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THE END OF THE RED QUEEN'S RACE: MEDICAL MARIJUANA IN THE NEW CENTURY

*Ruth C. Stern and J. Herbie DiFonzo **

Lately it occurs to me
What a long strange trip it's been. ¹
Robert Hunter

I. INTRODUCTION

More than forty years after the Summer of Love, marijuana still soothes and vexes the public consciousness. Research data on the therapeutic uses of cannabis continue to accumulate, adding fuel to an ongoing controversy about permissible drug use. In recent decades the contours of the debate have shifted, and adapted to the drive to legalize medicinal marijuana. But there is something eerily familiar about the rhetoric, the partisan fury, even the ubiquity of that bright green botanical logo. The Red Queen, so cheerfully quoted in the 1960s, was right: it really does take all the running you can do to stay in the same place.²

The Flower Children have long since vanished from Haight-Ashbury and Golden Gate Park. Some of their spiritual descendants migrated across the bay to what has become known as Oaksterdam, Odam for short, a downtown district that, from the late 1990s until 2004, was redolent of Amsterdam with its cannabis café culture. Established by way of California voter initiative to provide medical marijuana to authorized patients, the cafés were largely replaced with the more tightly

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1. GRATEFUL DEAD, *Truckin'*, on AMERICAN BEAUTY (Warner Bros. Records 1970).

2. LEWIS CARROLL, *THROUGH THE LOOKING GLASS* 191 (1871). Carroll's Red Queen is sharp-tongued and pedantic, a talking chess piece given to bossiness and arbitrary pronouncements. Though not often logical, she is unfailingly sure of herself.

regulated dispensaries decreed by California state law and by local ordinances.³ Oaksterdam is also home to the original Oakland Cannabis Buyers' Cooperative, which offers self-help and ID card services to medical marijuana patients.⁴ The Cooperative itself is prohibited by federal court order from distributing medical cannabis,⁵ but there are dispensaries throughout California operating openly in accordance with state and municipal laws. That these facilities exist at all is something of a modern miracle. To the federal government, and those who share its views, they are more of a modern scourge.

Although twelve other states offer legal protection to medicinal cannabis users,⁶ it is California that remains the vanguard for legal and political activism and the source of most of the news headlines. In 1996, California voters approved Proposition 215, the Compassionate Use Act, removing state-level criminal penalties for possession and use of marijuana by patients with a doctor's recommendation.⁷ A turbulent period of raids and prosecutions by the federal Drug Enforcement Agency (DEA) followed almost immediately, as did a series of federal court challenges. In 2005, the U.S. Supreme Court confirmed the federal government's hegemony over marijuana through exercise of the Commerce Clause.⁸ For more than a decade, the DEA has conducted incursions against California cannabis dispensaries in various cities. For example, in July of 2007, the DEA raided and closed ten medical marijuana facilities in Los Angeles.⁹ On July 29, 2008, fourteen DEA agents brandishing assault rifles seized medical marijuana, money, and equipment at a dispensary in Orange, California.¹⁰ On August 6, 2008, Federal narcotics agents raided and seized marijuana at four San Diego

3. S.B. 420, 2003 Leg., Reg. Sess. (Cal. 2003).

4. *United States v. Cannabis Cultivator's Club*, 5 F. Supp.2d 1086 (N.D. Cal. 1998).

5. *See id.* at 1106.

6. They are Alaska, Colorado, Hawaii, Maine, Michigan, Montana, Nevada, New Mexico, Oregon, Rhode Island, Vermont, and Washington. *See infra* notes 333-36 and accompanying text discussing state laws.

7. Compassionate Use Act of 1996, CAL. HEALTH & SAFETY CODE § 11362.5 (West 2007).

8. *See Gonzales v. Raich*, 545 U.S. 1 (2005).

9. Scott Glover, *Morro Bay Pot Dispensary Owner Found Guilty of Federal Charges*, L.A. TIMES, Aug. 6, 2008, available at <http://www.latimes.com/news/local/la-me-pot6-2008aug06,0,516054.story>; Steve Hymon, *DEA Raids 10 Pot Shops*, L.A. TIMES, July 26, 2007, at B4.

10. Eugene W. Fields, *Rifle-toting DEA Agents Raid Marijuana Store*, ORANGE COUNTY REGISTER, July 30, 2008, available at <http://www.ocregister.com/articles/adams-orange-agents-2109067-city-going>.

dispensaries.¹¹ Federal forays continued into the first weeks of the Obama administration, targeting four medical marijuana establishments in the Los Angeles area.¹² In late February of 2009 Attorney General Eric Holder announced a halt to the DEA's anti-medical cannabis campaign, citing President Obama's previously-stated support for controlled use of therapeutic marijuana.¹³ Given the current administration's reluctance to utilize federal resources to "circumvent state laws,"¹⁴ DEA policy changes may well be in the wind. Historically, however, the federal government has been medical marijuana's most intransigent foe.¹⁵

Still, California's dispensaries proliferate and thrive, with hundreds currently in operation in the state and 400 in southern California alone.¹⁶ The willingness of some doctors to furnish patients with medical authorization for marijuana use has resulted in a populous and diverse clientele, some of whom do not have diagnosed medical conditions.¹⁷ Indeed, at least one disgruntled therapeutic cannabis advocate, Scott Imler, has decried the ease with which recreational marijuana users can avail themselves of the dispensaries' offerings.¹⁸ Although proposition 215 was designed to protect legitimate medical marijuana users from criminal prosecution, "a lot of what we have now," he says, "is basically pot dealers in storefronts"¹⁹—or in vending machines.²⁰

11. Pauline Repard & Alexa Capeloto, *Three People Held in Raids at Marijuana Dispensaries*, UNION-TRIBUNE (San Diego), Aug. 6, 2008, at B3, available at <http://www.signonsandiego.com/news/metro/20080806-9999-1m6pot.html>.

12. Stephen Dinan and Ben Conery, *DEA Pot Raids Go On; President Opposes*, WASHINGTON TIMES, February 5, 2009, available at <http://www.washingtontimes.com/news/2009/feb/05/dea-led-by-bush-continues-pot-raids/>.

13. Alex Johnson, *DEA to Halt Medical Marijuana Raids*, MSNBC.COM, February 27, 2009, available at <http://www.msnbc.msn.com/id/29433708/>.

14. *Id.*

15. The Obama administration's promise to halt the incursions was short-lived. A week after Attorney General Holder's announcement, federal agents raided a San Francisco medical marijuana dispensary, claiming that the establishment was in violation of state and federal law. Rachel Gordon, *DEA Raids Pot Dispensary in SF*, SAN FRANCISCO CHRON., Mar 26, 2009, available at <http://www.sfgate.com/cgi-bin/article.cgi?file=c/a/2009/03/26/BA5B16N9LR.DTL>.

16. *60 Minutes, The Debate on California's Pot Shops*, (CBS television broadcast Sept. 23, 2007), available at <http://www.cbsnews.com/stories/2007/09/20/60minutes/main3281715.shtml> [hereinafter *Debate on California's Pot Shops*]

17. *Id.*

18. *Id.*

19. *Id.* States with medical marijuana statutes have not, however, experienced a concomitant rise in general marijuana use. See *infra* notes 597-600 and accompanying text discussing recent studies.

Pursuant to the federal Controlled Substances Act (CSA), the sale and possession of marijuana is illegal for all purposes.²¹ Marijuana, along with heroin and LSD, is classified as Schedule I—a controlled substance with a high potential for abuse, no currently accepted medical use, and a lack of accepted safety for use under medical supervision.²² States that have enacted legislation permitting the use of medicinal cannabis have done so in outright defiance of federal statutes and regulations. They have done so in the belief that cannabis has proven medicinal properties that help to alleviate suffering caused by diseases such as AIDS, cancer, and multiple sclerosis. The federal government has responded by discounting or ignoring any scientific evidence that marijuana use may be therapeutic. To embrace such research would imply that marijuana is good for us, and would lead us down the path to legalization. There is nothing surprising about this stance. Over the past seventy years, even when its own experts and agencies have recommended a reevaluation of marijuana regulations, the U.S. government has unfailingly gone the route of prohibition.

The direct defiance of federal law by those thirteen states, however, is quite remarkable. Not only do they expose themselves to federal litigation and prosecution, they have also taken on the complex task of implementing and regulating medicinal cannabis distribution. The states' willingness to do so, whether by voter initiative or legislation, draws strength from widespread public endorsement of these programs. In a November 2005 Gallup Poll, seventy-eight percent of Americans supported the legal availability of doctor-prescribed marijuana in the treatment of pain and suffering.²³ This is not to suggest that state endorsement of medical cannabis results in complete tranquility and tolerance at the local level. Some municipalities oppose state-sponsored cannabis programs and have sought to invalidate them.²⁴ Smaller cities,

20. Associated Press, *Pot Vending Machines Take Root in Los Angeles*, BREITBART.COM, Jan. 30, 2008, http://www.breitbart.com/article.php?id=D8UG5J001&show_article=1&catnum=0.

21. Controlled Substances Act, 21 U.S.C. §§ 801-971 (2000).

22. 21 U.S.C. § 812(b)(1) (2000).

23. See MARIJUANA POLICY PROJECT FOUNDATION, PROPOSITION 215 TEN YEARS LATER: MEDICAL MARIJUANA GOES MAINSTREAM 11 (2006), available at http://www.mpp.org/assets/pdfs/download-materials/PROP215_1006_FINAL.PDF (citing National Gallup Poll on illegal drugs (Nov. 1, 2005)).

24. See *ACLU, Others to Defend California's Medical Marijuana Law*, 14 No. 3 ANDREWS HEALTH L. LITIG. REP., July 27, 2006, at 2.

though sympathetic to patients who use medicinal cannabis, recoil at the prospect of dispensaries in their own back yards.

Despite clear support for medical marijuana, the great majority of Americans oppose the legalization of drugs in general. They therefore remain susceptible to arguments that emphasize the dangerousness of drugs and the fear that tolerating them will be wrongly interpreted by their children. The minority that resists medicinal cannabis, given the unbending posture of the federal government and the states aligned with it, is assisted by powerful and zealous political representatives. Hostility to medical marijuana is persistent and potent at all government and societal levels. In the face of this resistance, and despite strong public opposition to federal prohibition, it is not at all certain that the therapeutic cannabis movement will survive. Even now, more than forty years after the Summer of Love, the lighting of a joint still sparks a personal revolt.

This Article explores the medicinal cannabis movement in the United States and the social, legal, and political forces that so strenuously oppose it. Alongside this tide of resistance runs a rising scientific recognition of marijuana's potential in addressing a variety of diseases and symptoms. Users and advocates of therapeutic cannabis adamantly insist that federal restrictions must yield to medical realities. Yet the conflict appears immune to compromise, with few resolutions likely to achieve consensus. The range and quality of scientific evidence favoring a medicinal role for marijuana legitimates the social and procedural experiments in progress in over a dozen states. But these measures can proceed effectively and, perhaps, succeed, only if the federal government embraces the right of these states to legislate for their citizens' health and safety.

Part I recounts the history of marijuana legislation in the United States and the origins of the plant's undeservedly bad reputation. The evidence of harm from smoking marijuana was not only falsified, but the prohibition of the "killer weed" was aimed at suspect groups, such as jazz musicians, African-Americans, and Latinos. Reputable studies documenting the minimal dangers of marijuana, such as the 1944 LaGuardia Report and the 1973 Shaffer Commission Report, were shelved or discredited by the federal government.

Part II explains how cannabis works as medicine. This section analyzes the therapeutic virtues and risks of cannabis and the growing dichotomy between botanical and pharmaceutical bases for expanding those uses. Synthetic cannabinoids can be administered orally and via

hypodermic syringe, but these types of infusions do not deliver the same array of compounds to the body as does smoking herbal marijuana. Current research suggests that the whole plant has therapeutic attributes unavailable in synthetic form. Promoting pharmaceuticals at the expense of botanicals ignores the full spectrum of the plant's uses.

In Part III, concerns of "cultural federalism" take the stage. The Supreme Court's 2005 decision in *Gonzales v. Raich*²⁵ decided the issue of constitutional federalism in medical marijuana. But the phenomenon of "cultural federalism," defined broadly as the experience of citizenship in a divided polity, with its psychological, social, and ultimately pragmatic components, remains far from resolved. Indeed, as nationwide popular support for medical marijuana continues to rise, and the number of states enacting statutes permitting its use increases, the implacable and vigorous opposition of the DEA suggests that the contest will become far more destructive before it is ended. In this struggle, the federal government is both jeopardizing the careers of compassionate physicians and disrupting the treatment of many seriously ailing and dying patients.

Part IV examines the complex interaction of cultural and scientific forces that impedes—rather than inspires—a workable medical marijuana policy. The politics of morality has resulted in a federal prohibition that is impervious to reason or science, even when voices urging a more tolerant view come from credible, established sources appointed by the federal government itself. The "war on drugs" has increasingly become a targeted "war on marijuana" costing the taxpayers ten to twelve billion dollars annually, with the number of marijuana arrests far exceeding the total number of arrests for violent crime. The Article concludes that medicinal marijuana use may be accompanied by risks, but marijuana is a substance with proven salutary capacity. Given the overwhelming evidence of therapeutic value, the only reasonable—indeed the only sane—policy option is legalization of medical marijuana.

25. *Gonzales v. Raich*, 545 U.S. 1 (2005).

II. CANNABIS COMES TO TOWN: MARIJUANA IN THE TWENTIETH-CENTURY UNITED STATES

[M]y substance appeared to me no grosser than the vapors of the atmosphere, and while sitting in the calm of the Egyptian twilight, I expected to be lifted up and carried away by the first breeze that should ruffle the Nile.²⁶

Bayard Taylor

If the hideous monster Frankenstein came face to face with the monster Marihuana, he would drop dead of fright²⁷

Harry J. Anslinger

One man's solace is another man's sin, and nowhere is this truer than in the medicinal cannabis movement. Marijuana has been reviled as a destroyer of youth, an inducement to sexual frenzy and murderous rage, a siren substance that lures its victims toward ever more dangerous drugs, madness, and criminality. Its users have been branded as lowlifes, Communists, anarchists, and libertines.²⁸ In 1937, America's first federal anti-marijuana legislation emerged from a boiling sea of invective, scare-mongering, and racial prejudice. Over the decades, the rhetoric has been tempered and modified, but the aura of scandal and lawlessness still hovers over cannabis and its constituents. Current proponents of medical use must overcome not only social and scientific objections, but an entire seventy years worth of anti-marijuana hysteria and opprobrium.

It seems a great burden for such a humble plant. Cannabis, also known as hemp, grows wild throughout all but the coldest portions of the globe.²⁹ It is a source of quality fiber for, among other products, rope, sail canvas, textiles, and fabrics.³⁰ Its seed contains nutritious oils, reportedly good for humans and strongly favored by the world's wild and domestic bird populations.³¹ Its first recorded use as an intoxicant

26. MARTIN BOOTH, *CANNABIS: A HISTORY* 77 (2003) (quoting BAYARD TAYLOR, *A JOURNEY TO CENTRAL AFRICA* (1854)).

27. RICHARD J. BONNIE & CHARLES H. WHITEBREAD II, *THE MARIHUANA CONVICTION: A HISTORY OF MARIHUANA PROHIBITION IN THE UNITED STATES* 117 (1974).

28. BOOTH, *supra* note 26 at 177; BONNIE AND WHITEBREAD, *supra* note 27, at 52; Linda Whitlock, *Marijuana*, 2 *CRIME & DELINQUENCY LITERATURE* 376 (1970).

29. JACK HERER, *THE EMPEROR WEARS NO CLOTHES* 3 (11th ed. 2000).

30. *Id.* at 5-10.

31. *Id.* at 9-10.

occurred in 2737 B.C. by the Chinese emperor Shen Nung.³² In addition to extolling its euphoric effects, “he recommended it [for treating] female weakness, gout, rheumatism, malaria, beriberi, constipation and absent-mindedness.”³³ The social and medicinal use of marijuana spread throughout Asia, North Africa, and the Muslim world, eventually reaching Europe, the Caribbean, and Central and South America.³⁴ In nineteenth-century America, cannabis was occasionally prescribed as a medicine for diverse ailments but rarely used as an intoxicant.³⁵

Today, marijuana is the world’s most commonly used illicit drug.³⁶ Arguably, it is more widely consumed than any other drug except tobacco, alcohol and aspirin.³⁷ In 2007, nearly 160 million of the planet’s inhabitants used marijuana.³⁸ “[I]f they all lived in the same place [they] would represent the seventh-largest country in the world.”³⁹ In 2007 the National Survey on Drug Use and Health (NSDUH) “estimated that 100 million Americans aged 12 or older had tried marijuana at least once in their lives,” 40.6 percent of that age group’s population.⁴⁰ In 2007, American cannabis consumers comprised 12.6 percent of the population aged fifteen to sixty-four.⁴¹

In the early twentieth century, however, so few Americans were familiar with the drug that it barely registered on the public radar. When Americans did begin taking notice of cannabis, their fear and loathing

32. OAKLEY RAY & CHARLES KSIR, *DRUGS, SOCIETY, AND HUMAN BEHAVIOR* 454 (9th ed. 2002).

33. *Id.* (quoting S.H. Snyder, *What We Have Forgotten about Pot*, N. Y. TIMES MAG., Dec. 13, 1970, at 27).

34. BOOTH, *supra* note 26, at 16-26. “Unlike alcohol that had to be distilled, or opium that had to be processed, cannabis was literally there for the picking.” *Id.* at 21. In the mid-sixteenth century, the introduction of tobacco use in Europe rapidly spread the technique of smoking dried substances. Previously, cannabis had been consumed in food or drink. Linda Whitlock, *supra* note 28, at 363.

35. BONNIE & WHITEBREAD, *supra* note 27, at 4.

36. Office of National Drug Control Policy, *Marijuana Facts & Figures*, http://www.whitehousedrugpolicy.gov/drugfact/marijuana/marijuana_ff.html (last visited Mar. 24, 2009) [hereinafter ONDCP].

37. BOOTH, *supra* note 26, at 5.

38. U.N. OFFICE OF DRUGS & CRIME, *2007 World Drug Report*, U.N. Doc. E.07.X1.5 (2007), available at http://www.unodc.org/pdf/research/wdr07/WDR_2007.pdf [hereinafter UNODC].

39. *The Drug Trade*, CBC NEWS, July 6, 2007, <http://www.cbc.ca/news/background/drugs/users.html> (last visited Mar. 24, 2009) [hereinafter *The Drug Trade*].

40. ONDCP, *supra* note 36.

41. UNODC, *supra* note 38, at 244. Canada leads the industrialized world in marijuana use at 16.8 percent, with New Zealand and Australia following at 13.4 and 13.3 percent respectively. The United States ranks fourth. *Id.*

were undoubtedly aroused as much—if not more—by those who used it than by the substance itself. Around 1910, a burgeoning Mexican immigrant population entered the United States, primarily to provide cheap agricultural labor.⁴² Seeking respite from “the drudgery of the beet fields,”⁴³ they carried marijuana into Texas and California. From there, cannabis use spread quickly to the poor blacks and jazz musicians of New Orleans.⁴⁴ As Mexicans and blacks migrated north, the drug went with them. In racially mixed lower-class neighborhoods, and in clubs “frequented by bohemian jazz enthusiasts,”⁴⁵ whites, too, became acquainted with the weed’s mildly euphoric effects.

In the western and southwestern states, the influx of low-wage Mexican laborers incited fear, contempt, and exploitation. When the workers fought back or became unruly, their use of marijuana was blamed as the precipitating cause.⁴⁶ In 1914, the city of El Paso, Texas passed a bylaw banning the sale and possession of cannabis.⁴⁷ Very likely, the citizens’ motivation was not so much to control the drug as to “suppress the Mexicans.”⁴⁸ By 1930, twenty-four states had banned the distribution of cannabis for other than medical use.⁴⁹ But it was in gaudy, uninhibited 1920s New Orleans that the notion of the “marijuana menace” was born.⁵⁰

In 1920, Dr. Oscar Dowling of the Louisiana Board of Health warned the governor and, subsequently, the U.S. Surgeon General about the “powerful narcotic” that caused “exhilaration, intoxication [and] delirious hallucinations.”⁵¹ In 1925, Dr. Fred Gomila, commissioner of Public Safety in New Orleans, charged that the city’s traffic in marijuana had grown to an annual yield of thousands of kilograms and that the weed was being peddled to innocent children.⁵² In the early 1930s, New Orleans physician Dr. A.E. Fossier published an article asserting that

42. Whitlock, *supra* note 28, at 363.

43. LARRY SLOMAN, *THE HISTORY OF MARIJUANA IN AMERICA: REEFER MADNESS* 219 (1979).

44. Whitlock, *supra* note 28, at 363.

45. *Id.* at 364.

46. BOOTH, *supra* note 26, at 132-3.

47. *Id.* at 133.

48. *Id.*

49. BONNIE & WHITEBREAD, *supra* note 27, at 52, 94.

50. *Id.* at 67.

51. *Id.* at 43.

52. *Id.* at 42; see BOOTH, *supra* note 26, at 136 (noting that these alleged infantile victims were actually Mexican or black adolescents in a culture which, for decades, had been familiar with the use of marijuana).

criminals "fortified themselves with marihuana as a prelude to violence."⁵³ Eugene Stanley, the city's district attorney, incorporated Fossier's article into a widely-disseminated pamphlet and began a vigorous campaign for federal anti-marijuana legislation.⁵⁴

In Washington, D.C., Harry J. Anslinger, steadfast government servant,⁵⁵ began to feel the tremors of this localized, yet ever louder, eruption against marijuana. He himself did not create the myth of demon cannabis, but he breathed such horrifying life into it that he shaped the public's perception of marijuana for decades to come.

A. *The World According to Anslinger*

He was a man "frightening in appearance," especially as he aged, with a disproportionately large square head, "huge ears and his eyes could be staring."⁵⁶ When he assumed control of the newly formed Federal Bureau of Narcotics (FBN) in 1930, Harry J. Anslinger had little or no animus toward marijuana. In fact, he later insisted that heroin had always been the Bureau's principal target.⁵⁷ Reluctantly at first, yet ever the "good soldier,"⁵⁸ Anslinger embraced the crusade for federal marijuana restrictions with prodigious energy and a dazzling display of "bureaucratic overkill."⁵⁹

By the beginning of the twentieth century, Americans had already been frightened by the specter of opiate addiction.⁶⁰ In response to a call to restrain the narcotics trade, Congress passed the Harrison Act of

53. BONNIE & WHITEBREAD, *supra* note 27, at 67.

54. *Id.* at 67-68.

55. By 1930, Anslinger's career had spanned twelve years, mostly in consular service, with a brief stint in prohibition. SLOMAN, *supra* note 40, at 36; BONNIE & WHITEBREAD, *supra* note 27, at 66.

56. BOOTH, *supra* note 26, at 146.

57. In a 1970 interview, Anslinger claimed that, if one of his agents got too fervent about making marijuana arrests, he was admonished to "get back to 'the hard stuff.'" David Musto, *The 1937 Marijuana Tax Act*, in MARIJUANA: MEDICAL PAPERS 1839-1972, at 419, 429 (Tod Mikuriya, ed., 1973).

58. SLOMAN, *supra* note 43, at 80.

59. Musto, *supra* note 57, at 433.

60. In the latter part of the nineteenth century, vast numbers of indentured Chinese workers arrived in the United States to build the railroads. Their opium dens caused them to be branded as a "degenerate race," and Americans viewed the drug as an insidious tool of social corruption. In reality, many Americans had taken opium at one time or another, as it was the most readily available analgesic. In 1900, an estimated three percent of the U.S. population was addicted to opiates. BOOTH, *supra* note 26, at 127-28.

1914.⁶¹ Relying on its powers to regulate interstate and foreign commerce and to raise revenue, Congress deemed it unlawful “for anyone to purchase, sell, dispense or distribute” opiates or coca leaves and their derivatives for legitimate medical purposes without registering and paying a tax.⁶² In the American mind, habitual drug use was linked with crime and moral decay. By the time Anslinger arrived in Washington, public antipathy toward narcotics addiction was well-entrenched.

As far as cannabis was concerned, Anslinger believed its regulation was best left to the states.⁶³ Resisting pressure for federal marijuana legislation, Anslinger focused instead on drafting the Uniform State Narcotic Drug Act. By 1931, however, he had adopted the view that cannabis use emboldened criminals and had convinced himself that the drug had no legitimate medical value.⁶⁴ He proposed a provision in the Uniform State Narcotic Drug Act banning all cannabis cultivation, sale, and possession, even for medical uses.⁶⁵ Opposition by the pharmaceutical industry, which had an interest in promoting cannabis extracts for various medical purposes, kept the provision from becoming mandatory.⁶⁶ It did survive as a supplemental provision, and “any state wishing to regulate the sale and possession of marihuana was instructed simply to add cannabis to the definition of ‘narcotic drugs.’”⁶⁷ Marijuana thus came to be labeled a “narcotic” in every state, legally indistinguishable from opiates.⁶⁸

Despite intense lobbying by the Bureau and Anslinger’s numerous speeches and radio broadcasts, states were slow to endorse the Uniform Act in full. Frustrated by the “combination of public apathy and administrative resistance,”⁶⁹ Anslinger determined to vilify marijuana in earnest. Around 1934, reports of gruesome rapes and murders committed by cannabis fiends began to appear regularly in the newspapers. Often, the perpetrators were black or Mexican and the victims were white.⁷⁰ Repeatedly, marijuana was associated with crime,

61. 38 Stat. 785 (1914) (repealed 1970).

62. BONNIE & WHITEBREAD, *supra* note 27, at 16.

63. SLOMAN, *supra* note 43, at 44, 47; Musto, *supra* note 57, at 428.

64. BONNIE & WHITEBREAD, *supra* note 27, at 77.

65. *Id.* at 83.

66. *Id.* at 89-90.

67. *Id.* at 90.

68. BONNIE & WHITEBREAD, *supra* note 27, at 90.

69. *Id.* at 97.

70. BOOTH, *supra* note 26, at 150.

and the more violent and perverted, the better the copy.⁷¹ A typical story, issued by the *Universal News Service* in 1936, referred to “slaughterings, cruel mutilations, maimings, done in cold blood, as if some hideous monster was amok in the land”⁷² The monster, of course, was marijuana, and these accounts were “emanating from Mr. Anslinger’s office and being received by a grateful yellow-tinged press.”⁷³ As the hearsay and fabrications piled higher, Anslinger and the FBN constructed a “pyramid of prejudice, with each level of the structure built upon the shaky foundations of earlier distortions.”⁷⁴

There were movies too, among them *Marijuana* in 1935, promising “Weird orgies! Wild parties! Unleashed passions!”⁷⁵ A better-known film, *Tell Your Children* (also known as *Reefer Madness*), was released in 1936⁷⁶—a dreary, doom-laden vehicle that could only have been convincing to the uninformed. That the public had to be so assiduously educated about the evils of cannabis suggests that, in the 1930s, its use was still very much a “regional, ethnic phenomenon.”⁷⁷ Anslinger’s campaign targeted an anxious, xenophobic Depression-era audience willing to believe the worst about immigrants and violent crime. It required only a short conclusory leap to scapegoat marijuana in the process.⁷⁸

The more monstrous the FBN’s portrayal of cannabis, the greater the pressure for federal control. As depicted by Anslinger, the clamor for a federal anti-marijuana law was “political,” arising from local police forces, circulating to western, southwestern, and Gulf state governors and then to the Secretary of the Treasury.⁷⁹ It was Treasury’s General Counsel, Herman Oliphant, who first proposed regulating marijuana by

71. RAY & KSIR, *supra* note 32, at 457.

72. BOOTH, *supra* note 26, at 151 (emphasis omitted).

73. SLOMAN, *supra* note 43, at 50.

74. Whitlock, *supra* note 34, at 367 (quoting Jerome H. Skolnick, *Coercion to Virtue: A Sociological Discussion on the Enforcement of Morals*, submitted to the President’s Commission on Law Enforcement and Administration of Justice, 1967). Another way the “pyramid” worked is as follows: an Anslinger agent’s testimony before Congress about marijuana-induced atrocities would be cited in an editorial or in a prestigious publication such as the *Journal of the American Medical Association* (JAMA). Anslinger and his minions would then, in turn, cite JAMA as source material for their own media publications. RAY & KSIR, *supra* note 32, at 457.

75. BOOTH, *supra* note 26, at 151.

76. *See id.*

77. BONNIE & WHITEBREAD, *supra* note 27, at 92.

78. *Id.* at 70-71.

79. Musto, *supra* note 57, at 429-30; SLOMAN, *supra* note 43, at 43.

means of a federal transfer tax.⁸⁰ Anslinger doubted that Congress could constitutionally regulate a plant “growing widely as a roadside weed or in gardens or fields all over the country.”⁸¹ Moreover, by the 1930s, marijuana was seldom used therapeutically and Anslinger questioned whether a federal law designed to tax the legitimate uses of cannabis could yield enough revenue to survive under the federal taxing power.⁸² The Harrison Act had narrowly escaped constitutional challenge in the U.S. Supreme Court by a five-to-four margin in 1919.⁸³ For Anslinger, who found the notion of a federal transfer tax on marijuana “ridiculous,” there was little reason to believe it would actually get through Congress.⁸⁴ Nevertheless, in January, 1937, he and thirteen other government representatives dutifully convened at the Treasury Building in Washington, D.C.

The purpose of the conference was to prepare a presentation to Congress on the proposed Marijuana Tax Act.⁸⁵ In the course of the proceedings, Anslinger offered up one of his grisly tidbits about marijuana, madness, and mayhem.⁸⁶ Suitably impressed, G.S. Tipton of the Treasury’s General Counsel’s Office delicately inquired, “Have you lots of cases on this—horror stories—that’s what we want.”⁸⁷ Anslinger did indeed, and at the preliminary Congressional hearings on the proposed bill in April, 1937, he trotted them out in force.⁸⁸

One of Anslinger’s confections was *Marijuana: Assassin of Youth*, co-authored with Courtney Riley Cooper in 1937.⁸⁹ It begins: “The sprawled body of a young girl lay crushed on the sidewalk the other day after a plunge from the fifth story of a Chicago apartment house.

80. Musto, *supra* note 57, at 429.

81. BONNIE & WHITEBREAD, *supra* note 27, at 121.

82. *Id.* at 61, 121.

83. *United States v. Doremus*, 249 U.S. 86, 93-95 (1919). The District Court had held the Harrison Act unconstitutional because it was not a revenue measure and it invaded the province of police power reserved to the states. *United States v. Doremus*, 246 F. 958, 965 (W.D. Tex. 1918). On reversing the lower court, the Supreme Court held that the Act did facilitate the collection of revenue and was thus within “the power of Congress acting under its constitutional authority to impose excise taxes.” *Doremus*, 249 U.S. at 95.

84. Musto, *supra* note 57, at 429.

85. *Id.* at 434. Or, in the words of Larry Sloman, to devise a way “to ramrod this objectionable bill down the throats of a lackluster Congress.” SLOMAN, *supra* note 43, at 58.

86. SLOMAN, *supra* note 43, at 57-58.

87. Musto, *supra* note 57, at 435.

88. BOOTH, *supra* note 26, at 154.

89. Harry J. Anslinger & Courtney Ryley Cooper, *Marijuana: Assassin of Youth*, AMERICAN MAGAZINE (July 1937) reprinted in THE AMERICAN DRUG SCENE 64 (James A. Inciardi & Karen McElrath eds., 2d ed. 1998).

Everyone called it suicide, but actually it was murder. The killer was a narcotic known to America as marijuana”⁹⁰

Anslinger need not have worried about Congressional opposition to the Marijuana Tax Act. It passed with minimal debate and even less public notice. During brief, uninformative hearings on Capitol Hill, “the legislators and the bureaucrats convinced one another” of the necessity for this largely unnecessary legislation.⁹¹ By 1937, a majority of states had already passed the Uniform Narcotic Drug Act.⁹² Those that did not adopt the Act’s marijuana provision enacted separate cannabis prohibition statutes.⁹³ The only dissenting voices heard at the hearings were those of the bird seed companies⁹⁴ and Dr. William C. Woodward of the American Medical Association (AMA). Charging the FBN with failing to present “competent primary evidence” that marijuana caused crime and insanity or that “schoolchildren are great users of marijuana cigarettes,” Woodward scathingly noted the absence of witnesses from the Bureau of Prisons, the Division of Mental Hygiene, or the Children’s Bureau.⁹⁵ Woodward also condemned the inhibitory effect the legislation’s taxes, penalties, and registration requirements would have on doctors and pharmacists.⁹⁶ He feared, correctly, that the law would foreclose any “future investigation [that] may show that there are substantial medical uses for cannabis.”⁹⁷

Woodward’s testimony was lost on a distinctly incurious Congress. The Marijuana Tax Act of 1937 was an “uncontroversial law” that had been “hastily drawn, heard, debated, and passed.”⁹⁸ It imposed such onerous registration and recordkeeping procedures on doctors and wholesale dealers of the drug that it put an end to the market in medical cannabis.⁹⁹ Individuals using marijuana for purposes not approved by the Act were required to pay a tax of \$1 per ounce or face stiff fines and

90. *Id.*

91. BONNIE & WHITEBREAD, *supra* note 27, at 154.

92. *Id.* at 115.

93. *Id.* at 114-15.

94. Testifying before Congress in 1937, bird food company representatives lamented that “[s]ong birds won’t sing without it.” They were ultimately allowed to import sterilized bird seed from Italy and China, among other countries. HERER, *supra* note 29, at 10.

95. SLOMAN, *supra* note 43, at 76-77.

96. *Id.* at 76.

97. *Id.*

98. BONNIE & WHITEBREAD, *supra* note 27, at 174.

99. SLOMAN, *supra* note 43, at 102; LESTER GRINSPOON, MARIHUANA RECONSIDERED 14 (2d ed. 1994).

lengthy prison sentences.¹⁰⁰ Until 1969, when the Act was declared constitutionally invalid on grounds not even anticipated by Anslinger,¹⁰¹ the law functioned as a model of prohibition in the guise of taxation.

Anslinger enforced the Act with as much zeal as the FBN budget allowed, going after jazz musicians with particular gusto.¹⁰² In 1951, amidst a wave of heroin addiction, Anslinger sought to justify harsh mandatory minimum sentences for marijuana offenses. His secret weapon was his new steppingstone theory, in which cannabis users “graduated” to heroin addiction, taking “the needle when the thrill of marihuana was gone.”¹⁰³ As before, falsehood was elevated to “the status of authoritative truth.”¹⁰⁴ And, more than ever, the lowly hemp plant became “inextricably bound to the opiates,” politically as well as legally.¹⁰⁵

B. Anslinger's Legacy

Writing in 1971, Lester Grinspoon, later Associate Professor Emeritus in Psychiatry at Harvard Medical School, declared that “the single greatest risk encountered by the user of marihuana in any state in this country is that of being apprehended as a common criminal, incarcerated, and subjected to untold damage to his social life and career.”¹⁰⁶ In the 1960s, a generation of Americans discovered that the use of marijuana made them neither violent nor insane, nor did it lead them to become hopelessly addicted, either to cannabis or to opiates. President Richard Nixon, convinced that drugs and crime went hand in hand, responded by launching a fierce foreign and domestic war on drugs, targeting major dealers and casual users alike.¹⁰⁷ Under his administration, the Drug Enforcement Agency (DEA) was born, endowed with extraordinary powers to gather intelligence, to conduct wiretaps and warrantless searches, and to freeze the assets and confiscate

100. Whitlock, *supra* note 34, at 364.

101. In *Leary v. United States*, 395 U.S. 6 (1969), the Supreme Court held that Dr. Timothy Leary's compliance with the Act's transfer tax provisions impermissibly exposed him to self-incrimination and prosecution under state narcotics laws. *Id.* at 14-18. At the time of Leary's noncompliance with the Act in 1965, possession of any quantity of marijuana was a crime in each of the fifty states. *Id.* at 16.

102. BOOTH, *supra* note 26, at 171-74, 180.

103. SLOMAN, *supra* note 43, at 189.

104. Whitlock, *supra* note 34, at 366.

105. BONNIE & WHITEBREAD, *supra* note 27, at 214-15.

106. GRINSPOON, *supra* note 99, at 2.

107. BOOTH, *supra* note 26, at 241.

the property of suspected traffickers.¹⁰⁸ Young cannabis users were often the casualties of these feverish anti-drug crusades.¹⁰⁹

It was also during the Nixon presidency that the Comprehensive Drug Abuse Prevention and Control Act of 1970 (also known as the Controlled Substances Act, or CSA) classified marijuana along with heroin and LSD as a Schedule I drug.¹¹⁰ Like those statutes devised by Anslinger, these statutory schemes perpetuated the myth that cannabis was a narcotic, indistinguishable from highly addictive, strongly psychoactive substances. Until the late 1960s, what Bonnie and Whitebread refer to as the “mari[h]uana consensus” had flourished, unchallenged, in an atmosphere of scientific disinterest.¹¹¹ With the medical community largely silent on the cannabis question, the FBN became the drug’s official “spokesman,” replacing the operation of science with that of law enforcement.¹¹²

In Anslinger’s time there were marijuana studies he could have consulted. Their conclusions, however, were often antithetical to the FBN party line. In 1890s India, widespread cannabis use among the lower and working classes had alarmed upper caste native administrators. At the behest of British authorities, the Indian Hemp Drugs Commission was formed to study every aspect of marijuana—from cultivation and taxation to its uses and effects—in the province of Bengal.¹¹³ The resulting report, running to seven volumes and well over 3,000 pages, recommended against prohibition and concluded that the moderate use of cannabis presented virtually no harm.¹¹⁴ In the Panama Canal Zone, where marijuana smoking was prevalent among American soldiers, the U.S. Army Medical Corps conducted clinical trials in 1925 and 1930.¹¹⁵ Both reports ruled marijuana non-addictive and far more innocuous than the alcohol with which its use was often associated.¹¹⁶ Anslinger’s theory of marijuana and criminal insanity was dealt a blow by Dr. Walter Bromberg in 1934. A senior psychiatrist at Bellevue

108. *Id.*

109. BONNIE & WHITEBREAD, *supra* note 27 at 239; BOOTH, *supra* note 26 at 225; Whitlock, *supra* note 34 at 382.

110. Controlled Substances Act, 21 U.S.C. § 812(b)(1) (2000).

111. BONNIE & WHITEBREAD, *supra* note 27, at 222.

112. *Id.* at 136.

113. BOOTH, *supra* note 26, at 113-14.

114. *Id.* at 115.

115. *Id.* at 132.

116. *Id.* at 132; RAY & KSIR, *supra* note 32 at 459. The report is available online. See *Marijuana Smoking in Panama*, MILITARY SURGEON (1933), available at <http://www.druglibrary.org/Schaffer/library/studies/panama/panama1.htm>.

Hospital, Bromberg published a study of over 2200 convicted felons in New York County. He concluded that none of the assaults under examination had been committed under the influence of cannabis and observed that no crimes were committed by the study's participants either during or immediately following intoxication.¹¹⁷

In 1938, New York's Mayor Fiorello LaGuardia appointed a panel of experts from the New York Academy of Medicine to study marijuana's medical, sociological and psychological effects. A precursor to the LaGuardia Report, written by Drs. Samuel Allentuck and Karl Bowman, appeared in 1942. The authors found that, while cannabis might "precipitate psychosis in an unstable, disorganized personality," it "will not produce psychosis *de novo* in a well-integrated, stable person."¹¹⁸ Furthermore, marijuana promoted neither biological nor physiological dependence and did not give rise to withdrawal symptoms.¹¹⁹ Unlike alcoholics, cannabis users did not indulge "beyond the point of euphoria," nor did they exhibit anti-social behavior.¹²⁰ The authors found no evidence that "continued use of marihuana is a stepping-stone to the use of opiates," and concluded that marijuana had "potentially valuable therapeutic applications" worthy of future study."¹²¹

The LaGuardia Report, entitled *The Marihuana Problem in the City of New York*, was not published until 1944, possibly due to suppression by the FBN after the appearance of the Allentuck-Bowman article.¹²² The Report described the "publicity concerning the catastrophic effects of marihuana smoking in New York City [as] 'unfounded.'"¹²³ It determined that marijuana use did not lead to addiction to or dependence upon morphine, heroin, or cocaine, nor was its use a determining factor in juvenile delinquency or serious criminal behavior.¹²⁴ Predictably, Anslinger and the FBN expressed outrage at the findings of the LaGuardia Report, but the American Medical Association's response to

117. GRINSPOON, *supra* note 99, at 18.

118. Samuel Allentuck & Karl M. Bowman, *The Psychiatric Aspects of Marihuana Intoxication*, 2 AM. J. PSYCHIATRY 248, 249 (1942).

119. *Id.*

120. *Id.* at 249-250.

121. *Id.* at 250.

122. BONNIE & WHITEBREAD, *supra* note 27, at 201; GRINSPOON, *supra* note 96, at 27.

123. LaGuardia Committee Report Sociological Study, *The LaGuardia Report—Sociological Study Conclusions*, <http://www.druglibrary.org/Schaffer/library/studies/lag/concl.htm> (last visited Mar. 25, 2009).

124. *Id.*

the report was a bit of a shock. Although the Journal of the American Medical Association (JAMA) had two years earlier greeted the Allentuck-Bowman article with a respectful, well-reasoned review, JAMA made an “extraordinary about-face” and aligned itself with the FBN against the LaGuardia Report.¹²⁵ In words most likely written by Anslinger, the Journal denounced the Report as “thoroughly unscientific.”¹²⁶ Nearly thirty years later, Grinspoon remarked upon how Anslinger’s enlistment of the American Medical Association in his anti-marijuana campaign had made the medical community both “a victim and an agent” in the whole “unfortunate process.”¹²⁷

President Nixon, like Anslinger, was not inclined to admit that the dangers of cannabis use may have been grossly exaggerated. In 1973, the Commission on Marijuana and Drug Abuse (also known as the Shafer Commission), formed under a provision in the CSA, released its final report.¹²⁸ Titled *Marihuana: A Signal of Misunderstanding*, it was a comprehensive study of the physiological and social impact of cannabis use as well as a prescription for social policy. The report concluded that, while society should seek to discourage drug use, it should devote its resources to prevention and treatment of abuse. The Commission judged that, in the scheme of social problems confronting contemporary America, marijuana did not “rank very high.”¹²⁹ To criminalize its possession for personal use was “self-defeating” and “out of proportion to the individual and social harm engendered by the use of the drug.”¹³⁰ The report infuriated Nixon who, after all, had “personally hand-picked nine of the study’s thirteen commissioners.”¹³¹

Driven by the efforts of groups such as the National Organization for the Reform of Marijuana Laws (NORML), the notion of decriminalization caught on in a number of states. By the end of the 1970s, ten states had abolished criminal penalties for possession of small amounts of marijuana.¹³² Cannabis use in the United States peaked in

125. GRINSPOON, *supra* note 99, at 27-28.

126. BONNIE & WHITEBREAD, *supra*, note 27, at 201.

127. GRINSPOON, *supra* note 99, at 29.

128. BOOTH, *supra* note 26, at 246.

129. NATIONAL COMMISSION ON MARIHUANA AND DRUG ABUSE, *MARIJUANA: A SIGNAL OF MISUNDERSTANDING* (1972), <http://www.druglibrary.org/Schaffer/Library/studies/nc/ncmenu.htm> (follow “V. Marijuana and Social Policy” hyperlink; then follow “Drugs and Social Responsibility” hyperlink) (last visited Apr. 11, 2009).

130. *Id.*

131. BOOTH, *supra* note 26, at 246.

132. RAY & KSIR, *supra* note 32, at 474-475; *see also* NORML, *State by State Laws*, http://norml.org/index.cfm?Group_ID=4516 (last visited Apr. 11, 2009).

1980, just in time for Ronald Reagan's entry into the White House.¹³³ Waging an all-out horticultural war, Reagan set about destroying cannabis plants around the globe and combating future cultivation. He directed law enforcement officers to seize cars, boats, and planes containing even minimal traces of marijuana and filled the federal prisons with controlled substances offenders, many of them possessors of marijuana.¹³⁴

During the 1980s and early 1990s cannabis use in the United States declined, then began rising again in the mid-1990s.¹³⁵ As tens of millions of Americans experienced the drug for themselves, Anslinger's histrionic claims began to appear more and more as quaint and risible relics. Even his steppingstone theory, refined over the years as the gateway theory, proved to be "not a theory at all."¹³⁶

Yet, largely due to a medicinal marijuana movement that began in the 1970s, and the spirited resistance it has inspired, Anslinger's legacy lives on. Science seems to have resurrected itself, resuming its proper place in discussions on cannabis, particularly in regard to its therapeutic uses. But research, no matter how good, holds few charms for those who are impatient with science, who distrust it, or who are downright dismissive of it. In the words of retired Arizona Court of Appeals Judge Rudolph J. Gerber, "Drug policy abhors a vacuum."¹³⁷ Prohibitionists have sooner filled it with platitudes and moralistic prejudice than meaningful analysis of risks and benefits. This "cart-before-the-horse"¹³⁸ style of lawmaking—the discarding of scientific research findings as "untimely truths"¹³⁹—causes officials to prop up ill-considered drug policies with "paternalism, hysteria and censorship of opposing views."¹⁴⁰ Unlike the leadership of most advanced societies,

133. RAY & KSIR, *supra* note 32, at 460.

134. *Id.* at 475.

135. *Id.* at 460.

136. LYNN ZIMMER & JOHN P. MORGAN, MARIJUANA MYTHS MARIJUANA FACTS 37 (1997). There is little support for the proposition that cannabis use leads directly to abuse of other substances. It is more likely that, among young cannabis users, there are some individuals with a propensity to use other illicit drugs. Once engaged in marijuana use, their social interaction with other drug users and their greater access to the drug market might increase their likelihood to use other, stronger illicit substances. *See generally* David M. Fergusson & L. John Horwood, *Early Onset Cannabis Use and Psychosocial Adjustment in Young Adults*, 92 ADDICTION 279 (1997) (analyzing adolescent drug use progression).

137. RUDOLPH J. GERBER, LEGALIZING MARIJUANA: DRUG POLICY REFORM AND PROHIBITION POLITICS 138 (2004).

138. *Id.* at 135.

139. *Id.* at 137.

140. *Id.* at 138.

our “pot warriors discount information able to enlighten the electorate,” thereby maintaining their own political advantage by keeping the citizenry ignorant.¹⁴¹

In April, 2006, despite mounting clinical evidence of marijuana’s medicinal value, endorsed by some of its own government experts, the Food and Drug Administration (FDA) confidently proclaimed that “there are no sound scientific studies” supporting the therapeutic use of cannabis.¹⁴² Harry J. Anslinger would have been proud.

III. THE MEDICINE IN MARIJUANA

As soon as I was diagnosed HIV+, I was put on AZT. It almost killed me
The thing with HIV is you have the same loss of appetite whether you’re on
AZT or not. If I didn’t have cannabis I would have starved to death a long
time ago.¹⁴³

Mark Tildon

Never let anyone persuade you to smoke even one marijuana cigarette. It is
pure poison.¹⁴⁴

FBN Publication, 1965

Mid-to-late nineteenth-century Americans of all ages imbibed marijuana in tinctures and elixirs made by companies like Squibb, Parke-Davis, and Lilly.¹⁴⁵ In the U.S. Pharmacopoeia, cannabis was listed as appropriate for treating fatigue, coughing fits, asthma, rheumatism, delirium tremens, migraine headaches, and menstrual symptoms.¹⁴⁶ By 1900, it had fallen into disuse for several reasons: it was insoluble in water and could not be injected via hypodermic syringe, it varied greatly in potency and doses were difficult to standardize, and it could not compete with newer, synthetic drugs designed for the same

141. GERBER, *supra* note 137, at 138.

142. Gardiner Harris, *F.D.A. Dismisses Medical Benefit from Marijuana*, N.Y. TIMES, Apr. 21, 2006, at A1.

143. Peter Gorman, *Marijuana and AIDS*, HIGH TIMES, Dec. 1994, available at <http://www.marijuanalibrary.org/aids.html>.

144. BOOTH, *supra* note 26, at 224.

145. SLOMAN, *supra* note 43, at 22.

146. HERER, *supra* note 29, at 9.

range of ailments.¹⁴⁷ In 1941, at the urging of FBN commissioner Harry J. Anslinger, it was removed from the U.S. Pharmacopoeia.¹⁴⁸

Marijuana-as-medicine remained quiescent until the 1970s, when it was found to ease intraocular pressure in glaucoma sufferers.¹⁴⁹ During the same period, cancer patients with chemotherapy-induced nausea and vomiting discovered marijuana's soothing, anti-emetic effects. In the ensuing decade, when the AIDS epidemic weakened its victims by robbing them of their appetites, many relied on cannabis to help rekindle a desire for food.¹⁵⁰

There are, by now, well-recognized therapeutic uses for cannabis, and many others are currently under investigation. But rather than achieving a kind of vindication, the hemp plant has arrived in the age of medical marijuana toting much of its 1930s and 1960s era baggage.¹⁵¹ It has never quite been able to shed its identity as a dangerous, mind-altering substance, or the reputation of its users as undesirables, drop-outs, upstarts, and prospective heroin addicts. As such, its fight for scientific legitimacy has been far more laborious than that of other drugs, including morphine. As perceived by Grinspoon and Bakalar, "[m]arijuana is caught in a dual web of regulations—those that control prescription drugs in general and the special criminal laws that control psychoactive substances. These laws strangle its medical potential."¹⁵² Add to these constraints the obdurate federal regimes, both Republican and Democratic, that have actively inhibited cannabis research and refused to credit existing studies, even their own. In 1999, the Institute

147. SLOMAN, *supra* note 43, at 26.

148. *Id.* at 102.

149. Although marijuana has been shown to reduce intraocular pressure, its effects are short-lived, requiring patients to seek higher and more frequent doses. Stanley J. Watson et al., *Marijuana and Medicine: Assessing the Science Base, A Summary of the 1999 Institute of Medicine Report*, 57 ARCHIVES GEN. PSYCHIATRY 547, 550 (2000). Current research efforts may prove promising in developing improved cannabis derivatives for management of glaucoma. RG Pertwee, *The Pharmacology of Cannabinoid Receptors and their Ligands: An Overview*, 30 INT. J. OBESITY S13, S16 (2006).

150. It appears today that HIV patients, but not those with actual AIDS, have the opposite problem. Rather than suffering from AIDS wasting syndrome, two-thirds of HIV patients have joined the general population in exhibiting signs of obesity. Alicia Chang, *Obesity a Problem in HIV Population*, ASSOCIATED PRESS, Oct. 4, 2007, available at <http://www.washingtonpost.com/wp-dyn/content/article/2007/10/04/AR2007100400561.html>.

151. Lester Grinspoon, *Marijuana as Wonder Drug*, BOSTON GLOBE, Mar. 1, 2007, available at http://www.boston.com/news/globe/editorial_opinion/oped/articles/2007/03/01/marijuana_as_wonder_drug.

152. LESTER GRINSPOON & JAMES BAKALAR, MARIJUANA, THE FORBIDDEN MEDICINE 174 (1993).

of Medicine (IOM) published a study funded by the White House Office of National Drug Policy on the risks and benefits of marijuana-as-medicine.¹⁵³ The IOM described marijuana's substantial analgesic effects as well as its moderate success as an anti-emetic and appetite stimulant.¹⁵⁴ Though recognizing that cannabis was not "a completely benign substance," the study's authors found enough therapeutic evidence to warrant further research.¹⁵⁵

Currently, a synthetic form of marijuana's principal component, delta-9-tetrahydrocannabinol (THC), is available by prescription in sesame oil encapsulated by soft gelatin. Known as Marinol (dronabinol), this synthetic drug is FDA-approved as an anti-emetic for cancer chemotherapy patients and as an appetite stimulant for sufferers of AIDS wasting syndrome.¹⁵⁶ Nabilone (cesamet), another synthetic compound similar to THC, is also approved for chemotherapy-induced nausea and vomiting.¹⁵⁷ A plant-based extract known as Sativex, available in an oral spray for use under the tongue, has been approved for use in Canada for treating painful symptoms associated with multiple sclerosis.¹⁵⁸ Unlike synthetic compounds, however, marijuana's plant-based compounds have faced formidable research and development obstacles because of their CSA Schedule I designation.¹⁵⁹ Like Grinspoon and Bakalar, Watson and Benson view the future of medicinal cannabis to be "as much in the hands of substance abuse policymakers as in those of health care providers and pharmaceutical companies."¹⁶⁰

Recent research suggests myriad medical uses for marijuana's chemical components. The novel issue, in view of the growing number of synthetic and plant-based cannabis compounds under investigation, is whether support for medical use of the whole plant itself can be sustained. Having survived as a social, political, and legal outcast, and now, having attracted so much scientific interest, the smokable

153. See DIV. OF NEUROSCIENCE & BEHAVIORAL HEALTH, INSTITUTE OF MEDICINE, MARIJUANA AND MEDICINE: ASSESSING THE SCIENCE BASE (Janet E. Joy et al., eds., 1999) [hereinafter IOM REPORT].

154. *Id.* at 144-45, 153-54, 159.

155. Watson et al., *supra* note 149, at 551-52.

156. RAY & KSIR, *supra* note 32, at 466-67; IOM REPORT, *supra* note 153, at 202-03.

157. MedLine Plus, U.S. National Library of Medicine, National Institutes of Health, available at <http://www.nlm.nih.gov/medlineplus/druginfo/meds/a607048.html>.

158. Wendy Koch, *Spray Alternative to Pot on the Market in Canada*, USA TODAY, June 23, 2005, available at http://www.usatoday.com/news/health/2005-06-23-pot-spray_x.htm.

159. IOM REPORT, *supra* note 153, at 210.

160. Watson et al., *supra* note 149, at 552.

medicinal hemp plant may be steering itself toward obsolescence.

A. How Cannabis Works

In the flowering tops and leaves of the marijuana plant is an array of chemicals known as cannabinoids. The plant's most potent psychoactive component, Tetrahydrocannabinol, or THC, is accompanied by more than sixty other cannabinoids that are unique to botanical marijuana.¹⁶¹ The mammalian brain also produces substances called endocannabinoids, the "brain's own marijuana," two of which have been identified as 2-AG and anandamide (from a Sanskrit word for "bliss").¹⁶² For 500 million years, all vertebrate species have been utilizing endocannabinoids by means of a complex signaling system in various regions of the brain.¹⁶³

When introduced into the body, cannabinoids mimic the properties and activities of the brain's own marijuana-like substances. Whether endogenous (produced by the body) or exogenous (smoked or ingested in plant or synthetic form), cannabinoids give rise to their effects by binding with cannabinoid (CB) receptors.¹⁶⁴ These receptors are "among the most ubiquitous neurotransmitter elements in the mammalian brain, as they are present in almost every brain region and many different types of neurons."¹⁶⁵ Marijuana intoxication's diverse effects—mild euphoria, sleepiness, cognitive dysfunction, short-term memory loss, changes in perception and time measurement, motor incoordination, and food cravings—are explained by this wide distribution of CB1 receptors. They occur at their highest densities in the cerebral cortex (psychoactive effects), the hippocampus (memory formation), the hypothalamus (appetite), the amygdala (emotional

161. RAY & KSIR, *supra* note 32, at 460.

162. Roger A. Nicoll & Bradley E. Alger, *The Brain's Own Marijuana*, SCIENTIFIC AM., Dec. 2004, at 68, 73.

163. *Id.*

164. The activation of CB1 receptors, by endogenous or exogenous cannabinoids, is thought to suppress neurotransmissions. Ken Mackie, *Cannabinoid Receptors as Therapeutic Targets*, 46 ANN. REV. PHARMACOLOGY & TOXICOLOGY 101, 104 (2006). This regulatory role endows endocannabinoids with "great potential" for disease pathologies caused by inappropriate neurotransmission. J. Ludovic Croxford & Takashi Yamamura, *Cannabinoids and the Immune System: Potential for the Treatment of Inflammatory Diseases?* 166 J. NEUROIMMUNOLOGY 3, 4 (2005).

165. Allyn C. Howlett et al., *Cannabinoid Physiology and Pharmacology: 30 Years of Progress*, 47 NEUROPHARMACOLOGY 345, 350 (2004). Neurons are the fundamental functional units of nerve tissue.

responses), and movement control centers.¹⁶⁶ In the brain stem and spinal chord, the CB1 receptor system governs pain reduction and the emesis reflex.¹⁶⁷

Another class of receptors, CB2, has been found in the pancreas as well as in the thymus, tonsils, bone marrow, and spleen, the “major tissues of immune cell production and regulation.”¹⁶⁸ Although not yet well-understood, these receptors and the endocannabinoids that bind to them appear to engage in “cross-talk” with brain neurochemicals, thereby establishing a brain-immune system connection.¹⁶⁹ Outside of the brain, endocannabinoids “are produced on demand” and interact with receptors near their site of origin.¹⁷⁰ Additional receptor sites are located in the digestive, reproductive, ocular and cardiovascular systems.¹⁷¹

CB receptors can be activated by certain substances (agonists) and suppressed by others (antagonists). In addition, manipulation of CB receptors may occur indirectly, by use of drugs that work to adjust the body’s endocannabinoid levels.¹⁷² Scientists have noted that release of endocannabinoids might “constitute a protective response” during injury to neurons.¹⁷³ In certain diseases or disorders, endocannabinoid levels increase “in response to skeletal muscle spasm or spasticity in multiple sclerosis and in response to inflammatory pain,” acting to ease these symptoms.¹⁷⁴ Other researchers suggest that endocannabinoids help to moderate post-traumatic stress disorder, phobias, and some forms of chronic pain by “extinguishing the bad feelings and pain triggered by reminders of past experiences.”¹⁷⁵ Marijuana, its plant extracts, and its synthetic compounds bind and signal throughout the body’s endocannabinoid receptor system. In short, marijuana “clearly does so

166. Nicoll & Alger, *supra* note 162, at 71-72.

167. *Id.*

168. Howlett et al., *supra* note 165, at 349; Croxford & Yamamura, *supra* note 164, at 5.

169. Thomas W. Klein et al., *The Cannabinoid System and Immune Modulation*, 74 J. LEUKOCYTE BIOLOGY 486, 493 (2003).

170. Daniele Piomelli, *The Molecular Logic of Endocannabinoid Signaling*, 4 NATURE REV. 873, 878 (2003).

171. M. Llanos Casanova et al., *Inhibition of Skin Tumor Growth and Angiogenesis in vivo by Activation of Cannabinoid Receptors*, 111 J. CLINICAL INVESTIGATION 43, 43 (2003).

172. Mackie, *supra* note 164, at 101.

173. Diego Centonze et al., *The Endocannabinoid System in Targeting Inflammatory Neurodegenerative Diseases*, 28 TRENDS PHARMACOLOGICAL SCI. 180, 182 (2007).

174. Pertwee, *supra* note 149, at S14.

175. Nicoll & Alger, *supra* note 162, at 74-75.

much because it goes everywhere.”¹⁷⁶

B. How Therapeutic Cannabinoids Work

Much of the current research on therapeutic cannabinoids centers on their activity at CB receptor sites. In a study on nonmelanoma skin cancer, one of the most common human malignancies, scientists noted the presence of CB1 and CB2 receptors in the skin and in skin tumors.¹⁷⁷ They further observed that activating local receptors by administering cannabinoids appeared to induce the regression of tumors.¹⁷⁸ In another study, endocannabinoids and synthetic cannabinoids were “observed to inhibit the proliferation of human breast cancer cells.”¹⁷⁹

In the words of one scientist, these are “exciting times” for the development of drugs targeting the endocannabinoid system and endocannabinoid receptors.¹⁸⁰ But this research owes much to previous, largely anecdotal, endorsements by those using medicinal whole-plant marijuana for a variety of symptoms. The efficacy of smoked cannabis in the treatment of multiple sclerosis (MS) has long been acknowledged.¹⁸¹ MS patients have encountered its beneficial effects on tremor, spasticity, anxiety, and pain.¹⁸² Furthermore, due to reduction of inflammation, MS sufferers who smoke marijuana experience fewer relapses.¹⁸³ Having recognized the endocannabinoid system’s role in moderating inflammation and inducing a self-protective response in nerve tissue, researchers are exploring cannabis-based treatments for amyotrophic lateral sclerosis (ALS), Parkinson’s disease, Huntington’s disease, and Alzheimer’s disease.¹⁸⁴ Researchers at Ohio State University have found that THC can stimulate the creation of new memory cells in aging rats.¹⁸⁵ Further, due to THC’s ability to decrease

176. *Id.*

177. Casanova et al., *supra* note 171, at 44.

178. *Id.* at 49.

179. Klein et al., *supra* note 169, at 492.

180. Mackie, *supra* note 164, at 112.

181. Centonze et al., *supra* note 173, at 183.

182. Croxford & Yamamura, *supra* note 164, at 11.

183. Centonze et al., *supra* note 173, at 184.

184. *Id.* at 180-84; Ismael Galve-Roperh et al., *The Endocannabinoid System and Neurogenesis in Health and Disease*, 13 NEUROSCIENTIST 109, 112-13 (2007); Pertwee, *supra* note 149, at 517.

185. Tom Jacobs, *Attacking Alzheimer’s with a Toke and a Tipple*, MILLER-MCCUNE, Nov. 21, 2008, <http://www.miller-mccune.com/article/attacking-alzheimer-s-with-a-tipple-and-a-toke>.

inflammation in the hippocampus (the region of the brain responsible for short-term memory), it may provide possible protective effects against Alzheimer's.¹⁸⁶

Cannabinoids have proven effective in bronchodilation and may benefit asthma sufferers.¹⁸⁷ In diabetes patients, cannabinoids may protect against the destruction of the pancreas and alleviate neuropathic pain.¹⁸⁸ As analgesics, marijuana's derivatives have benefited patients whose severe, persistent cancer pain resisted traditional medications. Equal to codeine in promoting pain relief, cannabinoids also improved mood, appetite, and well-being.¹⁸⁹

The use of CB1 receptor antagonists in the treatment of obesity was also inspired by the experiences of cannabis users. When scientists observed how smoking marijuana enhances appetite, they correctly posited that blocking CB1 receptors could control dysfunctional craving and reduce food consumption. Animal studies predict "that CB1 antagonists "will have long-term efficacy for weight loss," as well as for improvements in fat metabolism.¹⁹⁰ One such antagonist, Rimonabant, has proved useful, not only in dysfunctional appetite suppression but also in smoking cessation and in reducing cravings for cocaine and opioids.¹⁹¹

Researchers at the University of California, San Francisco, recently discovered that smoking cannabis alleviates symptoms of a peripheral nerve disorder associated with HIV infection.¹⁹² A debilitating condition causing pain and numbness, usually in the feet, it can create difficulties with walking or standing. Smoking marijuana significantly reduces pain levels, with results that are comparable to powerful analgesics such as morphine.¹⁹³ A study reported in the June, 2008

186. *Id.*

187. Croxford & Yamamura, *supra* note 164, at 13.

188. *Id.* at 12. Neuropathic pain is caused by tissue injury or degenerative disorders of the nervous system. Cleveland Clinic Information on Neuropathic Pain, http://my.clevelandclinic.org/disorders/Chronic_Pain/hic_Neuropathic_Pain.aspx (last visited Apr. 11, 2009).

189. Wayne Hall et al., *Cannabinoids and Cancer: Causation, Remediation, and Palliation*, 6 LANCET ONCOLOGY 35, 39 (2005).

190. Mackie, *supra* note 164, at 107.

191. Howlett et al., *supra* note 165, at 353-54.

192. D. I. Abrams et al., *Cannabis in Painful HIV-Associated Sensory Neuropathy*, 68 NEUROLOGY 515, 519 (2007).

193. Jeff Sheehy, *Smoked Cannabis Reduces Pain Caused by HIV-Associated Neuropathy*, UCSF NEWS OFFICE, Feb. 12, 2007, <http://pub.ucsf.edu/newsservices/releases/200702061/>.

Journal of Pain found that marijuana significantly reduced neuropathic pain associated with diabetes and spinal cord injury.¹⁹⁴

Despite the demonstrated benefits of smoked cannabis in treating various symptoms, not all patients welcome or appreciate its psychoactive properties. Marijuana also contains two compounds, cannabinal (CBN) and cannabidiol (CBD), which are non-psychoactive and have low affinity for CB receptors, but which reduce inflammation.¹⁹⁵ CBD also has promise in anti-convulsive, anti-anxiety, and anti-psychotic therapies¹⁹⁶ and, along with other non-psychoactive synthetic compounds, may alleviate joint pain in rheumatoid arthritis.¹⁹⁷ Another synthetic cannabinoid, dexamabinol (HU 211), significantly limits brain swelling and brain cell damage for victims of stroke and severe head injury.¹⁹⁸ CB2 agonists have great potential for treatment of pain, as well as benefits for cardiovascular disease and osteoporosis.¹⁹⁹

As promising as these developments are, the hidden risks and consequences of CB receptor system manipulation have yet to be explored fully. For example, use of the appetite suppressant, Rimonabant, has been shown to exacerbate spasm and spasticity in patients with MS.²⁰⁰ Rather than rely on substances that agonize or antagonize CB receptors, some scientists prefer drugs that enhance the role of the body's own cannabinoids, summoning them in circumstances and locations where they are needed.²⁰¹ The endocannabinoid system has been described as "an orchestrated network of various cell types, receptors and pathways" in which therapeutic strategies must "maintain or restore the well-controlled and finely tuned balance between protection and damage in the nervous and immune system."²⁰² Although the function of the endocannabinoid system and the compounds affecting it have yet to be completely understood, the medicinal marijuana movement has been instrumental in promoting and expanding this field of inquiry.

194. See Jill U. Adams, *A Balm for Pain*, L.A. TIMES, Aug. 18, 2008, at F6.

195. Croxford & Yamamura, *supra* note 164, at 5.

196. Centonze et al., *supra* note 173, at 186.

197. Croxford & Yamamura, *supra* note 164, at 12.

198. Lester Grinspoon, *Medical Marijuana in a Time of Prohibition*, 10 INT. J. DRUG POLICY 145, 153 (1999); Oliver Ullrich, et al., *Immune Control by Endocannabinoids—New Mechanisms of Neuroprotection?*, 184 J. NEUROIMMUNOLOGY 127, 128 (2006).

199. Mackie, *supra* note 164, at 113.

200. Pertwee, *supra* note 149, at 517; Ullrich et al., *supra* note 198, at 128.

201. Nicoll & Alger, *supra* note 162, at 8; Centonze et al., *supra* note 173, at 186.

202. Ullrich et al., *supra* note 198, at 132.

C. Risks of Therapeutic Cannabis Use

Worldwide, there is not a single published case of human death by cannabis poisoning.²⁰³ In 1995, the esteemed British medical journal, the *Lancet*, announced that “[t]he smoking of cannabis, even long term, is not harmful to health.”²⁰⁴ Three years later it modified its position to the extent that “moderate indulgence has little ill-effect on health” and advised intoxicated individuals not to operate motor vehicles.²⁰⁵ In 2007, however, the *Lancet* published a study purporting to establish a “consistent association between cannabis use and psychotic symptoms,” cautioning that cannabis use in the young could increase their chances of “developing a psychotic illness later in life.”²⁰⁶ These warnings kicked up a flurry of reaction on the internet and in the media; as the bad news about marijuana is prone to travel faster and farther than the good.

In rare instances, an individual, usually one with a history of mental illness, can exhibit transient psychotic symptoms or acute psychosis after smoking marijuana.²⁰⁷ The authors of the 2007 *Lancet* article, after reviewing and analyzing seven prior studies of schizophrenia and other psychotic disorders, declined to conclude that cannabis causes psychosis.²⁰⁸ Their data, however, revealed an increased psychosis risk of forty percent in the study participants who had never used cannabis.²⁰⁹ Bruce Spring, MD, assistant professor of clinical psychiatry at the University of California Keck School of Medicine, Los Angeles, has reviewed the study, although he did not participate in it. He finds the results to be “cause for concern,” but does not regard the increased risk of psychosis to be statistically significant.²¹⁰ He has not, however, performed additional studies.

203. Wayne Hall & Nadia Solowij, *Adverse Effects of Cannabis*, 352 LANCET 1611, 1612 (1998).

204. Editorial, *Deglamorising Cannabis*, 346 LANCET 1241, 1241 (1995).

205. Editorial, *Dangerous Habits*, 352 LANCET 1565, 1565 (1998).

206. Theresa H. M. Moore et al., *Cannabis Use and Risk of Psychotic or Affective Mental Health Outcomes: A Systematic Review*, 370 LANCET 319, 327 (2007).

207. Asif R. Malik & Deepak Cyril D'Souza, *Gone to Pot: The Association Between Cannabis and Psychosis*, 23 PSYCHIATRIC TIMES 28 (2006), available at <http://www.psychiatristimes.com/display/article/10168/49641>.

208. See Moore et al., *supra* note 206, at 327.

209. *Id.* at 325.

210. Generally, a person's risk of developing a psychotic illness is three percent. An increase of forty percent would raise that risk to 4.2 percent. Kathleen Doheny, *Are Smoking Pot and Psychosis Linked?: Marijuana Boosts Later Psychotic Illness Risk by 40%, Study Shows*, WEBMD MEDICAL NEWS, July 26, 2007, at <http://www.webmd.com/mental-health/news/20070726/pot-now-psychotic-later>.

Similarly, although it is not yet known whether cannabis use can precipitate psychosis in mentally healthy individuals, it is just as plausible that a tendency toward psychosis might “increase the likelihood of early cannabis use.”²¹¹ Researchers who noted a “sixfold higher risk of schizophrenia” in cannabis users with a family history of schizophrenia suspect neurochemical and/or genetic factors may be responsible for this finding.²¹² Reasoning that cannabinoid receptor dysfunction contributes to the development of schizophrenia, these scientists proposed that it is this irregularity which supplies the underlying link between cannabis use and psychosis.²¹³ Thus, any association between cannabis use and psychosis might be limited to a distinct, vulnerable population. Countries such as Australia, Canada, and the United States, with high percentages of marijuana users, have not experienced a commensurate increase in the incidence of psychosis.²¹⁴

Without conclusive evidence, marijuana has also been labeled a cancer hazard. Long-term exposure to cannabis smoke has long been thought to increase the risk of respiratory cancers as well as cancers of the mouth, tongue, and esophagus.²¹⁵ In 2006, Donald Tashkin, a pulmonologist at the University of California at Los Angeles, discovered “no association at all” between cannabis smoking and lung, head, or neck cancer.²¹⁶ Having observed no increased risk of these three cancers, even among heavy marijuana smokers, Tashkin posited that THC actually induced a protective effect by killing aging cells and preventing them from becoming cancerous.²¹⁷

Marijuana is known to have an impact on the immune system; an effect that is difficult to understand because studies have been

211. Leslie Iversen, *Long-term Effects of Exposure to Cannabis*, 5 PHARMACOLOGY 69, 70 (2005).

212. Malik & D’Souza, *supra* note 207.

213. *Id.*

214. Iversen, *supra* note 211, at 70; Malik & D’Souza, *supra* note 207; Posting of Paul Armentano & Mitch Earleywine to THE HUFFINGTON POST, http://www.huffingtonpost.com/paul-armentano-and-mitch-earleywine/interpreting-hazy-warning_b_59543.html (Aug. 7, 2007, 19:05).

215. Hall et al., *supra* note 189, at 37.

216. See Marc Kaufman, *Study Finds No Cancer-Marijuana Connection*, WASH. POST, May 26, 2006, at A3.

217. See *id.* For a further discussion of Tashkin’s studies, see Jill U. Adams, *Damaging Habit?*, L.A. TIMES, Aug. 18, 2008, at F6. In 2008, the European Respiratory Journal published a study purporting to show a fivefold increase in lung cancer risk among daily users of marijuana for a period of ten years. Dr. Tashkin, however, viewed the study’s sample size as too small to create creditable risk estimates. *Id.*

contradictory. Although a majority of studies show that cannabinoids have an inhibitory effect on immune functions, others demonstrate that cannabis stimulates the immune system and plays an important role in controlling immune responses.²¹⁸ These features have special implications for medicinal marijuana users with compromised immune systems. Yet, a twenty-one-day trial of oral or smoked cannabinoids did not prove unsafe to patients infected with HIV.²¹⁹ It also appears that, because cannabinoids suppress the activation of white blood cells, they are particularly useful in the treatment of inflammatory disease.²²⁰ Possibly, the impact of cannabinoids on the immune system is transient, allowing “the inhibitory effect to be overcome when the immune system needs to be activated in response to infection.”²²¹ There is as yet no definitive proof that cannabinoids impair human immune system functioning. This is, however, an area in need of further research.

When it issued its report on marijuana and medicine in 1999, the Institute of Medicine labeled marijuana a “crude THC delivery system,” the smoking of which also conveys “harmful substances.”²²² In all other respects, the adverse effects of cannabis use were deemed “within the range tolerated for other medications.”²²³ A recent study of marijuana’s effect on pulmonary structure and function found that the predominant symptoms associated with cannabis use are “wheezing, cough, chest tightness and sputum production, large airways obstruction and hyperinflation, but not emphysema.”²²⁴ The same study also found major public health significance in the finding that one cannabis joint is the equivalent of 2.5 to 5 tobacco cigarettes in causing airflow obstruction.²²⁵ Unlike tobacco cigarettes, “[c]annabis is usually smoked without a filter” and burns at a higher temperature.²²⁶ Furthermore, marijuana “smokers inhale more deeply and hold their breath for longer” than tobacco smokers.²²⁷

Despite these very real concerns, Tashkin’s findings on the lack of

218. Croxford & Yamamura, *supra* note 164, at 6.

219. Ullrich et al., *supra* note 198, at 129.

220. MedicalNewsToday.com, Marijuana-like Compounds Suppress the Immune Response, <http://www.medicalnewstoday.com/articles/42345.php> (last visited Apr. 11, 2009).

221. Croxford & Yamamura, *supra* note 164, at 13.

222. IOM REPORT, *supra* note 153, at 10.

223. *Id.* at 126-27.

224. Sarah Aldington et al., *Effects of Cannabis on Pulmonary Structure, Function and Symptoms*, 62 THORAX 1058, 1063 (2007).

225. *Id.* at 1062.

226. *Id.*

227. *Id.*

association between smoked cannabis and certain cancers,²²⁸ as well as the recent development of a vaporizing device for smoking,²²⁹ suggest that whole plant marijuana is still a viable therapeutic delivery system. Continuing objections to the smoking of cannabis, possibly stemming from legal or moral concerns, are likely to be based on judgments that cannabinoid derivatives are better medicine. Given the complex chemical nature of botanical marijuana, the question, medically speaking, is whether the whole is more effective than some or any of its component parts.

D. Herbal Marijuana vs. Pharmaceutical Cannabinoids

One advantage of synthetic cannabinoids is that they can be administered intravenously. Chemical analogs such as dexamabinol (HU 211) can be given to unconscious victims of hemorrhagic stroke or brain injury.²³⁰ Those who wish to avoid marijuana's psychoactive effects might also prefer derivatives or chemical analogs to botanical marijuana. Cannabidiol, for example, may have greater success as an anti-anxiety drug "without THC, which sometimes generates anxiety."²³¹ But the problem with reducing marijuana to its component parts, and using those components in highly specific ways, is that we have yet to unravel completely the mystery of how the whole plant actually works. Marijuana's broad spectrum of therapeutic uses largely depends on the combinations and interactions of its numerous cannabinoids.²³² This synergy is lost when, in place of the plant, one or more of marijuana's elements are isolated and restricted to specialized use.

Nor can the therapeutic benefits of cannabis be divorced from its psychoactive properties.²³³ Patients who smoke marijuana may experience an elevation of mood as well as relief from symptoms.²³⁴ The combined result is a greater sense of well-being.²³⁵ Whatever its desirability, the psychoactivity in the FDA-approved drug, Marinol (dronabinol), is considerably more difficult to manage than that of smoked cannabis. Prescribed for chemotherapy-induced nausea and

228. See *supra* note 216 and accompanying text.

229. See *infra* notes 252-54 and accompanying text.

230. Grinspoon, *supra* note 198, at 153.

231. *Id.*

232. *Id.* at 154-55.

233. Lester Grinspoon, *Puffing is the Best Medicine*, L.A. TIMES, May 5, 2006, at B13.

234. *Id.*

235. *Id.*

AIDS wasting syndrome, Marinol is THC in capsule form.²³⁶ Once swallowed, it can require an hour or more to take effect, with results that are difficult to predict, even from one use to another.²³⁷ These varying and delayed outcomes can make it difficult for Marinol users to calculate the appropriate dosage.²³⁸ In addition, the psychoactive effects of orally ingested THC are often more intense than those produced by smoked cannabis and can last as much as three times longer.²³⁹

When THC is inhaled through the lungs rather than absorbed through the gastrointestinal tract, it acts quickly. Smokers can more easily adjust, or "self-titrate dosages to realize therapeutic levels" while minimizing psychoactive effects.²⁴⁰ As pure THC, Marinol lacks the additional active agents available in crude marijuana, such as cannabidiol, which may serve to modulate THC's psychoactivity.²⁴¹

On a more practical level, patients suffering extreme nausea may find it easier to inhale their medicine than to swallow it and try to keep it down. Another oral preparation, Sativex (not available in the United States), is a liquid cannabinoid administered under the tongue. Due to its unpleasant taste, however, it is difficult to hold in place long enough to achieve absorption. When portions of it "trickle down the esophagus," it behaves like Marinol or any other orally ingested THC.²⁴²

A recent study comparing Marinol to smoked marijuana found both medications effective for gastrointestinal problems, but only marijuana produced improved sleep ratings.²⁴³ Except for low-dose dronabinol, the cannabinoids produced "significant intoxication" which was not only well-tolerated but "rated positively . . . with little evidence of discomfort and no impairment of cognitive performance."²⁴⁴ The marijuana used in the study was supplied by the National Institute of Drug Abuse (NIDA)

236. ZIMMER & MORGAN, *supra* note 136, at 18.

237. *Id.* at 19.

238. *Id.*

239. *Id.* at 19-20.

240. Richard E. Doblin & Mark A. R. Kleiman, *Marijuana as Antiemetic Medicine: A Survey of Oncologists' Experiences and Attitudes*, 9 J. CLINICAL ONCOLOGY 1314, 1318 (1991).

241. ZIMMER & MORGAN, *supra* note 136, at 20.

242. Grinspoon, *supra* note 233.

243. Margaret Haney et al., *Dronabinol and Marijuana in HIV-Positive Marijuana Smokers: Caloric Intake, Mood and Sleep*, 45 J. ACQUIRED IMMUNE DEFICIENCY SYNDROME 545 (2007).

244. *Id.* at 545.

and contained a weak 3.9 percent THC.²⁴⁵ It took eight times the current recommended dose of Marinol to produce effects comparable to NIDA's low-grade hemp.²⁴⁶ These results, as well as the demonstrated success of smoked cannabis in treating HIV-associated sensory neuropathy, suggest that herbal marijuana has proven to be much more than a crude delivery system for THC. Moreover, as there are "no FDA-approved treatments for HIV-related neuropathy," botanical cannabis is these patients' sole source of effective relief.²⁴⁷ Dr. Donald Abrams, chief of hematology and oncology at San Francisco General Hospital, routinely sees cancer patients suffering from pain, loss of sleep and appetite, depression, and nausea and vomiting from treatment.²⁴⁸ He says he is grateful to be living in the state of California where he "can talk to patients about medicinal cannabis" and often recommend it to them for their symptoms.²⁴⁹

Lester Grinspoon, a tireless advocate of herbal medical marijuana, has calculated its benefits as "extraordinarily high as compared to the risks."²⁵⁰ Although, in time, the pharmaceutical industry might develop more useful and cheaper cannabis-based products, "the analogs they have produced so far are more expensive than herbal marijuana, and none has shown any improvement over the plant nature gave us to take orally or to smoke."²⁵¹ In the meantime, the smoking of the plant recently got much safer. Researchers have developed a smokeless cannabis-vaporizing device which heats the plant matter to a temperature just below combustion.²⁵² The resulting vapor provides the same effect as smoked cannabis but without the by-products produced by burning plant materials.²⁵³ Dr. Igor Grant, psychiatrist and director of the UC Center for Medicinal Cannabis Research in San Diego, describes

245. Michael Hess, *Weak Marijuana Works as Well as High-Dose THC Pills*, BBS NEWS, July 3, 2007, <http://bbsnews.net/article.php/20070703235428924>.

246. *Id.*; Haney et al., *supra* note 243, at 545.

247. Sheehy, *supra* note 193.

248. Jill U. Adams, *Medical Marijuana: What Does Science Say?*, L.A. TIMES, Aug. 18, 2008, at F1.

249. *Id.*

250. Grinspoon, *supra* note 198, at 155.

251. Grinspoon, *supra* note 151. *But see* ProCon.org, *How Does the Cost of Marijuana Compare to the Cost of Marinol?*, <http://medicalmarijuana.procon.org/viewanswers.asp?questionID=000091> (last visited Apr. 11, 2009). Although an average daily dose of Marinol costs about six dollars more than an average dose of marijuana, Marinol is now a Schedule III drug, and most insurance companies cover its cost, except for patients' co-payments. *Id.*

252. Adams, *supra* note 217.

253. *Id.*

vaporization as "a safe and effective delivery system."²⁵⁴ Not only does the device benefit medicinal marijuana users who prefer smoking to oral ingestion, it also opens up new possibilities for research regarding the therapeutic value of smoked cannabis; it would, that is, if the federal government did not so severely inhibit scientists from obtaining legal supplies of marijuana.

E. Obstacles to Research

In 1986, after well over a decade of legal wrangling, the DEA began conducting hearings on a petition to transfer marijuana from Schedule I to Schedule II.²⁵⁵ In his ruling, issued in 1988, Administrative Law Judge Francis L. Young stated that "[m]arijuana, in its natural form, is one of the safest, therapeutically active substances known to man,"²⁵⁶ and recommended that the DEA Administrator grant the proposed schedule change.²⁵⁷ In a remarkably acidic Final Rule issued in 1992, DEA Administrator Robert C. Bonner dismissed all claims as to marijuana's medicinal value as "false, dangerous and cruel" and concluded that "[b]y any modern scientific standard, marijuana is no medicine."²⁵⁸ Bonner further opined that proponents of medical marijuana "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."²⁵⁹

Taking this advice to heart, in 1995 Donald Abrams, then a research scientist at the University of California, San Francisco, designed an FDA-approved study comparing the efficacy of inhaled

254. *Id.*

255. NORML had initiated the administrative proceedings in 1972. *In re Marijuana Rescheduling Petition*, DOJ ALJ No. 86-22, at 2-5 (U.S. Dep't of Justice, Drug Enforcement Administration, Sept. 6, 1988) (Young, A.L.J.), available at <http://www.druglibrary.org/Schaffer/library/studies/YOUNG/young1.html> (reciting the procedural history of the case).

256. *Id.* at 58-59.

257. *Id.* at 68. At the time, Schedule II drugs included Marinol (later transferred to Schedule III), methadone, morphine, methamphetamine, and cocaine. A transfer from Schedule I to Schedule II would have credited marijuana with a currently accepted medical use and, under limited conditions, would have allowed physicians to prescribe it. See Controlled Substances Act, 21 U.S.C. § 812 (2000).

258. Marijuana Scheduling Petition, 57 Fed. Reg. 10499, 10503, 10508 (Mar. 26, 1992).

259. Lester Grinspoon et al., *Marijuana, the AIDS Wasting Syndrome, and the U.S. Government*, 333 NEW ENGLAND J. MED. 670, 670-71 (1995) (citing Marijuana Scheduling Petition, 57 Fed. Reg. at 10503).

marijuana with dronabinol in treating AIDS wasting syndrome.²⁶⁰ It took NIDA nine months to respond to Dr. Abrams' request for a legal allotment of marijuana and to deny him access to federal cannabis supplies grown exclusively at the University of Mississippi.²⁶¹

For forty years, the U.S. government has held a monopoly on research-grade marijuana. Its repeated refusal to make it available for privately-funded, FDA-approved research has severely hampered researchers' attempts to legitimize herbal marijuana as a legal prescription medicine.²⁶² Marijuana is the only Schedule I drug that the DEA prohibits private laboratories from producing for scientific research.²⁶³ Controlled substances such as heroin, cocaine, LSD, and MDMA ("ecstasy") may all be obtained by researchers from DEA-licensed private laboratories.²⁶⁴ In 2007, DEA Administrative Law Judge Mary Ellen Bittner granted the petition of a University of Massachusetts plant biology professor to grow marijuana for medical studies.²⁶⁵ (Professor Lyle Craker's petition had been pending for six years.)²⁶⁶ Finding the existing supply of licensed cannabis inadequate, Bittner deemed Craker's application to cultivate marijuana for research purposes to be "in the public interest" and recommended it be granted.²⁶⁷ The determination was subject to review by the DEA Administrator and, as occurred with Administrative Law Judge Young's earlier decision on rescheduling, was rejected.²⁶⁸

260. *See id.*

261. *See id.* The DEA also refused Dr. Abrams permission to import marijuana from a company licensed in the Netherlands to cultivate cannabis for pharmaceutical and botanical research. *See id.*

262. *Medical Marijuana One Step Away from FDA Development Process*, AM. CIVIL LIBERTIES UNION, May 23, 2007, <http://www.aclu.org/drugpolicy/medmarijuana/29857prs20070523.html> [hereinafter ACLU, *One Step Away*] (last visited Apr. 11, 2009).

263. *Id.*

264. *Id.*

265. *See* Bob Egelko, *Judge Sides with Botanist on Pot Supply*, SAN FRANCISCO CHRON., Feb. 13, 2007, at B8.

266. *Id.*

267. *Id.*; *In re* Lyle E. Craker, DOJ ALJ No. 05-16, at 87 (U.S. Dep't of Justice, Drug Enforcement Administration, Feb. 12, 2007) (Bittner, A.L.J.), *available at* http://www.aclu.org/images/asset_upload_file116_28341.pdf.

268. Lyle E. Craker, 74 Fed. Reg. 2101, 2133 (Jan. 14, 2009). Among her reasons for denying Professor Craker's application, Deputy DEA Administrator Michele M. Leonhart seems to have been worried about flooding the marijuana market: "It is axiomatic that the proliferation of suppliers of bulk Schedule I and II controlled substances heightens the risk of oversupply, which in turn increases the risk of diversion." *Id.* at 2133.

A 2008 position paper, prepared by the American College of Physicians (ACP) and endorsed by its governing board, unequivocally supported increased research and scientific evaluation of marijuana's potentially therapeutic benefits.²⁶⁹ Among its additional recommendations, the report strongly supports exemption from federal criminal and civil liability for patients who use, and doctors who prescribe, marijuana pursuant to state law.²⁷⁰ It further urges that doctors dispensing or prescribing medicinal cannabis in accordance with state law be exempt from professional sanctioning such as loss of credentialing or licensure.²⁷¹ While the ACP cautioned against possible health risks associated with chronic use of smoked marijuana, it noted promising research on the use of vaporization as a delivery system.²⁷² Observing that marijuana's classification as a Schedule I controlled substance conflicts with the findings of the Institute of Medicine, the ACP declared that "[a] clear discord exists between the scientific community and federal legal and regulatory agencies over the medical value of marijuana, which impedes the expansion of research."²⁷³

Federal officials greeted the ACP position paper with characteristic unabashed predictability. Essentially, the FDA reiterated its 2006 position that marijuana has no value as a medical treatment.²⁷⁴ Bertha Madras, the White House drug czar's deputy director for demand reduction, announced that, "What this would do is drag us back to 14th-century medicine It's so arcane."²⁷⁵ But what seems inscrutable to Ms. Madras is, more importantly, far less "arcane" to the 124,000 doctors of internal medicine who compose the ACP.²⁷⁶ One wonders just how great the weight of medical evidence must be before it can

269. See AMERICAN COLLEGE OF PHYSICIANS, SUPPORTING RESEARCH INTO THE THERAPEUTIC ROLE OF MARIJUANA 6-8 (2008) available at http://www.acponline.org/advocacy/where_we_stand/other_issues/medmarijuana.pdf.

270. *Id.* at 9.

271. *Id.*

272. *Id.* at 8.

273. AMERICAN COLLEGE OF PHYSICIANS, *supra* note 269, at 9; see also Jocelyn Elders, *Former Surgeon General: Mainstream Medicine Has Endorsed Medical Marijuana*, ALTERNET, Mar. 26, 2008, <http://www.alternet.org/drugreporter/80582> ("The ACP position paper demolishes several myths, starting with the notion still proclaimed by some politicians that marijuana is unsafe for medical use.").

274. Eric Bailey, *Doctors Urge Easing of Marijuana Ban*, L.A. TIMES, Feb. 15, 2008, at A14; Harris, *supra* note 142.

275. Bailey, *supra* note 274.

276. Only the AMA, with 240,000 members, is a larger physician organization than the ACP. *Id.*

budge the mountain of stalwart prejudice constructed by federal agencies like the FDA.

Even with a thorough knowledge of marijuana's troubled legal and political history in the United States, the recalcitrance of the federal government is hard to fathom. After the FDA's wholesale dismissal of medical marijuana's scientific basis in 2006, one exasperated observer accused the agency of jettisoning "science, objectivity, and logic to help politicians prop up a morally and scientifically bankrupt policy."²⁷⁷ Another commentator, calling for expanded research efforts on behalf of therapeutic cannabis, averred that "drugs should be admitted to medical practice based on science rather than plebiscite."²⁷⁸ But it is not the common people who have kept medicinal cannabis hobbled and chained to its burdensome past. In the mid-1990s, while tens of millions were using marijuana in relative safety, while scientists were discovering the role of cannabinoids in treating human disease, and while the politicians were willfully ignoring all of them, the "plebiscite" began to take matters into its own hands.

IV. A DIVIDED LAND: MEDICAL MARIJUANA AND CULTURAL FEDERALISM

The Framers split the atom of sovereignty. It was the genius of their idea that our citizens would have two political capacities, one state and one federal, each protected from incursion by the other.²⁷⁹

Justice Anthony M. Kennedy

[T]hat which we call sin in others, is experiment for us.²⁸⁰

Ralph Waldo Emerson

The idea of "federalism" generally brings up constitutional associations, born of a late-eighteenth-century political bargain.

277. *Marijuana, Medicine & the FDA: Jettisoning Science, Objectivity and Logic in Favor of Morally Bankrupt Politics*, GENETIC ENGINEERING & BIOTECH. NEWS, June 1, 2006, available at <http://www.genengnews.com/articles/chitem.aspx?aid=1676&chid=0>.

278. L.E. Hollister, *An Approach to the Medical Marijuana Controversy*, 58 DRUG & ALCOHOL DEPENDENCE 3, 4 (2000).

279. *U.S. Term Limits, Inc. v. Thornton*, 514 U.S. 779, 838 (1995) (Kennedy, J., concurring).

280. RALPH WALDO EMERSON, *Experience*, in *ESSAYS: FIRST AND SECOND SERIES* 137 (2007) (1844).

Thirteen quasi-independent states surrendered a portion of their sovereignty to a central government, an accommodation memorialized in the United States Constitution. Indeed, the Constitution established a system of "dual sovereignty," through which the states yielded a fair sum of their powers but retained "a residuary and inviolable sovereignty."²⁸¹ This legal dimension of federalism was shaped at the outset: its premises were highlighted in the Constitution's Supremacy Clause²⁸² and rationalized in the Federalist Papers, the twenty-seventh of which observed it as "merit[ing] particular attention . . . that the laws of the Confederacy as to the *enumerated* and *legitimate* objects of its jurisdiction will become the supreme law of the land . . ."²⁸³ Sovereignities in tension are at the heart of our Constitutional order.

We have lived in a divided polity for over two centuries. Familiarity with it may dull us to its uniqueness. Justice Kennedy's paean to our parallel citizenship serves to remind us of the evocative arrangement: "The . . . Constitution created a legal system unprecedented in form and design, establishing two orders of government, each with its own direct relationship, its own privity, its own set of mutual rights and obligations to the people who sustain it and are governed by it."²⁸⁴

But the Constitution does not resolve all the clashes between "the two different governments created and confirmed by the Constitution."²⁸⁵ The continuing conflicts over medical marijuana exemplify how the resolution of legal "supremacy" has only succeeded in muddying the cultural dilemmas of federalism.

281. *Printz v. United States*, 521 U.S. 898, 918 (1997) (quoting *Gregory v. Ashcroft*, 501 U.S. 452, 457 (1991); THE FEDERALIST NO. 39, 245 (James Madison)).

282. The Supremacy Clause provides that "the Laws of the United States . . . shall be the supreme Law of the Land . . . , any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. CONST. art. VI, cl. 2. The Supreme Court has described the Supremacy Clause as "a decided advantage," which the "Federal Government holds . . . in this delicate balance." *Gregory, v. Ashcroft*, 501 U.S. 452, 460 (1991).

283. THE FEDERALIST NO. 27 (Alexander Hamilton) (emphasis in original); *see also* *New York v. United States*, 505 U.S. 144, 156 (1992) ("Congress exercises its conferred powers subject to the limitations contained in the Constitution.").

284. *Thornton*, 514 U.S. at 838 (Kennedy, J., concurring).

285. *Id.* at 839. The constitutional structure of federalism does, however, "allow the States great latitude under their police powers to legislate as to the protection of the lives, limbs, health, comfort, and quiet of all persons." *Gonzales v. Oregon*, 546 U.S. 243, 270 (2006) (internal quotations omitted) (striking down a federal rule aimed at undermining Oregon's physician-assisted suicide law).

A. The States Revolt

As of this writing, thirteen states have become conscientious objectors in the federal government's drug war.²⁸⁶ As a legal matter, medical marijuana represents a sparring contest between federal and state governments over the regulatory framework for the control of narcotics substances. The Federal Controlled Substances Act (CSA) has, since 1970, banned marijuana as a "Schedule I controlled substance."²⁸⁷ Possession of a controlled substance is a criminal offense.²⁸⁸ Federal law also proscribes "dispensing"²⁸⁹ a controlled substance, a term which has been read to include the writing of prescriptions by physicians.²⁹⁰ Beginning in 1996, with the passage of California's Compassionate Use Act, a number of states began their dissent from the complete ban on the use of marijuana.²⁹¹ The California Act permits use of marijuana for medical purposes when recommended by a physician.²⁹² A patient or a patient's caregiver, who possesses or cultivates marijuana for medical treatment upon the recommendation of a physician, is exempt from state criminal anti-drug provisions.²⁹³ Although the laws enacted by the twelve other states that have contravened the federal statute differ in several significant details, they all legalize what the federal government criminalizes.²⁹⁴ The

286. See ProCon.org, Thirteen Legal Medical Marijuana States, <http://medicalmarijuana.procon.org/viewresource.asp?resourceID=881> (last visited Apr. 11, 2009). Canada, the Netherlands, and Israel have also legalized medical marijuana. See Kathleen T. McCarthy, Comment, *Conversations About Medical Marijuana Between Physicians and Their Patients*, 25 J. LEGAL MED. 333, 348 (2004) (Canada and Netherlands); Corinne Heller, *Israel to Soothe Battle Trauma with Marijuana*, REUTERS NEWMEDIA, Oct. 2, 2004, available at <http://www.aegis.com/news/re/2004/RE041003.html> (Israel); Miriam Bulwar David-Hay, *Clinic Offers Puff of Relief for Chronically Ill*, JERUSALEM POST, Jan. 6, 2008, available at <http://www.jpost.com/servlet/Satellite?cid=1198517303901&pagename=JPost%2FJPArticle%2FShowFull> (Israel).

287. 21 U.S.C. § 812(c) (2000).

288. 21 U.S.C. § 841(a)(1) (2000).

289. *Id.*

290. See *infra* notes 412-48 and accompanying text (discussing the dilemmas faced by physicians whose patients could benefit from medical marijuana).

291. Compassionate Use Act of 1996, CAL. HEALTH & SAFETY CODE § 11362.5 (West 2007); see *infra* notes 333-43 and accompanying text (discussing the range of state laws permitting marijuana for medicinal purposes).

292. CAL. HEALTH & SAFETY CODE § 11362.5(b)(1)(A) (West 2007).

293. *Id.* § 11362.5(d).

294. The twelve other states that have enacted medical marijuana legislation include Alaska, Colorado, Hawaii, Maine, Michigan, Montana, Nevada, New Mexico, Oregon, Rhode Island, Washington, and Vermont. See *infra* notes 333-43 and accompanying text; see also U.

upshot of these statutes is clear: a substantial number of states and their citizens have commenced a brush war on the federal government's marijuana enforcement policy, a conflict with important legal and cultural aspects.

The Supreme Court theoretically resolved the issue of legal predominance in *Gonzales v. Raich*,²⁹⁵ a 2005 decision that held that Congress' Commerce Clause authority includes the power to prohibit the local cultivation and use of medical marijuana in compliance with California law.²⁹⁶ The five-member majority found it an application of "[w]ell-settled law"²⁹⁷ that Congressional authority "to regulate interstate markets for medicinal substances encompasses the portions of those markets that are supplied with drugs produced and consumed locally."²⁹⁸ The California law allowing for limited marijuana use contravened Constitutionally-sanctioned Congressional authority, to which it must yield, as the Supremacy Clause makes clear.²⁹⁹

But in upholding the CSA's total prohibition of marijuana, the *Raich* majority acknowledged "the troubling facts of this case."³⁰⁰ It admitted that the evidence "regarding the effective medical uses for marijuana, if found credible after trial, would cast serious doubt on the accuracy of the findings that require marijuana to be listed in [the CSA's] Schedule I."³⁰¹ The majority opinion also noted that "[t]he case

S. GENERAL ACCOUNTING OFFICE, MARIJUANA: EARLY EXPERIENCES WITH FOUR STATES' LAWS THAT ALLOW USE FOR MEDICAL PURPOSES 46-50 (2002), *available at* <http://www.gao.gov/new.items/d03189.pdf> (reporting on implementation of medical marijuana programs in Alaska, California, Hawaii, and Oregon).

295. *Gonzales v. Raich*, 545 U.S. 1 (2005).

296. *Id.* at 9.

297. *Id.*

298. *Id.* Justice Scalia concurred in the judgment, agreeing that the CSA may be applied validly to the cultivation, distribution, and possession of marijuana for personal medicinal use. *Raich*, 545 U.S. at 33 (Scalia, J., concurring). Three Justices dissented: Justice O'Connor, Chief Justice Rehnquist, and Justice Thomas.

299. *Id.* at 29 (majority opinion) ("The Supremacy Clause unambiguously provides that if there is any conflict between federal and state law, federal law shall prevail. It is beyond peradventure that federal power over commerce is superior to that of the States to provide for the welfare or necessities of their inhabitants, however legitimate or dire those necessities may be.") (internal quotation marks omitted). Note that the Supreme Court did not hold that the Supremacy Clause impinged upon California's right to devise medical marijuana legislation. Congress has not usurped the field of marijuana regulation, and so states are free to craft their own regulatory efforts. All *Raich* held on this score was that the CSA was a valid exercise of Congress's Commerce Clause power, California's inconsistent laws on the subject of medical marijuana notwithstanding. *See id.* at 29-33.

300. *Raich*, 545 U.S. at 9.

301. *Id.* at 27 n.37.

is made difficult by respondents' strong arguments that they will suffer irreparable harm because, despite a congressional finding to the contrary, marijuana does have valid therapeutic purposes."³⁰² In dissent, Justice O'Connor decried the 'majority's reliance on what she termed "Congress' abstract assertions," resulting in the Supreme Court's "endorse[ment that it is] a federal crime to grow small amounts of marijuana in one's own home for one's own medicinal use."³⁰³ Similarly, Justice Thomas criticized the majority for "prevent[ing] States like California from devising drug policies that they have concluded provide much-needed respite to the seriously ill."³⁰⁴ Referring to the increasing acceptance of medicinal marijuana on the state level, Justice Thomas opined that "[o]ur federalist system, properly understood, allows California and a growing number of other States to decide for themselves how to safeguard the health and welfare of their citizens."³⁰⁵

The impact of *Gonzales v. Raich* on federalism has generated extensive commentary describing the appropriate balance between the federal and state governments.³⁰⁶ But even if "the modern American model offers a pragmatic accommodation of federal and state authority,"³⁰⁷ in which we must simply accept the conclusion that "there

302. *Id.* at 9.

303. *Id.* at 57 (O'Connor, J., dissenting). O'Connor also noted that "[t]his overreaching stifles an express choice by some States, concerned for the lives and liberties of their people, to regulate medical marijuana differently." *Id.*

304. *Raich*, 545 U.S. at 74 (Thomas, J., dissenting).

305. *Id.* at 74.

306. See, e.g., Jonathan H. Adler, *Is Morrison Dead? Assessing a Supreme Drug (Law) Overdose*, 9 LEWIS & CLARK L. REV. 751 (2005); Steven K. Balman, *Constitutional Irony: Gonzales v. Raich, Federalism and Congressional Regulation of Intrastate Activities Under the Commerce Clause*, 41 TULSA L. REV. 125 (2005); George D. Brown, *Counterrevolution?—National Criminal Law After Raich*, 66 OHIO ST. L.J. 947 (2005); A. Christopher Bryant, *The Third Death of Federalism*, 17 CORNELL J.L. & PUB. POL'Y 101 (2007); Samuel Issacharoff & Catherine M. Sharkey, *Backdoor Federalization*, 53 UCLA L. REV. 1353 (2006); Andrew King, *What the Supreme Court isn't Saying about Federalism, the Ninth Amendment, and Medical Marijuana*, 59 ARK. L. REV. 755 (2006); Denise C. Morgan & Rebecca E. Zietlow, *The New Parity Debate: Congress and Rights of Belonging*, 73 U. CIN. L. REV. 1347 (2005); Glenn H. Reynolds & Brannon P. Denning, *What Hath Raich Wrought? Five Takes*, 9 LEWIS & CLARK L. REV. 915 (2005); Norman R. Williams, *The Commerce Clause and the Myth of Dual Federalism*, 54 UCLA L. REV. 1847 (2007); Ernest A. Young, *Just Blowing Smoke? Politics, Doctrine, and The Federalist Revival after Gonzales v. Raich*, 2005 SUP. CT. REV. 1 (2005); Karl Crow, Note & Comment, *Inevitable and Inexorable Consequences?: Massachusetts' Healthcare Reform and Post-Raich Federalism*, 17 TEMP. POL. & CIV. RTS. L. REV. 251 (2007).

307. Williams, *supra* note 306, at 1929.

can never be any clear resolution of American federalism,”³⁰⁸ very little attention has been paid to the working relationships and trade-offs between federal and state and even local authority. Even less commentary has focused on the risks individuals face when they obey the legal commands of one sovereign and disregard the contrary laws of the other. Medical marijuana sharply focuses these concerns. On this issue, Congress has made its sovereign decision, and thirteen states have to date revolted. Any “pragmatic accommodation”³⁰⁹ is occurring not in the area of legal doctrine, but in the world of ambiguous legal relationships and workaday consequences.

As a question of legal federalism, the issue of medical marijuana was resolved (or perhaps simply put on hold) in the *Raich* decision. But viewed as a problem of *cultural federalism*, the medical marijuana dilemma is far from a denouement. *Raich* simply did not speak to growing state, local, and individual citizen obstinacy in the face of the blanket federal prohibition which triumphed in the Supreme Court. Indeed, public opinion polls have repeatedly shown that an overwhelming percentage of Americans disagree with the DEA on medical marijuana. Gallup poll results reflect that nationwide support for medical marijuana is increasing, from seventy-three percent in 1999 to seventy-eight percent in 2005.³¹⁰ This deepening disenchantment with federal law, with its social, psychological, and ultimately pragmatic components, has more to do with the “culture of federalism”³¹¹ than with the allocation of legal power between the central government and the states. Lawrence M. Friedman defined “legal culture” to mean “the ideas, attitudes, values, and opinions about law held by people in a society.”³¹² Our use of the term “cultural federalism” follows this usage

308. Brown, *supra* note 306, at 1012. After all, federalism has been characterized as both the “oldest question of constitutional law,” see H. Jefferson Powell, *The Oldest Question of Constitutional Law*, 79 VA. L. REV. 633 (1993), and the “most enduring question of constitutional law,” Edward A. Purcell, Jr., *Evolving Understandings Of American Federalism: Some Shifting Parameters*, 50 N.Y.L. SCH. L. REV. 635, 636 (2006).

309. Williams, *supra* note 306, at 1929.

310. See Ronald Frazer, Editorial, *Action Lags on Medical Marijuana Poll Results*, ROANOKE TIMES, May 18, 2006, <http://www.roanoke.com/editorials/commentary/wb/65570>. Other national polls conducted between 2001 and 2005 indicate support for medical marijuana ranging from sixty-five to eighty percent of respondents. See ProCon.org, Votes and Polls, National, <http://medicalmarijuana.procon.org/viewadditionalresource.asp?resourceID=000151> (listing polling results) (last visited Apr. 11, 2009).

311. LAWRENCE M. FRIEDMAN, *AMERICAN LAW: AN INTRODUCTION* 149 (2d ed. 1998).

312. LAWRENCE M. FRIEDMAN, *TOTAL JUSTICE* 31-32 (1985); see also *id.* (“The assumption is that these ideas and attitudes influence legal behavior, especially the level of demands placed on the legal system. Legal culture, then, is a network of values and attitudes

and relates to the experience, broadly defined, of coping with citizenship in a divided polity.³¹³

Incompatible state and federal laws affect both legal and cultural federalism. If Congress demonstrates the intent to occupy a given field of law, any state law trespassing on that perimeter is preempted.³¹⁴ But the centripetal principles of federalism dictate the outcome even when Congress has not entirely displaced state regulation over the matter. Theoretically, state law is superseded whenever “it is impossible to comply with both state and federal law.”³¹⁵ Yet it is impossible both to possess *medical marijuana* and not to possess *marijuana*. This Zen-like puzzle emanates from a broad-based state effort to decriminalize what the federal government continues to declare illegal.³¹⁶

which determines when and why and where people turn to law or government or turn away. It is thus the immediate source of legal change, whatever the ultimate source may be.”) (internal quotation marks omitted).

313. See Larry Kramer, *Understanding Federalism*, 47 VAND. L. REV. 1485, 1551 (1994) (“Whatever the limits *might* be, however power *could* be allocated, the way authority actually is distributed depends to a considerable extent on the customs, ideas, beliefs, experiences, and practices of the people involved.”); Austin Sarat & Thomas R. Kearns, *The Cultural Lives of Law*, in *LAW IN THE DOMAINS OF CULTURE* 1, 6 (Austin Sarat & Thomas R. Kearns eds., 1998) (“[C]ultural analysis of law . . . insists on examining the ways that the cultural lives of law contribute to . . . ‘asymmetries in the abilities of individuals and social groups to define and realize their needs.’”) (quoting Richard Johnson, *What is Cultural Studies Anyway?*, 16 SOCIAL TEXT 39, 39 (1986)). The argument in the text is unrelated to the one made elsewhere that, in order to preserve “cultural” federalism, the Court should strike down Congress’s use of the commerce clause to legislate social or cultural norms. Grant S. Nelson & Robert J. Pushaw, Jr., *Rethinking the Commerce Clause: Applying First Principles to Uphold Federal Commercial Regulations but Preserve State Control over Social Issues*, 85 IOWA L. REV. 1, 118 (1999); see also Grant S. Nelson, *A Commerce Clause Standard for the New Millennium: “Yes” to Broad Congressional Control Over Commercial Transactions; “No” To Federal Legislation on Social and Cultural Issues*, 55 ARK. L. REV. 1213, 1217 (2003) (advocating “a more active Commerce Clause role for Congress in dealing with commercial transactions and a more limited role in the social and cultural sphere”). Nor is our use of the term “cultural federalism” related to support for cultural projects. Cf. Michael Kammen, *Culture and the State in America*, 83 J. AM. HIST. 791, 814 (1996) (defining cultural federalism as “government support for cultural needs along with collaboration at all levels”) (emphasis omitted); Kevin V. Mulcahy, *The State Arts Agency: An Overview of Cultural Federalism in the United States* (Univ. of Chicago Cultural Pol’y Center, Working Paper 2001), available at <http://culturalpolicy.uchicago.edu/workingpapers/Mulcahy7.pdf>.

314. *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248 (1984) (citing *Pac. Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Corp.*, 461 U.S. 190, 203-04 (1983)).

315. *Id.*

316. See, e.g., *People v. Mower*, 49 P.3d 1067, 1076 (Cal. 2002) (stating that the California Compassionate Use Act “operates . . . to render noncriminal certain conduct that otherwise would be criminal”).

This fundamental tension can be illustrated in the 2008 federal conviction of Charles Lynch for growing and distributing marijuana. Lynch was the owner of a California medical marijuana dispensary, Central Coast Compassionate Caregivers, which was raided by DEA agents and deputies of a local county sheriff “who was unable to use his office to close the facility since it was in full compliance with state and local laws.”³¹⁷ Central Coast Compassionate Caregivers was one of over sixty California dispensaries raided by the DEA in 2007 and 2008.³¹⁸ Lynch’s dispensary complied fully with state and local laws, and local officials had attended a Chamber of Commerce ribbon-cutting ceremony at its opening.³¹⁹ Jury selection in the Lynch trial became difficult, “with potential jurors citing confusion about the conflict between state and federal laws or strong opinions about medical marijuana.”³²⁰ The judge ruled that state laws governing medical marijuana possession were irrelevant, and forbade the use of the term “medical marijuana” in front of the jury.³²¹ Despite—or perhaps because of—the effort to banish state law from federal court, the jury forewoman in the Lynch case reported that “it was a tough decision for all of us because the state law and the federal law are at odds.”³²²

317. Marijuana Policy Project, *Protest Supporting Convicted Medical Marijuana Dispensary Owner Draws 350 Patients and Advocates Call for an End to Federal Obstruction of State Law*, YUBANET.COM, Oct. 7, 2008, <http://yubanet.com/california/Protest-Supporting-Convicted-Medical-Marijuana-Dispensary-Owner-Draws-350.php>.

318. Kylie Mendonca, *Guilty on All Charges*, NEW TIMES, Aug. 7, 2008, <http://www.newtimesslo.com/cover/752/guilty-on-all-charges/>.

319. Scott Glover, *Dueling Pot Laws Tested in Federal Court*, L.A. TIMES, July 26, 2008, at B1.

320. Alys Landry, *Legalize Marijuana?: Farmington Graduate in Medical Drug Debate*, FARMINGTON DAILY TIMES (New Mexico), Sept. 28, 2008. One potential juror in this federal case confessed to her cross-legal bias: “I don’t think I’d be a fair juror because I tend to side with the state law.” Glover, *supra* note 319.

321. Jacob Sullum, *Fair-Weather Federalists: Conservatives Should Oppose Federal Prosecution of Medical Marijuana Providers*, REASONONLINE, Aug. 13, 2008, <http://www.reason.com/news/show/128062.html> (“U.S. District Judge George Wu . . . decreed there would be no talk of the symptoms marijuana relieves, no references to California’s recognition of marijuana as a medicine, no mention even of the phrase *medical marijuana* in front of the jury.”). One defense witness, Owen Beck, had lost a leg to bone cancer and had obtained a marijuana referral from his oncologist. When Beck took the stand, he “began by explaining his cancer, and his doctor’s recommendation that he seek medical marijuana.” Kylie Mendonca, *Earthquake and Entrapment Roil Lynch’s Medical Marijuana Trial*, NEW TIMES, July 30, 2008, <http://www.newtimesslo.com/news/698/earthquake-and-entrapment-roil-lynchs-medical-marijuana-trial/>. After debate as to whether he was a proper character witness, the judge asked Beck to leave the witness stand, and later instructed jurors to disregard his testimony. *Id.*

322. Glover, *supra* note 319.

In a larger sense, the centrifugal pressures of divergent state laws engender cultural conflict, as individuals and institutions pursue their contradictory ends under the banners of rival statutes. But the broad cultural acceptance of medical marijuana also drives the changes to the legal system. One key illustration is the number of state laws on this issue enacted by large majorities through ballot initiatives: nine.³²³ These examples of citizen lawmaking signify voter disaffection with the federal prohibition and a determination to strike out in a radically different way. In this hotly contested struggle between the central government and almost one quarter of the states, the fractured legal system has become a mirror of society's "ragged multiplicity."³²⁴

California is the most prominent medical marijuana battleground. Indeed, one measure of the scope of the issue is the sheer number of involved individuals, estimated at 200,000 medical marijuana patients in California alone.³²⁵ Legalized medical marijuana came to California in 1996 by a ballot initiative, which overwhelmingly enacted the Compassionate Use Act.³²⁶ The text of the Act sets out its purpose:

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.³²⁷

323. See *infra* notes 333-43 and accompanying text.

324. LAWRENCE M. FRIEDMAN & ROBERT V. PERCIVAL, *THE ROOTS OF JUSTICE: CRIME AND PUNISHMENT IN ALAMEDA COUNTY, CALIFORNIA, 1870-1910*, at 325 (1981); see also JAMES WILLARD HURST, *THE LEGITIMACY OF THE BUSINESS CORPORATION IN THE LAW OF THE UNITED STATES, 1780-1970*, at 139 (1970) ("The more important any legal theme is in United States history, the more likely it is that it has been significantly affected by the coexistence and interplay of the national and the state governments.").

325. Eric Bailey, *State Issues Guide to Legal Pot Use*, L.A. TIMES, Aug. 26, 2008, at B1.

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

327. CAL. HEALTH & SAFETY CODE § 11362.5(b)(1)(a) (West 2007); see also *People v. Bianco*, 113 Cal. Rptr. 2d 392, 395 (Cal. Ct. App. 2001) (noting that this Act includes "precatory language" which shows that the intent of the people was to approve of medical marijuana, and to "exempt" those who use medical marijuana from criminal liability); *People v. Trippet*, 66 Cal. Rptr. 2d 559, 567 (Cal. Ct. App. 1997) (noting that the Act was "presented to California's voters as an act of compassion to those in severe pain"). The "ballot pamphlet" given to California voters considering the issue contained arguments by proponents and opponents. *Id.* In that pamphlet, San Francisco District Attorney Terence Hallinan stated, "I support [Proposition 215] because I don't want to send cancer patients to jail for using marijuana." *Id.*

The Act further provides that, with the “recommendation or approval” of a physician, patients and their primary caregivers are free to possess marijuana for medical use.³²⁸

The Compassionate Use Act is expansive. In 2002, the California Supreme Court observed that the possession and cultivation of marijuana, pursuant to the Act, “is no more criminal . . . than the possession and acquisition of any prescription drug with a physician’s prescription.”³²⁹ In 2003, the California Legislature strengthened the Compassionate Use Act by enacting the Medical Marijuana Program (MMP).³³⁰ The Legislature declared that the MMP was intended in part to “facilitate the prompt identification of qualified patients and their designated primary caregivers in order to avoid unnecessary arrest and prosecution of these individuals and provide needed guidance to law enforcement officers.”³³¹ The MMP also expanded the categories of

328. CAL. HEALTH & SAFETY CODE § 11362.5(b)(2)(d).

329. *People v. Mower*, 49 P.3d 1067, 1082 (Cal. 2002). The *Mower* Court held that the law grants a defendant limited immunity from prosecution, a defense which may not only be raised at trial, but also in a pre-trial motion to set aside an indictment or information. *Id.* at 1070.

330. Medical Marijuana Program, CAL. HEALTH & SAFETY CODE §§ 11362.7-11362.9; *see also* *City of Garden Grove v. Superior Court*, 68 Cal. Rptr. 3d 656, 667 (Cal. Ct. App. 2007) (“In enacting the MMP, the Legislature quite clearly intended to broaden the scope of the [Compassionate Use Act] in order to facilitate greater access to marijuana for those patients in need of the drug.”). That the legislature aimed to bolster and extend the reach of the Compassionate Use Act, even in the face of the federal Controlled Substances Act, is also apparent in its stated intent to “[e]nhance the access of patients and caregivers to medical marijuana through collective, cooperative cultivation projects.” S.B. 420, 2003 Leg. Reg. Sess. § 1(b)(3) (Cal. 2003). Furthermore, the MMP “recognizes the possibility that, with specific medical approval, qualified patients may be entitled to handle significant amounts of dried marijuana for their personal medical use.” *People v. Wright*, 146 P.3d 531, 546 (Cal. 2006) (Baxter, J., concurring and dissenting). *See* CAL. HEALTH & SAFETY CODE § 11362.77(b).

331. S.B. 420, 2003 Leg. Reg. Sess. § 1(b)(1) (Cal. 2003). To achieve these goals, the MMP extended immunity from prosecution to a number of marijuana-related offenses that had not been specified in the Compassionate Use Act, making it clear that this protection from criminal liability encompassed appropriate medical-marijuana-related activity relating to possession, cultivation, possession for sale, transportation, maintaining place for the sale, giving away or use of marijuana, making available premises for the manufacture, storage or distribution of controlled substances, and abatement of nuisance created by premises used for manufacture, storage, or distribution of controlled substance. *See* CAL. HEALTH & SAFETY CODE §§ 11357-11362.9. The MMP also established a voluntary program for the issuance of identification cards to such qualified patients. *Id.* at §§ 11362.71-11362.78. But the legislation did not limit the availability of a Compassionate Use Act defense to individuals who chose to participate in the card identification program. Rather, it defined the individuals exempt from criminal liability for these offenses as either “[a] qualified patient or a person with an identification card who transports or processes marijuana for his or her own personal

illness and pain that qualified as a “serious medical condition” under the Compassionate Use Act.³³²

Many other states have enacted laws symbolically challenging the federal CSA proscription on medical marijuana.³³³ Some of these laws established state marijuana therapeutic research programs,³³⁴ and others exempted physicians from state criminal prosecution if they prescribe marijuana to certain categories of seriously ill patients.³³⁵ Since federal law prohibits writing such prescriptions, however, few doctors are willing to risk their medical licenses to do so.³³⁶ Moreover, even if a doctor were to give a patient an official “prescription” for marijuana, it would remain a federal crime for pharmacies to distribute it, so patients could not legally fill their marijuana prescriptions.³³⁷ By 1991, thirty-

medical use.” *Id.* at §11362.765(b)(1). A “qualified patient” is defined as “a person who is entitled to the protections of [the Compassionate Use Act], but who does not have an identification card issued pursuant to this article.” *Id.* at § 11362.7(f).

332. CAL. HEALTH & SAFETY CODE § 11362.7(h). The MMP defined a “[s]erious medical condition,” for which medical marijuana may be obtained, as including the following symptoms: acquired immune deficiency syndrome (AIDS), anorexia, arthritis, cachexia, cancer, chronic pain, glaucoma, migraine, persistent muscle spasms (including spasms associated with multiple sclerosis), seizures (including seizures associated with epilepsy), severe nausea, and any other chronic or persistent medical symptom that either “[s]ubstantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990 (Public Law 101-336); or [i]f not alleviated, may cause serious harm to the patient’s safety or physical or mental health.” *Id.*

333. See MARIJUANA POLICY PROJECT, STATE-BY-STATE MEDICAL MARIJUANA LAWS: HOW TO REMOVE THE THREAT OF ARREST 4 (2007), http://www.mpp.org/assets/pdfs/general/SBSR_2007.pdf (stating that “most of these laws have been largely symbolic, with little or no practical effect”) [hereinafter, MPP, STATE-BY-STATE].

334. See ROSALIE LICCARDO PACULA ET AL., STATE MEDICAL MARIJUANA LAWS: UNDERSTANDING THE LAWS AND THEIR LIMITATIONS, IMPACTEEN RESEARCH PAPER SERIES, NO. 13 (Oct. 2001), at 6-7, available at http://www.impactteen.org/generalarca_PDFs/medicalmarijuanapaper100301.pdf.

335. See MPP, STATE-BY-STATE, *supra* note 333, at 4; see also, e.g., ARIZ. REV. STAT. ANN. § 13-3412.01 (LexisNexis 2008) (“Notwithstanding any law to the contrary, any medical doctor licensed to practice in this state may prescribe a controlled substance included in schedule I . . . to treat a disease, or to relieve the pain and suffering of a seriously ill patient or terminally ill patient . . .”).

336. See generally *Federal Criminal Liability of Licensed Physician for Unlawfully Prescribing or Dispensing “Controlled Substance” or Drug in Violation of the Controlled Substances Act* (21 U.S.C.A. § 801 *et seq.*), 33 A.L.R. Fed. 220 (1977).

337. See MPP, STATE-BY-STATE, *supra* note 333, at 5. Most states with medical marijuana provisions have circumvented the prescription bar by allowing doctors to recommend marijuana to their patients who qualify. The Colorado Department of Public Health and Environment summarizes the problem and the most common solution:

Pharmacies can only dispense medications that are prescribed. Marijuana is currently classified by the federal government as a Schedule I drug, which means it cannot be prescribed by any health care professional. [Colorado’s Medical

four states had passed this type of ineffective legislation symbolically protesting the firm federal position.³³⁸

Only after the passage of the California's Compassionate Use Act in 1996 did other states begin enacting laws to provide viable alternatives for medical marijuana users and providers.³³⁹ By 2004, ballot initiatives decriminalizing marijuana for qualifying patients who grow, possess, and use it had been passed by wide margins in Alaska, Arizona, Colorado, Maine, Montana, Nevada, Oregon, Washington, and the District of Columbia.³⁴⁰ In 2000, Hawaii became the first state to enact a medical marijuana law authored by the state legislature, rather than by ballot initiative.³⁴¹ Similar laws were passed by the Vermont legislature in 2004 and by the legislatures of Rhode Island and New Mexico in 2007.³⁴² In November 2008, Michigan's voters passed the

Marijuana Amendment] allows doctors to *recommend* marijuana, and it allows patients to grow their own medical marijuana for their private use.

Colorado Department of Public Health and Environment Frequently Asked Questions About Medical Marijuana, <http://www.cdph.state.co.us/hs/Medicalmarijuana/marijuanafaqs.html> (last visited Apr. 14, 2009) (emphasis added).

338. See MPP, STATE-BY-STATE, *supra* note 333, at 4.

339. See *id.* at 14-18.

340. See COLO. CONST. art. XVIII, § 14 (LexisNexis 2008); NEV. CONST. art. 4, § 38 (LexisNexis 2008); ALASKA STAT. §§ 11.71.090, 17.37.010-.080 (LexisNexis 2008); ARIZ. REV. STAT. ANN. § 13-3412.01 (LexisNexis 2008); ME. REV. STAT. ANN. tit. 22, § 2383-B5 (LexisNexis 2008); MONT. CODE ANN. § 50-46-101 (LexisNexis 2008); OR. REV. STAT. §§ 475.300-.346 (West 2004 & Supp. 2008); WASH. REV. CODE § 69.51A.005 (LexisNexis 2007 & Supp. 2009). Arizona's initiative requires a doctor's prescription, which renders it a largely symbolic law. ARIZ. REV. STAT. ANN. § 13-3412(A)(8); see also Andrew J. Boyd, *Medical Marijuana and Personal Autonomy*, 37 J. MARSHALL L. REV. 1253, 1260 (2004) ("The status of medical marijuana in Arizona . . . is in reality an effective prohibition on the use of medical marijuana."). Virginia has a similar symbolic law permitting possession of marijuana upon a doctor's prescription. VA. CODE ANN. § 18.2-251.1 (LexisNexis 2004 & Supp. 2008). Congress was able to prevent the District of Columbia's initiative from taking effect because the District's legal status subjects it to strict federal oversight. See MPP, STATE-BY-STATE, *supra* note 333, at 5.

341. HAW. REV. STAT. § 329-121 (LexisNexis 2008); see MPP, STATE-BY-STATE, *supra* note 333, at 5.

342. See VT. STAT. ANN. tit. 18, § 4471 (West 2007); N.M. STAT. ANN. § 26-2B-1 (LexisNexis 2007); R.I. GEN. LAWS § 21-28.6-1 (West 2007). Maryland's legislature passed a medical marijuana affirmative defense law in 2003. This law requires the court to consider a defendant's use of medical marijuana to be a mitigating factor for sentencing in a marijuana-related state prosecution. If the patient successfully shows that his or her use of marijuana is one of "medical necessity," then the maximum penalty that the court may impose upon conviction is a \$100 fine. MD. CODE ANN., CRIM. LAW § 5-619 (LexisNexis 2002 & Supp. 2008). By comparison, the maximum penalty for possession of a small amount of *non-medical* marijuana in California is also a \$100 fine. CAL. HEALTH & SAFETY CODE § 11357(b) (West 2007).

most recent voter initiative by a margin of sixty-three to thirty-seven percent.³⁴³

B. The Limits of "Supremacy"

The federal government may not compel state law enforcement agents to enforce federal laws or regulations.³⁴⁴ In *Printz v. United States*, the U.S. Supreme Court emphasized that the framers of the Constitution had learned from their experience under the Articles of Confederation "that using the States as the instruments of federal governance was both ineffectual and provocative of federal-state conflict."³⁴⁵ The Federal Constitution thus embodies the opposite presumption, "that a State's government will represent and remain accountable to its own citizens."³⁴⁶ The application of these principles to the conflict between the federal drug laws and the states' medical marijuana provisions reflects the tensions of federalism in a political world in which the federal and state governments are often intertwined.

As a bald proposition, a state may not be compelled to adhere to the Controlled Substances Act's penal regime for marijuana. In enacting the Medical Marijuana Program, California's legislature declared that its authority for contravening federal drug policy derived from "the powers reserved to the State of California and its people under the Tenth Amendment to the United States Constitution."³⁴⁷ Similarly, Rhode Island's medical marijuana statute notes that "[s]tates are not required to enforce federal law or prosecute people for engaging in activities prohibited by federal law," and that "compliance with [its medical marijuana law] does not put the state of Rhode Island in violation of federal law."³⁴⁸ But even if compliance with a state law at variance with

343. See *Michigan Voters Approve Medical Marijuana Measure*, MLIVE.COM, Nov. 4, 2008, http://www.mlive.com/politics/index.ssf/2008/11/michigan_voters_approve_medica.html.

344. See *Printz v. United States*, 521 U.S. 898, 935 (1997) ("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.").

345. *Id.* at 919.

346. *Id.* at 920 (citing *New York v. United States*, 505 U.S. 144, 166 (1992) (noting "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"))).

347. 2003 Cal. Legis. Serv. ch. 875 §1(e) (West).

348. R.I. GEN. LAWS § 21-28.6-2(4) (West 2007).

strong federal policy does not place the state itself in a quandary, it certainly may be problematic for individual law enforcement officers, physicians, patients, and caregivers.

Consider the immunity provisions of the Controlled Substance Act.³⁴⁹ Under this federal statute, no civil or criminal liability may be imposed, *inter alia*, upon an officer of any state or political subdivision thereof “who shall be lawfully engaged in the enforcement of any law or municipal ordinance relating to controlled substances.”³⁵⁰ By its terms, the statute sweeps well beyond the enforcement of federal drug laws. But does it provide immunity for state or local law enforcement officers carrying out duties in connection with state medical marijuana laws which contradict the terms of the CSA?

This question has been presented in cases in which municipalities objected to court orders directing their police officers to return marijuana to defendants after a showing that it was properly possessed pursuant to a state medical marijuana law. In *State v. Kama*,³⁵¹ the City of Portland argued that, even though Oregon law required the return of the marijuana to defendant, this action by police officers “would constitute delivery of a controlled substance in violation of federal law.”³⁵² But the Oregon appellate court agreed with defendant’s argument that “federal law expressly makes law enforcement personnel immune from any civil or criminal liability arising out of their handling of controlled substances as part of their official duties.”³⁵³

In a 2007 case, the city of Garden Grove, California, contended that instead of returning medical marijuana to defendant, it was obliged to destroy it, “consistent with federal drug policy.”³⁵⁴ On appeal, the California Court of Appeal agreed with the Oregon appellate court’s *Kama* decision that the federal immunity statute shielded from federal liability local police obeying court orders to return marijuana to

349. 21 U.S.C. § 885(d).

350. *Id.*

351. *State v. Kama*, 39 P.3d 866 (Or. Ct. App. 2002).

352. *Id.*, at 867. The Oregon statute provides:

Usable marijuana and paraphernalia used to administer marijuana that was seized by any law enforcement office shall be returned immediately upon a determination . . . that the person from whom the marijuana or paraphernalia used to administer marijuana was seized is entitled to the protections contained in [the medical marijuana law].

OR. REV. STAT. § 475.323(2) (2004 & Supp. 2008).

353. *Kama*, 39 P.3d at 867.

354. *City of Garden Grove v. Superior Court*, 68 Cal. Rptr. 3d 656, 660 (Cal. Ct. App. 2007).

defendants.³⁵⁵ The court considered at some length the conflicts faced by local police officers, who often cooperate with federal drug enforcement efforts.³⁵⁶ The court expressed sympathy for the intergovernmental dilemmas, but observed that forbidding police officers from thwarting the beneficent purposes of state law is “an entirely manageable consequence of our federal form of government.”³⁵⁷ Moreover, in complying with the court’s order to return the marijuana to its rightful owner,³⁵⁸ “the Garden Grove police will actually be facilitating a primary principle of federalism, which is to allow the states to innovate in areas bearing on the health and well-being of their citizens.”³⁵⁹

These considerations are significant in no small part because of the enormous disparity between state and federal efforts in drug enforcement. In this dance of federalism, one partner—the federal government—lays claim to constitutional supremacy. But the other partner—the states—lay claim in this area to resources that dwarf those of the federal government. State officers carry out the vast majority of drug arrests in the United States. In 2006, state and local authorities arrested 1,889,810 persons for drug abuse violations.³⁶⁰ The DEA made

355. *Id.* at 663-64.

356. *Id.* at 681.

357. *Id.*

358. *Garden Grove*, 68 Cal. Rptr. 3d at 680 (“Since the prosecution dismissed the drug charge he was facing, he is nothing more than an aggrieved citizen who is seeking the return of his property.”).

359. *Id.* at 681. Two contrasting cases dealing with probation revocation illustrate the difficulties when the federal and state legal systems both combine and collide. In *People v. Bianco*, 113 Cal. Rptr. 2d 392 (Cal. Ct. App. 2001), the court upheld a probation condition prohibiting the use of marijuana even though the defendant was a qualified patient under the Compassionate Use Act. The court reasoned that because marijuana possession is illegal under federal law, the condition was “reasonably directed at defendant’s future criminality.” *Id.* at 397. In *People v. Tilekkooh*, 7 Cal. Rptr. 3d 226 (Cal. Ct. App. 2003), however, the court held that the state’s medical marijuana law provides a defense to a probation revocation based on marijuana possession or use, despite the probation condition that defendant obey not only the laws of California but also the laws of the United States. The court held that a proceeding to revoke a state-imposed probation could only be premised upon a violation of state law. *Id.* at 229. State courts should not enforce federal marijuana laws for probationers who qualify for the immunity provided by the Compassionate Use Act. *Id.* at 235-36. Nor is the probation revocation controversy limited to California. See, e.g., Matt Gouras, *Medical Pot Ban Sought for Parolees*, ASSOCIATED PRESS, Jan. 4, 2008, available at <http://www.washingtonpost.com/wp-dyn/content/article/2008/01/03/AR2008010303669.html> (describing “stiff resistance” to the proposal by the Montana Department of Corrections to prohibit all probationers and parolees from obtaining medical marijuana).

360. FEDERAL BUREAU OF INVESTIGATION, CRIME IN THE UNITED STATES: 2006, http://www.fbi.gov/ucr/cius2006/data/table_29.html.

29,800 arrests that year.³⁶¹ Thus, only two percent of all drug arrests were carried out by federal authorities.

Indeed, federal drug interdiction policies rely substantially on the states' enforcement of their own laws to achieve federal objectives. In Congressional testimony following the passage of California's Compassionate Use Act, DEA Administrator Thomas A. Constantine criticized medical marijuana laws for undermining the important symbiosis between federal and state law enforcement.³⁶² In view of the huge resource differential, he maintained that "the federalization of crime is very difficult to carry out."³⁶³ The states with medical marijuana laws are, of course, aware of this enormous discrepancy; indeed, they rely on it to further their policy aims of protecting the health of their citizens. Rhode Island's General Assembly noted the tiny ratio of federal to state marijuana arrests in its legislative findings on the state's medical marijuana statute, concluding that "changing state law will have the practical effect of protecting from arrest the vast majority of seriously ill people who have a medical need to use marijuana."³⁶⁴ The drafters of Michigan's successful 2008 medical marijuana ballot initiative incorporated identical language into the measure's findings.³⁶⁵

Congressional authority may thus be seriously undermined in fact if not in law. The ambiguous legal relationships and workaday consequences that most impact medical marijuana users center on their local authorities and access to a local distribution network. Marijuana "is incredibly pervasive in our society"³⁶⁶ and, at the level of the individual user, *relatively* safe from the reach of the DEA. In 2008, the U.S. Department of Justice confirmed that the "DEA does not investigate or target individual "patients" who use cannabis, but instead the Drug Trafficking Organizations (DTOs) involved in marijuana trafficking."³⁶⁷ The DEA's campaign to cut off the supply of medical

361. U.S. DRUG ENFORCEMENT ADMINISTRATION, STATS AND FACTS, <http://www.usdoj.gov/dea/statistics.html#arrests>.

362. *The California and Arizona Medical Drug Use Initiatives: Hearing Before the S. Judiciary Comm.*, 104th Cong. 42-45 (1996) (statement of Thomas A. Constantine, Administrator, Drug Enforcement Administration).

363. *Id.* at 42.

364. R.I. GEN. LAWS § 21-28.6-2 (West 2007).

365. MICH. COMP. LAWS ANN. § 333.26422(2)(b) (LexisNexis 2007).

366. Ben Leubsdorf, *Mich. Medical Pot Law Now in Effect Amid Questions*, MLIVE.COM, Dec. 4, 2008, http://www.mlive.com/kzgazette/news/index.ssf/2008/12/mich_medical_pot_law_now_in_ef.html (quoting Bruce Mirken, Communications Director for the Marijuana Policy Project).

367. Letter from Keith B. Nelson, Principal Deputy Assistant Attorney General, U.S.

marijuana to individual 'patients' may, however, pose an even greater threat to them than does arrest.

Although the CSA prohibits possession of even the smallest quantity of marijuana, the reality is that most federal prosecutors file charges "only if a marijuana case involves the cultivation of at least 500 plants grown indoors, 1,000 plants grown outdoors, or the possession of more than 1,000 pounds."³⁶⁸ In 2008, the United States Attorney for the Northern District of California indicated that, despite his personal disagreement with the state's Compassionate Use Act, the federal government's attempts to prosecute "pot clubs" and medical marijuana dispensaries "would be terribly unproductive and probably not an efficient use of precious federal resources."³⁶⁹

Despite the U.S. Attorney's warning, "precious federal resources" continue to be marshaled in the battle against medical marijuana.³⁷⁰ The Drug Enforcement Administration targets marijuana dispensaries, and has for many years raided California dispensaries and other sources for medical marijuana set up in compliance with the Compassionate Use Act.³⁷¹ In some cases, the struggle is literally one of life or death, pitting the DEA against seriously ill and dying patients, as well as their supportive local governments.³⁷² In one well-publicized 2002 raid,

Department of Justice, to Rep. John Conyers, Jr., Chairman, Committee on the Judiciary (July 25, 2008), available at <http://judiciary.house.gov/hearings/pdf/Nelson080725.pdf>.

368. Tim Golden, *Doctors are Focus of Plan to Fight New Drug Laws*, N.Y. TIMES, Dec. 23, 1996, at A10; see also ALAN BOCK, WAITING TO INHALE: THE POLITICS OF MEDICAL MARIJUANA 86 (2000) (referring to a 1994 memorandum by a California U.S. Attorney advising federal narcotics agents not to pursue cases with fewer than "500 plants on private land").

369. Vic Lee, *Russoniello Outlines Top Priorities*, ABC NEWS (San Francisco), Jan. 31, 2008, <http://abclocal.go.com/kgo/story?section=news/local&id=5928173>.

370. See, e.g., *County of Santa Cruz v. Ashcroft*, 279 F. Supp. 2d 1192, 1200 (N.D. Cal. 2003) (referring to the "robust and ongoing debate as to whether the public interest in fact is served by the DEA's use of its limited resources to target for raids and potential prosecution seriously ill and dying patients . . . who use and possess marijuana only for medicinal purposes").

371. See, e.g., Doug Oakley, *City Considers Aiding Marijuana Patients*, CONTRA COSTA TIMES, Jan. 26, 2008, available at <http://www.safeaccessnow.org/article.php?id=5438> (describing DEA closings of medical marijuana dispensaries throughout California); Eric Bailey, *Medical Pot Store Operators Indicted*, L.A. TIMES, July 18, 2007, at B6 (stating that "[t]hese dispensary operators are no different than any other drug trafficker: They prey on people in our communities to make a profit") (quoting Timothy J. Landrum, special agent in charge of the DEA in Los Angeles). On the federal efforts to thwart the state law in the early years after passage of the Compassionate Use Act, see BOCK, *supra* note 368, at 58-65, 85-87.

372. See, e.g., *DEA Ordered Seizure of Medical Marijuana from Paraplegic Patient According to Local Law Enforcement*, AM. CIVIL LIBERTIES UNION NEW MEXICO, Feb. 15, 2008, http://www.aclu-nm.org/News_Events/news_2_15_08.html (describing affidavit of

“between twenty and thirty armed agents led by [DEA officers]” served a search warrant on a farm that supplied medicinal marijuana to a California hospice.³⁷³ This hospice had 250 patients, the vast majority of whom were terminally ill and suffering from “HIV or AIDS, multiple sclerosis, glaucoma, epilepsy, various forms of cancer, and other serious illnesses.”³⁷⁴ The farm was owned by the hospice founder, Valery Corral, who was herself a medical marijuana patient, and her husband, Michael Corral, who was Valery’s designated primary caregiver.³⁷⁵ “The DEA agents forcibly entered the [Corrals’] premises, pointed loaded firearms at [them], forced them to the ground, and handcuffed them.”³⁷⁶ The Corrals were then “transported to the federal courthouse in San Jose, California, where they were released without being charged. DEA agents remained on the premises for eight hours, seizing 167 marijuana plants, “many of the [hospice patients’] weekly allotments of medicinal marijuana”³⁷⁷

Both the cultivation and use of marijuana by hospice members were carried out “on the recommendation of the patients’ respective physicians in compliance with California’s medicinal marijuana statute.”³⁷⁸ Local California officials reacted furiously to the raid, as they had worked “closely with the Corrals for six years to devise a system to define medical users and issue identification cards, and provide organically grown [marijuana] free of charge” to the hospice patients.³⁷⁹ The California Attorney General also condemned the DEA actions, demanding a meeting with the U. S. Attorney General to discuss “the federal government’s unprecedented attacks on locally authorized medical marijuana operations.”³⁸⁰

Within two weeks of the DEA’s raid, the Supervisors of the County of Santa Cruz “adopted a resolution condemning the raid and urging the

local law enforcement official attesting that the 2007 seizure of medical marijuana from a New Mexico paraplegic man “was done at the direction of and under the guidance and control of the . . . DEA”).

373. *Santa Cruz*, 279 F. Supp. 2d at 1197.

374. *Id.* at 1195.

375. *Id.* at 1196.

376. *Id.* at 1197. Suzanne Pfeil, a paraplegic patient on the premises, was told to stand up to be handcuffed. When she could not stand up, she was handcuffed to her bed. GERBER, *supra* note 137, at 132.

377. *Santa Cruz*, 279 F. Supp. 2d at 1197.

378. *Id.* at 1196.

379. GERBER, *supra* note 137, at 132.

380. *Id.* (quoting California Attorney General William Lockyer).

federal government not to indict the Corrals for their activities.”³⁸¹ That same week, the City of Santa Cruz permitted hospice patients “to receive their weekly allotments of medicinal marijuana at the Santa Cruz City Hall.”³⁸² Thereafter, the City Council adopted a resolution deputizing the founders of the hospice to function as City-authorized medicinal marijuana providers pursuant to state law and the City’s medicinal marijuana ordinance.³⁸³

The DEA responded to the state and local condemnation of its actions by reiterating its power under federal law: “No one in the United States is allowed to distribute illegal drugs, period.”³⁸⁴ The intensity of the federal campaign against medical marijuana is mounting, as measured by the escalating number of raids on growers and dispensaries.³⁸⁵ In 2007, the DEA “sent letters to landlords of buildings that housed medical cannabis dispensaries” in California, threatening them with seizure of the property and other assets, charging them with felonies, and incarcerating them for up to twenty years.³⁸⁶ As a result, many of these dispensaries have closed.³⁸⁷ In 2008, the head of the San Francisco DEA office indicated that nothing had changed in the

381. *Santa Cruz*, 279 F. Supp. 2d at 1197.

382. *Id.* at 1198.

383. *Id.* at 1197.

384. GERBER, *supra* note 137, at 132 (quoting DEA spokesperson Richard Meyer).

385. See Steven Wishnia, *Drug Warrior's Shadow Looms Over California's Pot Clubs*, ALTERNET, Dec. 30, 2007, <http://www.alternet.org/story/71263> (describing the increasing frequency of DEA actions); Americans for Safe Access, *Recent Escalation of DEA Intervention in Legal Medical Marijuana States*, http://safeaccessnow.org/downloads/dea_escalation.pdf (stating that “the DEA has been stepping up its focus on raiding medical marijuana patients and providers across the West,” and providing statistical evidence) (last visited Apr. 14, 2009); News Release, California NORML, DEA Robs California of Millions in Tax Revenues, Seizes Tax Payments from State Board of Equalization (Dec. 13, 2007), *available at* [http://www.canorml.org/news/DEASeizesStateTax\\$\\$_relse.htm](http://www.canorml.org/news/DEASeizesStateTax$$_relse.htm) (reporting that “[r]ecent DEA raids have cost [California] millions of dollars in sales tax revenues plus scores of paying jobs”).

386. Wyatt Buchanan, *Pot Dispensaries Shut in Response to Federal Threat*, SAN FRAN. CHRON., Feb. 7, 2008, at B1. According to a DEA spokesperson, these “courtesy letters” to landlords constituted the first step in a new effort to shut down dispensaries. *Id.* To view one of these “courtesy letters” signed by Javier F. Pena, the Special Agent in Charge of the DEA’s San Francisco office, see Letter from Javier F. Pena, Special Agent, U.S. Dep’t of Justice, Drug Enforcement Admin., to unidentified recipient (Dec. 7, 2007), *available at* http://safeaccessnow.org/downloads/DEA_Landlord_Letter_SF.pdf.

387. Buchanan, *supra* note 386; see also Nicki Payne, *New Pot Raids Call For New National Leadership*, DAILY 49ER (Long Beach, California), Dec. 11, 2007, *available at* <http://www.safeaccessnow.org/article.php?id=5335> (describing the closure of the Long Beach medical marijuana dispensary after a federal raid).

Agency's view of its mission: "Anyone who breaks the [federal] law is at risk of getting arrested."³⁸⁸

The existence and extent of cross-jurisdictional cooperation and/or interference on this issue is highly controverted.³⁸⁹ Acting at arguably the outer limits of its authority, the DEA monitors local elections for sheriff and district attorney in California, and supplies warnings about the support received by candidates favorable to medical marijuana.³⁹⁰ At times, the DEA secures the collaboration of local officials in carrying out federal policies in contravention of state law.³⁹¹ But some local authorities are incensed at what they perceive as federal overreaching. Responding to recent DEA anti-medical marijuana actions, the mayor of Oakland wrote that "[t]he DEA's recent surge tactics, such as the dissemination of threatening letters to property owners and unrelenting raids that continue to place citizens in harm's way, undermine state and local authority, and jeopardize the integrity of state law."³⁹²

388. Oakley, *supra* note 371 (quoting Javier Pena, special agent in charge of the DEA field office in San Francisco).

389. See Bailey, *supra* note 371 (referring to "the ongoing friction between the state and federal authorities" and describing the federal government as having "waged war against the state's pot rules by conducting raids and mounting court challenges").

390. U.S. DRUG ENFORCEMENT ADMINISTRATION, CALIFORNIA MEDICAL MARIJUANA INFORMATION, <http://www.usdoj.gov/dea/ongoing/calimarijuana.html>. The DEA's website notes that in 2007, the DEA "arrested a major marijuana trafficker in Humboldt County who was an undeclared candidate for sheriff." *Id.*

391. See, e.g., Dan Bernath, *The Federal War on Medical Marijuana Becomes a War on Children*, ALTERNET, Sept. 25, 2007, <http://www.alternet.org/drugreporter/62330>. Bernath described a raid targeted at Ronnie Naulls, owner of two California medical marijuana dispensaries:

[A]t 5:50 a.m., July 17, Naulls' home and businesses were invaded by DEA agents armed with shotguns, automatic rifles—even helicopters. They seized everything he owned: his businesses, his property, all of his accounts.

... But that wasn't the worst of it. County child protective services came along on the raid and took Naulls' three daughters, aged 1 to 5, and charged him and his wife with child endangerment. They weren't even accused of breaking any state laws.

Id.; see also Susan Herendeen, *Pot Dispenser Suing Modesto*, MODESTO BEE (California), Mar. 5, 2008, available at <http://www.safeaccessnow.org/article.php?id=5472> (describing cooperation between city and federal officials); Patrick McCartney & Martin A. Lee, *Government Shows No Compassion for Medical Pot Consumption*, ALTERNET, June 16, 2007, <http://www.alternet.org/stories/54183> (discussing the same).

392. Kelly Rayburn, *Dellums Seeks Probe of 'Threats' to Pot Sites*, BAY AREA NEWS GROUP, Dec. 22, 2007, available at <http://www.safeaccessnow.org/article.php?id=5351> (quoting Oakland Mayor Ron Dellums); see also Betty T. Yee & Carole Migden, *Hell-Bent On Shutting Medical Marijuana Dispensaries*, SAN FRANCISCO CHRON., Feb. 15, 2008, available at <http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2008/02/15/ED0UV1RNP.DTL> (calling for "the federal government . . . to back off and respect state compassionate use laws that authorize a network of responsible, law abiding and tax-paying medical marijuana

In August 2008, the California Attorney General, Edmund G. Brown, Jr., issued legislatively-mandated guidelines aimed at helping legitimate marijuana patients avoid arrest while giving state police the tools to distinguish legal medical marijuana providers from illegal marijuana growers and criminal middlemen.³⁹³ The guidelines detailed requirements for identification cards and proof of qualified patient status.³⁹⁴ Possession guidelines specified the maximum amount of marijuana permitted per patient, as well as exceptions upon medical recommendation.³⁹⁵ Permissions and prohibitions regarding the location of marijuana use were detailed, as well as requirements for police to return seized marijuana if the person from whom the marijuana was seized mounts a successful medical marijuana defense.³⁹⁶

Responding to the federal raids and the sometime ambivalence of state police, the guidelines contain provisions dealing with “qualified patients and primary caregivers who come together to collectively or cooperatively cultivate physician-recommended marijuana.”³⁹⁷ In regulating collectives and cooperatives, the guidelines aim at “ensur[ing] the security of the crop and safeguard[ing] against diversion for non-medical purposes.”³⁹⁸ They prescribe that the collectives or cooperatives maintain non-profit operations, be subject to state taxation, verify membership applications and distribute only to valid members, acquire only lawfully-cultivated marijuana, and provide adequate security.³⁹⁹

Finally, the Attorney General’s Office provided enforcement guidelines describing cash-and-carry cannabis clubs and dispensaries—frequent targets of federal raids—as “likely unlawful.”⁴⁰⁰ The

providers,” and providing illustrations of businesses which provided employment with benefits to many workers, paid taxes, and which were shut down by DEA raids).

393. EDMUND G. BROWN, JR., ATTORNEY GENERAL, GUIDELINES FOR THE SECURITY AND NON-DIVERSION OF MARIJUANA GROWN FOR MEDICAL USE (2008), *available at* http://ag.ca.gov/cms_attachments/press/pdfs/n1601_medicalmarijuanaguidelines.pdf.

394. *Id.* at 5.

395. *Id.* at 5-6.

396. *Id.* at 6-7.

397. BROWN, *supra* note 393, at 8.

398. *Id.*

399. *Id.* at 9-11.

400. *Id.* at 11; *see, e.g.*, Jesse McKinley, *Marijuana Hotbed Retreats on Medicinal Use*, N.Y. TIMES, June 9, 2008, at A1 (reporting that the federal government “has been increasingly aggressive about prosecuting [marijuana] club owners they feel have crossed the line into commercial drug dealing,” and quoting California Attorney General Brown’s statement that “[t]hese dispensaries aren’t supposed to be big profit centers This is supposed to be for individual use”).

guidelines distinguished the slapdash methods employed by dispensaries with the now carefully-regulated state cooperatives and collectives. Attorney General Brown clearly stated that his intent was to induce federal acquiescence in California's medical marijuana program: "Hopefully the feds will back off in instances where people are really following these guidelines."⁴⁰¹

In a quite different scenario, Colorado state officials who opposed their own jurisdiction's medical marijuana law invited federal prosecution so as to effectively annul their state's law, only to be reminded by the top federal prosecutor that the primary enforcers of drug laws are the states themselves. This contretemps occurred in 2001, when Colorado's governor and attorney general issued a joint statement "remind[ing] anyone intending to register for the [medical marijuana] program—as well as physicians considering prescribing marijuana to their patients—that it remains a federal crime to possess, manufacture, distribute or dispense marijuana."⁴⁰² Referring to their supposed "duties under federal law," the two chief state law enforcement officials added that they were contacting the state medical association to warn physicians of the risk of federal prosecution,⁴⁰³ and that they were writing Colorado's federal prosecutor "to encourage the criminal prosecution of anyone who attempts to use this state program to circumvent federal anti-drug laws."⁴⁰⁴ In response, the U. S. Attorney's Office rebuffed the notion that federal drug prosecution was the solution to the state's problems: "That solution (if there is one) lies with the 22 duly elected district attorneys and local police."⁴⁰⁵

401. Bailey, *supra* note 371 (quoting California Attorney General Edmund G. Brown, Jr.).

402. Boyd, *supra* note 340, at 1264 n.82 (quoting joint statement of Colorado Governor Bill Owens and Attorney General Ken Salazar).

403. The Colorado constitutional amendment that encompasses the state medical marijuana provisions does not require a prescription for marijuana, instead permitting a doctor to "[p]rovide a patient with written documentation, based upon the physician's contemporaneous assessment of the patient's medical history and current medical condition and a bona fide physician-patient relationship, stating that the patient has a debilitating medical condition and might benefit from the medical use of marijuana." COLO. CONST. art. 18, § 14 (II). On whether physicians face federal regulatory action by making such a "statement," see *infra* notes 422-441, and accompanying text.

404. Boyd, *supra* note 340, at 1264 n. 82.

405. *Colorado Medical Marijuana Law Now in Effect: Governor and Attorney General Urge Feds to Bust Patients, Feds Say No Thanks*, DRUG WAR CHRON., June 8, 2001, <http://stopthedrugwar.org/chronicle-old/189/colorado.shtml> (quoting Acting U.S. Attorney Richard Spriggs); see also *id.* ("Neither the governor nor the attorney general should engage in unfounded speculation about who might be prosecuted in federal court.") (quoting Spriggs).

DEA raids are not the only problems medical marijuana patients face. Even in states with favorable laws, medical marijuana patients' fears extend beyond having their medical supply confiscated or facing arrest and conviction for obtaining treatment. In some instances, courts have held that an employer can fire an employee for the use of medical marijuana. In 2008, the California Supreme Court held that state disability discrimination protections did not require an employer to accommodate an employee who used medicinal marijuana at home on his physician's recommendation.⁴⁰⁶ Even though the employee's marijuana use was legal pursuant to California law, the court found that the Compassionate Use Act was not intended to eliminate the employer's legitimate interest in maintaining a workplace free from employees who use drugs that are banned by federal law.⁴⁰⁷ Essentially, the California high court ruled that the ballot initiative and subsequent legislative action had altered state criminal law while leaving employment law unchanged.⁴⁰⁸

Looming over the shoulder of the state court, however, was federal drug policy, even in this apparently quintessential state-law case. The majority opinion conceded that the employee's legal argument "might have merit if the Compassionate Use Act gave marijuana the same status as any legal prescription drug."⁴⁰⁹ But that designation would be beyond the power of any state voter initiative, legislature, executive, or judiciary. Even employment law cases fall under the shadow of the CSA: "No state law could completely legalize marijuana for medical

In 2002, a General Accounting Office Report on the experiences of four states with medical marijuana laws recounted that the impact of medical marijuana on the overall federal drug program was relatively small. U.S. GENERAL ACCOUNTING OFFICE, *supra* note 294, at 32-35. Significantly, the report observed that "none of the federal officials we spoke with provided information to support a statement that abuse of medical marijuana laws was routinely occurring in any of the states, including California." *Id.* at 37.

406. *Ross v. RagingWire Telecomm., Inc.*, 174 P.3d 200 (Cal. 2008).

407. *Id.* at 204-05.

408. *Id.* at 205-06. The dissent derided the "cruel choice" imposed by the majority on medical marijuana patients who wanted or needed to work. *Id.* at 211 (Kennard, J., dissenting) ("The majority's decision leaves many Californians with serious illnesses just two options: continue receiving the benefits of marijuana use 'in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or other illness' and become unemployed, giving up what may be their only source of income, or continue in their employment, discontinue marijuana treatment, and try to endure their chronic pain or other condition for which marijuana may provide the only relief.") (quoting CAL. HEALTH & SAFETY CODE § 11362.5 (b)(1)(A) (West 2007)).

409. *Ross*, 174 P.3d at 204 (majority opinion).

purposes because the drug remains illegal under federal law.”⁴¹⁰

C. *The Doctors’ Dilemma*

Physicians face the dilemmas of cultural federalism, not to mention the risk of arrest, each time they deal with a patient whose illness may be alleviated by marijuana. The federal government has classified marijuana in Schedule I, meaning that the drug “has no currently accepted medical use in treatment in the United States.”⁴¹¹ In 1992, the Drug Enforcement Agency made the identically-phrased finding that marijuana has “no currently accepted medical use in treatment in the United States,”⁴¹² and the Court of Appeals for the District of Columbia Circuit affirmed that determination.⁴¹³ Thus, physicians who prescribe medical marijuana—or any controlled substance listed in Schedule I—are violating the CSA.⁴¹⁴

The states have adopted various means for patients to obtain certification that they are suffering from a serious medical condition that could be alleviated by marijuana.⁴¹⁵ Michigan’s law requires a “written certification” reciting a “debilitating medical condition” as defined in the statute and “stating that, in the physician’s professional opinion, the patient is likely to receive therapeutic or palliative benefit from the medical use of marihuana”⁴¹⁶ California’s Compassionate Use Act does not require that doctors endorse a prescription to authorize their patients to obtain medical marijuana, but only that they provide a

410. *Id.* In the wake of the state supreme court decision, the state legislature passed a bill aimed at providing job protection for medical marijuana users, but Governor Schwarzenegger vetoed it. Kenny Goldberg, *Governor Kills Medical Marijuana Measure*, KPBS.ORG, Oct. 2, 2008, <http://www.kpbs.org/news/local/id=12896>.

411. 21 U.S.C. § 812(b) (2000).

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

413. *Alliance for Cannabis Therapeutics v. Drug Enforcement Admin.*, 15 F.3d 1131 (D.C. Cir. 1994); *see also* *United States v. Oakland Cannabis Buyers’ Cooperative*, 532 U.S. 483, 493 (2001) (“It is clear from the text of the Act that Congress has made a determination that marijuana has no medical benefits worthy of an exception.”).

414. *See* *United States v. Davis*, 564 F.2d 840, 844 (9th Cir. 1977) (“It is clear that, when a doctor steps out of the usual course of his professional duties and writes a prescription for someone for a controlled substance not pursuant to a legitimate medical purpose, he has initiated a transfer of that controlled substance.”); *United States v. Jobe*, 487 F.2d 268, 269 (10th Cir. 1973) (holding that physicians who offer prescriptions without a “legitimate medical purpose” have violated the federal law against dispensing a controlled substance).

415. *See generally*, MPP, STATE-BY-STATE, *supra* note 333, at H-1.

416. Michigan Medical Marihuana Act, MICH. COMP. LAWS ANN. § 333.26423(1) (LexisNexis 2005 & Supp. 2008).

“recommendation or approval,” which may be “written or oral.”⁴¹⁷ By contrast, Arizona only permits the possession or use of medical marijuana pursuant to the prescription of a doctor.⁴¹⁸ Vermont supplies a unique procedure, requiring only that the physician certify “that the patient has a [specified] debilitating medical condition.”⁴¹⁹ The patient then submits the medical verification form, along with other paperwork, to the appropriate Vermont state agency, which then “transmit[s] the completed medical verification form to the physician and contact[s] him or her for purposes of confirming the accuracy of the information contained in the form.”⁴²⁰ The statute is constructed so that the physician’s certification need not refer to marijuana at all.⁴²¹

Recommending or approving marijuana would not appear to constitute the *actus reus* of “dispens[ing] . . . a controlled substance”

417. CAL. HEALTH & SAFETY CODE §11362.5(d) (West 2007). Similarly, Alaska allows a patient to be placed on the state’s “confidential registry for the medical use of marijuana,” by providing the following:

[A] statement signed by the patient’s physician

(A) stating that the physician personally examined the patient and that the examination took place in the context of a bona fide physician-patient relationship and setting out the date the examination occurred;

(B) stating that the patient has been diagnosed with a debilitating medical condition; and

(C) stating that the physician has considered other approved medications and treatments that might provide relief, that are reasonably available to the patient, and that can be tolerated by the patient, and that the physician has concluded that the patient might benefit from the medical use of marijuana.

ALASKA STAT. § 17.37.010(c)(1) (LexisNexis 2008).

418. ARIZ. REV. STAT. ANN. § 13-3412.01(A) (LexisNexis 2008). The Arizona statute declares that “[n]otwithstanding any law to the contrary, any medical doctor licensed to practice in this state may prescribe [marijuana].” The reference to “any law” is, of course, limited to any state law, thus making the statute ineffective, since physicians who prescribe marijuana face criminal and regulatory penalties from the federal government. See Boyd, *supra* note 340, at 1260 n.53 (noting that “Arizona doctors have refused to write prescriptions for marijuana, fearing prosecution under federal law”); Michael Kiefer, *Court Snuffs Medicinal Pot; Federal Law Prevails Over Ariz.*, ARIZ. REPUBLIC, June 7, 2005, at 1A (noting that the state law “has never been used because it is against federal law for doctors to write such prescriptions”); Robbie Sherwood & Elvia Diaz, *State Still a Medical Pot Foe; Top Court Likely Won’t Change Arizona, Experts Say*, ARIZ. REPUBLIC, Nov. 30, 2004, at 14A (reporting on Arizona doctors’ fears of having their federal certifications revoked, and the impossibility of filling a marijuana prescription in a pharmacy).

419. VT. STAT. ANN. tit. 18 § 4473(b)(2)(B)(iii) (West 2007).

420. *Id.* § 4473(b)(3)(A).

421. See MPP, STATE-BY-STATE, *supra* note 333, at H-2 (suggesting that the type of certification in use in Vermont “should fully eliminate physicians’ concerns that they might face liability related to medical marijuana.”)

under the CSA.⁴²² In response to state medical marijuana initiatives in California and Arizona, however, the federal government declared "that it would prosecute physicians, revoke their prescription licenses, and deny them participation in Medicare and Medicaid for recommending medical marijuana."⁴²³ Pursuant to this policy, the federal government sent letters to medical practitioner associations and licensing boards cautioning that physicians who "intentionally provide their patients with oral or written statements in order to enable them to obtain controlled substances in violation of federal law . . . risk revocation of their DEA prescription authority."⁴²⁴

In 1997, a U. S. District Court in the Northern District of California granted a preliminary injunction against the federal government on the grounds that the enforcement policy against the physicians who recommended the use of marijuana as a treatment modality threatened to interfere with expression protected by the First Amendment.⁴²⁵ A permanent injunction was granted in 2000,⁴²⁶ and affirmed by the Ninth Circuit in 2002.⁴²⁷ In a concurring opinion, Judge Alex Kozinski

422. 21 U.S.C. § 841(a)(1) (2000).

423. *Conant v. McCaffrey*, 172 F.R.D. 681, 686 (N.D. Cal. 1997). As the District Court characterized the federal government's argument, "a physician who recommends marijuana violates the public interest, making such a recommendation grounds for revocation of that physician's license." *Id.* at 699. The policy was entitled "The Administration's Response to the Passage of California Proposition 215 and Arizona Proposition 200" and was released on December 30, 1996, by Barry R. McCaffrey, the Director of the Office of National Drug Control Policy (ONDCP) at the time. See *Administration Response to Arizona Proposition 200 and California Proposition 215*, 62 Fed. Reg. 6164 (Feb. 11, 1997). The "public interest" provision of the CSA's physician registration requirements includes consideration of "conduct which may threaten the public health and safety." 21 U.S.C. § 823 (f)(5) (2000). In another case, the federal government argued that because patients in some states can take a doctor's recommendation to a buyer's club to obtain medical marijuana, the federal government would treat such a recommendation as "analogous to a prescription." *Pearson v. McCaffrey*, 139 F. Supp. 2d 113, 120-21 (D. D.C. 2001). The district court upheld that position, noting that "a physician who recommends marijuana in a state that recognizes that such an act facilitates the ability of a patient to receive marijuana is essentially writing a prescription." *Id.* at 124.

424. *Conant v. Walters*, 309 F.3d 629, 633 (9th Cir. 2002) (quoting the federal government's letter).

425. *Conant v. McCaffrey*, 172 F.R.D. 681 (N.D. Cal. 1997). The plaintiffs included patients suffering from serious illnesses, physicians licensed to practice in California who treat patients with serious illnesses, a patient's organization, and a physician's organization. *Id.* at 686. The court emphasized that "this case is about the ability of doctors, on an individualized basis, to give advice and recommendations to bona fide patients suffering from serious, debilitating illnesses regarding the possible benefits of personal, medical use of small quantities of marijuana." *Id.*

426. *Conant v. McCaffrey*, No. 97-00139, 2000 WL 1281174, at *16 (N.D. Cal. Sept. 7, 2000).

427. *Walters*, 309 F.3d at 632.

pointedly characterized the risk of harm to physicians: “By speaking candidly to their patients about the potential benefits of medical marijuana, they risk losing their license to write prescriptions, which would prevent them from functioning as doctors. In other words, they may destroy their careers and lose their livelihoods.”⁴²⁸

Given the susceptibility to pressure of practitioners in this highly regulated field, Judge Kozinski concluded that “only the most foolish or committed of doctors will defy the federal government’s policy and continue to give patients candid advice about the medical uses of marijuana.”⁴²⁹ The federal government has a peculiar view about the physician’s role in counseling patients. As one federal court recorded it, counsel for the United States asserted that “[t]he Federal Government has drawn a very clear line . . . [that] nothing in Federal law prevents doctors from discussing the possible risks and benefits of marijuana, but . . . they cannot recommend it to patients.”⁴³⁰ The notion that physicians are permitted to discuss the dangers and advantages of a course of treatment, but not to recommend it, embodies a cramped view

428. *Id.* at 639-40 (Kozinski, J., concurring).

429. *Id.* at 640. The mental gymnastics engaged in by physicians and courts in order to evade the federal prescription ban are illustrated in *People v. Jones*, 4 Cal. Rptr. 3d 916 (Cal. Ct. App. 2003). During a pre-trial hearing in this prosecution for cultivating marijuana, the central issue was whether defendant had obtained the statutorily-required “written or oral recommendation or approval” of marijuana from his doctor. *Id.* at 918. Dr. Morgan testified that defendant mentioned finding that marijuana provided relief for migraine headaches. *Id.* The physician added that his “general approach is, if it works on something that’s difficult, I support it. But I’m sure in this case I would not have recommended it specifically because of its controversial legal status.” *Id.* Dr. Morgan believed that he “would be in trouble for prosecution if [he] would have at that time recommended or approved [defendant’s] marijuana use.” *Jones*, 4 Cal. Rptr. 3d at 920. The defendant testified that Dr. Morgan told him that “he didn’t want to put it in writing,” and although the physician did not use the word “approve,” he did say, “If it helps, use it.” *Id.* at 921. On this record, the appellate court reversed the trial court and found that defendant could raise a Compassionate Use Act defense at trial. *Id.* at 923. The court reasoned that the term “approval” implied a lesser degree of approbation than “recommendation,” and that “approval” was a fair reading of the events in the case, when the patient raised the issue of marijuana use and the physician expressed a favorable opinion of marijuana use as a treatment for the patient. *Id.* The holding and rationale of *Jones* have been incorporated into the California Medical Association’s medical marijuana treatment guidelines for physicians. See CMA LEGAL COUNSEL, THE COMPASSIONATE USE ACT OF 1996: THE MEDICAL MARIJUANA INITIATIVE 10 (2009) http://www.cmanet.org/bookstore/freeoncall2.cfm/CMAOnCall1315.pdf?call_number=1315&CFID=745764&CFTOKEN=27566287 (responding to these questions: “Does this mean that I can actually suggest that my patient use medicinal cannabis? Can I use the word ‘recommend’?”).

430. *Pearson v. McCaffrey*, 139 F. Supp. 2d 113, 120 (D. D.C. 2001).

of the First Amendment, not to mention a total misconception of the physician's ethical responsibility in giving patients medical advice.⁴³¹

Regulating medical practice is theoretically the province of states, not the federal government. That the states are "the primary regulators of professional conduct"⁴³² is one of the cardinal principles of federalism. The practice of medicine is controlled by "[s]tate statutes, state medical boards, and state regulations."⁴³³ Nor did the Controlled Substances Act change that premise, for federal law "was never intended, and the [U.S. Department of Justice] and DEA were never authorized, to establish a national medical practice or act as a national medical board."⁴³⁴ To the contrary, the organization of the federal drug laws "presume and rely upon a functioning medical profession regulated under the States' police powers."⁴³⁵ Yet, even though the CSA "manifests no intent to regulate the practice of medicine generally,"⁴³⁶ the Supreme Court noted that "Congress regulates medical practice insofar as it bars doctors from using their prescription-writing powers as a means to engage in illicit drug dealing and trafficking as conventionally understood."⁴³⁷ Thus clouded, the regulation of medical

431. See, e.g., AMERICAN MEDICAL ASSOCIATION, CODE OF MEDICAL ETHICS, § 2.17, available at http://www.ama-assn.org/ama1/pub/upload/mm/Code_of_Med_Eth/opinion/opinion217.html (noting that a physician's focus should be on "what is best for the individual patient and not the avoidance of a burden to the family or to society").

432. *Walters*, 309 F.3d at 639 (9th Cir. 2002); see also *Whalen v. Roe*, 429 U.S. 589, 603 n.30 (1977) (recognizing the states' broad police powers to regulate the administration of drugs by health professionals); *Linder v. United States*, 268 U.S. 5, 18 (1925) (discussing the Harrison Narcotics Tax Act, which was superseded by the CSA, and holding that "direct control of medical practice in the states is beyond the power of the federal government").

433. *Oregon v. Ashcroft*, 192 F. Supp. 2d 1077, 1092 (D. Or. 2002), *aff'd*, 368 F.3d 1118 (9th Cir. 2004), *aff'd sub nom. Gonzales v. Oregon*, 546 U.S. 243 (2006).

434. *Id.*

435. *Gonzales*, 546 U.S. at 270.

436. *Id.*

437. *Id.*; see also *Gonzales v. Raich*, 545 U.S. 1, 27 (2005) (referring to the CSA as a "comprehensive regulatory regime specifically designed to regulate which controlled substances can be utilized for medicinal purposes, and in what manner"). Although the decision by a patient whether to have a treatment or not is a constitutionally protected right, the "selection of a particular treatment, or at least a medication, is within the area of governmental interest in protecting public health." *Rutherford v. United States*, 616 F.2d 455, 457 (10th Cir. 1980). Other courts have agreed with the Tenth Circuit that the selection of a particular treatment or medicine is not a constitutionally protected right. See *Carnohan v. United States*, 616 F.2d 1120 (9th Cir. 1980) (per curiam) (the Ninth Circuit found that constitutional rights of privacy and personal liberty did not give the plaintiff the right to obtain laetrile free of lawful exercise of government police power); *Kulsar v. Ambach*, 598 F. Supp. 1124 (W.D.N.Y. 1984) (medical patients had no constitutional right to a drug treatment that the FDA ordered removed from the marketplace).

practice with regard to marijuana has slipped into a shadow world of ambiguous legal relationships with uncertain consequences.⁴³⁸

These vagaries place physicians in a dangerous predicament. A cardinal principle of medical ethics provides that a “physician shall, while caring for a patient, regard responsibility to the patient as paramount.”⁴³⁹ Doctors who risk harassment or criminal prosecution by the federal government for behavior which is an obligation of medical ethics are victims of federalism run amok, squeezed between contradictory federal and state norms.⁴⁴⁰ For example, the Medical Board of California considers medical marijuana “an emerging treatment modality” and prescribes standards for physician recommendation of the drug to patients.⁴⁴¹ But doctors who follow these medical board procedures are subject to harassment and possible prosecution by the federal government.

The battle over medical marijuana is joined not only in the rival texts of federal statutes and state initiatives, but also in lawmakers’ use of scientific evidence. The federal government unflinchingly takes the position that marijuana’s effects are deleterious and in no way medicinal.⁴⁴² The states and their citizens review the same scientific evidence but come to the opposite conclusion. For example, Oregon’s

438. See generally Lars Noah, *Ambivalent Commitments to Federalism in Controlling the Practice of Medicine*, 53 KAN. L. REV. 149 (2004) (discussing the federal government’s recent assumption of a greater role in supervising the traditionally state-controlled practice of medicine).

439. AMERICAN MEDICAL ASSOCIATION, *PRINCIPLES OF MEDICAL ETHICS*, available at <http://www.ama-assn.org/ama/pub/category/2512.html>.

440. See McCarthy, *supra* note 286, at 344 (arguing that a physician’s “duty should not be sacrificed to avoid prosecution by the federal government for mere conversations concerning what is in the patient’s best interest.”) The federal government and the states are also waging a shadow war in the field of medicine devoted to pain management. In contrast to the CSA’s refusal to countenance pain relief via marijuana, consider the California Legislature’s 1997 enactment of the Pain Patient’s Bill of Rights, which made effective treatment of pain a statewide priority. See CAL. HEALTH & SAFETY CODE § 124960 (West 2007). In doing so, the Legislature recognized both that “inadequate treatment of acute and chronic pain . . . is a significant health problem” and that “[f]or some patients, pain management is the most important treatment a physician can provide.” CAL. HEALTH & SAFETY CODE § 124960(b)-(c).

441. Medical Board of California, *Statement Concerning Medical Marijuana*, http://www.medbd.ca.gov/medical_marijuana.html (last visited Apr. 14, 2009). See generally U. S. GENERAL ACCOUNTING OFFICE, *supra* note 294, at 29, Table 11: Doctor Guidance Provided by Selected State Medical Organizations (describing medical marijuana advice provided to physicians).

442. See 21 U.S.C. § 812(b)(1) (2000) (declaring marijuana’s “high potential for abuse,” its lack of any “currently accepted medical use in treatment in the United States,” and its “lack of accepted safety for use . . . under medical supervision”).

statute affirms at the outset that “[p]atients and doctors have found marijuana to be an effective treatment for suffering caused by debilitating medical conditions.”⁴⁴³ Rhode Island’s legislative declaration contradicts the federal government’s central claim by relying on the most prominent marijuana study commissioned by the federal government: “Modern medical research has discovered beneficial uses for marijuana in treating or alleviating pain, nausea and other symptoms associated with certain debilitating medical conditions, as found by the National Academy of Sciences’ Institute of Medicine in March 1999.”⁴⁴⁴ Arizona’s initiative asserted that “[t]housands of Arizonans suffer from debilitating diseases such as glaucoma, multiple sclerosis, cancer, and AIDS, but cannot have access to the necessary drugs they need.”⁴⁴⁵ Permitting Arizona physicians “to prescribe schedule I controlled substances could save victims of these diseases from loss of sight, loss of physical capacity, and greatly reduce the pain and suffering of the seriously ill and terminally ill.”⁴⁴⁶

The appearance of a scientific debate on this issue, by contrasting the federal pronouncements with state declarations in opposition, is illusory. As discussed above,⁴⁴⁷ a broad scientific consensus has emerged supporting the therapeutic claims for marijuana and calling for the federal government to rescind its prohibitions and allow physicians to use their medical judgment in deciding when to prescribe marijuana to their patients.

D. Punitive Federalism for Patients

The substantial dilemmas faced by doctors pale beside the trauma of seriously ill patients, deprived of information and possible palliative care to relieve their sometimes excruciating pain. As Judge Kozinski noted, “[t]hose immediately and directly affected by the federal government’s policy are the patients, who will be denied information

443. OR. REV. STAT. § 475.300 (2004 & Supp. 2008); *see also* WASH. REV. CODE. § 69.51A.005 (West 2007 & Supp. 2009) (“The people of Washington state find that some patients with terminal or debilitating illnesses, under their physician’s care, may benefit from the medical use of marijuana.”).

444. R.I. GEN. LAWS § 21-28.6-2 (West 2007). Michigan’s law pointed to the same report as the basis for a nearly identically-phrased finding. MICH. COMP. LAWS. ANN. § 333.26422 (LexisNexis 2005 & Supp. 2008).

445. Proposition 200, § 2(C), *codified as* The Drug Medicalization, Prevention, and Control Act of 1996, ARIZ. REV. STAT. ANN. § 13-3412.01 (2008).

446. *Id.*

447. *See supra* notes 145-254 and accompanying text.

crucial to their well-being.”⁴⁴⁸ An appendix to Judge Kozinski’s concurring opinion in *Conant v. Walters* supplied capsule summaries of four medical marijuana patients, taken from an amicus brief filed in the case.⁴⁴⁹ These patients are members of a minuscule group who receive medical marijuana directly from the federal government under a special federal Compassionate Investigational New Drug Study program.⁴⁵⁰ Their narratives, briefly noted below, suggest the chasm between the rhetoric of “reefer madness” and the reality of great pain assuaged through the “evil weed.”⁴⁵¹

With the help of regularly-supplied cannabis from the federal government, Barbara M. Douglass achieved relief from the pain of multiple sclerosis and her appetite was stimulated to counteract the wasting syndrome from which she had previously suffered.⁴⁵² Ms. Douglass believed that she would have died without the marijuana.⁴⁵³

George Lee McMahon was born with a rare genetic disorder that causes severe pain, nausea, and muscle spasms; side effects from conventional medications were intolerable, but cannabis alleviated his

448. *Conant v. Walters*, 309 F.3d 629, 640 (9th Cir. 2002) (Kozinski, J., concurring).

449. *Id.* at 648-49.

450. The United States government began its Emergency and Treatment Investigational New Drug (IND) Study programs (also known as also known as “Compassionate” INDs) in the 1970s. In 1992, in response to a flood of new applications from AIDS patients, the federal government closed the program to all new applicants. In 1999, the U.S. Department of Health and Human Services updated its medical marijuana policy, restating that the IND program would not be reopened. Consequently, the IND program remains in operation only for the seven surviving previously approved patients. See Ethan Russo et al., *Chronic Cannabis Use in the Compassionate Investigational New Drug Program: An Examination of Benefits and Adverse Effects of Legal Clinical Cannabis*, 2 J. CANNABIS THERAPEUTICS 3, 51-52 (2002), available at <http://medicalmarijuana.procon.org/sourcefiles/RussoChronicCannabisUse.pdf> (describing the federal cannabis IND program and concluding that “[c]annabis smoking . . . provides effective symptomatic relief of pain, muscle spasms, and intraocular pressure elevations in selected patients failing other modes of treatment.” The authors also called for the “Compassionate IND program [to] be reopened and extended to other patients in need of clinical cannabis”). For the current status of Compassionate INDs, see U.S. Food and Drug Administration, Center for Drug Evaluation and Research, Frequently Asked Questions on Drug Development and Investigational New Drug Applications, <http://www.fda.gov/cder/about/smallbiz/faq.htm> (last visited Apr. 14, 2009); Treatment Use of an Investigational New Drug, 21 C.F.R. § 312.34 (1999) (providing for FDA permission for “treatment use” of unapproved new drugs).

451. See *Seeley v. State*, 940 P.2d 604, 624 n.7 (Wash. 1997) (Sanders, J., dissenting) (“The record is replete with uncontroverted evidence that [the Plaintiff] and many similarly situated cancer patients undergo unbearable pain and digestive unrest as a result of chemotherapy and radiation treatments and that they claim leaf marijuana is one of the only efficacious agents available to ease their suffering.”).

452. See *Conant v. Walters*, 309 F.3d 629, 648 (9th Cir. 2002).

453. See *id.*

pain, nausea, and spasms, stimulated his appetite, and permitted him to sleep through the night.⁴⁵⁴ After admission to the federal program, he was able to receive and smoke 300 cannabis cigarettes each month from the United States government.⁴⁵⁵ After a decade of using federal marijuana, he and his physician asserted that "without cannabis Mr. McMahon would not be alive today."⁴⁵⁶

Elvy Musikka was a glaucoma patient who similarly could not tolerate conventional medications.⁴⁵⁷ Marijuana provided her immediate relief, substantially lowering her intraocular pressure as no other medication had, and with few side effects.⁴⁵⁸ Fearful of the legal consequences of smoking cannabis, Ms. Musikka underwent several risky surgeries in an attempt to correct her condition, but they were unsuccessful and left her blind in one eye.⁴⁵⁹ In 1988, Ms. Musikka was convicted of marijuana possession, but she successfully appealed, becoming the first person in Florida to establish a medical necessity defense for cannabis.⁴⁶⁰ Shortly thereafter, the federal government enrolled her in its medical cannabis program and has provided her with one and one-half pounds of herbal cannabis on a quarterly basis ever since.⁴⁶¹ Both she and her physician believe that if she were deprived of cannabis she would go blind.⁴⁶²

Irvin Henry Rosenfeld was diagnosed with multiple congenital cartilaginous exostosis, a disease causing both the continuous growth of bone tumors and the generation of new tumors on the ends of most of the long bones in his body.⁴⁶³ Conventional medications not only had minimal efficacy in reducing his painful symptoms, they produced debilitating side effects, but marijuana proved highly efficacious in alleviating pain, reducing swelling, relaxing the muscles and veins that surround the bone tumors, and preventing hemorrhaging.⁴⁶⁴ Beginning in 1982, the federal government has provided him with the twelve

454. *See id.*

455. *Id.* at 648.

456. *Walters*, 309 F.3d at 648. When, earlier in his treatment, his physician had instructed him to cease his cannabis use and return to prescription medications, Mr. McMahon's health rapidly and progressively degenerated. *Id.*

457. *Id.* at 648-49.

458. *Id.* at 649.

459. *Walters*, 309 F.3d at 649.

460. *Id.*

461. *Id.*

462. *Id.*

463. *Walters*, 309 F.3d at 649.

464. *Id.*

marijuana cigarettes he needs every day to control the symptoms of his disease.⁴⁶⁵ In the thirty years that Mr. Rosenfeld has used herbal cannabis as a medicine, he has experienced no adverse side effects (including no “high”), has been able to discontinue his prescription medications, and he has worked successfully for the past thirteen years as a stockbroker handling multi-million dollar accounts.⁴⁶⁶ “Mr. Rosenfeld and his physicians believe that but for herbal cannabis, Mr. Rosenfeld might not be alive, or, at the very least, would be bed-ridden.”⁴⁶⁷

In sum, the medical histories of these patients “provide compelling support for the view that medical marijuana can make the difference between a relatively normal life and a life marred by suffering.”⁴⁶⁸ But these thoroughly-documented medical marijuana success stories are extraordinarily rare, not because of the efficacy of marijuana as a treatment, but because of the patients’ amazing fortune to have been included in the tiny federal program, which shares the aims of thirteen states’ medical marijuana programs that the federal government seeks to eliminate.

Patients who endure agonizing pain which could be alleviated with marijuana are confronted by the federal government’s efforts to disrupt their sources of treatment in a number of ways: by seeking to have their suppliers evicted and arrested; by prosecuting patients themselves; by threatening to detain, professionally embarrass, and ruin the careers of their physicians; and by deploying federal officers to mount and implement a campaign of misinformation and fear. On one level, these experiences and dislocations are the consequences of federalism. But in a more profound sense, they are the results of a brutal and incoherent federal policy.

465. *Id.*

466. *Id.*

467. *Walters*, 309 F.3d at 649.

468. *Id.* at 643; *see also* *Seeley v. State*, 940 P.2d 604, 627-28 (Sanders, J., dissenting) (noting that “the government’s argument that the ingestion of marijuana may have uncertain medical consequences seems unpersuasive when, at the same time, the government concedes that it cannot dispute [Plaintiff’s] testimony about how its ingestion affects him, the tragic medical fact that he is terminally ill, nor the fact that [his] doctor states on the record it is in [the patient’s] interest to use marijuana for medical reasons”).

V. ASTRIDE THE TROJAN HORSE: MEDICAL MARIJUANA AND THE CASE FOR LEGALIZATION

Now at midnight all the agents
And the superhuman crew
Come out and round up everyone
That knows more than they do⁴⁶⁹
Bob Dylan

The casual [drug] user should be taken out and shot⁴⁷⁰
Los Angeles Police Chief Daryl F. Gates

When Harry J. Anslinger died in 1975, he is said to have been dependent on morphine to ease the pain of his last days.⁴⁷¹ This is not mentioned in the spirit of malice or perverse vindication. Rather, it demonstrates, in the course of a life, how permeable our moral boundaries are and, sometimes, how irrelevant. This kind of irony is often visible with heartbreaking clarity on a personal level. But when we pull back the lens it tends to blur, as much that is individual fuses into the larger societal whole. For the sake of governance, smaller ironies, contradictions, and logical inconsistencies give way to prevailing social norms. Morality, the force that defines a community and determines its voice, “seeps into all kinds of political issues, in both dramatic and subtle ways.”⁴⁷² When inflamed, morality becomes moral fervor, driving a diverse array of political movements, from temperance to civil rights to the wars against abortion and drugs.⁴⁷³ Moral fervor is also a reason why crusades such as Anslinger’s succeed so well and survive so long after their premises have been eroded by doubt.

Just before the passage of the Marihuana Tax Act in 1937, cannabis was freely dispensed in neighborhood pharmacies without a prescription, and more than twenty-five medicinal preparations containing marijuana

469. Bob Dylan, *Desolation Row*, on HIGHWAY 61 REVISITED (Columbia Records 1965).

470. Testimony of Daryl F. Gates, Hearing before the Committee on the Judiciary, U.S. Senate, 101st Cong., 2d Session, Sep. 5, 1990, at 77.

471. BOOTH, *supra* note 26, at 250.

472. James A. Morone, *Morality, Politics and Health Policy*, in POLICY CHALLENGES IN MODERN HEALTH CARE 13, 16 (David Mechanic et al., eds., 2005).

473. *Id.*

were on the market.⁴⁷⁴ The hemp industry was about to be revitalized and expanded by a machine capable of stripping and separating plant fibers from the pulp, saving countless hours in human labor.⁴⁷⁵ Without the FBN's intervention, the hemp plant may have persevered in its therapeutic and industrial uses. As a recreational drug, it may have remained a largely regional phenomenon, or spread slowly and intermittently across the United States. Given the chance to adapt itself to society, it may, like coffee, tea, tobacco, and alcohol, have become "acculturated."⁴⁷⁶

That the course of cannabis could be altered so quickly and so irrevocably is due to several factors. Anslinger and his cohorts were able to exploit an existing moral framework, infusing it with xenophobia and fear enough to sway the ignorant and the undecided. As these were the great majority of the population, the resulting biases proved sweeping, insidious, and durable. Scientific studies daring to suggest that the dangers of cannabis had been exaggerated were suppressed, ignored, or attacked. Morality trumped science and, by the time the medicinal cannabis movement had arrived, most of its opponents were immune to scientific argument. Therapeutic marijuana was viewed with suspicion as a mere pretense for intoxication. The prospect of compromise, had it ever existed, receded even further as old prejudices conformed to new realities.

Medicinal cannabis, straddling the line between prohibition and legalization, might seem to give the appearance of compromise. But, as the states that have sanctioned its use are aware, defending the very existence of therapeutic marijuana has little to do with conciliation. That these states are in open rebellion against the federal government underscores the absence of a meeting of the minds on this issue. And, while some pharmaceutical cannabinoids are able to satisfy current federal regulatory requirements, herbal marijuana eludes most prescription drug classifications.

As a medicine, a mild relaxant, and as industrial raw material, the hemp plant remains exceedingly viable. If utility, low toxicity and

474. PETER MCWILLIAMS, *AIN'T NOBODY'S BUSINESS IF YOU DO: THE ABSURDITY OF CONSENSUAL CRIMES IN A FREE SOCIETY* 529, 540 (1993).

475. HERER, *supra* note 29, at 13-14. Herer's book contains a reprint of a February 1938 *Popular Mechanics* article describing the new invention, its effect on hemp production, and promising thousands of jobs to Americans as well as hundreds of millions of dollars in profits. *Id.* at 14-16.

476. RAY & KSIR, *supra* note 32, at 473.

centuries of relatively safe consumption were determining factors, marijuana would be legal. That it is not legal, and is not very likely to become so, has less to do with its intrinsic properties than with the nature of the impulse to prohibit it.

A. Morality and the Lost Art of Compromise

On July 25, 2007, the U.S. House of Representatives defeated the Hinchey-Rohrbacher Amendment by a vote of 262 to 165.⁴⁷⁷ A bipartisan effort sponsored by Maurice Hinchey (D-NY) and Dana Rohrbacher (R-Calif), the Amendment would have barred the DEA and the Department of Justice (DOJ) from using appropriated funds to arrest and prosecute medical marijuana patients and their providers in the thirteen states that have approved such use.⁴⁷⁸

A brief excerpt of the debate on the measure highlights the cognitive and ideological chasm that separates both sides. In support of the amendment, Rep. Rohrbacher spoke of the deaths of his mother and brother from cancer. He said that “[if] marijuana would have helped them, it would have been a horrible thing to think that the federal government would have come in and interfered with that, if their doctor had recommended it.”⁴⁷⁹ In opposition, Rep. Dave Weldon (R-Fla) averred that marijuana “does cause cancer. I’ve seen it.” He further stated, “Most people who want to use [medical marijuana] want to get high.”⁴⁸⁰

To envision a middle ground between these positions would require the use of something far stronger than cannabis. In the broadest social and cultural sense, defending the status quo is profoundly American. According to James A. Morone, the United States has the distinction of being “the industrial world’s foremost Puritan nation.”⁴⁸¹ Part of the Puritan legacy, a passion for rooting out the sinners in our midst,

477. Fred Gardner, *Write off your Congressman*, COUNTERPUNCH, Aug. 4, 2007, <http://www.counterpunch.org/gardner08042007.html>. The Hinchey-Rohrbacher Amendment did not come up for a vote in 2008, the first time the amendment was not voted on since 2002.

478. *Id.*

479. *Id.*

480. *Minor Gains in Bid to get Congress to Block Federal Raids on Medical Marijuana Patients, Providers*, DRUG WAR CHRON., July 27, 2007, available at http://stopthedrugwar.org/chronicle/495/hinchey_rohrbacher_amendment_defeated_in_House.

481. Morone, *supra* note 472, at 14. See generally JAMES A. MORONE, *HELLFIRE NATION: THE POLITICS OF SIN IN AMERICAN HISTORY* (2003) (describing how America’s religious roots inform policy).

promotes a polarity of “us” versus “them.”⁴⁸² Because our policy debates often revolve around protecting “us” from “them,” political differences are inevitably transformed into moral disputes.⁴⁸³ Having designated the government as standard bearer for our Puritan heritage, we have also appointed it the “Great Protector,”⁴⁸⁴ and rely on it to set and preserve social norms. Presumably, these rules are based on what is morally acceptable to the average citizen. Experimentation with alternative social beliefs is actively discouraged and we are called on “to adapt and fit in as best we can.”⁴⁸⁵ The medicinal cannabis movement, seeking positive recognition of an illicit substance, threatens to upset the applecart of established social conduct. As the movement has mobilized the moral dynamic of “us” versus “them,” the mechanics of compromise are effectively excluded from the dialogue. As physician and medical historian David Musto has observed, once health issues become moral issues, “and once you’ve decided your opponent is morally bankrupt, and you get a political majority, why should you compromise?”⁴⁸⁶

In this divisive atmosphere, the voice of science is often lost in the popular moral uproar. Groups intent on pushing their own agendas “will stand up and oppose even the most unambiguous scientific findings.”⁴⁸⁷ This kind of ideological absolutism was especially marked in late twentieth-century anti drug and alcohol campaigns. Because their mandate was to preach total abstinence, public school drug and alcohol education programs prohibited the teaching of responsible use of these substances, even as it pertained to adults.⁴⁸⁸ Along with the suppression of opposing viewpoints, hyperbole and alarmist rhetoric fueled the 1980s War on Drugs,⁴⁸⁹ despite the absence of “a groundswell of public opinion” demanding it.⁴⁹⁰ With tactics strikingly similar to those of Anslinger, drug czar William Bennett “used his office as a bully

482. Morone, *supra* note 472, at 17.

483. *Id.* at 14, 17.

484. McWILLIAMS, *supra* note 474, at 260.

485. *Id.*

486. Philip E. Ross, *The Futile Crackdown*, FORBES.COM, Oct. 18, 1999, <http://members.forbes.com/forbes/1999/1018/6410070a.html> (quoting David Musto).

487. Morone, *supra* note 472, at 13.

488. RUTH CLIFFORD ENGS, *CLEAN LIVING MOVEMENTS: AMERICAN CYCLES OF HEALTH REFORM* 11 (2000).

489. *Id.* at 12.

490. Bruce L. Benson & David W. Rasmussen, *The American Drug War: Anatomy of a Futile and Costly Police Action*, INDEP. INST., July 10, 2000, <http://www.independent.org/newsroom/article.asp?id=323>.

pulpit,”⁴⁹¹ whipping up anti-drug hysteria and piling on the arrests. By 1989, it was apparent that “policy led public opinion, not the other way around.”⁴⁹²

In the heat of these moral escapades, a realistic assessment of the substance to be prohibited is a liability rather than a necessity. Thus, marijuana did not become illegal because “it was shown to be dangerous;”⁴⁹³ it became illegal because an uninformed public was primed to believe the worst. The enactment of Prohibition did not depend on converting the drinkers but on swaying and energizing the nondrinkers.⁴⁹⁴ Or, as Bonnie and Whitebread so elegantly put it, temperance movements have always counted on “the support of those members of the community who, although indulging occasionally themselves, were willing to concede the moral superiority of those who abstained.”⁴⁹⁵ When prompted by Puritanism rather than pragmatism, legislators shrink from challenging existing orthodoxies. The status quo remains intact, compromise is improbable, reform is impossible, and a “punitive stasis prevails.”⁴⁹⁶

B. Messages, We Get Messages

Sometime within the last three decades we became a nation of cryptographers. We are preoccupied with how the public, especially children, will interpret “messages” and “signals” encoded within our laws and policy statements. Of particular concern is how we influence the young by what we say about drug use. The problem with reducing policy choices to “signals,” however, is that it invites censorship. As information is pared down and sculpted into “messages,” countervailing views are cast aside, along with any motivation to delve deeper.

The current trend may have its origins in the 1970s, when parents began to recognize that “marijuana’s growing acceptance in the culture made it harder for them to produce drug-free children.”⁴⁹⁷ In response, they formed parent groups and organizations committed to ensuring that their children would be insulated from any and all encouragement to

491. *Id.*

492. *Id.*

493. Franjo Grotenhermen, *How to Prevent Cannabis-Induced Psychological Distress . . . in Politicians*, 363 LANCET 1568 (2004).

494. Ross, *supra* note 486.

495. BONNIE & WHITEBREAD, *supra* note 27, at 24.

496. Peter Schrag, *Hooked on Narcomylths*, THE NATION, Nov. 26, 2001, at 44.

497. ZIMMER & MORGAN, *supra* note 137, at 157.

experiment with drugs.⁴⁹⁸ One tactic involved the scrutinizing of federal publications for content that was favorable to drug use and either editing it out or withdrawing the documents from circulation.⁴⁹⁹ When arguments for and against medical marijuana began to infiltrate the drug policy arena, the signaling problems got even thornier. In 1996, while passage of California's Proposition 215 was looming, Senator Joseph Biden (D-DE) worried that, if teenagers acknowledged cannabis as medicine, it would be difficult for parents to convey the message that marijuana is "a very bad thing."⁵⁰⁰ Health and Human Services Secretary Donna Shalala complained that medical marijuana use imparted "a signal that maybe it's safe,"⁵⁰¹ and exhorted one and all to send an unequivocal message that drugs are illegal, dangerous, and wrong.

Certainly, no one can defensibly advocate illicit drug use by children, but this obsession with cipher over substance severely underestimates the intelligence of young people. It also limits the category of acceptable messages by excluding others that are just as powerful and important. When, in 1988, Administrative Law Judge Francis L. Young recommended changing marijuana from Schedule I to Schedule II, he acknowledged the concern that doing so would "send a signal" that marijuana use is "OK."⁵⁰² Nevertheless, he reasoned that the call for compassion outweighed the primacy of anti-drug messages: "The fear of sending such a signal cannot be permitted to override the legitimate need . . . of countless sufferers for the relief marijuana can provide when prescribed by a physician in a legitimate case."⁵⁰³

In 2007, the U.S. Supreme Court extended the reach of signal detection to encompass those that are not only unintended, but not even really there. In 2002, Joseph Frederick, a Juneau, Alaska high school student, had decided to garner a little media attention. Hoping to appear on television as the Olympic torch passed through his town, he stationed

498. *Id.* at 156-59.

499. ENGS, *supra* note 488, at 220.

500. *Senate Judiciary Committee Stokes Flames of "Drug War," MARIJUANA POLICY PROJECT*, <http://www.mpp.org/legislation/104th-congress/senate-judiciary-committee-stokes-flames-of.html> (quoting excerpts from the Sept./Oct. Senate Judiciary Committee's Marijuana Policy Report) (last visited Apr. 14, 2009).

501. *Id.*

502. *In re Marijuana Rescheduling Petition*, DOJ ALJ No. 86-22, at 40 (U.S. Dep't of Justice, Drug Enforcement Administration, Sept. 6, 1988) (Young, A.L.J.), *available at* <http://www.druglibrary.org/Schaffer/library/studies/YOUNG/young1.html>.

503. *Id.*

himself on a public sidewalk across from his school and unfurled a fourteen foot banner reading "Bong Hits 4 Jesus."⁵⁰⁴ Principal Deborah Morse confiscated the banner and suspended Frederick for ten days.⁵⁰⁵ Years after the incident Frederick explained that the banner had no particular meaning: "I wasn't trying to say anything about religion. I wasn't trying to say anything about drugs. I was just trying to say *something*. I wanted to use my right to free speech, and I did it."⁵⁰⁶

When he took his free speech claim to the Supreme Court, Frederick learned that his intentions in displaying the banner were hugely irrelevant. Writing for the Court in *Morse v. Frederick*, Chief Justice Roberts admitted that the banner's message was "cryptic," and that it offended, amused, or "mean[t] nothing at all" to those who had viewed it.⁵⁰⁷ Nonetheless, he concluded that "Principal Morse thought the banner would be interpreted . . . as promoting illegal drug use, and that interpretation is plainly a reasonable one."⁵⁰⁸ Had she not suppressed the banner, Morse's failure to act "would send a powerful message to the students in her charge . . . about how serious the school was about the dangers of illegal drug use."⁵⁰⁹ Justice Stevens' dissent, joined by Justices Ginsburg and Souter, derided an imaginary First Amendment rule that authorizes "censorship of any student speech that mentions drugs, at least so long as someone could perceive that speech to contain a latent pro-drug message."⁵¹⁰ Rather than suppress speech with which it disagreed, the school would have served its students far better by conducting an open, honest discussion on the pros and cons of marijuana prohibition.⁵¹¹

Recently, this signaling frenzy crossed the border into Canada and snared another unsuspecting youth. Kieran King, an honor roll high school student from Saskatchewan, had never even tried marijuana, but he suspected that what his teachers were telling him about the dangers of drug use "didn't ring true," so he decided to do some research of his own.⁵¹² Among his discoveries was the fact that marijuana seemed to

504. *Morse v. Frederick*, 127 S. Ct. 2618, 2622 (2007).

505. See Robert Barnes, *Justices to Hear Landmark Free-Speech Case*, WASH. POST, Mar. 13, 2007, at A03.

506. *Id.*

507. *Morse*, 127 S. Ct. at 2624.

508. *Id.*

509. *Id.* at 2629.

510. *Id.* at 2650 (Stevens, J., dissenting).

511. *Morse*, 127 S. Ct. at 2651.

512. *Sask. Teen Suspended Over Pot Debate Protest Gets Back on Honour Roll*, CBC

cause less harm than alcohol and tobacco, and he shared this information with several other students.⁵¹³ Upon learning of King's subversive activities, the principal warned him that his discussions amounted to promoting drug use and would not be tolerated.⁵¹⁴ She further threatened to involve the police if King persisted in talking about marijuana at school.⁵¹⁵ After staging a small protest at the school, King was suspended and barred from taking his final exams.⁵¹⁶ All of this, it should be noted, took place in a country that leads the industrial world in cannabis consumption,⁵¹⁷ and which, in 2002, became the first nation to legalize and regulate medical marijuana use,⁵¹⁸ and where, in 2007, fifty-five percent of adults polled thought cannabis should be legalized.⁵¹⁹ Curiously, both Joseph Frederick and Kieran King ended up in China, teaching English and learning Mandarin.⁵²⁰ "When Kieran gets back," wrote one Canadian columnist, "I'm thinking of calling him up and asking him what it's like to live in a free country."⁵²¹

C. Dazed, Confused, and Divided

The politics of morality are drawn to health issues like flies to honey. Activities that threaten public health—drug and alcohol abuse, teenage pregnancy, sexually transmitted diseases, and so on—typically incite moral outrage and expedient, repressive responses.⁵²² What divides us on these issues is not necessarily a difference in moral perspective. Rather, it is the feeling that morality has no place at all in the analysis of certain behaviors. Thirty-five percent of Americans think that smoking marijuana is not a moral issue.⁵²³ The Puritans themselves

NEWS.CA, June 28, 2007, <http://www.cbc.ca/canada/saskatchewan/story/2007/06/28/teen-marijuana.html> [hereinafter *Teen Suspended*].

513. *Id.*

514. Colby Cosh, *Put Kieran on a Poster*, NATIONAL POST, June 22, 2007, <http://www.nationalpost.com/scripts/story.html?id=d2027490-6b52-4088-ab83-7ed898a68e6d&k=14828>.

515. *Teen Suspended*, *supra* note 512.

516. *Id.* The school later relented, allowed him to take the exams, and restored his straight-A average.

517. *The Drug Trade*, *supra* note 39.

518. *Canadians Support Marijuana Legalization*, ANGUS REID GLOBAL MONITOR, June 28, 2007, <http://www.angus-reid.com/polls/view/16300>.

519. *Id.*

520. *Teen Suspended*, *supra* note 512; Barnes, *supra* note 505.

521. Cosh, *supra* note 514.

522. Morone, *supra* note 472, at 23-24.

523. *A Barometer of Modern Morals: Sex, Drugs and the 1040*, PEW RESEARCH

were tolerant of wine but highly critical of drunkenness.⁵²⁴ It was not the substance itself, alcohol, that posed a hazard, but the individuals who abused it and disrupted the life of the community. Americans evinced at least a partial understanding of this when they repealed Prohibition. But, within no time at all, Anslinger and his minions descended on cannabis and demonized it to the extent that the distinction between *substance* and *substance abuse* no longer mattered. The prohibition of marijuana, without regard to whether the herb itself presents a threat to public health has, nevertheless, become a legitimate moral stance.

The war on drugs is damaging on many levels, beginning with the unjust condemnation of our basic selves. Long before he became a prominent health guru, Andrew Weil asserted that the quest for “periodic episodes of altered consciousness” is an innate human drive.⁵²⁵ Ronald Siegel, professor at UCLA medical school, argues that the drive is acquired rather than innate, but no less powerful for being so.⁵²⁶ In addition to the basic innate drives of hunger, thirst, and sex, Siegel posits the existence of an acquired “fourth drive,”⁵²⁷ a natural urge to “alter our mental state.”⁵²⁸ The desire for intoxication, he says, “is no more abnormal than the pursuit of love, social attachments, thrills, power, or any number of other acquired motives.”⁵²⁹ Aldous Huxley recognized that humans hunger for escape, and that “the longing to transcend [ourselves] if only for a few moments, is and has always been one of the principal appetites of the soul.”⁵³⁰ With blunter eloquence, T.S. Eliot announced that “human kind / Cannot bear very much reality.”⁵³¹

The war on drugs promotes a war within and upon ourselves. As a result, Americans are “deeply confused, inconsistent and ambivalent

CENTER, Mar. 28, 2006, <http://pewresearch.org/pubs/307/a-barometer-of-modern-morals>.

524. The Puritans viewed the drinking of intoxicants as “conducive to good health.” Katherine Van Wormer, *Harm Induction vs. Harm Reduction: Comparing American and British Approaches to Drug Use*, 29 J. OFFENDER REHABILITATION 35, 37 (1999).

525. Scott Rosenberg, *In Drugs We Trust*, SALON.COM, July 14, 1997, <http://www.salon.com/july97/drugintro970714.html>, (quoting ANDREW WEIL, *THE NATURAL MIND* (1972)).

526. RONALD K. SIEGEL, *INTOXICATION: LIFE IN PURSUIT OF ARTIFICIAL PARADISE* 209 (1989).

527. *Id.*

528. Benson & Rasmussen, *supra* note 490.

529. SIEGEL, *supra* note 526, at 209.

530. Richard Smith, Editorial, *The War on Drugs: Prohibition Isn't Working—Some Legalisation Will Help*, 311 BRITISH MED. J. 25 (Dec. 1995) (quoting ALDOUS HUXLEY, *THE DOORS OF PERCEPTION* (1959)).

531. T.S. ELIOT, *Burnt Norton*, in *FOUR QUARTETS* 3, 4 (1943).

about drugs.”⁵³² Further, our very inability to “draw any kind of useful distinctions among different drugs”⁵³³ has led to unimaginable suffering. The American Medical Association estimates that seventy-five million Americans experience chronic and debilitating pain.⁵³⁴ Although medications are available to help them, many patients receive insufficient palliative care. Fifty percent of advanced-stage cancer patients are undertreated for pain, as are eighty-five percent of elderly Americans residing in long-term-care facilities.⁵³⁵ Medical school and postgraduate education clearly has been deficient in providing training in palliative care.⁵³⁶ It is only in recent years that a growing number of doctors have become aware that “pain is more than a symptom; it’s a disease by itself that can trigger a cascade of other health problems.”⁵³⁷

Morphine and other opioid medications such as oxycodone (the chemical in OxyContin), when properly prescribed, relieve pain “without fogging patients’ brains or turning them into drug addicts.”⁵³⁸ In spite of this, doctors and patients avoid these medications due to pervasive misconceptions about addiction. “Physicians [are] trained to suspect there’s an abuser lurking behind every painkiller request,”⁵³⁹ and thus prolong preventable suffering by steering patients away from opioids. As late as 2001, one doctor advised his patient to forego analgesics and “let the pain kill the cancer.”⁵⁴⁰

Despite this rampant undertreatment of physical suffering, sales of painkillers in the United States rose ninety percent between 1997 and 2005.⁵⁴¹ The fact that Americans are growing older and more in need of pain medicine is one factor, as is greater willingness by some physicians to engage in effective palliative care.⁵⁴² Moreover, “[d]rugmakers have

532. Rosenberg, *supra* note 525.

533. *Id.*

534. See Barry Yeoman, *Prisoners of Pain*, AARP MAGAZINE, Sept./Oct. 2005, available at http://www.aarpmagazine.org/health/prisoners_pain.html.

535. *Id.*

536. Joanne E. Mortimer & Nancy L. Bartlett, *Assessment of Knowledge About Cancer Pain Management by Physicians in Training*, 14 J. PAIN & SYMPTOM MANAGEMENT 21, 24-5 (1997).

537. Yeoman, *supra* note 534.

538. *Id.*

539. *Id.*

540. *Id.*

541. Frank Bass, *Pain Medicine Use Has Nearly Doubled*, ASSOCIATED PRESS, Aug. 20, 2007, available at <http://www.washingtonpost.com/wp-dyn/content/article/2007/08/20/AR2007082000147.html>.

542. *Id.*

embarked on unprecedented marketing campaigns,”⁵⁴³ spending nearly thirty billion dollars to promote painkillers while reaping profits “three and four times higher than in other Fortune 500 industries.”⁵⁴⁴ Though more Americans are abusing prescription pain medicines, the DEA estimates that only one percent of the nation’s physicians illegally prescribe them.⁵⁴⁵ People are far more likely to procure the drugs illegally from family members and friends.⁵⁴⁶

Some patients have such chronic and intractable pain that they require long-term, high-dose opioid regimens. With proper medical supervision, they can function on high opioid levels for years.⁵⁴⁷ Due to the rise in prescription drug abuse, however, doctors who prescribe high and frequent opioid doses are increasingly at risk of criminal prosecution. In 2006, the DEA arrested seventy-one doctors on suspicion of diverting prescription medicine into illegal drug markets.⁵⁴⁸ It also initiated 735 doctor investigations, a process that can lead to doctors losing their licenses, losing their practices, and having “their homes, offices and cars seized even if no federal criminal charges are filed.”⁵⁴⁹ The result is the creation of an inhibitory environment that “scares doctors away from practicing good medicine.”⁵⁵⁰ To avoid investigation and possible prosecution, more and more physicians are refusing to prescribe painkillers, even to their sickest patients.⁵⁵¹ People in desperate need of strong pain medicine must drive long distances, often to different states, in search of doctors willing to help them.⁵⁵²

As long ago as 1993, physicians treating cancer patients and prescribing opioids were advised to “establish a dialogue with drug regulators and medical examining boards.”⁵⁵³ It was hoped that, by opening communication channels, doctors could ensure that uncontrolled cancer pain would not become “an unintended product of the war on

543. *Id.*

544. *Id.*

545. Bass, *supra* note 541.

546. *Id.*

547. Tina Rosenberg, *Doctor or Drug Pusher?* N.Y. TIMES MAG., July 17, 2007, 48, 51.

548. *Id.*

549. *Id.*

550. Yeoman, *supra* note 534.

551. Bass, *supra* note 541.

552. *Id.*

553. Jamie H. Von Roenn et al., *Physician Attitudes and Practice in Cancer Pain Management: A Survey From the Eastern Cooperative Oncology Group*, 119 ANNALS INTERNAL MED. 121, 125 (July 15, 1993), available at <http://www.annals.org/cgi/content/full/119/2/121>.

drugs.”⁵⁵⁴ Not only has this not occurred, but the DEA, by seizing on medicinal cannabis and holding it out as an evil, has intensified this climate of fear. Marijuana, like morphine, is a substance with tremendous therapeutic potential. Yet many patients, along with their doctors, are made to feel that asking for drugs to relieve pain is a sign of moral failing. Worse, in a majority of states, medical marijuana users are forced to resort to illicit drug transactions and face criminal sanctions. It is not enough that these individuals are sick, suffering, or dying; society also demands that they be branded as morally and legally suspect.

Dr. Jerome Kassirer, former editor-in-chief of the *New England Journal of Medicine*, describes the federal interdiction of medical marijuana as “misguided, heavy-handed and inhumane.”⁵⁵⁵ The rights of “those at death’s door” are subservient to “the absolute power of bureaucrats whose decisions are based more on reflexive ideology and political correctness than on compassion.”⁵⁵⁶ Instead of empathy and respite from pain, the suffering get “signals” and “messages.” What the politicians fail to grasp is that, if they would only do the right thing, the messages would take care of themselves.

D. Breaking Away

Some see medical marijuana as a “Trojan horse,”⁵⁵⁷ a device for decriminalization in the guise of exploiting public sympathy for the ill. Since NORML’s involvement in initial efforts to reschedule marijuana in 1972, the medicinal cannabis movement has been “closely linked” with the philosophy of decriminalization.⁵⁵⁸ Medicinal marijuana activism has largely been the work of middle-class adults who, short of advocating legalization, seek to endorse a viable alternative to the war on drugs.⁵⁵⁹ To serious opponents of drug prohibition, embracing the medical movement is a tactic sure to derail the repeal of oppressive drug laws.⁵⁶⁰ Promoting marijuana solely as a medicine implies that it cannot

554. *Id.*

555. Jerome P. Kassirer, *Federal Foolishness and Marijuana*, 336 NEW ENGLAND J. MED. 366 (Jan. 30, 1997).

556. *Id.*

557. IOM REPORT, *supra* note 153, at 18.

558. *Id.* at 17.

559. ENGS, *supra* note 488, at 222.

560. Thomas Szasz, *Drug Use Should Be an Individual Choice*, in LEGALIZING DRUGS 52, 52 (Louise I. Gerdes ed., 2001).

be legitimated for other uses. This view plays into the hands of those who denigrate the safety and efficacy of therapeutic cannabis by "exaggerating its dangers when used for other purposes."⁵⁶¹ By allowing the prohibitionists to define the terms of the debate, medical marijuana advocates put their own credibility at risk. Both sides end up pawing at the same moral ground and the war on drugs drags on. Because the rhetoric that fuels this war is resistant to logic and appeasement, advocates of legalization must find ways to break out of the existing limits of the controversy.

Having excited much public awareness and support, however, the therapeutic cannabis movement finds itself continually constrained by federal regulations. Try as the movement might, whole plant marijuana will never satisfy the demands of the FDA, even with a Schedule change. A substance that is cultivated rather than manufactured, herbal marijuana is not readily mass-produced with uniform quality and potency. It does not easily conform to the structure of clinical trials devised by the FDA for the approval of drugs. These restrictions prevent whole plant cannabis from achieving the government-sanctioned status accorded to prescription medicines, including synthetic cannabinoids. Without the power to surmount FDA regulatory requirements, overturn them, or circumvent them the strategies of the medical marijuana movements are essentially self-limiting. Unless it expands its ideology to embrace a whole-hearted, comprehensive rejection of the war on cannabis, the therapeutic movement, as a form of activism, is destined for a dead end.

Lester Grinspoon spent well over thirty years thinking and writing about marijuana as medicine. He concluded that the "only workable way of realizing the full potential of this remarkable substance" is to free it from the controls that govern prescription drugs as well as from those laws that criminalize its use.⁵⁶² Cannabis, he argued, should be made available on a basis similar to that of alcohol,⁵⁶³ and presumably subject to a similar scheme of regulation and taxation.

Even if the DEA were to allow it, transferring marijuana to Schedule II would label it a substance with a high potential for abuse, the use of which may lead to severe psychological or physical dependence.⁵⁶⁴ Marijuana has never been shown to be physically

561. Grinspoon, *supra* note 198, at 156.

562. GRINSPOON, *supra* note 99, at xv.

563. Grinspoon, *supra* note 198, at 156.

564. 21 U.S.C. § 812 (2000).

addictive, and the vast majority of those who use it do so only occasionally.⁵⁶⁵ Withdrawal, such as it is, is “mild and subtle,”⁵⁶⁶ especially when compared to the physical upheaval of alcohol or heroin withdrawal.

A Schedule II designation would not be sufficient to guarantee marijuana’s availability as a prescription drug. In order to qualify as a medicine under FDA guidelines, cannabis would have to undergo rigorous, double-blind controlled studies. Such procedures are enormously time-consuming and expensive, costing hundreds of millions of dollars.⁵⁶⁷ Nor can the FDA be trusted to provide competent oversight of clinical drug trials. In a Department of Health Services report issued in September 2007, the agency was found to be largely ignorant of how many clinical trials were being conducted, “audited fewer than 1 percent of the testing sites and, on the rare occasions when inspectors did appear, generally showed up long after the tests had been completed.”⁵⁶⁸ Arthur L. Caplan, chairman of the University of Pennsylvania’s department of medical ethics, stated that “rats and mice get greater protection as research subjects in the United States than do humans.”⁵⁶⁹ Calling the FDA underfunded and gutless, Rep. Rosa DeLauro (D-Conn.) described it as “passive” and “reactive,” an agency that often chooses to side with industry over public health.⁵⁷⁰

The federal government has grossly impeded research efforts by stringently limiting access to marijuana for experimental purposes.⁵⁷¹ Further, government agencies such as the National Institutes of Health

565. ZIMMER & MORGAN, *supra* note 136, at 26.

566. IOM REPORT, *supra* note 153, at 90.

567. Lester Grinspoon, Op-Ed, *Why Won't Government Let Us Use Marijuana as Medicine?*, BOSTON GLOBE, Dec. 7, 2000, at A23.

568. Gardiner Harris, *Report Assails F.D.A. Oversight of Clinical Trials*, N.Y. TIMES, Sept. 28, 2007, at A1.

569. *Id.*

570. *Id.*; see also Gardiner Harris, *The Safety Gap*, N.Y. TIMES MAG., Nov. 2, 2008, at 46 (“Several independent assessments of the F.D.A. have called attention to the agency’s poor organization and shortage of funds—and to the hazard those shortfalls pose to the nation’s supply of food and medicinal drugs. A board of scientific advisers to the F.D.A. released a report last year that concluded that nothing less than the lives of U.S. citizens were at stake.”). In a letter to Congress, dated October 14, 2008, a group of FDA scientists charged top federal health officials with approving drugs and medical devices on equivocal data, corrupting the scientific review process and “ordering experts to change their opinions and conclusions in violation of the law.” Gardiner Harris, *F.D.A. Scientists Accuse Agency Officials of Misconduct*, NY TIMES, Nov. 18, 2008, at A15.

571. Harris, *supra* note 142.

have repeatedly refused to finance medicinal marijuana studies.⁵⁷² Typically, pharmaceutical companies assume the cost of researching and demonstrating the therapeutic benefits of new drugs. Once they receive FDA approval of a drug for which they hold a patent, pharmaceutical companies stand to benefit in a very big way. As a natural substance, however, marijuana is not patentable,⁵⁷³ and drug companies have little incentive to expend energies and resources studying it.

In Grinspoon's view, marijuana is exempt from the requirement of controlled experiments, having proven its medical value through its use by millions of people for thousands of years with little toxic effect.⁵⁷⁴ Controlled experiments, he has reasoned, were not necessary for recognition of the benefits of aspirin, chloral hydrate, barbiturates, curare, lithium, insulin, or penicillin.⁵⁷⁵ We know more about marijuana's adverse effects "than about those of most prescription drugs."⁵⁷⁶ Kassirer notes that, unlike morphine, where "the difference between the dose that relieves symptoms and the dose that hastens death is very narrow," smoking marijuana carries no risk of death.⁵⁷⁷ Given marijuana's margin of safety, "[w]hat really counts for a therapy . . . is whether a seriously ill patient feels relief as a result of the intervention, not whether a controlled trial 'proves' its efficacy."⁵⁷⁸

Drug development today relies less and less on plants; whereas previously drugs were *discovered*, they are now *designed*.⁵⁷⁹ Generally, these substances consist of a single synthetic chemical developed and patented by a pharmaceutical company.⁵⁸⁰ FDA guidelines are formulated to evaluate these single chemical compounds rather than a substance containing many chemicals, like cannabis.⁵⁸¹ Perhaps because of its complex chemical nature, marijuana is extremely versatile.⁵⁸² According to noted botanist Dr. Jim Duke, whole plant herbs are far more useful than synthetic drugs, called "silver bullet[s]," made from one of their compounds.⁵⁸³ Because humans have co-evolved with these

572. *Id.*

573. Grinspoon, *supra* note 567.

574. Grinspoon, *supra* note 198, at 148.

575. *Id.*; Grinspoon, *supra* note 567.

576. *Id.*

577. Kassirer, *supra* note 555.

578. *Id.*

579. IOM REPORT, *supra* note 153, at 19-20.

580. Grinspoon, *supra* note 198, at 147.

581. *Id.* at 148.

582. *Id.* at 145.

583. JANE E. BRODY & DENISE GRADY, THE NEW YORK TIMES GUIDE TO

natural botanical substances, our bodies have learned to use what is good in them while discarding what may be harmful.⁵⁸⁴ Unlike the “silver bullet,” the whole plant offers a “menu” of compounds, which the body “already knows or has mechanisms for utilizing or excluding.”⁵⁸⁵ Clinical experience and case histories attest to marijuana’s usefulness in treating “more than two dozen symptoms and syndromes.”⁵⁸⁶ In California, patient groups clamoring for access to medical cannabis were so numerous and diverse, voters passed a law including not only cancer and AIDS but “any other illness for which marijuana provides relief.”⁵⁸⁷

Were marijuana placed in Schedule II, severe state and federal restrictions would subject every medical cannabis transaction to centralized computer monitoring.⁵⁸⁸ The DEA would know who was prescribing it and who was receiving it as well as how much and how often. Such close scrutiny would have the same threatening, inhibitory effect on doctors prescribing marijuana as on those who prescribe opioids. Moreover, marijuana dosages are difficult to standardize and are dependent on plant potency and individual patient needs. Even states with medical marijuana statutes disagree on how to calculate a legally permissible two-month supply.⁵⁸⁹

For many patients, marijuana’s psychoactive properties are integral to its therapeutic effects.⁵⁹⁰ To minimize the existence of these

ALTERNATIVE HEALTH: A CONSUMER REFERENCE 59 (2001) (quoting Dr. Jim Duke); *see also* ANDREW WEIL, HEALTH AND HEALING 99-100 (1998) (stating that synthetic drugs isolated from plant compounds are generally more toxic than those from botanical sources, and result in more rapid onset, greater intensity, and shorter duration).

584. BRODY & GRADY, *supra* note 583, at 59.

585. *Id.*

586. Grinspoon, *supra* note 198, at 145.

587. *Debate on California's Pot Shops*, *supra* note 16.

588. Grinspoon, *supra* note 198, at 151-52.

589. Curt Woodward, *Wash. To Set Medical Marijuana Limits*, ASSOCIATED PRESS, July 7, 2007, available at <http://www.washingtonpost.com/wp-dyn/content/article/2007/07/07/AR2007070701085.html>. After ten years of “confusion and uncertainty [that] led to conflict between police and patients,” the state of Washington’s Department of Health has promulgated a new rule. Sara Jean Green, *State Rule Clarifies 60-day Supply of Medical Marijuana*, SEATTLE TIMES, Oct. 3, 2008, available at http://seattletimes.nwsources.com/html/localnews/2008224424_medpot03m0.html. Effective November 2, 2008, a sixty-day supply of medical marijuana is defined as twenty-four ounces plus fifteen plants. *Id.* Those who require more do not have to submit a doctor’s note, but there is no clear standard for proving necessity for more than the rule’s stated amount. *Id.* Despite assurances from King County Prosecuting Attorney Dan Satterberg that, “if you’re . . . dying of cancer, we’re not going to prosecute you if you have 15 plants or 30,” a number of medical marijuana advocates oppose the limits as far too low. *Id.*

590. Grinspoon, *supra* note 233.

psychoactive elements and disengage them from the medical debate seems illogical and disingenuous. Marijuana is a broad-range substance that fails to conform to federal regulatory guidelines.⁵⁹¹ Herbal cannabis cannot alter its inherent structure and characteristics any more than the FDA is likely to change its approval criteria in order to accommodate it.

As the medical marijuana movement does harbor a rationale for legalization, the “Trojan horse” analogy is more apt than we realize. Lester Grinspoon explained:

At one time I thought medical use could be treated as a distinct issue, because even people who might never see the urgency of legalizing nonmedical use would respond to medical need. Now I have changed my mind. On the contrary, I believe that making marihuana fully available as a medicine is one of the reasons for general legalization.⁵⁹²

From its earliest incarnation as a multi-purpose herbal remedy, marijuana seems to have traveled a long, hard road back to its roots.

The medicinal cannabis movement has succeeded admirably in arousing interest in marijuana’s therapeutic benefits. As a distribution system, however, its mechanisms are, at best, temporary “stopgap”⁵⁹³ measures. But, merely by enacting medical marijuana statutes, thirteen states have revitalized and reified the basic tenet of American federalism, that it is “designed for experimentation in its laboratories of democracy.”⁵⁹⁴ To date, the sanctioning of medical marijuana use has had no adverse impact on rates of cannabis consumption. After analyzing data from California, Colorado, Oregon, and Washington, researchers at the Texas A&M Health/Science Center found that “medical cannabis laws do not increase use of the drug.”⁵⁹⁵ In regard to teen use, a 2005 study by O’Keefe and Earleywine reported that not one state with a medical marijuana statute has experienced increased youth marijuana use since enactment of its law.⁵⁹⁶ Further, the decrease in

591. Grinspoon, *supra* note 198, at 148-49.

592. *Id.* at 156.

593. *Id.* at 150.

594. Benson & Rasmussen, *supra* note 490.

595. Hess, *supra* note 245. The study’s authors note further that linking cannabis with medical applications has had the effect of “de-glamoris[ing]” it, making it less alluring to young people who might associate its use with illness. Dennis M. Gorman & J. Charles Huber Jr., *Do Medical Cannabis Laws Encourage Cannabis Use?* 18 INT’L J. DRUG POLICY 160, 166 (2007).

596. Karen O’Keefe & Mitch Earleywine, *Marijuana Use By Young People: The Impact of State Medical Marijuana Laws*, at 1, <http://www.csdp.org/research/2005TeenUseReport.pdf>.

teen marijuana use in those states “has slightly exceeded the national decline.”⁵⁹⁷ In view of these findings, the study’s authors strongly suggest that “legislators should evaluate medical marijuana proposals based on their own merits—without regard for the speculative and unsupported assertions about the bills sending the ‘wrong message.’”⁵⁹⁸

For decades, the federal government has unduly involved itself in drug issues that are properly and primarily the responsibility of states and localities.⁵⁹⁹ Since the Reagan administration, federal entities have interfered with state decriminalization efforts and “discourage[d] local innovation in drug policy.”⁶⁰⁰ Perhaps a slight breeze of change has begun to blow in the federal legislature. In July, 2008, Rep. Barney Frank (D-Mass.) introduced House Resolution 5843, titled the Personal Use of Marijuana by Responsible Adults Act of 2008.⁶⁰¹ It proposes to end federal penalties for possession of fewer than 100 grams of marijuana, about 3.5 ounces.⁶⁰² Although the resolution does not remove penalties for growing, importing, exporting, or selling marijuana for profit, it does permit the “nonprofit transfer”⁶⁰³ of an ounce or less of cannabis. If passed, the law would be especially welcomed by medical marijuana patients and advocates. Given the all but immutable nature of the federal outlook, however, such relief could be long in coming. For now, at least, the movement to reform oppressive drug laws is an impetus arising from the states.

With far less fanfare than the medical marijuana movement, advocates of industrial hemp have also demonstrated a willingness to take on the federal government. Despite a federal ban on growing hemp because the plant contains THC, the North Dakota legislature recently passed a bill permitting farmers to cultivate hemp.⁶⁰⁴ Maine, Montana,

597. *Id.* at 14.

598. *Id.* at 2.

599. Benson & Rasmussen, *supra* note 490.

600. *Id.*

601. Act to Remove Federal Penalties for the Personal Use of Marijuana by Responsible Adults, H.R. 5843, 110th Cong. (2008). In support of the bill, Rep. Frank stated, “The vast amount of human activity ought to be none of the government’s business I don’t think it is the government’s business to tell you how to spend your leisure time.” *Legislators Aim to Snuff Out Penalties for Pot Use*, CNN POLITICS, July 30, 2008, <http://www.cnn.com/2008/POLITICS/07/30/frank.marijuana/index.html>.

602. H.R. 5843, 110th Cong. (2008).

603. *Id.*

604. See Monica Davey, *Sober North Dakotans Hope to Legalize Cannabis Without the Kick*, N.Y. TIMES, July 21, 2007, at A1.

West Virginia, and other states have passed similar measures.⁶⁰⁵ Although they are cognizant that industrial hemp contains mere traces of THC, drug enforcement officials worry that marijuana growers will sneak into harmless hemp patches and conceal more potent varieties of the plant.⁶⁰⁶ Roger Johnson, North Dakota's agricultural commissioner, dismissed such concerns. Hemp fields, he explained, are subject to unannounced searches and crop testing.⁶⁰⁷ Moreover, plants in a hemp field would cross-pollinate, reducing the potency of any other existing marijuana plants.⁶⁰⁸ "We're not wide-eyed liberals," Mr. Johnson said. "The D.E.A., they're the crazy ones on this."⁶⁰⁹

The war on drugs has such a tight grip on public consciousness and policy that, according to Thomas Szasz, "legalizing marijuana in the United States is about as practical as is legalizing Scotch in Saudi Arabia."⁶¹⁰ Still, there are growing indications that more and more Americans neither want nor need the federal government to protect them from themselves. In 2007, Americans for Safe Access (ASA) brought suit against the Department of Health and Human Services and the FDA, seeking to enjoin those agencies from disseminating false information about marijuana's currently acceptable medical use.⁶¹¹ On a local government level, a California Superior Court upheld a Santa Barbara voter initiative directing police to give low priority to marijuana

605. *Id.*

606. *Id.*

607. *Id.*

608. Davey, *supra* note 604.

609. *Id.* In 2007, two North Dakota farmers brought suit against the DEA, seeking a declaratory judgment that their cultivation of industrial hemp pursuant to state licensing laws would not be prohibited by the CSA. *Monson v. D.E.A.*, 522 F. Supp. 2d 1188 (D. N.D. 2007). In granting the DEA's motion to dismiss, the court averred that, while industrial hemp "may not be the terrible menace the DEA makes it out to be, . . . [it] is still considered to be a Schedule I controlled substance." *Id.* at 1202. In an earlier case regarding an ordinance of the Oglala Sioux permitting the growth of industrial hemp, the U.S. Court of Appeals for the Eighth Circuit had confirmed that "the language of the CSA unambiguously bans the growing of marijuana, regardless of its use." *United States v. White Plume*, 447 F.3d 1067, 1072 (8th Cir. 2006). Further, however negligible the quantity of THC contained in the industrial hemp, the CSA "does not distinguish between marijuana and hemp in its regulation." *Id.* at 1073. In *Monson*, Chief Judge Daniel L. Hovland characterized the plaintiffs' policy arguments as "[better] suited for Congress than [for] a federal courtroom." *Monson*, 522 F. Supp. 2d at 1202.

610. Szasz, *supra* note 560, at 53.

611. *Americans for Safe Access v. Dep't of Health and Human Servs.*, No. 07-01049, 2007 U.S. Dist. LEXIS 55597 (N.D. Cal. July 24, 2007), *motion to dismiss granted*, No. 07-01049, 2007 U.S. Dist. LEXIS 89257 (N.D. Cal., Nov. 20, 2007).

arrests.⁶¹² Similar ordinances are currently in effect in Seattle and Missoula County, Montana, and officials appear to be heeding them.⁶¹³ Seattle's city attorney, however, expressed discomfort with the ordinance, stating that he and the police are bothered by "the message that marijuana smoking is O.K."⁶¹⁴

The social and cultural frictions endemic to federalism persist in the hierarchy of state, municipal, and local government as well. In 2005, voters in Denver approved a measure legalizing adult possession of an ounce or less of marijuana.⁶¹⁵ Officials chose to enforce state law, and actually increased the number of misdemeanor arrests for possession by nearly 2,000 since 2005.⁶¹⁶ A Denver ballot initiative making marijuana enforcement the lowest city police priority passed in November 2007.⁶¹⁷ Unfortunately, police and prosecutors may choose to simply ignore the will of the voters and enforce superseding laws. Sergeant Ernie Martinez of the Denver Police Department, for one, balked at the idea of promoting the "self-indulgence of marijuana use at the risk of the public."⁶¹⁸

Local strategies to overlook or decriminalize minor marijuana possession evoke the federalist spirit of the states that support medicinal cannabis. But "turning a blind eye on users . . . leaves production and distribution in the hands of criminals."⁶¹⁹ In this way, interim measures that focus on personal use ignore the bigger problem. Decriminalization, too, is a "muddy term";⁶²⁰ a concession to drug policy rather than a reevaluation of it. Where medical marijuana and hemp growing differ from the decriminalization of "marijuana use" is in calling attention to

612. *City of Santa Barbara v. Poet*, No. 1243675, 2007 WL 2348238 (Cal. Super. Ct., July 10, 2007); *Court Upholds Law Making Marijuana Santa Barbara's Lowest Law Enforcement Priority*, AM. CIVIL LIBERTIES UNION, July 10, 2007, <http://www.aclu.org/drugpolicy/medmarijuana/30449prs20070710.html>.

613. Dan Frosch, *In Denver, A Ballot Fight Over Marijuana Arrests*, N.Y. TIMES, Nov. 5, 2007, available at www.nytimes.com/2007/11/05/us/06pot.html.

614. *Id.*

615. *Id.*

616. *Id.*

617. See Felisa Cardona, *Denver Puts Pot Busts on Cops' Back Burner*, DENVER POST, Nov. 7, 2007, at B5.

618. Frosch, *supra* note 613.

619. John Gray, *Injecting Some Sense*, GUARDIAN, July 10, 2001, <http://www.guardian.co.uk/politics/2001/jul/10/drugsandalcohol>.

620. Gary E. Johnson, *Drugs Should Be Made Controlled Substances*, in LEGALIZING DRUGS 48, 50 (Louise I. Gerdes ed., 2001). Johnson was Republican governor of New Mexico from 1995 to 2003. See *id.*

the plant itself; presenting it as a remarkably useful product invites speculation about the wisdom of the costly war against it.

It is also a war of gross inequities. Nationally, blacks have long been disproportionately targeted for drug law violations.⁶²¹ From 1997 to 2006, New York City police arrested and jailed 360,000 people for minor marijuana offenses, more than any other city in the world.⁶²² Eighty-five percent of those arrested were black and Hispanic, despite the fact that whites consume marijuana more frequently than either of those groups.⁶²³ The majority of those arrested possessed only small amounts, usually “nickel” or “dime bags,” were not smoking in public, and were merely carrying these minute quantities in their pockets.⁶²⁴ Since blacks and Hispanics are far more likely than whites to be arrested for such minor misdemeanor infractions, they are also more likely to end up with criminal records and to have their DNA and personal information entered into criminal justice databases. As a result, these databases are built on bias, and are so “racially and demographically skewed”⁶²⁵ that they constitute “an embarrassment to [New York City’s] citizens and policy makers.”⁶²⁶

Thomas Szasz has chided opponents of the war on drugs for refusing to “recognize that their adversaries are priests waging a holy war on Satanic chemicals, not statesmen who respect the people”⁶²⁷ or who will willingly engage in realistic assessment of the risks and benefits of drugs. If opponents of medical marijuana are unmoved by scientific arguments, perhaps the economic practicalities of anti-cannabis enforcement might convince them. In 2006, police arrested 829,625 people for marijuana violations, eight-nine percent of them for possession.⁶²⁸ In total, U.S. marijuana arrests in 2006 “far exceeded the

621. See HUMAN RIGHTS WATCH, PUNISHMENT AND PREJUDICE: RACIAL DISPARITIES IN THE WAR ON DRUGS, available at <http://www.hrw.org/legacy/reports/2000/usa/>.

622. *Regarding Pending and Proposed Legislation to Collect DNA from All People Convicted of a Misdemeanor in New York State, and also Regarding New York City’s Epidemic of Marijuana Possession Arrests: Hearing Before the New York State Assembly Committees on Codes and on Corrections 1* (2007) (statement of Harry G. Levine, Professor of Sociology, Queens College), available at http://www.nyclu.org/files/dna_database_levine_tstmny_053107.pdf [hereinafter Statement of Harry Levine]. See also Andrew Golub et al., *The Race/Ethnicity Disparity in Misdemeanor Marijuana Arrests in New York City*, 6 CRIMINOLOGY & PUB. POL’Y 131, 143 (2007).

623. Statement of Harry Levine, *supra* note 622, at 2.

624. *Id.* at 1.

625. *Id.* at 5.

626. *Id.*

627. Szasz, *supra* note 560, at 53.

628. *Marijuana Arrests for Year 2006—829,625 Tops Record High . . . Nearly 6 Percent*

total number of arrests in the United States for all violent crimes, including murder, manslaughter, forcible rape, robbery and aggravated assault.”⁶²⁹ According to Allen St. Pierre, executive director of NORML, “Enforcing marijuana prohibition costs taxpayers between \$10 billion and \$12 billion annually and has led to the arrest of nearly 20 million Americans”⁶³⁰—all of this money and turmoil to suppress a drug that wreaks less physical havoc than aspirin.⁶³¹ In a recent study assessing physical and social harm and dependence caused by various drugs (including alcohol and tobacco), cannabis failed to make the top ten.⁶³² In their conclusion, the study’s authors express the fond hope that a formal analysis of harm rather than “prejudice and assumptions might help society to engage in a more rational debate about the relative risks and harms of drugs.”⁶³³ It is hard, however, to have a rational debate in the midst of a cognitive chaos reminiscent of alcohol prohibition. Drug enforcement efforts to obstruct supplies from Latin America have spawned a thirty-two billion dollar domestic marijuana industry, making marijuana America’s largest cash crop.⁶³⁴ The spectacular failure of the war on drugs is our best reason to renounce it and explore new tactics, including legalization.⁶³⁵

If neither practicality nor science will sway supporters of the war on drugs, it seems doubtful that an appeal to their sense of compassion will fare any better. A serious rethinking of drug war strategy, however, demands a pragmatic, apolitical view of human suffering. People throughout the world endure intolerable, unnecessary pain, and rigid, prohibitionist attitudes toward drugs are hurting them even further. In the developing countries of Africa, Asia, and Latin America, a shortage of painkillers has been brought on by restrictive national drug policies and fears of addiction.⁶³⁶ Many of the world’s poor are “destined to die in pain” because antibiotics and vaccines have helped them to “grow old

Increase Over 2005, NORML, Sept. 24, 2007, http://norml.org/index.cfm?Group_ID=7370.

629. *Id.*

630. *Id.*

631. Aspirin causes 1,000 to 2,000 deaths per year; ibuprofen kills 7,000 per year. See Grinspoon, *supra* note 198, at 151.

632. David Nutt et al., *Development of a Rational Scale to Assess the Harm of Drugs of Potential Misuse*, 369 LANCET 1047, 1051 (2007).

633. *Id.* at 1052.

634. Benson & Rasmussen, *supra* note 490.

635. *Id.*

636. Donald G. McNeil, Jr., *Painkillers in Short Supply in Poor Countries*, N.Y. TIMES, Oct. 9, 2007, at F6.

enough to die slowly of cancer.”⁶³⁷ Although morphine is not inordinately expensive, countries like Sierra Leone refuse to import it for fear that it will fall into the wrong hands and cause addiction and crime.⁶³⁸

It seems to be a regrettable aspect of human nature that, when confronted with a potential threat, our overriding impulse is to stamp it out rather than to seek to understand it and harness it for good use. Certainly this has been true of those who would happily put an end to the medical marijuana movement. But it does not matter which substance is the target of the impulse. In Afghanistan, “the United States and Britain waste more than \$800 million a year, as well as soldiers’ lives, trying futilely to eradicate poppies.”⁶³⁹ In response to a proposal to buy the poppies to make morphine for the poor, the U.S. and British governments expressed vigorous opposition, pledging a clear preference for “tough eradication tactics.”⁶⁴⁰

Marijuana use is not without risk. It may not be quite the medical miracle that advocates like Lester Grinspoon believe it to be or the industrial savior envisioned by hemp activists like Jack Herer. It is, however, a substance of far greater therapeutic and practical value than our policymakers will allow. That they obstinately cling to such demonizing and erroneous notions about the substance can only mean that they are acting on interests completely unrelated to the well-being of their constituents.

In every corner of the world, science, economic reality, and compassion are losing out to the war on drugs. If this is its end result, we might want to consider whether this crusade does justice to ourselves as a species. Millions undergo intense yet avoidable suffering while others staunchly deny them access to the drugs that might help them. To withhold relief on principle, and for no other reason, is heartless,

637. Donald G. McNeil, Jr., *Drugs Banned, World's Poor Suffer in Pain*, N.Y. TIMES, Sept. 10, 2007, at A1.

638. *Id.* Six of the world's countries (United States, Germany, France, Britain, Canada, and Australia) consume seventy-nine percent of the world's morphine. *Id.*

639. Donald G. McNeil, Jr., *Could Afghan Poppies be Painkillers for the Poor?* N.Y. TIMES WEEK IN REV., Oct. 14, 2007, at 4. In one province of Afghanistan, many farmers have replaced forbidden poppy crops with cannabis. Without government assistance and better markets for their legal crops, farmers regard cannabis cultivation as their only reasonable subsistence alternative. Kirk Semple, *The War on Poppy Succeeds, but Cannabis Thrives in an Afghan Province*, N.Y. TIMES, Nov. 4, 2007, at 6.

640. McNeil, *supra* note 639.

irrational, and—all our righteous posturing to the contrary—deeply immoral.

VI. CONCLUSION

An important, if unintended, consequence of the medical cannabis movement is that it has forced a serious rethinking of marijuana prohibition. To the detriment of multitudes, we have squandered our resources on the war on drugs. It is a battle that has taken on the nature of a blood feud, thriving on its own momentum, with no discernible resolution. It is an enterprise that saps our energies and destroys our capacity for humane reasoning. The medical marijuana movement inspires a new way to envision drug policy, calling on us to abandon the drug war's unprofitable logic and break out of the monotonous, stultifying rhythms of the prohibition debate. It's time to stop running in place.

