A California appeals court

rejected Peron's argument and ruled that buyer's clubs do not fit the criteria of a primary

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caregiver.

The court also ruled that Proposition 215 only protects patients and primary care givers from prosecution for marijuana possession and cultivation. It does not provide any defense for people who sell or distribute it outside of a patient-primary caregiver relationship. Thus.. . one who sells, furnishes, or gives away marijuana to a patient or qualified primary caregiver...

<sup>80</sup>Cal. Health and Safety Code §11362.5(e).

<sup>81</sup>Mary Curtius and Maria L. La Ganga, Judge Orders Closure of Cannabis Club, Los Angeles Times, April 16, 1998, A 3.

<sup>82</sup>The Attorney General's Office brought suit prior to Proposition 215, and Peron asserted the defense after its passage.

<sup>83</sup>Lungren v. Peron, 59 Cal. App. 4th 1383, 1390, 70 Cal. Rptr. 2d 20 (1997).

violates the law.<sup>84</sup> The court noted that the drafters expressly avoided providing a defense for sale and distribution, even though they could have easily done so.<sup>85</sup> Although it recognized the dilemma of patients who, while immune from prosecution themselves, put those from whom they purchased marijuana at risk, the court refused to interpret the statute in a manner that would contradict the way it was presented to the electorate.<sup>86</sup> On April 16, 1998 a state court issued a permanent injunction against Peron, citing illegal sales as the primary reason for the injunction.<sup>87</sup> The criminal trial is still pending.<sup>88</sup>

In a twist of events that shows the strong division among government authorities in California on the medical marijuana issue, the San Francisco County Sheriff refused to close the club as ordered by the judge. Although Lungren announced that he would act to enforce the injunction if the Sheriff refused, he found himself on weak footing because prosecutions for violating the injunction fall under the jurisdiction of the San Francisco District Attorney, who also supports the buyers clubs and appeared unlikely to prosecute.<sup>89</sup> Ultimately, the sheriff closed the buyers club, which reopened the next day under a new name, and Lungren is now in litigation to close the new buyers club.

<sup>84</sup>Id. at 1395. The court did acknowledge that a patient could reimburse a caregiver for expenses related to cultivation, or preclude a caregiver from charging the patient for caregiver services. Id. at 1399-1400.

<sup>85</sup>Lungren v. Peron, 59 Cal. App. 4th at 1394.

<sup>86</sup>Id. at 1394-5.

<sup>87</sup>Mary Curtius and Maria L. La Ganga, Judge Orders Closure of Cannabis Club, Los Angeles Times, April 16, 1998, A 3.

<sup>88</sup>California Department of Justice, Proposition 215 Update #10, December 8, 1997; People v. Dennis Peron, Beth Moore, et al. (Alameda County).

<sup>89</sup>William Claiborne, San Francisco's Political Potboiler in Fight Over Marijuana as Medicine. Sheriff Backs Growers, Washington Post, April 17, 1998, A3.

Notwithstanding Lungren's battle with Peron, Lungren appears to have mildly softened his stance on buyers clubs. After his office obtained the injunction against Peron's club, Lungren declined to discuss possible actions against other buyers clubs in the state, possibly indicating that he recognizes that law enforcement against buyers clubs will not resolve the medical marijuana issue. Lungren said, rather than continuing the debate about cannabis buyers clubs, let's turn our focus to a question that is still undetermined—whether marijuana has any medicinal

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Positive developments

Not all government responses to Proposition 215 have been negative, especially at the local level. Many community leaders have voiced their support for the initiative and many communities have made efforts to accommodate patients. In response to a suit by the federal government seeking to shut down the buyers clubs in California, on March 18, 1998 mayors from four cities, including San Francisco Mayor Willie Brown, sent letters to the White House asking the Clinton Administration to let local communities handle the buyers clubs.<sup>97</sup> They do not want to see their residents compelled to seek out their marijuana in back alleys and street corners. <sup>92</sup> In a further act of defiance, San Francisco City District Attorney threatened to use city workers to distribute marijuana if the federal government shut down the local buyers clubs.<sup>9</sup> Other

<sup>97</sup>Mary Curtius and Maria L. La Ganga, Judge Orders Closure of Cannabis Club, Los Angeles Times, April 16, 1998, Part A; Page 3.

<sup>91</sup>Russell Sabin, 4 Mayors Call on Clinton to Stop Pot Club Prosecutions, The San

Francisco Chronicle, March 19, 1998, A 15. The following mayors wrote letters to President

Clinton: San Francisco Mayor Willie Brown, Oakland Mayor Elihu Harris, West Hollywood

Mayor Steve Martin, and Santa Cruz Mayor Celia Scott.

<sup>92</sup>Id.

<sup>9</sup>John Lyons, S.F. Set to Defend Medical Pot Clubs, Sacramento Bee, March 22, 1998, A8.



communities have responded to proposition 215 by instituting guidelines to regulate medical marijuana in their communities. The City Council of San Jose, California unanimously passed an ordinance regulating marijuana dispensaries within the city.<sup>94</sup>

Local Law enforcement officials have also shown their willingness to accommodate Proposition 215. In San Francisco, the Sheriff announced that he would accommodate prisoners who needed marijuana for medical purposes.<sup>95</sup> In Arcata, California, the Chief of Police has issued forty watermarked cards with the patient's photograph, the city's seal, and his signature to those for whom physicians have recommended marijuana. His attitude is The spirit of the law here is you have a defense, let's assert it on the corner instead of in court. It's a 10-second contact where before it would take hours.<sup>97</sup> This registration system has even received guarded praise from John Gordnier, the Deputy Attorney General prosecuting the civil case against Denis Peron's buyers club.<sup>98</sup> Perhaps the most surprising show of cooperation occurred in Mountain View, California where police arrested an AIDS patient for cultivating marijuana. The district attorney's office told the police it would not prosecute anyone who cultivated marijuana solely for medical purposes and that they should give his marijuana and cultivating equipment back, which they did.<sup>99</sup>

<sup>94</sup>City of San Jose, California Ordinance No. 25280, March 25, 1997.

<sup>95</sup>Alex Roth, S.F. Sheriff Will Permit Medical use of Marijuana by County-jail Inmates, Los Angeles Daily Journal, April 28, 1997, 3.

<sup>96</sup>Kate Rix, Grass Roots Take Hold of Prop 215, The Recorder, March 11, 1998, 1.

<sup>97</sup>Id.

<sup>98</sup>Id.

<sup>99</sup>Emelyn Cruzlat, Cops Give Back Aids Patient's Pot Plants, The San Francisco Examiner. March 2, 1997, A I.

E. Lessons learned form the California and Arizona Initiatives.

In this section I will discuss what drafters of medical marijuana initiatives can learn from the California and Arizona experiences. In these discussions I will also allude to currently active initiatives, although I will not discuss them in detail until Section V. I will first address how certain aspects of the initiatives created political liabilities, and which of those liabilities can be avoided and which cannot depending on if they are necessary for a properly functioning initiative. Second, I will discuss which aspects of the initiative hindered the goal of creating a workable statute. Some of these problematic aspects are not necessarily attributable to the presence of problematic text or the absence of necessary text, but can also result from judicial decisions and state agency interpretations. A properly functioning statute must withstand or prevent adverse judicial and administrative interpretations. Finally I will discuss the aspects of the initiatives that have not yet proven problematic, but still pose hazards to a properly functioning statute.

1. Political issues

a. Political Issues Resulting From Necessary Provision in the Initiative

Although not requiring patients to obtain prescriptions from their physicians for marijuana, subjects an initiative to harsh criticism, protecting physicians from prosecution and discipline is imperative to a workable statute. Therefore, no initiative should require patients to obtain a prescription for marijuana. The term recommend is the term of choice; however, Conant v. McCaffrey has not yet resolved the issue of whether a physician recommending marijuana to a patient is protected by the First Amendment. Although the physicians won the preliminary injunction, the issue must still be resolved at trial. The Florida drafters have tried an interesting approach to avoid the uncertainty of the term recommend. By merely requiring physicians to

certify that marijuana is medically appropriate and the patient may benefit from its use. This

language merely requires the physician to express an opinion, something clearly covered by the First Amendment. Regardless of whether drafters choose recommend, certify, or some other term, they cannot require a prescription, regardless of the political liability such an omission can create.

k<sub>1</sub> Avoidable Political Issues

One of the most politically damaging criticisms of Proposition 215, that it permits unfettered use by minors, was avoidable. The initiative did not address the issue of minors, mostly due to its simplicity. Nevertheless, it provided opponents with a persuasive argument, illustrated by such headlines as Even Children Could Smoke Pot Legally!<sup>201</sup> The California Attorney General interprets the initiative to allow children to grow and use marijuana, and warns that minors with primary caregivers who are not their parents could conceivably use marijuana legally without parental knowledge or consent. His office has taken a position, however, that doctors would be on weak footing if they recommended marijuana to minors. He notes that

numerous studies indicate marijuana is dangerous to youths and claims that no anecdotal studies

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that indicate medical benefits of marijuana in children exist. mmends using child

200 James P. Fox, Michael J. Meyers, M.D., & Sharon Rose, Argument Against Proposition

215, 1996 California Election Pamphlet, reprinted in Cal. Att'y General's Office, Proposition

215: An Analysis (Dec. 20, 1996) Appendix I.

<sup>201</sup>Cal. Att'y General's Office, Proposition 215: An Analysis (Dec. 20, 1996) at 9; Cal. Att'y Gen Peace Officer Guide: Compassionate Use Act of 1996, 3. Although the Attorney general's office claims that no anecdotal studies indicating medical benefits of marijuana in children exist, and has made this claim to police departments throughout the state in its Peace Officer Guide, this information is inaccurate. In his decision stemming from the public hearing on NORMIL's rescheduling, Judge Young found several anecdotal claims that marijuana helped children and teenagers with the side-effects of chemotherapy to be persuasive. In the Matter of Marijuana Rescheduling Petition, Opinion and Recommended Ruling, Findings of Fact, Conclusions of Law and Decision of Administrative Law Judge Francis L. Young, September 6, 1988, No. 86-22, pages 20-23, accessed at <<http://mojo.calyx.notkolsenJMIEDICAL/yoUNG/yo~g I.html>>

welfare laws to intervene and warns of possible police department liability for not intervening. when a minor is involved<sup>202</sup>

Opponents of the initiative conveniently interpret it in two ways. During the election, they interpreted it broadly in an effort to scare voters with tales of children supplying children. After the election, they construed it narrowly to prevent any access to children. The initiative's silence on the issue was more harmful than any reasonable approach. If initiate drafters do not want to provide access to minors, then they should explicitly exclude them, thereby avoiding harsh criticism for allowing minors. If they do want to provide access to minors, they should include them and provide guidelines to avoid minors using marijuana without their parents' consent. Whether a drafter wishes to include minors or not, the issue is too explosive to ignore and all initiatives should contain a clause addressing the issue.

c. Judgement calls

**I.** Illnesses that qualify for treatment with marijuana

Some aspects of initiatives that create political liability are avoidable, while others are unavoidable. In other cases, drafters must make a judgment call after weighing the political liability against the desirability of the provision. First, drafters must decide whether they want to allow patients to use marijuana for any illness and trust physicians to recommend it prudently, or restrict the list of eligible conditions to an enumerated list. Proposition 215 has a clause at the end of its list of serious illnesses that says, or any other illness for which marijuana provides relief. This clause garnered substantial criticism from opponents. They claimed that this clause opened the door to any disease including stress, headaches, upset stomach, insomnia, a stiff

(January 10, 1998).

<sup>202</sup>Cal. Att'y Gen Peace Officer Guide: Compassionate Use Act of 1996, 3

neck. . . or just about anything.<sup>203</sup> General McCaffrey cited a medical adviser to Proposition 215 who listed writer's cramp and corns on toes as conditions for which marijuana may provide relief.<sup>204</sup> The statute leaves a lot to the discretion of doctors. While such discretion is common with most other drugs, it poses a political problem in this case.

Some initiative drafters may not want to limit the scope of what marijuana can be used to treat. One cannot contemplate what new diseases may occur, for which marijuana may prove useful. Had the California initiative been drafted in the 1970's, it would not have included AIDS, a relatively new disease. Furthermore, with the increased interest in medical uses of marijuana, new uses may be discovered, requiring a new initiative if the original did not include a savings clause. On the other hand, drafters may feel that marijuana's use should be limited until it can be tested in clinical trials. For these drafters, the state initiatives are primarily focused on pressuring the federal government to change its policy. Consequently, limiting marijuana to those illnesses that marijuana is currently reputed to affect would be acceptable. Regardless of which philosophy drafters subscribe to, they need to balance the political risks associated with an open definition of illness against the benefits of including all individuals who may benefit from marijuana.

ii. Legalizing other Schedule I drugs as well

The second issue requiring drafters to make judgement calls is whether the initiatives should legalize drugs other than marijuana for medical use. Arizona's Proposition 200 legalizes all schedule I drugs for medical purposes. The drafters of the initiative nevertheless view it as a

<sup>203</sup>James P. Fox, Michael J. Meyers, M.D., & Sharon Rose, Argument Against Proposition 215 1996 California Election Pamphlet, reprinted in Cal. Att'y General's Office, Proposition

215: An Analysis (Dec. 20, 1996) Appendix I

<sup>204</sup>Hearings on the Arizona and California Medical Drug Use Initiatives Before the Senate Comm. on (December 2, 1996).

medical marijuana initiative because the initiative requires physicians to document existing scientific research to support a drug's use, and the drafters indicate that they are aware of no other schedule I drug for which scientific research exists to support its use. They contend that they chose to include all Schedule I drugs so that if scientific research established the validity of the use of a substance for medical purposes, they would not have to return to the public with another initiative.<sup>205</sup> Although this reasoning makes sense, drafting an initiative that potentially legalizes drugs such as PCP and heroin is politically dangerous. Many attribute the failure of a 1997 Washington State initiative to its inclusion of all Schedule I drugs instead of just marijuana. Although including other drugs besides marijuana is a judgement call of the drafters, in most cases, it would be unwise.

2. Problems That Have Arisen in the Wake of Propositions 200 and 215 In addition to the political issues that relate to whether voters will pass an initiative,

drafters of initiatives need to be aware of a number of issues that have proven problematic in terms of deriving a workable system from an initiative.

205\$~ Hearings on the Arizona and California Medical Drug Use Initiatives Before the Senate Comm. on the Judiciary, (December 2, 1996) (Comments by Marvin Cohen, treasurer of Arizonans for Drug Policy Reform).

While I am not sure which side of the debate would consider the following information more advantageous to their arguments, evidence exists to support claims that MDMA, commonly known as Ecstasy, has medical value in psychotherapeutic treatment. In 1986, an administrative law judge determined that MDMA had an accepted medical use for treatment in the United States and was safe to use under medical supervision. *S. Grinspoon, M.D., v. DEA*, 828 F.2d 881, 884 (1st Cir. 1987). Furthermore, significant research is being pursued to ascertain the safety and efficacy of MDMA. The Multidisciplinary Association for Psychedelic Studies (MAPS) currently facilitates such research and has opened a Drug Master File for MDMA with the FDA. The opponents of Proposition 215 could point to these facts to show that the initiative would apply to more than marijuana. On the other hand, one could point to the battle marijuana advocates have been forced to wage, and argue that the Proposition 200 drafters are right not to want to have to go through such efforts each time a Schedule I drug shows medical promise.

a. No distribution mechanism

The California initiative does not address the issue of access to marijuana, except to allow the patient and primary caregiver to grow the marijuana for personal uses.<sup>206</sup> The initiative drafters included a clause that encouraged the federal and state governments to implement a plan to provide for the safe and affordable distribution of marijuana.,<sup>207</sup> They did not, however, provide a mechanism for distribution.

The main reason the drafters did not include a distribution system was to make the initiative more politically attractive.<sup>208</sup> They felt that the government would recognize the conundrum and turn a blind eye to buyers clubs.<sup>209</sup> They also wanted to avoid conflicts with federal law.<sup>210</sup> As the initiative was written, there is no positive conflict with federal law. The government has no ability to attack the initiative on preemption grounds and must attack it collaterally, by closing buyers clubs, sanctioning physicians, or arresting patients under federal law. Regardless of the reasons, the strategy backfired in California.

With both the federal and California state government prosecuting buyers clubs, and the case law determination that distributors are not protected, California patients are put in a precarious situation. They can either grow their own marijuana, which would entail obtaining seeds on the black market; not use marijuana at all, which would defeat the purpose of allowing medical use; or obtain marijuana on the black market, which would place patients at risk as they

<sup>206</sup>Cal. Proposition 215 §1; Cal. Health and Safety Code §11362.5(d).

<sup>207</sup>Cal. Proposition 215 §1; Cal. Health and Safety Code §11362.5(b)(1)(C).

<sup>208</sup>Telephone Interview with Ed Rosenthal (April 22, 1998).

<sup>209</sup>Id.

<sup>210</sup>E mail from Dave Fratello, Spokesperson, Americans for Medical Rights to Don Christen. Maine Vocals (on file with author).

associated with a criminal element. Probably the biggest problem with creating an initiative that lacks a distribution system is that even if the federal government changes its policy towards buyers clubs, they will still violate state law. Theoretically, the federal government could either explicitly or implicitly permit buyers clubs to operate, and the California Attorney General could still shut them down and thwart distribution.

To protect patients and create a workable distribution system, drafters have three options:

exempt marijuana sales along with possession and cultivation, distribute the marijuana themselves, or license marijuana distributors.<sup>21</sup> All three approaches have drawbacks. It is important to note that no system would protect distributors from federal laws against marijuana and that federal agencies are more likely to prosecute a marijuana distributor than a patient.

The first option to rescind state laws as they apply to the sale or distribution of medical marijuana avoids positive conflict with federal law and would permit buyers clubs to operate without fear of state law enforcement. It is not a state's refusal to impose some law that typically triggers preemption concerns, but a state's positive regulation of some matter in a manner inconsistent with federal regulation.<sup>212</sup> On the other hand, legalizing marijuana sales without any government control or oversight creates political liabilities. Opponents would focus on how the initiative legalizes drug dealing and protects hardened drug dealers from police intrusion into their deals. For voters, protecting patients is more palatable than drug dealers.

The second approach requiring the state to set up a distribution program would give the state total control over marijuana distribution and avoids turning the system over to drug dealers. A state agency would be able to limit diversion of marijuana for recreational users. Police

<sup>21</sup> idea was developed by Colorado Citizens for Compassionate Cannabis.

<sup>212</sup>U.S. v. Leal, 75 F.3d 219, 227 (6th Cir. 1996).



officers would know for a certainty that observed street deals were illegal because all legitimate sales of marijuana would occur through the state agency. This program is ideal, except that such a provision would require states to directly violate federal law, subjecting the initiative to preemption. Such a provision is probably preempted under the Supremacy Clause of the United States Constitution: ~ In essence, a state distribution system equates to no distribution system until the federal government agrees to turn a blind eye.<sup>214</sup>

The third approach, licensing marijuana distributors, is somewhat of a compromise between the two other options. Under this approach, the state can maintain some level of control over the sale or distribution of marijuana for medical purpose, but it does not have to directly violate federal law. The primary danger of this option is that the federal government would demand the list of licensees from the state, and then prosecute them. While this danger is real, people involved in distributing marijuana are aware of the risks they take. The buyers clubs are not trying to keep themselves hidden from the DEA. This third option also raises a question of federal preemption, but one can make a strong argument that a state licensing requirement does not conflict with federal law prohibiting the activity for which the license must be obtained.

<sup>213</sup>U. S. Const. art. VI.

<sup>214</sup>Lawyers in California are currently considering whether 21 U.S.C.A. 885(d) may provide a way for state and local governments to distribute marijuana. Section 885(d) exempts state and local officials from liability when they are engaged in the enforcement of laws or ordinances relating to controlled substances. One could argue that distributing marijuana in compliance with a state law or local ordinance would be exempt from the CSA under this statute. Telephone Interview with Jeff W. Jones, Co-Founder and Executive Director, Oaldand Cannabis Buyers' Cooperative (April 23, 1998). On the other hand, the underlying law or ordinance can be preempted. This clause has virtually no case law and the intricacies of an issue of first impression such as this are beyond the scope of this paper.

The Supreme Court has found that a federal statute pre-empts state law if the federal statute indicates congressional intent to exclusively occupy a field of law or if the state law is in actual conflict with the federal law.<sup>215</sup> Congress declared in 21 U.S.C.A. §903 that it did not intend to exclusively occupy the field of controlled substances and that the federal act should only pre-exempt a state law if a positive conflict exists so that the two cannot consistently stand together.<sup>216</sup> The difficult question is whether a state statute that allows the state to grant licenses for activities that conflict with the CSA positively conflicts with the federal law so that they cannot consistently stand together. In other words, does a licensing requirement move from a refusal to impose a law to positive regulation that prevents the full implementation of the CSA? As long as the state acknowledges that people who distribute marijuana are still subject to federal law, a licensing program would not hinder the CSA.

Although the courts have not addressed the issue directly, one can analogize a state licensing program for behavior prohibited by federal law to a state tax on an activity that violates federal law. For example, as long as a state avoids double jeopardy issues, it may tax the possession of marijuana.<sup>217</sup> Such a tax would constitute state regulation of an activity that violates federal law. Furthermore, the Supreme Court has recognized that, in some circumstances, granting a license must be regarded as a form of imposing a tax, and grants no rights nor implies any protection except that the licensee will not be subject to penalties for not having a license.<sup>218</sup> Finally, if states seek to license medical marijuana distributors and do not

<sup>215</sup>*Freightlin v. Myrick*, 115 S.Ct. 1483, 1487, 514 U.S. 280 (1995).

21621 U.S.C.A. §903.

<sup>217</sup>*Department of Revenue of Montana v. Kurth Ranch*, 114 S.Ct. 1937, 1945, 511 U.S. 767 (1994).

<sup>218</sup>*License Tax Cases*, 72 U.S. 462, 471, 18 L.Ed. 497 (1866).

attempt to regulate them in any way that would require them to violate federal law, the state regulation should be viewed merely as a regulation less stringent in nature than federal law. States have the authority to co-regulate the field of controlled substances, but are not required to institute regulation as strict as federal law.<sup>219</sup> Although the law relating to state licensing of marijuana distributors is not completely clear, drafters should feel relatively comfortable including a licensing program as a way of providing a distribution system while maintaining a level of oversight and control.

k<sub>1</sub> The Initiative Does Not Define Usable Marijuana or Personal Use.

The California initiative fails to define the terms usable marijuana and personal use. It states that a patient who possesses or cultivates marijuana for personal medical purposes is exempt from marijuana laws, but it does not define what personal use means. The California courts have indicated that in the context of cultivation, the amount constituting personal use varies depending on the circumstances, and personal use is determined by intent, not amount.<sup>220</sup> Such a determination is not one that a district attorney or police officer can make. It is a question of fact that the courts must decide.<sup>221</sup> While California law is equipped to handle Proposition 215's lack of precision, initiative drafters should not rely on state law or state law enforcement officials to define acceptable levels of marijuana.

For example, notwithstanding the case law, the California Attorney General has taken the position that more than two plants, 60 cigarettes, or 28.5 grams (one ounce) of marijuana may exceed that which is necessary for personal use, and individuals caught with more than that

<sup>219</sup>21 U.S.C.A. §903.

<sup>220</sup>See *People v. Williamson*, 137 Cal. App. 3d 419, 422, 187 Cal. Rptr. 107 (1982).

<sup>221</sup>See *Id.* See also *People v. Brackett*, 25 Cal. App. 4th 488, 497-98, 30 Cal. Rptr. 2d 557 (1994) (explaining *State v. Williamson*).

amount may not be covered by the Compassionate Use Act.<sup>222</sup> While the Attorney General recognizes that possession of amounts in excess of his guidelines may be legal, in his Peace Officer Guide, intended to guide California police in dealing with the Compassionate Use Act, he notes in bold type that quantities over 28.5 grams or two plants may violate the Act.<sup>223</sup> Police not familiar with the nuances of California common law will probably not ponder the use of the word may when deciding whether to arrest a patient. This situation illustrates that state officials given significant discretion could gut an initiative by not allowing patients to have enough marijuana to treat their conditions.

Before an initiative drafter decides how much marijuana cultivation and possession to allow, one needs to look at patient needs and how much they use, as well as how many plants it takes to produce that supply. Patient need depends on a host of variables such as weight, tolerance, type of illness, quality and potency of marijuana, and method of use (eaten, smoked, tincture, etc.). This paper does not purport to perform an in-depth analysis of patient needs. It only seeks to give rough estimates to show what a reasonable amount of marijuana would be.

The federal government currently distributes eight grams per day to the remaining eight patients in the compassionate ND program, although the Oakland Cannabis Buyers' Cooperative notes that the government marijuana is poor quality.<sup>224</sup> The Oakland buyers club offers two to five grams as a reasonable average for its patients. Taking a daily average three grams less than what the government supplies its patients, if a patient uses five grams of marijuana per day, that

<sup>224</sup> Telephone Interview with Jeff W. Jones, Co-Founder and Executive Director, Oakland Cannabis Buyers' Cooperative (April 23, 1998).

would amount to 1,825 grams (64 ounces), or four pounds, per year. Therefore, even a weeks supply would exceed the California Attorney General's definition of personal use.

The following discussion outlines amounts and yields of marijuana plants indoor and outdoor)<sup>25</sup> Marijuana experts note that production is generally not measured in yield per plant, but per square foot cultivated. Furthermore, yield depends greatly on size of the plant. This discussion, therefore, should not be considered anything more than a rough guide intended to allow a reader to conceptualize the scale on which patients must cultivate to satisfy their personal use needs.

Patients generally use only the flowers or buds of the female plant. Except for baking into food, such as brownies, they rarely use the leaves. Therefore, male plants are of little use to patients. If leaves were included, the per plant yield calculations would change dramatically. An indoor grow can produce four harvests per year, or has a three month growing cycle, while an outdoor grow results in one harvest per year. Plants are generally discarded after a single harvest. Indoors, an average plant might yield one-half ounce of usable marijuana. Therefore, to grow enough marijuana to last the patient through the next growing cycle, a patient would need thirty-two plants and a harvest of one pound. Outdoors, a patient needs to obtain an entire year's supply from one grow. A reasonable yield for an outdoor plant is three ounces. Therefore, to grow the necessary four pounds that would constitute an average year supply, a patient would need twenty-two plants.

<sup>25</sup>The information regarding marijuana cultivation was provided by Jeff W. Jones, Cofounder and Executive Director of the Oaldand Cannabis Buyers' Cooperative and Ed Rosenthal. Both felt that the number of variables involved in cultivating marijuana prevented an accurate estimate of per plant yields. Mr. Jones did provide some rough numbers from which I could calculate. Mr. Rosenthal maintains that per plant yields cannot be accurately estimated.

An average patient, using less than the government supplies the compassionate ND participants with could reasonably possess thirty-two flowering plants and a number of nonflowering plants and seedlings right before a harvest, or four pounds of useable marijuana right after a harvest. These figures do not take into account poor farming techniques, loss of crop, above average medical need, male plants, or a host of other variables.

The problem these numbers create for initiative drafters is that even reasonable limits on possession such as 100 plants, 40 of which may be flowering, or five pounds of usable marijuana would probably shock voters and give opponents additional fodder to claim surreptitious legalization. Taking voters through the steps I just outlined is impossible in an election campaign that functions on ten second sound bites and emotion. Therefore, attempting to enumerate specific limits on possession and cultivation is unwise. Limits that accurately fit patient needs would be politically harmful while limits that may appear reasonable to voters would continue to place patients in jeopardy of state law. Avoiding the issue, however, places the initiative in danger of interpretations such as the California Attorney General's. Initiative drafters face a conundrum. As discussed in Section V, both AMR's Washington D.C. initiative and ACT UP's Washington D.C. initiative limit the allowable amount to that which is necessary under the circumstances, while AMIR's initiative still imposes a two month limit. This approach may prove to be the best course of action. Personal use is a loaded term in the area of controlled substances because it is used, often arbitrarily, to determine harshness of criminal sentences. Moving to a medically necessary, or similar, definition would avoid the baggage accompanying the term personal use and still maintain the flexibility patients need.

c. The Initiative Restricts Coverage to California Residents

The initiative states that it is intended to ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes... (emphasis added). The California Attorney General's Office has interpreted this clause to mean that only California residents are protected by this law. In his Peace Officer Guide, the Attorney General advised law enforcement authorities that the initiative does not cover out-of-state residents, temporary visitors, or illegal aliens.<sup>226</sup>

The Attorney General's attempt to limit the application of the Compassionate Use Act of 1996 to California residents is problematic in two ways. First, the term resident is difficult to define. The California Supreme Court noted: Residence, as used in the law, is a most elusive

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and indefinite term. Whether a person is a resident depends upon the context and purpose of the statute in

which it is used.<sup>228</sup> How will college students be treated? How will patients who come from other states to California hospitals for extended, yet hopefully temporary treatment be affected? The law is unclear. Furthermore, police officers will have a difficult time determining in a field encounter whether someone is a Californian for the purposes of the Compassionate Use Act of 1996. To compound the problem, a person can be a resident of more than one state and have several 'residences' for different purposes.<sup>229</sup> On the other hand, using the term domicile does not offer a solution because domicile requires an intent to remain.<sup>230</sup> Therefore, under a

<sup>226</sup>Cal. Att'y Gen Peace Officer Guide: Compassionate Use Act of 1996, 1.

<sup>227</sup>Smith v. Smith, 45 Cal. 2d 235, 239, 288 P. 2d 497, 499 (quoting Briggs v. Superior Court,

81 Cal. App. 2d 240, 245).

<sup>228</sup>Myers v. Carter, 3 Cal. Rptr. 205, 207, 178 Cal. App.2d 622, 625 (1960).

<sup>229</sup>People v. McCleod, 55 Cal. App. 4th 1205, 1217, 64 Cal. Rptr. 2d 545, 552 (1997)

<sup>230</sup>Smith, 45 Cal. 2d at 239, 288 P. 2d at 499.

domicile requirement, people who have lived in California for years could be excluded from the Act.

Second, interpreting the Act to exclude illegal aliens poses an equal protection problem. The Supreme Court has held that although illegal aliens do not constitute a suspect class, the due process protection covers illegal aliens.<sup>231</sup> Even if a distinction between groups does not target a fundamental right or burden a suspect class, the distinction must bear a rational relation to some legitimate end.<sup>232</sup> California will have a difficult time showing any legitimate end served by not covering illegal aliens under the Compassionate Use Act. Furthermore, the State of California would surely fail to demonstrate an intent by the drafters of the Act to exclude illegal aliens, thus hindering its ability to articulate a legitimate end.

The most problematic issue for initiative drafters to consider is how limiting a state's medical marijuana exemption to state residents will be affected if several neighboring states pass similar initiatives. One could end up with a situation where two adjoining states allow medical marijuana use, but patients would still be unable to use marijuana while visiting the other state. Drafters need to protect against abuses of people crossing borders to get marijuana, but should avoid using a residency requirement.

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Initiative Drafters Should Avoid Giving Legislatures Control over the Implementing the Initiative

In California only voters can modify voter approved initiatives. This rule proved valuable when Assembly Member Margett introduced a bill that would have thwarted Proposition 215. The bill defined primary caregiver as a blood relative or in-law of the patient, thus excluding

<sup>231</sup>Plyer v. Doe, 457 U.S. 202, 210-212, 102 S.Ct. 2382, 2391-2392.

<sup>232</sup>Romer v. Evans, 116 S.Ct. 1620, 1627 (1996).

<sup>233</sup>Cal Assembly Bill 610 (1997).



domestic partners and other good friends?<sup>34</sup> It also required marijuana to be grown only by state licensed growers who paid a \$20,000 licensing fee, thus excluding any patients from growing their own marijuana.<sup>35</sup> Finally, it defined the term recommend to mean prescribe and required marijuana to be distributed through a licensed pharmacy, which would have effectively exposed physicians and pharmacists to federal prosecution and sanction.<sup>36</sup> The Attorney General opposed the bill on the grounds that California law did not allow the legislature to alter voter approved initiatives.<sup>37</sup>

Arizona's initiative did not have such protections and its legislature gutted the medical marijuana provisions, necessitating a second initiative campaign. The lesson drafters should take from these experiences is to avoid giving authority to the legislature. State rules regarding legislatures' power to alter codified initiatives vary. Nonetheless, drafters should be wary of any clauses that expressly allow the legislature to involve itself in the initiative's implementation.

e. Importance of Textual Precision

Drafters should be very careful and precise in their wording and have prospective initiatives reviewed by lawyers and as many outside readers as possible. A poorly worded initiative, no matter how good its supporters' intentions are, has the potential to cause more harm than good. This following illustration does not appear to pose a danger, given the courts' sympathetic view toward Proposition 215, but it shows the need for care.

<sup>34</sup>Id.

<sup>35</sup>Id

<sup>37</sup>Letter to the Honorable Bob Margett from California Attorney General Dan Lungren dated March 27, 1997.

While the illustration is California specific, the lesson future drafters can learn is universal. Proposition 215's text protects patients and primary caregivers from marijuana laws upon the recommendation or approval of a physician.<sup>238</sup> This language indicates that recommendation and approval are two distinct activities. The California Attorney General

interprets the two words as: approve is to validate an action already taken..., while recommend

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is the act of suggesting taking an action. y General's definitions, a patient

who begins using marijuana on the recommendation of a physician, and a patient who is already using marijuana and merely receives approval of a physician are both covered by the Act. Thus, the Act provides no penalty for not waiting for a physician's recommendation. On the other hand, a physician may not be punished for having recommended marijuana to a patient for medical purposes. The Act does not mention approval. While First Amendment issues arise because an approval is even farther removed from a prescription than a recommendation, the Attorney General notes the omission of the term approve as significant and maintains that physicians who approve the use of marijuana by a person already doing so is not protected under the Act.<sup>2</sup>

While the Attorney General's interpretation is not binding on any court, and probably would fail in a prosecution of a physician who approved marijuana,<sup>24</sup> drafters of other initiatives should learn from this issue the importance of precision in technical language. Waiting for case

<sup>238</sup>Cal. Health & Safety Code §11362.5(d).

<sup>239</sup>Cal. Att'y General's Office, Proposition 215: An Analysis (Dec. 20, 1996) at 3.

<sup>240</sup>Id. at 3, 8 (a physician who merely approves a self-prescribed use has no defense).

<sup>241</sup>A number of powerful arguments could be brought to bear against the Attorney General's interpretation, including First Amendment rights and legislative intent analysis. Most importantly, by the Attorney General's own definition, the act of recommending is more active than approving.

law to clarify an issue is extremely inconvenient for at least one individual—the one pursuing their case through the appellate system.

### 3. Potential Problems that have not yet Become Problematic

The California initiative has provided future drafters with a real world laboratory from which to observe and learn. Not all potential problems, however, have emerged. The following two issues have not proven problematic, even through a negative interpretation by the Attorney General. Nevertheless drafters should take notice of the potential problems when drafting their initiatives.

#### a. Requirements That the Patients Health Benefit.

The first section in Proposition 215, which expresses the intent of the drafters, expresses an intent that patients be protected when marijuana use has been recommended by a physician who has determined that tJ~ persons's health ~u14 benefit. (emphasis added)<sup>242</sup> This language is dangerous because determining that a patient ~~il4 benefit puts a heavy burden on a physician. While the Attorney General interprets the statute to require a physician to act in a medically sound manner,<sup>243</sup> one could argue that physicians would not be protected by the statute unless they knew for sure that the patient would benefit. This requirement goes beyond sound medical practice. Physicians often try more than one drug on a patient, experimenting to see which one will work. Furthermore, some patients have adverse reactions to even the most benign drugs. Requiring a physician to know anything for sure about a treatment is a daunting demand. Future drafters of initiatives should consider toning down the language to require a physician to act in a medically sound manner or determine that they reasonably expect the patient to benefit.

<sup>242</sup>Cal. Health & Safety Code § 11 362.5(b)(A)

<sup>243</sup> Cal. Att'y General's Office, Proposition 215: An Analysis (Dec. 20, 1996) at 6.

b. Severability

Proposition 215 included a severability clause protecting the remainder of the initiative if part were deemed invalid by a court. One can view such a clause in two ways. First, on the other hand, a partially functioning initiative may indeed be preferable to pursuing a campaign for a second initiative. Furthermore, if an initiative contains a distribution system, a severability clause can save it if the distribution system is preempted. California has illustrated that an initiative can work without a distribution system. Also, one would not want an effective initiative struck down due to an insignificant part being invalidated.

On the other hand, if part of the initiative is deemed invalid, such an action may negatively impact the entire initiative. Merely passing the initiative achieved the first two goals involved in the state medical marijuana initiative campaign: to get it passed and send a message to the federal government. It may be preferable to run a new initiative than live with a partially functioning one, and voters may be less likely to approve a new one if they think they still have one that works well enough. Notwithstanding the potential problems, the benefits to a severance clause outweigh the potential problems and drafters should seriously consider including one.

V. Analysis of State Initiatives Currently Being Advanced by Sponsors

The following portion of this paper analyzes the various state initiatives currently on ballots or in the signature gathering phase of placing them on ballots. Some states have more than one initiative as some groups have chosen not to work together. Americans For Medical Rights (AMR) is currently promoting initiatives in six states, Alaska, Colorado, Maine, Nevada,<sup>2</sup> Oregon, and Washington D.C.. States that have non AMR initiatives being promoted include Alaska, Colorado, Florida, Maine, Washington, and Washington D.C.. Therefore, I have

<sup>2</sup>Nevada is AMIR's latest initiative. Its text is included, but it was not received in time to include a discussion of it in this paper.

divided this section into AMP. initiatives and non-AMIR initiatives. Because a number of AMIR initiatives are similar, I will use the Colorado initiative as a model, and then note how the other initiatives follow or diverge from it.

The following descriptions do not fully elaborate on the technical details of the initiatives. They are intended to provide a summary understanding of each one. Footnotes to specific clauses and sections enable closer examination of the initiatives when a summary invokes questions or does not provide the desired detail.

This section also includes a discussion of interesting, unique, or problematic provisions drafters have included in the various initiatives. When a provision raises an issue discussed in the section on lessons learned from the California and Arizona initiatives, the discussion is superficial to avoid redundancy. In some cases, a provision or lack thereof does not warrant any additional discussion, such as the inclusion or omission of a severance clause or provision relating to minors. Additionally, most initiatives include the basic requirements necessary to protect patients, physicians, and in most cases primary caregivers. These provisions generally require no special discussion. As a result, the analysis of current initiatives may appear excessively negative. The purpose of the analysis is not to disparage the initiatives, or assert that they are poorly drafted. It is, however, intended to subject them to a critical evaluation.

A. AMR Initiatives

## 1. Colorado

Background

AMR's Colorado initiative amends Article XVIII of the Colorado Constitution. It is presently in the signature gathering stage with signatures due in August.

Registry and Identification Card

The Colorado initiative requires the governor to designate a state health agency (Agency) to establish a confidential patient registry of individuals who have applied for approval to use marijuana for medical purposes.<sup>245</sup> If a patient's application is approved, the agency issues a registry identification card identifying the patient and the patient's primary caregiver as certified to engage in the use of marijuana for medical purposes.<sup>2</sup> This card (or proof of application for a card<sup>241</sup>) protects the patient and primary caregiver from arrest and prosecution.<sup>248</sup> Access to information contained in the registry is restricted to authorized employees of the Agency and state or local law enforcement agencies seeking to verify the validity of a card presented to them.<sup>249</sup>

Applications for registration must include: (1) written documentation showing a diagnosis of a debilitating medical condition and the physician's conclusion that the patient might benefit from the medical use of marijuana; (2) the patient's name, address, date of birth, and social

<sup>245</sup>Coloradans for Medical Rights (CMR), Colorado, Amendment for Medical Use of Marijuana, §14(7).

<sup>246</sup>CMR-Colorado, § 14(3)(c).

<sup>247</sup>CMR-Colorado, § 14(3)(d).

<sup>248</sup>CMR-Colorado, § 14(3)(a).

<sup>249</sup>CMR-Colorado, § 14(3)(a).

security number; (3) the name, address and telephone number of the patient's physician; and (4) the name and address of the patient's primary caregiver (if any).<sup>250</sup> The Agency may not reject an application without a legitimate reason,<sup>251</sup> and failure by the Agency to approve or reject an application within thirty-five days results in the application's automatic approval.<sup>252</sup>

The initiative includes various administrative rules directed at how the program functions. For example, the agency may charge a reasonable fee to cover the administrative costs of the program.<sup>253</sup> Also, if an application is denied, patients may not reapply to the registry for six months.<sup>254</sup> Patients must submit updated written documentation and information on their primary caregivers on an annual basis.<sup>255</sup> Finally, state employees are required to notify the state health agency of violations of the medical marijuana law.<sup>256</sup>

#### Non-registry Exemption

Participation in the patient registry program is not mandatory. The initiative also provides an affirmative defense to individuals who can show that they have been diagnosed with a debilitating medical condition and their physician advised them (orally or in writing) that they

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might benefit from marijuana. The targe of participation in the registry is that a police officer may not arrest patients for possession of marijuana once they show their registry

<sup>250</sup>CMR-Colorado, § 1 4(3)(b).

<sup>251</sup>CM1R-Colorado, § 14(3)(c).

<sup>252</sup>CM1R-Colorado, § 1 4(3)(d).

<sup>253</sup>CMR-Colorado, § 14(3)(i).

<sup>254</sup>CM1R-Colorado, § 1 4(3)(e).

<sup>255</sup>CM1R-Colorado, § 14(3)(f).

<sup>256</sup>CM1R-Colorado, §14(3)(g).

<sup>257</sup>CM1R-Colorado, § 14(3)(a).

identification cards. Those who choose not to participate in the registry are subject to arrest and carry the burden of proof at trial.

#### Limitations

Patients using medical marijuana are limited to two ounces of marijuana in useable form or six plants, of which no more than three may produce useable marijuana at any one time.<sup>258</sup> Patients or primary caregivers in possession of more than the allowed amount may be arrested, but have an affirmative defense if they can show that the greater amount was medically necessary.<sup>259</sup> Furthermore, the initiative explicitly states that non-medical marijuana is not covered under this initiative, even for approved patients.<sup>260</sup>

#### Restrictions on Use

Patients are restricted from using medical marijuana in public or in a way that would endanger others. Patients who violate these restrictions will lose their identification cards for a year.<sup>261</sup> The initiative also states that it does not require employers to accommodate medical use of marijuana at work.<sup>262</sup>

<sup>258</sup>CM1R-Colorado, § 14(4)(a).

<sup>259</sup>CM1R-Colorado, § 14(4)(b).

<sup>260</sup>CMR-Colorado, § 14(2)(d).

<sup>261</sup>CM1R-Colorado, § 14(5). The initiative does not indicate whether patients who lose their registry identification cards for a year due to discipline may still take advantage of the non-registry exemption. The plain language of the text found in §14(5)(b) merely states that a patient who violates the restrictions on medical use under §14(5)(a) may not use an identification card for a year. On the other hand, the non-registry exemption specifically states that it applies [e]xcept as otherwise provided in subsection 5. One could argue that since the one year suspension of the identification card is in subsection 5, one loses all rights to use marijuana for medical uses. It is impossible to predict how a court would rule on this issue.

<sup>262</sup>CMR-Colorado, §14(10)(b). It is interesting to note that the initiative does not require employees to accommodate marijuana use, whereas the initiative explicitly prohibits the public use of marijuana. Therefore, the state could still allow marijuana to be used in these situations,



Physician Liability

Physicians are free from prosecution for advising bona-fide patients about the risks and benefits of medical marijuana, and from providing the written documentation required for application to the registry, as long as the advice is based on an assessment of the patient's medical history and current medical condition.<sup>263</sup> Physicians are also free from prosecution or discipline for providing the written documentation required for application to the registry. Minors

Minors are excluded from the non-registry exemption clause and must adhere to the following requirements:

1. Diagnosis of debilitating medical condition by two physicians;
2. Explanation by one of the physicians to the patient and each parent residing in Colorado of the risks and benefits of using marijuana;
3. Written documentation provided by physician indicating that the patient might benefit from marijuana;
4. Written consent of each parent residing in Colorado;
5. A parent who is a resident of Colorado must agree to be the primary caregiver;
6. Application and receipt of a registry identification card;
7. Possession limitations apply to parent and minor collectively;
8. The parent must take responsibility for controlling the use of marijuana.<sup>265</sup>

but it is not required to do so. Conversely, the state would have to change the law if it wanted to allow the use of marijuana in public.

<sup>263</sup>CM1R-Colorado, § 14(2)(c).

<sup>264</sup>For adults, proof of application to the registry is sufficient to prevent arrest, while minors must have received the registry identification card.

<sup>265</sup>CM1R-Colorado, § 14(6).

Miscellaneous Provisions

- No property forfeiture is allowed unless it is in connection with a criminal conviction or a guilty plea. Marijuana and its paraphernalia must be returned upon determination that a suspect may use marijuana for medical purposes. A decision not to prosecute, dismissed charges, and acquittals are all evidence of eligibility to use marijuana.<sup>266</sup>
- No governmental or private health insurance providers can be required to pay for the cost of marijuana for medical uses.<sup>267</sup>
- The initiative requires the General Assembly to enact criminal penalties for fraud committed in connection with the laws created by this initiative.<sup>268</sup>
- No severability clause.

Definitions

Debilitating medical condition means:

- (1) the following diseases: cancer, glaucoma, HIV+, AIDS;
- (2) diseases which produced one of the following symptoms: cachexia<sup>269</sup>, severe pain, severe nausea, seizures (including those characteristic of epilepsy), muscle spasms (including those characteristic of multiple sclerosis);
- (3) The Agency has authority to include other medical conditions.<sup>270</sup>

Primary caregiver means a person eighteen years of age or older who has significant responsibility for managing the well-being of a

<sup>266</sup>CM1R-Colorado, § 14(2)(e).

<sup>267</sup>CM1R-Colorado, § 14(10).

<sup>268</sup>CMR-Colorado, § 14(8).

<sup>269</sup>Physical wasting and malnutrition. Merriam Webster's Collegiate Dictionary 159 (10th ed. 1994).

<sup>270</sup>CMR-Colorado, § 14(1)(a).

<sup>271</sup>CIvJJ~Colorado § 14(1)(f).

'Usable form' and 'usable marijuana' means the seeds, leaves, buds, and flowers of the plant (genus) Cannabis, but does not include the stalks, stems, or roots.<sup>272</sup>

'Written documentation' means a statement signed by a patient's physician or copies of the patient's pertinent medical records.<sup>273</sup>

## 2. Alaska Background

In Alaska, marijuana is schedule VIA, which means it has the lowest degree of danger.<sup>274</sup> This initiative amends Alaska Statutes § 11.71.190 to exempt marijuana possessed for medical purposes from the list of Schedule VIA drugs.<sup>275</sup> The rest of the initiative amends Title 17, Chapter 35 of the Alaska Statutes.

As of April 2, 1998 the Alaska initiative is in the supplemental period. The initiative fell 1,000 signatures short but AMIR has 3,000 more to turn in.<sup>276</sup> It should be on the November 1998 ballot.

<sup>272</sup>CM1R-Colorado, § 14(1)(i).

<sup>273</sup>CM1R-Colorado, § 14(1)(j).

<sup>274</sup>Alaska Stat. §11.71.190

<sup>275</sup>Alaskans for Medical Rights (ALMR), Alaska, Bill Allowing Medical Use of Marijuana. §2 AS 11.71.190(b).

<sup>276</sup> Telephone interview with Dave Fratello, Spokesperson, Americans For Medical Rights (January 16, 1998).

Registry and Identification Card

The Alaska initiative establishes a confidential patient registry in the same format as the model Colorado initiative with a few differences.<sup>277</sup> It does not include the requirement that state employees report patients for violations of the medical marijuana law, yearly renewals, or a waiting period before one may reapply after being denied.

Non-registry Exemption

Just as in the model initiative, patients also have the affirmative defense option. Therefore, participation in the patient registry program is not mandatory.<sup>278</sup>

Limitations

Patients are limited to one ounce of marijuana (as opposed to two ounces in the model initiative) or six plants (the same as in the model), of which no more than three may produce useable marijuana at any one time.<sup>279</sup> Individuals in possession of more than the allowed amounts are not excepted from the criminal laws (they can be arrested), but they can provide an affirmative defense at trial that they needed more than the allowed amounts.<sup>280</sup> The initiative parallels the model initiative in its lack of protection for non-medical marijuana use.<sup>281</sup>

<sup>277</sup>ALMIR-Alaska, § 1. AS 17.35.010; (a)-(b) (confidentiality of registry); (c) (requirements of application); (d) (issuance of registration card); (e) (automatic approval if not rejected); (h)(i) (reasonable administrative fee allowed); (b) (identification card protects patient from arrest); AS 17.35.010 (e) (proof of application sufficient to protect patient from arrest).

<sup>278</sup>No written documentation would be required. ALMIR-Alaska, §1. AS 17.35.030 (a).

<sup>279</sup>ALMIR-Alaska, §1. AS 17.35.020 (a).

<sup>280</sup>ALMR-Alaska, §1. AS 17.35.020 (b).

<sup>281</sup>ALMR-Alaska, §1. AS 17.35.030 (d).

Restrictions on Use

In addition to the model initiative's restriction against using medical marijuana in public or in a way that would endanger others, it also prohibits patients from distributing marijuana to any person who is known to the patient not to be either in lawful possession of a registry identification card or eligible for such card.<sup>282</sup> Patients who violate these restrictions would lose their identification cards for one year.<sup>283</sup>

The initiative does not require accommodation for medical use of marijuana at work, in correctional facilities, within 500 feet of a school, within 500 feet of a recreation or youth center, or on a school bus.<sup>284</sup>

Physician Liability

Physicians are free from prosecution or discipline for advising bona-fide patients about the risks and benefits of medical marijuana as long as the advice is based on an assessment of the patient's medical history and current medical condition. Physicians are also free from prosecution or discipline for providing the written documentation required for application to the registry.

<sup>282</sup>The language of the initiative appears to avoid placing a burden of verification on the patient. It prohibits a patient from distributing marijuana to a person the patient knows is not eligible to use it, as opposed to prohibiting distribution if the patient is unaware of the person's eligibility. The wording of the initiative appears to permit ignorance as an excuse. There is a high probability, however, that courts will require some level of care. Alaska, §1 AS 17.35.040 (a).

<sup>283</sup> See CMR-Colorado discussion at note 17 regarding the issue of whether patients still have

an affirmative defense if their registrations have been revoked. See also ALMR-Alaska, § 1. AS

17.35.030(a), 17.35.040.

<sup>284</sup>ALMIR-Alaska, § 1. AS 17.35.040 (d). ~ CMR.-Colorado discussion at note 18 regarding the difference between prohibiting certain acts versus not requiring the state to accommodate certain act.

Minors

Minors are excluded from the non-registry exemption clause and must adhere to the following guidelines, which differ slightly from the model:

1. Diagnosis of debilitating medical condition;
2. Explanation by the physician to the patient and one parent or guardian residing in Alaska of the risks and benefits of using marijuana;
3. Written documentation from the physician that the patient might benefit from marijuana;
4. Written parental consent;
5. Written parental agreement to act as primary caregiver;
6. Application and receipt of a registry identification card;<sup>285</sup>
7. Possession limitations apply to parent and minor collectively;
8. Parent must take responsibility for controlling the use of marijuana.<sup>286</sup>

Miscellaneous Provisions

- The same property forfeiture prohibition as in the model applies.<sup>287</sup>
- As in the model, no governmental or private health insurance providers can be required to pay for the cost of marijuana for medical uses.<sup>288</sup>

<sup>285</sup> For adults, proof of application to the registry is sufficient to prevent arrest, while minors must have received the registry identification card.

<sup>286</sup> ALMR-Alaska, § 1. AS 17.35.050.

<sup>287</sup> ALMIR-Alaska, § 1. AS 17.35.030(e).

<sup>288</sup> The language of the initiative appears to avoid placing a burden of verification on the patient. It prohibits a patient from distributing marijuana to a person the patient knows is not eligible to use it, as opposed to prohibiting distribution if the patient is unaware of the person's eligibility. The wording of the initiative appears to permit ignorance as an excuse. There is a high probability, however, that courts will require some level of care. ALMR-Alaska, § 1. AS 17.35.040 (c).

Definitions

The Alaska initiative's definitions for debilitating medical condition, primary caregiver, and written documentation are the same as those in the model.<sup>289</sup> The model initiative's definition of usable marijuana excludes stalks, stems and roots, while the Alaska initiative excludes only stalks and roots.<sup>200</sup>

## 3. Oregon

Background

The Oregon initiative is in the signature gathering process and signatures are due on July 3rd, 1998.

Registry and Identification Card

The Oregon initiative establishes a confidential patient registry in the same format as the model Colorado initiative, established and administered by the Health Division of the Oregon Department of Human Resources.<sup>291</sup> The only difference is that this initiative does not require the registry to include names of people who have applied for the registry but have not yet been approved.

<sup>289</sup>ALMR-Alaska, §1. AS 17.35.070.

<sup>200</sup>ALMiR-Alaska, §1. AS 17.35.070 (j).

<sup>291</sup>Oregonians for Medical Rights (OMR), Oregon, The Oregon Medical Marijuana Act, §4(2), § 12(1). Oregon §4(1) (identification card protects patient from arrest); §4(2) (requirements of application); §4(2) (reasonable administrative fee allowed); §4(6)(a) (approval required within five days if no cause to deny exists); §4(9) (proof of application sufficient to protect patient from arrest); § 12(2) (confidentiality of registry).

Non-registry Exemption

The patient registry program is optional because the Oregon initiative provides an affirmative defense for patients who would otherwise be eligible for the registry.<sup>292</sup> This affirmative defense, however, is not available to primary caregivers, who are not permitted outside the context of the registry system.<sup>293</sup> Therefore, registration is mandatory for any patient who needs a primary caregiver, to the extent that the patient wishes to protect the primary caregiver from prosecution.

Limitations

Patients may only use marijuana for medical purposes.<sup>294</sup> The initiative limits patients and primary caregivers collectively to the following amounts of marijuana:

1. If in a location where marijuana is not produced, one ounce of usable marijuana;
2. If in a location where marijuana is produced, three mature plants,<sup>295</sup> four immature plants and one ounce of usable marijuana per mature plant.<sup>2</sup>

The initiative provides an affirmative defense similar to the model for amounts exceeding the limitation.<sup>297</sup>

<sup>292</sup>OMR-Oregon, §6(1).

<sup>293</sup>OMIR-Oregon, §3(10).

<sup>294</sup>OMIR-Oregon, §7(1).

<sup>295</sup>The Health Division shall define mature and immature. OMR-Oregon, §7(3).

<sup>2</sup>OMR-Oregon, §7(1). Usable marijuana is defined as dried leaves and flowers, so the mature plants would not count as useable marijuana.

<sup>297</sup>OMR-Oregon, §7(2).



Restrictions on Use

Patients using medical marijuana are still subject to the following restrictions and may be criminally prosecuted for the following violations:

1. Driving under the influence of marijuana;
2. Using marijuana in a public place;
3. Delivering marijuana to any individual known not to be in possession of a registry identification card;<sup>298</sup>
4. Selling marijuana to anybody, including one in possession of a registry identification card.<sup>2</sup>
6. Violating any other provision of the initiative.<sup>300</sup>

Patients who violate these restrictions may lose their identification cards for six months.<sup>301</sup> The initiative does not require accommodation for medical use of marijuana at work.<sup>302</sup>

Physician Liability

Physicians are not be subject to civil liability or professional discipline for advising people about the risks and benefits of using marijuana for medical purposes, for advising people that marijuana may help their conditions, or for providing written documentation that marijuana

<sup>298</sup> See ALMR-Alaska discussion at note 282 regarding the level of care a patient must take to verify a recipient's registry identification card.

<sup>2</sup>OMIR-Oregon, §5

<sup>300</sup>OMR-Oregon, § 11

<sup>301</sup> See CMIR-Colorado discussion at note 261 regarding the issue of whether patients still have an affirmative defense if their registrations have been revoked.

See also OMR-Oregon,

§§5(2), 6(1).

<sup>302</sup>OMIR-Oregon, § 16(2).

may help their conditions, if such advice is based on a personal assessment of the person’s medical history and current condition.<sup>303</sup>

Minors

Minors may receive a registry identification card. In addition to the standard requirements, one of the minor’s parents or guardians must sign a written statement indicating the following:

- 1. The physician explained to the patient and one parent or guardian the risks and benefits of medical marijuana;
- 2. The parent consents to the minor’s use of marijuana;
- 3. The parent agrees to serve as primary caregiver;
- 4. The parent will control the use of marijuana.<sup>304</sup>

Miscellaneous Provisions

- Possession of a registry identification card does not give law enforcement probable cause to search people or their property.<sup>305</sup>

- The property forfeiture restrictions are the same as those in the model initiative’s.<sup>306</sup>

- As in the model, no governmental or private health insurance providers can be required to pay for the cost of marijuana for medical uses.<sup>307</sup>

- Professional licensing organizations may not discipline its licensees for using medical

marijuana or acting as a primary 308

- Severability Clause<sup>309</sup>

<sup>303</sup>0M1R-Oregon, §9.

<sup>304</sup>0M1R-Oregon, §4(3).

<sup>305</sup>0MR-Oregon, §8(1).

<sup>306</sup>0M1R-Oregon, § 8(2).

<sup>307</sup>0MR-Oregon, § 16(1).

<sup>308</sup>0M1R-Oregon, § 10.

<sup>309</sup>0M1R-Oregon, § 18.

Definitions

The Oregon initiative's definitions for debilitating medical condition and written documentation are the same as those in the model initiative.<sup>310</sup>

Usable marijuana means dried leaves and flowers of the plant Cannabis family Moraceae, excluding seeds, stalks and roots.<sup>311</sup>

Designated primary caregiver means an adult who has significant responsibility for managing the well-being of a patient and has been designated as such on the patient's application for a registry identification card or in other written notification to the Health Division of the Oregon Department of Human Resources.<sup>312</sup> A person may not have more than one primary caregiver.<sup>313</sup>

4. Washington D.C.

Background

The initiative amends Title 33 of the Washington D.C. Code. It is currently in the signature gathering stage.

Registry and Identification Card

There is no provision for a registration system.<sup>314</sup>

Non registry Exemption

The initiative provides an affirmative defense for patients and primary caregivers charged with violating District marijuana laws when the patients have been diagnosed with a debilitating

<sup>310</sup>OMR-Oregon, §3(1), (11).

<sup>311</sup>OMR-Oregon, §3(10). Note that the Alaska definition does not exclude stems but the Colorado definition does.

<sup>312</sup>OMR-Oregon, §3(4).

<sup>313</sup>OMR-Oregon, § 13(2).

<sup>314</sup>On privacy grounds, ACT UP opposes any system that would require patients to register with the government. Telephone interview with Paul Wolf, ACT UP (January 17, 1998).

medical condition and were advised by their physicians that they might benefit from using marijuana.<sup>315</sup> No written documentation is required.

Limitations

The Washington D.C. initiative does not specify limitations on the amount of marijuana a patient may possess. It limits patients and primary caregivers collectively to an amount necessary under the circumstances or 60 days, whichever is less.<sup>316</sup> The initiative does not cover non-medical marijuana, even for patients approved for medical use.<sup>317</sup> Restrictions on Use

Just as with Alaska and Colorado, patients are restricted from using marijuana in public or in a way that would endanger others.<sup>318</sup> The initiative also explicitly states that it will not negate the mens rea for any offense or provide a defense to any crimes involving violence, danger to others, or operating motor vehicles while impaired.<sup>319</sup>

The initiative does not require any accommodation for medical use of marijuana by an employer, on school grounds, at a recreation or youth center, or on a school bus.<sup>320</sup>

<sup>315</sup>D.C. Voters for Medical Rights (DCMIR), Washington D.C., Medical Use of Marijuana Initiative of 1998, Chapter 11 §33-1102 (a).

<sup>316</sup>DCMIR-D.C., §33-1104 (a). This provision is a product of negotiations between AMP and ACT UP. ACT UP felt that AMIR's typical limitations were too restrictive and could inhibit patients' flow of marijuana, forcing them onto the black market. Telephone interview with Paul Wolf, ACT UP (January 17, 1998).

<sup>317</sup>DCMIR-D.C., §33-1102 (d).

<sup>318</sup>DCMIR-D.C., §33-1105 (a).

<sup>319</sup>D.C., §33-1105 (b).

<sup>320</sup>DCMIR-D.C., §33-1105 (d). See CMIR-Colorado discussion at note 262 regarding the difference between prohibiting certain acts versus not requiring the state to accommodate certain acts.

Physician Liability

In language comparable but not identical to the model initiative, the initiative protects physicians from prosecution or discipline for advising bona-fide patients about the risks and benefits of medical marijuana and for providing written documentation stating that the patient might benefit from the medical use of marijuana.<sup>321</sup> A clause unique to the Washington D.C. initiative allows physicians called to testify in court to do so in camera and request their names be kept confidential and redacted from public documents.<sup>322</sup>

Minors

Minors may not use marijuana for medical purposes unless the following guidelines are met.

1. Diagnosis of debilitating medical condition by two physicians;
2. Explanation by one of the physicians of the risks and benefits to the patient and each parent or guardian residing in the District;
3. Advice by one of the physicians that the patient might benefit;
4. Parental consent by each parent residing in the District of Columbia;
5. One parent agrees to serve as primary caregiver;
6. Possession limitations apply to parent and minor collectively;
7. Parent controls the use of marijuana.<sup>323</sup>

<sup>321</sup>DCMR-D.C., §33-1102 (b).

<sup>322</sup>DCMIR-D.C., §33-1 105 (c). Due to federal supremacy, a physician called to testify on behalf of a patient prosecuted under federal law would probably not remain anonymous.

<sup>323</sup>DCMR-D.C., §33-1106

Distribution

The Director of the District of Columbia Department of Health shall develop a plan to provide marijuana to eligible patients. The plan must allow for non-profit buyers clubs to operate and provide for affordable distribution to all patients covered by Medicaid or a Ryan White CARE Act-funded program.<sup>324</sup>

Miscellaneous Provisions.

- The property forfeiture restrictions are the same as those in the model initiative.

- No private health insurance providers can be required to pay for the cost of marijuana for medical uses.<sup>325</sup>

- Severability clause.<sup>326</sup>

Definitions

Debilitating medical condition and written documentation have the same definition as the model initiative.<sup>327</sup>

Primary caregiver means an adult who has significant responsibility for managing the well being of a patient. A patient may not have more than one primary caregiver without a showing of

<sup>328</sup>

necessity.

The initiative has no definition of useable marijuana. It defines marijuana as the plant genus Cannabis.<sup>329</sup>

<sup>324</sup>DCMR-D.C., §33-1103

<sup>325</sup>Contrary to the model initiative, the government is excluded from this clause because the initiative specifically includes Medicare and the Ryan White CARE programs. DCMR-D.C., §33-1105 (c).

<sup>326</sup>DCMIR-D.C., §33-1 109.

<sup>327</sup>DCMR-D.C., §33-1101 (1), (9).

<sup>328</sup>DCMIR-D.C., §33-1 101 (7).

<sup>329</sup>DCMR-D.C., §33-1101 (8).

5. Maine Background

This initiative enacts new language and also amends the language of various existing statutes to achieve its purpose. The Maine initiative fell 4,000 signatures short of the number required to place it on the ballot. AMP. is currently challenging the state's decision not to put the initiative on the November 1998 ballot.<sup>330</sup> It will certainly be on the November 1999 ballot because signatures carry to the next year, giving AMIR a year to collect 4,000 more signatures.

Requirements

Persons at least eighteen years of age may lawfully possess marijuana for medical use if they meet certain conditions. First, the patient must be diagnosed by a physician with one of the following conditions: nausea; vomiting; wasting syndrome or loss of appetite due to AIDS or cancer treatments; glaucoma; seizures associated with diseases such as epilepsy; or muscle spasms associated with diseases such as multiple sclerosis.<sup>331</sup> Second, the patient's physician must discuss the risks and benefits of marijuana, provide a professional opinion of the balance of risks and benefits, and advise the patient that the patient may benefit from marijuana.<sup>332</sup> Third, patients must disclose their medical use of marijuana to their physicians and remain under the physician's continuing care.<sup>333</sup>

<sup>330</sup> Telephone interview with Dave Fratello, Spokesperson, Americans for Medical Rights (April 2, 1998).

<sup>331</sup> Mainers for Medical Rights (MMR), Maine, An Act to Permit the Medical Use of Marijuana, §10 (5)(A)(1).

<sup>332</sup> MM1R-Maine, § 10 (5)(A)(2).

<sup>333</sup> M1vIR-Maine, §10 (5)(A)(3), (4).

Limitations

A patient may not possess more than 1 1/4 ounces of harvested marijuana and six plants, of which no more than 3 may be mature, flowering plants.<sup>334</sup>

Restrictions on Use

A patient may not use marijuana in public or at work when prohibited.<sup>335</sup>

Physician Liability

A physician may not be disciplined for advising patients that they might benefit from the medical use of marijuana.<sup>336</sup>

Minors

Minors may use medical marijuana if, in addition to meeting the requirements for patients over 18 years of age, the minor patient has written parental consent.<sup>337</sup>

Miscellaneous Provisions

The initiative prevents the forfeiture of property based on the medical use of marijuana.<sup>338</sup>

Definitions

Designated caregiver means a person over 18 years of age who is a family member or other person who has consistently assumed responsibility for a person's housing, health or safety and is either the patient's legal parent or guardian or has been designated in writing by the patient as

<sup>334</sup>MMR-Maine, §§10 (5)(A), 9.

<sup>335</sup>M1MR-Maine, §10 (5)(F).

<sup>336</sup>MMR-Maine, § 10 (F).

<sup>337</sup>MMR-Maine, §10 (5)(B).

<sup>338</sup>MMR-Maine, §3.



his or her designated caregiver<sup>339</sup> Designated caregivers may lawfully possess a usable amount of marijuana to provide to the patient.<sup>340</sup>

#### 6. Evaluation of AMR Initiatives

AMIR has taken a conservative strategy with its initiatives. One of its primary goals is to draft initiatives that voters will pass and that will avoid federal pre-emption. It sees the pressure exerted on the federal government caused by voters approving initiatives as more powerful in the long term than the actual provisions in an initiative. Furthermore, an initiative that is invalidated under federal supremacy provides only initial influence, but fails to apply continuous pressure on the federal government. While other initiatives may provide better protection for patients, AMIR has taken the position that the risk of harm resulting from an initiative's election failure or subsequent invalidation outweighs the benefit it would provide to the patient if the initiative stood. While reasonable minds can disagree, AMIR's position is rational.

##### a. Evaluation of AMR's Colorado Initiative

AMIR's Colorado initiative shows good textual precision. The only uncertainty I noticed was whether patients who lose their licenses also lose the affirmative defense, thus preventing them from using marijuana for medical purposes during their suspension.<sup>341</sup> Nuances in the initiative also demonstrate that AMIR chose its words carefully. For example, it distinguished between cases where it prohibits certain acts and where it does not require the state to allow

<sup>339</sup>1vllv1R-Maine, §7 A- 1.

<sup>340</sup>MMR-Maine, §10 (C). The initiative does not aggregate the amount of marijuana possessed by the patient and primary caregiver as in the other AMIR initiatives. One may reasonably read the initiative to allow for 2 1/2 ounces of harvested marijuana and 12 plants between the patient and designated caregiver.

<sup>341</sup> See CMR-Colorado discussion at note 261 regarding the issue of whether patients still have an affirmative defense if their registrations have been revoked.

certain acts. Also, it allows adults to use marijuana from the time they apply to the registry, but requires minors to wait for approval. These subtleties demonstrate that AMR gave careful consideration to, and anticipated ramifications from, its choice of wording.

AMIR's Colorado initiative (as well as its other initiatives) takes an interesting approach to physician liability. It does not use the word recommend and appears to require less active encouragement than a recommendation would connote. For patients to conform to the law, their physicians must discuss the possible risks and benefits of using marijuana with them and provide a professional opinion or conclusion that the patient might benefit from the use of marijuana (the benefits may outweigh the risks). Such a requirement appears to require nothing more than an admission or expression of a medical opinion by a physician. This approach may help shield doctors from DEA sanctions better than the term recommend by bringing them more securely under the First Amendment. The drawback of this approach is that it opens the initiative to attack by opponents who will probably argue that not only is no prescription required, physicians do not even have to recommend its use; they must merely opine that it may help. If the initiative can succeed with the voters, this provision will be an excellent protection for physicians.

Probably the most controversial aspect of the Colorado initiative is its registration system. The registration experiment in Arcata, California has received considerable praise, and even guarded optimism from the California Attorney General's office.<sup>342</sup> This system protects patients from arrest, as opposed to protecting them from conviction through an affirmative defense. Without a registration system police are generally free to arrest a patient because an affirmative defense is one that a defendant raises at trial. The question of whether the marijuana use was medical is a question of fact, the answer to which is decided by a jury. Police need not answer

<sup>342</sup>Kate Rix, Grass Rots Take Hold of Prop 215, The Recorder, March 11, 1998, 1.

that question in the field. On the other hand, under a registration system, the police must show a reasonable belief that the patient is not complying with the law. Furthermore, the system is voluntary and patients who do not want to register may still avail themselves of the affirmative defense. Therefore, a registration system provides greater protection for patients.

On the other hand, ACT UP and other AIDS groups are opposed to any system that keeps records on patients with AIDS.<sup>343</sup> This opposition stems from the fear of persecution and discrimination against AIDS patients. ACT UP's fear materialized recently when police seized the patient records from the Santa Clara County Medical Cannabis Center during their criminal investigation into the club.<sup>3</sup> While patients could choose not to register and avail themselves of the affirmative defense, ACT UP fears that the existence of a registry program would hurt those who did not register. For example, police would assume that legitimate users would have no reason not to register; therefore, they would be more likely to arrest an unregistered patient than if no registration system existed.<sup>345</sup> Also, the federal government could conceivably overrule the state's confidentiality requirements and demand access to the records so they could investigate the patients for federal crimes. AMR appears to rely on political restraints to prevent such breaches of the registry's confidential protections.

A registration system has an enormous potential to protect patients. On the other hand, it raises legitimate privacy concerns. The issue of registration is really a judgement call by drafters and voters. If an initiative drafter feels that its benefits outweigh its risks, AI\4iR has developed a well-thought-out system worthy of emulation.

<sup>343</sup>Telephone interview with Wayne Turner, ACT UP (April 2, 1998).

<sup>3</sup>Russell Sabin, Medical Privacy at Issue in Pot Club Records Seizure, The San Francisco Chronicle, April 2, 1998, A17.

<sup>345</sup>Telephone interview with Paul Wolf, ACT UP (January 17, 1998).

In terms of what conditions qualify a patient to use marijuana, AMR chose a balanced approach. It restricts the diseases to those enumerated in the initiative, but provides for the Agency to include new conditions. This approach fends off the argument that the initiative permits marijuana use for any condition including writer's cramp without requiring a new initiative to include new conditions. The drawback is that if the Agency is opposed to using marijuana for medical uses, it may refuse to include new diseases.

One area where AMR chose an ill-advised strategy was in not including a severability clause or a distribution system and placing limits on the amount of marijuana patients and primary caregivers could possess and cultivate. For the reasons discussed in Section IV E2, AMIR should have avoided placing enumerated limits on possession and cultivation. The initiative will not adequately protect patients who grow their own marijuana; however, it offers patients no alternative method of obtaining marijuana. The initiative does allow patients to possess greater quantities, but places the burden to prove necessity on the patient. Providing patients an affirmative defense for more than two ounces or six plants would defeat the purpose of the registration system, which is to protect patients from arrest. The initiative relies too heavily on the anticipated political pressure holding government officials in check so that patients can obtain marijuana. Granted, even initiatives that offer better protections for patients only do so at the state level. The federal government's inability to enforce small possession and cultivation violations of federal law, however, means that state protections do offer real protections for patients. AMR should not have included enumerated limits on amounts a patient may possess, should have included a distribution system, and should have protected the rest of the initiative with a severability clause.

b. Evaluation of AMIR's Alaska Initiative

AMR's Alaska initiative is very similar to the Colorado initiative and subject to the same praise and criticism. The Alaska initiative does have one provision not included in the Colorado initiative that may prove problematic. It does not require the state to allow use of medical marijuana within 500 feet of a school, recreation center, or youth center. At first glance, this provision appears reasonable. It does not, however, address what might happen to patients who live within 500 feet of one of these locations.

c. Evaluation of AMIR's Oregon Initiative

AMR's Oregon initiative is also patterned after the Colorado initiative; however, it has a problematic provision that may make registration compulsory. Primary caregivers are defined as people who have been declared primary caregivers on a patient's application for a registry identification card. Furthermore, the provision that provides an affirmative defense to patients who choose not to register does not provide such a defense to primary caregivers. Therefore, patients who need primary caregivers must register if they wish to protect them from prosecution. As I asserted earlier, the choice to include a voluntary registration system is a judgement call with either answer acceptable. A compulsory registration system, however, is inappropriate and should not be included.

d. Evaluation of AMR's Washington D.C. Initiative

AMIR's Washington D.C. initiative differs from the traditional AMIR initiative. Its text is a product of negotiations between AIVIR and ACT UP.<sup>3</sup> ACT UP had failed in a petition drive to place initiative 59 on the ballot in 1997. It resubmitted the essentially identical text which became initiative 59. When AMIR expressed its intention to enter Washington D.C. using its

<sup>3</sup>Telephone interview with Dave Fratello, Spokesperson, Americans for Medical Rights (January 16, 1998).

traditional language, ACT UP protested and the two groups met to find a text that both groups could support.<sup>347</sup> They developed a mutually agreeable language that both groups submitted separately to the District.<sup>348</sup> Disagreements later arose and ACT UP withdrew its version of the modified initiative and is presently working to place initiative 59 on the ballot. AMIR is proceeding with the compromise initiative.

AMR's policy is to avoid issues of distribution in its initiatives. Distribution plans cause two problems from AMR's point of view. First, involving the state in either distributing or sanctioning the distribution of marijuana poses political risks.<sup>349</sup> AMR's highest priority is to write legislation that can pass. Second, by becoming involved in distribution, a state may find itself in direct conflict with federal law, which can allow a court to overturn the initiative.<sup>350</sup> AMR seeks to pass bills that will remain on the books as opposed to bills that will come into conflict with federal law and be overturned.<sup>351</sup>

Nevertheless, AMR did include a distribution system and severability clause in its initiative as a result of the compromise with ACT UP.<sup>352</sup> It exempts buyers clubs from state marijuana laws and it requires the District Department of Health to develop a distribution plan as well. The exemption for buyers clubs is not susceptible to preemption because it does not

<sup>347</sup>Telephone interview with Dave Fratello, Spokesperson, Americans for Medical Rights (January 16, 1998). Telephone interview with Paul Wolf, ACT UP (January 17, 1998).

<sup>348</sup>Telephone interview with Wayne Turner, ACT UP (April 2, 1998).

<sup>349</sup>E-mail from Dave Fratello, Spokesperson, Americans for Medical Rights to Don Christen, Maine Vocals (on file with author).

<sup>350</sup>E-mail from Dave Fratello, Spokesperson, Americans for Medical Rights to Don Christen, Maine Vocals (on file with author).

<sup>351</sup>Telephone interview with Dave Fratello, Spokesperson, Americans for Medical Rights (April 2, 1998).

<sup>352</sup>Telephone interview with Paul Wolf, ACT UP (January 17, 1998).

conflict with federal law. Buyers clubs would merely be exempt from state law, yet still subject to federal law. The Department of Health distribution plan is a closer call. The initiative requires the Department to develop a plan, so the statute could avoid preemption under the argument that it requires a plan that does not conflict with state law. The plan could be quashed, however, because it would necessarily cause the District to violate federal law. Nevertheless, the provision provides the statutory authority to institute a plan as soon as the federal government alters its policy.

AMR takes a different approach to limits on the amount of marijuana a patient and primary caregiver may cultivate and possess. It limits the amount to that which is necessary under the circumstances or sixty days. This restriction is more realistic than the ones in the Colorado, Alaska, and Oregon initiatives. It shelters the initiative from attacks claiming that it would allow enormous amounts of marijuana, it avoids placing unreasonable restrictions on patients, and it avoids the baggage of using the term personal use. The provision's weakness is its sixty day supply limit. AMR should have permitted a ninety day supply to allow patients to possess enough to last through an indoor growing period. Allowing the one year supply for outdoor cultivation is neither necessary, because Washington D.C.'s urban environment would not lend itself to outdoor cultivation, not politically feasible.

e. Evaluation of AMR's Maine Initiative

AMR's Maine initiative does not use the standard AMIR format and does not include a registration program. Although it takes a more succinct approach, it stays true to the AMR philosophy, such as addressing the issue of minors and offering physicians increased protection.

This initiative has several of the same weaknesses as well. It does not have a distribution system or severability clause and its limits on possession are unreasonably low. Also, in a departure from the other AMIR initiatives, it restricts the medical conditions that qualify a patient to use marijuana without providing a method to add a new condition when evidence supports its inclusion. Such a provision is the best politically to ward off attacks that marijuana will be used for every ailment imaginable. On the other hand, it is dangerous because in the future, science may indicate a new use for marijuana that state law will not permit.

#### B. Non-AMR Initiatives

##### 1. Alaska Summary

The Alaska initiative adds Section 18.08.016 to the Alaska Statutes. The initiative is almost an exact copy of the California Compassionate Use Act of 1996. Therefore, instead of summarizing the text, I will highlight the differences between the Alaska and California texts. The first difference is that the Alaska initiative uses the term cannabis instead of marijuana. Also, in the list of eligible conditions for which cannabis may be prescribed, the Alaska initiative includes chronic depression, which the California initiative does not. Furthermore, the initiative explicitly states that cultivation of cannabis by a patient or primary health care provider is protected by the Ravin<sup>3</sup> decision. Finally, the Alaska initiative uses the term primary health care provider instead of primary caregiver. Nevertheless, the definition is the same, except Alaska explicitly includes licensed home health care workers.

<sup>353</sup>Ravin v. State, 537 P.2d 494 (1975). In this decision, the Alaska Supreme Court ruled that under the Alaska Constitution's right to privacy, the state could not prohibit individuals from smoking marijuana in their homes.



Discussion

Because the Alaska initiative is almost identical to the California initiative, one can refer to the discussion of Proposition 215 for a discussion of the Alaska initiative's text. One must, however, keep in mind that California courts have written two opinions interpreting the Compassionate Use Act and Alaska courts could rule a different way.

One provision of the Alaska initiative requires discussion. Section 1(d) of the California initiative exempts patients and their primary caregivers from state marijuana laws. Section 1(d) of the Alaska initiative exempts patients' primary health providers, but fails to exempt the patients. Taking the intent and surrounding text into account, a court will most likely read the clause to also exempt patients. Nevertheless, this inadvertent omission illustrates the need for textual precision in drafting. Initiative sponsors need to keep in mind that the initiative placed on the ballot will become law, even if it includes mistakes.

## 2. Colorado

Background

The Colorado initiative would amend the state constitution. One of the initiative's provisions replaces the terms marijuana and marihuana **in** all Colorado statutes with the most appropriate of the following terms: cannabis (traditional marijuana), cannabis concentrate (hashish), or hemp (marijuana stalks and low THC industrial marijuana).<sup>354</sup> The initiative refers to marijuana used for medical purposes as therapeutic cannabis. As a measure of respect for the drafters, who obviously feel strongly about the terminology, I will refer to marijuana used for medical purposes as therapeutic cannabis in this section.

<sup>354</sup>CCCC Colorado §§3(3)(a), 4(1)(a).

Commission

The initiative creates the Colorado Therapeutic Cannabis Commission (Commission), a seven member commission appointed by the governor.<sup>355</sup> The Commission is an administrative body with a broad mandate. It has jurisdiction over all issues pertaining to therapeutic cannabis,<sup>356</sup> and its primary duty is to implement the initiative.<sup>3</sup> In order to accomplish its mandate it can recommend statutory changes,<sup>358</sup> promulgate administrative law,<sup>359</sup> and enlist the assistance of other government agencies.<sup>360</sup> Furthermore, it has the power to issue subpoenas, hold hearings, compel testimony and hire experts.<sup>361</sup>

In addition to general mandates, the Commission has specific duties that it must fulfill. The Commission must develop special rules to regulate therapeutic cannabis use by minors, develop a system for providing amnesty for patients convicted of therapeutic cannabis use prior to the initiative's passage, and create penalties for violations of the provisions in the initiative.<sup>362</sup> The Commission is also responsible for issuing licenses to therapeutic cannabis dispensaries,<sup>363</sup> which can include state agencies, non profit corporations, physicians or pharmacies.<sup>364</sup> For this

<sup>355</sup>CCCC Colorado §8.

<sup>356</sup>CCCC Colorado §10.

<sup>357</sup>CCCC Colorado §9(14).

<sup>358</sup>CCCC Colorado §9(3).

<sup>359</sup>CCCC Colorado §9(8).

<sup>360</sup>CCCC Colorado § 13(2).

<sup>361</sup>CCCC Colorado §9(9).

<sup>362</sup>CCCC Colorado §3.

<sup>363</sup>CCCC Colorado §9(2).

<sup>364</sup>CCCC Colorado §2(12).

service it may charge a reasonable licensing fee.<sup>365</sup> This licensing clause appears to provide for buyers clubs in Colorado. Finally, the Commission must establish discussions between federal agencies, state agencies, and outside parties to establish a cohesive transition where conflict of law may exist.<sup>366</sup>

#### Patients and Primary Caregivers

The initiative provides an affirmative defense for any person who reasonably believes their actions conform to the requirements of the initiative.<sup>367</sup> It also protects patients and their primary caregivers from arrest, prosecution, or sanction for using therapeutic cannabis if they have a written recommendation prescribing therapeutic cannabis from a physician or their medical records indicate such an opinion.<sup>368</sup> The medical conditions for which patients may use marijuana include: conditions such as cancer, AIDS, glaucoma, multiple sclerosis, epilepsy, chronic pain, cachexia (wasting syndrome), and nausea caused by chemotherapy and radiation therapy.

Primary caregivers are defined as adults who have significant responsibility for managing the well-being of a patient and who have been designated in writing as primary caregivers.<sup>369</sup> Primary caregivers must possess both a copy of the patient's written physician recommendation

<sup>365</sup>CCCC Colorado §9(10).

<sup>366</sup>CCCC Colorado §9(6).

<sup>367</sup>CCCC Colorado §5(1).

<sup>368</sup>CCCC Colorado §6(2).

<sup>369</sup>CCCC Colorado §6(3).

or medical records and a document showing their designation as a primary caregiver.<sup>370</sup> A patient may have up to four primary caregivers at one time.<sup>371</sup>

#### Physician Liability

A physician is protected from arrest, prosecution, and sanction for providing a professional opinion or written documentation that prescribes the use of therapeutic cannabis for a medical condition.<sup>372</sup>

#### Miscellaneous provisions

- The initiative includes various provisions directing how the Colorado Attorney General and governor should act.<sup>373</sup>

- The initiative notes that it is a constitutional amendment and that all state government agencies must protect and defend the state constitution. Therefore, they must protect and defend this initiative. It requires state officer's who's personal beliefs prevent them from implementing the initiative as their duties require to resign.<sup>374</sup>

- Severability clause.<sup>3</sup>

- The initiative requires that it be liberally construed to achieve its goals.<sup>376</sup>

- It is unlawful for individuals to misrepresent their status as eligible patients.<sup>377</sup>

<sup>370</sup>CCCC Colorado §6(3)(f).

<sup>371</sup>CCCC Colorado §6(3)(b).

<sup>372</sup>CCCC Colorado §6(1).

<sup>373</sup>CCCC Colorado §§1, 12.

<sup>374</sup>CCCC Colorado §13(3)(b).

<sup>375</sup>CCCC Colorado §15.

<sup>376</sup>CCCC Colorado §16.

<sup>377</sup>CCCC Colorado §7(2).

Discussion

This initiative is difficult to interpret. In the areas of patient and primary caregiver exemption from cannabis laws, I gave what I consider the most reasonable interpretation in light of the wording and declared intent. Other interpretations are possible. For example, a patient may possibly be exempt from prosecution even without a physician's recommendation. The initiative states that patients may not be arrested if they are in compliance with the provisions in the initiative and that a physician's recommendation constitutes prima facie evidence of such compliance. The physician recommendation is not the requirement, only an evidence of compliance, implying that a physician's recommendation is not required, only convenient. The initiative, however, does not indicate what provisions one must be in compliance with.

The initiative's lack of clarity comes from circular definitions. It states that a patient may lawfully engage in therapeutic cannabis use.<sup>378</sup> This sentence indicates that whether something is lawful depends on whether it qualifies as therapeutic cannabis use. Therapeutic cannabis is defined as cannabis intended for use in treatment of medical conditions by patients.<sup>379</sup> Therapeutic cannabis use is defined as the lawful use, acquisition, cultivation, possession, or transportation of an adequate supply of therapeutic cannabis by a patient.<sup>380</sup> Thus, whether something constitutes therapeutic cannabis use depends on whether it is lawful. None of the clauses define lawful use. This lack of clarity illustrates the need for care and precision in drafting.

<sup>378</sup>CCCC Colorado §6(2).

<sup>379</sup>CCCC Colorado §2(11).

<sup>380</sup>CCCC Colorado §2(13).

This initiative seems to be hovering in between requiring a recommendation and a prescription from physicians, referring to it as a recommendation prescribing therapeutic cannabis.<sup>381</sup> Since there is no question that the federal government may take action against physicians who prescribe therapeutic cannabis and the question regarding whether a physician can recommend it without sanction is not completely resolved, it is unwise to lean towards requiring a doctor to do anything that might be construed as a prescription or as assisting a patient in breaking the law. Some of the other initiatives take a better approach, moving farther away from any semblance of active encouragement toward a passive expression of opinion.

The initiative also seems to strike a balance on what medical conditions allow for the use of therapeutic cannabis. The list of eligible conditions is preceded by the phrase such as, which indicates that the list is not exhaustive.<sup>382</sup> On the other hand, the list is not open ended because the phrase such as indicates similarity. Thus other acceptable conditions would need to be similar to the enumerated conditions, although what conditions would be eligible is not clear. The drafters should have considered precluding this uncertainty by assigning the duty of defining eligible conditions to the Commission. Nevertheless, the wording allows other diseases without opening the initiative up to attacks that patients with ingrown toenails or simple headaches will be able to use therapeutic cannabis.

The initiative also attempts to strike a balance on the distribution problem. By providing

for a program where the state licenses dispensaries that may sell therapeutic cannabis, the initiative likely avoids federal pre-emption, but allows some state control over distributors.<sup>383</sup>

<sup>381</sup>CCCC Colorado §6(2)(c).

<sup>382</sup>CCCC Colorado § 1.

<sup>383</sup>see Section IV.E.2.a. discussing preemption of distribution systems.

The initiative also authorizes the state of Colorado to create a state agency to dispense therapeutic cannabis. Although this provision creates supremacy issues surrounding a state agency violating federal law, the initiative has a potential safety mechanism to defend against preemption. It requires the Commission to establish discussions with the federal government to work out a transition in areas where law conflicts. This transition clause may save the distribution mechanism because the state could argue that the provision does not require the state to violate federal law, but requires it to seek an agreement with the federal government. Under such a situation, the distribution system would not be struck from the initiative, but merely put on hold until the federal government relents to permitting buyers clubs. Under this provision, the initiative avoids preemption, but when the federal government changes its policy, a state distribution program is in place without the need for additional legislation.

### 3. Florida Summary<sup>384</sup>

The initiative allows for patients to use marijuana for medical purposes when a physician certifies that the use is medically appropriate and the patient may benefit. Eligible diseases include: cancer, HIV, AIDS, anorexia, glaucoma, arthritis, chronic pain, spasticity, migraine, and any other specified condition, symptom, or illness. The initiative protects physicians who certify the use of marijuana from prosecution or discipline. It also protects individuals from prosecution for cultivation, transportation, provision, or sale of marijuana to certified patients. The statute does not address primary caregivers; however, the language indicates that the concept could exist under the proposed section.<sup>385</sup>

<sup>384</sup>The text of the Florida is very short. Therefore, I will not footnote the summary.

<sup>385</sup>The language in paragraph (d) allows the provision or sale of marijuana for, or to, a person who has obtained marijuana for certified medical use under this section. One could interpret

The initiative authorizes the Florida legislature to implement physician certification procedures. It also contains a severability clause.

Discussion

The Florida initiative provides a distribution provision by exempting from marijuana laws the provision and sale of marijuana to qualified patients.<sup>386</sup> This provision could prove politically problematic, but if it receives the necessary votes, it avoids the preemption danger and provides buyers clubs with much needed protection.

The initiative also provides for strong physician protection in a unique way. It used the term certify instead of recommend. Physicians need only certify that marijuana is medically appropriate and the patient's health may benefit. The certification provision moves physicians farther away from the active endorsement that recommend connotes toward a First Amendment protected expression of opinion. Nevertheless, certification has an official sounding ring that may help politically.

The drafters big mistake may have been allowing the Florida legislature to authorize a certification procedure. The lesson learned from Arizona is that if the legislature can thwart the law it will. Furthermore, legislation submitted in California under the guise of clarification actually attempted to make the initiative unworkable.<sup>387</sup> The legislature could enact measures requiring a physician's certification to include a prescription, effectively preventing physicians from certifying patients. Or the legislature could follow the Arizona route and require FDA

this section to allow one to possess marijuana for a patient, which would allow for primary caregivers.

<sup>386</sup>see Section IV.E.2.a. discussing distribution systems.

<sup>387</sup>see Section IV.E.2.d. regarding protecting initiatives from state legislatures.



approval for certification. The drafters should not trust the legislature to faithfully execute the initiative.

In addition to these beneficial provisions, the Florida statute has two political susceptibilities. First, the statute does not address the issue of minors.<sup>388</sup> Second, the statute allows marijuana to be used for virtually any illness, leaving it vulnerable to the opponent's' predictions of patients using marijuana for insignificant ailments.<sup>389</sup> Nevertheless, including all diseases is a reasonable judgement call because it prevents beneficial uses discovered in the future from being prohibited.

#### 4. Maine ~nmm&y

Maine's initiative is one of the shortest and simplest. It enacts 22 Me. Rev. Stat. 2383-C, permitting a patient or primary caregiver'~ to possess or cultivate marijuana on the written or oral recommendation of a physician. It also allows patients to use marijuana if they have been diagnosed with an illness for which marijuana can provide relief. Physicians are also protected from punishment or sanction for recommending marijuana to patients. The initiative does not supersede any law that prohibits dangerous conduct, nor does it condone marijuana use for non-medical purposes.

The initiative requires the establishment of a seven person study committee comprised of legislators, proponents of medical marijuana, and the Maine Attorney General to create a program to supply medical marijuana to patients who cannot grow their own or do not have a

<sup>388</sup>see Section IV.E. 1.b. discussing the treatment of minors.

<sup>389</sup>see Section IV.E. 1.c.i. discussing limitations on eligible illnesses.

<sup>3</sup>Primary caregiver means the individual designated by the patient who has consistently assumed responsibility for the housing, health or safety of that patient.

primary caregiver. The program must be implemented within six months of the initiative's passage.

#### Discussion

The Maine initiative has two problems similar to California's initiative. It fails to address the issue of minors, and it includes the provision protecting patients who use marijuana for personal medicinal use without defining what personal medical use means.<sup>391</sup>

The initiative also takes a unique and potentially controversial position on when a patient may use marijuana and for what medical conditions. It appears to allow patients to use marijuana on a doctor's recommendation or if they have been diagnosed with an illness for which marijuana can provide relief. This second clause seems to render the first one unnecessary. If a patient who has been diagnosed with an eligible condition does not need a doctor's recommendation, the doctor would have no other reason to recommend marijuana. The initiative effectively precludes the need for a physician's recommendation and allows self prescription after an initial diagnosis. Such a situation will raise serious political issues since opponents will assuredly focus on the fact that a patient does not even need a physician's approval to use marijuana. To compound the problem, the list of conditions for which marijuana may be used is also open ended.

In addition to protections for patients, the initiative contains a provision for distribution. The drawback to this provision is that it requires the state government to violate federal law.<sup>392</sup> State law can legalize distribution without conflicting with federal law, but will conflict when the state law requires the state to act **in** violation of federal law. Additionally, the initiative faces a

<sup>391</sup>See Section IV.E.2.b. discussing allowable amounts of marijuana.

<sup>392</sup>See Section IV.E.2.a. regarding distribution systems.

strong danger of federal preemption due to the distribution provision, but does not contain a

severability clause. Therefore, the entire initiative is at risk of federal preemption. The drafters of the Maine initiative take the position that the federal government is

wrong, and therefore marijuana activists should not have to appease it. To them any efforts at incremental advances, compromise, or provisions not fully directed towards benefiting patients constitutes pandering to the federal government, police and politicians.<sup>393</sup> What they fail to recognize is that an initiative that seeks to accomplish too much will provide opponents with more leverage in the election to make the sky is falling arguments that will sway moderate voters. Furthermore, regardless of why an initiative fails, the federal government will showcase such failure as proof that the state's citizens do not support medical marijuana. As I have already argued, failure may harm the movement more than not trying at all.

<sup>393</sup>E-mail from Don Christen, Maine Vocals/Maine Citizens for Medical Marijuana to author (Feb. 14, 1998).

5. Washington Background

Washington's Initiative 692 adds a new chapter to Title 69 Wash. Rev. Code. Patients and Primary Caregivers

Initiative 692 provides an affirmative defense for any state law relating to marijuana for qualified patients and primary caregivers.<sup>394</sup> To qualify, patients must meet the following requirements :

1. Be under the care of a physician;
2. Have been diagnosed with a terminal or debilitating disease;
3. Be a resident of the state of Washington;
4. Have been advised by their physicians about the risks and benefits of using marijuana for medical purposes; and
5. Have been advised by their physicians that they may benefit from using marijuana.

Primary caregivers are defined as adults, designated in writing as primary caregivers, who are responsible for the housing, health or care of a patient.<sup>395</sup> Primary caregivers must possess both documentation certifying the patient as eligible and written documentation showing their designation as a primary caregiver.<sup>397</sup> They may not consume marijuana (unless they are patients in as well), or be a primary caregiver to more than one person at a time.<sup>398</sup>

<sup>394</sup>Washington Citizens for Medical Rights, Washington, Washington State Medical Use of Marijuana Act, Initiative 692 §5(1).

<sup>395</sup>Washington Initiative 692 §6.

<sup>396</sup>Washington Initiative 692 §6(2).

<sup>397</sup>Washington Initiative 692 §5(4)(c), (d).

<sup>398</sup>Washington Initiative 692 §5(4)(d), (e).

Limitations

Patients and their primary caregivers may not cumulatively possess more marijuana than is necessary for the patient's personal, medical use, nor more than a sixty day supply.<sup>3</sup> What constitutes a necessary amount is not defined and presumably depends on each patient's circumstance.

Restrictions on use

It is a misdemeanor to use marijuana in public.<sup>400</sup> Patients are also subject to the normal state laws against driving while under the influence of marijuana.<sup>9</sup> Furthermore, the initiative does not require employers to accommodate the use of marijuana at work, on school buses, at school, or at youth centers.<sup>402</sup>

Physician Liability

The initiative protects physicians from prosecution or sanction for advising patients about the risks and benefits of using marijuana and for providing a written statement that in the physician's opinion, the potential benefits of marijuana outweigh the health risks for that patient.<sup>3</sup>

<sup>3</sup>Washington Initiative 692 §5(2)(b), (4)(b).

<sup>400</sup>Washington Initiative 692 § 8(1).

Washington Initiative 692 §8(6).

<sup>402</sup>Washington Initiative 692 § 8(4). See CMR-Colorado discussion at note 262 regarding the difference between prohibiting an act versus not requiring accommodation for an act.

<sup>403</sup>Washington Initiative 692 §4(5)(a).

Minors

Minors may use marijuana if they qualify under the normal qualification requirements.

Parents or guardians, however, must assume responsibility to acquire, possess, and control usage of the marijuana to the minor.<sup>404</sup>

Miscellaneous Provisions

- No property forfeiture is allowed for marijuana use permitted by this ~
- Health insurance providers are not required to cover the costs of marijuana.<sup>406</sup>
- The initiative makes it a class C felony to fraudulently qualify as a patient eligible to use marijuana.<sup>407</sup>
- A state may not be held liable for harm incurred by a patient due to marijuana use for medical purposes.<sup>408</sup>
- Severability.<sup>409</sup>

Definitions

Terminal or debilitating disease means: cancer, HIV, multiple sclerosis, epilepsy or other seizure disorder, spasticity disorders, intractable pain, and glaucoma.<sup>410</sup> The Washington State Medical Quality Assurance Board may designate additional qualifying diseases.<sup>411</sup>

<sup>404</sup>Washington Initiative 692 §5(3).

<sup>405</sup> Washington Initiative 692 §7(1).

<sup>406</sup> Washington Initiative 692 § 8(2).

<sup>407</sup>Washington Initiative 692 §8(5).

<sup>408</sup>Washington Initiative 692 §7(3).

<sup>409</sup>Washington Initiative 692 § 10.

<sup>410</sup>Washington Initiative 692 §6(4).

<sup>411</sup>Washington Initiative 692 §§6(4)(d), 9.

Discussion

The Washington initiative has three constructive provisions that deserve discussion. First, it takes a moderate approach to defining what medical conditions would qualify for treatment with marijuana. Marijuana use is limited to enumerated terminal or debilitating conditions, indicating an intent to limit marijuana use to only serious diseases. This limitation to enumerated conditions will help the initiative politically, preventing opponents from arguing that marijuana will become available for the simplest problems. On the other hand, it provides for the Medical Quality Assurance Board to designate additional qualifying diseases. This approach is a well thought out, good balance between thwarting opponent arguments and providing a method for including additional conditions that marijuana may prove useful in alleviating.

Second, the initiative avoids placing limits on the amount of marijuana patients may possess, except that patients may not possess more than a sixty day supply. This approach to the quantity issue is a good one, similar to AIVIR's Washington D.C. approach. The initiative is also subject to the same criticism, however, of not allowing patients enough marijuana to sustain them through one indoor growing season. Although outdoor grows are feasible in Washington, voters would surely have more difficulty accepting an initiative that permitted possession of a year's supply of marijuana. Allowing a ninety day supply would be a reasonable compromise.

Third, the initiative takes a more lenient approach with physicians, similar to AMIR and Florida. It requires physicians to discuss the risks and benefits of marijuana use with their patients, and then state a medical opinion about whether the potential benefit of marijuana use outweighs the likely risks for that patient. This provision moves away from the active connotation of the words prescribe and recommend to a more passive statement of opinion. If courts ultimately deem recommending marijuana to constitute a level of encouragement not

protected by the First Amendment, a mere discussion of risk and benefits followed by a statement of opinion would most likely remain protected.

In addition to these advantageous provisions, the initiative also includes two problematic provisions. First, the initiative requires patients to be residents of Washington.<sup>412</sup> Requiring some form of Washington identification card may be an attempt to avoid California's problem of not being able to define residency. Nevertheless, a residency requirement may still prejudice long term visitors and illegal aliens. The initiative is presumably attempting to avoid making Washington a magnet for out of state residents who want to use marijuana. Nevertheless, such people are still subject to their state laws when they return home. A better solution would be to prohibit the export of marijuana from the state, regardless of whether a patient is eligible to use it or not.

Second, the initiative allows a person to be a primary caregiver to only one patient at a time. Such a restriction is ill-advised. In People v. Peron,<sup>413</sup> California tried assert that primary caregivers may not serve more than one patient. The court rejected this argument, noting that such a requirement would prevent individuals from qualifying as a primary caregiver for both mother and father, or directors of convalescent hospitals or nursing homes from serving as primary caregivers for more than one resident patient.<sup>414</sup> The court found that such a restriction would unduly burden the goal of the initiative to ensure that patients have the right to obtain and

<sup>412</sup>See Section IV.E.2.c. regarding limiting eligible patients to state residents.

<sup>413</sup>59 Cal. App. 4th 1383, 70 Cal. Rptr. 2d 20 (1997).

<sup>414</sup>Id at 1399.



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use marijuana for medical purposes.<sup>415</sup> The court's reasoning is the most powerful argument against limiting primary caregivers to serving one patient.

## **6. Washington D.C.**

### Background

ACT UP in Washington, an AIDS activist group in Washington D.C., originally sponsored Initiative 57 in 1997, but failed to acquire the necessary 17,010 signatures. Initiative 59 is identical to number 57 and is ACT UP's second attempt in Washington D.C.. Primary Intent

Initiative 59 excepts patients and primary caregivers from the prohibitions against marijuana possession and cultivation when a physician gives a written or oral recommendation that marijuana is medically necessary for the patient's treatment.<sup>416</sup> The conditions for which patients may use marijuana include AIDS, glaucoma, muscle spasm, cancer and any other serious or chronic illnesses.<sup>417</sup> Minors are allowed to use marijuana for medical purposes with written consent of a parent or guardian that indicates that the parent understands the minor's medical condition and the risks and benefits of using marijuana generally and in the minor's situation.<sup>418</sup>

As I noted, primary caregivers who assist individuals with their marijuana needs are also exempt from marijuana laws. A primary caregiver is defined as a licensed health care practitioner, relative, domestic partner, case manager, or close friend who is helping the patient

<sup>416</sup>ACT UP, Washington D.C. Initiative 59, Legalization of Marijuana for Medical Treatment Initiative §2, 6(a).

<sup>417</sup>ACT UP-D.C. §2.

<sup>418</sup>ACT UP-D.C. §9.

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with daily needs while the patient is in a weakened state. Patients may have up to four primary caregivers at one time, and they need not designate their primary caregivers in writing, although doing so provides prima facie evidence of such designation.

Limitations

The initiative restricts the amount a patient or primary caregiver may cultivate or possess to that which is necessary for a medical supply.<sup>419</sup> A medicinal supply means a sufficient quantity to maintain an uninterrupted supply for treatment.<sup>420</sup>

Restrictions on use

The initiative does not provide a defense for crimes committed while using marijuana for medical purposes, nor does marijuana use negate the requisite mens rea for any defense.<sup>421</sup> Distribution of marijuana for non medical purposes is also prohibited.<sup>422</sup>

Physician Liability

The initiative protects physicians from prosecution or sanction for recommending marijuana for medical purposes. Physicians required to testify in court regarding the recommendations may testify before a judge in camera and have their names kept confidential and redacted from public documents.<sup>423</sup>

<sup>419</sup>ACT UP-D.C. §6.

<sup>420</sup>ACT UP-D.C. §6.

<sup>421</sup>ACT UP-D.C. §4(a).

<sup>422</sup>D. C. §4(b).

<sup>423</sup>ACT UP-D.C. §5.

### III

#### Distribution

The drafters envision a distribution system involving both government involvement and private actors. They provided a mechanism for distribution by allowing for the creation of non profit buyers clubs, which may only distribute marijuana to patients authorized to use it for medical purposes. The language in this section indicates that the buyers clubs would be required to verify such authorization through means such as requiring evidence of a doctor's recommendation.<sup>424</sup> Illegal dealers may not use this law as a defense because it only exempts buyers clubs, patients, and primary caregivers from cultivation laws. Furthermore, the initiative requires the Washington D.C. Department of Health Director to develop an affordable distribution plan for all Medicaid patients and those enrolled in plans funded by the Ryan White CARE Act.<sup>425</sup>

#### Miscellaneous provisions

- Severability clause.<sup>426</sup> Discussion

ACT UP has developed a number of provisions worth discussing. ACT UP included a distribution provision and severability clause, which was included in AMR's Washington D.C. initiative. It is subject to the same praise and criticism expressed in the discussion of AMR's Washington D.C., initiative, which for convenience, this paper repeats in this section. The initiative exempts buyers clubs from state marijuana laws and it requires the District Department of Health to develop a distribution plan as well. The exemption for buyers clubs is not

<sup>424</sup>ACT UP-D.C. §§6(b), 8.

<sup>425</sup>ACT UP-D.C. § 10(a).

<sup>426</sup>ACT UP-D.C. §11.

susceptible to preemption because it does not conflict with federal law. Therefore, buyers clubs would be exempt from state law, yet still subject to federal law. The Department of Health distribution plan is a closer call. The initiative merely requires the Department to develop a plan, so the statute could avoid preemption under the argument that it requires a plan that does not conflict with state law. The plan could be quashed, however, because it would necessarily cause the District to violate federal law. Nevertheless, the provision provides the statutory authority to institute a plan as soon as the federal government alters its policy.

Also, the drafters of Initiative 59 attempted to find a middle ground in defining which conditions marijuana may be used for. California's initiative received harsh criticism for its open ended clause that according to critics allowed marijuana to be used for virtually any problem or discomfort. Initiative 59 maintained a general savings clause but restricts the qualifying conditions to serious and chronic.

Another good provision prevents defendants from claiming that being high on marijuana, justified under state law, prevented them from developing the requisite mens rea to commit a crime. If criminals were gaining refuge under a medical marijuana law, it would quickly lose much of the support it enjoyed during the elections. A number of initiatives have praiseworthy provisions that expressly disavow protection for driving or engaging in other dangerous acts while using marijuana; however, Washington D.C. is the only one that addresses the potential argument that patients using marijuana may not be responsible for their actions.

Finally, the drafters came up with an ingenious way of protecting doctors. Doctors may testify in camera regarding their marijuana recommendations to patients, and have their names kept confidential. While the federal government could easily ascertain the doctors' names in the course of a criminal investigation, doctors have plenty of other reasons to remain anonymous.

Doctors fear retribution from a number of sources: professional organizations, colleagues, the

District, and the federal government. If doctors must be afraid few will recommend marijuana.

#### VI. Conclusion

When the medical marijuana advocacy movement shifted its focus to state initiatives, many people decried this strategy as a surreptitious attempt to completely legalize drugs. They accused drug legalization supporters of using people afflicted with cancer and AIDS as pawns to further their agenda. To bolster their assertions, opponents pointed out that the initiatives did not even require a prescription or FDA approval. They argued that the United States has a system in place to protect patients from snake oil and harmful drugs and that voters should not jeopardize the health of patients by subverting this system.

Some opponents may believe these arguments, which might be valid if the United States drug approval system was not flawed, both technically and politically, in such a manner that prevents the approval of marijuana even if it does have medical benefits. Granted, marijuana legalization activists naturally supported the initiatives, but so did patients, physicians, nurses, and groups such as ACT UP who do not have a unified opinion regarding drug legalization. They merely recognize the overwhelming anecdotal evidence—through their numerous first hand experiences—that marijuana does help ill patients in certain instances where nothing else does, and in other cases it helps them with fewer negative side effects than traditional drugs. In order to deal with federal laws that continue to prohibit medical uses of marijuana, initiative drafters had to write them in a manner that is concededly less than ideal. Nevertheless, these provisions, such as not requiring a doctor's prescription, are rational provisions intended to provide some measure of regulation, and not to legalize marijuana for all.

Over the last twenty-five years, marijuana advocates have sought to obtain patient access to marijuana. During these twenty-five years, the government maintained a position that existing scientific evidence did not support approval of marijuana for medical uses, while thwarting

efforts to perform scientific studies that might show medical benefits. Notwithstanding the government's resistance to using marijuana as medicine, polls and surveys indicated that the general public supported such use. Therefore, redirecting their efforts to state voter initiatives was a natural and reasonable strategy. Even if marijuana ultimately proves medically useless, state initiative proponents are not misguided. Not only can they not currently prove marijuana's medical efficacy according to contemporary scientific standards, neither can opponents prove that it is not efficacious. It is not misguided to demand that the question be answered.

Until the federal government gives in to the pressure created by states who pass medical marijuana initiatives and allows the traditional drug approval process to function as it was intended, medical marijuana advocates have no other option than to continue their state efforts through both voter initiatives and state legislatures. California's Proposition 215 demonstrated the wisdom of medical marijuana advocates' choice to redirect their efforts toward the states. Since its passage, the federal government has instituted a study to determine what evidence pertaining to marijuana's medical efficacy currently exists, and has provided not only the marijuana, but a million dollar grant for the study that it spent years trying to thwart.

For those who wish to draft voter initiatives, this paper critiques past and present initiatives with the goal of providing future drafters with a guide so they do not have to start from scratch. Because various groups have different goals and priorities, no ideal initiative exists. Nevertheless, certain issues transcend diverse goals. Regardless of whether the drafter's goal is to pass the first initiative in a step-by-step approach, to pass one that will pressure the federal government politically or through additional pressure on its law enforcement capabilities, or to provide the best initiative for the patients, analyzing other initiatives and the subsequent developments of those that have passed is imperative.