OFFICE OF THE CITY ATTORNEY
Long Beach, California

R-10

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November 10, 2009

HONORABLE MAYOR AND CITY COUNCIL
City of Long Beach
California

RECOMMENDATION:

On August 4, 2009, the City Council requested that the City Attorney report back to the City Council on the "feasibility, legality, and enforcement of potential local ordinances the Council may enact regarding medical marijuana, pursuant to state law."

That report, which is attached, was submitted to you on October 23, 2009 and is now presented for your consideration and direction. (A draft ordinance will be submitted under separate cover).

SUGGESTED ACTION:

Receive public input and discuss draft ordinance.

Very truly yours,

ROBERT E. SHANNON
City Attorney

RES:kdh
Attachment

City of Long Beach
Working Together to Serve

Office of the City Attorney

Memorandum

DATE: October 22, 2009

TO: Mayor and City Councilmembers

FROM: Cristyl Meyers, Deputy City Attorney

SUBJECT: Legal Analysis - Regulating Medical Marijuana

On August 4, 2009, the Long Beach City Council requested that the City Attorney prepare a report for the City Council addressing a number of issues concerning medical marijuana and the potential enactment of ordinances relating to its distribution and use. This memorandum responds to that request.

FEDERAL LAW

The Federal *Controlled Substances Act ("CSA")* defines marijuana as a Schedule I drug subject to criminal regulation. Further, the United States Supreme Court has ruled that federal law supersedes any state regulation authorizing cultivation or possession of medical marijuana. U.S. Attorney General Eric H. Holder, Jr. has recently announced that the U.S. Department of Justice ("DOJ") would limit investigation and prosecution of medical marijuana, thereby deferring said actions to the states. (*See* Attachment "1") However, this action does not legalize marijuana related violations of federal or state law.

CALIFORNIA LAW

Under the *California Uniform Controlled Substances Act ("UCSA")*, codified in *California Health and Safety Code Sections 11000 et seq.*, marijuana is also deemed a controlled substance for which possession, possession for sale, sale, cultivation, distribution, transportation, and maintenance of places used for storage or distribution of marijuana are criminal offenses. The *UCSA also* provides for civil sanctions. Pursuant to the *Health and Safety Code, "[e]very building or place used for the purpose of unlawfully selling, serving, storing, keeping, manufacturing, or giving away any controlled substance [including marijuana], ... and every building or place wherein or upon which those acts take place, is a nuisance which shall be enjoined, abated, and prevented, and for which damages may be recovered, whether it is a public or private nuisance."*

CALIFORNIA COMPASSIONATE USE ACT

In 1996, voters enacted *The Compassionate Use Act ("CUA")* by passing Proposition 215. The *CUA* ensured that: 1) *"seriously ill Californians have the right to obtain and use*

marijuana for medical purposes where the 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;" 2) *"patients and their primary caregivers who obtain and use marijuana for medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction;"* and 3) California licensed medical or osteopathic physicians making oral or written recommendations to their patients for medical marijuana cannot be *"punished or denied any right or privilege"* for having recommended cannabis.

However, the *CUA* did not establish an absolute immunity from arrest or prosecution. What it did provide was a limited defense which may be raised by qualified patients and designated primary care givers to protect against criminal conviction for marijuana possession and cultivation. Further, the *CUA* failed to identify what in fact constitutes permissible quantities of medical marijuana qualified patients and designated primary caregivers are permitted to possess or cultivate. Instead of quantified limits, the *CUA* identified permissible amounts to be that which is consistent with the *"personal medical purposes of the patient upon the written or oral recommendation or approval of a [licensed] physician."* Although the *CUA* is also unclear whether it applies to concentrated cannabis or hashish, in 2003, the California Attorney General issued an opinion stating the *CUA* applies to concentrated cannabis or hashish. *(See* Attachment "2") Thereafter, in an attempt to clarify and expand the provisions of the *CUA*, the California Legislature enacted the *California Medical Marijuana Program Act.*

CALIFORNIA MEDICAL MARIJUANA PROGRAM ACT

In 2003, the California State Legislature enacted the *Medical Marijuana Program Act ("MMP").* The *MMP* expanded and clarified the scope of the *CUA* by establishing guidelines 1) for a voluntary medical marijuana identification card issuance and registry program for patients and primary caregivers; 2) articulated quantities of marijuana that patients and primary caregivers can presumptively possess; 3) provided affirmative defenses to the possession, possession for sale, transportation, sale, distribution, cultivation and maintenance of places used for storage or distribution of marijuana by qualified patients and primary caregivers who associate as members of a legally recognized cooperative in order to collectively and cooperatively cultivate medical marijuana for the use of its members; and 4) identified locations and circumstances wherein medical marijuana is prohibited. However, nothing in the law *"authorize[s] any individual or group to cultivate or distribute marijuana* ***for profit.***"

Voluntary Identification Cards

The *MMP* establishes a voluntary identification card program for patients and primary caregivers to protect them against detainment and arrest. Qualified patients and caregivers submit information to the department of public health in the county of their residence. The county health department then issues a photo identification card bearing a unique identification number to the patient and, if applicable, a separate photo identification card to the patient's designated primary caregiver. The county submits the identification numbers to the California

Department of Health Services, which maintains a 24-hour, toll-free telephone number, as well as an on-line database to enable law enforcement to verify the validity of an identification card. ID cards are valid for one year and can be renewed. The *MMP* prohibits state and local law enforcement from refusing to accept ID cards with valid identification numbers, unless there is reasonable cause to believe that the card is fraudulent. With or without ID cards, qualified patients with *bona fide* physician recommendations, and their primary care givers, are still entitled to the protections of the *CUA*, as well as most of the provisions afforded by the *MMP*.

Permissible Quantities of Medical Marijuana

The *MMP* establishes limits on the amount of medical marijuana that can be legally possessed or cultivated. The amounts are as follows: six (6) mature or twelve (12) immature plants, and eight (8) ounces of dried marijuana, unless a physician recommends a larger amount of marijuana to address the patient's medical condition. (*See* Attachment "3") However, this provision of the *MMP* is currently under review by the California Supreme Court.

Affirmative Defenses for Collectives and Cooperatives

This provision of the *MMP* is arguably the cornerstone of the collective/cooperative versus dispensary/cannabis club model debate:

> *"Qualified patients, persons with valid identification cards, and the designated primary caregivers of qualified patients and persons with identification cards, who associate within the State of California in order collectively or cooperatively to cultivate marijuana for medical purposes, shall not solely on the basis of that fact be subject to state criminal sanctions under Section 11357, 11358, 11359, 11360, 11366, 11366.5, or 11570."*

Therefore, qualified patients and their primary caregivers who collectively or cooperatively cultivate marijuana for medical use by members of the collective or cooperative, are protected from criminal prosecution for possessing, cultivating, possessing for sale, sale, or transportation of marijuana, as well as opening/maintaining/renting/leasing any place for the cultivation or distribution of marijuana.

Although the terms collective and cooperative are not defined in the *MMP*, it appears that California law requires any medical marijuana collective or cooperative to file articles of incorporation as a non-profit entity comprised solely of qualified patients and their primary caregivers, or in the alternative, organize as an unincorporated non-profit association, such as a collective, which would require a democratic governing body, a director, articles of association, and bylaws or other writings that govern the purpose or operation of the unincorporated association. Addressing this issue, California Attorney General, Edmund G. Brown, Jr. advised that as a practical matter, collectives may be required to "organize as some sort of business to carry out its activities." (*See* Attachment "4") Supporting this position, in the 2005 case of *People v. Urziceanu*, the California Court of Appeal reasoned that the *MMP*

"contemplate[d] the formation and operation of medicinal marijuana cooperatives that would receive reimbursement for marijuana and the services provided in conjunction with the provision of that marijuana."

That said, the *MMP* also made clear that collectives, cooperatives or other groups shall not *"cultivate or distribute marijuana* ***for profit*** *(emphasis added)."* Collectives and cooperatives comporting with State law are distinguished from store front dispensaries selling marijuana over the counter, which are not protected under the *MMP*. Currently, *bona fide* medical marijuana collectives and cooperatives are limited to cooperative cultivation of medical marijuana which may be distributed solely to its members. The *MMP* does not protect against the sale of marijuana cultivated by the collective or cooperative to members or non members, distribution of marijuana cultivated by the collective or cooperative to non members, or distribution and/or sale of marijuana not cultivated by the collective or cooperative to members or non members. Moreover, on October 8, 2009, Los Angeles County District Attorney, Steve Cooley, announced that all medical marijuana dispensaries selling marijuana in Los Angeles County are illegal and that "they are going to be prosecuted." (*See* Attachment "5")

Medical Marijuana Use - Prohibited Locations

The *MMP* also identified circumstances and locations wherein use of medical marijuana is strictly prohibited, including, but not limited to, *"any place where smoking is prohibited by law;" "[i]n or within 1,000 feet of the grounds of a school, recreation center, or youth center, unless the medical use occurs within a residence;" " [o]n a school bus;" "[w]hile in a motor vehicle that is being operated; or "[w]hile operating a boat."* Further, recent California case law holds that neither the *MMP* nor the *CUA* preempt municipalities from enforcing local regulations and business licensing requirements.

PRIMARY CARE GIVER – *PEOPLE V. MENTCH*

The California Supreme Court, which, simply stated, is the last word on the law in this matter, rendered its unanimous decision in the case of *The People v. Roger William Mentch.* The Court held that under the *CUA*, merely obtaining and/or providing marijuana to a qualified patient does not qualify for *"primary caregiver"* immunity from criminal prosecution. Rather, *"primary caregiver"* is *"the individual, designated by a qualified patient or by a person with an identification card, who has consistently assumed responsibility for the housing, health, or safety of that person."* To avail oneself of this defense, a primary caregiver must be designated by the medical marijuana patient, and that designated primary caregiver must be a person *"who has consistently assumed responsibility for the housing, health, or safety"* of the patient. These responsibilities *"imply a caretaking relationship directed at the core survival needs of a seriously ill patient, not just one single pharmaceutical need."* Once the criteria are met, the Court identified three additional factors, all of which must be met, to assert primary caregiver status.

First, the person asserting the defense must have consistently provided care to a qualified patient. Second, the care giving services must be independent from any assistance provided involving medical marijuana. Finally, the non-medical marijuana services must have been provided to the qualified patient prior to providing medical marijuana assistance. Bottom line, simply providing marijuana does not satisfy the definition of *"primary caregiver." "One who merely supplies a patient with marijuana has no defense under the Act."*

According to the Calif. Supreme Court, the *CUA "simply does not provide ... protection where the provision of marijuana is itself the substance of the relationship."* The Court reasoned that *"a defendant whose care giving consisted principally of supplying marijuana and instructing on its use, and who otherwise only sporadically took some patients to medical appointments, cannot qualify as a primary caregiver under the Act...."* Moreover, the Court held that *"what is not permitted is for an individual to establish an after the fact care giving relationship in an effort to thereby immunize from prosecution previous cultivation or possession for sale."* By extension, the Court concluded that the *CUA* does not protect against prosecution for persons *"cultivating marijuana and providing it to cannabis clubs"* because *"[t]he primary caregiver defense does not extend to supplying marijuana to a cooperative."*

The immunities conveyed by the *CUA* and *MMP* have *"three defining characteristics: (1) they each apply only to a specific group of people; (2) they each apply only to a specific range of conduct; and (3) they each apply only against a specific set of laws."* So, qualified patients cannot be prosecuted for *"transportation or possession for personal use."* Likewise, designated primary caregivers cannot be prosecuted for *"transportation, processing, administration, delivery, or donation"* of medical marijuana to the qualified patient who designated that person as a primary caregiver, as long as that person meets the three primary caregiver requirements set forth above. Of equal importance, while a primary caregiver may provide services to more than one qualified patient, the *MMP* requires the caregiver to reside in the same city or county as the qualified patients they serve. If a primary caregiver resides outside the city or county of the qualified patient, the primary caregiver may not be designated by any other patient.

LOCAL REGULATION

Section 11362.83 of the *MMP* states: *"Nothing in this article shall prevent a city or other local governing body from adopting and enforcing laws consistent with this article."* Since passage of the *CUA*, local governments have enacted ordinances regulating medical marijuana, have established moratoriums prohibiting marijuana dispensaries, and have also banned marijuana dispensaries outright. To date, these regulations include, but are not limited to, commercial/industrial zoning restrictions; square footage cultivation restrictions; cultivation grow area restrictions including health and safety, electrical, building and mechanical requirements; exterior signage restrictions; mandatory security; restricted public view; registration of collective/cooperative members by name, phone number, residential address and status as patient or primary caregiver (*See HIPAA* Attachment 6); property owner approval of the medical marijuana land use; prohibitions of edible marijuana products; verifications that medical marijuana distributed to members was cultivated onsite or at a location previously

registered with the municipality; distance prohibitions from schools, playgrounds, parks, libraries, places of religious worship, licensed day care facilities, licensed youth facilities and other medical marijuana collectives/cooperatives; prohibitions against medicating onsite; maintenance of onsite records including financial compensation received from collective/cooperative members for cultivation related services; onsite inspections without prior notification; limitations on the number of collectives/cooperatives allowed to operate within the municipality or county; restricted operating hours; and mandatory criminal background checks.

In August of this year, the California Court of Appeal, in the case, *City of Claremont v. Darrell Kruse,* held that the *CUA* does not preempt local government police powers from regulating zoning and business licenses. The case involved an individual who, despite being advised his proposed business was not permitted, opened a marijuana dispensary. When he refused to cease operations, the city issued repeated citations, and then filed suit, and was granted an injunction to close the dispensary as a public nuisance. In another recent case, *City of Corona v. Naulls*, the court held that *"where a particular use of land is not expressly enumerated in a city's municipal code as constituting a permissible use, it follows that such use is impermissible."*

More recently, on October 9, 2009, a Fresno County Superior Court judge, citing the decisions in *Naulls* and *Kruse*, ordered nine marijuana dispensaries, allegedly in violation of local municipal codes, to temporarily cease operations pending further litigation. Meanwhile, on September 23, 2009, the Fourth District Court of Appeal heard oral argument in the case, *Qualified Patients Association v. City of Anaheim,* regarding the city's 2007 ordinance banning dispensaries from operating. A decision is expected no later than December 22, 2009.

It is again important to emphasize that no ordinance may purport to regulate over the counter/for profit sales of marijuana, since the Supreme Court in *Mentch* has determined that they may not legally operate.

REGULATION AT A GLANCE

While neither the *CUA* nor the *MMP* require local enforcement, the statutory language encourages municipalities to enact ordinances regulating the possession, cultivation and distribution of medical marijuana. Following are examples of permissible regulation:

- No. of Entities Authorized
- Zoning
- Square Footage
- Membership Size
- Distance Prohibitions
- Signage
- Public View
- Operating Hours
- Property Owner Approval
- Quantity Limits
- Edibles
- Paraphernalia
- Alcohol
- Security
- Onsite Medicating
- Application Fees
- Background Checks
- Team Inspections
- Member Registration
- Patient/Caregiver Verification
- Permit Fees
- Spot Inspections
- Onsite Records
- Daily Distribution Limits
- Inventory Report/Control System
- Criminal/Civil Penalties

Attachments

cc: Robert E. Shannon, City Attorney
Thomas M. Reeves, City Prosecutor
Patrick H. West, City Manager
Suzanne M. Frick, Asst. City Manager
Billy Quach, Interim Police Chief
Heather A. Mahood, Asst. City Attorney
Michael J. Mais, Asst. City Attorney

Attachment 1

U.S. Department of Justice

Office of the Deputy Attorney General

The Deputy Attorney General

Washington, D.C. 20530

October 19, 2009

MEMORANDUM FOR SELECTED UNITED STATES ATTORNEYS

FROM: David W. Ogden
Deputy Attorney General

SUBJECT: Investigations and Prosecutions in States Authorizing the Medical Use of Marijuana

This memorandum provides clarification and guidance to federal prosecutors in States that have enacted laws authorizing the medical use of marijuana. These laws vary in their substantive provisions and in the extent of state regulatory oversight, both among the enacting States and among local jurisdictions within those States. Rather than developing different guidelines for every possible variant of state and local law, this memorandum provides uniform guidance to focus federal investigations and prosecutions in these States on core federal enforcement priorities.

The Department of Justice is committed to the enforcement of the Controlled Substances Act in all States. Congress has determined that marijuana is a dangerous drug, and the illegal distribution and sale of marijuana is a serious crime and provides a significant source of revenue to large-scale criminal enterprises, gangs, and cartels. One timely example underscores the importance of our efforts to prosecute significant marijuana traffickers: marijuana distribution in the United States remains the single largest source of revenue for the Mexican cartels.

The Department is also committed to making efficient and rational use of its limited investigative and prosecutorial resources. In general, United States Attorneys are vested with "plenary authority with regard to federal criminal matters" within their districts. USAM 9-2.001. In exercising this authority, United States Attorneys are "invested by statute and delegation from the Attorney General with the broadest discretion in the exercise of such authority." *Id.* This authority should, of course, be exercised consistent with Department priorities and guidance.

The prosecution of significant traffickers of illegal drugs, including marijuana, and the disruption of illegal drug manufacturing and trafficking networks continues to be a core priority in the Department's efforts against narcotics and dangerous drugs, and the Department's investigative and prosecutorial resources should be directed towards these objectives. As a general matter, pursuit of these priorities should not focus federal resources in your States on

individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana. For example, prosecution of individuals with cancer or other serious illnesses who use marijuana as part of a recommended treatment regimen consistent with applicable state law, or those caregivers in clear and unambiguous compliance with existing state law who provide such individuals with marijuana, is unlikely to be an efficient use of limited federal resources. On the other hand, prosecution of commercial enterprises that unlawfully market and sell marijuana for profit continues to be an enforcement priority of the Department. To be sure, claims of compliance with state or local law may mask operations inconsistent with the terms, conditions, or purposes of those laws, and federal law enforcement should not be deterred by such assertions when otherwise pursuing the Department's core enforcement priorities.

Typically, when any of the following characteristics is present, the conduct will not be in clear and unambiguous compliance with applicable state law and may indicate illegal drug trafficking activity of potential federal interest:

- unlawful possession or unlawful use of firearms;
- violence;
- sales to minors;
- financial and marketing activities inconsistent with the terms, conditions, or purposes of state law, including evidence of money laundering activity and/or financial gains or excessive amounts of cash inconsistent with purported compliance with state or local law;
- amounts of marijuana inconsistent with purported compliance with state or local law;
- illegal possession or sale of other controlled substances; or
- ties to other criminal enterprises.

Of course, no State can authorize violations of federal law, and the list of factors above is not intended to describe exhaustively when a federal prosecution may be warranted. Accordingly, in prosecutions under the Controlled Substances Act, federal prosecutors are not expected to charge, prove, or otherwise establish any state law violations. Indeed, this memorandum does not alter in any way the Department's authority to enforce federal law, including laws prohibiting the manufacture, production, distribution, possession, or use of marijuana on federal property. This guidance regarding resource allocation does not "legalize" marijuana or provide a legal defense to a violation of federal law, nor is it intended to create any privileges, benefits, or rights, substantive or procedural, enforceable by any individual, party or witness in any administrative, civil, or criminal matter. Nor does clear and unambiguous compliance with state law or the absence of one or all of the above factors create a legal defense to a violation of the Controlled Substances Act. Rather, this memorandum is intended solely as a guide to the exercise of investigative and prosecutorial discretion.

Finally, nothing herein precludes investigation or prosecution where there is a reasonable basis to believe that compliance with state law is being invoked as a pretext for the production or distribution of marijuana for purposes not authorized by state law. Nor does this guidance preclude investigation or prosecution, even when there is clear and unambiguous compliance with existing state law, in particular circumstances where investigation or prosecution otherwise serves important federal interests.

Your offices should continue to review marijuana cases for prosecution on a case-by-case basis, consistent with the guidance on resource allocation and federal priorities set forth herein, the consideration of requests for federal assistance from state and local law enforcement authorities, and the Principles of Federal Prosecution.

cc: All United States Attorneys

Lanny A. Breuer
Assistant Attorney General
Criminal Division

B. Todd Jones
United States Attorney
District of Minnesota
Chair, Attorney General's Advisory Committee

Michele M. Leonhart
Acting Administrator
Drug Enforcement Administration

H. Marshall Jarrett
Director
Executive Office for United States Attorneys

Kevin L. Perkins
Assistant Director
Criminal Investigative Division
Federal Bureau of Investigation

MEDICAL BOARD OF CALIFORNIA

Attempting to provide further guidance on this matter, in 2004 the Medical Board of California developed a set of standards for physicians to use when recommending medical marijuana for their patients. These standards require physicians to have or obtain patient histories and to conduct a "good faith" patient examination prior to recommending medical marijuana, to develop treatment plans, to periodically review the "treatment's efficacy," and to maintain "proper record keeping that supports the decision to recommend the use of medical marijuana." According to the Medical Board, "if physicians use the same standard of care in recommending medical marijuana to patients as they would recommending or approving any other medication, they have nothing to fear from the Medical Board." Otherwise, if a "physician's conduct has not met the applicable standard of care, the Medical Board may seek to impose disciplinary action against the physician."

Attachment 2

TO BE PUBLISHED IN THE OFFICIAL REPORTS

OFFICE OF THE ATTORNEY GENERAL
State of California

BILL LOCKYER
Attorney General

OPINION	:	No. 03-411
of	:	October 21, 2003
BILL LOCKYER Attorney General	:	
GREGORY L. GONOT Deputy Attorney General	:	

THE HONORABLE ANTHONY J. CRAVER, SHERIFF-CORONER, COUNTY OF MENDOCINO, has requested an opinion on the following question:

Is concentrated cannabis or hashish included within the meaning of "marijuana" as that term is used in the Compassionate Use Act of 1996?

CONCLUSION

Concentrated cannabis or hashish is included within the meaning of "marijuana" as that term is used in the Compassionate Use Act of 1996.

ANALYSIS

On November 5, 1996, the voters of California adopted Proposition 215, an initiative statute authorizing the medical use of marijuana. (*People v. Mower* (2002) 28 Cal.4th 457, 463; *People v. Bianco* (2001) 93 Cal.App.4th 748, 751; *People v. Rigo* (1999) 69 Cal.App.4th 409, 412.) The measure added section 11362.5 to the Health and Safety Code[1] and entitled the statute the "Compassionate Use Act of 1996." (§ 11362.5, subd. (a).) Section 11362.5 "creates an exception to California laws prohibiting the possession and cultivation of marijuana." (*United States v. Oakland Cannabis Buyers' Cooperative* (2001) 532 U.S. 483, 486.) "These prohibitions no longer apply to a patient or his primary caregiver who possesses or cultivates marijuana for the patient's medical purposes upon the recommendation or approval of a physician." (*Ibid.*; see *People v. Mower, supra,* 28 Cal.4th at pp. 471-474; *People v. Galambos* (2002) 104 Cal.App.4th 1147, 1160-1162; *People v. Young* (2001) 92 Cal.App.4th 229, 235.)[2] We are asked to determine whether section 11362.5's reference to "marijuana" includes concentrated cannabis or hashish. We conclude that it does.

Section 11362.5 provides:

> "(a) This section shall be known and may be cited as the Compassionate Use Act of 1996.
>
> "(b)(1) The people of the State of California hereby find and declare that the purposes of the Compassionate Use Act of 1996 are as follows:
>
> "(A) To ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief.

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[1] All references hereafter to the Health and Safety Code are by section number only.

[2] The possession and distribution of marijuana remain unlawful under the federal Controlled Substances Act (21 U.S.C. § 801 *et seq.*). (*People ex rel. Lungren v. Peron* (1997) 59 Cal.App.4th 1383, 1387, fn. 2.) The federal law contains no medical necessity exception. (*United States v. Oakland Cannabis Buyers' Cooperative*, *supra*, 532 U.S. at p. 486; *People v. Mower, supra,* 28 Cal.4th at p. 465, fn. 2; *People v. Bianco, supra,* 93 Cal.App.4th at p. 753.)

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

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

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

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

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

"(e) For the purposes of this section, 'primary caregiver' means the individual designated by the person exempted under this section who has consistently assumed responsibility for the housing, health, or safety of that person."

Section 11362.5 uses only the term "marijuana" and contains no direct reference to "concentrated cannabis" or "hashish."

Although section 11362.5 does not define the term "marijuana," the statute is part of the California Uniform Controlled Substances Act (§§ 11000-11651; "Act"), which contains the following definition of marijuana in section 11018:

" 'Marijuana' means all parts of the plant Cannabis sativa L., whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant, its seeds or resin. It does not include the mature stalks of the plant, fiber produced from the stalks, oil or cake made from the seeds of the plant, any other compound, manufacture, salt, derivative, mixture,

> or preparation of the mature stalks (except the resin extracted therefrom), fiber, oil, or cake, or the sterilized seed of the plant which is incapable of germination."

Federal law has a similar definition of marijuana. (21 U.S.C. § 802(16); see *People v. Hamilton* (1980) 105 Cal.App.3d 113, 116-117; *People v. Van Alstyne* (1975) 46 Cal.App.3d 900, 916; *United States v. Kelly* (9th Cir. 1976) 527 F.2d 961, 963-964; *U.S. v. Schultz* (S.D. Ohio 1992) 810 F.Supp. 230, 233; *cf. Haynes v. State* (1975) 54 Ala.App. 714, 717-718 [312 So.2d 406].) "Unless the context otherwise requires" (§ 11001), the definition of marijuana found in section 11018 controls our interpretation of section 11362.5.

"Concentrated cannabis" is defined for purposes of the Act, "[u]nless the context otherwise requires" (§ 11001), in section 11006.5: " 'Concentrated cannabis' means the separated resin, whether crude or purified, obtained from marijuana." Concentrated cannabis "includes hashish" (*Hooks v. State Personnel Board* (1980) 111 Cal.App.3d 572, 579), which is commonly defined as "[a] form of cannabis that consists largely of resin from the flowering tops and sprouts of cultivated female plants" (Stedman's Medical Dict. (5th ed. 1982), p. 621).[3]

Tetrahydrocannabinol ("THC") is marijuana's most active pharmacological ingredient. (*People v. Rigo, supra,* 69 Cal.App.4th at p. 413; *People v. Hamilton, supra,* 105 Cal.App.3d at p. 116; *People v. Van Alstyne, supra,* 46 Cal.App.3d at pp. 910, 917.) We are informed that the THC level of ordinary marijuana varies widely from 5 to 60 percent; for concentrated cannabis, as defined in section 11006.5, it may range up to 70 percent. The quality, purity, and strength of ordinary marijuana and concentrated cannabis, including hashish, depend upon a number of different factors. (See *People v. Hamilton, supra,* 105 Cal.App.3d at pp. 115-116; *People v. Van Alstyne, supra,* 46 Cal.App.3d at pp. 909-911; *U.S. v. Schultz, supra,* 810 F.Supp. at pp. 231-234; *Haynes v. State, supra,* 312 So.2d at pp. 717-719.)

Returning to the language of section 11362.5, we find that subdivision (d) provides the operative terms of the statute. If a patient or caregiver "possesses or cultivates marijuana for the personal medical purposes of the patient upon the written or oral recommendation or approval of a physician," two statutes do not apply to the patient or caregiver: "Section 11357, relating to the possession of marijuana, and Section 11358, relating to the cultivation of marijuana." (See *People v. Fisher* (2002) 96 Cal.App.4th 1147, 1151-1152; *People v. Bianco, supra,* 93 Cal.App.4th at p. 751; *People v. Rigo, supra,* 69

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[3] Accordingly, we will treat concentrated cannabis and hashish as being equivalent for purposes of our analysis.

Cal.App.4th at p. 412; *People ex rel. Lungren v. Peron, supra,* 59 Cal.App.4th at pp. 1387-1394; *People v. Trippet* (1997) 56 Cal.App.4th 1532, 1550.) Section 11357 states:

> "(a) Except as authorized by law, every person who possesses any concentrated cannabis shall be punished by imprisonment in the county jail for a period of not more than one year or by a fine of not more than five hundred dollars ($500), or by both such fine and imprisonment, or shall be punished by imprisonment in the state prison.
>
> "(b) Except as authorized by law, every person who possesses not more than 28.5 grams of marijuana other than concentrated cannabis, is guilty of a misdemeanor and shall be punished by a fine of not more than one hundred dollars ($100)). . . .
>
> "(c) Except as authorized by law, every person who possesses more than 28.5 grams of marijuana, other than concentrated cannabis, shall be punished by imprisonment in the county jail for a period of not more than six months or by a fine of not more than five hundred dollars ($500), or by both such fine and imprisonment.
>
> "(d) Except as authorized by law, every person 18 years of age or over who possesses not more than 28.5 grams of marijuana, other than concentrated cannabis, upon the grounds of, or within, any school providing instruction in kindergarten or any of grades 1 through 12 during hours the school is open for classes or school-related programs is guilty of a misdemeanor and shall be punished by a fine of not more than five hundred dollars ($500), or by imprisonment in the county jail for a period of not more than 10 days, or both.
>
> "(e) Except as authorized by law, every person under the age of 18 who possesses not more than 28.5 grams of marijuana, other than concentrated cannabis, upon the grounds of, or within, any school providing instruction in kindergarten or any of grades 1 through 12 during hours the school is open for classes or school-related programs is guilty of a misdemeanor and shall be subject to the following dispositions:
>
> "(1) A fine of not more than two hundred fifty dollars ($250), upon a finding that a first offense has been committed.

"(2) A fine of not more than five hundred dollars ($500), or commitment to a juvenile hall, ranch, camp, forestry camp, or secure juvenile home for a period of not more than 10 days, or both, upon a finding that a second or subsequent offense has been committed."

Section 11358 provides:

"Every person who plants, cultivates, harvests, dries, or processes any marijuana or any part thereof, except as otherwise provided by law, shall be punished by imprisonment in the state prison."

We believe that concentrated cannabis comes within the provisions of section 11362.5 for several reasons. First, the statutory definition of marijuana for purposes of the Act as set forth in section 11018 plainly includes concentrated cannabis. Concentrated cannabis is "the separated resin . . . obtained from marijuana" (§ 11006.5) and thus constitutes "the resin extracted from any part of the plant" (§ 11018). In the context of section 11362.5, we find neither intent nor need to construe the term "marijuana" any differently from the definition contained in section 11018. "Both the Legislature and the electorate by the initiative process are deemed to be aware of laws in effect at the time they enact new laws and are conclusively presumed to have enacted the new laws in light of existing laws having direct bearing upon them. [Citations.]" (*Williams v. County of San Joaquin* (1990) 225 Cal.App.3d 1326, 1332.)

Second, section 11357 uses the phrase "other than concentrated cannabis" when concentrated cannabis is intended to be distinguished from ordinary marijuana. The framers of Proposition 215 did not employ similar exclusionary language for concentrated cannabis when they proposed the Compassionate Use Act of 1996. "Where a statute on a particular subject omits a particular provision, the inclusion of such a provision in another statute concerning a related matter indicates an intent that the provision is not applicable to the statute from which it was omitted." (*Marsh v. Edwards Theatres Circuit, Inc.* (1976) 64 Cal.App.3d 881, 891; see also *Traverso v. People ex rel. Dept. of Transportation* (1993) 6 Cal.4th 1152, 1166; *Holmes v. Jones* (2000) 83 Cal.App.4th 882, 890; *People ex rel. Lungren v. Peron, supra,* 59 Cal.App.4th at p. 1392; *People v. Trippet, supra,* 56 Cal.App.4th at p. 1550.)[4]

Of course, if concentrated cannabis were not "marijuana" in the first instance, there would be no need in section 11357 to employ the phrase "other than concentrated

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[4] "In interpreting a voter initiative . . . we apply the same principles that govern statutory construction. [Citation.]" (*People v. Rizo* (2000) 22 Cal.4th 681, 685.)

cannabis." "Where reasonably possible, we avoid statutory constructions that render particular provisions superfluous or unnecessary. [Citations.]" (*Dix v. Superior Court* (1991) 53 Cal.3d 442, 459.) The contrary construction with respect to section 11357 would mean that a person could not *possess* concentrated cannabis for medical purposes under section 11357 but could *process* it for such purposes pursuant to section 11358. "[W]e consider portions of a statute in the context of the entire statute and the statutory scheme of which it is a part" (*Curle v. Superior Court* (2001) 24 Cal.4th 1057, 1063) " ' "in order to achieve harmony among the parts" ' " (*People v. Hull* (1991) 1 Cal.4th 266, 272) "and avoid an interpretation that would lead to absurd consequences" (*People v. Jenkins* (1995) 10 Cal.4th 234, 246; accord, *Wilcox v. Birtwhistle* (1999) 21 Cal.4th 973, 978).

Most significantly, as previously mentioned, the provisions of section 11357 are expressly rendered inapplicable under the conditions specified in section 11362.5, and the first subdivision of section 11357 sets forth the penalty for possession of "concentrated cannabis." Hence, it is manifest that one may possess concentrated cannabis without violating the terms of section 11357 as long as the requirements of section 11362.5 are met.[5]

Finally, we have carefully reviewed the ballot materials accompanying Proposition 215 and have found nothing therein to indicate that the voters intended for concentrated cannabis to be treated differently from ordinary marijuana when used for medical purposes. (See *People v. Trippet, supra,* 56 Cal.App.4th at pp. 1545-1546.) Proposition 215 was approved by the voters without specificity as to the strength, quality, or quantity of marijuana to be used for medical purposes as long as the use is reasonably related to the patient's current medical needs and was recommended or approved by a physician. (See *People v. Mower, supra,* 28 Cal.4th at pp. 471-474; *People v. Galambos, supra,* 104 Cal.App.4th at pp. 1161-1162, 1165-1168; *People v. Rigo, supra,* 69 Cal.App.4th at pp. 413, 415; *People ex rel. Lungren v. Peron,* 59 Cal.App.4th at p. 1394; *People v. Trippet, supra,* 56 Cal.App.4th at pp. 1545-1549.) If anything, the fact that ordinary marijuana and concentrated cannabis, including hashish, may have similar levels of THC supports our interpretation that the terms of section 11362.5 apply to concentrated cannabis.

We conclude that concentrated cannabis or hashish is included within the meaning of "marijuana" as that term is used in the Compassionate Use Act of 1996.

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[5] We view the phrase "relating to the possession of marijuana" contained in subdivision (d) of section 11362.5 as an abbreviated description of section 11357's provisions rather than as a limitation upon such provisions in a manner intended to exclude the possession of concentrated cannabis. (See, e.g., *People ex rel. Lungren v. Peron, supra,* 59 Cal.App.4th at pp. 1386, 1394, 1400.)

Attachment 3

MEDICAL BOARD OF CALIFORNIA

May 13, 2004

Medical Board Reaffirms its Commitment to Physicians Who Recommend Medical Marijuana

Board adopts statement clarifying implementation of California's Compassionate Use Act to insure California's physicians and consumers receive appropriate guidance under the law

SACRAMENTO—The Medical Board of California marked a milestone for California consumers and physicians by adopting a statement clarifying that the recommendation of medical marijuana by physicians in their medical practice will not have any effect against their physician's license if they follow good medical practice.

"The intent of the statement is to clearly and succinctly reassure physicians that if they use the same proper care in recommending medical marijuana to their patients as they would any other medication or treatment, their activity will be viewed by the Medical Board just as any other appropriate medical intervention," said Hazem Chehabi, M.D., immediate past president of the board. "This is consistent with the board's mission to protect and advance the interests of California patients."

In November 1996, the voters of California passed Proposition 215, the "Compassionate Use Act of 1996." The purposes of the act were "to ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where the 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....and to ensure that patients and their primary caregivers who obtain and use marijuana for medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction."

In January 1997 the Medical Board published standards for physicians when recommending medical marijuana. According to the board's new statement, consultation should include:

- History and good faith examination of the patient
- Development of a treatment plan with objectives
- Provision of informed consent including discussion of side effects
- Periodic review of the treatment's efficacy
- Consultation, as necessary
- Proper record keeping that supports the decision to recommend the use of medical marijuana

"The clarification of the guidelines regarding the recommendation for the use of medical marijuana assists both physicians and patients," said Dr. Chehabi. "Establishing clearly defined guidelines will allow the medical community to concentrate on the important medical needs of the patient and end the confusion about when recommendation of medical marijuana is appropriate."

According to testimony received by the board at its hearing on this issue last week, the author of the Act, Dennis Peron, supported the board's efforts to implement the law and assist California's physicians and their patients who receive a recommendation for the use of medical marijuana. "The Medical Board is in a unique position to guide physicians and patients on the proper standards for medical intervention for those who can benefit from treatment using medical marijuana," stated Mr. Peron. "I applaud the board's efforts and hope their action puts an end to the controversy that has surrounded this issue since California citizens voted to support the Compassionate Use Act."

For a copy of the Medical Board's statement, please contact the board's information officer, Candis Cohen, at (916) 263-2394.

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The mission of the Medical Board is to protect healthcare consumers through the proper licensing and regulation of physicians and surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act.

If you have a question or complaint about the healthcare you are receiving, the Board encourages you to visit its Web site at www.caldocinfo.ca.gov or for questions call the Consumer Information Line at (916) 263-2382, or with complaints call (800) 633-2322.

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Document #1315
The Compassionate Use Act of 1996: The Medical Marijuana Initiative

CMA Legal Counsel
January 2009

"The Compassionate Use Act of 1996" (CUA), was passed by a vote of the people on November 5, 1996, and became effective on November 6, 1996. (Health & Safety Code §11362.5.) In addition, on October 12, 2003, the governor signed S.B. 420 into law, which established the Medical Marijuana Program (MMP). The MMP, codified at Health & Safety Code §§11362.7-11362.83, seeks to implement the CUA by, among other things, clarifying the scope of its application, facilitating the prompt identification of qualified patients/caregivers, and promoting uniform and consistent application of the Act among the counties across the state. This document contains a discussion of the questions most likely to be asked about those laws.

BASIC PROVISIONS OF THE COMPASSIONATE USE ACT (CUA)

1. What did California law formerly prohibit?

Under former state law, a patient was prohibited from obtaining, possessing, or cultivating, cannabis for any purpose, including medical treatment purposes. *The same continues to be true under federal law.* Under federal law, cannabis is currently classified as a Schedule I drug, which means that it has no generally recognized medical use. On June 6, 2005, the United States Supreme Court ruled that the federal Controlled Substances Act is valid even as applied to the intrastate, noncommercial cultivation, possession and use of cannabis for personal medical use on the advice of a physician. (*Gonzales v. Raich* (2005) 162 L.Ed.2d 1, 125 S.Ct. 2195.) The Court's ruling maintains the existing federal prohibition against possession, cultivation, and distribution of cannabis. The ruling has no direct impact on California's current law (CUA and MMP), nor does it narrow or otherwise negatively effect the Ninth Circuit's ruling in *Conant v. Walters*, which stated that physicians have a First Amendment right to discuss treatment options with their patients, including treatment with medicinal cannabis (*see* discussion below).

2. What does the CUA allow patients to do?

The CUA provides that the state criminal law prohibitions against cultivation and possession of cannabis do not apply to a seriously ill patient (and his or her "primary caregiver") who possesses or cultivates cannabis for (the patient's) personal medical treatment, with the oral or written recommendation or approval of a physician. The California Attorney General has opined that the term "marijuana" in the CUA applies to concentrated cannabis or hashish. (Ops.Cal.Atty.Gen. No. 03-411 (2003).) In addition, the MMP clarifies that a patient or designated primary caregiver may **transport or process** cannabis for the patient's personal medical use. A primary caregiver may also administer medicinal cannabis to a patient. (Health & Safety Code §11362.765.)

The MMP establishes a ***voluntary, fee-based*** identification card program which enables patients and primary caregivers to offer affirmative proof of their status if they are challenged by state or local law enforcement personnel. The Legislative Counsel of California has opined that **requiring** qualified patients to participate in the ID card program would constitute an unconstitutional amendment of the CUA. (Legislative Counsel of California, "Medical Marijuana: Identification Program (S.B. 420)" #16771 (Aug. 20, 2003).) A patient must submit certain information to the county health department. If the information is complete and accurate, the county will issue a photo identification card to the patient and, if applicable, a

separate photo ID card to the patient's designated primary caregiver. The county will submit the cardholder's unique user ID number, and the card's expiration date, to the State Department of Health Services. The Department in turn will maintain 24-hour, toll-free telephone number to enable state and local law enforcement officers to verify the validity of the ID card. The card is valid for one year and can be renewed. (Health & Safety Code §§11362.71-76.)

3. Which medical conditions are covered by the CUA and the MMP?

The CUA applies to patients with cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine. In addition, it applies to "any other illness for which marijuana provides relief." The MMP clarifies the concept of a "serious medical condition," which can qualify a patient to obtain an ID card and use medicinal cannabis upon a physician's recommendation: AIDS, anorexia, arthritis, cachexia, cancer, chronic pain, glaucoma, migraine, persistent muscle spasms (including those associated with MS), seizures (including those associated with epilepsy), and severe nausea. Furthermore, the concept includes *any other chronic or persistent medical symptom that either 1) substantially limits the ability of the person to conduct one or more major life activities as defined in the ADA; or 2) if not alleviated, may cause serious harm to the patient's safety or physical or mental health.* (Health & Safety Code §11362.7(h).) Further information can be obtained from the State of California at the following website: www.dhs.ca.gov/hisp/ochs/mmp/Frequently_Asked_Questions/default.htm.

4. Must a patient have tried all other conventional treatments before I can consider recommending medicinal cannabis?

No. Nothing in the CUA or the MMP requires a physician to determine that a patient has failed (or would fail) on all other conventional medicines before the physician may recommend or approve the use of medicinal cannabis. For the perspective of the Medical Board on this issue, *see* Question No. 11.

5. Are minors covered by the CUA?

The CUA does not exclude minors. Moreover, the MMP clarifies that minors are covered by the CUA and can obtain identity cards with the consent of their parents or guardians. (Health & Safety Code §11362.715.) However, a physician should proceed cautiously. The physician should ensure that 1) the parents or guardians are fully informed about the risks and benefits of medicinal cannabis and give their consent to such treatment; 2) the minor has a serious medical condition; and 3) all conventional treatments have been tried unsuccessfully, or considered and rejected (e.g., because of probable unacceptable side effects), before recommending the use of medicinal cannabis. The physician may wish to warn the parents or guardian that child protective agencies in the past have attempted to take action against parents/guardians who have provided medicinal cannabis to their child. Careful documentation in the medical record is particularly essential. For the perspective of the Medical Board on this issue, *see* Question No.11 .

6. How can a patient establish that he or she qualifies for a card under the MMP?

A patient must provide "written documentation" by the attending physician in the patient's medical records stating that the person has been diagnosed with a serious medical condition and that the medical use of cannabis is appropriate. In addition, the patient must provide his/her name; proof of county residency; the name, office address, office telephone number, and California medical license number of his/her attending physician; the name and duties of his/her primary caregiver; and a government-issued photo ID card (of the patient and the primary caregiver, if any). (Health & Safety Code §11362.715.) "Written documentation" means accurate reproductions of the relevant portions of the patient's medical record. (Health & Safety Code §11362.7(i).) *See* Question No.34 , below. In Washington, the state supreme court recently ruled that a recommendation from a California physician was not sufficient to qualify a patient residing in

Washington under that state's medicinal cannabis law. (*State of Washington v. Tracy* (Wash. 2006) 158 Wash.2d 683, 147 P.3d 559.

7. What happens if a patient does not wish to participate in the ID card system but has the bona fide recommendation of a physician to use medicinal cannabis?

If a qualified patient chooses **not** to obtain a card, he or she will still be entitled to the protections of the CUA. Furthermore, many of the provisions of the MMP apply equally to patients and designated caregivers, whether or not they possess ID cards.

8. Does the CUA protect a patient from being arrested if he or she has a physician's recommendation?

No. The CUA does not absolutely immunize a patient from the possibility of arrest. A patient might still be arrested if, for example, law enforcement officers believe that the patient is not cultivating cannabis for his or her personal medical use. Instead it means that a patient or caregiver has a *limited* immunity from prosecution under state law. In People v. Mower (2002) 28 Cal.4th 457, 122 Cal.Rptr.2d 326, the California Supreme Court ruled that pursuant to the CUA the patient may raise his or her status as a patient or caregiver 1) as a basis for moving to set aside an indictment or information before trial on the ground of the absence of reasonable or probable cause to believe that his or she is guilty; or 2) as an affirmative defense at trial. The Court further ruled that the patient/defendant has the burden of proof to establish the facts of his or her status. However, he or she need only raise a reasonable doubt as to his or her guilt, rather than having to prove his or her status by a preponderance of the evidence. (The latter evidentiary standard would require a greater degree of proof.)

The MMP is intended to protect patients with ID cards against improper arrest. The law prohibits state or local law enforcement officers from refusing to accept an ID card unless the officer has **reasonable cause to believe** that the information in the card is false or fraudulent or the card is being used fraudulently. (Health & Safety Code §1362.78.) Hence, the MMP should help to ensure that a patient or primary caregiver is not arrested in the absence of good evidence that he/she is violating the provisions of The CUA and/or the MMP.

The California Court of Appeals for the Fourth Appellate District recently ruled that, if a patient is arrested and is thereafter found to be in lawful possession of marijuana under the CUA and/or the MMP, the police must return the marijuana to him or her. The court opined that law enforcement officers would not be subject to federal sanctions, since they would be acting pursuant to their official duties in complying with the trial court's order to return the marijuana to the patient, and were therefore entitled to immunity under 21 U.S.C. §885(d). City of Garden Grove v. Superior Court (Kha) (2007) 157 Cal.App.4th 355, 68 Cal.Rptr.3d 656. *See also, State v. Kama* (2002)178 Ore.App. 561; 39 P.3d 866. However, a different outcome may result if a person possesses more marijuana than is permitted under state law, Chavez v. Superior Court (2004) 123 Cal.App.4th 104; 20 Cal.Rptr.3d 21.

9. When should a patient seek a physician's advice about medicinal cannabis?

As with all medications, it would be best if a patient were to seek the physician's advice and approval before beginning to use cannabis. There may be "exigent circumstances" in which a physician's approval/ recommendation may be contemporaneous with, or subsequent to, a patient's possession (although prior to actual usage). (People v. Trippet (1997) 56 Cal.App.4th 1532, 1548 n. 13, 66 Cal.Rptr.2d 559.) However, an appellate court ruled that the Act did not apply to a patient who was self-medicating with cannabis, who had not consulted a physician for several years before his arrest, and who did not seek a physician's approval for his cannabis use until three months after his arrest. (People v. Rigo (1999) 69 Cal.App.4th

409, 81 Cal.Rptr.2d 624.) In refusing to apply the Act's protections, the court stressed that "Medical marijuana should be prescribed [by a physician] for specific relief for clearly defined medical problems."

MEDICAL BOARD ISSUES

10. What does the CUA allow physicians to do?

The language of the CUA provides that physicians cannot be "punished or denied any right or privilege" for having recommended cannabis to a patient for medical purposes. Therefore, it should be impermissible for a state governmental entity to punish a physician either criminally or civilly under *state law, or to subject the physician to loss of license or other administrative sanction*, **solely** on the basis of having made an oral or written recommendation for the medical use of cannabis (at least for a serious medical condition).

Unlike patients, whose possession and/or cultivation of cannabis would be illegal but for the CUA, a physician's discussion and, if appropriate, recommendation, of the use of medicinal cannabis, **in accordance with standard physician office practices**, does not, in the absence of other factors, violate either state law or the professional standard of practice. Therefore, in the unlikely event that a physician were criminally prosecuted under state law, solely on the basis of having recommended the use of medicinal cannabis, it is unclear whether the physician would enjoy the limited immunity established in Mower, or a broader immunity against arrest. However, since immunity from arrest is exceptional, the limited Mower immunity would probably apply. In a subsequent administrative proceeding initiated by the Board, the administrative law judge did, indeed, apply a limited immunity.

11. Does this mean that the Medical Board cannot take any action against me because I have recommended cannabis to a patient?

No. The Medical Board should not attempt to punish a physician **solely** on the basis of the fact that the physician approved the use of medicinal cannabis. However, if the Medical Board believes that the physician's conduct has not met the applicable standard of care, the Medical Board may seek to impose disciplinary action against the physician. When the CUA was first enacted, the Medical Board issued a statement stating that a physician who recommends the use of medicinal cannabis should have arrived at that decision in accordance with accepted standards of medical responsibility. On May 7, 2004, the Board adopted an informational statement to give further guidance to physicians who may recommend the use of medicinal cannabis to their patients. The statement stressed that physicians would not be subject to investigation or disciplinary action if they arrive at the decision to recommend medicinal cannabis in accordance with accepted standards of medical responsibility that "any reasonable and prudent physician would follow when recommending or approving any other medication or prescription drug treatment." The statement described these standards as follows:

- History and good faith examination of the patient;
- Development of a treatment plan with objectives;
- Provision of informed consent, including discussion of side effects;
- Periodic review of the treatment's efficacy;
- Consultation, as necessary; and
- Proper record keeping that supports the decision to recommend the use of cannabis.

The statement also provides information on a number of specific issues. The statement:

- Acknowledges that a patient need not have failed on all other medications in order for a physician to recommend or approve the use of medicinal cannabis.

- Cautions physicians to determine that the use of medicinal cannabis will not mask an acute or treatable progressive condition that could lead to a worsening of that condition.

- Clarifies that physicians may recommend or approve medicinal cannabis for conditions other than those specifically set forth in the CUA and, in doing so, the physician may rely upon 1) the results of clinical trials, if available; 2) medical literature and reports; 3) the experience of that physician or other physicians; or 4) credible patient reports. The risk-benefit ratio must be as good, or better, than other medications that could be used for that patient.

- Notes that a physician who is not the patient's primary treating physician may still recommend medicinal cannabis for the patient's symptoms. However, the physician must either consult with the patient's treating physician or obtain the patient's prior medical records that confirm the patient's diagnosis and treatment history.

- Warns that recommendations must be limited to the time necessary to monitor the patient. Periodic reviews must occur at least annually or more frequently as warranted.

- Recognizes that a physician may recommend the use of medicinal cannabis for a minor, but the parents or guardians must be fully informed of the risks and benefits and consent to that use.

The full statement is available at www.medbd.ca.gov/Medical_Marijuana.html. The Board amended its original statement to delete the conclusion that the accepted practice standards for recommending or approving medicinal cannabis should be those applicable to "prescription drug treatment." The current statement provides that: "These accepted standards are the same as any reasonable and prudent physician would follow when recommending or approving any other medication." CMA believes that the document provides helpful guidance to physicians and commends the Board for its efforts in developing the statement.

Accordingly, if the Medical Board believes that a physician has failed adequately to follow proper practice standards when recommending the use of medicinal cannabis, the Medical Board may initiate an investigation against the physician.

However, the First Amendment constrains the Board's discretion to investigate a physician. By extension of a decision from the US Court of Appeals for the Ninth Circuit, *Conant v. Walters,* the Board should not be able to initiate such an investigation solely on the basis of a recommendation given within a *bona fide* physician-patient relationship unless the Board in good faith believes that it has substantial evidence of criminal conduct or conduct that fails to meet appropriate standards of care. *See* discussion below. Although this ruling applies specifically to the federal government, the constitutional principles articulated therein would apply equally to actions taken, or sanctions imposed, by state or local governmental entities. In its 2004 statement, the Board stressed that the mere receipt of a complaint that a physician is recommending medicinal cannabis will **not** trigger an investigation "absent additional information that the physician is not adhering to accepted medical standards."

12. What if I give my patient a written recommendation to use medicinal cannabis, and someone complains to the Medical Board? Does the mere fact that I made such a written

recommendation allow the Board to act upon the complaint and seek to obtain my patient's medical records?

No. In Bearman v. Superior Court (2004) 117 Cal.App.4th 463, 11 Cal.Rptr.3d 644, the California Court of Appeal for the Second Appellate District ruled that the mere fact that a physician has issued a written recommendation for a significant medical condition does not empower the Board to obtain the patient's medical records, as part of the Board's effort to investigate the physician's practices. Under the California constitutional right of privacy, the Board cannot delve into a patient's private medical information merely because it wants assurance that the law has not been violated or a physician is not negligent. The Board must provide sufficient "competent evidence" to enable a court to determine that "good cause" exists to order the records disclosed. The mere fact that a physician has written a recommendation constitutes neither.

The court of appeal further stressed that the patient does not waive his or her constitutional right of privacy merely by disclosing that recommendation to a law enforcement officer for the purpose of establishing the patient's right to possess and/or cultivate cannabis pursuant to the Compassionate Use Act. Such waiver does not occur, even if the physician states, in the written document, the medical condition for which he or she is recommending medicinal cannabis. Under Bearman, then, the Board effectively cannot initiate an investigation based only on a complaint or other information which merely states that the physician has made a recommendation for the use of medicinal cannabis—**since the Board cannot obtain patient medical information to support that investigation**. The Board's 2004 statement appears to confirm this principle.

HEALTH INSURANCE/EMPLOYMENT ISSUES

13. Must a health insurer reimburse a patient for the physician's services in examining and evaluating the patient and making a recommendation and/or for the cost of obtaining medicinal cannabis?

The MMP does not require a government, private or any other health insurance provider or health care service plan to be liable for any claim for reimbursement for the use of medicinal cannabis. (Health & Safety Code §11362.785(d).) The CUA is silent on the issue. It is probable that the courts would interpret the CUA in a manner consistent with the MMP. Thus, the issue of reimbursement will depend on the scope of the patient's health plan. In August 2006, the Director of the California Department of Health Services determined that the cost of medicinal cannabis, which a qualified patient regularly purchased from her primary caregiver, constituted a *bona fide* medical expense that should be deducted from her income for the purpose of determining her share of cost under the Medi-Cal Personal Care Services Program. (*In the Matter of Sylvia Price* (Sept. 25, 2006) CDHS 2003106214.)

14. Must I allow my employees to use medicinal cannabis in my workplace?

The MMP does not require any accommodation of the use of medicinal cannabis on the property or premises of any place of employment or during the hours of employment. (Health & Safety Code §11362.785(a).) Again, the CUA is silent on the issue. In Ross v. Ragingwire Telecommunications (2008) 442 Cal.4th 920, 70 Cal.Rptr.3d 382, the California Supreme Court concluded that an employer did not violate either the Fair Employment and Housing Act (FEHA) or public policy (as expressed in the CUA) by discharging a recent employee who failed a pre-employment drug test because of his use (outside of the workplace/working hours) of medicinal cannabis. The Court determined that nothing in the text or history of the CUA suggested that the voters intended for the initiative to address the respective right and obligations of employers and employees. On October 1, 2008, Governor Schwarzenegger vetoed AB 2279, a bill that would have prohibited employment discrimination against those who use cannabis outside

the workplace in compliance with state law. For more information on drug testing, *see* CMA ON-CALL document #0525, "Physician Obligations Regarding Drug or Alcohol Testing."

FEDERAL CONTROLLED SUBSTANCE ACT

15. I'm sure that my practices will meet the standard of care, but I don't want to run afoul of federal law. What should I do or avoid in order to keep from violating the federal Controlled Substances Act?

Physicians who intentionally make certain oral or written statements, or take other action, for the purpose of assisting patients to obtain cannabis in violation of federal law, may be subject to serious liability under federal law. The Ninth Circuit has affirmed that the First Amendment protects physicians' right to recommend or advise that their patients use medicinal cannabis so long as the physicians do not aid and abet, or conspire with, their patients to violate the federal drug laws. (*Conant v. Walters* (9th Cir. 2002) 309 F.3d 629.) It is extremely important for physicians to understand the difference between permissible and impermissible recommendations. This document explains that difference below.

PHYSICIANS' ABILITY TO RECOMMEND THE USE OF CANNABIS

16. I understand that physicians can be punished for recommending cannabis to their patients. How can this be true?

Federal law establishes a clear prohibition against knowingly or intentionally distributing, dispensing, or possessing cannabis. *See* 21 U.S.C. §§841-44. A person who aids and abets another in violating federal law, 18 U.S.C. §2, or engages in a conspiracy to purchase, cultivate, or possess marijuana, 21 U.S.C. §846, can be punished to the same extent as the individual who actually commits the crime. The penalty for a first-time violation of these provisions in the case of less than 50 kilograms of cannabis is imprisonment for a term of up to five (5) years, a fine of up to $250,000, or both. The penalty for a violation committed after a prior drug conviction is imprisonment for a term of up to ten (10) years, a fine of $500,000, or both. (21 U.S.C. §841(b)(1)(D).)

Other federal sanctions are also possible. If a physician were to aid and abet or conspire in a violation of federal law, the federal government might revoke the physician's DEA registration through an administrative procedure. This would seriously hinder the physician's ability to provide proper medical care to his or her patients. Physicians should also be aware that a felony conviction relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance results in mandatory exclusion from the Medicare and Medi-Cal programs. (42 U.S.C. §1320a-7(a)(4).)

17. Why has there been so much confusion over whether or to what extent a physician may "recommend" to a patient the medical use of cannabis?

Before the enactment of the CUA, a physician could discuss with, and recommend to, a patient the medical use of cannabis, but any recommendation did not, as either a legal or practical matter, assist the patient in obtaining cannabis. After the CUA, however, a patient who can demonstrate a physician's recommendation can lawfully (under state law) possess and/or cultivate cannabis for his or her personal medical use. *Furthermore, as a practical matter, a patient with a physician's recommendation can obtain medicinal cannabis at a cannabis dispensary ("buyers' club") or some other source.* A few cannabis dispensaries were in existence before the enactment of the CUA, but their numbers and public visibility increased after the law was passed.

As a result, the federal government argues that, now, a "recommendation" has the same effect as a prescription because it enables a patient to obtain and possess cannabis; therefore, those physicians who

intentionally provide recommendations, only for the purpose of assisting patients in obtaining and possessing cannabis, may be guilty of aiding and abetting a federal crime.

Unfortunately, the terms "recommend" and "recommendation" can refer to a wide variety of discussions and actions. Because of this uncertainty, a number of physicians, who were uncertain whether and to what extent they could converse with their patients about cannabis, brought a lawsuit against the federal government, asking a federal court to determine what types of discussions and recommendations were protected by the First Amendment freedom of speech.

The courts have now definitively ruled in favor of the physicians as discussed below. (*Conant v. Walters* (9th Cir. 2002) 209 F.3d 629, affirming *Conant v. McCaffrey* (N.D.Cal. Sept. 7, 2000) 2000 WL 1281174. *See also Conant v. McCaffrey* (N.D.Cal. 1997) 172 F.R.D. 681).)

18. What do these rulings allow physicians to do? Can I provide my patients with information and advice about cannabis if I think that might help them make decisions about their medical care?

In *Conant*, the court made the following rulings:

> Physicians licensed in California may discuss and recommend the medical use of cannabis to patients suffering from severe nausea (commonly associated with HIV/AIDS and cancer), wasting syndrome (commonly associated with HIV/AIDS), increased intraocular pressure (commonly associated with glaucoma), seizures or muscle spasms associated with a chronic, debilitating condition (commonly associated with epilepsy, multiple sclerosis, and paraplegia/quadriplegia/hemiplegia), and/or severe, chronic pain (commonly associated with diagnosed paraplegia/quadriplegia/hemiplegia, HIV/AIDS, metastasized cancers, and cervical disk disease). *It is important to note that the court's ruling does not explicitly extend to physicians recommending cannabis to patients with other diseases or conditions.* Physicians who recommend the use of cannabis to other types of patients may still be protected by the First Amendment, but the availability of such constitutional protection is not certain.
>
> A physician's recommendation must be made in the context of a bona fide physician-patient and must be based on the physician's best medical judgment.
>
> Physicians have a legitimate need to discuss with, and to recommend to, their patients all medically acceptable forms of treatment. If a physician could not communicate his or her opinion that cannabis is the best therapy or at least should be tried, the physician-patient relationship would be seriously impaired.
>
> A physician's recommendation may not necessarily lead to a violation of the federal drug laws. Patients may use such a recommendation to urge the government to change those laws, i.e., to petition the government for a redress of grievance or a change in policy. Furthermore, a recommendation may enable a patient to gain admittance to a federally approved research program; to obtain cannabis in a foreign country where such access is not prohibited; or to establish that the patient's use of cannabis is "medically necessary."[1]

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[1]This last use may no longer be valid after the Supreme Court's decision in *U.S. v. Oakland Cannabis Buyers' Cooperative* (2001) 532 U.S. 483, 149 L.Ed.2d 722, establishing that medical necessity does not constitute an exception to the federal Controlled Substances Act, , at least with regard to the distribution of medicinal cannabis. On remand, the Ninth Circuit rejected Raich's remaining challenges to the Controlled Substances Act. *See Raich v. Gonzales* (9th Cir. 2007) 500 F.3d 850. However, on August 20, 2008, a federal district court refused to dismiss a lawsuit brought by the city of Santa Cruz and the Wo/Men's Alliance for Medical Marijuana, which asserts that the federal government has sought to nullify California' medical marijuana laws, thereby violating the 10th Amendment. (*Santa Cruz v. Mukasey* (N.D.Cal. 2008) No. C 03-01802 JF (not for citation).)

Physicians may issue writings [in addition to normal documentation in the patient's medical record] that memorialize their recommendations, if the patient may need such a writing for the above purposes. However, if these purposes do not apply, a physician "should proceed more cautiously." If the physician concludes that the "sole use and reason" for the writing would be simply to obtain cannabis in violation of federal law, the writing would probably not be entitled to First Amendment protection. **Therefore, a physician should document in his or her records the reason for each recommendation and the reason for each written certification.**

Some patients may use recommendations to obtain cannabis from cannabis clubs in violation of the federal law. However, if a physician issues a sincere recommendation based on his or her best medical judgment, then he or she has not violated federal law, even if the physician foresees that the recommendation could be used to facilitate a federal crime. The Ninth Circuit affirmed that the mere fact that a physician anticipates that a patient will use the recommendation to obtain marijuana "does not translate into aiding and abetting or conspiracy." Nevertheless, the Court cautioned that, "[i]f, in making the recommendation, the physician intends for the patient to use it as the means for obtaining marijuana, as a prescription is used as a means for a patient to obtain a controlled substance, then a physician would be guilty of aiding and abetting the violation of federal law." The Court explained that a physician would aid and abet "by acting with the specific intent to provide a patient with the means to acquire marijuana." In addition, "a conspiracy would require that a doctor have knowledge that a patient intends to acquire marijuana, agree to help the patient acquire marijuana, and intend to help the patient acquire marijuana."

Bad faith recommendations are not entitled to protection. Thus, physicians who issue insincere recommendations without a medical basis and with the knowledge and intention that the recommendation would be used illegally to obtain cannabis, would be subject to DEA revocation or other federal sanctions. If the patient asks a physician how to obtain cannabis, the physician (if he or she chooses to address the subject) should advise the patient that cannabis is prohibited under the present federal drug laws and inform the patient about the availability of cannabis under federal research programs or foreign laws (if the physician possesses information about such programs or laws). However, federal law would prohibit a patient from bringing cannabis or a cannabis-based medicine across the U.S. border.

Recently, a physician brought First Amendment and equal protection challenges based upon the alleged undercover investigation of his medical practice. The physician contended that the DEA and various state and federal officials had conducted a retaliatory investigation of his practice in response to his statements concerning medical marijuana. The federal trial court denied the defendants' motions to dismiss and for summary judgment with respect to the First Amendment and equal protection claims, applying "strict scrutiny" to the challenged governmental actions. At trial, the physician must provide evidence to support his claim that the government should have employed alternate methods to achieve their stated purpose of obtaining a physician recommendation in order to investigate a medical marijuana dispensary. (*Denney v. DEA* (E.D. Cal. 2007) 508 F.Supp.2d 815.)

19. Does this mean that I can actually suggest that my patient use medicinal cannabis? Can I use the word "recommend"?

Under the *Conant* court's ruling, a physician should be able to conduct in good faith a traditional physician-patient conversation in the physician's office as follows:

The physician may describe the relevant scientific literature and provide the patient with information about the possible health risks and therapeutic benefits of cannabis for use in the patient's condition (including informing the patient that those potential risks and benefits have not, for many indications, been fully

tested in, or even fully identified by, properly-controlled clinical trials). The physician can attempt to answer the patient's medical questions.

The physician may describe (without identifying information) anecdotal evidence concerning medicinal cannabis use by other patients with the same or similar condition.

The physician may provide his or her professional opinion concerning the possible balance of risks and benefits in the patient's particular case, including, if appropriate, a specific recommendation that the patient use medicinal cannabis for medical purposes. A physician might say, "For you, cannabis might be worth a try," "I recommend that you use cannabis," "In your case, the benefits of using cannabis appear to outweigh the risks." There are no "magic words" that a physician must use or avoid in order to inform a patient that the physician believes cannabis may be a medically-appropriate treatment for that patient.

In many cases, a patient may already have discovered that cannabis provides relief from his/her symptoms and may be seeking the physician's agreement that the use of medicinal cannabis is appropriate in the patient's case. Without a physician's concurrence, the patient's use of cannabis remains illegal under state law. In such a case, a physician is probably providing an "approval," rather than a "recommendation." In People v. Jones (2003) 112 Cal.App.4th 341, 4 Cal.Rptr.3d 916, the court of appeal stated that the word "approval" "connotes a less formal act than a 'recommendation'." The court indicated that the word "recommendation" suggests that the physician has raised the issue of medicinal cannabis and presented it to the patient as a potentially appropriate treatment, whereas the word "approval" suggests that the patient has raised the issue, and the physician has "expressed a favorable opinion" of the use of medicinal cannabis for that patient. It should be noted that, while a physician's approval would have prospective effect, it may not "retroactively" authorize a patient's prior use of cannabis (which is relevant if a patient is being prosecuted for such use). *See* Question No. 9 above.

CMA also urges physicians to advise their patients that, notwithstanding the CUA, the cultivation, possession and use of cannabis, even for medical purposes, is illegal under federal law. *See Gonzales v. Raich* Question No. 1, above. Generally, physicians are not required to be familiar with, nor warn patients about, the legal consequences of a patient's health care treatment decision. However, there has been much controversy and confusion about the legality of the therapeutic use of cannabis, and many patients may think that, if their physician believes cannabis on balance may be beneficial for them, they can cultivate, obtain, and use cannabis *without risk of any punishment.* They may not understand that they could still be subject to prosecution or other sanctions under federal law. (For example, a U.S. Customs Inspector wrote to a physician, urging the physician to advise patients that they may be subject to severe penalties for transporting even a small amount of cannabis.) Therefore, if the physician engages in a conversation with a patient, such as that described above, the physician should ensure that the patient understands what legal risks exist for the patient under federal law. The physician should further make it clear that he or she cannot take any action for the purpose of enabling the patient to obtain or possess cannabis.

20. What is a "*bona fide*" physician-patient relationship? May I discuss and advise a patient about medicinal cannabis if I am not the patient's primary treating physician?

The federal government's threats have frightened and deterred many physicians from being willing to discuss and advise their patients about medicinal cannabis. Furthermore, many physicians do not believe that they are sufficiently well informed about the risks and benefits of medicinal cannabis to be able accurately to counsel their patients. Therefore, patients may seek such information and advice from other physicians who feel both knowledgeable and confident in their ability to address these issues, but who will not be responsible for the ongoing care of the patient's medical condition(s). It is possible that a bona fide physician-patient relationship may be established in such a situation if the physician engages in the same activities ordinarily undertaken by a specialist, for example, by:

- Conducting a good faith examination of, and obtains a medical history from, the patient before discussing and advising the patient about cannabis;

- Ensuring that the patient has a serious medical condition;

- Documenting the results of that exam/history and discussion in the patient's medical record, including the basis for the physician's conclusion that cannabis might be therapeutic;

- Consulting with the patient's primary care physician and/or obtaining a copy of the portion of the patient's medical record relating to the condition for which the physician has recommended the use of cannabis, e.g., which establishes the patient's diagnosis and previous care and treatment;

- Referring a patient to a specialist where appropriate; and

- Providing follow-up assessment at regular intervals including, but not limited to, telephonic communication with the patient, in order to ascertain the safety and effectiveness of cannabis on the patient's condition and overall health. In order to ensure such contact, the physician may limit the duration of the recommendation.[2]

In light of the Medical Board's 2004 statement (*see* Question No. 11), it would appear that such practices constitute a *bona fide* physician-patient relationship. Nevertheless, a physician who seeks to provide information and advice in such a situation should consult his or her legal counsel.

MEDICAL NECESSITY

21. I have read a lot about a case involving "medical necessity." What does the idea mean, and does it allow cannabis clubs to distribute medicinal cannabis to certain patients?

A number of years ago, the federal government filed six (6) civil suits against buyers' clubs in Northern California, arguing that the clubs were violating federal law, which prohibits the sale, manufacture or distribution of cannabis. Those suits were consolidated before a single federal judge. A federal district court issued a preliminary injunction to close the clubs. (*U.S. v. Cannabis Cultivators Club* (N.D.Cal. 1998) 5 F.Supp.2d 1086.) The court thereafter refused to modify its injunction to permit the Oakland Cannabis Buyers Cooperative to distribute medicinal cannabis to patients demonstrating "medical necessity." The case was appealed and ultimately reached the U.S. Supreme Court.

In May 2001, the U.S. Supreme Court ruled against the Cooperative. The Court ruled that there is no "medical necessity" exception to the Controlled Substances Act's (CSA) prohibition against manufacturing and distributing cannabis. (*U.S. v. Oakland Cannabis Buyers' Cooperative* (2001) 532 U.S. 483, 149 L.Ed.2d 722.) The Court concluded that a necessity exception for cannabis is "at odds" with the terms of the CSA, the provisions of which leave "no doubt" that the defense is unavailable. Cannabis's placement in Schedule I of the CSA "reflects a determination" that cannabis has no medical benefits worthy of an exception and cannot be used outside the confines of a government-approved research project.

On remand, the defendants in the OCBC case, and the parties in a related case involving a Santa Cruz medicinal cannabis cooperative (WAMM), contended that the federal constitution protects *patients' rights* to use and obtain medicinal cannabis, at least when all conventional treatments have failed, and that the

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[2] In People v. Windus (2008) 165 Cal.App.4th 634, 81 Cal.Rptr.3d 227, the California Court of Appeal for the Second District ruled that the CUA does not itself require a patient periodically to renew a physician's recommendation. However, the Medical Board has determined that proper medical practice does require a physician to conduct regular follow-up assessments.

Controlled Substances Act cannot validly be applied to noncommercial intrastate activity. As noted above in Question No. 1, the Supreme Court in *Gonzales v. Raich* rejected the Commerce Clause argument, and, on remand, the Ninth Circuit rejected the remaining arguments.

22. Do the U.S. Supreme Court's rulings in *OCBC* or *Raich* affect the CUA?

In neither case did the U.S. Supreme Court rule on the validity of the CUA, nor do its holdings implicitly nullify that law. The CUA merely abrogates the state law prohibitions against possession and cultivation of cannabis for seriously ill patients (and their primary caregivers) who have the recommendation or approval of their physicians to use cannabis medicinally. Both before, and after, the Supreme Court's rulings, federal law prohibits such possession and cultivation.

DISCUSSING RISKS AND BENEFITS

23. How can I learn more about the risks and benefits of medicinal cannabis? Where can I get more information?

There have been few properly controlled clinical trials investigating the safety and efficacy of medicinal cannabis, although information is growing. The Center for Medicinal Cannabis Research (CMCR) at the University of California San Diego has funded a number of Phase 2 clinical trials using smoked cannabis. Several have been completed, and a number are currently underway. For the results of this research, *see* www.cmcr.ucsd.edu. Several CMCR-funded studies have been published, demonstrating statistically-significant improvements in several pain conditions. Abrams, DI, et al., "Cannabis in Painful HIV-associated Sensory Neuropathy: a Randomized, Placebo-controlled Clinical Trial," *Neurology* 68(7):515-21 (2007) (painful HIV-related peripheral neuropathy); Wilsey, B, et al., "A Randomized, Placebo-Controlled, Crossover Trial of Cannabis Cigarettes in Neuropathic Pain," The Journal of Pain 9(6):56-21 (2008) (neuropathic pain); Ellis, RJ, et al., "Smoked Medicinal Cannabis for Neuropathic Pain in HIV: A Randomized, Crossover Clinical Trial," Neuropsychopharmacology 1-9 (2008) (painful HIV-related neuropathy). See also, Wallace, M, et al., "Dose-dependent Effects of Smoked Cannabis on Capsaicin-induced Pain and Hyperalgesia in Healthy Volunteers," Anesthesiology 107785-96 (2007) (dose-dependent effects in an experimental pain model).

In addition, a UK pharmaceutical company just completed ten Phase 3 double blind, randomized, placebo-controlled clinical trials. These trials, involving patients with multiple sclerosis and/or neuropathic pain, investigated the safety and efficacy of a cannabis-derived pharmaceutical product, comprised of specific cannabinoid ratios and delivered as an oromucosal spray. The results demonstrated statistically significant benefit in a range of symptoms, including neuropathic pain, spasticity, and sleep disturbance. The extracts were shown to have an excellent safety profile, and most patients were able to titrate (adjust) their dose in order to achieve improvements in their symptoms without incurring any notable psychoactive side effects that would interfere with day-to-day living. The company's first product, Sativex®, was approved in 2005 in Canada for the adjunctive treatment of neuropathic pain in multiple sclerosis and in 2007 (also in Canada) for the adjunctive treatment in patients with advanced cancer whose pain is not being adequately controlled by strong opioids. It is available by prescription in Canadian pharmacies under the Bayer label. The FDA has allowed the product to enter directly into large scale clinical trials in advanced cancer patients whose pain is not adequately relieved by opioids. The company began a Phase II/III dose-ranging trial in the US in November 2007.

The extent of information about the various forms of unstandardized herbal cannabis is still limited. Therefore, physicians should be cautious when undertaking to discuss the risks and benefits of medicinal cannabis use. A physician may be at risk of malpractice liability if a patient suffers an adverse effect, of which the physician was unaware, that would likely have been identified if such testing had taken place.

Little is known about potential health risks, particularly of long-term use of smoked cannabis. Furthermore, certain patient populations may be at greater risk of adverse side effects, such as patients with psychiatric illness. It is also uncertain whether cannabis may interact with various prescription medications. Finally, because cannabis is not a regulated pharmaceutical, the crude herbal form may contain impurities or contaminants that could be harmful, particularly to patients with immunodeficiency problems. Physicians should warn patients about these potential risks when appropriate.

The following books and articles also provide extensive sources of information about the risks and benefits of the medical use of cannabis:

- Institute of Medicine, National Academy of Sciences, *Marijuana as Medicine: Assessing the Science Base* (1999).
- McCarberg, BH, "Cannabinoids: Their Role in Pain and Palliation," *Journal of Pain & Palliative Care Pharmacotherapy.* 21(3):19-28 (2007).
- McCarberg, BH, and Barkin, RL, "The Future of Cannabinoids as Analgesic Agents: A Pharmacologic, Pharmacokinetic, and Pharmacodynamic Overview," *American Journal of Therapeutics* 14(5): 475-483 (2007).
- Russo, EB, "The Role of Cannabis and Cannabinoids in Pain Management," in Cole, BE, and Boswell, M., eds., *Weiner's Pain Management: A Practical Guide for Clinicians* 7th ed. Boca Raton, FL: CRC Press, p. 823-844 (2006).
- Russo, EB, "The Solution to the Medicinal Cannabis Problem," in: Schatman ME, ed., *Ethical Issues in Chronic Pain Management.* Boca Raton, FL: Taylor & Francis. p 165-194 (2006).
- Russo, EB, and Guy GW, "A Tale of Two Cannabinoids: the Therapeutic Rationale for Combining Tetrahydrocannabinol and Cannabidiol," *Medical Hypotheses* 66(2):234-246 (2006).
- Mechoulam R., ed., *Cannabinoids as Therapeutics*, Basel, Switzerland: Birkhauser Verlag (2005).
- Grinspoon, L and Bakalar, J., *Marijuana: The Forbidden Medicine* (1997).
- Mathre, M.L., ed., *Cannabis in Medical Practice: A Legal, Historical and Pharmacological Overview of the Therapeutic Use of Marijuana* (1997).
- *Cannabis and Cannabinoids: Pharmacology, Toxicology, and Therapeutic Potential*, eds. F. Grotenherman and E.B. Russo, Binghamton, NY: Haworth Press (2002).
- Iversen, L.L., *The Science of Marijuana* (2000)
- Guy, G., Whittle, B.A., and Robson, P.J, eds. *The Medicinal Uses of Cannabis and Cannabinoids* (2004).

PROFESSIONAL LIABILITY COVERAGE

24. What if a patient uses herbal cannabis on my recommendation and suffers some adverse health event as a result? If I am sued, will my professional liability insurance cover me?

Different malpractice carriers have different policies. Some refuse to insure for harms resulting from medications, including cannabis, that are not approved by the FDA. *See* Mead, A.P., "Cannabis-Based Medicines: What Does the Future Hold?" *Physician Insurer* (Nov. 2006). A physician should discuss the issue with his/her liability carrier.

OBTAINING CANNABIS/PERMISSIBLE QUANTITIES

25. How are patients or caregivers supposed to obtain cannabis?

The CUA was intended to authorize a patient or a patient's "designated primary caregiver" to cultivate and possess cannabis for the patients' medical use. A "primary caregiver" is the individual designated by the patient who has consistently assumed responsibility for the patient's housing, health, or safety. The MMP clarifies the conditions under which an individual may serve as a designated primary caregiver for one or more patients (whether or not the patients have ID cards). *See* Health & Safety Code §11362.7(d). Furthermore, the law specifically states that the caregiver may receive compensation for actual expenses, including reasonable compensation incurred for services provided to a patient to enable that person to use medicinal cannabis. (Health & Safety Code §11362.765(c).)

Even with a valid recommendation from a physician, many patients (and caregivers) were arrested on the charge that they were cultivating more cannabis than was needed for the patient's personal medical needs and hence were cultivating for purposes of sale. The MMP attempts to address that problem by providing that a patient or primary caregiver may possess eight ounces of dried cannabis, and in addition, six (6) mature or twelve (12) immature plants, per patient. However, if a patient has a physician's statement that this quantity does not meet the patient's medical needs, the patient or primary caregiver may possess a larger amount consistent with those medical needs. (Health & Safety Code §11362.77.) Several counties have also previously established specific limits on the number of plants and the quantity of plant material that an individual patient may possess. The MMP allows cities and counties to retain or enact guidelines permitting patients and caregivers to exceed these amounts. (*Id*[3].)

Many patients are too ill to cultivate their own marijuana, and many caregivers lack the skill or location for such cultivation. However, the CUA did not authorize any individual or entity (such as cannabis buyers' clubs or dispensaries) to sell, or even give, cannabis to a patient or caregiver, even with a physician's written or oral recommendation. After the CUA was initially passed, the operators of some dispensaries were designated by hundreds of patients as the patients' "primary caregiver."

However, under the CUA, a cannabis dispensary may not qualify as a "primary caregiver" under the law. (People ex rel Lungren v. Peron (1997) 59 Cal.App.4th 1383; 70 Cal.Rptr.2d 20.) In Peron, the court stressed that the state criminal statutes prohibiting both the selling and the giving away of cannabis were not affected by the CUA. However, the Peron case involved a dispensary that was open to the public, i.e., to any individual qualified under the initiative, that charged for the cannabis (albeit on an allegedly nonprofit basis), and that potentially served as only one of several sources of supply for any patient who

[3] Recently, two California Courts of Appeal have struck down the MMP limits as constituting an invalid modification of the CUA (an initiative cannot be amended by legislation unless the initiative text explicitly permits such legislative amendment, which the CUA does not). *See* People v. Kelly (2008) 163 Cal.App.4th 124; 77 Cal.Rptr.3d 390; People v. Phomphakdy (2008) 165 Cal.App.4th 857; 81 Cal.Rptr.3d 443. The California Supreme Court has accepted review of these cases

chose to purchase cannabis there. *See also* People v. Galambos (2002) 104 Cal.App.4th 1147, 128 Cal.Rptr. 844 (neither defense of medical necessity nor limited immunity of the CUA can be claimed by an individual who purported to cultivate cannabis for medicinal cannabis dispensary). The Peron court stressed that the language of the CUA does **not** preclude a primary caregiver from serving more than one patient, and indeed the MMP explicitly allows more than one patient to designate the same caregiver, if the patients and caregiver reside in the same county. However, the California Supreme Court ruled that a person whose "caregiving" consists principally of supplying cannabis and instructing on its use, and who otherwise only sporadically takes some patients to medical appointments, cannot qualify as a "primary caregiver" under the CUA. (People v. Mentch (2008) 45 Cal.4th 274, 85 Cal.Rptr.3d 480.) The Court concluded that a primary caregiver must prove at a minimum that he/she 1) consistently provided caregiving, 2) independent of any assistance in taking medical marijuana, 3) at or before the time he/she assumed responsibility for assisting with medical marijuana. A primary caregiver must be the principal, lead, or central person responsible for rendering assistance in the provision of daily life necessities.

The MMP recognizes that patients and caregivers may associate in order collectively or cooperatively to cultivate medicinal cannabis. (Health & Safety Code §11362.775.) In August 2008, the California Attorney General's office issued "Guidelines for the Security and Non-diversion of Marijuana Grown for Medical Use." *See* http://ag.ca.gov/cms_attachments/press/pdfs/n1601_medicalmarijuanaguidelines.pdf.

The AG's Guidelines stressed that a "cooperative" must file articles of incorporation with the state and conduct its business for the mutual benefit of its members. It must follow strict rules on organization, articles, elections, and distribution of earnings, and must report individual transactions from individual members each year. A "collective," while not defined under California law, should be an organization that merely facilitates the collaborative efforts of patient and caregiver members. Neither collectives nor cooperatives should purchase cannabis from, or sell to, non-members. The Guidelines also set forth suggested practices to ensure that these entities operate in compliance with state and local law and ensure security and non-diversion of cannabis to illicit markets. Mere storefront dispensaries are illegal.

In addition, many cities and counties in California have issued bans or moratoria on the establishment of dispensaries, believing that such dispensaries are not authorized under state law and/or create unacceptable risks to public health and safety. *See* Riverside County, "Medical Marijuana: History and Current Complications," (white paper) (Sept. 2006).

26. How can a patient know how much medicinal cannabis to take?

Because medicinal cannabis in its unrefined herbal form is not consistent and standardized like conventional pharmaceutical products, both physicians and patients are often uncertain about how the patient should use the substance. Physicians are placed in a difficult position if a patient inquires how much medicinal cannabis the patient should take to obtain therapeutic relief, while avoiding undesirable side effects. Patients may also ask how the cannabis should be administered. Physicians should warn patients of the potential risks of pulmonary harm that could result from smoking, particularly if the patient is using medicinal cannabis for a chronic condition. Furthermore, physicians should be able to inform patients about the existence of alternative, non-smoked delivery forms, such as vaporizers, baked goods, teas, etc. Since the federal government has taken the position that physicians may not lawfully prescribe cannabis for medical use, physicians should be cautious when advising a patient about such issues. If the physician's advice becomes too specific, e.g., how to prepare a tea, how much to drink and at what time of day, where vaporizers can be purchased, it could be construed as a prescription, a form of incitement, or a type of aiding and abetting. Furthermore, many physicians do not have the knowledge to be able to give patients guidance in such matters. Physicians could refer patients to Internet and print resources (*see* partial list above) that can provide a wide spectrum of information about medicinal cannabis. *See* Carter GT,

Weydt P, Kyashna-Tocha M, Abrams DI, "Medicinal Cannabis: Rational Guidelines for Dosing," *IDrugs* 7(5):464-70 (2004).

The city of Oakland has guidelines governing the amounts of cannabis that patients may lawfully possess and cultivate. As of 2006, those guidelines stated that patients may exceed those limits if they have a physician's statement indicating that the amounts allowed by the guidelines do not meet the patient's medical needs. Such a statement allows a patient to cultivate/use an amount of cannabis "consistent with those needs." *A physician should be free to opine that the allowable amount of cannabis does not appear to meet a particular patient's medical needs, if the physician has a reasonable basis for such an opinion. However, CMA does not advise physicians to* ***specify*** *the amount of cannabis that* ***would*** *be consistent with the patient's needs.* CMA believes that a physician may lawfully record the patient's reports of his or her extent of cannabis use and his or her description of symptom relief, or lack thereof. The Oakland guidelines further provide that patients are encouraged to record their actual usage with their physicians and to match their "garden yield" with that documented usage. Again, a physician should be free to record a patient's description of his or her actual usage. However, for the reasons stated in this document, CMA does not encourage physicians to provide specific recommendations of daily usage levels.

27. What if a patient asks me how he or she can obtain cannabis?

Physicians should **not** provide a patient with the name and address of a cannabis club or other type of cannabis distributor. While physicians may be sympathetic to a patient who cannot otherwise obtain medicinal cannabis, physicians may risk serious sanctions if they direct a patient to a specific cannabis source. Physicians should inform a patient that the physician cannot affirmatively assist the patient in obtaining cannabis.

MEDICAL RECORD DOCUMENTATION

28. May I record my conversation with the patient in the patient's medical record?

Most certainly. As with all physician-patient discussions, a conversation about medicinal cannabis should be documented in the medical record, in accordance with the physician's normal charting practices. Such recordation will ensure that this, like all information that relates to the patient's health care, will be available for the future reference of the physician or other health care providers. In addition, if a patient should use cannabis and suffer an untoward side effect (or be prosecuted under federal law), the physician can demonstrate that he or she warned the patient of that possibility.

29. What should I do if a patient asks for a copy of his or her medical record?

A patient has a right under state law to obtain a copy of his or her medical record. Since a separate statutory scheme requires physicians to provide patients with their medical records on request, the physician-patient conversation described above should not be construed as deliberately assisting the patient to obtain cannabis, even if the patient, on his or her own, decides to take the medical record to a cannabis dispensary, and even if the physician is aware that the patient may do so. However, a physician might be subject to sanctions if there is clear evidence that the physician is conspiring in the patient's plan. Therefore, physicians should *not* state that the physician is making the recordation in order to enable the patient to obtain cannabis from a buyers' club, nor should the physician actively encourage a patient to request a copy of the medical record for that purpose. When providing the patient with a copy of his or her medical record, the physician again should follow his or her normal practice. Typically, when copying medical records for any purpose, physicians should provide a complete medical record, i.e., one that contains all the patient's medical information, or at least all that is relevant to the condition at issue.

RESPONDING TO PATIENT REQUESTS FOR TESTIMONY

30. What do I do if a patient is prosecuted under state law for possessing or cultivating, and I am subpoenaed to testify about the office conversation in order to establish the patient's right to a limited immunity under the CUA?

A physician may be required by subpoena to testify in court, or to provide a sworn written statement, to describe the information and advice that he or she provided a patient. The district court's earlier ruling in the *Conant* case indicates that a physician cannot be punished for providing such testimony or statement under compulsion of law. Under the court's later September 7 ruling, it would seem a physician cannot be sanctioned for providing such oral or written testimony *voluntarily*, i.e., without a subpoena, although this is not completely free from doubt. The Ninth Circuit did not explicitly address this issue.

RESPONDING TO LAW ENFORCEMENT REQUESTS

31. I understand that local police in some areas have contacted physicians directly in order to determine whether or not patients have recommendations from those physicians for the medical use of cannabis. How should I deal with their requests?[4]

Physicians must be extremely cautious in this situation. The California Confidentiality of Medical Information Act severely limits the circumstances under which physicians may disclose patient medical information to a third party, including the police. In short, physicians may discuss or testify about such information only pursuant to 1) a written consent from the patient which meets the formal requirements of the Act, including identification of the specific medical information that can be disclosed; or 2) a court order, or (if patient office records are being sought) search warrant. (If the records are sought by search warrants, they can only be released to a special master. (Penal Code §1524(c).) A "special master" is an attorney who is a member in good standing of the California State Bar who has been selected by the court from a list maintained by the State Bar. The special master must accompany the person serving the warrant and must inform the person upon whom the warrant is being served of the specific items being sought and that the party being served will have an opportunity to produce the items requested. If the physician being served states that certain items should not be disclosed, those items shall be sealed by the special master and taken to court for a hearing. The physician must be informed of the date, time, and place of the hearing, which ordinarily must be held within three days. (Gordon v. Superior Court (1997) 55 Cal.App.4th 1546, 65 Cal.Rptr.2d 53.)

Even if the physician is required (by court order or search warrant) or permitted (by patient authorization) to testify about or discuss the existence of a recommendation with the police, the physician would be well advised to reveal as little as necessary about the patient's actual medical condition. There are a number of state and federal laws that provide heightened protection to drug and alcohol abuse treatment records, AIDS test results, and certain mental health information. In addition, the California constitutional right of privacy protects patient medical information whenever the patient would have had a "legitimate expectation under the circumstances" that certain information would remain private. Although the application of the constitutional protection is sometimes uncertain, its prohibitions apply to the conduct of private actors (like physicians), and its breach can result in serious damage liability. Therefore, physicians should reveal no more patient information than is essential to serve the legitimate purposes of the inquiring party.

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[4]In one recent case, federal law enforcement personnel seized the patient records of a physician who had provided recommendations to approximately 6,000 patients. The physician, who allegedly has a medical condition that is covered by the CUA, was also cultivating thirty-two (32) cannabis plants.

Thus, again, even if there is a patient consent or a court order, CMA encourages physicians only to reveal whether or not 1) the patient has a serious medical condition (but not the nature of the condition) and 2) the physician has recommended or approved the patient's medicinal use of cannabis. This should be sufficient to enable the police to determine whether the patient is acting in accordance with the intent of the CUA. If a patient registry and ID card program is operating within the city/county, the police should be able to confirm the legitimacy of an ID card without directly contacting the physician.

Physicians who testify or have such discussions with the police should have nothing to fear from the federal government. By confirming to the police that the physician approved the patient's use of medicinal cannabis, the physician is merely providing evidence that is relevant to the criminal proceeding involving the patient.

RESPONDING TO PATIENT REQUESTS FOR COMPLETION OF FORMS

32. Patients have asked me to sign and/or complete different types of forms that relate to the patient's use of cannabis for medical reasons. Can I provide a patient with such a form?

As indicated above, physicians should avoid providing a patient with any writing whose **sole** purpose is to enable the patient to obtain cannabis at a cannabis dispensary or some other source. Under no circumstances should a physician sign a form that contains a logo or letterhead of a cannabis dispensary or that mentions a cannabis dispensary in the body of the letter.

Furthermore, even if there is no mention of a cannabis dispensary, a physician must be cautious. As the *Conant* rulings state, a writing is not protected if the physician's purpose in providing the writing is to enable the patient to obtain cannabis in violation of federal law. If the only credible answer to the question "Why did you give this writing to the patient?" is "To enable the patient to obtain cannabis," then the physician may be subject to liability under federal law. It must be remembered that whether or not a physician is merely attempting to help a patient obtain cannabis is a question of fact, and the physician's subjective intent and knowledge must be determined on the facts of each case. The actual wording on a form may not be the only factor that is taken into account in making this determination.

The *Conant* rulings did not specifically address the situation of the physician who gives a patient a letter of recommendation for the purpose of enabling the patient to reduce the likelihood of arrest, or, if arrested, to exercise his or her rights under Mower (*see* Question No. 8). An argument can be made that a recommendation letter which is provided for "defensive" purposes should be protected. However, others have argued that, since such a letter intends to enable a patient to cultivate and/or possess/retain cannabis, it therefore still constitutes aiding and abetting a violation of federal law. It should be noted that the *Conant* district court did state that a physician could be subject to punishment for aiding and abetting the *cultivation or possession* of cannabis.

Physicians should, in any event, avoid making any written statements which "warrant" or "certify" that a particular patient is "in compliance" with the law. It has come to our attention that certain individuals/ organizations may be distributing forms which contain such statements. The physician has no way of knowing whether a particular patient, who possesses or cultivates cannabis, is actually "in compliance with" the law. For example, a patient may be cultivating cannabis for purposes of sale, in addition to his or her personal medical use. The California law does not authorize such activity.

COUNTY CERTIFICATION PROGRAMS

33. I have heard that some cities and counties have their own patient registry programs in which governmental officials will provide a patient with evidence (such as an identity card) that the patient is using cannabis for medical purposes within the protection of the CUA. Should I cooperate with county officials in these programs?

It is impossible to provide an answer that will apply to each and every such certification program, particularly those that were put in place before S.B. 420 was implemented in that county. The Attorney General has determined that the statewide registry and ID card program preempts the operation of a city's (or county's) own registry and ID card program, although a city/county may adopt other ordinances consistent with the statewide program. (Health & Safety Code §11362.83.) However, a city/county may continue to operate its own program until the statewide program is operational in that county, at least to the extent that none of its provisions conflicts with state law. For example, a city's program could not restrict possession of cannabis to levels less than that permitted by state law, nor make having an ID card a mandatory prerequisite for avoiding arrest. (Ops.Cal.Atty.Gen. No. 04-709 (June 2005).)

The state began pilot programs in May 2005 in Amador, Del Norte and Mendocino counties. You should contact your county health department to determine whether your country is currently participating in the statewide program, has its own county (or city) program, or has no program. For further information about the program, *see* www.dhs.ca.gov/hisp/ochs/mmp/default.htm. Record retention policies will differ by county. The county of San Diego has refused to issue ID cards pursuant to the MMP and has filed a lawsuit challenging the validity of the MMP under federal law, contending that by participating in the state program, the county would be in violation of federal law. The Court of Appeal ruled that federal law does not preempt the MMP or the CUA. (County of San Diego et al., v. San Diego NORML et al., (2008) 165 Cal.App.4th 798, 81 Cal.Rptr.3d 461.) The California Supreme Court denied review.

Physicians must carefully examine any local governmental certification program to ensure that the program's stated purpose is not to enable a patient to obtain cannabis from some source, but rather to enable a patient to avoid arrest or conviction under the law. Even in such cases, the treating physician should avoid direct discussion with third parties (including county officials) confirming that the physician has recommended or approved a patient's use of medicinal cannabis. However, a physician can probably safely confirm with county officials that an individual is a patient of the physician's and perhaps also confirm the patient's diagnosis, assuming the patient has provided the physician with the appropriate written authorization for such disclosure. Certainly, the patient has a right to obtain copies of his or her medical records documenting the physician-patient discussion and to submit that documentation to governmental officials in order to obtain an ID card. The physician can confirm the authenticity of such medical records.

It appears that, ostensibly pursuant to the MMP, the California Department of Health Services has developed a physician form entitled "Written Documentation of Patient's Medical Records." The form asks for the physician's name and certain professional information and for the patient's name and diagnosis. The patient must be "under the medical care and supervision" of that diagnosing physician. It also asks the physician to sign a statement confirming that the patient has been diagnosed with the above medical condition(s) and that the "use of medical marijuana is appropriate."

The MMP was carefully crafted to minimize the potential liability risks to physicians under federal law. The MMP clearly states that the requirement of "written documentation" from the attending physician means "accurate reproduction of the relevant portions of the patient's medical records," which the patient has a legal right to request. (Health & Safety Code §11362.7(i).) CMA believes that it would be more prudent for physicians to decline to sign the state form, instead providing a patient (upon the patient's

request) with a copy of the relevant portion of the patient's medical record, which the patient can submit along with his/her application for an ID card. An argument can be made that by filling out the state form, the physician is merely assisting the patient (and the State) in ensuring that a qualified patient is not subject to improper arrest by state or local law enforcement. Such a "defensive" purpose may not put a physician in violation of federal law. However, among the "legitimate" reasons listed by *Conant* as justifying a physician in giving a patient a recommendation, the patient's "avoiding arrest" was not one of them

ACTIONS TO AVOID

34. Are there any other types of actions that I should avoid?

A physician should avoid the following:

a) Providing cannabis to a patient;

b) Describing to a patient how the patient may obtain cannabis, for example, by giving the name and address of a cannabis distributor;

c) Communicating with a cannabis distributor, such as a cannabis dispensary, to confirm a recommendation made to a patient in an office dialogue;

d) Offering a specific patient ***individualized*** advice concerning appropriate dosage timing, amount, and route of administration.

Whether a particular recommendation or action is permissible will depend on the surrounding circumstances. Again, physicians cannot intentionally take an action for the purpose of enabling a patient to obtain cannabis or otherwise to violate the federal drug laws. There will be a gray area between the clearly permissible and clearly impermissible categories of action. Physicians will need to use their own judgment in assessing the level of risk involved in particular conduct.

POTENTIAL LIABILITY TO THIRD PARTIES

35. What if one of my patients gets involved in some sort of an accident as a result of using cannabis for medical purposes?

The Initiative does not a) supersede legislation prohibiting persons from engaging in endangering conduct; nor b) condone the diversion of cannabis for non-medical purposes. Therefore, if a patient using cannabis drives an automobile and injures another individual in an accident, the patient's physician could in theory be sued by the injured party (and/or by an injured patient him or herself) claiming that the physician, who had discussed the potential health risks and therapeutic benefits of cannabis with the patient, had not adequately warned the patient not to engage in such endangering activity while impaired.

If a physician chooses to discuss with a patient the risks and benefits of cannabis, the physician should be sure to warn the patient not to engage in dangerous activities, such as driving, operating large machinery, etc., if impaired by cannabis (or any other medication or substance) and should scrupulously document the conversation in the patient's medical record. In addition, if the physician knows or has reason to believe that the patient will not heed the physician's advice, the physician may be well-advised to warn the patient's family, or other individuals who are likely to occupy an automobile with the patient, about the patient's potentially impaired driving ability. Physicians should be aware that a failure to warn may result in the physician's being liable to the patient if the patient is injured, as well as to third parties who are injured by the patient.

For recent articles on this issue, *see* Ramaekers, J.G., et al., *Cognition and Motor Control as a Function of Delta-9-THC Concentration in Serum and Oral Fluid: Limits of Impairment*, www.sciencedirect.com/science?_ob=ArticleURL&_udi=B6T63-4K1G57Y-1&_user=10&_rdoc=1&_fmt=&_orig=search&_sort=d&view=c&_acct=C000050221&_version=1&_urlVersion=0&_userid=10&md5=14f4a3bf1fd7d0a8220c0f8624d45177 (Elsevier); Smiley, A., *Marijuana: On-Road and Driving Simulator Studies*, pp. 173-88, in The Health Effects of Cannabis, eds. H. Kalant, et al., Toronto: Center for Addiction and Mental Health (1998); Sexton, B.F. et al., *The Influence of Cannabis on Driving*, Transport Research Laboratory Limited, Berkshire, UK (2002), www.trl.co.uk/store/report_detail.asp?srid=2694; Bates, M. and Blakeley, A.T., *Role of Cannabis in Motor Vehicle Crashes*, Epidemiologic Reviews 21: 222-232 (1999); EMCDDA, "Cannabis Use and Driving: Implications for Public Health and Transport Policy, " www.emcdda.europa.eu/themes/driving.

CMA POLICY

36. What is CMA's position on the medical use of cannabis?

Physician-patient dialogue: CMA opposes any governmental threats against physicians arising from discussion of medicinal cannabis in the context of an established physician-patient relationship. Therefore, CMA strongly supports the principles articulated by the federal court in the *Conant* case described above.

Opposition to prosecution of patients: CMA opposes the criminal prosecution of patients who possess or use smoked herbal cannabis for medical reasons upon the recommendation of a physician.

Therapeutic use: CMA has consistently maintained its position that cannabis should be available for therapeutic use as a Schedule II drug only if there are properly controlled studies proving that it is efficacious. CMA believes that seriously ill patients should not be offered a therapy whose efficacy may be illusory and which in some cases may actually worsen the patient's medical condition. Therefore, CMA has opposed the "medicalization" of cannabis unless and until there is objective proof that such use is scientifically justifiable.

Medical necessity: At the same time, however, CMA believes that, if a physician concludes that there are no standard therapies available that will sufficiently relieve the suffering of a seriously ill patient, and cannabis is the only treatment that can provide such relief, the patient should be able to seek out, and obtain access to, that treatment without interference from the federal government. Therefore, CMA filed an amicus brief with both the Ninth Circuit and the US Supreme Court in *U.S. v. Oakland Cannabis Buyers Cooperative* and *Gonzales v. Raich*, discussed above, supporting the concept of medical necessity.

Research encouraged: CMA continues to support scientifically rigorous research, including all FDA-approved Phase II and Phase III clinical trials and to examine the current science concerning the therapeutic role of cannabinoid-based pharmaceuticals. To this point, CMA has supported efforts to remove cannabis from Schedule I in order to allow greater access for research, limited prescriptive access and appropriate oversight of the supply for the protection of patients and society. In addition, CMA has supported efforts to create, and to obtain federal government approval for, a reliable and high-quality source of cannabis within California for the purposes of (1) facilitating research; and (2) providing controlled distribution (of cannabis) to appropriate patients, upon recommendation of their physician, through pharmacies or other closely regulated sources. However, CMA believes that it should re-examine the need for continued research on smoked herbal cannabis in light of recent research on its benefits and harm and the long-term prospect of smoked herbal cannabis as a medicine.

Medical Board scrutiny: In March 2003, CMA's House of Delegates concluded that CMA should urge the Medical Board to revise its guidelines concerning medicinal cannabis so that the guidelines include the requirement for a good faith exam with diagnosis, treatment and follow up recommendations, and more

fully clarify and affirm the legitimate role of physicians in recommending cannabis to appropriate patients. CMA also believes that the Medical Board should apply clinically appropriate standards of care to all physicians, and should **not** apply a higher standard of care or to require a higher degree of evidence in cases where medicinal cannabis is involved. As a result of this policy, CMA worked with the Medical Board to develop an appropriate informational document concerning medicinal cannabis, as discussed in Question No. 11.

CURRENT RESEARCH AND THE POSITION OF THE FDA

CMA supported a piece of legislation, S.B. 847, authored by Senator Vasconcellos, which established the Cannabis Research Act. This legislation authorized the University of California to implement a three-year research program (the California Cannabis Research Program) to ascertain the general medical safety and efficacy of cannabis and, if it is found to be therapeutically valuable, to establish guidelines for its appropriate administration and use. *See* Health & Safety Code §11362.9. Three million dollars were appropriated for the first three years of the program. As a result, the Center for Medicinal Cannabis Research (CMCR), whose administrative offices are based at the University of California in San Diego, has awarded a number of research grants. For more information, you may wish to call the Center at (619) 543-5024 or view its website at www.cmcr.ucsd.edu. Under recent legislation, CMCR was established as a permanent research center within the University of California.

In addition, GW Pharmaceuticals, a British pharmaceutical company founded for the purpose of developing cannabis-derived pharmaceutical products, has been conducting controlled clinical trials in the UK for the past nine years. GW is focusing on symptoms of cancer pain, neuropathic dysfunction, and neuropathic pain. GW has obtained marketing approval in Canada for its first prescription product, Sativex®. GW has just begun clinical trials in the US with advanced cancer patients whose pain is not adequately controlled by strong opioids. For more information about GW's research program, *see* www.gwpharm.com.

In 2004, the Food and Drug Administration (FDA) issued a guidance document entitled "Botanical Drug Products," in which it acknowledged that modern pharmaceutical products can be developed from botanical materials and set forth the elements of that development path. Food and Drug Administration, "Botanical Drug Products," www.fda.gov/CDER/guidance/4592fnl.pdf. In April 2006, the FDA released an interagency statement stating that recent voter initiatives or legislative actions making smoked cannabis available for medical use are "inconsistent with efforts to ensure that medications undergo the rigorous scientific scrutiny of the FDA approval process and are proven safe and effect under the standards of the FD&C Act." The Statement concluded that "[e]fforts that seek to bypass the FDA drug approval process would not serve the interest of public health because they might expose patients to unsafe and ineffective drug products." Food and Drug Administration, "Inter-Agency Advisory Regarding Claims That Smoked Marijuana is a Medicine," www.fda.gov/bbs/topics/NEWS//2006/NEW01362.html.

Currently, the University of Mississippi (pursuant to a contract with the National Institute on Drug Abuse) provides the sole source of research-grade herbal cannabis in the US. The University of Massachusetts Amherst (Prof. Lyle Craker) is seeking to obtain from the DEA a bulk manufacturing license in order to cultivate and supply cannabis for FDA-approved research projects. An Administrative Law Judge has recommended to the DEA that the application be granted. *In the Matter of Lyle E. Craker, Ph.D., Docket No. 05-16, Opinion and Recommended Ruling, Findings of Fact, Conclusions of Law, and Decision of Administrative Law Judge* (Feb. 12, 2007). The ALJ's recommendation is pending before the DEA Administrator.

Two cannabinoid pharmaceutical products are presently on the US market. Cesamet® (nabilone) and Marinol® (dronabinol). Both are approved for nausea and vomiting associated with cancer chemotherapy

in patients who have failed to respond adequately to conventional treatments. Marinol® is also approved for appetite loss associated with weight loss in people who have acquired immunodeficiency syndrome (AIDS). Cesamet®, a synthetic analogue of tetrahydrocannabinol (THC) is in Schedule II of the Controlled Substances Act, and Marinol® is in Schedule III. THC in any other form remains in Schedule I (as does marijuana).

We hope this information is helpful to you. CMA is unable to provide specific legal advice to each of its more than 30,000 members. For a legal opinion concerning a specific situation, consult your personal attorney.

For information on other legal issues, use CMA ON-CALL, or refer to CMA's *California Physician's Legal Handbook*. This book contains legal information on a variety of subjects of everyday importance to practicing physicians. Written by CMA's Legal Department, the book is available on a fully searchable CD-ROM, or in a seven-volume, softbound format. To order your copy, call (800) 882-1262 or visit CMA's Bookstore at www.cmanet.org.

Attachment 4

CALIFORNIA ATTORNEY GENERAL GUIDELINES

On August 25, 2008, California Attorney General Edmund G. Brown, Jr. sought to clarify and harmonize the *CUA* and its subsequent enabling legislation, the *MMP*, by releasing a set of Guidelines for patients, caregivers and law enforcement to ensure that medical marijuana is not diverted to illicit markets. (*See* Attachment "4") The document stated that "California voters approved an initiative legalizing medical marijuana, not street drugs. Marijuana intended for medicinal use should not be sold to non-patients or on illicit markets.... [and that] [t]hese guidelines will help law enforcement agencies perform their duties in accordance with California law and help patients understand their rights under Proposition 215."

Under the Guidelines, entities dispensing medical marijuana must operate as non-profit collectives or cooperatives, and are prohibited from buying marijuana from growers who are not themselves patients or registered caregivers, and the only fees dispensaries can collect are those covering overhead and operating expenses. The Guidelines identified cooperatives as entities which 1) filed articles of incorporation with the State pursuant to *California Corporation Codes*; 2) were properly organized and registered as corporations under the *California Corporations or Food and Agriculture Codes*; 3) are "democratically controlled and are not organized to make a profit for themselves, as such, or for their members, as such, but primarily for their members as patrons;" and 4) do not purchase marijuana from, or sell to, non members, but, rather, facilitate transactions solely between cooperative members.

Whereas, a collective is defined as an organization that "merely facilitates the collaborative efforts of patient and caregiver members, including the allocation of costs and revenue," and does not purchase marijuana from, or sell to, non-members, but instead, provides a means for facilitating or coordinating transactions between members. Aside from providing protections to patients and non-profit dispensaries organized as cooperatives or collectives, the Guidelines prohibited qualified patients from ingesting/smoking marijuana near school, recreation centers and places of employment, required cooperatives and collectives to document their activities and record the source of the marijuana they purchase, and authorized criminal sanctions for non compliant dispensaries.

Since the Guidelines were issued, California Courts have generated binding case law regarding distribution of medical marijuana. As a result, the California Attorney General has taken the position that the term "primary caregiver" precludes marijuana clubs from asserting the defense they are primary caregivers. Based in part on the plain statutory language utilizing the noun "individual" the Attorney General's opinion requires that a caregiver must be a "person" who has demonstrated a relationship with the qualified patient over a meaningful period of time. However, the Attorney General's analysis of the term "primary caregiver" does allow for the possibility of a small cooperative/collective, of qualified patients and/or primary caregivers associating together, to use a common plot of land to grow, harvest and divide for patient use the marijuana grown.

EDMUND G. BROWN JR.
Attorney General

DEPARTMENT OF JUSTICE
State of California

GUIDELINES FOR THE SECURITY AND NON-DIVERSION OF MARIJUANA GROWN FOR MEDICAL USE

August 2008

In 1996, California voters approved an initiative that exempted certain patients and their primary caregivers from criminal liability under state law for the possession and cultivation of marijuana. In 2003, the Legislature enacted additional legislation relating to medical marijuana. One of those statutes requires the Attorney General to adopt "guidelines to ensure the security and nondiversion of marijuana grown for medical use." (Health & Saf. Code, § 11362.81(d).[1]) To fulfill this mandate, this Office is issuing the following guidelines to (1) ensure that marijuana grown for medical purposes remains secure and does not find its way to non-patients or illicit markets, (2) help law enforcement agencies perform their duties effectively and in accordance with California law, and (3) help patients and primary caregivers understand how they may cultivate, transport, possess, and use medical marijuana under California law.

I. SUMMARY OF APPLICABLE LAW

A. California Penal Provisions Relating to Marijuana.

The possession, sale, cultivation, or transportation of marijuana is ordinarily a crime under California law. (See, e.g., § 11357 [possession of marijuana is a misdemeanor]; § 11358 [cultivation of marijuana is a felony]; Veh. Code, § 23222 [possession of less than 1 oz. of marijuana while driving is a misdemeanor]; § 11359 [possession with intent to sell any amount of marijuana is a felony]; § 11360 [transporting, selling, or giving away marijuana in California is a felony; under 28.5 grams is a misdemeanor]; § 11361 [selling or distributing marijuana to minors, or using a minor to transport, sell, or give away marijuana, is a felony].)

B. Proposition 215 - The Compassionate Use Act of 1996.

On November 5, 1996, California voters passed Proposition 215, which decriminalized the cultivation and use of marijuana by seriously ill individuals upon a physician's recommendation. (§ 11362.5.) Proposition 215 was enacted 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," and to "ensure that patients and their primary caregivers who obtain and use marijuana for

[1] Unless otherwise noted, all statutory references are to the Health & Safety Code.

medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction." (§ 11362.5(b)(1)(A)-(B).)

The Act further states that "Section 11357, relating to the possession of marijuana, and Section 11358, relating to the cultivation of marijuana, shall not apply to a patient, or to a patient's primary caregiver, who possesses or cultivates marijuana for the personal medical purposes of the patient upon the written or verbal recommendation or approval of a physician." (§ 11362.5(d).) Courts have found an implied defense to the transportation of medical marijuana when the "quantity transported and the method, timing and distance of the transportation are reasonably related to the patient's current medical needs." (*People v. Trippet* (1997) 56 Cal.App.4th 1532, 1551.)

C. Senate Bill 420 - The Medical Marijuana Program Act.

On January 1, 2004, Senate Bill 420, the Medical Marijuana Program Act (MMP), became law. (§§ 11362.7-11362.83.) The MMP, among other things, requires the California Department of Public Health (DPH) to establish and maintain a program for the voluntary registration of qualified medical marijuana patients and their primary caregivers through a statewide identification card system. Medical marijuana identification cards are intended to help law enforcement officers identify and verify that cardholders are able to cultivate, possess, and transport certain amounts of marijuana without being subject to arrest under specific conditions. (§§ 11362.71(e), 11362.78.)

It is mandatory that all counties participate in the identification card program by (a) providing applications upon request to individuals seeking to join the identification card program; (b) processing completed applications; (c) maintaining certain records; (d) following state implementation protocols; and (e) issuing DPH identification cards to approved applicants and designated primary caregivers. (§ 11362.71(b).)

Participation by patients and primary caregivers in the identification card program is voluntary. However, because identification cards offer the holder protection from arrest, are issued only after verification of the cardholder's status as a qualified patient or primary caregiver, and are immediately verifiable online or via telephone, they represent one of the best ways to ensure the security and non-diversion of marijuana grown for medical use.

In addition to establishing the identification card program, the MMP also defines certain terms, sets possession guidelines for cardholders, and recognizes a qualified right to collective and cooperative cultivation of medical marijuana. (§§ 11362.7, 11362.77, 11362.775.)

D. Taxability of Medical Marijuana Transactions.

In February 2007, the California State Board of Equalization (BOE) issued a Special Notice confirming its policy of taxing medical marijuana transactions, as well as its requirement that businesses engaging in such transactions hold a Seller's Permit. (http://www.boe.ca.gov/news/pdf/medseller2007.pdf.) According to the Notice, having a Seller's Permit does not allow individuals to make unlawful sales, but instead merely provides a way to remit any sales and use taxes due. BOE further clarified its policy in a

June 2007 Special Notice that addressed several frequently asked questions concerning taxation of medical marijuana transactions. (http://www.boe.ca.gov/news/pdf/173.pdf.)

E. Medical Board of California.

The Medical Board of California licenses, investigates, and disciplines California physicians. (Bus. & Prof. Code, § 2000, et seq.) Although state law prohibits punishing a physician simply for recommending marijuana for treatment of a serious medical condition (§ 11362.5(c)), the Medical Board can and does take disciplinary action against physicians who fail to comply with accepted medical standards when recommending marijuana. In a May 13, 2004 press release, the Medical Board clarified that these accepted standards are the same ones that a reasonable and prudent physician would follow when recommending or approving any medication. They include the following:

1. Taking a history and conducting a good faith examination of the patient;
2. Developing a treatment plan with objectives;
3. Providing informed consent, including discussion of side effects;
4. Periodically reviewing the treatment's efficacy;
5. Consultations, as necessary; and
6. Keeping proper records supporting the decision to recommend the use of medical marijuana.

(http://www.mbc.ca.gov/board/media/releases_2004_05-13_marijuana.html.)

Complaints about physicians should be addressed to the Medical Board (1-800-633-2322 or www.mbc.ca.gov), which investigates and prosecutes alleged licensing violations in conjunction with the Attorney General's Office.

F. The Federal Controlled Substances Act.

Adopted in 1970, the Controlled Substances Act (CSA) established a federal regulatory system designed to combat recreational drug abuse by making it unlawful to manufacture, distribute, dispense, or possess any controlled substance. (21 U.S.C. § 801, et seq.; *Gonzales v. Oregon* (2006) 546 U.S. 243, 271-273.) The CSA reflects the federal government's view that marijuana is a drug with "no currently accepted medical use." (21 U.S.C. § 812(b)(1).) Accordingly, the manufacture, distribution, or possession of marijuana is a federal criminal offense. (*Id.* at §§ 841(a)(1), 844(a).)

The incongruity between federal and state law has given rise to understandable confusion, but no legal conflict exists merely because state law and federal law treat marijuana differently. Indeed, California's medical marijuana laws have been challenged unsuccessfully in court on the ground that they are preempted by the CSA. (*County of San Diego v. San Diego NORML* (July 31, 2008) --- Cal.Rptr.3d ---, 2008 WL 2930117.) Congress has provided that states are free to regulate in the area of controlled substances, including marijuana, provided that state law does not positively conflict with the CSA. (21 U.S.C. § 903.) Neither Proposition 215, nor the MMP, conflict with the CSA because, in adopting these laws, California did not "legalize" medical marijuana, but instead exercised the state's reserved powers to not punish certain marijuana offenses under state law when a physician has recommended its use to treat a serious medical condition. (See *City of Garden Grove v. Superior Court (Kha)* (2007) 157 Cal.App.4th 355, 371-373, 381-382.)

In light of California's decision to remove the use and cultivation of physician-recommended marijuana from the scope of the state's drug laws, this Office recommends that state and local law enforcement officers not arrest individuals or seize marijuana under federal law when the officer determines from the facts available that the cultivation, possession, or transportation is permitted under California's medical marijuana laws.

II. DEFINITIONS

A. **Physician's Recommendation:** Physicians may not prescribe marijuana because the federal Food and Drug Administration regulates prescription drugs and, under the CSA, marijuana is a Schedule I drug, meaning that it has no recognized medical use. Physicians may, however, lawfully issue a verbal or written recommendation under California law indicating that marijuana would be a beneficial treatment for a serious medical condition. (§ 11362.5(d); *Conant v. Walters* (9th Cir. 2002) 309 F.3d 629, 632.)

B. **Primary Caregiver:** A primary caregiver is a person who is designated by a qualified patient and "has consistently assumed responsibility for the housing, health, or safety" of the patient. (§ 11362.5(e).) California courts have emphasized the consistency element of the patient-caregiver relationship. Although a "primary caregiver who consistently grows and supplies . . . medicinal marijuana for a section 11362.5 patient is serving a health need of the patient," someone who merely maintains a source of marijuana does not automatically become the party "who has consistently assumed responsibility for the housing, health, or safety" of that purchaser. (*People ex rel. Lungren v. Peron* (1997) 59 Cal.App.4th 1383, 1390, 1400.) A person may serve as primary caregiver to "more than one" patient, provided that the patients and caregiver all reside in the same city or county. (§ 11362.7(d)(2).) Primary caregivers also may receive certain compensation for their services. (§ 11362.765(c) ["A primary caregiver who receives compensation for actual expenses, including reasonable compensation incurred for services provided . . . to enable [a patient] to use marijuana under this article, or for payment for out-of-pocket expenses incurred in providing those services, or both, . . . shall not, on the sole basis of that fact, be subject to prosecution" for possessing or transporting marijuana].)

C. **Qualified Patient:** A qualified patient is a person whose physician has recommended the use of marijuana to treat a serious illness, including cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief. (§ 11362.5(b)(1)(A).)

D. **Recommending Physician:** A recommending physician is a person who (1) possesses a license in good standing to practice medicine in California; (2) has taken responsibility for some aspect of the medical care, treatment, diagnosis, counseling, or referral of a patient; and (3) has complied with accepted medical standards (as described by the Medical Board of California in its May 13, 2004 press release) that a reasonable and prudent physician would follow when recommending or approving medical marijuana for the treatment of his or her patient.

III. GUIDELINES REGARDING INDIVIDUAL QUALIFIED PATIENTS AND PRIMARY CAREGIVERS

A. State Law Compliance Guidelines.

1. **Physician Recommendation**: Patients must have a written or verbal recommendation for medical marijuana from a licensed physician. (§ 11362.5(d).)

2. **State of California Medical Marijuana Identification Card**: Under the MMP, qualified patients and their primary caregivers may voluntarily apply for a card issued by DPH identifying them as a person who is authorized to use, possess, or transport marijuana grown for medical purposes. To help law enforcement officers verify the cardholder's identity, each card bears a unique identification number, and a verification database is available online (www.calmmp.ca.gov). In addition, the cards contain the name of the county health department that approved the application, a 24-hour verification telephone number, and an expiration date. (§§ 11362.71(a); 11362.735(a)(3)-(4); 11362.745.)

3. **Proof of Qualified Patient Status**: Although verbal recommendations are technically permitted under Proposition 215, patients should obtain and carry written proof of their physician recommendations to help them avoid arrest. A state identification card is the best form of proof, because it is easily verifiable and provides immunity from arrest if certain conditions are met (see section III.B.4, below). The next best forms of proof are a city- or county-issued patient identification card, or a written recommendation from a physician.

4. **Possession Guidelines**:

a) **MMP**:[2] Qualified patients and primary caregivers who possess a state-issued identification card may possess 8 oz. of dried marijuana, and may maintain no more than 6 mature or 12 immature plants per qualified patient. (§ 11362.77(a).) But, if "a qualified patient or primary caregiver has a doctor's recommendation that this quantity does not meet the qualified patient's medical needs, the qualified patient or primary caregiver may possess an amount of marijuana consistent with the patient's needs." (§ 11362.77(b).) Only the dried mature processed flowers or buds of the female cannabis plant should be considered when determining allowable quantities of medical marijuana for purposes of the MMP. (§ 11362.77(d).)

b) **Local Possession Guidelines:** Counties and cities may adopt regulations that allow qualified patients or primary caregivers to possess

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[2] On May 22, 2008, California's Second District Court of Appeal severed Health & Safety Code § 11362.77 from the MMP on the ground that the statute's possession guidelines were an unconstitutional amendment of Proposition 215, which does not quantify the marijuana a patient may possess. (See *People v. Kelly* (2008) 163 Cal.App.4th 124. 77 Cal.Rptr.3d 390.) The Third District Court of Appeal recently reached a similar conclusion in *People v. Phomphakdy* (July 31, 2008) --- Cal.Rptr.3d ---, 2008 WL 2931369. The California Supreme Court has granted review in *Kelly* and the Attorney General intends to seek review in *Phomphakdy*.

medical marijuana in amounts that exceed the MMP's possession guidelines. (§ 11362.77(c).)

c) **Proposition 215**: Qualified patients claiming protection under Proposition 215 may possess an amount of marijuana that is "reasonably related to [their] current medical needs." (*People v. Trippet* (1997) 56 Cal.App.4th 1532, 1549.)

B. **Enforcement Guidelines.**

1. **Location of Use**: Medical marijuana may not be smoked (a) where smoking is prohibited by law, (b) at or within 1000 feet of a school, recreation center, or youth center (unless the medical use occurs within a residence), (c) on a school bus, or (d) in a moving motor vehicle or boat. (§ 11362.79.)

2. **Use of Medical Marijuana in the Workplace or at Correctional Facilities:** The medical use of marijuana need not be accommodated in the workplace, during work hours, or at any jail, correctional facility, or other penal institution. (§ 11362.785(a); *Ross v. RagingWire Telecomms., Inc.* (2008) 42 Cal.4th 920, 933 [under the Fair Employment and Housing Act, an employer may terminate an employee who tests positive for marijuana use].)

3. **Criminal Defendants, Probationers, and Parolees:** Criminal defendants and probationers may request court approval to use medical marijuana while they are released on bail or probation. The court's decision and reasoning must be stated on the record and in the minutes of the court. Likewise, parolees who are eligible to use medical marijuana may request that they be allowed to continue such use during the period of parole. The written conditions of parole must reflect whether the request was granted or denied. (§ 11362.795.)

4. **State of California Medical Marijuana Identification Cardholders**: When a person invokes the protections of Proposition 215 or the MMP and he or she possesses a state medical marijuana identification card, officers should:

a) Review the identification card and verify its validity either by calling the telephone number printed on the card, or by accessing DPH's card verification website (http://www.calmmp.ca.gov); and

b) If the card is valid and not being used fraudulently, there are no other indicia of illegal activity (weapons, illicit drugs, or excessive amounts of cash), and the person is within the state or local possession guidelines, the individual should be released and the marijuana should not be seized. Under the MMP, "no person or designated primary caregiver in possession of a valid state medical marijuana identification card shall be subject to arrest for possession, transportation, delivery, or cultivation of medical marijuana." (§ 11362.71(e).) Further, a "state or local law enforcement agency or officer shall not refuse to accept an identification card issued by the department unless the state or local law enforcement agency or officer

has reasonable cause to believe that the information contained in the card is false or fraudulent, or the card is being used fraudulently." (§ 11362.78.)

5. **Non-Cardholders:** When a person claims protection under Proposition 215 or the MMP and only has a locally-issued (i.e., non-state) patient identification card, or a written (or verbal) recommendation from a licensed physician, officers should use their sound professional judgment to assess the validity of the person's medical-use claim:

a) Officers need not abandon their search or investigation. The standard search and seizure rules apply to the enforcement of marijuana-related violations. Reasonable suspicion is required for detention, while probable cause is required for search, seizure, and arrest.

b) Officers should review any written documentation for validity. It may contain the physician's name, telephone number, address, and license number.

c) If the officer reasonably believes that the medical-use claim is valid based upon the totality of the circumstances (including the quantity of marijuana, packaging for sale, the presence of weapons, illicit drugs, or large amounts of cash), and the person is within the state or local possession guidelines or has an amount consistent with their current medical needs, the person should be released and the marijuana should not be seized.

d) Alternatively, if the officer has probable cause to doubt the validity of a person's medical marijuana claim based upon the facts and circumstances, the person may be arrested and the marijuana may be seized. It will then be up to the person to establish his or her medical marijuana defense in court.

e) Officers are not obligated to accept a person's claim of having a verbal physician's recommendation that cannot be readily verified with the physician at the time of detention.

6. **Exceeding Possession Guidelines**: If a person has what appears to be valid medical marijuana documentation, but exceeds the applicable possession guidelines identified above, all marijuana may be seized.

7. **Return of Seized Medical Marijuana:** If a person whose marijuana is seized by law enforcement successfully establishes a medical marijuana defense in court, or the case is not prosecuted, he or she may file a motion for return of the marijuana. If a court grants the motion and orders the return of marijuana seized incident to an arrest, the individual or entity subject to the order must return the property. State law enforcement officers who handle controlled substances in the course of their official duties are immune from liability under the CSA. (21 U.S.C. § 885(d).) Once the marijuana is returned, federal authorities are free to exercise jurisdiction over it. (21 U.S.C. §§ 812(c)(10), 844(a); *City of Garden Grove v. Superior Court (Kha)* (2007) 157 Cal.App.4th 355, 369, 386, 391.)

IV. GUIDELINES REGARDING COLLECTIVES AND COOPERATIVES

Under California law, medical marijuana patients and primary caregivers may "associate within the State of California in order collectively or cooperatively to cultivate marijuana for medical purposes." (§ 11362.775.) The following guidelines are meant to apply to qualified patients and primary caregivers who come together to collectively or cooperatively cultivate physician-recommended marijuana.

A. Business Forms: Any group that is collectively or cooperatively cultivating and distributing marijuana for medical purposes should be organized and operated in a manner that ensures the security of the crop and safeguards against diversion for non-medical purposes. The following are guidelines to help cooperatives and collectives operate within the law, and to help law enforcement determine whether they are doing so.

1. **Statutory Cooperatives:** A cooperative must file articles of incorporation with the state and conduct its business for the mutual benefit of its members. (Corp. Code, § 12201, 12300.) No business may call itself a "cooperative" (or "co-op") unless it is properly organized and registered as such a corporation under the Corporations or Food and Agricultural Code. (*Id.* at § 12311(b).) Cooperative corporations are "democratically controlled and are not organized to make a profit for themselves, as such, or for their members, as such, but primarily for their members as patrons." (*Id.* at § 12201.) The earnings and savings of the business must be used for the general welfare of its members or equitably distributed to members in the form of cash, property, credits, or services. (*Ibid.*) Cooperatives must follow strict rules on organization, articles, elections, and distribution of earnings, and must report individual transactions from individual members each year. (See *id.* at § 12200, et seq.) Agricultural cooperatives are likewise nonprofit corporate entities "since they are not organized to make profit for themselves, as such, or for their members, as such, but only for their members as producers." (Food & Agric. Code, § 54033.) Agricultural cooperatives share many characteristics with consumer cooperatives. (See, e.g., *id.* at § 54002, et seq.) Cooperatives should not purchase marijuana from, or sell to, non-members; instead, they should only provide a means for facilitating or coordinating transactions between members.

2. **Collectives:** California law does not define collectives, but the dictionary defines them as "a business, farm, etc., jointly owned and operated by the members of a group." (*Random House Unabridged Dictionary*; Random House, Inc. © 2006.) Applying this definition, a collective should be an organization that merely facilitates the collaborative efforts of patient and caregiver members – including the allocation of costs and revenues. As such, a collective is not a statutory entity, but as a practical matter it might have to organize as some form of business to carry out its activities. The collective should not purchase marijuana from, or sell to, non-members; instead, it should only provide a means for facilitating or coordinating transactions between members.

B. **Guidelines for the Lawful Operation of a Cooperative or Collective:** Collectives and cooperatives should be organized with sufficient structure to ensure security, non-diversion of marijuana to illicit markets, and compliance with all state and local laws. The following are some suggested guidelines and practices for operating collective growing operations to help ensure lawful operation.

1. **Non-Profit Operation**: Nothing in Proposition 215 or the MMP authorizes collectives, cooperatives, or individuals to profit from the sale or distribution of marijuana. (See, e.g., § 11362.765(a) ["nothing in this section shall authorize . . . any individual or group to cultivate or distribute marijuana for profit"].

2. **Business Licenses, Sales Tax, and Seller's Permits**: The State Board of Equalization has determined that medical marijuana transactions are subject to sales tax, regardless of whether the individual or group makes a profit, and those engaging in transactions involving medical marijuana must obtain a Seller's Permit. Some cities and counties also require dispensing collectives and cooperatives to obtain business licenses.

3. **Membership Application and Verification**: When a patient or primary caregiver wishes to join a collective or cooperative, the group can help prevent the diversion of marijuana for non-medical use by having potential members complete a written membership application. The following application guidelines should be followed to help ensure that marijuana grown for medical use is not diverted to illicit markets:

a) Verify the individual's status as a qualified patient or primary caregiver. Unless he or she has a valid state medical marijuana identification card, this should involve personal contact with the recommending physician (or his or her agent), verification of the physician's identity, as well as his or her state licensing status. Verification of primary caregiver status should include contact with the qualified patient, as well as validation of the patient's recommendation. Copies should be made of the physician's recommendation or identification card, if any;

b) Have the individual agree not to distribute marijuana to non-members;

c) Have the individual agree not to use the marijuana for other than medical purposes;

d) Maintain membership records on-site or have them reasonably available;

e) Track when members' medical marijuana recommendation and/or identification cards expire; and

f) Enforce conditions of membership by excluding members whose identification card or physician recommendation are invalid or have expired, or who are caught diverting marijuana for non-medical use.

4. **Collectives Should Acquire, Possess, and Distribute Only Lawfully Cultivated Marijuana**: Collectives and cooperatives should acquire marijuana only from their constituent members, because only marijuana grown by a qualified patient or his or her primary caregiver may lawfully be transported by, or distributed to, other members of a collective or cooperative. (§§ 11362.765, 11362.775.) The collective or cooperative may then allocate it to other members of the group. Nothing allows marijuana to be purchased from outside the collective or cooperative for distribution to its members. Instead, the cycle should be a closed-circuit of marijuana cultivation and consumption with no purchases or sales to or from non-members. To help prevent diversion of medical marijuana to non-medical markets, collectives and cooperatives should document each member's contribution of labor, resources, or money to the enterprise. They also should track and record the source of their marijuana.

5. **Distribution and Sales to Non-Members are Prohibited**: State law allows primary caregivers to be reimbursed for certain services (including marijuana cultivation), but nothing allows individuals or groups to sell or distribute marijuana to non-members. Accordingly, a collective or cooperative may not distribute medical marijuana to any person who is not a member in good standing of the organization. A dispensing collective or cooperative may credit its members for marijuana they provide to the collective, which it may then allocate to other members. (§ 11362.765(c).) Members also may reimburse the collective or cooperative for marijuana that has been allocated to them. Any monetary reimbursement that members provide to the collective or cooperative should only be an amount necessary to cover overhead costs and operating expenses.

6. **Permissible Reimbursements and Allocations:** Marijuana grown at a collective or cooperative for medical purposes may be:

a) Provided free to qualified patients and primary caregivers who are members of the collective or cooperative;
b) Provided in exchange for services rendered to the entity;
c) Allocated based on fees that are reasonably calculated to cover overhead costs and operating expenses; or
d) Any combination of the above.

7. **Possession and Cultivation Guidelines**: If a person is acting as primary caregiver to more than one patient under section 11362.7(d)(2), he or she may aggregate the possession and cultivation limits for each patient. For example, applying the MMP's basic possession guidelines, if a caregiver is responsible for three patients, he or she may possess up to 24 oz. of marijuana (8 oz. per patient) and may grow 18 mature or 36 immature plants. Similarly, collectives and cooperatives may cultivate and transport marijuana in aggregate amounts tied to its membership numbers. Any patient or primary caregiver exceeding individual possession guidelines should have supporting records readily available when:

a) Operating a location for cultivation;
b) Transporting the group's medical marijuana; and
c) Operating a location for distribution to members of the collective or cooperative.

8. **Security**: Collectives and cooperatives should provide adequate security to ensure that patients are safe and that the surrounding homes or businesses are not negatively impacted by nuisance activity such as loitering or crime. Further, to maintain security, prevent fraud, and deter robberies, collectives and cooperatives should keep accurate records and follow accepted cash handling practices, including regular bank runs and cash drops, and maintain a general ledger of cash transactions.

C. **Enforcement Guidelines**: Depending upon the facts and circumstances, deviations from the guidelines outlined above, or other indicia that marijuana is not for medical use, may give rise to probable cause for arrest and seizure. The following are additional guidelines to help identify medical marijuana collectives and cooperatives that are operating outside of state law.

1. **Storefront Dispensaries:** Although medical marijuana "dispensaries" have been operating in California for years, dispensaries, as such, are not recognized under the law. As noted above, the only recognized group entities are cooperatives and collectives. (§ 11362.775.) It is the opinion of this Office that a properly organized and operated collective or cooperative that dispenses medical marijuana through a storefront may be lawful under California law, but that dispensaries that do not substantially comply with the guidelines set forth in sections IV(A) and (B), above, are likely operating outside the protections of Proposition 215 and the MMP, and that the individuals operating such entities may be subject to arrest and criminal prosecution under California law. For example, dispensaries that merely require patients to complete a form summarily designating the business owner as their primary caregiver – and then offering marijuana in exchange for cash "donations" – are likely unlawful. (*Peron, supra*, 59 Cal.App.4th at p. 1400 [cannabis club owner was not the primary caregiver to thousands of patients where he did not consistently assume responsibility for their housing, health, or safety].)

2. **Indicia of Unlawful Operation:** When investigating collectives or cooperatives, law enforcement officers should be alert for signs of mass production or illegal sales, including (a) excessive amounts of marijuana, (b) excessive amounts of cash, (c) failure to follow local and state laws applicable to similar businesses, such as maintenance of any required licenses and payment of any required taxes, including sales taxes, (d) weapons, (e) illicit drugs, (f) purchases from, or sales or distribution to, non-members, or (g) distribution outside of California.

Attachment 5

LOS ANGELES COUNTY DISTRICT ATTORNEY'S OFFICE
MEDIA RELATIONS DIVISION

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Medical marijuana statement Oct. 8, 2009
Quiet Cannon Restaurant, Montebello

Law enforcement and prosecutors are sworn to uphold the law as it is written.

What the voters approved in Proposition 215 was to allow the use of marijuana for those seriously ill and with a legitimate doctor's recommendation. Law enforcement recognizes and responds to the compassionate cases and the law that makes medical marijuana available to those qualified to receive it.

Prop. 215 did not and does not provide for over-the-counter sales of marijuana for profit. As law enforcement officers and prosecutors, it is our job to ensure that the law is followed as written and approved by California voters. Current and future enforcement and prosecutions actions are directed at illegal over-the-counter sales for profit operations.

sg

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Attachment 6

HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT (HIPAA)

The *Health Insurance Portability and Accountability Act (HIPAA)* is a federal law enacted in 1996 to, in part, address security and privacy issues related to patient health data. The *HIPAA* Privacy Rule, which took effect on April 14, 2003, regulates use and disclosure of patient medical records and payment histories maintained by "covered entities" including health plans, insurance companies, and health care providers including doctors, clinics, hospitals, psychologists, chiropractors, nursing homes, pharmacies and dentists. Yet, does *HIPAA* apply to medical marijuana collectives and cooperatives?

The Federal Department of Health and Human Services developed Administrative Simplification Standards to determine whether an organization or individual meets *HIPAA* criteria for "covered entities." A *HIPAA* covered entity must be a natural person, business or government agency that furnishes, bills or receives payment for, health care in the normal course of business. Because medical marijuana collectives and cooperatives fail to meet these standards, they are not deemed a *HIPAA* covered health care provider. Moreover, because marijuana remains an illegal drug that is indisputably illegal to possess or sell under Federal law, it is unlikely that Federal HIPAA Privacy Rules would apply to medical marijuana collectives/cooperatives. Further, under California law, collectives and cooperatives are not licensed by the State as Health Care Providers, and therefore do not qualify as "covered entities" under HIPAA, and therefore the privacy provisions of HIPAA are not applicable to medical marijuana.