

COMMENTS

Medical Marijuana: State Law Undermines Federal Marijuana Policy — Is the Establishment Going to Pot?

INTRODUCTION

Availability of medical marijuana¹ in the past has been, and remains today, the subject of heated debate at the federal level, both in the legislature and with administrative agencies.² Proponents of availability have pursued efforts to reclassify marijuana under the Controlled Substances Act³ for more than two decades. Meanwhile, various state legislatures, courts and voters have moved toward easier availability of marijuana for medicinal use. This comment examines the treatment of medical marijuana use in several states, its conflict with federal policy, and proposes a reconciliation between the two.

¹ The Controlled Substances Act, 21 U.S.C.S. § 802(16) (Law. Co-op. Supp. 1996), defines marijuana to mean:

all parts of the plant *Cannabis sativa* L., whether growing or not; the seeds thereof; the resin extracted from any part of such plant; and every compound, manufacture, salt, derivative, mixture, or preparation of such plant, its seeds or resin. Such term does not include the mature stalks of such plant, fiber produced from such stalks, oil or cake made from the seeds of such plant, any other compound, manufacture, salt, derivative, mixture, or preparation of such mature stalks (except the resin extracted therefrom), fiber, oil, or cake, or the sterilized seed of such plant which is incapable of germination.

The term is alternately spelled “marihuana.”

² The Controlled Substances Act, 21 U.S.C.S. § 811(a) (Law. Co-op. 1984), authorizes the Attorney General to determine appropriate scheduling of controlled substances. The Attorney General has delegated this authority to the Administrator of the Drug Enforcement Administration. 28 C.F.R. § 0.100(b) (1996).

³ 21 U.S.C.S. §§ 801-904 (Law. Co-op 1984).

Marijuana use in the United States was not particularly a matter of state or federal regulation until 1915, when the first state—California—prohibited its possession or sale.⁴ By the time Congress passed the Marijuana Tax Act of 1937,⁵ virtually all states had enacted prohibitions similar to that of California.⁶ The 1951 Boggs Act⁷ established mandatory prison terms and large fines for violation of any federal drug law, and the Narcotic Control Act of 1956⁸ strengthened those penalties.⁹ In 1970, Congress enacted the Controlled Substances Act (CSA);¹⁰ marijuana's Schedule I designation under the Act¹¹ was the catalyst for the medical marijuana controversy which still rages today.¹²

Beginning in the early 1970's various organizations formed to campaign for easing of restrictions on marijuana use, including the National Organization for Reform of Marijuana Laws (NORML),¹³ the

⁴ ROGER A. ROFFMAN, *MARIJUANA AS MEDICINE* 38 (1982).

⁵ Marijuana Tax Act, Pub. L. No. 75-238, ch. 553, 50 Stat. 551 (1937) (repealed 1970).

⁶ ROFFMAN, *supra* note 4.

⁷ Boggs Act of 1951, Pub. L. No. 82-235, 65 Stat. 767 as amended by the Narcotic Control Act of 1956, Pub. L. No. 84-728, 70 Stat. 567.

⁸ Narcotic Control Act of 1956, Pub. L. No. 84-728, 70 Stat. 567.

⁹ ANNE GELPERIN & WILLIAM J. HERMES, *MARIJUANA, ITS EFFECTS ON MIND & BODY* 36 (The Encyclopedia of Psychoactive Drugs, Series 1, 1992).

¹⁰ Controlled Substances Act, *supra* note 3. For an in-depth review of marijuana's criminalization, see Richard J. Bonnie & Charles H. Whitebread, II, *The Forbidden Fruit of the Tree of Knowledge: An Inquiry Into the Legal History of American Marijuana Prohibition*, 56 VA. L. REV. 971 (1970).

¹¹ 21 U.S.C.S. § 812 Schedule I(c)(10) (Law. Co-op. 1984). Schedule I placement requires findings that:

“(A) The drug or other substance has a high potential for abuse.

(B) The drug or other substance has no currently accepted medical use in treatment in the United States.

(C) There is a lack of accepted safety for use of the drug or other substance under medical supervision.”

Id. § 812(b)(1).

¹² The marijuana debate continues, despite the fact that dronabinol, a synthetic form of delta-9-tetrahydrocannabinol (THC)—the primary active ingredient in marijuana—is prescribable in pill form as an antiemetic, under the brand name Marinol. Pursuant to DEA final rule, dronabinol in sesame oil encapsulated in a soft gelatin capsule was placed in schedule II of the Controlled Substances Act in 1986. Rescheduling of Synthetic Dronabinol, 51 Fed. Reg. 17,476 (1986) (codified as 21 C.F.R. § 1308.12). Marijuana advocates claim synthetic THC in pill form absorbs more slowly than, and thus is slower to manifest the therapeutic qualities of, marijuana. Christopher S. Wren, *Doctors Criticize Move Against State Measures*, N.Y. TIMES, Dec. 31, 1996, at D18.

¹³ Founded in 1970, NORML seeks full legalization of marijuana. ROFFMAN, *supra*

Alliance for Cannabis Therapeutics (ACT),¹⁴ the National Drug Strategy Network,¹⁵ and various regional groups.¹⁶ These and other similar organizations petition and lobby for federal marijuana law reform.

The Controlled Substances Act¹⁷ sets forth procedures for removal from or transfer between schedules, including action initiated “on the petition of any interested party.”¹⁸ NORML began its reform campaign in May 1972 by petitioning the Bureau of Narcotics and Dangerous Drugs (BNDD)—now the Drug Enforcement Administration (DEA)—to remove marijuana from federal drug schedules or, alternatively, to reclassify it in a less restrictive schedule.¹⁹ The DEA denied the petition.²⁰ Many appeals by NORML, later joined by ACT, followed,²¹ culminating with the DEA’s final order denying reclassification in 1992.²² In 1994, the court of appeals denied a petition for review of the 1992 final order.²³ NORML recently filed a new petition with the Drug Enforcement Administration,²⁴ resurrecting the reform campaign

note 4, at 19.

¹⁴ Established in 1980, ACT works to “ ‘end the federal prohibition of cannabis in medicine, and construct a medically meaningful, ethically correct and compassionate system of regulation which permits the seriously ill to legally obtain cannabis [sic].’ ” ROFFMAN, *supra* note 4, at 20.

¹⁵ Founded by Eric E. Sterling, former counsel to the United States House of Representatives. STEVEN B. DUKE & ALBERT C. GROSS, *AMERICA’S LONGEST WAR* 275 (1993).

¹⁶ Californians for Compassionate Use is an example.

¹⁷ Controlled Substances Act, 21 U.S.C.S. §§ 801-904 (Law. Co-op. 1984).

¹⁸ 21 U.S.C.S. § 811(a) (Law. Co-op. 1984).

¹⁹ Marijuana Scheduling Petition, 37 Fed. Reg. 18,097 (1972).

²⁰ *Id.* The order reflected the DEA’s refusal to accept the petition for filing, on the ground NORML lacked standing to petition for rescheduling.

²¹ NORML appealed the DEA’s refusal to accept its petition for filing and the court remanded, ordering the DEA to conduct formal hearings and consider the petition based on the evidence presented. *National Org. for the Reform of Marijuana Laws v. Ingersoll*, 497 F.2d 654 (D.C. Cir. 1974). Medical marijuana advocates appealed subsequent DEA decisions denying rescheduling as follows: *National Org. for the Reform of Marijuana Laws v. DEA*, 559 F.2d 745 (D.C. Cir. 1977); *National Org. for the Reform of Marijuana Laws v. DEA & Dep’t of Health, Educ. & Welfare*, No. 79-1660 (D.C. Cir. Oct. 16, 1980); *Alliance for Cannabis Therapeutics v. DEA*, 930 F.2d 936 (D.C. Cir. 1991).

²² Marijuana Scheduling Petition, 57 Fed. Reg. 10,499 (1992).

²³ *Alliance for Cannabis Therapeutics v. DEA*, 15 F.3d 1131 (D.C. Cir. 1994).

²⁴ Jon Gettman, *Petition for Repeal of a Rule* (visited Oct. 15, 1996) <<http://www.natlnorml.org/activist/gettman>>. In this petition, filed July 1995, NORML changed its tactics. Rather than arguing that marijuana has an accepted medical use, NORML contends the DEA cannot lawfully retain marijuana in schedule I absent conclusive evidence that the drug has high potential for abuse. *Id.*

at the federal level.²⁵

In the states, many legislatures have enacted therapeutic research programs in an attempt to provide medical marijuana legally.²⁶ Often the solutions crafted by state legislatures or judiciaries are inconsistent with explicit federal policy.²⁷

This comment explores state legislative and judicial policy on the use of marijuana as medicine, the conflict with established federal policy, and the effects of this inconsistency. To eliminate the undermining effect of state action on federal policies and to address concerns raised in marijuana rescheduling, this author proposes a pilot program that allows the federal government to preserve its steadfast stance against drug abuse.

I. FEDERAL POLICY: MARIJUANA HAS NO RECOGNIZED MEDICAL USE

After a 20-year-long effort by marijuana advocates, who challenged each order denying their rescheduling petition, the DEA Administrator's 1992 final order²⁸ withstood appellate scrutiny.²⁹ In that final order, the Administrator set forth the five necessary characteristics³⁰ of a

²⁵ Judging by NORML's 1972 petition, decades may pass before we know the outcome of this new petition.

²⁶ See discussion *infra* part II.A.

²⁷ The fact that various states have enacted therapeutic research acts does not establish an accepted medical use for marijuana, according to the DEA Administrator. Marijuana Scheduling Petition, 57 Fed. Reg. 10,499 (1992). However, allowance of the medical necessity defense directly conflicts with articulated federal policies.

²⁸ Marijuana Scheduling Petition, 57 Fed. Reg. 10,499 (1992).

²⁹ Alliance for Cannabis Therapeutics v. DEA, 15 F.3d 1131 (D.C. Cir. 1994).

³⁰ Previously, the DEA utilized an eight-part test to determine whether a drug has a currently accepted medical use, and accepted safety for use under medical supervision, as enumerated in 54 Fed. Reg. 53,767 (1989):

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; and
8. Recognition and use of the substance by a substantial segment of the medical practitioners in the United States.

This eight part test was reformulated due to the court's concern over the seeming

drug with a “currently accepted medical use in treatment in the United States, within the meaning of the Federal Controlled Substances Act,” and applied them to marijuana.³¹ Briefly, a drug must have: 1) a known and reproducible chemistry; 2) adequate safety studies; 3) proven efficacy through adequate and well-controlled studies; 4) acceptance by qualified experts; and 5) widely available scientific evidence.³² The Administrator found marijuana possessed none of these characteristics.

The order cited concern over the highly variable chemical makeup of marijuana, noting the variability inherent in the plant *Cannabis Sativa* L.³³ Variations in soil, geographical region, water, light, harvesting and storage conditions magnify the inconstant chemical makeup,³⁴ making marijuana impossible of standardized reproduction.³⁵ Additionally, effects on chemical composition from burning the plant are unknown.³⁶

The Administrator expressed his opinion that “[t]hose who insist marijuana has medical uses would serve society better by promoting or sponsoring more legitimate scientific research, rather than throwing their time, money and rhetoric into lobbying, public relations campaigns and perennial litigation.”³⁷ The lack of adequate research studies is cited by federal officials, both in the DEA’s order,³⁸ and now³⁹ to bolster opposition to medical marijuana. There are inadequate safety studies on human beings, and no adequate, well-controlled scientific studies of marijuana’s therapeutic application.⁴⁰ Researchers blame the scant scientific data on federal agencies, who either do not approve studies on medical marijuana, or approve the studies but then fail to

impossibility for anyone to comply with parts four, five and eight when dealing with a Schedule I substance. *Alliance for Cannabis Therapeutics v. DEA*, 930 F.2d at 940.

³¹ Marijuana Scheduling Petition, 57 Fed. Reg. 10,499 (1992).

³² *Id.*

³³ *Id.*

³⁴ *Id.*

³⁵ “[M]arijuana’s chemistry is neither fully known, nor reproducible. Thus far, over 400 different chemicals have been identified in the plant. The proportions and concentrations differ from plant to plant” Marijuana Scheduling Petition, 57 Fed. Reg. 10,499 (1992).

³⁶ *Id.*

³⁷ *Id.*

³⁸ *Id.*

³⁹ *Arizona and California Drug-use Initiatives: Hearings Before the Senate Committee on the Judiciary*, 104th Cong., 1st Sess. (1996) [hereinafter *Hearings*] (testimony of Thomas A. Constantine, Administrator, DEA, U.S. Dep’t of Justice).

⁴⁰ Marijuana Scheduling Petition, 57 Fed. Reg. 10,499 (1992).

dispense the marijuana necessary to conduct them.⁴¹ Conflicting views in this area are explored further in Part III of this comment.

Given the lack of adequate studies of medicinal marijuana, the fourth and fifth characteristics implicitly cannot be met. Marijuana cannot achieve acceptance by qualified experts, "a consensus of the national community of experts, qualified by scientific training and experience to evaluate the safety and effectiveness of drugs,"⁴² because, by their very definition, such experts would not rely on inadequate research to formulate an opinion on a drug's accepted medical use.⁴³ Lack of adequate studies similarly precludes wide availability of scientific evidence supporting claims of marijuana's therapeutic value.⁴⁴

Apart from the scientific concerns outlined above, federal officials consider marijuana a gateway drug, which makes further drug abuse likely.⁴⁵ Prominent federal officials view efforts to make medical marijuana available as "undermin[ing] safe medical procedures . . ." and "send[ing] the wrong message to our children . . ."⁴⁶ Officials posit that because there is "no clinical evidence demonstrat[ing] that smoked marijuana is good medicine . . .," the efforts by groups such as NORML are thinly-veiled steps toward full legalization of drugs.⁴⁷ The states, on the other hand, appear more willing to recognize medical potential for marijuana, as discussed below.

II. STATES' VARIATIONS ON MARIJUANA POLICY

Virtually every state has a controlled substances act, which categorizes each drug based on its potential for abuse and recognized medical use, among other criteria. While some states independently determine appropriate scheduling,⁴⁸ many states' laws mirror the federal

⁴¹ Rick Doblin, *NIDA Blocks Medical Marijuana Research* (visited Dec. 29, 1996) <<http://www.mpp.org/MAPS.html>>.

⁴² Marijuana Scheduling Petition, 57 Fed. Reg. 10,499 (1992).

⁴³ The Administrator emphasized those forms of proof irrelevant to a determination of currently accepted medical use, including "[s]tudies or reports so lacking in detail as to preclude responsible scientific evaluation." *Id.*

⁴⁴ *Id.*

⁴⁵ *Hearings, supra* note 39 (testimony of Retired General Barry McCafferty, Director, Office of Nat'l Drug Control Policy).

⁴⁶ *Hearings, supra* note 39 (testimony of Retired General Barry McCafferty, Director, Office of Nat'l Drug Control Policy).

⁴⁷ *Hearings, supra* note 39 (testimony of Retired General Barry McCafferty, Director, Office of Nat'l Drug Control Policy).

⁴⁸ Alaska's statute reads:

"(a) A substance shall be placed in schedule VIA if it is found under AS

Controlled Substances Act for marijuana, thus placing it in the most restrictive schedule and criminalizing its use or possession for any purpose.⁴⁹ Though retaining marijuana in a strict drug schedule, many states have programs for medical use of the substance.

*A. Therapeutic Research Programs:
Supplying Marijuana to the Medically Needy*

Many states retaining marijuana in a highly restrictive drug schedule have enacted statutory exceptions to that rule through legislative recognition of potential therapeutic use for marijuana. Alabama's "Controlled Substances Therapeutic Research Act"⁵⁰ illustrates the legislative intent⁵¹ behind similar programs implemented in more than one-half of the states.⁵² Alabama law specifically exempts authorized program participants from criminal prosecution for use, possession or cultivation of marijuana.⁵³ The program is research-oriented⁵⁴ and does not purport to give credence to marijuana's medical efficacy, yet it embraces therapeutic potential for marijuana in cancer and glaucoma

11.71.120(c) to have the lowest degree of danger or probable danger to a person or the public.

(b) Marijuana is a schedule VIA controlled substance."

ALASKA STAT. § 11.71.190 (1995).

⁴⁹ For example, the Washington Controlled Substances Act designates marijuana as a Schedule I drug. WASH. REV. CODE § 69.50.204(c)(14) (1996). The state criteria for Schedule I placement reads much the same as that of the federal act:

"(1) has high potential for abuse; and

(2) has no accepted medical use in treatment in the United States or lacks accepted safety for use in treatment under medical supervision."

WASH. REV. CODE § 69.50.203 (1995).

⁵⁰ ALA. REV. CODE ANN. §§ 20-2-110 to 2-120 (1996).

⁵¹ ALA. REV. CODE ANN. § 20-2-111 (1996), reads:

The legislature finds that recent research has shown that the use of cannabis may alleviate nausea and ill-effects of cancer chemotherapy, and may alleviate the ill-effects of glaucoma. The legislature further finds that there is a need for further research and experimentation with regard to the use of cannabis under strictly controlled circumstances

See also N.J. REV. STAT. § 26:2L-2 (1995); WASH. REV. CODE § 69.51.020 (1995).

⁵² As of 1985, legislation recognizing medical use for marijuana in some form had been enacted in 33 states. 131 CONG. REC. H2678 (1985).

⁵³ ALA. REV. CODE ANN. § 20-2-114 (1996) limits the research program to patients certified by authorized physicians. The section further provides that "[t]o the extent of the applicable authorization, persons are exempt from prosecution in this state for possession, production, manufacture or delivery of cannabis."

⁵⁴ ALA. REV. CODE ANN. § 20-2-111 (1996).

treatment which the DEA⁵⁵ and the federal legislature⁵⁶ repeatedly reject. Except for purposes of the therapeutic research program, Alabama retains marijuana in its designated schedule.⁵⁷ Other states, such as New York⁵⁸ and Massachusetts,⁵⁹ enacted research programs that were similar, but included additional diseases within the scope of the programs, such as asthma.⁶⁰ A bill pending in the Washington state legislature seeks to expand that state's program to include AIDS and other HIV-related illnesses, multiple sclerosis "and other life-threatening diseases."⁶¹

The majority of therapeutic research acts set forth a requirement that the respective program obtain marijuana through the National Institute on Drug Abuse (NIDA).⁶² At first only mildly difficult, procurement of marijuana from NIDA is now a practical impossibility.⁶³ The New York legislature must have anticipated such difficulty because, from its inception, the New York act authorized an alternative means for procurement of the marijuana necessary to carry out its purpose.⁶⁴ In

⁵⁵ See *supra* notes 32-44 and accompanying text.

⁵⁶ Federal bills introduced for medical marijuana include, H.R. 4498, 97th Cong., 1st Sess. (1981); H.R. 2232, 99th Cong., 1st Sess. (1985); H.R. 2618, 104th Cong., 2d Sess. (1995).

⁵⁷ "The enumeration of cannabis, tetrahydrocannabinols or a chemical derivative thereof as a schedule I or II controlled substance under article 2 of Title 20, as amended, does not apply to the use of such drugs or chemical derivatives thereof pursuant to the provisions of this article." ALA. REV. CODE ANN. § 20-2-119 (1996). Marijuana—cannabis—is a schedule I substance in Alabama. ALA. REV. CODE ANN. § 20-2-23(3)(j) (1996).

⁵⁸ See N.Y. PUB. HEALTH LAW § 3397-a (1996), finding that "use of marijuana may alleviate the nausea and ill-effects of cancer chemotherapy, may alleviate the ill-effects of glaucoma and may have other therapeutic uses."

⁵⁹ The Massachusetts program, created in 1991, included research of marijuana's efficacy "in decreasing airway resistance in asthmatics." Controlled Substances Therapeutic Research Act, 1991 Mass. Acts 480, codified as MASS. ANN. LAWS ch. 94D, § 2 (Law. Co-op. 1996).

⁶⁰ *Id.*

⁶¹ S. 6744, 54th Leg., Reg. Sess. § 1 (Wash. 1996).

⁶² See, e.g., GA. CODE ANN. § 43-34-125(a) (1996).

⁶³ In 1992, the Bush administration closed the Compassionate Investigative New Drug Program to all but twelve individuals already approved and receiving marijuana from the government, citing fears of sending the wrong message to the public. Eugene L. Meyer, *Uncle Sam's Farm: Imagine — Getting Marijuana Free From the Government. It's A Reality for the Acapulco Eight, Who are Supplied as Part of an Old Medical Program* [hereinafter *Uncle Sam's Farm*], L.A. TIMES, Dec. 11, 1995, at E1. Arguably, the federal government implicitly recognizes marijuana as a medicine, by virtue of this program.

⁶⁴ N.Y. PUB. HEALTH LAW § 3397-f (1996) governs distribution of marijuana under

Washington, a bill to amend the therapeutic research act would add a legislative directive requiring a study "to determine the appropriate entity to cultivate and manufacture the marijuana plant."⁶⁵ Clearly, states endeavoring to give ailing citizens access to medicinal marijuana will continue those efforts, in spite of obstacles from the federal government.

*B. Marijuana Policy on Trial:
The Medical Necessity Defense in Criminal Prosecutions*

Proponents of medical marijuana are fighting the battle at the state level not only in the legislature, but in the trenches of criminal prosecutions as well. Defendants attempting to avoid criminal convictions based upon marijuana use for medicinal purposes raise the affirmative defense of necessity. There is wide disparity among the states in affording criminal defendants the medical necessity defense in marijuana use, possession or cultivation prosecutions. The decision often hinges on the presence or absence of therapeutic research acts, and judicial interpretation thereof. A different rationale pervades in states where the legislature has never enacted a therapeutic program.

Necessity is customarily defined as a "controlling force; irresistible compulsion; a power or impulse so great that it admits no choice of conduct. That which makes the contrary of a thing impossible."⁶⁶ The necessity defense originated in the common law, and is alternately referred to as the "necessity," "choice of evils," or "competing harms"

the New York program:

1. The commissioner shall obtain marijuana through whatever means he deems most appropriate, consistent with regulations promulgated by the national institute on drug abuse, the [FDA] and the [DEA] and pursuant to the provisions of this article.

2. If, within a reasonable time, the commissioner is unable to obtain controlled substances pursuant to subdivision one of this section, he shall conduct an inventory of available sources of such drugs, including but not limited to the New York state police bureau of criminal investigation and local law enforcement officials. Said inventory shall be for the purpose of determining the feasibility of obtaining controlled substances for use in the program. Upon conducting said inventory, the commissioner shall contract with the available source for the receipt of controlled substances.

3. The commissioner shall cause such marijuana to be transferred to a hospital for distribution to the certified patient pursuant to this article.

⁶⁵ S. 6744, 54th Leg., Reg. Sess. § 1 (Wash. 1996).

⁶⁶ BLACK'S LAW DICTIONARY 1030 (6th ed. 1990).

defense.⁶⁷ Where the finder of fact determines that a defendant meets the elements of the necessity defense,⁶⁸ they deem the act, though a violation of the word of the law, to be lawful.⁶⁹

Most states having a medical marijuana therapeutic use program have rejected allowing the medical necessity defense, relying on existing research acts to provide a lawful alternative for defendants.⁷⁰ Typical of such rejection is *Kauffman v. State*, where a paraplegic defendant presented the defense.⁷¹ Kauffman endured intense pain from uncontrollable muscle spasms and crippling symptoms⁷² and his prescribed medication was ineffective to alleviate his symptoms.⁷³ Marijuana was the only substance Kauffman found that relieved his pain.⁷⁴ The trial court refused to allow a medical necessity defense and Kauffman was convicted for unlawful possession and sentenced to prison for ten years.⁷⁵

The Alabama legislature adopted the common law of England, and with it the defense of necessity, "so far as it is not inconsistent with the Constitution, laws and institutions of this state"⁷⁶ The appellate court noted, however, that the legislature precluded assertions of the medical necessity defense when it enacted the Controlled Substances Therapeutic Research Act.⁷⁷ Relying on Minnesota precedent, the court held that research act " 'provisions demonstrate that the legislature has specifically addressed and determined the possible medical uses of marijuana.' "⁷⁸

⁶⁷ Michael J. Yaworsky, Annotation, *Driving While Intoxicated: "Choice of Evils" Defense that Driving Was Necessary to Protect Life or Property*, 64 A.L.R. 4TH 298, § 1a n.2 (1995).

⁶⁸ See *infra* text accompanying notes 113 & 130 for the elements to establish a necessity defense, as interpreted by two courts.

⁶⁹ George C. Blum, Annotation, *Defense of Necessity, Duress, or Coercion in Prosecution for Violation of State Narcotics Laws*, 1 A.L.R. 5TH 938 (1995).

⁷⁰ Such reliance is questionable, due to most programs' dependence on federal cooperation that is not forthcoming, i.e., NIDA supplying marijuana for research. See *supra* text accompanying note 41.

⁷¹ *Kauffman v. State*, 620 So. 2d 90 (Ala. Crim. App. 1992), *reh'g denied*, (Ala. Crim. App. Jan. 22, 1993), *cert. denied*, *Ex parte Kauffman* (Ala. Apr. 30, 1993).

⁷² *Id.* at 90.

⁷³ *Id.* at 91.

⁷⁴ *Id.*

⁷⁵ *Id.* at 90.

⁷⁶ ALA. CODE § 1-3-1 (1996).

⁷⁷ Pub. L. No. 79-472, 1979 Ala. Acts 820, codified as ALA. CODE §§ 20-2-110 to 120 (1996).

⁷⁸ *Kauffman*, 620 So. 2d at 92-93 (quoting *Minnesota v. Hanson*, 468 N.W.2d 77, 78-9 (Minn. App. 1991)).

The court in *Minnesota v. Hanson*,⁷⁹ cited in *Kauffman*, affirmed rejection of the medical necessity defense, finding the THC Therapeutic Research Act foreclosed the defense.⁸⁰ The legislature enacted the "THC Therapeutic Research Act," finding a need for research of medical use of THC for cancer patients.⁸¹ This act remains in the Minnesota code, though synthetic THC has been available for prescription since 1986.⁸² From the outset, this statute's proclivity to misguide Minnesota courts is apparent by its failure to distinguish between marijuana and THC.⁸³

At the time of appeal, Hanson had suffered from epilepsy for 35 years.⁸⁴ Doctors had prescribed many medications, but each caused disturbing side-effects.⁸⁵ Hanson began using marijuana to treat his condition in 1975.⁸⁶

In support of the proffered defense, Hanson presented expert medical testimony of two neurologists, one specializing in epilepsy, the other in drug research and development.⁸⁷ The experts testified (1) that marijuana is "therapeutically useful in controlling epileptic seizures," and (2) Hanson had not been prescribed some recently-developed seizure medications.⁸⁸ The trial court refused to allow the defense.⁸⁹

The appellate court articulated the established rule of deference to the legislature, that "the defense of necessity is available only in situations wherein the legislature has not itself, in its criminal statute, made a determination of values. If it has done so, its decision governs."⁹⁰ The *Hanson* court went on to reason that, through its enactment of the THC Therapeutic Research Act, exempting from prosecution those who receive marijuana through the program, the legislature had deter-

⁷⁹ *Minnesota v. Hanson*, 468 N.W.2d 77 (Minn. App. 1991).

⁸⁰ *Id.*

⁸¹ MINN. STAT. § 152.21 (1996).

⁸² *Supra* note 12.

⁸³ The Act twice mentions marijuana: first, it explains that THC is the primary active ingredient in marijuana, MINN. STAT. § 152.21 subd. (1) (1996); and second, defines it to be "marijuana as defined in section 152.01, subdivision 9, and [THC], tetrahydrocannabinols or a chemical derivative of tetrahydrocannabinols, and all species of the genus *Cannabis*." MINN. STAT. § 152.21 subd. (2)(b) (1996).

⁸⁴ *Minnesota v. Hanson*, 468 N.W.2d 77 (Minn. App. 1991).

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ *Id.* at 78.

⁸⁸ *Id.*

⁸⁹ *Id.*

⁹⁰ *Id.*

mined the single exception for medical use of marijuana.⁹¹ Additionally, the court perceived a clear legislative intent to foreclose any other use of marijuana through the legislature's retention of marijuana in schedule I.⁹²

The *Hanson* court relied in part on the New Jersey Supreme Court decision in *New Jersey v. Tate*⁹³ for the proposition that enactment of a therapeutic research program signifies legislative intent to forbid the medical necessity defense.⁹⁴ The *Tate* case involved a quadriplegic defendant's claim of medical necessity for spasticity.⁹⁵ Prosecutors countered that Tate had never applied for admission to the state's therapeutic research program, a legal means to obtain relief from his symptoms, and therefore the court should deny him use of the necessity defense.⁹⁶

Testimony in the trial court established that the state's program had not begun operation due to inadequate funding, but was expected to open within approximately eight months.⁹⁷ Admission would be limited to cancer patients at first, later expanding to glaucoma patients, and eventually to include spasticity patients.⁹⁸ The trial court found no legal alternative to Tate's predicament and allowed the medical necessity defense.⁹⁹ The state appealed.¹⁰⁰

⁹¹ *Id.* at 78-79.

⁹² *Id.* at 78. The court's rationale appears flawed. The statutory exemption from criminal prosecution does not encompass possession of marijuana; it specifies THC only. MINN. STAT. § 152.21 subd. 6 (1996). The legislature transferred THC from schedule I to schedule II for purposes of the Act, but left marijuana in schedule I. The appellate court found that the legislature's actions "show conclusively that the possible medical uses of marijuana have been brought to the legislature's attention." *Minnesota v. Hanson*, 468 N.W.2d at 79. In fact, the legislature did not consider *marijuana's* medicinal value at all, and any reference to the substance appears to be, at best, excess verbiage which remains a source of great confusion.

⁹³ *New Jersey v. Tate*, 505 A.2d 941 (N.J. 1986).

⁹⁴ *Minnesota v. Hanson*, 468 N.W.2d at 78.

⁹⁵ *New Jersey v. Tate*, 505 A.2d at 942.

⁹⁶ *Id.* at 943.

⁹⁷ *New Jersey v. Tate*, 477 A.2d 462, 469-70 (N.J. Super. Ct. Law. Div. 1984).

⁹⁸ *Id.*

⁹⁹ *Id.* at 468-69.

¹⁰⁰ The New Jersey Supreme Court summarily remanded the matter to the appellate division of the superior court (which had denied the State's motion for leave to appeal) to hear the merits of the appeal. *New Jersey v. Tate*, 97 N.J. 679 (1984). The appellate division, in a brief opinion, noted that if Tate successfully defended on the basis of medical necessity at trial, "his continued use of marijuana will be justifiable . . . only until either the [TRA] makes marijuana available . . . or until the [federal program] makes tetrahydrocannabinol (THC) available . . ., whichever first occurs."

The supreme court examined the necessity defense and determined the legislature had set forth three limited criteria governing the defense:

(1) conduct is justifiable only to the extent permitted by law, (2) the defense is unavailable if either the Code or other statutory law defining the offense provides exceptions or defenses dealing with the specific situation involved, and (3) the defense is unavailable if a legislative purpose to exclude the justification otherwise plainly appears.¹⁰¹

The court applied the three factors and found the legislature contemplated possible medical uses for marijuana, determined appropriate exceptions to its criminal status, and made provision for change in status if such change became warranted.¹⁰² The majority further determined that the legislature clearly intended to exclude the defense in Tate's circumstances,¹⁰³ and, even under the common law, Tate would not prevail because he was unable to prove the absence of a legal alternative by virtue of the Therapeutic Research Act.¹⁰⁴ The court summarily dismissed the dissenters' concerns¹⁰⁵ over Tate's lack of a real alternative in the Therapeutic Research Act.¹⁰⁶ The majority found the alternative was not "unavailable," though the program had approved no applications, its funding had repeatedly lapsed, and it would not include Tate's condition any time in the near future.¹⁰⁷ The court went on, stating that even absent a therapeutic research program, marijuana was legally obtainable through the FDA for Tate's condition.¹⁰⁸ In New Jersey, as a matter of law, resorting to marijuana was not justifiable.¹⁰⁹

New Jersey v. Tate, 486 A.2d 1281 (N.J. Super. Ct. App. Div. 1984). The supreme court granted the State's motion for leave to appeal. New Jersey v. Tate, 505 A.2d 941 (N.J. 1986).

¹⁰¹ New Jersey v. Tate, 505 A.2d 941, 944 (N.J. 1986).

¹⁰² *Id.*

¹⁰³ *Id.* at 944-45.

¹⁰⁴ A prerequisite to pleading the affirmative defense of necessity. *Id.* at 946.

¹⁰⁵ *Id.*

¹⁰⁶ *Id.* at 952 n.2 (Handler, J., dissenting). Justice Garibaldi aptly noted the flaw implicit in the majority's rationale, in that, "[a]lthough there is surface appeal to the assertion that the TRA program offers such an alternative, it is refuted by reality." *Id.* at 957 (Garibaldi, J., dissenting).

¹⁰⁷ *Id.* at 946.

¹⁰⁸ *Id.*

¹⁰⁹ *Id.* The dissent crafted an extensive test it would require a defendant to meet to assert the medical necessity defense, drawing on principles of the common law defense of necessity. *Id.* at 954-55 (Handler, J., dissenting).

While the above three cases represent the typical treatment of medical necessity in states having a therapeutic use program, at the opposite end of this legal spectrum is the 1979 case of *Washington v. Diana*,¹¹⁰ where the court confronted medical necessity claimed by a defendant suffering from multiple sclerosis.¹¹¹ Relying on *United States v. Randall*¹¹² and the state's recent enactment of a therapeutic research act,¹¹³ the court held that Samuel Diana could utilize the defense. The court instructed that Diana's conviction should be set aside if he showed by a preponderance of the evidence:

(1) [he] reasonably believed his use of marijuana was necessary to minimize the effects of multiple sclerosis; (2) the benefits derived from its use are greater than the harm sought to be prevented by the controlled substances law; and (3) no drug is as effective in minimizing the effects of the disease.¹¹⁴

Reasonableness of the belief must be sustained by corroborating medical testimony.¹¹⁵ The court recognized that Washington's TRA limits medical marijuana use to alleviating the effects of cancer chemotherapy and glaucoma,¹¹⁶ but did not comment on the impact, if any, of multiple sclerosis' exclusion from maladies encompassed in the TRA.

Again in 1994, a Washington Court of Appeal determined the propriety of the medical necessity defense.¹¹⁷ Fred Cole, a repeat offender,¹¹⁸ suffered chronic back pain.¹¹⁹ The state moved to bar the medical necessity defense, alleging Cole caused the condition requiring marijuana, and failed to avail himself of legal sources of medical ma-

¹¹⁰ *Washington v. Diana*, 604 P.2d 1312 (Wash. App. 1979).

¹¹¹ *Id.*

¹¹² 104 Daily Wash. L. Rptr. 2249 (D.C. Super. Ct. Nov. 24, 1976). Robert Randall, now the head of ACT, *see supra* note 14, suffers from glaucoma and uses marijuana to relieve the intraocular pressure symptomatic of the disease. *Washington v. Diana*, 604 P.2d at 1315.

¹¹³ Controlled Substances Therapeutic Research Act, Laws of 1979, ch. 136, effective March 27, 1979 (codified as WASH. REV. CODE ANN. §§ 69.51.020-69.51.080). The act post-dated Diana's criminal act, alleged to have occurred in early 1977. *Washington v. Diana*, 604 P.2d at 1313.

¹¹⁴ *Washington v. Diana*, 604 P.2d at 1316-17.

¹¹⁵ *Id.* at 1317.

¹¹⁶ *Id.*

¹¹⁷ *Washington v. Cole*, 874 P.2d 878 (Wash. App. 1994).

¹¹⁸ *Id.* at 880. At sentencing on the previous charge, the judge told Cole, "I hope they get you a prescription for marijuana if that's the only thing that works . . . You cannot in the future grow marijuana for your own consumption without a prescription." *Id.* Within three months of sentencing, the state charged Cole with the identical offense.

¹¹⁹ *Id.*

rijuana.¹²⁰ The trial court found that Cole had failed to produce adequate evidence to support the defense.¹²¹

The appellate court found that the lower court's scrutiny of the evidence was improper.¹²² The court held, if Cole produced some evidence on each of the *Diana* factors, it was for the jury sitting as trier of fact, rather than the judge hearing a motion in limine, to balance Cole's need to preserve his health against the state's interest in regulating marijuana, and decide if the marijuana use was justified.¹²³ Washington's TRA was neither raised by the state nor discussed by the court in its analysis.

With few exceptions, the case opinions show the courts' propensity to refuse the medical necessity defense. However, the cases also evince a pattern of making medicinal marijuana available to citizens in some tangible way. When courts foreclose the defense, it is often on the rationale that marijuana is theoretically available to individuals through legal means.

Decisional law in states that do not legislatively recognize any medicinal use for marijuana similarly reveals attempts to make marijuana accessible, or its possession excusable, to those for whom it is medically necessary. Three states with no therapeutic research acts have addressed the medical necessity defense since 1990: Florida, Idaho and Massachusetts.

In 1991, a Florida Court of Appeals reversed convictions of a husband and wife for marijuana cultivation.¹²⁴ The court found the couple met their burden of establishing a medical necessity defense at trial,

¹²⁰ *Id.*

¹²¹ *Id.* at 881-82. Cole testified that he was injured in 1987 and has suffered from chronic back spasms since then; he has seen five doctors and various agencies and clinics for the pain; the Department of Labor and Industry determined he was employable in 1990; prescribed medications caused debilitating side effects such as disorientation and constant sleeping; and he has requested prescribed marijuana from numerous doctors. *Id.*

The trial court applied the factors delineated in *Washington v. Diana*, 604 P.2d 1312 (Wash. App. 1979), and determined that Cole failed to establish medical necessity by a preponderance of the evidence. *Washington v. Cole*, 874 P.2d at 881-82. On motion for reconsideration, proffered evidence included testimony of Robert Randall, *see supra* notes 14 & 110, medical records and a letter from a treating physician. The court denied reconsideration, reiterating the previous findings. *Washington v. Cole*, 874 P.2d at 881-82.

¹²² *Washington v. Cole*, 874 P.2d at 882.

¹²³ *Id.* at 882-83.

¹²⁴ *Jenks v. Florida*, 582 So. 2d 676 (Fla. Dist. Ct. App. 1991).

and directed the trial court to enter a judgment of acquittal.¹²⁵

The Jenks' both suffered from the AIDS virus.¹²⁶ Upon arrest, they admitted to officers that they grew marijuana, and explained they had AIDS and used marijuana to alleviate symptoms of the virus.¹²⁷ At bench trial, stipulated medical testimony from the Jenks' physician established (1) the doctor was unable to find any effective treatment for the Jenks' nausea; (2) their nausea was so severe that, if left uncontrolled, they could die;¹²⁸ (3) marijuana was the only drug that controlled the nausea, and the doctor would prescribe it if the law allowed; and (4) the doctor was actively seeking legal marijuana for the Jenks' through the federal government.¹²⁹ The trial judge denied the medical necessity defense and found the couple guilty of cultivation.¹³⁰

The appellate court formulated the necessity defense as follows:

1. That the defendant did not intentionally bring about the circumstance which precipitated the unlawful act;
2. That the defendant could not accomplish the same objective using a less offensive alternative available to the defendant; and
3. That the evil sought to be avoided was more heinous than the unlawful act perpetrated to avoid it.¹³¹

Marijuana's schedule I classification did not preclude the Jenks' proffered defense. Specifically, the court pointed to further language in the statute, that "[n]otwithstanding the aforementioned fact that Schedule I substances have no currently accepted medical use, the Legislature recognizes that certain substances are currently accepted for certain limited medical uses in treatment in the United States but have high potential for abuse."¹³²

Medical necessity was afforded similar treatment in *Idaho v. Hastings*,¹³³ where the defendant used marijuana to ease pain associated with rheumatoid arthritis and requested a jury instruction on the de-

¹²⁵ *Id.*

¹²⁶ *Id.* at 677. Kenneth Jenks contracted AIDS from a blood transfusion and then unknowingly infected his wife, Barbara; once infected, Barbara's health rapidly declined. *Id.*

¹²⁷ *Jenks*, 582 So. 2d at 677.

¹²⁸ Over a three week span, Barbara went from 150 to 112 pounds due to continuous vomiting. Kenneth also lost weight, though not as severely. *Id.*

¹²⁹ *Id.* at 677, 678.

¹³⁰ *Id.* at 678. The trial judge was not without sympathy; he placed the Jenks' on unsupervised probation for one year and "ordered the Jenks to perform 500 hours of community service, to be discharged only by 'providing care, comfort and concern for each other.'" *Id.*

¹³¹ *Id.* at 679.

¹³² *Id.*

¹³³ *Idaho v. Hastings*, 801 P.2d 563 (Idaho 1990).

fense.¹³⁴ The trial judge refused, finding no such defense existed in Idaho law.¹³⁵ The Idaho Supreme Court declined to create a special medical necessity defense,¹³⁶ but held that Hastings could present evidence under the common law defense of necessity, comprised of elements similar to those articulated in *Florida v. Jenks*.¹³⁷ The court did not comment on the evidence except to note that its sufficiency for the necessity defense is a determination for the finder of fact.¹³⁸

In contrast to both *Jenks* and *Hastings*, in 1991 the Massachusetts Supreme Court rejected the medical necessity defense as a matter of law.¹³⁹ The court denied the request of defendant Hutchins, whom doctors had diagnosed with scleroderma¹⁴⁰ accompanied by Raynaud's phenomenon,¹⁴¹ holding:

In our view, the alleviation of the defendant's medical symptoms, the importance to the defendant of which we do not underestimate, would not clearly and significantly outweigh the potential harm to the public were we to declare that the defendant's cultivation of marijuana and its use for his medicinal purposes may not be punishable. We cannot dismiss the reasonably possible negative impact of such a judicial declaration . . . on the enforcement of our drug laws, . . . nor can we ignore the government's overriding interest in the regulation of such substances.¹⁴²

For purposes of its ruling, the court accepted the defendant's offer of proof as to his condition: that he suffers many debilitating symptoms and has been unable to work since 1978; physicians have unsuccess-

¹³⁴ *Id.* at 564.

¹³⁵ *Id.*

¹³⁶ *Id.*

¹³⁷ *Id.* at 564-65.

¹³⁸ *Id.* at 565. Such is the customary ruling of an appellate court, unlike the extraordinary ruling of *Florida v. Jenks*, directing the trial court to enter judgment of acquittal.

¹³⁹ *Commonwealth v. Hutchins*, 575 N.E.2d 741 (Mass. 1991).

¹⁴⁰ "[A] chronic disease that results in the buildup of scar tissue throughout the body. The cause . . . is not known and no effective treatment or cure has been discovered. In the most severe cases, scleroderma may result in death." *Commonwealth v. Hutchins*, 575 N.E.2d 741, 742 (Mass. 1991).

¹⁴¹ *Id.* Raynaud's Phenomenon is a problem that occurs with the blood vessels, usually arteries, causing coldness, blueness, numbing, tingling and pain in the fingers and toes it affects. NATIONAL INSTITUTES OF HEALTH, U.S. DEP'T OF HEALTH & HUMAN SERVICES, PUB. NO. 93-2263, FACTS ABOUT RAYNAUD'S PHENOMENON (1993).

¹⁴² *Commonwealth v. Hutchins*, 575 N.E.2d 741, 745 (Mass. 1991). For analysis of this decision and a persuasive argument for the impropriety of taking the "competing harms" and "governmental interest" findings away from the jury, see Todd H. Whilton, Note, *Commonwealth v. Hutchins: A Defendant Is Denied the Right to Present a Medical Necessity Defense*, 27 NEW ENG. L. REV. 1101 (1993).

fully attempted numerous medications and therapies; and the extreme effects of the disease prompted his physician to recommend invasive surgical procedures involving replacing his esophagus with other body tissue.¹⁴³ Since 1975, Hutchins used marijuana to alleviate symptoms and reported its positive effect to his physicians.¹⁴⁴ Two physicians testified that marijuana appeared to lessen Hutchins' symptoms;¹⁴⁵ another physician did not find the marijuana affected the symptoms.¹⁴⁶ The court held that evidence of necessity could not be considered until the trial court first considered "whether the harm that would have resulted from compliance with the law significantly outweighs the harm that reasonably could result from the court's acceptance of necessity as an excuse in the circumstances presented"¹⁴⁷ The court concluded that, while circumstances *can* overcome the "competing harms" test,¹⁴⁸ Hutchins' circumstances were insufficient.¹⁴⁹

In 1991, the year of the *Hutchins* decision, the Massachusetts legislature approved a controlled substances therapeutic research act.¹⁵⁰ On August 8, 1996, the Governor of Massachusetts signed a bill that provides a "prima facie defense to a charge of possession of marijuana . . . that the defendant is a patient certified to participate in a therapeutic research program . . . and possessed the marijuana for personal use pursuant to such program."¹⁵¹ While these laws will not help Mr. Hutchins—because the program does not include his disease—clearly Massachusetts, like many states, is working to make medical marijuana available to its citizens.

¹⁴³ *Hutchins*, 575 N.E.2d at 742-43, 745.

¹⁴⁴ *Id.* at 743.

¹⁴⁵ *Id.*

¹⁴⁶ *Id.*

¹⁴⁷ *Id.* at 744. In the immediately preceding paragraph, the court defined "competing harms" as a defense that "exonerates one who commits a crime 'under 'pressure of circumstances' if the harm that would have resulted from compliance with the law significantly exceeds the harm actually resulting from the defendant's violation of the law.'" *Id.* at 743-44 (emphasis added). See Whilton, *supra* note 140, for a discussion of the court's contradiction in policy.

¹⁴⁸ *Commonwealth v. Hutchins*, 575 N.E.2d 741, 744 (citing *Commonwealth v. Thurber*, 418 N.E.2d 1253 (Mass. 1981) (necessity as defense to prison escape); *Commonwealth v. Iglesia*, 525 N.E.2d 1332 (Mass. 1989) (necessity defense to charge of unlawfully carrying a firearm)).

¹⁴⁹ *Commonwealth v. Hutchins*, 575 N.E.2d at 745.

¹⁵⁰ MASS. ANN. LAWS ch. 94D, § 2 (Law. Co-op. 1996).

¹⁵¹ 1996 Mass. Adv. Legis. Serv. 271 (Law. Co-op. 1996)

C. Codification of the Defense of Medical Necessity

Ohio legislatively recognized the medical necessity defense on August 10, 1995, providing "it is an affirmative defense . . . to a charge of possessing marihuana under this section that the offender, pursuant to the prior written recommendation of a licensed physician, possessed the marihuana solely for medicinal purposes."¹⁵² The legislature approved this defense despite marijuana's schedule I status under state law.¹⁵³ The defense requires proof of a physician's *written* recommendation before an accused may successfully plead the affirmative defense,¹⁵⁴ which appears restrictive when compared with California's new law discussed below.

D. Voter Initiatives Revamp State Medical Marijuana Policy

California is the site for the newest development in medicinal marijuana law. State law provided for a Cannabis Therapeutic Research Program from 1979 until its repeal in 1984.¹⁵⁵ On November 5, 1996, California voters approved Proposition 215,¹⁵⁶ an expansive medical

¹⁵² S. 2, 121st Leg., 1st Reg. Sess. (Ohio 1995), codified as OHIO REV. CODE ANN. § 2925.11 (1996).

¹⁵³ OHIO REV. CODE ANN. § 3719.41(C)(17) (1996).

¹⁵⁴ OHIO REV. CODE ANN. § 2925.11 (1996).

¹⁵⁵ Former CAL. HEALTH & SAFETY CODE §§ 11260-11270, *added by* 1979 Cal. Stats. 300, *amended by* 1984 Cal. Stats. 417, § 1-5, repealed operative June 30, 1989 by the terms of CAL. HEALTH & SAFETY CODE § 11270 (1996 West).

¹⁵⁶ *Compassionate Use Act of 1996*, to be codified as CAL. HEALTH & SAFETY CODE § 11362.5, reads in pertinent part:

(b)(1) The People of the State of California hereby find and declare that the purposes of the Compassionate Use Act of 1996 are as follows:

(A) To ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief.

(B) To ensure that patients and their primary caregivers who obtain and use marijuana for medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction.

(C) To encourage the federal and state governments to implement a plan to provide for the safe and affordable distribution of marijuana to all patients in medical need of marijuana.

(2) Nothing in this section shall be construed to supersede legislation prohibiting persons from engaging in conduct that endangers others, nor to condone the diversion of marijuana for nonmedical purposes.

marijuana initiative. Within the scope of the initiative are diseases ranging from AIDS to migraine, and "any other illness for which marijuana provides relief."¹⁵⁷

The new law exempts medical marijuana users and their primary caregivers¹⁵⁸ from criminal prosecution for possession or cultivation of marijuana.¹⁵⁹ California law enforcement officials are uncertain how to deal with marijuana offenders in light of Proposition 215,¹⁶⁰ and invariably express concern over the obscure language of the law.¹⁶¹ The law itself invites state and federal lawmakers to develop and implement a plan for medical marijuana distribution;¹⁶² federal officials vehemently oppose such a plan.¹⁶³ Realization of federal acceptance of medical marijuana has evaded proponents for more than two decades. But with California taking the lead, federal officials fear an approaching trend across the nation, which they have vowed to fight.¹⁶⁴

On November 5, 1996, Arizona voters approved Proposition 200.¹⁶⁵

(c) Notwithstanding any other provision of law, no physician in this state shall be punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes.

(d) Section 11357, relating to possession of marijuana, and Section 11358, relating to the cultivation of marijuana, shall not apply to a patient, or to a patient's primary caregiver, who possesses or cultivates marijuana for the personal medical purposes of the patient upon the written or oral recommendation or approval of a physician.

¹⁵⁷ *Id.*

¹⁵⁸ CAL. HEALTH & SAFETY CODE § 11362.5(e) (West 1996), created by passage of Proposition 215, will provide: "For the purposes of this section, 'primary caregiver' means the individual designated by the person exempted under this section who has consistently assumed responsibility for the housing, health, or safety of that person."

¹⁵⁹ CAL. HEALTH & SAFETY CODE § 11362.5(d) (West 1996).

¹⁶⁰ *Law Enforcement Officials Fear Marijuana Law Fallout* (CNN television broadcast, November 16, 1996).

¹⁶¹ Dan Reed, *Medicinal Pot May Be Just a Pipe Dream: Prop. 215 Hasn't Made Marijuana Easier to Get*, SAN JOSE MERCURY NEWS, Dec. 2, 1996, at A1.

¹⁶² *Compassionate Use Act of 1996*, *supra* note 154.

¹⁶³ *Republicans, White House Unite to Fight New Drug Laws* (CNN television broadcast, Dec. 2, 1996).

¹⁶⁴ *Law Enforcement Officials Fear Marijuana Law Fallout*, *supra* note 160.

¹⁶⁵ *Drug Medicalization, Prevention and Control Act of 1996*, to be codified in pertinent part as ARIZ. REV., STAT. ANN. § 13-3412.01, reads:

(A) Notwithstanding any law to the contrary, any medical doctor licensed to practice in Arizona may prescribe a controlled substance included in Schedule 1 of § 36-2512 to treat a disease or to relieve the pain and suffering of a seriously ill patient or terminally ill patient, subject to the provisions of §13-3412.01. In prescribing such a controlled substance, the medical doctor shall comply with professional medical

The "Drug Medicalization, Prevention and Control Act," is broader than California's proposition 215 and would basically "medicalize" Arizona's drug policy.¹⁶⁶ Among other provisions, the Act permits doctors to prescribe not only marijuana, but other schedule I controlled substances such as heroin and LSD, to patients with serious illnesses such as glaucoma, cancer, multiple sclerosis, and AIDS.¹⁶⁷

III. HAS FEDERAL POLICY GONE UP IN SMOKE? THE CONTRADICTION BETWEEN STATE AND FEDERAL LAW AND ITS EFFECT ON FEDERAL MARIJUANA POLICY

Medicinal marijuana bills introduced in Congress repeatedly fail to reach fruition. A frequently cited reason is federal policy: the government seeks to avoid sanctioning—or appearances that it sanctions—illegal or addictive drug use, and to avoid sending the wrong message to citizens, especially our youth.¹⁶⁸ These are laudable goals. The question remains, however, whether federal medical marijuana policy furthers federal goals; or does the lack of action on this issue exacerbates the very problems federal policy seeks to avoid.

In Congress, opponents of medical marijuana frequently assert that such bills are but veiled attempts to decriminalize the drug.¹⁶⁹ Close examination reveals, however, that it is the failure to pass a federal medicinal marijuana bill that brings threateningly close the endorsement, albeit unintentional, of criminal activities.

California's bold and expansive Proposition 215¹⁷⁰ will have critical implications on law enforcement. Consider: a seriously ill Californian seeks a physician's advice on whether marijuana may alleviate his or her pain or symptoms; if a physician is of the opinion that marijuana may help, then the patient will purchase it illegally¹⁷¹ or grow his or

standards.

¹⁶⁶ *Id.*

¹⁶⁷ *Id.*

¹⁶⁸ When the Bush Administration began phasing out the Compassionate Investigational New Drug Program, James Mason, M.D., Director of the Public Health Service (PHS) commented, "[i]f it's perceived that the [PHS] is going around giving marijuana to folks, there would be a perception that this stuff can't be so bad." Michael Isikoff, *HHS to Phase Out Marijuana Program; Officials Fear Sending 'Bad Signal' by Giving Drug to Seriously Ill*, WASH. POST, June 22, 1991, at A14.

¹⁶⁹ 140 CONG. REC. E1217 (1994); accord 141 CONG. REC. E2240 (1995).

¹⁷⁰ *Compassionate Use Act of 1996*, *supra* note 156.

¹⁷¹ Selling marijuana remains criminal in California, whether or not it is for medicinal purposes. CAL. HEALTH & SAFETY CODE § 11360 (West 1996).

her own plants.¹⁷² At least initially, it is likely that patients will purchase, rather than grow, marijuana due to time involved for cultivation. If the police subsequently arrest the patient for possession or cultivation, the law provides a defense. Though legally possessed under California law, patients will regularly obtain marijuana through criminal enterprise.¹⁷³

Those states with courts recognizing the medical necessity defense similarly sanction conduct stemming from criminal activities. This practice directly conflicts with federal prohibition of marijuana use. The federal government cannot ignore state-sanctioned conduct in flagrant violation of established federal policy; yet, federal officials recognize their inability to combat personal-use violators.¹⁷⁴ Promises made by federal officials to ferret out these violators¹⁷⁵ are pure rhetoric. If federal officials truly intend to keep such promises, then their decisions allocating limited funds for law enforcement are ill-advised indeed. In part, it is the stigma of marijuana use that fuels this debate.

Federal legislators and agency administrators find themselves in a quandary by their complete rejection of medicinal marijuana. If they reschedule marijuana to be legally prescribable, federal officials risk being labeled pro-drug-use and abuse and fear increased drug abuse; if they do not reschedule marijuana, state decisional and legislative law will continue to undermine federal policy.

Clinton Administration officials recently announced the federal strategy in response to voter-approved medical marijuana laws. Physicians recommending marijuana under new state laws may face repercussions from the federal government.¹⁷⁶ Possible penalties to physicians include being excluded from federally-funded Medicaid and Medicare programs, facing federal criminal charges, and having their DEA certification—which grants the authority to prescribe controlled substances

¹⁷² Presumably, only “reasonable” amounts grown for personal medical use come within the exception. Individuals growing large crops should not fall within the purview of the act.

¹⁷³ It is manifestly unreasonable to think patients will plant marijuana seeds and wait patiently in pain for plants to grow.

¹⁷⁴ William Claibourne & Robert Suro, *Medicinal Marijuana Brings Legal Headache: Officials ‘Puzzle Through’ Conflicts Raised by Two States’ New Laws*, WASH. POST, Dec. 5, 1996, at A01.

¹⁷⁵ *Id.*

¹⁷⁶ David G. Savage & Jenifer Warren, *U.S. Threatens penalties if Doctors Prescribe Pot; Drugs: Criminal Charges, Other Sanctions Are Possible, Officials Warn California and Arizona Physicians*, L.A. TIMES, Dec. 31, 1996, at A3.

listed in schedules II through V—revoked.¹⁷⁷ The focus of the plan is strict enforcement of federal law, and officials consider it “a balanced way to respond to the propositions.”¹⁷⁸ However, the plan does little or nothing to diminish policy conflicts; to the contrary, the federal response will more likely foster litigation than clarify issues for state law enforcement. It muddies the waters.

California’s initiative exempts individuals from criminal prosecution if they have a prior written or oral physician’s recommendation for marijuana use. While the federal plan was still rumor, marijuana advocates responded that the first amendment protects a physician’s right to express an opinion, and that no federal law would be violated by recommending, rather than prescribing, marijuana.¹⁷⁹ Advocates intend to seek a federal court order enjoining enforcement of the plan.¹⁸⁰

Arizona’s initiative, on the other hand, purports to authorize physicians to *prescribe* schedule I drugs. Action by physicians pursuant to this law appears vulnerable to federal intervention.

Ironically, marijuana is not widely embraced by the medical community. Threatened federal action may prevent some physicians, who were skeptical but contemplating making recommendations, from doing so. The policy will not affect physicians already rejecting the drug as medicine, which, according to federal officials, is the majority of the medical community. In contrast, physicians convinced of marijuana’s therapeutic value—who were previously the most likely to recommend marijuana—are equally likely to rise to the challenge posed by federal officials and litigate their right to express a medical opinion. The controversy continues.

Without federal cooperation, marijuana cannot be legally prescribed, but denying physicians the ability to prescribe merely causes patients to filter medical marijuana through the criminal establishment. Federal officials must balance the implications of rigid denial of schedule II status against the law enforcement nightmare looming on the horizon.

IV. RECOMMENDATIONS

Reinforcing federal mandates and providing a consistent medical marijuana policy is a concern more readily redressible by a distribution source at the federal level. Our government already uses a Minnesota farm to supply the marijuana for the limited government distribu-

¹⁷⁷ *Id.*

¹⁷⁸ Paul Recer, *Marijuana Docs May Be Punished*, AP, Dec. 23, 1996.

¹⁷⁹ *Id.*

¹⁸⁰ Savage & Warren, *supra* note 176.

tion that exists.¹⁸¹ Congress or the DEA each has the capability and resources to develop an effective marijuana distribution program.¹⁸²

For a specified period, marijuana should be transferred to schedule II to be prescribable by physicians. The oversight agency would carry out the duty to ensure and distribute an adequate marijuana supply¹⁸³ and determine the appropriate cost payable by patients to allow for a self-supporting program. Labeling and packaging requirements, requisite to other controlled substances,¹⁸⁴ would apply to marijuana as well.

This would address several concerns leveled at Proposition 215. The program would empower only authorized physicians to prescribe the substance and the labeling requirement provides concrete evidence of lawful possession — certainly preferable to the nebulous “recommendation” language contained in Proposition 215. Moreover, this program would reduce, if not eliminate, law enforcement concerns in the wake of Proposition 215 over use of appropriate measures to detect marijuana crimes.¹⁸⁵ Prescribed medicine is easily identified and does not lend itself to a fictional defense.¹⁸⁶ It would restore private marijuana cultivation to its criminal status, as opposed to the nebulous position it occupies in California and the various jurisdictions which recognize the medical necessity defense.

¹⁸¹ See *Uncle Sam's Farm*, *supra* note 63 and accompanying text.

¹⁸² For example, during the rescheduling process for dronabinol, the DEA Administrator proposed amending the Code of Federal Regulations to impose more stringent “controls on the prescribing, administering, dispensing, and the conducting of research with Schedule II dronabinol products than those required for other Schedule II controlled substances.” Changes in Protocol Requirements, 50 Fed. Reg. 42,184 (1985) (to be codified as 21 C.F.R. pts. 1301 and 1306) (proposed Oct. 18, 1985). That proposed rule was later withdrawn, and dronabinol in sesame oil encapsulated in soft gelatin capsules was moved to schedule II, while all other forms of dronabinol remained in schedule I. Rescheduling of Synthetic Dronabinol, 51 Fed. Reg. 17,476 (1986).

¹⁸³ “The Attorney General shall determine the total quantity and establish production quotas for each basic class of controlled substance in schedules I and II to be manufactured each calendar year to provide for the estimated medical, scientific, research, and industrial needs of the United States . . .” 21 U.S.C.S. § 826 (Law. Co-op. 1984). This authority could be delegated to the chosen oversight agency.

¹⁸⁴ 21 U.S.C.S. § 825 (Law. Co-op. 1984).

¹⁸⁵ *Law Enforcement Officials Fear Marijuana Law Fallout*, *supra* note 160.

¹⁸⁶ The argument is often made that prescription marijuana is just a form of, or step toward, complete decriminalization of the drug. 142 CONG. REC. E542 (1996). This is a specious argument. One need only review other schedule II substances to see that transfer to schedule II does not signify imminent decriminalization: opium, morphine, cocaine, methadone, amphetamine and methamphetamine. Schedules of Controlled Substances, 21 C.F.R. § 1308.12 (1996).

Additionally, such a pilot program would remove much of the variability over which the DEA Administrator expressed concern because it would derive plants from a single source, utilizing consistent soil, geographic, irrigation, harvesting and storage conditions.¹⁸⁷ Transferring marijuana to schedule II would also make it more accessible for private research studies,¹⁸⁸ which in turn will provide scientific data upon which to evaluate its therapeutic potential, the lack of which is often cited as a concern of federal officials.

An appropriate pilot project must mandate specific, well-controlled and documented studies of the substance's medicinal efficacy and explore alternate means of administration. The administering agency must ensure an adequate supply of marijuana, and distribute supplies to research programs, pharmacies and physicians. Built-in sunset provisions, severable for each disease for which studies are completed, would be an appropriate safeguard. That is, if studies show marijuana is ineffective as a treatment for AIDS wasting syndrome, the sunset provision would remove that disease from the program, thereby canceling authorization of physicians to study the effects of or prescribe marijuana for that ailment. This would additionally address concerns over widespread use under the guise of medical use.

To be effective, this pilot program must be of sufficient duration to allow performance of adequate scientific studies, and include a sufficient number of subjects.¹⁸⁹ The DEA has been intimately involved in the medical marijuana debate from the beginning; the Administrator enumerated many concerns with existing studies in his 1992 final order. Thus, it is appropriate for DEA officials to have a prominent role in implementing this pilot program. Their active participation will ensure the adequacy and reliability of performed studies.

¹⁸⁷ Currently, federal marijuana resources are severely limited. (Letter from Alan I. Leshner, Ph.D., Director, NATIONAL INSTITUTE ON DRUG ABUSE, to Donald I. Abrams, M.D., Director, UCSF AIDS PROGRAM (April 19, 1995) (visited Dec. 31, 1996) <<http://www.mpp.org/rejection.html>>.) Additional contracts are necessary to carry out a program of the magnitude proposed, but plant consistency will be superior when the marijuana is obtained through a limited number of known sources.

¹⁸⁸ The registration process for research with schedule II drugs is considerably less rigorous than the mind-boggling process required for schedule I drugs. *See* 21 C.F.R. § 1301.32-33 (1996).

¹⁸⁹ As stated by the DEA Administrator, "[s]ophisticated epidemiological studies of marijuana use in large populations are required, similar to those done for tobacco use." *Marijuana Scheduling Petition*, 57 Fed. Reg. 10,499 (1992).

CONCLUSION

Various states have begun a trend of making medicinal marijuana available to citizens through narrow therapeutic research programs, judicial interpretation of public policy and the necessity defense, voter initiatives, or legislation — each in contravention of federal policy. The effect of this conflict between state and federal laws includes increasing difficulty for law enforcement, federally-induced ignorance of whether the substance has actual therapeutic value, and indirect state sanction of criminal enterprise.

To end this war within the war on drugs, the federal government must create a pilot program for the distribution and study of medical marijuana. If federal officials do not take the initiative now to provide scientific means to accept or reject medical marijuana, they are not only wasting taxpayer dollars fighting challenges to their policy, but, more important, blindly depriving citizens of a potentially beneficial medication.

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