MEDICAL NECESSITY DEFENSE IN CANNABIS PROSECUTIONS
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Presented by:

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I. It’s a drug case.

• Is it plead properly?
• Is the evidence admissible?

II. Where Am I?

Crux of the biscuit:

What is legally provable we admit, and assert we had no other choice. We are not guilty, but if convicted, our medical necessity so mitigates the offense as to support a sanction of no sanction.

In this sense, it is functionally a justification or choice of evils defense. The law on the availability of this defense varies jurisdiction to jurisdiction.

List of Medical Necessity Statutes and Caselaw online here:

<http://www.norml.org/index.cfm?Group_ID=5814>

If not available, try the Governor Reagan defense -> Vote with your feet!

excerpt from Washburn v. Columbia Forest Products Inc. (Merits Brief of Amici Curiae Oregon ACLU, NORML and ASA)(Filed October 26, 2005, with the Oregon Supreme Court) concerning availability of defense in Federal court:

C. Columbia Forest Products and its amici misunderstand the import of the United States Supreme Court decisions regarding state medical marijuana laws.

In its merits brief, Columbia Forest Products asserts that ‘[a]fter the Supreme Court’s decision in Gonzales v. Raich, ____ US ____, 125 S Ct 2195 (2005), it can no longer be doubted that even the purely intrastate cultivation, possession and use of marijuana for personal medical use is illegal under federal drug laws.” Petitioner’s Merit’s Brief at 7.
Their *amici* cite to *United States v. Oakland Cannabis Buyers’ Cooperative and Jeff Jones, et. al.*, 532 US 483, 121 S Ct 1711, 149 L Ed 2d 722 (2001) for the proposition that a medical necessity defense is unavailable as against a prosecution under the federal Controlled Substances Act (CSA). Neither assertion is completely accurate.

In *Raich*, the limited holding is that application of SCA provisions criminalizing manufacture, distribution, or possession of marijuana to intrastate growers and users of marijuana for medical purposes does not violate the Commerce Clause. At least one commentator\(^1\) has explained that all the Court did was remove this one defense (no commerce clause authority to enact) from the list of possible defenses to a federal prosecution under the CSA. Similarly, in the *Oakland CBC* case, the government had used the injunction power of the CSA to enjoin the distribution of therapeutic cannabis. The Ninth Circuit Court of Appeals reversed the injunction (190 F3d 1109 (1999) holding that the distributors had a medical necessity defense. The Supreme Court reversed the Ninth Circuit but, as the concurring opinion points out “Most notably, whether the defense might be available to a seriously ill patient for whom there is no alternative means of avoiding starvation or extraordinary suffering is a difficult issue that is not presented here.” 532 US 483 at 501, 149 L Ed 2d 722 at 738.

In *Raich*, the Court expressly acknowledged that

\(^{1}\) Oregon Assistant Attorney General Steven Bushong (speaking for himself, and not on behalf of the Attorney General), Oregon State Bar Health Law Section Brown Bag Lunch CLE “Medical Marijuana Legal Update” Noon, August 3, 2005, 208 Multnomah County Courthouse, Portland.
evidence proffered by respondents in this case regarding the effective medical uses for marijuana, if found credible after trial, would cast serious doubt on the accuracy of the findings that require marijuana to be listed in Schedule I. See, e.g., Institute of Medicine, Marijuana and Medicine: Assessing the Science Base 179 (J. Joy, S. Watson & J. Benson eds. 1999) (recognizing that “[s]cientific date indicate the potential therapeutic value of cannabinoid drugs, primarily THC (Tetrahydrocannabinol] for pain relief, control of nausea and vomiting, and appetite stimulation”); see also Conant v. Walters, 309 F3d 629, 640-643 (C.A.9 2002)(Kozinski, J., concurring)(chronicling medical studies recognizing valid medical uses for marijuana and its derivatives).

125 S Ct at 2211, n. 37.

Acknowledging the therapeutic use of medicinal cannabis is the condition precedent to authorizing a medical necessity defense.

III. Why they fight so hard to deny us the opportunity to present the defense.

- Polling from Measure 33 campaign
- Other national polling
- Recent victories in Michigan
- Montel Williams on Joe Scarborough (video)

IV. Where’s the science?

Affidavit of Dr. Lester Grinspoon in Canadian Constitutional challenge to Cannabis Prohibition in Canada

URL: http://www.mapinc.org/drugnews/v97/n000/a005.html

Newshawk: Richard Lake rlake@mapinc.org
Pubdate: 26 Mar 1997
Source: Chris Clay
Author: Dr. Lester Grinspoon
Note: MAP is archiving each of the affidavits filed in the Chris Clay Constitutional Challenge to preserve these important documents.
ONTARIO COURT (GENERAL DIVISION)
(Southwest Region)

BETWEEN:

HER MAJESTY THE QUEEN
Respondent

-and-

CHRISTOPHER CLAY
Applicant

AFFIDAVIT OF DR LESTER GRINSPOON

I, LESTER GRINSPOON M.D., of the City of Boston in the State of Massachusetts, MAKE OATH AND SAY AS FOLLOWS:

1. I am currently an Associate Professor of Psychiatry at the Harvard Medical School in Boston and have been a professor at Harvard since 1973. I have written approximately 29 articles on various aspects of the use of cannabis, and I have been studying the social and medical aspects of cannabis use since 1967. In addition, I have authored two books on cannabis; namely, Marihuana Reconsidered (1971, Harvard University Press. 1st ed.; 1977, 2nd ed.; classic ed. 1994) and Marihuana... The Forbidden Medicine (1993, Yale University Press). My book, Marihuana: The Forbidden Medicine has been translated into eight languages. In 1990, I was awarded the Alfred Lindesmith Award for Achievement in the Field of Scholarship. Attached hereto as Exhibit "A" is a true copy of my curriculum vitae. Attached hereto as Exhibit "B" are copies of the two books noted in this paragraph.

2. In addition to my publications on the use of cannabis, I have had occasion to testify before the National Marihuana Commission (1972), the House Select Commission on Narcotics (1977, 1978, 1979), the Controlled Substances Advisory Committee and the Drug Abuse Research Advisory Committee (1978). Additionally, in 1975, I testified before the Alaska Supreme Court in Ravin v. State 537 P.2d 494 (1975). In that case, the Alaska Supreme Court concluded that possession of marihuana by adults for personal use is constitutionally protected. In making its decision, the Court took into consideration the information provided in my book, Marihuana Reconsidered.
3. It is believed that Cannabis sativa has been cultivated for over 10,000 years. There is definitive proof that it was cultivated in China by 4,000 B.C. and in Turkestan by 3,000 B.C. It has long been used as a medicine in India, China, the Middle-East, South-East Asia, South-East Africa and South America. The first evidence of medicinal use is in a document entitled Herbal (an ancient equivalent of the US. Pharmacopoeia) that was published during the reign of the Chinese Emperor Chen Nung five thousand years ago. Herbal recommended cannabis sativa for malaria, constipation, rheumatic pains, absent-mindedness and female disorders. Another Chinese Herbal recommended a mixture of hemp, resin and wine as an analgesic during surgery. In India, cannabis was recommended to quicken the mind, lower fevers, induce sleep, cure dysentery, stimulate appetite, improve digestion, relieve headaches and cure venereal disease. In Africa, it was used for dysentery, malaria and other fevers. Cannabis was also considered to be a remedy by Galen and other physicians of the classical and Hellenistic eras. It was also highly valued in medieval Europe.

4. Definitively labeled Cannabis Sativa by Linnaeus in 1753, the plant is in most parts of the world better known by its popular name, Indian Hemp. This plant, and its fibre, were widely used in Europe for industrial purposes. The pharmacological properties of the plant were largely unknown in Western medicine until various physicians started to recommend its use for medicinal purposes in the 19th century. These physicians had taken note of its medicinal use in other parts of the world. Eventually, it appeared as a reliable therapeutic in the US. Pharmacopoeia and the National Formulary and, until 1937, tincture of cannabis could be prescribed by physicians as a remedy for a variety of ailments. It was ultimately removed from the US. Pharmacopoeia in 1941.

5. It was during this century that cannabis lost its appeal as a medicinal product. This was largely a result of the development of apparently suitable alternatives, such as the hypodermic needle, water-soluble analgesics and synthetic hypnotics. In addition, after the passage of the Marihuana Tax Act in 1937, it became increasingly difficult for physicians to prescribe cannabis.

6. Through the 19th century and the early part of the 20th century, cannabis was primarily used for medicinal purposes. In the 19th century, cannabis was the subject of experimentation among the literary giants of France and England, including Baudelaire, Gautier, Balzac and Hugo. In the 1840s, these writers founded Le Club de Hachichins in which these writers would ingest hashish brought from Egypt and then record their observations on how this substance affected their literary muse. In America, its recreational use was limited to a small group of jazz musicians and itinerant Mexican workers crossing the border from Mexico into Texas. By the 1930's, national newspapers carried horror-filled stories of the "Marihuana Menace" - this caused a great deal of consternation because the substance was being used almost exclusively by minority groups (i.e. Mexican immigrants and African-American jazz...
musicians). As a result, cannabis became the subject of criminal sanction in most states through the 1920's and 1930's.

7. When cannabis became the subject of criminal sanction in the 1920's and 1930's, there were little or no clinical studies indicating that cannabis was harmful to the body or mind. I have reviewed and analyzed the various studies conducted in the intervening years, and, in my opinion, there is no sound scientific evidence that chronic use of cannabis does any serious damage to the body or the mind. Among the psychoactive drugs available, cannabis seems to be the least dangerous. The only well-documented adverse effects common to the prolonged use of marihuana are related to residual substances in the smoke and not to the drug itself. The question remains whether some pathology has been ignored either because it is too subtle to be detected, even with modern laboratory techniques, or because it is too rare to be uncovered without full-scale epidemiological analysis. In my opinion, the search for damaging effects of marihuana has been more of a fishing expedition and less of an attempt to scientifically validate a causal connection with an observed clinical abnormality. A summary of my review of the existing clinical studies on medical harm is found in Chapter 14 of my book, Marihuana Reconsidered.

8. With respect to the claim that marihuana is addictive, there is no longer any doubt that marihuana is not a drug of addiction. Studies have indicated that the use of cannabis does not give rise to biological or physiological dependence and that the discontinuance of the drug does not result in withdrawal symptoms. The World Health Organization's Expert Committee of Drugs Liable to Produce Addiction, has revised its views on addiction and has re-written its definition in terms of "drug dependence". According to the W.H.O., the characteristics of an addictive substance are

1) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means;
2) a tendency to increase the dose; and
3) a psychological, and sometime a physical, dependence on the effects of the drug.

Cannabis does not exhibit any of these characteristics; however, the claim has been made that cannabis, although not physically addictive, can result in a psychological dependency. In my view, the concept of psychological dependence is so vague and ill defined that it is as applicable to the consumption of a psychoactive substance as it is to a person's strong attachment to a car, a pair of trousers or a spouse. A summary of my review of the existing clinical studies on addiction is found in Chapter 9 of my book, Marihuana Reconsidered.

9. In regards to the claim that marihuana is a "stepping stone" or "gateway" drug leading to the use of more dangerous psychoactive substances, there is absolutely no evidence that any

The National Organization for the Reform of Marijuana Laws (www.norml.org)

12/7/2005
property of marihuana produces a particular susceptibility to heroin addiction or that marihuana users tend to graduate to heroin abuse. There is simply no valid evidence of anything inherent in cannabis, or in cannabis use, which would make the marihuana user more likely to become a heroin or other opiate user.

Marihuana is, so far as has been determined, only a precursor of further marihuana use. A summary of my review of the existing clinical studies on the "gateway" theory is found in Chapter 9 of my book, Marihuana Reconsidered.

10. With respect to the claim that marihuana use is criminogenic, the contention that marihuana use causes crime has now been thoroughly discredited, presumably beyond hope of revival. There is no convincing evidence that the pharmacological properties of marihuana incite or enhance human aggression. In fact, the pharmacological properties of marihuana tend to manifest itself in passive behaviour, introspection, tendency to hilarity and sensory enhancement. The notion that marihuana leads to aggressive and violent behaviour was largely a product of misinformation disseminated by law enforcement agencies given responsibility to enforce the prohibition in the 1930's and 1940's. A summary of my review of the existing clinical studies on the relationship between marihuana use and crime is found in Chapters 11 and 14 of my book, Marihuana Reconsidered.

11. With respect to the claim that marihuana can induce psychoses, there is no convincing evidence that marihuana use is causally related to the development of mental disorder. In the few studies in which marihuana use appeared to result in psychotic behaviour, it is apparent that many of these individuals who demonstrated psychotic behaviour were suffering from a pre-existing mental disorder. It seems clear that among populations of illicit drug users there will be found more psychopathology than among nonusers. However, the critical questions are (1) whether the drug use comes before the psychopathology and, if it does, whether it is causally related to the development of the psychopathology (either as a precipitating factor or a synergistic one), and (2) whether the drug use is completely independent of the psychopathology or, at the most, an expression of it. In fact, there is evidence that marihuana use is not psychologically destructive, but rather restitutive; that is, individuals have consumed marihuana as a mechanism for dealing with conflict, anxiety and depression. A summary of the existing clinical studies on the relationship between marihuana use and psychoses is found in Chapter 10 of my book, Marihuana Reconsidered.

12. There has never been a death directly attributable to the consumption of marihuana. After five thousand years of cannabis use by hundreds of millions of people throughout the world, there is no credible evidence that this drug has caused a single death. The lethality of drugs is ordinarily measured by a value called the "LD50", the dose that will cause 50 percent of
animals or human beings taking it to die. The LD50 for cannabis in human beings is not known, because there are no data from which it can be derived.

13. It appears that for the most part of this century the medical dangers of marihuana have been vastly overstated, while the medical value of this substance has been grossly understated and ignored. There is now a growing body of evidence indicating that consumption of marihuana is a medically valuable treatment:

1) as an anti-emetic to control nausea and vomiting associated with cancer chemotherapy;

2) as an anti-emetic to control nausea and vomiting associated with the use of drugs employed to control the spread of the AIDS virus (marihuana allows AIDS patients to take these drugs without the fear that these nausea-inducing drugs will be regurgitated prior to being absorbed by the body. It also retards or reverses the weight reduction syndrome of AIDS);

3) to control seizures in patients suffering from epilepsy;

4) to reduce intra-ocular pressure (i.e. pressure within the eyes) associated with glaucoma;

5) which alleviates muscle spasms associated with multiple sclerosis; and

6) which alleviates pain and muscle spasms for paraplegics and quadriplegics;

In addition, there is some evidence that marihuana may be medically useful as a bronchodilator in the treatment of asthma, as a hypnotic to combat insomnia, and as an antibacterial agent resistant to conventional antibiotics in the treatment of staphylococcus. There is also evidence that marihuana has tumour-reducing properties and that patients with idiopathic dystonia (a disorder characterized by spasms and abnormal muscle contractions) have improved their condition when smoking marihuana. A summary of the existing clinical studies and anecdotal evidence relating to the therapeutic value of marihuana can be found in my book, Marihuana: The Forbidden Medicine.

14. Although there is a growing body of evidence indicating that marihuana has multi-faceted use, as medicine, it is difficult to make definitive statements as a result of the fact that there is a paucity of funding for research on the medicinal value of cannabis. The government is not likely to fund many studies as this may be perceived as inconsistent with the policy of prohibition. Pharmaceutical companies are not likely to fund these
studies because marihuana, as an organic plant substance, cannot be the subject of a pharmaceutical patent. This lack of funding is most regrettable because marihuana as an effective treatment agent would not trigger the same deleterious side-effects associated with the use of conventional, synthetic drugs that patients would otherwise be forced to rely upon.

15. Despite the lack of funded medical research, in 1988 administrative law judge Francis J. Young reviewed the existing evidence and concluded that approval by a "significant minority" of physicians was enough to meet the standard of "currently accepted medical use in treatment in the United States" required by the Controlled Substances Act for a Schedule II drug. He added that marihuana, in its natural form, is one of the safest therapeutically active substances known to man. One must reasonably conclude that there is accepted safety for use of marihuana under medical supervision. To conclude otherwise, on the record would be unreasonable, arbitrary, and capricious." Young went on to recommend "that the Administrator [of the DEA] conclude that the marihuana plant considered as a whole has currently accepted medical use in treatment in the United States, that there is no lack of accepted safety for use of it under medical supervision and that it may lawfully be transferred from Schedule I [a drug with no medical use] to Schedule II [a drug with recognized medical use]." The DEA, however, disregarded the opinion of its own administrative law judge and refused to re-schedule cannabis. In 1991, the District of Columbia Court of Appeals ordered the DEA to re-examine its standards for reclassifying a drug as having medicinal value. The DEA issued a final rejection of all pleas for reclassification in March of 1992.

16. Since 1985, oncologists in the U.S. have been legally permitted to administer synthetic THC (the active ingredient in marihuana) orally in capsule form. The trade name is "Marinol". However, it is apparent that inhaled cannabis maybe preferable for a number of reasons. Oral THC is absorbed erratically and slowly into the bloodstream. Furthermore, a patient who is severely nauseated and constantly vomiting may find it almost impossible to keep the capsule digested until it activates. In addition, the effectiveness of THC is dependent on how much is absorbed into the blood stream; investigators have shown that smoked THC is absorbed more effectively. Most patients also prefer smoking marihuana to taking THC orally, as the latter makes them anxious and uncomfortable. One reason that the oral ingestion of THC makes patients anxious and uncomfortable is the difficulty of titrating the dose of oral THC to control the amount that reaches the blood and brain. In 1990, a survey of over 2,000 members of the American Society of Clinical Oncology found that only 43% were satisfied that the available legal anti-emetic drugs (including oral THC) provided adequate relief to all or most of their patients. On average, they considered smoked marihuana more effective than oral synthetic THC and roughly as safe.
17. While there can be no question that the use of psychoactive drugs may be harmful to the social fabric, the harm resulting from the use of marihuana is of a far lower order of magnitude than the harm caused by abuse of narcotics, alcohol, and other drugs. Marihuana itself is not criminogenic: it does not lead to sexual debauchery, it is not addictive, there is no evidence that it leads to the use of narcotics. It does not, under ordinary circumstances, leads to psychoses, and there is no convincing evidence that it causes personality deterioration. Even with respect to automobile driving, evidence exists that marijuana is less detrimental to this skill than alcohol. Marihuana use, even over a considerable period of time, does not lead to malnutrition or to any known organic illness. There is no evidence that mortality rates are any higher among users of marijuana than nonusers. In fact, relative to other psychoactive drugs, it is remarkably safe.

SWORN BEFORE ME )
at the City of Boston )
in the Commonwealth of Massachusetts, USA )
this 26th day )
of March, 1997 )

DR. LESTER GRINSPOON

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Medical Cannabis (Marijuana) Bibliography
(Note: Hypertext links are printed rather than buried in text to make the bibliography more meaningful when printed. Links to PDF files require Adobe® Reader™. For a free copy click here <http://www.adobe.com/products/acrobat/readstep.html>)

Books

Cannabis and Cannabinoids: Pharmacology, Toxicology, and Therapeutic Potential edited by Franjo Grotenhermen, MD and Ethan Russo, MD (Haworth Press 2002)
The Oregon Medical Marijuana Guide: A Resource for Patients & Health Care Providers by Ed Glick, RN (Contigo-Conmigo 2001). This is the most comprehensive guide to the Oregon Medical Marijuana Act. It is available online at www.or-coast.net/contigo/ <http://www.or-coast.net/contigo/> and for purchase on CD - ROM or paper.

Marijuana Myths, Marijuana Facts: A Review of the Scientific Evidence by Lynn Zimmer, PhD, and John Morgan, MD (The Lindesmith Center 1997) www.marijuanafacts.org/

Marijuana: The Forbidden Medicine by Lester Grinspoon, MD and James Bakalar, JD (Yale University Press 1997) 1-800-YUP- READ www.rxmarihuana.com/ 


Cancer Treatment & Marijuana Therapy edited by Robert Randall (Galen Press 1990)


Why Our Drug Laws Have Failed and What We Can Do About It: A Judicial Indictment of the War on Drugs by Judge James P. Gray (Temple Press 2001)

Drug Crazy: How We Got Into This Mess and How We Can Get Out by Mike Gray (Random House 1998)

Smoke and Mirrors: The War on Drugs and the Politics of Failure by Dan Baum (Little, Brown 1996)

From Chocolate to Morphine: Everything You Need to Know about Mind-Altering Drugs by Andrew Weil, MD and Jennifer Rosen (Houghton Mifflin 1983 and 1993)

Books not available in your local bookstore may be available through www.amazon.com <http://www.amazon.com/>

Scientific Articles Online


O'Shaughnessy's Journal of the California Cannabis Research Medical Group (CCRMG) www.ccrmg.org/journal.html <http://www.ccrmg.org/journal.html>

Vaporizers Reduce Toxins in Marijuana Smoke” by Dale Gieringer, PhD
www.canorml.org/healthfacts/vaporizers.html
Also see www.mikuriya.com/vaporize.html

― Cannabis is more than simply D 9 – tetrahydrocannabinol” by E Russo, J McPartland

“The Role of Cannabis and Cannabinoids in Pain Management” by Ethan Russo, MD. Chapter 31
from Pain Management: A Practical Guide for Clinicians edited by Richard S. Weiner, PhD (6th
www.montananorml.org/docs/Russo-AAPM_chapter.pdf

― Cannabis Treatments in Obstetrics and Gynecology: A Historical Review” by Ethan Russo. Journal

― Chronic Cannabis Use in the Compassionate Investigational New Drug Program: An Examination
of Benefits and Adverse Effects of Legal Clinical Cannabis” by Ethan Russo, Mary Lynn Mathre,
Al Byrne, Robert Velin, Paul Bach, Juan Sanchez-Ramos, and Kristin Kirlin. Journal of Cannabis

― Therapeutic Cannabis (Marijuana) as an Antiemetic and Appetite Stimulant in Persons with Human
Immunodeficiency Virus (AIDS)” by Richard Bayer, MD. Journal of Cannabis Therapeutics 1(3/4)

― Cannabis and Cannabis Extracts: Greater than the Sum of their Parts?” by McPartland & Russo J

Entire Charter Issue Online: Journal of Cannabis Therapeutics 1(1) 2001 www.cannabis-
med.org/jcant/Jcant1(1).pdf
This includes
― Marijuana (Cannabis) As Medicine” by Leo Hollister, MD and “Effects of Smoked Cannabis and
Oral D 9 Tetrahydrocannabinol on Nausea and Emesis After Cancer Chemotherapy: A Review of
State Clinical Trials” by Richard Musty and Rita Rossi.
― Marijuana Does Not Appear to Alter Viral Loads of HIV Patients Taking Protease Inhibitors” by
Trinkl, News Director. Source: Jeff Sheehy (415) 597-8165
www.ucsf.edu/pressrel/2000/07/071302.html

1999 National Academy of Sciences/ Institute of Medicine report: Marijuana and Medicine:
Assessing the Science Base edited by Janet Joy, Stanley Watson, Jr., and John Benson, Jr., Institute of
Medicine. www.nap.edu/catalog/6376.html

― Cannabis for Migraine Treatment: The Once and Future Prescription? An Historical and Scientific

The National Organization for the Reform of Marijuana Laws (www.norml.org)


“Marihuana as Medicine: A Plea for Reconsideration by Lester Grinspoon”, MD and James Bakalar, JD Journal of the American Medical Association 273(23)1995

“Deglamorising Cannabis” editorial in The Lancet, volume 346, number 8985, November 11, 1995


“Marijuana as Antiemetic Medicine: A Survey of Oncologists' Experience and Attitudes” by R. Doblin and M. Kleiman J Clinical Oncology 9(7)1991

“Delta-9-THC as an Antiemetic in Cancer Patients Receiving High-Dose Methotrexate” by Alfred Chang, MD et al Annals of Internal Medicine 91(6)1979


Scientific articles’ abstracts can often be found at the National Library of Medicine

Websites and Links to Learn More about Medical Cannabis

Contigo-Conmigo Website by Oregon RN, Ed Glick

Patients Out of Time

National Organization to Reform Marijuana Laws (NORML)

The Drug Policy Alliance (formerly Lindesmith Center and Drug Policy Foundation)
Drug Reform Coordination Network www.drcnet.org/ <http://www.drcnet.org/>
Media Awareness Project www.mapinc.org/ <http://www.mapinc.org/>

Is the United States Federal Government Really Delaying Clinical Research?
Nearly everyone (including the American and Oregon Medical Associations and American Cancer Society) supports research efforts involving marijuana as medicine. The Multidisciplinary Association for Psychedelic Studies (MAPS) www.maps.org/mmj <http://www.maps.org/mmj> is a 501 (c) (3) non-profit research and educational organization. Please learn for yourself and make up your own mind about the current climate for clinical research. Please recall that under our current U.S. federal system of laws, it is illegal for doctors to prescribe marijuana/cannabis as medicine even to dying and suffering patients to whom we routinely give drugs such as morphine.


Who Supports Access to Medical Cannabis?
Analysis of public opinion polls: www.ohiopatient.net/projects/Poll_Analysis.htm <http://www.ohiopatient.net/projects/Poll_Analysis.htm>

Single page list of organizations supporting access to therapeutic cannabis:
Multi-page list of organizations including actual statements and types of endorsements:

Of significance is that the Oregon Medical Association (OMA) is "neutral" on the Oregon Medical Marijuana Act (OMMA) www.ommen1998.org/Doctors_keep_mum_on_marijuana.htm <http://www.ommen1998.org/Doctors_keep_mum_on_marijuana.htm> and has issued guidelines for doctors www.ommen1998.org/OMA_guidelines.html <http://www.ommen1998.org/OMA_guidelines.html> to comply with the OMMA. The California Medical Association (CMA) has recommended that Cannabis (marijuana) be removed from Schedule I and rescheduled so that doctors can prescribe marijuana as medicine just as doctors currently prescribe morphine.

IV. Medical Necessity definition:

OCBC contends that the district court abused its discretion by refusing to modify its injunction to permit cannabis distribution to patients for whom it is a medical necessity. A few days after the district court issued its contempt citation instructing the Marshals to padlock its premises, OCBC asked the district judge to modify the injunction to allow continuing cannabis distribution to patients whose physicians certify that(1) the patient...
suffers from a serious medical condition; (2) if the patient does not have access to cannabis, the patient will suffer imminent harm; (3) cannabis is necessary for the treatment of the patient's medical condition or cannabis will alleviate the medical condition or symptoms associated with it; (4) there is no legal alternative to cannabis for the effective treatment of the patient's medical condition because the patient has tried other legal alternatives to cannabis and has found them ineffective in treating his or her condition or has found that such alternatives result in intolerable side effects.

These factors were modeled on this court's recognition of a necessity defense to violations of federal law in United States v. Aguilar, 883 F.2d 662, 692 (9th Cir. 1989).

US v Oakland Cannabis Buyers' Cooperative, Jeff Jones, et. al, 190 F.3d 1109, 1113-1114 (9th Cir. 1999) reversed on other grounds...

Shorthand version: No other medicine is as efficacious, or if it is, the side effects are intolerable.

V. How to Prove

- Debilitating Medical Condition
  - obtain medical records and authority for proposition that cannabis is therapeutic.

- Other medication not efficacious
  - client experiences and PDR
  - Pharmacology expert testimony (e.g. drjulien.com)

- Quantity issues
  - IND program (6 pounds/year)
  - www.chrisconrad.com (re difference between therapeutic and recreational dosage)
  - Cookbooks
  - People who have witnessed client’s use

- Punchline - LD50 = 0
VI. Alternative defense: Substantive Due Process

Subj: Substantive Due Process MM argument
Date: 00-05-19 19:36:48 EDT
From: wgpanzer@earthlink.net (William G. Panzer)
To: lawberger@aol.com

Lee:

I think I am doing this right and you should be able to read this. I hope it helps.

Bill

I. THE GOVERNMENT'S ABSOLUTE BAN ON THE MEDICAL USE OF CANNABIS VIOLATES THE PLAINTIFFS' SUBSTANTIVE DUE PROCESS RIGHTS.

A. Plaintiffs Enjoy Constitutional Protection of Their Fundamental Liberty Interests

The United States Supreme Court has established that individuals are protected under the Due Process clauses of the Fourteenth and Fifth Amendments from state or federal infringement upon their "fundamental liberty interests." As Justice Rehnquist recently described in Washington v. Glucksberg, _ U.S. _, 117 S. Ct. 2258 (1997):

The Due Process Clause guarantees more than fair process, and the "liberty" it protects includes more than the absence of physical restraint .... The Clause also provides heightened protection against government interference with certain fundamental rights and liberty interests.

Glucksberg, at 2267 (citations omitted).

In applying substantive due process analysis, the Chief Justice in Glucksberg explained that where a fundamental liberty interest is involved, government action must be "narrowly tailored to serve a compelling [government] interest." Id., at 2268.

B. Plaintiffs Have A Substantive Due Process Interest In Receiving Medical Treatment For Their Serious and Debilitating Medical Conditions
 Plaintiffs assert Constitutional protection from the federal government's interference with their right to legally obtain medical cannabis for treatment of painful and life-threatening medical conditions. Plaintiffs can show that they suffer from various medical conditions that can be alleviated, relieved, or reduced by treatment with cannabis. Without the treatment some will suffer pain, some will risk blindness, and others will die by wasting away. The only barrier to this treatment is the broad federal proscription against the distribution of marijuana. For three separate and independent reasons, the interest asserted by plaintiffs, the right to receive medical treatment for a serious debilitating medical condition, is a fundamental right protected by the Constitution.

First, there is no liberty more firmly established than the fundamental interest to be free from physical pain imposed by the government for arbitrary and capricious reasons. The Supreme Court has continuously and persistently measured and evaluated substantive due process claims in terms of the physical pain imposed upon the individual by government restraints. See e.g. Furman v. Georgia, 408 U.S. 238 (1972) (substantive due process implicated where death penalty imposed under a method inflicting "unnecessary pain"); Cruzan v. Director, MDH, 497 U.S. 261 (1990) (pain suffered by patient in persistent vegetative state relevant to inquiry of fundamental interest to deprive oneself of nutrition and hydration); Planned Parenthood v. Casey, 505 U.S. 833 (1992) ("anxieties," "physical constraints," and "pain" of women carrying child to term basis of substantive due process right to elect abortion); and Washington v. Glucksberg, _ U.S. _, 117 S. Ct. 2258 (1997) (terminally ill patient rights to palliative treatment implicate substantive due process).

The concurring opinions in Glucksberg also suggest that substantive due process protects an individual's right to obtain medical treatment to alleviate unnecessary pain. Justice O'Connor's opinion makes clear that suffering patients are presumed to have access to any palliative medication that would alleviate pain even where such medication might hasten death. "[A] patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining medication, from qualified physicians." Glucksberg, at 2303 (emphasis added).

Similarly. Justice Breyer's concurrence suggested that a "right to die with dignity" would include a right to "the avoidance of unnecessary and severe physical suffering." Glucksberg, at 2311 (J. Breyer, concurring). "This liberty interest in bodily integrity was phrased ... by [Justice] Cardozo when he said, '[e]very human being of adult years and sound mind as a right to determine what shall be done with his own body' in relation to his medical needs." Glucksberg, at 2288 (Souter, J., concurring).

Justice Stevens asserted with regard to the protected "sphere of substantive liberty":

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Whatever the outer limits of the concept may be, it definitely includes protection for matters "central to personal dignity and autonomy." It includes, "the individual's right to make certain unusually important decisions that will affect his own, or his family's, destiny." The Court has referred to such decisions as implicating 'basic values,' as being 'fundamental,' and as being dignified by history and tradition.

Glucksberg, at 2307 (Stevens, J., concurring) (citation omitted).

Finally, Justice Stevens observed that "[a]voiding intolerable pain and the indignity of living one's final days incapacitated and in agony is certainly [a]t the heart of [the] liberty ... to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." Glucksberg, at 2307 (quoting Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833, 851 (1992).

Second, plaintiffs have an established fundamental interest in the right to provide care for oneself. The Supreme Court has found due process interests in preserving life and caring for oneself. Deshaney v. Winnebago Cty., 489 U.S. 189, 200 (1989). Although this right is usually implicated where an individual is incarcerated and does not have access to necessary medical treatment, the argument is equally applicable to a situation where the government denies medical treatment by enacting laws proscribing such treatment:

In the substantive due process analysis, it is the State's affirmative act of restraining the individual's freedom to act on his own behalf -- through incarceration, institutionalization, or other similar restraint of personal liberty -- which is the "deprivation of liberty" triggering the protections of the Due Process Clause.

Deshaney, 489 U.S. at 200 (citation omitted).

The government's restraint on the distribution of cannabis prevents plaintiffs from obtaining medical care for themselves. This restraint is particularly egregious where the treatment sought is that to alleviate pain.

Third, plaintiffs have an unquestionable and firmly rooted liberty interest in preserving their lives. As the Supreme Court explained in Cruzan, supra, "[i]t cannot be disputed that the Due Process Clause protects an interest in life." Cruzan, at 281. Plaintiffs can show that many in their ranks would find their lives needlessly placed in jeopardy were they denied the right to the medical use of cannabis. For example, many chemotherapy patients and AIDS patients are so plagued with nausea and discomfort that they are unable to eat. Without basic nourishment, their conditions are aggravated and they are essentially at risk of starving to death.

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For all of these reasons, the government's actions plainly infringe upon the well-established fundamental rights of plaintiffs. Accordingly, the government bears the burden of justifying these restrictions. As discussed below, the government cannot meet this burden.

C. Application Of Substantive Due Process Analysis To Plaintiffs

Plaintiffs fall into two classes: 1) those for whom cannabis is the preferred treatment, and 2) those for whom cannabis is the only effective treatment available. The application of Substantive Due Process requires a separate analysis for each class.

1. Plaintiffs For Whom Treatment With Medical Cannabis Is The Preferred, Though Not Exclusive, Available Treatment

Plaintiffs concede that their fundamental right to receive medical treatment does not necessarily include a fundamental right to a particular medical treatment. However, where the government has chosen to restrict access to a particular treatment or provider, courts have recognized that such restriction violates constitutional rights if the government's restrictions are irrational or arbitrary. Connecticut v. Menillo, 423 U.S. 9 (1975) (state may require that abortions be performed only by licensed physicians, even in the first trimester of pregnancy); Mitchell v. Clayton, 995 F.2d 772, 774 (7th Cir. 1993) (state regulation of acupuncture evaluated under rational basis test); New York State Ophthalmological Soc'y v. Bowen, 854 F.2d 1379 (D.C. Cir. 1988) (state regulation of ophthalmology not entitled to strict scrutiny review); Carnohan v. United States, 616 F.2d 1120, 1122 (9th Cir. 1980) (government ban on Laetrile permissible where party challenging the ban fails to show that government regulation of laetrile traffic bears no reasonable relation to the legitimate state purpose of protecting public health).

"Where rational basis review is appropriate, a statute withstands a substantive due process challenge if the state identifies a legitimate state interest that the legislature rationally could conclude was served by the statute." Sammon v. New Jersey, 66 F.3d 639 (3rd Cir. 1995).

Plaintiffs allege in their complaint that cannabis is an extraordinarily safe and effective medicine. (For example, while more than 1000 Americans die annually from aspirin toxicity, not a single human being has ever died as a result of cannabis toxicity). In promulgating the Controlled Substances Act, Congress declared that "[m]any... drugs... have a useful and legitimate medical purpose and are necessary to maintain the health and general welfare of the American people." 21 USC §801(1). Congress further declared that "[t]he illegal importation, manufacture, distribution, and possession and improper use of controlled substances have a substantial and detrimental effect on the health and general welfare of the..."
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American people." 21 USC § 801(2). Plaintiffs acknowledge that the government has a legitimate interest both in assuring that appropriate medicines are made available, and in stemming the abuse of controlled substances.

In the case of numerous substances, including cocaine, opiates, amphetamines, barbiturates, and even thalidomide, the government has acted to provide for medical use while limiting abuse. In the case of cannabis, plaintiffs allege that the means employed by the government abysmally fail to accomplish the purpose stated in 21 USC §801(1). Plaintiffs should therefore not be precluded from establishing the arbitrary and irrational nature of the ban without requiring of the government even a hint of explanation of the reasoning behind the ban of all medical use of cannabis.

2. Plaintiffs For Whom Treatment With Medical Cannabis Is The Only Effective Treatment Though Not Exclusive, Available Treatment

When applied to plaintiffs for whom cannabis is the only effective treatment, the government's ban on treatment with cannabis is effectively a bar to those plaintiffs above-mentioned fundamental right to receive medical treatment. As such, the government's actions must be analyzed under a traditional strict scrutiny standard. The government must establish a compelling interest and the use of the least restrictive means to achieve that interest. Plaintiffs allege that the government can do neither

a. The Broad Federal Proscription Against Distribution And Use Of Medical Cannabis Is Not Narrowly Tailored To Meet A Compelling Government Interest

Where fundamental liberty interests have been demonstrated, any restraint on those interests must be narrowly tailored to serve a compelling state interest. Glucksberg, at 2268. The federal proscription against the possession and distribution of medical cannabis is unnecessarily overbroad and arbitrary where it restrains the terminally ill and others in chronic pain from obtaining an essential medication to alleviate their pain and in some cases contribute to the preservation of life. See Andrews v. Ballard, 498 F. Supp. 1038, 1044-1051, 1052, 1056 (S.D. Tx. 1980) (recognizing constitutional right to obtain medical treatment for pain and holding that state restriction on availability of acupuncture was not narrowly drawn to further compelling state interest).

The government has a legitimate interest both in assuring that appropriate medicines are made available, and in stemming the abuse of controlled substances. The government cannot show, however, that a blanket prohibition, disregarding the medical needs of seriously ill
persons for whom cannabis is the only effective treatment, furthers any legitimate interest. In the case of numerous other substances, including cocaine and morphine, the government has acted to provide for medical use while limiting abuse. In the case of medical cannabis, however, the means employed by the government abysmally fail to accomplish the government's purposes and are therefore an affront to the concept of substantive due process.

Thus the government's application of the Controlled Substances Act to the distribution of medical cannabis violates the substantive due process rights of plaintiffs to be free from unnecessary pain, to receive palliative treatment for a painful medical condition, to care for oneself and to preserve one's own life. Plaintiffs are entitled to present this evidence at trial.

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VII. Misc. Issues

Arises in other contexts including pre-trial release, DUII diversion, probation and parole. Also arises in non-criminal settings including employment, and housing.

VIII. Misc. Reform

Travel - *Kent v. Dulles*, full faith and credit, and the need for legislative change.