LIST OF ATTACHMENTS

ATTACHMENT A – December 17, 2004 Zoning Administrator Interpretation

ATTACHMENT B – Memo from the City of Rocklin Police Chief

ATTACHMENT A

ZONING ADMINISTRATOR INTERPRETATION

DATE: December 17, 2004

CODE SECTION: 17.16.010

QUESTION NEEDING INTERPRETATION: What use does a medical marijuana dispensary fall into?

INTERPRETATION:

A medical marijuana dispensary is a use where medical marijuana is made available to or distributed to a primary caregiver, qualified patient, or a person with an identification card in compliance with California Health and Safety Code Section 11362.5 et seq. Currently the Pasadena Zoning Code does not have a specific use classification for this use.

Under 17.16.010, the Zoning Administrator is permitted to determine whether a specific use shall be deemed to be within one or more use classifications or not within any classification in the Zoning Code. The Zoning Administrator may determine that a specific use is not within a use classification if its characteristics are substantially incompatible with those typical of uses named within the classification.

A medical marijuana dispensary does not fit perfectly into a specific land use category. However, it is similar to a pharmacy which is classified as a retail sales use. In further researching this, I have found that medical marijuana facilities in other California communities have had secondary impacts on the health, safety, and welfare of the community. The City of Rocklin's Police Chief has researched this issue by speaking to other cities about this use. In his research he contacted the police departments for Roseville, Oakland, Hayward, Fairfax, and Lake County. His memo was included in a report to the Rocklin City Council and was dated July 13, 2004. It enumerates various issues that show that the characteristics of a medical marijuana dispensary are not compatible with the use, retail sales. These issues included:

- Street level dealers trying to sell to those going to the dispensary at a lower price;
- People smoking marijuana in public around the facility;
- Complaints of illegal drugs being sold inside the dispensaries;
- Street criminals in search of drugs are robbing medical use patients for their marijuana; and
- Thefts and robberies around the location drug commerce.

These impacts are not ones commonly associated with pharmacies or retail sales. Therefore, it is my interpretation that this use does not fall into any use classification within the Zoning Code and is not an allowed use within the City.

Denver E. Miller
Zoning Administrator

ATTACHMENT B

CITY OF ROCKLIN

MEMORANDUM

DATE: July 13, 2004

TO: Honorable Mayor and Members of the City Council

FROM: Mark Siemens, Chief of Police

RE: Medical Marijuana Dispensaries

SUMMARY AND RECOMMENDATION:

California voters approved Proposition 215, which codified into the California Health and Safety Code the "The Compassionate Use Act of 1996". The intent of Proposition 215 was to enable people in need of marijuana for medical purposes the ability to obtain and use it without fear of criminal prosecution under limited, specific circumstances.

Some entrepreneurial types have used the situation to spawn commercial endeavors to distribute marijuana to those who qualify under "The Compassionate Use Act of 1996". Unfortunately, the proposition is unclear about the details of doctor recommendation and how the substance is distributed. The act was specifically developed far enough away from traditional prescriptive drug distribution systems and activities to be distinguishable from them. This was done purposefully as prescription medicines are controlled by the Federal Food and Drug Administration and in Federal law the use, possession, transportation and distribution of marijuana is specifically illegal. At any rate, the use of marijuana under "The Compassionate Use Act of 1996" is not the issue before the Commission. At issue here is the location of commercial distribution of marijuana businesses and the potential impacts to the public health, safety and welfare of our community.

RECOMMENDATION: The City of Rocklin is now addressing how the issue of commercial marijuana distribution under the guise of Proposition 215 will be allowed to impact our community. Staff has given the Council three options as discussed in the Planning Department Staff Report for consideration. As the Police Chief, I recommend the change to zoning law, specifically the approval of the Ordinance adding Section 17.04.348 and adding Subpart D to Section 17.64.030 of the Rocklin Municipal Code regarding medical marijuana dispensaries to avoid the impacts experienced in other communities.

DISCUSSION:

The City of Rocklin has not experienced the impacts of medical marijuana dispensaries but other communities have. I contacted some of the law enforcement leaders where marijuana dispensaries were located and learned the following:

I spoke with Joel Neves, Chief of Police of Roseville, about the impacts from the dispensary there. Chief Neves related the following impact based on his observations and discussions with involved parties including the owner/operator of the marijuana dispensary.

CITY OF ROSEVILLE IMPACTS:

- Street level dealers trying to sell to those going to the dispensary at a lower price
- People are smoking marijuana in public around the facility
- People coming to the community from out of town and out of state to obtain Marijuana (Nevada State, San Joaquin County, etc)
- Marijuana DUI by people who have obtained from dispensary
- At least one burglary attempt into building

I also spoke with Rich Word, the Chief of Police for the City of Oakland about the impacts of Marijuana Dispensaries in his city. Chief Word has extensive experience with marijuana dispensaries.

CITY OF OAKLAND IMPACTS:

- Large criminal element drawn to the dispensary location
    - Marijuana dealers who have a doctor recommendation are purchasing from the dispensary and then conducting illegal street sales to those who do not have a recommendation.
    - Street criminals in search of the drugs are robbing medical use patients for their marijuana as they leave the dispensary.
    - Thefts and robberies around the location are occurring to support the illegal and legal (by State law) drug commerce.
- Chief Word mentioned that a shoe repair business next door to a dispensary has been severely impacted because of the concentration of criminals associated with the dispensary. The shoe repair business owner is considering shutting down his business.
- They had more than 15 total in city, now limited to four by ordinance but control is not very strong. The fines are too small to control a lucrative business.
- Most of the crime goes unreported because the users do not want to bring negative publicity to the dispensary.
- The dispensaries have an underground culture associated with them.
- At least one of the dispensaries had a doctor on the premises giving recommendations on site for a fee.

- One location was a combination coffee shop and dispensary and marijuana was sold in baked goods and for smoking.
- Dispensary management has told the police that they cannot keep the criminal element out.

During early July, I was also able to contact several other law enforcement agencies that had experience with marijuana dispensaries. I received the following information:

CITY OF HAYWARD IMPACTS:
In conversation with Acting Chief Lloyd Lowe, I learned the following:

- Hayward has three dispensaries total, two legal under local ordinance and one illegal.
- They have had robberies outside the dispensaries
- They have noticed more and more people hanging around the park next to one of the dispensaries and learned that they were users in between purchases
- They have problems with user recommendation cards – not uniform, anyone can get them
- One illegal dispensary sold coffee, marijuana and hashish – DA would prosecute the hashish sales and possession violations after arrests were made
- They have received complaints that other illegal drugs are being sold inside of dispensaries
- The dispensaries are purchasing marijuana from growers that they will not disclose
- Chief Lowe believes that the dispensaries do not report problems or illicit drug dealers around their establishments because they do not want the police around
- Hayward Police arrested a parolee attempting to sell three pounds of marijuana to one of the dispensaries
- Hayward has recently passed an ordinance that will make marijuana dispensaries illegal under zoning law in 2006

LAKE COUNTY IMPACTS
In conversation with Sheriff Rod Mitchell, I learned the following:

- Lake County has one marijuana dispensary in Upper Lake
- The biggest problem is the doctor, close by the dispensary who is known across the state for being liberal in his recommendations to use marijuana for a fee of $175
- Many "patients" come from hours away and even out of state, Oregon specifically, to get a marijuana recommendation from the doctor
- Upper Lake has been impacted by the type of people coming for the marijuana doctor and dispensary. Citizens report to the Sheriff that the people coming to Upper Lake for marijuana look like drug users ("dopers").

Rodriguez, Jane

From: Paul Little [plittle4pasadena@earthlink.net]
Sent: Monday, March 21, 2005 12:45 PM
To: city_council@cityofpasadena.net
Cc: jrodriguez@cityofpasadena.net
Subject: Fw: Web Comments to Paul Little

-----Forwarded Message-----
From: cityweb-server@cityofpasadena.net
Sent: Mar 21, 2005 12:44 PM
To: plittle@cityofpasadena.net
Subject: Web Comments to Paul Little

Subject: Medical Marijuana
Name: Mary Pfeiffer
Address: 1565 Las Lunas St
City: Pasadena
State: CA
Zip: 91106
Email: Shaman@altrionet.com
Date: Monday, 21. March 2005

Comment

Dear Mr Little, I have just finished reading this morning's Star News, article on banning "pot-clubs". This type of superstitious fear tactics has just got to stop. The reason marijuana is not prescribed more often in this area is because it's unavailability in a legitimate manner.. I am a hospice nurse, I've seen one too many old men spend their final hours nauseated and vomiting while their distressed and helpless families watched. One too many women with cancer who linger, bone-thin and languid, as their loved ones beg for "something" to make them feel better. And I, like so many nurses and doctors, have witnessed the therapeutic relief that many such patients experience after using marijuana. Their illnesses become less miserable, their difficult deaths are made more tolerable. And those reasons explain precisely why the federal government's relentless attempts to bar patients from access to medical marijuana constitute both cruel and unusual crimes against us all. They are wrong-headed and politically driven obsessions, not compassionate advisements intended to relieve human suffering. It boggles my mind to think that our government officials are spending so much time and money to obstruct the use of a medication that might actually help cancer patients tolerate their chemotherapy, AIDS patients gain a little weight, glaucoma patients suffer less. We have yet to see any data from the Feds that explains why medicinal marijuana should be excluded from pharmacy shelves that already contain morphine and codeine -- as well as a host of other drugs for conditions like heart disease or seizures that have longer potential side effect profiles. Do what you can to make marijuana available through the pharmacy..then we wouldn't have to deal with these "scary" pot-clubs"..that only "dopers" use.. sheeze...must politics always feed the uncompassionate self rightious this type of misinformation? Thank you Mary Pfeiffer

03/21/2005
6.B. (8:00 P.M.)

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Phone: 510-251-1856
Fax: 510-251-2036

Americans for Safe Access

March 18, 2005

Dear City Councils and County Boards of Supervisors,

The last year has seen a significant increase in the number of medical cannabis collectives and cooperatives opening in California. Until recently, most were concentrated in the San Francisco Bay Area. We are now seeing dispensaries opening in larger numbers in Southern California, suburban cities, and rural areas.

This trend presents a respectable challenge for California City Councils and County Boards of Supervisors to create and adopt ordinances, which have both the patients and the public in mind. Regardless of the federal government's position on medical marijuana, it is up to the states, and their counties and municipalities to determine what is best for the health of its people. Appropriately, and in accordance with SB 420, state lawmakers have placed the responsibility with cities and counties to take action to regulate the provision of medical cannabis to California's estimated 150,000 qualified patients.

The goals of local regulation should be: (1) to ensure that there is a safe, reliable, and sanctioned source of medication for legal patients in the community; and (2) to protect the community from nuisance activity or other harm that may result from the improper operation of these organizations. With these goals in mind, Americans for Safe Access (ASA) is working with policy makers in cities and counties across the state to develop sensible and compassionate regulations for medical cannabis collectives and cooperatives that comply with both the letter and the spirit of the law.

It is reasonable for civic leaders to have concerns about medical cannabis programs. This is an entirely new area of activity, but there are successful precedents to follow. It is important to remember that medical cannabis is legal under state law, and that we are developing regulations for access to legitimate medicine. For this reason, policy makers must approach the issue of collectives and cooperatives from the standpoint of regulating a condoned and legal activity. As such, it is more appropriate for city councils, boards of supervisors or even departments of public health to create and propose regulations than it is for law enforcement.

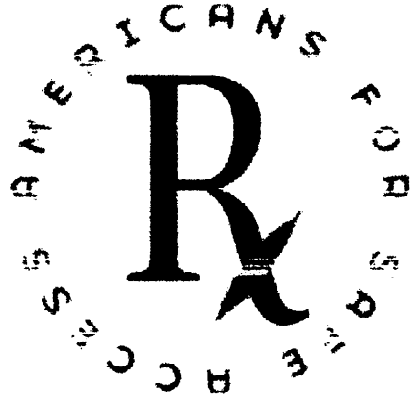
03/21/2005
6.B. (8:00 P.M.)

Medical cannabis collectives and cooperatives can be a positive part of a community. When properly regulated and operated, they will prevent lawful patients from unnecessary and potentially harmful entanglements with illicit markets or law enforcement. They will also be a key element in ensuring that patients are legally qualified and well educated about their rights and responsibilities under the law. Most importantly, a medical cannabis collective or cooperative will be a place that community members suffering from AIDS, cancer, multiple sclerosis, and other serious illnesses can find support, safety, and healing.

We need the participation of the entire community to develop and successfully implement effective regulations for medical cannabis collectives and cooperatives. Our hope is that the voices of patients, caregivers, and advocates will be heard along side those of law enforcement and civic leaders. ASA is committed to help local governments find ways to implement the will of California voters while protecting the interests of patients and their neighbors. Thank you for taking the time to create safe and legal access for California's most vulnerable citizens. Our knowledgeable staff is available to answer any questions you may have. Please do not hesitate to call.

Regards,

Steph Sherer
Executive Director
Americans for Safe Access
(510) 251-1856
www.SafeAccessNow.org



Why Dispensing Collectives and Cooperatives are Critical to Ensuring Safe Access to Medical Marijuana and Why They Must Be Condoned and Protected

March 14, 2005

AMERICANS FOR SAFE ACCESS

www.SafeAccessNow.org

Introduction
As municipalities and counties throughout the state of California grapple with whether or not and how to regulate the provision of medical marijuana, it is important to review the rights of patients and caregivers as well as the role of state and local government to protect such conduct.

In 1996, California voters approved Proposition 215, the Compassionate Use Act (CUA) in order to "ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes...in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine or any other illness for which marijuana provides relief"[1]

Not as commonly recognized, the CUA also encourages "federal and state governments to implement a plan for the safe and affordable distribution of marijuana to all patients in medical need of marijuana."[2] In 2003, the California legislature passed SB 420, helping to clarify the rights of patients and specify their legal protection. The legislation states that patients and caregivers are "not subject to criminal liability."

California voters and legislators were the first in the nation to respond to the needs of medical marijuana patients by providing them safe access to the medicine that they need to alleviate their suffering and, in some cases, keep them alive.

State and Local Government is Responsible for its Peoples' Health and Welfare
Traditionally, the states have taken the responsibility for the health and welfare of their citizens. It follows that counties and municipalities prescribe further policy with its most vulnerable citizens in mind. While the federal government does maintain control over many aspects of medicine and treatment in the U.S., over-riding autonomy exists on the part of the states to control the health and welfare of their people.

It is reasonable to expect many patients in California to either cultivate their own medical marijuana or find a caregiver who will do it for them. However, there are many patients in both urban and rural areas that cannot effectively do either. Given the estimated 75,000 patients in California,[3] there are thousands of people who rely on local dispensing cooperatives and collectives for their supply of medicine.

It is incumbent on the state, its counties and municipalities to implement fully the CUA and SB 420 with the health and welfare of its people paramount. If regulation of dispensing facilities is necessary at all, it should be developed with the leadership of local departments of health in cooperation with city and county governments. An effort spearheaded by California Department of Public Health will implement voluntary ID card programs in all counties in 2005. This will certainly help to further foster the safety and protection of patients and caregivers. However the ability exists today to develop and adopt reasonable policies around the provision of medical marijuana. Cities and Counties that have established moratoriums on the provision of medical marijuana need not wait for instruction from some other authority. Local departments of health must be involved in this aspect of the health and welfare of its citizens and the time to act is now.

Law Enforcement is Obligated to Uphold State Law in the Protection of its Citizens
Local law enforcement is prohibited by state law from enforcing federal proscriptions of conduct, which has been decriminalized by the State. Local law enforcement is charged with enforcing state

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[1] Cal. Health & Safety Code Section 11362.5(b)(1).
[2] Ibid.
[3] Cal. NORML Estimates Over 75,000 Medical Marijuana Patients in California, 2004, http://www.canorml.org/

law, which allows for the use and provision of medical marijuana. Local law enforcement officials may not refuse to enforce state medical marijuana law due to a purported conflict with federal law.[4]

Under our federalist system of government, the states, rather than the federal government, are entrusted to exercise a general police power for the benefit of their citizens.[5] Due to this constitutional division of authority between the federal government and the states, the State of California may elect to decriminalize conduct, such as medical marijuana activity, which remains illegal under federal law.[6] Even if law enforcement officers take a personal position on any conflict between state and federal law, they are bound to uphold only state law.[7]

The California Supreme Court stated in *People v. Mower* (2002) that the State of California is responsible for enforcement of its own marijuana laws, and not those of the federal government.[8] Under California medical marijuana law, patients and caregivers are exempt from prosecution by the state[9] regardless of federal law.

In *People v. Tilehkooh* (2003), the California courts "long ago recognized that state courts do not enforce the federal criminal statutes."[10] The same court also stated that "the federal criminal law is cognizable as such only in the federal courts."[11] In *People v. Kelly* (1869), it was determined that "State tribunals have no power to punish crimes against the laws of the United States as such. The same act may, in some instances, be an offense against the laws of both, and it is only an offense against the State laws that it can be punished by the State, in any event."[12]

It is California's public policy to encourage state and federal governments to implement a plan to provide for the safe and affordable distribution of marijuana to all patients in medical need of marijuana.[13] Given the right of seriously ill Californians to use and obtain medical marijuana, and that

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[4] Section 3.5 of Article III of the California Constitution provides:
An administrative agency, including an administrative agency created by the Constitution or an initiative statute, has no power:
(a) To declare a statute unenforceable, or refuse to enforce a statute, on the basis of it being unconstitutional unless an appellate court has made a determination that such statute is unconstitutional;
(b) To declare a statute unconstitutional;
(c) To declare a statute unenforceable, or to refuse to enforce a statute on the basis that federal law or federal regulations prohibit the enforcement of such statute unless an appellate court has made a determination that the enforcement of such statute is prohibited by federal law or federal regulations.

[5] *See United States v. Morrison* (2000) 529 U.S. 598, 618 & n.8 ["the Founders denied the National Government [the police power] and reposed [it] in the States" "the Constitution reserves the general police power to the States"]; *United States v. Lopez* (1995) 514 U.S. 549, 566 ["The Constitution . . . withhold[s] from Congress a plenary police power"]; *Metropolitan Life Ins. Co. v. Massachusetts* (1985) 471 U.S. 724, 756 ["The States traditionally have had great latitude under their police powers to legislate as to 'the protection of the lives, limbs, health, comfort, and quiet of all persons'"] [quotation omitted]; *Whalen v. Roe* (1977) 429 U.S. 589, 603 n.30 [recognizing states' broad police power to regulate the administration of drugs by health professionals]; *Jacobson v. Massachusetts* (1905) 197 U.S. 1, 24-25 (1905) ["The authority of the State to enact [public health legislation] is . . . commonly called the police power -- a power which the State did not surrender when becoming a member of the Union under the Constitution"].

[6] *See People v. Tilehkooh* (2003) 113 Cal.App.4th 1433, 1446.

[7] *See Lockyer v. City and County of San Francisco* (2004) 33 Cal.4th 1055, 1094; see also ibid. at 1107 ["a local executive official has no authority to impose his or her personal view on others by refusing to comply with a ministerial duty imposed by statute"].

[8] *See People v. Mower* (2002) 28 Cal.App.4th at 457, 465 n.2.

[9] Cal. Health & Safety Code Sections 11362.5, 11366, 11366.5 & 11570.

[10] *See People v. Tilehkooh*, (2003) 113 Cal.App.4th at 1445 & 1447.

[11] *See People v. Tilehkooh*, (2003) 113 Cal.App.4th at 1445 n.13.

[12] *See People v. Kelly* (1869) 38 Cal. 145, 150

[13] Cal. Health & Safety Code Section 11362.5(b)(1)(c).

California law provides for public policy that encourages the provision of that medicine, dispensing collectives and cooperatives should be encouraged and protected.

The U.S. Supreme Court Decision Will Not Impact California Medical Marijuana Law

The Supreme Court will rule in 2005 on *Ashcroft v. Raich*[14] to determine the extent to which the federal government has authority to interfere in the conduct of medical marijuana patients like plaintiffs Angel Raich and Diane Monson. If *Raich* is overturned, giving the federal government constitutional authority under its limited power to regulate interstate commerce and the activity of marijuana cultivation for personal medical use, the decision will not alter state law. Conduct currently protected under California law, as defined above, will continue to be enforced regardless of the Supreme Court's ruling.

The purpose of the federal Controlled Substances Act (CSA), in regulating conduct concerning marijuana, was not meant to regulate the practice of medicine or put limits on states' ability to regulate and care for the health and safety of their people. Nothing indicates that Congress wished to give the federal government (Drug Enforcement Administration) control over the practice of medicine by way of the CSA. The CSA itself recognizes that states are the primary regulators of the practice of medicine.[15] Ultimately, the CSA was never meant to preclude the judgment of sovereign states on what constitutes the legitimate practice of medicine.

A number of cities and counties are currently addressing the issue of regulating dispensing collectives and cooperatives. Many current moratoriums have been adopted to limit the establishment of such facilities until such time that the Supreme Court can rule on *Raich*. While it is reasonable to allow time for the development of sensible and fair policies, it is unnecessary and unduly burdensome to patients to wait for the High Court's decision.

It is also unacceptable to use any ruling in *Raich* to ban dispensing collectives and cooperatives, as that activity would be contrary to the spirit and intent of the CUA and SB 420. The ruling will not say anything about the regulation or operation of medical marijuana cooperatives and collectives and, as such, City Councils and Boards of Supervisors are still bound to uphold and enforce California law, including the provisions of the CUA and SB 420. The ruling will neither force nor authorize local law enforcement officers to arrest patients and caregivers. The ruling will not mandate the closure of dispensing collectives and cooperatives around the state. The ruling will not declare California's medical marijuana law unconstitutional or invalid. In fact, neither collective nor cooperative dispensaries are at issue in *Raich* at all.

Regardless of any assumed constitutional authority held by the federal government, California officials do not have the authority under state law to seek to enforce more expansive federal law, and the federal government may not constitutionally compel state law enforcement agents to enforce its law. In *Printz v. United States* (1997),[16] the federal court ruled that "the Federal Government may neither issue directives requiring the States to address particular problems, nor command the State's officers, or those of their political subdivisions, to administer or enforce a federal regulatory program...the Constitution contemplates that a State's government will represent and remain accountable to its own citizens." In *New York v. United States*, (1992),[17] the federal court stated that, "we have always understood that even where Congress has the authority under the Constitution to pass laws requiring or prohibiting certain acts, it lacks the power directly to compel the States to require or prohibit those acts."

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[14] *See Raich v. Ashcroft*, 352 F.3d 1222 (9th Cir. 2003), *cert. granted by Ashcroft v. Raich*, 124 S.Ct. 2909 (June 28, 2004).
[15] *See* Federal Controlled Substances Act, 21 USC Section 823(g)(2)(H)(i)(II).
[16] *See Printz v. United States*, 521 U.S. 898, 935 (1997).
[17] *See New York v. United States*, 505 U.S. 144, 166 (1992).

Cities and Counties Must Expeditiously Allow for Dispensing Collectives and Cooperatives
Medical marijuana patients must have safe and legal means to get their medication, rather than being forced to rely on the illicit drug market. Most patients do not have the means or ability to grow their own, and many patients do not know of people willing to act as caregiver and grow the medicine for them. SB 420 further restricts patients' access to their medicine by requiring that patient and caregiver reside in the same county.[18]

The reasonable alternative is an entity that exists solely to provide medicine to qualified patients, much as a pharmacy exists to provide prescribed medication. Dispensing collectives and cooperatives meet this need. Therefore, in order to fully implement the CUA and SB 420, cities and counties must expeditiously allow for these facilities providing safe access for medical marijuana patients.

Whether choosing to regulate or not, cities and counties must allow for the establishment of medical marijuana dispensing collectives and cooperatives. It is also critically important that patients remain at the center of any adopted policy providing for safe and affordable access to their medicine. As such, the leadership of local departments of health should be at the helm of developing sensible policies. In their development, consideration should be made to allow for onsite marijuana consumption as well as the sale of non-medical marijuana-related items. It is unnecessary to over-regulate these facilities and doing so can prove detrimental to the best interests of the patient.

Nothing currently prohibits cities and counties from allowing collective and cooperative dispensaries from existing. It is abundantly clear that public officials and local law enforcement are bound to uphold and enforce state law. In fact, evidence of the need to address this issue regardless of any decision by the U.S. Supreme Court can be found in the ordinances already developed and adopted by 10 counties and 10 cities within California. Therefore, local government must act expediently to implement medical marijuana law, thereby condoning and protecting the formation of dispensing collectives and cooperatives throughout the state.

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[18] *See* Health & Safety Code Section 11362.7(d)(2).

Testimony of Claudia Jensen, M.D.
for the House Committee on Government Reform
Subcommittee on Criminal Justice, Drug Policy and Human Resources

Marijuana and Medicine:
The Need for a Science Based Approach

April 1, 2004

I am very grateful for the opportunity to submit my written testimony to the Members of the Subcommittee of the Committee on Government Reform. Thank-you. I am also thankful for the opportunity to have five minutes of oral presentation time. I apologize for the summarized nature of this report as I was invited to speak on March 16, 2004 and have had minimal time to prepare. I pray Members of the Subcommittee as well as the Committee on Government Reform will read the enclosed information with the intention of considering actual social reform.

I am a 49 year old mother of two teenage daughters, and a Physician educated at the University of Arkansas for both undergraduate and medical schools. I studied Pediatrics at the University of California at Irvine, completing my Internship and Residency training in 1981. I have a total of 23 years working as a Pediatrician, first as an HMO physician with Cigna HealthPlans, then in private practice in Ventura, CA.[1]

I currently work two days a week in a small community clinic servicing a poor patient population, three days a week in my own private office and I teach first year medical students one day a week at the University of Southern California Keck School of Medicine. I have always had a reputation for being a patient advocate since the very beginning of my training.

Congressman Souder has asked me to discuss my "practice" of recommending "marijuana" for use by "dozens of patients, including children with ADD.[2]" This "practice" is a direct consequence of California's passing of the Compassionate Use Act of 1996[3] (Health and Safety Code 11362.5, also known as Proposition 215) and my compliance with the law as determined by State of California[4] and the United States Supreme Court.[5] The people of the State of California, as well as a majority of Americans[6] believe marijuana should be available to patients who are ill or in pain. Contrary to popular opinion and scientific fact, it is the position of the Government of the

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[1] Jensen, Claudia, M.D., Curriculum Vitae, 2004.
[2] Invitation to speak to the Subcommittee on Criminal Justice, Drug Policy and Human Resources, March 16, 2004.
[3] Health and Safety Code 11362.5, entire text.
[4] State of California, Senate Bill 420.
[5] Conant v. McCaffrey, No. C97-00139 WHA, subsequent Ninth Circuit Court of Appeals Decision and Supreme Court refusal to hear the appeal.
[6] Stein, Joel, "The Politics of Pot", Time, November 4, 2002, page 57.

United States of America that there are no known medicinal uses for marijuana[7]. Consequently, marijuana has been classified as a drug as dangerous as heroin and LSD. This is clearly contrary to the truth. At this time, while Americans are dying overseas and at home in the service of protecting democracy, it is even more critical for the American people to have faith in the information being disseminated by government. Enclosed in this testimony are references to corroborating documents refuting the position of the Drug Enforcement Administration, the official watchdog of American Physicians and the medications they prescribe, and an agency under the guardianship of this committee. (A full copy of all of the references will be provided to Chairman Souder upon my arrival at the Hearing.)

AN ABBREVIATED HISTORY OF CANNABIS

"Marijuana" is a term used to describe the plants *Cannabis sativa* and *Cannabis indica.* Cannabis has been used as a medication for over five thousand years. "The first evidence of the medicinal use of cannabis is an herbal published during the reign of the Chinese Emperor Chen Nung five thousand years ago. It was recommended for malaria, constipation, rheumatic pains, 'absentmindedness,' and 'female disorders.'"[8] Marijuana was also recommended for "senile insomnia", analgesia, as a sleep inducer (hypnotic), in the treatment of gastric ulcers, morphine addiction, migraine headaches, tic douloureux, depression, and epilepsy.[9] "The first Western physician to take an interest in cannabis as a medicine was W. B. O'Shaughnessy, a young professor at the Medical College of Calcutta, who had observed its use in India."[10] Dr. O'Shaughnessy studied cannabis in India, then introduced the medication to European and American physicians. It was listed in the "United States Dispensatory" in 1854. By 1860, American doctors used cannabis to treat a multitude of medical problems "including tetanus, neuralgia, dysmenorrhea (painful menstruation), convulsions, the pain of rheumatism and childbirth, asthma, post-partum psychosis, gonorrhea, and chronic bronchitis. As a hypnotic (sleep-inducing drug) he compared it to opium"..."The whole effect of hemp being less violent, and producing a more natural sleep."[11]

Cannabis was readily dispensed by U.S. pharmacies until after passage of the Marihuana Tax Act of 1937, a strictly political shuffle motivated by Harry Anslinger under the Federal Bureau of Narcotics. Anslinger's campaign was orchestrated through an aggressive, but largely hysterical media campaign.[12] During Congressional hearings to decide the fate of cannabis as a medication, a spokesman from the American Medical Association, W. C. Woodward, M.D., J.D. noted, "It has surprised me, however, that the

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[7] US.GOV website, House of Representatives, Committee on Government Reform, Subcommittee on Criminal Justice, Drug Policy and Human Resources, News, "Chairman Souder wants you to know that Marijuana is not Medicine" plus related links.

[8] Grinspoon, Lester, M.D., Bakalar, James B., Marihuana, the Forbidden Medicine, Yale University Press, New Haven and London, 1997, page 3.

[9] Ibid., page 6.

[10] Ibid., page 4.

[11] Ibid., page 5.

[12] Ibid., pages 7-8.

facts on which these statements have been based have not been brought before this committee by competent primary evidence."[13] From the very beginning, the choice to ignore the medical therapeutics of cannabis was politically motivated, not based on truth.

In 1970, during a period of great upheaval in America, Congress passed the Comprehensive Drug Abuse Prevention and Control Act (also called the Controlled Substances Act), which placed cannabis in a category called "Schedule I." Schedule I drugs "have no known medicinal use" by definition.[14] Clearly, this was not scientifically based as evidenced by 5000 years of a longitudinal outcome-based folk medicine "study" (i.e. people from all over the world have been using cannabis for medicine after 5000 years of observation of how it works.) Nonetheless, cannabis became illegal with the passage of both these Acts, neither of which was based on scientific facts.

Subsequent to the Controlled Substances Act, several patients applied for special permission to use cannabis to relieve pain and suffering. As there was, indeed, evidence to support the use of cannabis as a medication, Federal drug agencies granted "Investigational New Drug" permits to patients to use marijuana medicinally. The Federal Government took over the dispensing,[15] of marijuana to several sick people and established a cannabis farm in Mississippi. Today there are seven Americans who continue to receive prescriptions of marijuana from the U.S. Government sent to them in the U.S. Mail.

In 1988, Francis L. Young, J.D., and Administrative Law Judge for the Drug Enforcement Administration reviewed the medical literature on Cannabis. "Based upon the foregoing facts and reasoning, the administrative law judge concludes that the provisions of the Act permit and require the transfer of marijuana from Schedule I to Schedule II. The Judge realizes that strong emotions are aroused on both sides of any discussion concerning the use of marijuana. Nonetheless it is essential for this Agency, and its Administrator, calmly and dispassionately to review the evidence of record, correctly apply the law, and act accordingly."[16] He *ordered* the DEA to change the classification of Cannabis such that patients could gain legal access through their physicians. The DEA disobeyed Judge Young and ignored his order. There were no enforcement measures available to force the DEA to comply.

The Compassionate Use Act of California ("Proposition 215") was passed in 1996. In it, patients who are "seriously ill Californians" are given the right to seek their physician's approval to use cannabis to aid in the treatment of their illnesses. Since passage of the act, much legislation has ensued. California lawmakers subsequently put into law a corollary to the Compassionate Use Act. Senate Bill 420 provides for systems to aid Law Enforcement in the compliance with California Law H&S Code Section 11362.5. Additional litigation resulted in a decision protecting patients and physicians from

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[13] Ibid., page 9.
[14] Op. cit.,
[15] "Medical Pot Users Win Key Ruling",
[16] United States Department of Justice Drug Enforcement Administration, Docket No. 86-22, September 6, 1988

interference in their relationships. The Supreme Court of the United States of America has upheld the right of autonomy in this matter for both patients[17] and physicians[18].

Although it is the Law, and although the Law has been supported by the Supreme Court, many enforcement measures have been meted out on both patients and physicians to try to prevent them from complying with California State Law. Many patients have lost their medicine and been subjected to criminal prosecution. William Eidelman, M.D. lost his license to practice medicine. Miriam ("Molly") Fry, M.D. lost her right to write prescriptions for antibiotics and everything else. The grandfather of the Medical Marijuana movement, Tod Mikuriya, M.D., was investigated at great length by the Medical Board of California and subsequently fined $75,000 for his care of medical marijuana patients.[19] Although no patient has complained to the Medical Board about my medical care, I am also under investigation for my care of three patients.

Many physicians who have medical marijuana patients in their practices are currently under investigation although the Medical Board of California's policy clearly states physicians are not to be unduly harassed: "The Board seeks to provide greater guidance to physicians to enable them to participate appropriately in the implementation of Proposition 215, while meeting their professional and ethical obligations under the relevant standard of care. Adherence to such guidance by both physicians and Medical Board enforcement staff will ensure that physicians are not investigated merely because they have issued recommendations for marijuana use to patients. Investigations must be based on information received by the Board which provides a reasonable basis to believe that the physician is not adhering to acceptable medical practice standards when making the recommendation."[20]

In fact, the Medical Board of California has not lived up to its own standards. Not only are the doctors being investigated, frequently without just cause, but physicians have benefited from no guidance from the Medical Board, whatsoever. Physicians evaluate whether a patient is ill and determine if the risk/ benefit ratio of using any medication warrants condoning the patient's use of the drug or not. Examining risk/ benefit ratios in the care of patients is exactly what physicians have been trained to do. It's our job.

Instead of trusting licensed physicians to make educated decisions regarding patient care, the Medical Board depends on its enforcement branch to attend to the physicians who care for medical marijuana patients. No physicians with the Medical Board of California have any experience or training in the management of this highly complex patient population. The care of Medical Marijuana patients is a specialty and requires much greater skills in many areas than does the traditional practice of medicine. The physicians of the California Cannabis Research Medical Group[21] have carved out

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[17] "Court Accepts Medical Pot Use", Los Angeles Times, July 19, 2002.
[18] "Medical Pot Use Given a Boost", Los Angeles Times, December 17, 2003.
[19] Ventura County Star, "Doctor could lose license over marijuana", July 14, 2003.
[20] Medical Board of California, Action Report, www.medbd.ca.gov, July, 2003.
[21] Gardner, Fred, O'Shaughnessy's, Journal of the California Cannabis Research Medical Group, "Cannabis Specialists Agree on Health History Questionnaire," Spring, 2004, page 2.

accepted Practice Guidelines, but they would greatly benefit from a cooperative relationship with the Medical Board rather than the current adversarial relationship. Doctors in the State of California are afraid to learn about how to use cannabis. In the eight years since passage of the Compassionate Use Act, only two educational programs for physicians have been presented.[22],[23]

Books have been written on the details of the history of cannabis. They are filled with facts, data, mystery, descriptions of maltreatment and calls for governmental reform. More and more literature is being published annually. Scientific studies documenting the safety and efficacy of "cannabinoids" (cannabis compounds) are being published (mostly in extra-American journals) with increasing frequency. The "medical marijuana movement" has evolved from a "grass roots" endeavor to become a progressively better organized demand for social reform. In the absence of a totalitarian government, the Medical Marijuana Movement will continue to flourish because its premise is exposing the misrepresentations about cannabis in the pursuit of compassion for sick people.

THE SCIENCE OF CANNABIS AS A MEDICATION

Even the government of the United States of America has documented the safety and efficacy of cannabis compounds in the treatment of chronic pain, neurological and movement disorders, nausea and vomiting, Glaucoma, appetite stimulation/ cachexia,[24] Wasting Syndrome, spasticity, Multiple Sclerosis, Tourette's Syndrome, Epilepsy, and Alzheimer's Disease.[25] A thorough review of the Institute of Medicine Report (a partial text is included in references) and the National Institutes of Health Report (included in references) clearly identify medicinal uses for marijuana sprinkled among the disclaimers about how it would be nice to do more research.

"Since oral delta-9 *THC has some analgesic activity*, it is highly likely that smoked marijuana has some analgesic activity in some kinds of clinical pain,"[26] is a direct quote from the NIH report. That's it. There is the science in review by a group of analysts who are clearly not part of the Medical Marijuana Movement. That statement alone warrants an order to the Drug Enforcement Administration to correct the mistake of labeling cannabis "without medical benefit". But, in fact, the entire report documents repeatedly that cannabis compounds in all formulations have medicinal benefit.

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[22] "Cannabis Therapy: Science, Medicine and the Law", University of California at San Francisco, San Francisco, CA, June 10, 2000.
[23] "Perspectives on the Clinical Application of *Cannabis Sativa* and *Cannabis Indica*", University of Southern California Keck School of Medicine, Los Angeles, CA, February 13, 2004.
[24] Ad Hoc Group of Experts, NIH.GOV, "Workshop on the Medical Utility of Marijuana. Report to the Director, National Institutes of Health", February 19-20, 1997, pages 1-30.
[25] Joy, Janet E., Watson, Stanley J., Jr. Benson, John A., Jr., Editors, Marijuana and Medicine Assessing the Science Base, Institute of Medicine, National Academy Press, Washington, D.C., 2003, http:books.nap.edu/catalog/6376.html, pages 137-191.
[26] Ibid., page 19 ("Analgesia: 2. What are the major unanswered scientific questions?")

"In conclusion, the available evidence from animal and human studies indicates that cannabinoids can have a substantial analgesic effect."[27] The IOM Report clearly refutes the position of the DEA in classifying Cannabis as a Schedule I drug. At the very worst, Cannabis should be included in the Schedule II classification (known medicinal uses with high abuse potential) along with cocaine and amphetamines.

In addition to the U.S. Government funded reports, a panoply of books have been written on the medical efficacy of cannabinoids. Of the many, I use Dr. Grinspoon's, Dr. Earleywine's and Dr. Russo's the most.[28,29,30]. (Dr. Earleywine has provided a copy of his book for the Committee.) Lynn Zimmer, Ph.D. and John P. Morgan, M.D.have published an excellent evaluation of the myths about marijuana.[31] Even the most cursory perusal of these texts reveals the great depth of science behind the use of cannabinoids in medicine.

Also available to review to discover the details about pharmacology, biochemistry, clinical uses and safety/ efficacy profiles of cannabinoids are *hundreds* of published scientific articles. I ran a literature search through the library at the University of Southern California Keck School of Medicine and printed hundreds of pages of recent studies documenting many therapeutic trials documenting the effectiveness of cannabis. I have attached a few as addenda to this testimony.

One article from the German literature, describes the "endogenous cannabis receptors" in the human body.[32] That is, human nerve cells and immune cells have pockets of tissue, like keyholes to a lock, whose sole responsibility is to bind to cannabis compounds. This discovery resulted in a search for an "endogenous" key-like compound produced by the body to plug in to those little locks. The discovery of the "endocannabinoid" (cannabis-like compounds produced in the body naturally), *Anandamide* has led researchers on a further quest to develop synthetic cannabinoids for use in medicine. There are over 483 natural compounds in the cannabis plant, with more than 66 "cannabinoids" (a distinctive class of compounds found only in the cannabis plant). Many cannabinoids function like delta-9 THC (tetrahydrocannabinol) to some degree. Many do not.

Perhaps the most important reason to value the use of cannabis as a medication is because of the testimonials from American citizens who have personally witnessed relief from suffering because of the ability to use cannabis as a medication.[33] We tend to undermine

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[27] Op. cit., Joy, Janet E., page 145.
[28] Op. cit., Grinspoon.
[29] Earleywine, Mitch, Ph.D., Understanding Marijuana A New Look at the Scientific Evidence, Oxford University Press, Oxford, New York, 2002, pages 1-317.
[30] Russo, Ethan, M.D., Grotenhermen, Franjo, M.D., Editors, Cannabis and Cannabinoids Pharmacology, Toxicology, and Therapeutic Potential, The Haworth Integrative Healing Press, New York, London, Oxford, 2002, pages 1-427.
[31] Zimmer, Lynn, Ph.D., Morgan, John P., M.D., Marijuana Myths Marijuana Facts, The Lindesmith Center, New York, San Francisco, 1997, pages 1-233.
[32] Pertwee, R. G., Forsch Komplementarmed, "Cannabis and Cannabinoids: Pharmacology and Rationale for Clinical Use", 1999;6 (suppl 3):12-15.
[33] CBS News, "Recipe for Trouble", CBSNEWS.com, March 7, 2002 12:21:49, pages 1-2.

these stories as "anecdotal", suggesting that a single patient's experiences are not that critical to care about. Many prefer to pretend these patients are merely lying, or manufacturing statements so that they can "get high." As a physician with twenty-three years experience caring for the sick and suffering, I find this attitude disrespectful and un-Christian (I beg forgiveness from those who are offended by my religious orientation.) If there is just one person who is truly benefited from the use of cannabis, it should not be denied to them. It is clearly inhumane and a violation of that poor soul's "right to life, liberty and the pursuit of happiness" to be forbidden access to *any medication* that can relieve his/her torment.

CANNABIS AND ATTENTION DEFICIT DISORDER (ADD)

Attention Deficit Disorder is a neuropsychiatric disorder which affects 3-7% of American children and 3-4% of adults.[34] ADD has three subtypes: Inattentive, Hyperactive and Combined. Patients with ADD or its partner ADHD (Attention Deficit Hyperactivity Disorder) have difficulty with the executive management of their ability to attend to tasks. They frequently and inappropriately have difficulty focusing, listening attentively, completing homework and projects, organizing tasks and activities. Many are forgetful ("absentminded" in archaic terminology), impatient, fidgety, overly active, talkative, intrusional and have difficulty in engaging in quiet play.

There are multiple variations on the syndrome, but approximately 70% of people who suffer from ADD also experience other neuropsychiatric problems, including mood disorders (15-75%) especially depression, antisocial disorders (23-64%) including oppositional-defiant behavior disorder, anxiety (8-30%), and learning disabilities (6-92%.)[35] ADD/ ADHD can be an extremely debilitating problem and generates untold cost to society. Studies suggest incarcerated criminals have a disproportionate incidence of ADD/ ADHD, up to 40% in some studies.[36]

From my experience, it is the adolescents who seem to be having the greatest difficulty in coping with ADD. A teenager with difficulty focusing, listening attentively, completing homework and projects, organizing tasks and activities who is also forgetful ("absentminded"), impatient, fidgety, overly active, talkative, intrusional and has difficulty in engaging in quiet play is likely to have social and academic problems. This is particularly true if the adolescent also experienced life events resulting in him/ her having a poor self image. Adolescents with mood disorders (15-75%) especially depression, antisocial disorders (23-64%) including oppositional-defiant behavior

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[34] Brown, Thomas E., Ph.D., "Recognizing ADHD: Neurobiology, Symptoms, and Treatment, New Approaches to ADHD: Addressing Patient Needs From a Whole-life Perspective, Pragmaton Office of Medical Education supported by an unrestricted education grant from Eli Lilly and Company, 2001, page 3.

[35] Spencer, Thomas J., M.D., "ADHD in Children and Adults: Diagnosis and Comorbidity Issues", New Approaches to ADHD: Addressing Patient Needs From a Whole-life Perspective, Pragmaton Office of Medical Education supported by an unrestricted education grant from Eli Lilly and Company, 2001, page 13.

[36] McCallon, M.D., T. Dwaine, "If He Outgrew It, What Is He Doing in My Prison?", http://add.org/images2/prison.htm, March 25, 2004, pages 1-3.

disorder, anxiety (8-30%), and learning disabilities (6-92%.)[37] can be dangerous. ADD/ ADHD can be an extremely debilitating problem and generates untold cost to society.

Patients with ADD/ ADHD frequently need medication to be able to function normally in society. Unfortunately, amphetamines are the most commonly used drugs to treat ADD in the United States today. Amphetamines can have very undesirable side effects. They can contribute to increased seizure activity, mental illness, cachexia and malnutrition, insomnia and severe behavior disorders. Only 70% of children with ADD respond well to amphetamines, anyway. The use of amphetamines in already emotionally impaired and academically challenged adolescents is not the best idea. Yet, Americans spend more than a billion of dollars every year buying legal amphetamines for their children who have ADD.

The more amphetamines we sell in the U.S., the more amphetamines we need to manufacture. The more amphetamines we manufacture, the more amphetamines can leak into the black market. Amphetamines in the black market fund crime. And they are addictive. Amphetamine users crave more and more drug. Amphetamine abuse is a serious problem in America, and we should limit amphetamine manufacture and distribution, *especially* for use in children and adolescents.

The other legal drugs used to treat ADD are helpful in many patients, but they all have side effects in some people. Actually, the other five of the nine drugs used to treat ADD in this country haven't even been scientifically tested to find out if they are effective treatments for ADD in children.[38,39] These are drugs for depression and high blood pressure, and they all have bad side effects in some people. Yet, doctors all over America write prescriptions for depression and high blood pressure medications to treat ADD in children. Even though those drugs have not been tested scientifically, if they do help the child, it is not uncommon to use a drug "off label"[40] I support the physician's right to be able to try them.

Although not all adolescents with ADD become violent while taking amphetamines, enough are emotionally impaired to warrant having a medication available, like cannabis, whose specific side effect is to make adolescents more peaceful. We really don't need another Columbine. With the help of knowledgeable physicians, adolescents who are suffering with ADD can have access to a medication that can help them function more normally in society while at the same time helping them to be more tranquil rather than more agitated, sleepless, irritable and anorexic. Because all medicines used to treat ADD have side effects, even cannabis, it is better to use any medication only if it is truly necessary; and only under the guidance of an *experienced* physician. Of all the drugs used to treat ADD, cannabis has the least number of serious side effects.[41,38]

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[37] Op. cit., Spencer, Thomas J., M.D., page 13.
[38] Op. cit., Brown, Thomas E., page 14.
[39] Thomson's Physician's Desk Reference, Fifty-eighth Editions, 2004, multiple pages.
[40] Thomson's Physician's Desk Reference, Fifty-eighth Editions, 2004, Page 3295 under "General Information."
[41] Physician's Desk Reference for Herbal Medicines, First Edition, Medical Economics Company, New Jersey, 1998, pages 712-714.

There are hundreds of case reports of patients who report improvement of their ADHD with Cannabis.[42] There is evidence in the laboratory to show cannabinoids are effective in treating rats with ADHD.[43] We need more research to define which routes of administration (oral seems preferable clinically), dosing, strain types to use, etc. Unfortunately, no pharmaceutical companies are motivated to spend the money on research and the United States Government has a monopoly on the available (poor quality) marijuana and research permits.

THE PROBLEM DEFINED

The problem of using Cannabis as a medication is not an issue of morality. It is immoral to deprive sick people of any medication that can help them.[44]

The real problem with allowing patients to use Cannabis as a medication is *economic*s.

If Cannabis were approved for use in just the ADD/ ADHD market alone, it could significantly impact the $1 Billion a year sales[45] for traditional ADD/ ADHD pharmaceuticals. Why would anyone want to give their child an expensive pill (averages about $100 a month)[46] with unacceptable side effects if s/he could just go into the backyard, pick a few leaves off a plant and make a tea for him/ her instead? Multiply those numbers by the tens of medical diagnoses that are effectively treated by Cannabis (for example chronic pain, which is a much bigger business than the treatment of ADD; or Glaucoma, or Multiple Sclerosis, etc) and it is easy to see the pharmaceutical industry would suffer beyond calculation.

We currently have the most expensive pharmaceuticals in the world, largely because American citizens are funding the research and development of new drugs. What company would want to invest the money in R & D if the expected revenues could be diminished by a plant able to be grown in the backyard? It's a serious and real problem. Of course, some companies would adapt. For example, Eli Lilly Pharmaceuticals manufactured a Tincture of Cannabis in the 1920's.[47] Perhaps Lilly would be wise to begin R & D in Cannabinoids to try to beat the foreign markets (e.g. GW Pharmaceuticals in Great Britain.) Perhaps Lilly's $575 million profit in the fourth

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[38] See 38 above.

[42] Gardner, Fred, "Which Conditions are Californians Actually Treating With Cannabis?", O'Shaughnessy's, Journal of the California Cannabis Research Medical Group, Summer, 2003.

[43] Adriani, Walter, et.al., "The spontaneously hypertensive-rat as an animal model of ADHD: evidence for impulsive and non-impulsive subpopulations," Neuroscience and Biobehavioral Reviews, 27 (2003(pages 639-651

[44] Clark, Peter A., "The Ethics of Medical Marijuana: Government Restrictions vs. Medical Necessity", Journal of Public Health Policy, (2001?), Volume 21, Number 1, pages 40-60.

[45] Attention Deficit Disorder Help Center, "Drug Concerta, Atomoxetine, Metadate CD, Ritalin LA, Focalin; The New Meds.", http://www.add-adhd-help-center.com/newsletters/newsletter_31dec02.htm.

[46] Jensen, Claudia, M.D., Telephone survey of local pharmacies, 2004.

[47] See photograph of Tincture of Cannabis and letter from Parke-Davis dated June 19, 1968.

quarter, 2001[48] and other annual profits could be invested in less risky business (although pharmaceuticals don't appear to be too risky at this time. If Cannabis stays off the market, pharmaceuticals are more secure.)

Two other American traditions would suffer if Cannabis were reclassified as (at worst) a Schedule II drug. It is highly likely Americans who could use Cannabis more would use alcohol and tobacco less. Most Cannabis users I have interviewed are not daily alcohol or tobacco consumers; and this seems to be a consensus among the Physicians who actually manage Medical Marijuana patients. Rarely do patients use other illicit drugs, although most of them have a history of having tried other drugs in their lifetimes.

But the real economic catastrophe to be expected if Cannabis is reclassified would be to the Law Enforcement and Judicial branches of government. "According to ONDCP, the $18.822 Billion spent by the federal government on the drug war in 2002 breaks down as follows:..."

"...Domestic Law Enforcement: $9.513 Billion (50.5% of total)
Interdiction: $2.074 Billion (11.0% of total)
International: $1.098 Billion (5.8% of total)
In other words, $12.686 Billion in 2002 was directed to supply reduction, i.e. law enforcement (67.4% of total.)"[49]

"Nearly eight cents of every dollar spent by State and local governments in 1999 was for justice activities."[50] And, as long as Cannabis is classified Schedule I, the Federal Government will be forced to continue to spend money on investigating, arresting, prosecuting, incarcerating, and "rehabilitating" medical marijuana users. The marijuana smokers of America (some 4.2% of the population, and the numbers actually rose since the "War on Drugs" has begun) will continue to funnel $10.6 billion annually into the black market to buy marijuana.[51] That is, *10.6 Billion Dollars* are spent funding criminals selling marijuana in this country, and the American people are paying it.

CONCLUSION: What Should We Do?

Tell the truth. Cannabis does not fit into the category "no known medicinal use."

Enforcement procedures should be implemented to carry out Judge Young's 1988 orders to the Drug Enforcement Administration. Marijuana should actually be rescheduled as

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[48] "Prozac's slippage cuts Lilly's earnings", The Indianapolis Star, January 25, 2002, http://www.indystar.com/library/factfiles/business/companies/lilly/stories/2002_0125.html, page 1.
[49] Office of National Drug Control Policy, "National Drug Control Strategy: FY 2003 Budget Summary" (Washington, DC: Office of the President, February 2002), Table 2, page 6 as reported by Drug War Facts at http://www.drugwarfacts.org/marijuan.htm.
[50] Gifford, Sidra Lea, US Department of Justice, Bureau of Justice Statistics, Justice Expenditure and Employment in the United States, 1999 (Washington, DC: US Department of Justice, February, 2002), page 4 as reported by Drug War Facts at http://www.drugwarfacts.org/marijuan.htm.
[51] "Changing the Way Americans Think About Marijuana Talking Points", http://reform.house.gov/CJDPHR/News/DocumentSingle.aspx?DocumentID=1692 plus attachments.

Schedule III because of its safety profile, but Schedule II would be more honest than what it is now.

Research grants should be awarded to investigators with the intention of producing studies to define how to use cannabis effectively.

Systems should be developed to divert the $10.6 billion Americans spend on marijuana annually into Public Health, Law Enforcement (to guard the crops and distribution), American farmers (to grow the medicine), to Pharmaceutical Industries to promote research and development on smoke-less delivery forms, and to the tobacco giants to manage the smoked products. The American farmers employed should preferably have previous experience in the cultivation and processing of Cannabis as the "medicine" being produced at the Mississippi farm reportedly is embarrassingly low quality. All of the funds could be administered through a "Tax Stamp" system which could feasibly generate $0.50 per gram of Cannabis sold.

We as a nation should value the truth about marijuana. It is the only compassionate thing to do. When law enforcement is freed from mercilessly targeting sick people, it can focus on hard drugs, like methamphetamine and cocaine.

The truth is: Americans should never have to be afraid of the law if they need a medication to relieve pain and suffering.

Thank God in California the law protects patients from being punished for using a medication that helps them. Thank God that the Supreme Court Justices of the United States of America have their eyes open to the truth. I pray that the Committee on Government Reform will take action. Please ask them to do so.

Use **Refresh** below to get the most recent results.

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[Navigation

1996 General Election Returns for

Ballot Propositions

A Special Note Regarding Post-Election Updates

As of Dec 18 at 8:35 am -- 100.0 % precincts reporting (25273 / 25273)

Propositions	Yes Votes	Pct.	No Votes	Pct.	
204 * Water Bond	6,019,951	62.9	3,560,084	37.1	[View map]
205 * Jail Bond	3,834,745	40.6	5,606,214	59.4	[View map]
206 * Veterans' Bond	4,993,677	53.6	4,330,354	46.4	[View map]
207 * Friv. Lawsuits	3,206,350	34.2	6,163,645	65.8	[View map]
208 * Com Cause Limit	5,716,349	61.3	3,612,813	38.7	[View map]
209 * CCRI	5,268,462	54.6	4,388,733	45.4	[View map]
210 * Minimum Wage	5,937,569	61.5	3,724,598	38.5	[View map]
211 * Security Fraud	2,414,216	25.6	6,997,003	74.4	[View map]
212 * CalPIRG Limit	4,539,403	49.1	4,694,166	50.9	[View map]
213 * Unins. Drivers	7,278,167	76.9	2,194,380	23.1	[View map]
214 * Health Care Reg	3,886,699	42.0	5,358,331	58.0	[View map]
215 * Marijuana	5,382,915	55.6	4,301,960	44.4	[View map]
216 * Health Reg-Fees	3,540,845	38.7	5,593,589	61.3	[View map]
217 * Top Tax Bracket	4,575,550	49.2	4,723,873	50.8	[View map]
218 * Prop. Tax Limit	5,202,429	56.6	3,996,702	43.4	[View map]

* - Proposition is winning

* - Proposition is losing

03/21/2005
6.B. (8:00 P.M.)

Favorable Medical Marijuana Polls

Nationwide Public Opinion Polls

72 percent of respondents agreed with the statement, "Adults should be allowed to legally use marijuana for medical purposes if a physician recommends it."
POLL: **AARP**
DATE: **November 2004**
Sample Size: **1,706**

80 percent of respondents supported allowing [illegible] to "legally use marijuana for medical purposes."
[illegible]: **Time Magazine/CNN Poll**
DATE: **October 2002**
Sample Size: **1,007**

70 percent of respondents answered affirmatively to the question, "Should the use of medical marijuana be allowed?"
POLL: **Center for Substance Abuse Research**
DATE: **January 2002**
Sample Size: **N/A**

73 percent of respondents supported allowing doctors "to prescribe marijuana."
POLL: **Pew Research Center Poll**
DATE: **March 2001**
Sample Size: **1,513**

73 percent of respondents said they "would vote for making marijuana legally available for doctors to prescribe." Top
POLL: **Gallup**
DATE: **March 1999**
Sample size: **1,018**

60 percent of respondents suppor

03/21/2005
6.B. (8:00 P.M.)

| Text of Proposed Law | This - 215 | Argument in Favor |

Analysis of Proposition 215

by the Legislative Analyst

BACKGROUND

Under current state law, it is a crime to grow or possess marijuana, regardless of whether the marijuana is used to ease pain or other symptoms associated with illness. Criminal penalties vary, depending on the amount of marijuana involved. It is also a crime to transport, import into the state, sell, or give away marijuana.

Licensed physicians and certain other health care providers routinely prescribe drugs for medical purposes, including relieving pain and easing symptoms accompanying illness. These drugs are dispensed by pharmacists. Both the physician and pharmacist are required to keep written records of the prescriptions.

PROPOSAL

This measure amends state law to allow persons to grow or possess marijuana for medical use when recommended by a physician. The measure provides for the use of marijuana when a physician has determined that the person's health would benefit from its use in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or "any other illness for which marijuana provides relief." The physician's recommendation may be oral or written. No prescriptions or other record-keeping is required by the measure.

The measure also allows caregivers to grow and possess marijuana for a person for whom the marijuana is recommended. The measure states that no physician shall be punished for having recommended marijuana for medical purposes. Furthermore, the measure specifies that it is not intended to overrule any law that prohibits the use of marijuana for *nonmedical* purposes.

FISCAL EFFECT

Because the measure specifies that growing and possessing marijuana is restricted to medical uses when recommended by a physician, and does not change other legal prohibitions on marijuana, this measure would probably have no significant state or local fiscal effect.

| Text of Proposed Law | This - 215 | Argument in Favor |

03/21/2005
6.B. (8:00 P.M.)

WHO QUALIFIES AS A PHYSICIAN?

Prop. 215 applies to physicians, osteopaths and surgeons who are licensed to practice in California. It does not apply to chiropractors, herbal therapists, etc. For a list of medical cannabis specialists, see the California NORML website. Under Prop. 215, physicians are required to state that they "approve" or "recommend" marijuana. Physicians are not allowed to "prescribe" marijuana, as federal law restricts drug "prescriptions."

WHAT ILLNESSES ARE COVERED?

Prop. 215 lists "cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, *or any other illness* for which marijuana provides relief." It qualifies this by stating that its purpose is "to ensure that **seriously ill** Californians have the right to obtain and use marijuana." A recent appellate court decision in *People v. Spark* ruled that the question of whether the patient's medical condition is "serious" is to be made by a physician only. Physicians have recommended marijuana for hundreds of indications, including such common complaints as insomnia, post-traumatic stress, PMS, depression, and substance abuse.

WHERE CAN MARIJUANA BE SMOKED?

SB420 disallows marijuana smoking in no smoking zones, within 1000 feet of a school or youth center except in private residences; on school buses, in a motor vehicle that is being operated, or while operating a boat. Patients are advised to be discreet or consume oral preparations in public. Some state colleges have refused to allow medical marijuana on campus, even in designated smoking areas; the legality of these bans is disputed.

CAN I USE MARIJUANA ON THE JOB?

SB420 does not require accommodation of medical use of marijuana at any place of employment. Under *Mower*, patients may have a strong argument in state court that medical marijuana recommendations should be respected. However, employers have broad discretion to reject job applicants in pre-employment tests. Prop 215 is no defense where drug testing is required under federal regulations. If you must take a drug test, the best defense is a Marinol prescription.

PRISONERS AND PROBATIONERS

SB420 allows probationers, parolees, and prisoners to apply for permission to use medical marijuana. However, it does not require correctional facilities to accommodate medical marijuana use by prisoners or arrestees.

WHAT ABOUT CHILDREN?

Children under 18 should have parental consent for medical marijuana.

WHEN ARE RECOMMENDATIONS VALID?

Under Prop. 215, a recommendation is valid so long as the doctor says it is. However, SB420 requires ID cards to be renewed annually, and many police refuse to recognize recommendations that are older than a year or so. Courts have ruled that patients must have a valid approval at the time of their arrest, though this can have been oral..

HOW DO I GET AN ID CARD?

Patients are not required to get an ID card to enjoy the protection of Prop. 215. All that is needed is a physician's statement saying that marijuana is "approved" or "recommended."

A state ID card will be necessary to enjoy the protections from arrest afforded under SB 420. When available (in spring 2005), these will be issued through local county health departments.

In the meantime, some counties and cities have issued ID cards of their own, which are often recognized by local law enforcement. In addition, some cannabis clubs and associated patients' groups issue their own, private cards. Local police are under no compulsion to recognize these.

SHOULD I REPORT MYSELF TO THE POLICE?

Patients are advised NOT to inform local law enforcement officials beforehand of their intent to grow medical marijuana; unfortunately, many patients have been busted after voluntarily reporting themselves!

California NORML Guide To Your Rights Under Prop. 215

03/21/2005
6.B. (8:00 P.M.)

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PROPOSITION 215, the California Compassionate Use Act, was enacted by the voters and took effect on Nov. 6, 1996 as California Health & Safety Code 11362.5. The law removes criminal penalties for personal use possession and cultivation of marijuana for medical purposes by patients (and their designated "primary caregivers") who have a physician's recommendation or approval.

SB420, a legislative statute, went into effect on January 1, 2004 as California H&SC 11362.7-.83. This law broadens Prop. 215 to transportation and other offenses in certain circumstances; allows patients to "collectively or cooperatively" cultivate for medical purposes; allows probationers, parolees, and prisoners to apply for permission to use medical marijuana; and sets limits on where marijuana may be smoked. The law also establishes a statewide, voluntary ID card system, which is supposed to be implemented by April 2005. Once it is operational, patients with ID cards will be protected from arrest provided they adhere to specified quantity limits.

HOW MUCH CAN I POSSESS OR CULTIVATE?

SB420 establishes a baseline statewide limit per patient of 6 mature or 12 immature plants, plus 1/2 pound (8 oz.) processed cannabis. Patients can be exempted from these limits if their physician specifically states that they need more. In addition, individual cities and counties are allowed to enact higher, but not lower, limits than the state standard. Local limites are posted at: www.canorml.org/prop/local215policies.html.

The legality of the limits in SB 420 has been disputed. Prior to SB 420, Prop 215 allowed patients whatever amount of marijuana they need for their medical purposes. Patients were not infrequently acquitted for personal use gardens of 100 plants or more. Some Prop. 215 advocates maintain that SB 420 cannot constitutionally limit the amount patients may legally have for personal use. This issue remains to be settled in the courts. To be safe, anyone exceeding the limits is advised to get a physician's exemption.

WHAT OFFENSES ARE COVERED?

Prop. 215 explicitly covers marijuana possession and cultivation (H&SC 11357 and 11358) for personal medical use. Hashish and concentrated cannabis, including edibles, (HSC 11357a) are also included. Transportation (HSC 11360) has also been allowed by some courts, and will be covered for state cardholders under SB 420. Within the context of a *bona fide* caregiver relationship and quantity limits, SB 420 provides qualified protection against charges for possession for sale (11359); transportation, sale, giving away, furnishing, etc. (11360); providing or leasing a place for distribution of a controlled substance (11366.5, 11570).

WHO IS PROTECTED BY PROP. 215?

Patients with a physician's recommendation and their primary caregivers, defined as, "The individual designated by the person exempted under this act who has consistently assumed responsibility for the housing, health, or safety of that person." Examples: spouse or partner, professional caregiver or nurse. Prop. 215 does not recognize multiple caregivers (despite this, the S.F. Health Department I.D. card program allows patients to record multiple caregivers). Caregivers may have more than one patient. However, SB 420 restricts individual caregivers to **no more than one patient outside their own "city or county"** (it's not clear whether this allows multiple patients from different cities within the same county).

CAN I STILL BE ARRESTED OR RAIDED?

YES, unfortunately. There is nothing in Prop. 215 to compel police to accept a patient as being valid. Many legal patients have been raided or arrested for having dubious recommendations, for growing amounts that cops deem excessive, on account of neighbors' complaints, etc. An essential aim of the state ID card system (once it becomes effective) will be to help avoid undue arrests.

Once patients have been charged, it is up to the courts to pass judgment on their medical claim.

A landmark State Supreme Court decision, *People vs. Mower,* holds that patients have the same legal right to marijuana as to any legally prescribed drug. Under *Mower*, patients who have been arrested can request dismissal of charges at a pre-trial hearing. If the defendant convinces the court that the prosecution hasn't established probable cause that it was for other than medical purposes, criminal charges are dismissed. If not, the patient goes on to trial, and the burden is on the prosecution to prove "beyond a reasonable doubt" that the defendant was guilty. Those who have had their charges dropped may file to have their property returned, and possibly claim damages.

In many cases, police raid patients and take their medicine without filing criminal charges. In order to reclaim their medicine, patients must then file a court suit on their own. For legal assistance in filing suit for lost medicine, contact Americans for Safe Access (www.safeaccessnow.org).

WHAT ABOUT FEDERAL LAW?

Under the federal Controlled Substances Act, possession of any marijuana is a misdemeanor and cultivation is a felony.

An important new Ninth Circuit appellate court ruling, ***Raich v. Ashcroft,*** protects Prop. 215 patients from federal prosecution for the intrastate, noncommercial cultivation, possession and use of marijuana for personal medical purposes. The basis for the decisions is that personal use is outside the scope of the federal government's powers under the commerce clause of the Constitution. The *Raich* ruling is currently under appeal to the U.S. Supreme Court, with a decision expected in Spring 2005. In the meantime, it remains federal law in the Ninth Circuit, which includes the Pacific Coast states.

WHO QUALIFIES AS A PHYSICIAN?

Prop. 215 applies to physicians, osteopaths and surgeons who are licensed to practice in California. It does not apply to chiropractors, herbal therapists,

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Cannabis Patients' Cooperatives and Support Groups

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- AHHS (Alternative Herbal Health Services) 7828 Santa Monica (@ Fairfax) **West Hollywood** (323) 654-8792 call for hours.
- Medical Marijuana Farmacy 7825 Santa Monica Blvd (323) 848-7981 (**LA area** deliveries) 10am-9pm.
- LA Patients and Caregivers Group - 7213 Santa Monica Blvd, **West Hollywood** (at Formosa) (323) 882-6033 www.LAMedicalMarijuana.com
- **West Hollywood** Center for Compassionate Healing, 8921 Sunset Blvd. (310) 626-3333
- Compassionate Caregivers, 1209 N. La Brea, **West Hollywood** (323) 850-9121 open 11-9 everyday.
- **Los Angeles** Crescent Alliance for Sickle-Cell Self-Help Group (Sister Somayah) (323) 232-0935
- Trichome Healing Caregivers, 7100 Van Nuys Blvd #204, **Van Nuys** (818) 373-5000. Open 10-7 daily except Wed. - disabled access

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WHAT ILLNESSES CAN MARIJUANA BE USED TO TREAT?

Prop. 215 lists "cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, **or any other illness for which marijuana provides relief**." It qualifies this by stating that its purpose is "to ensure that **seriously ill** Californians have the right to obtain and use marijuana." A recent appellate court decision in *People v. Spark* ruled that the question of whether the patient's medical condition is "serious" is to be made by a physician only. Physicians have recommended marijuana for hundreds of indications, including such common complaints as insomnia, post-traumatic stress, PMS, depression, and substance abuse.

WHERE CAN MEDICAL MARIJUANA BE SMOKED?

SB420 disallows marijuana smoking in no smoking zones, within 1000 feet of a school or youth center except in private residences; on school buses, in a motor vehicle that is being operated, or while operating a boat. Patients are advised to be discreet or consume oral preparations in public. Some state colleges have refused to allow medical marijuana on campus, even in designated smoking areas, the legality of these bans is disputed.

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