

THE GARDEN STATE JUST GOT GREENER: NEW JERSEY IS THE FOURTEENTH STATE IN THE NATION TO LEGALIZE MEDICAL MARIJUANA

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I. INTRODUCTION

On January 11, 2010, both houses of the New Jersey Legislature passed the New Jersey Compassionate Use Medical Marijuana Act (the NJCMA or the “Act”),¹ making it the fourteenth state in the nation to decriminalize the medical use of marijuana under state law.²

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¹ *Bills*, NEW JERSEY STATE LEGISLATURE, <http://www.njleg.state.nj.us/bills/bills0001.asp> (click “Bills 2008-2009”; then select “Search by Bill Number”; then search for “S119”) (last visited Mar. 27, 2011). On January 8, 2008, members of both houses of the New Jersey legislature introduced bills intended to legalize the medical use of marijuana via enactment of the NJCMA. *Id.* The bills are General Assembly Bill 804 (A804 or “the Assembly bill”) and Senate Bill 119 (S119 or “the Senate bill”). *Id.* On December 15, 2008, S119 was reported out of the Senate Health, Human Services and Senior Citizens Committee with amendments. *Id.* On February 23, 2009, the Senate passed bill S119 with a vote of 22–16, and three days later, the General Assembly received it and referred it to the Assembly Health and Senior Services Committee. *Id.* On June 4, 2009, the Senate bill was reported out of the Assembly Health and Senior Services Committee with amendments. *Id.* On January 7, 2010, the General Assembly further amended the Senate bill on the assembly floor. *Id.* On January 11, 2010, just over two years after the 2008–2009 legislative session when the medical-marijuana bills were introduced, the General Assembly passed Senate bill S119 (as amended by the General Assembly on January 7, 2010) with a vote of 48–14, and the Senate passed it with a vote of 25–13. *Id.*

² *See Active State Medical Marijuana Programs*, NORML, http://norml.org/index.cfm?Group_ID=3391 (last visited Oct. 20, 2010). In fact, medical-marijuana bills have been introduced in the New Jersey Legislature since 2004. *See* Gen. Assem. 804, 213th Leg., 2008–2009 Sess. (N.J. 2008); S. 119, 213th Leg., 2008–2009 Sess. (N.J. 2008); Gen. Assem. 933, 212th Leg., 2006–2007 Sess. (N.J. 2006); S. 88, 212th Leg., 2006–2007 Sess. (N.J. 2006); Gen. Assem. 4501, 211th Leg., 2004–2005 Sess. (N.J. 2004); S. 2200, 211th Leg., 2004–2005 Sess. (N.J. 2004); *see also*

Seven days later, then-Governor Jon S. Corzine signed the measure into law.³ Members of both major political parties introduced and supported the Act throughout the long legislative process,⁴ which signals that the legalization of medical marijuana and the desire to provide relief to people suffering from debilitating medical conditions are not partisan issues.

Despite the widely accepted therapeutic value of marijuana,⁵ possession, use, or cultivation of the drug, even for medicinal purposes, have been criminal offenses with harsh penalties under both federal and New Jersey law for many years.⁶ Additionally, as a Schedule I controlled substance under the federal Controlled Substances Act (CSA),⁷ marijuana cannot be prescribed by a physician or distributed by a pharmacy.⁸ In fact, the federal government continues to not only discourage but also hinder research on botanical medical marijuana.⁹

Medicinal marijuana advocates have had success at the state level. Between 1978 and 2008, thirty-six states and the District of Columbia enacted laws intended to provide suffering patients with legal

Phillip Smith, *New Jersey Medical Marijuana Bill Heads for Senate Floor After Favorable Committee Vote*, DRUG WAR CHRONICLE (Dec. 19, 2008, 12:00 AM), http://stopthedrugwar.org/chronicle/2008/dec/19/feature_new_jersey_medical_marij.

³ *New Jersey Gov. John Corzine Signs Medical Marijuana Bill into Law*, N.Y. DAILY NEWS (Jan. 18, 2010), http://www.nydailynews.com/news/2010/01/18/2010-01-18_new_jersey_gov_corzine_signs_.html. Interestingly, while some have stated that Governor Chris Christie would have opposed the measure, others have reported that he supports medical marijuana. *Medical Marijuana Bill 'Workable,' N.J. Attorney General Says*, NJ.COM (Apr. 21, 2009), http://www.nj.com/news/index.ssf/2009/04/medical_marijuana_bill_workabl.html [hereinafter *Medical Marijuana Bill*]; Brian Thompson, *Stunning Reversal at Medical Marijuana Trial*, NBC NEW YORK, (Dec. 16, 2009), <http://www.nbcnewyork.com/news/local-beat/Stunner-at-Medial-Marijuana-Trial-in-NJ-79447032.html>.

⁴ See N.J. Gen. Assem. B. 804; N.J. S.B. 119; see also *supra* note 1.

⁵ See *infra* Part II.

⁶ See 21 U.S.C. §§ 841(a)(1), 844(a) (2006); see also N.J. STAT. ANN. §§ 2C:35-1 to -29, 2C:36-1 to -10 (West 2010).

⁷ 21 U.S.C. § 812 (2006); see also discussion *infra* Part III.A.

⁸ *United States v. Oakland Cannabis Buyers' Coop.*, 532 U.S. 483, 491 (2001); see also 21 U.S.C. § 829 (2006) (detailing how drugs classified in Schedules II through V may be prescribed and dispensed).

⁹ See Gardiner Harris, *Researchers Find Study of Medical Marijuana Discouraged*, N.Y. TIMES, Jan. 19, 2010, at A14.

access to marijuana.¹⁰ In 1996, California became the first state to pass a law legalizing medical use of the drug, and twelve states followed its lead.¹¹ New Jersey is now the fourteenth state to remove state-level criminal penalties for medical marijuana and recognize its medicinal value. The NJCMA carves out a limited but necessary exemption from criminal liability for individuals who need marijuana to ease the symptoms of debilitating illnesses when other treatment options do not work.

The NJCMA is among the most restrictive state medical-marijuana laws in the nation and it was created to provide marijuana to individuals with specific enumerated debilitating medical conditions¹² via a reasonable system that is highly regulated and extensively overseen.¹³ New Jersey's Attorney General at the time of passage, Anne Milgram, deemed the NJCMA to be "workable."¹⁴ This is important because for the legislation to be effective, it must have the support of the state government and state and local law enforcement. Additionally, public opinion in New Jersey overwhelmingly supports the legalization of marijuana for medical use.¹⁵ According to a poll conducted in May 2006, eighty-six percent of voters were convinced that "seriously ill patients should have access to marijuana for medical purposes if a physician recommends it."¹⁶ Significantly, fifty-nine percent of New Jersey voters even said that they would defy current law

¹⁰ MARIJUANA POLICY PROJECT, STATE-BY-STATE MEDICAL MARIJUANA LAWS: HOW TO REMOVE THE THREAT OF ARREST 10 (2008), available at http://docs.mpp.org/pdfs/download-materials/SBSR_NOV2008_1.pdf.

¹¹ See *infra* notes 154–55 and accompanying text.

¹² See S. 119, 213th Leg., 2008–2009 Sess. (N.J. 2008) (as passed by both houses of the N.J. Legislature on Jan. 11, 2010).

¹³ See *infra* Part IV.

¹⁴ *Medical Marijuana Bill*, *supra* note 3. Acknowledging existing concerns about ensuring that the law allows access to marijuana only to those with debilitating medical conditions, Attorney General Milgram's office "sent recommendations to the governor on ways to guard against abuses." *Id.*

¹⁵ See THE POLLING COMPANY, INC., MEDICAL MARIJUANA: STATEWIDE SURVEY OF 700 REGISTERED VOTERS OF NEW JERSEY 3 (June 2006), available at <http://www.pollingcompany.com/cms/files/DPANJ%20Medical%20Marijuana%20Executive%20Summary.pdf>.

¹⁶ *Id.* at 3. In fact, agreement on this issue "spanned demographic divides, with no less than three-quarters of every major demographic group studied, including members of all three political parties, endorsing access to medical marijuana with a doctor's recommendation." *Id.* at 4. Further, when told that "the use of marijuana, including for medical reasons, is illegal in New Jersey [but] about 11 other states now allow seriously ill patients to have medical marijuana with a doctor's recommendation . . . eighty-three percent indicated that patients in their own state should have the same rights." *Id.*

to obtain the drug for a “close friend or family member [who] was suffering from a condition that could be eased by marijuana.”¹⁷

Finally, while federal policymakers remain ambivalent about the wisdom of state medical-marijuana legalization,¹⁸ the Obama administration has taken a very different stance than previous administrations regarding federal drug enforcement in states that have legalized marijuana for medical use.¹⁹ Thus, now is the time for states like New Jersey to enact medical-marijuana legislation. Ultimately, reason, compassion, and medical evidence support New Jersey’s elimination of criminal penalties for the medical use of marijuana under state law.

Part II of this Comment reviews the history of marijuana as medicine and the science behind the controversy of whether marijuana has therapeutic value. Part III provides a brief overview of marijuana’s current status under federal and state law and discusses the interplay between the two. In Part IV, this Comment provides an overview and critique of the NJCMA and suggests ways in which the Act can be improved.

II. MARIJUANA AS MEDICINE

A. *Brief History of the Use of Marijuana for Medicinal Purposes*

Marijuana,²⁰ also known as cannabis or hemp, is one of the oldest known psychoactive plants on earth.²¹ Marijuana grows as both a weed and a cultivated plant all over the world.²² While it has only been used as a medicine in the United States since the middle of the 1800s, marijuana has been used medicinally throughout the world for thousands of years.²³ The first evidence of the medical use of mariju-

¹⁷ *Id.* at 5. Seventy-one percent of those who responded agreed “with the New Jersey state legislature passing a bill that would permit patients to possess ‘one ounce of marijuana and six marijuana plants for medical purposes if they have a recommendation from a doctor,’ and forty-seven percent did so ‘strongly.’” *Id.* at 6.

¹⁸ See Harris, *supra* note 9, at A1.

¹⁹ See *infra* Part III.C.2.

²⁰ The word is alternatively spelled “marihuana,” most often in U. S. government literature. Throughout this Comment, “marijuana,” “marihuana,” and “cannabis” may be used interchangeably to refer to the natural, botanical form of the substance.

²¹ LESTER GRINSPOON & JAMES BAKALER, *MARIHUANA, THE FORBIDDEN MEDICINE* 1 (rev. ed. 1997).

²² *Id.*

²³ *Id.* at 3–7. “Cannabis may have been cultivated as long as ten thousand years ago” and “has long been used as a medicine in India, China, the Middle East, Southeast Asia, South Africa, and South America.” *Id.* at 3. In addition to its therapeutic properties, cannabis “fiber has been used to produce cloth and paper for centuries,”

ana was published five thousand years ago, recommending cannabis for “malaria, constipation, rheumatic pains, ‘absentmindedness,’ and female disorders.”²⁴ Cannabis “did not come into its own” as a medicine in the West “until the middle of the nineteenth century.”²⁵ In 1839, the first Western physician to take an interest in the medical properties of cannabis, W.B. O’Shaughnessy, wrote about the plant’s analgesic and muscle relaxant properties and called it “an anticonvulsive remedy of the greatest value.”²⁶ Soon after, doctors in Europe and the United States started to recognize marijuana’s therapeutic potential and began prescribing cannabis “for a variety of physical conditions”; preparations made from cannabis were available in drug stores.²⁷ Some doctors believed marijuana to be as effective a pain reliever as opium but with the added benefit of acting as an appetite stimulant.²⁸ Marijuana was also said to “subdue restlessness and anxiety and distract a patient’s mind in terminal illness.”²⁹ Cannabis was included in the *United States Pharmacopoeia*³⁰ in 1850,³¹ and, between

and until the development of synthetic fibers, it “was the most important source of rope.” *Id.* at 1. In fact, the Declaration of Independence was drafted on hemp paper. See Christen D. Shepherd, Comment, *Lethal Concentration of Power: How the D.E.A. Acts Improperly to Prohibit the Growth of Industrial Hemp*, 68 UMKC L. REV. 239, 261 n.33 (1999). Additionally, the oil in marijuana seeds that was once “used for lighting and soap” is sometimes still used in the production of varnish, linoleum, and paint. GRINSPOON & BAKALER, *supra* note 21, at 1.

²⁴ GRINSPOON & BAKALER, *supra* note 21, at 3. The evidence was published “during the reign of the Chinese emperor Chen Nung.” *Id.* Throughout the world, cannabis or hemp (including its oil) has been recommended or used to treat, *inter alia*, malaria, coughs, and urinary incontinence, “to quicken the mind, lower fevers, induce sleep, cure dysentery, stimulate appetite, improve digestion, relieve headaches, and cure venereal disease.” *Id.* Marijuana might also be used to treat depression. *Id.*

²⁵ *Id.* at 4. While marijuana did not “come into its own” in the West until the 1800s, “the first definite record of the marijuana plant in the New World dates from 1545 A.D., when Spaniards introduced it into Chile.” GARY J. MILLER, *DRUGS AND THE LAW: DETECTION, RECOGNITION & INVESTIGATION* 405 (2nd ed. 1997). From the early 1600s until after the Civil War, the cannabis plant was a major crop in North America primarily because of its use in the production of hemp fabric. See *id.* at 405–06.

²⁶ GRINSPOON & BAKALER, *supra* note 21, at 4. After testing cannabis on animals and satisfying himself that it was safe, O’Shaughnessy gave it to “patients suffering from rabies, rheumatism, epilepsy, and tetanus.” *Id.* O’Shaughnessy created a “tincture of hemp (a solution of cannabis in alcohol, taken orally).” *Id.*

²⁷ *Id.* at 4.

²⁸ *Id.* at 5.

²⁹ *Id.*

³⁰ The U.S. Pharmacopoeia is a non-governmental, not-for-profit public-health organization that serves as “an official public standards-setting authority for all prescription and over-the-counter medicines and other health care products manufactured or sold in the United States.” See *About USP*, U.S. PHARMECOPEIA, <http://www.usp.org/aboutUSP/> (last visited Mar. 27, 2011). The health organization publishes the *United States Pharmacopoeia*, an official compendium. *USP–NF—An*

1840 and 1900, “more than one hundred papers were published in Western medical literature recommending cannabis for ‘various illnesses and discomforts.’”³²

By 1890, physicians in the United States began reducing their reliance on marijuana based, in part, on the fact that “the potency of cannabis preparations was too variable.”³³ Instead, physicians prescribed more chemically stable and reliable synthetic drugs like aspirin, chloral hydrate, and barbiturates.³⁴ The advent of the hypodermic needle also resulted in increased use of opiates for fast pain relief.³⁵ Opiates, unlike hemp products, are water soluble, and, therefore, are easily administered by syringe.³⁶ Despite its decline in use, medical marijuana remained legal in the United States throughout much of the twentieth century. In fact, not until 1970 did Congress make the possession, use, or cultivation of marijuana illegal under federal law.³⁷

Overview, U.S. PHARMECOPEIA, <http://www.usp.org/USPNF/> (last visited Mar. 27, 2011). While many sources use “pharmacopoeia,” the current accepted spelling appears to be “pharmacopeia.”

³¹ Gregg A. Bilz, *The Medical Use of Marijuana: The Politics of Medicine*, 13 *HAMLIN J. PUB. L. & POL'Y* 117, 118 (1992) (citing JEROME L. HIMMELSTEIN, *THE STRANGE CAREER OF MARIJUANA* 22 (1983)). Marijuana was subsequently removed from the U.S. Pharmacopeia in 1941. See GRINSPOON & BAKALER, *supra* note 21, at 8.

³² GRINSPOON & BAKALER, *supra* note 21, at 4 (citing *MARIJUANA: MEDICAL PAPERS, 1839–1972* (T.H. Mikuriya, ed. 1973)); see also RICHARD E. ISRAELOWITZ & DARWIN TELIAS, *DRUG USE, POLICY, AND MANAGEMENT* 96 (1998)

Among the recommended uses were as an analgesic (in the form of tincture of hemp—a solution of cannabis in alcohol taken orally); as a topical anesthetic for the mouth and tongue; and for problems and discomfort related to tetanus, neuralgia, dismenorrhea (painful menstruation), convulsions, rheumatic and childbirth pain, asthma, postpartum psychosis, gonorrhea, and chronic bronchitis, for preventing migraine attacks, certain kinds of epilepsy, depression, asthma, rheumatism, gastric ulcer, and drug addiction, particularly of morphine and other opiate substances.

Id.

³³ GRINSPOON & BAKALER, *supra* note 21, at 7.

³⁴ *Id.*; see also ISRAELOWITZ & TELIAS, *supra* note 32, at 96.

³⁵ GRINSPOON & BAKALER, *supra* note 21, at 7; see also ISRAELOWITZ & TELIAS, *supra* note 32, at 96.

³⁶ GRINSPOON & BAKALER, *supra* note 21, at 7; see also ISRAELOWITZ & TELIAS, *supra* note 32, at 96. Even with use in decline, marijuana’s medicinal properties continued to interest physicians, and in 1891, Dr. J.B. Mattison called cannabis “a drug that has a special value in some morbid conditions and the intrinsic merit and safety of which entitles it to a place it once held in therapeutics.” GRINSPOON & BAKALER, *supra* note 21, at 6 (citing J.B. Mattison, *Cannabis Indicia as an Anodyne and Hypnotic*, 61 *ST. LOUIS MED. SURGICAL J.* 266 (1891)).

³⁷ See *infra* Part III.A.

B. The Controversy Behind the Science

Over the last hundred years, public opinion in the United States has been divided on the medical value of marijuana.³⁸ Anecdotal evidence³⁹ emerged in the late twentieth century suggesting that marijuana has medicinal properties⁴⁰ that provide relief from symptoms associated with numerous illnesses, including “AIDs wasting, spasticity from multiple sclerosis, depression, chronic pain, nausea associated with chemotherapy,”⁴¹ glaucoma,⁴² epilepsy,⁴³ and migraines.⁴⁴ Today there are “well-recognized therapeutic uses for cannabis, and many others are currently under investigation.”⁴⁵

The federal government and other opponents of marijuana legalization, however, have staunchly maintained a position that is reflected in U.S. law “that botanical marijuana is a dangerous drug without any legitimate medical use.”⁴⁶ In support of their position, opponents emphasize that “marijuana intoxication can impair a per-

³⁸ INST. OF MEDICINE, *MARIJUANA AND MEDICINE: ASSESSING THE SCIENCE BASE 1* (Janet E. Joy et al., eds., 1999). “Some dismiss medical marijuana as a hoax that exploits our natural compassion for the sick; others claim it is a uniquely soothing medicine that has been withheld from patients through regulations based on false claims.” *Id.*

³⁹ For instance, in the 1970s, people began to report that “marijuana relieved nausea associated with chemotherapy” and in the 1980s, “when the AIDs epidemic spread . . . patients found that marijuana sometimes relieved their symptoms, most dramatically those associated with AIDs wasting.” *Id.* at 18.

⁴⁰ Susan Corey, *Recent Developments in the Therapeutic Potential of Cannabinoids*, 24 P. R. HEALTH SCI. J. 19, 19 (2005).

⁴¹ See INST. OF MEDICINE, *supra* note 38, at 23 (stating that “patients who reported their experience with marijuana at the public workshops said that marijuana provided them with great relief” of symptoms associated with these illnesses).

⁴² See GRINSPOON & BAKALER, *supra* note 21, at 40–57.

⁴³ See *id.* at 58–67.

⁴⁴ See *id.* at 106–09.

⁴⁵ Ruth C. Stern & J. Herbie DiFonzo, *The End of the Queen’s Race: Medical Marijuana in the New Century*, 27 QUINNIPIAC L. REV. 673, 693 (2009).

⁴⁶ MARK EDDY, CONG. RESEARCH SERV., RL 33211, *MEDICAL MARIJUANA: REVIEW AND ANALYSIS OF FEDERAL AND STATE POLICIES* 24 (2009) (internal citation omitted). Ironically, “in 1978, the FDA created the Investigational New Drug (IND) Compassionate Access Program, allowing patients whose serious medical conditions could be relieved only by marijuana to apply for and receive marijuana from the federal government.” *Id.* at 8. The program “was not a clinical trial to test the drug for eventual approval,” but it was instead a way “for the government to provide medical marijuana to patients demonstrating necessity.” *Id.* at 8, n.32. Over the years, less than one hundred patients “were admitted to the program for conditions including chemotherapy induced nausea and vomiting (emesis), glaucoma, spasticity, and weight loss,” and “in 1992, in response to a large number of applications from AIDS patients who sought to use medical cannabis to increase appetite and reverse wasting disease, the George H.W. Bush administration closed the program to all new applicants.” *Id.* at 8. “Several previously approved patients remain in the program today and continue to receive their monthly supply of government-grown medical marijuana.” *Id.*

son's coordination and decision-making skills and alter behavior" and that "[c]hronic marijuana smoke can adversely affect the lungs, the cardiovascular system, and possibly the immune and reproductive systems."⁴⁷

C. *The Science Behind the Controversy: The Benefits of Botanical Medical Marijuana Often Outweigh the Risks*

Underlying much of the controversy is the fact that proponents of medical marijuana seek to legalize use of the actual plant rather than a synthetic version of its primary chemical, tetrahydrocannabinol (THC). Marijuana generally "refers to the dried flowers, leaves, stems and seeds of the *Cannabis sativa* plant."⁴⁸ It contains over 460 known compounds,⁴⁹ including at least sixty chemicals known as cannabinoids.⁵⁰ Among these are delta-9 THC, the primary psychoactive component in marijuana, and cannabigerol, cannabinol, and cannabidiol—non-psychoactive cannabinoids.⁵¹ While THC is the primary psychoactive component of marijuana, not all of the effects of marijuana on the human body are the result of THC.⁵²

Studies show that "cannabinoids produce most of their effect" by binding to receptors on the surface of certain types of cells, each of which only recognizes "a few specific molecules, known collectively as ligands."⁵³ "When the appropriate ligand binds to its receptor, it typically sets off a chain of biochemical reactions inside the cell."⁵⁴ The receptors that bind cannabinoids are "cannabinoid receptors."⁵⁵ To date, researchers have discovered two types of cannabinoid receptors: CB1 and CB2.⁵⁶ CB1 "mediates the central nervous system," and CB2

⁴⁷ *Id.* at 24 (citing *Exposing the Myth of Medical Marijuana*, DEP'T OF JUSTICE, DRUG ENFORCEMENT AGENCY, <http://www.justice.gov/dea/ongoing/marijuanap.html> (last visited Feb. 19, 2010)).

⁴⁸ *Marijuana as Medicine: Consider the Pros and Cons*, MAYO CLINIC (Oct. 27, 2009), http://www.riversideonline.com/health_reference/Articles/GA00014.cfm.

⁴⁹ GRINSPOON & BAKALER, *supra* note 21, at 2.

⁵⁰ MAYO CLINIC, *supra* note 48.

⁵¹ *See id.*; *see also* ALLISON MACK & JANET JOY, MARIJUANA AS MEDICINE? THE SCIENCE BEYOND THE CONTROVERSY 27 (2001).

⁵² MACK & JOY, *supra* note 51, at 8 ("[A] complex mixture of chemical compounds [exists in the marijuana plant and] . . . the effects of marijuana on the body include those of THC . . . not all of marijuana's effects are necessarily due to THC alone.").

⁵³ *Id.* at 27.

⁵⁴ *Id.*

⁵⁵ *Id.* at 28.

⁵⁶ AM. COLL. OF PHYSICIANS, POSITION PAPER: SUPPORTING RESEARCH INTO THE THERAPEUTIC ROLE OF MARIJUANA 4 (2008), *available at* <http://www.csdp.org/research/medmarijuana.pdf>.

“occurs outside the [central nervous system] and is believed to have anti-inflammatory and immunosuppressive activity.”⁵⁷

In 1985, the Food and Drug Administration (FDA) approved Marinol (Dronabinol), a synthetic form of THC encapsulated in sesame oil,⁵⁸ to treat “nausea and vomiting associated with cancer chemotherapy patients who fail to respond to conventional antiemetic treatments.”⁵⁹ The FDA later approved Marinol “for the treatment of anorexia associated with weight loss in patients with AIDs.”⁶⁰ Although Marinol was originally a Schedule II drug, the DEA moved it to Schedule III in 1999 after it and the “Department of Health and Human Services found little evidence of illicit abuse of the drug.”⁶¹ In 2006, the FDA approved Cesamet (Nabilone), another synthetic cannabinoid similar to THC, for the treatment of chemotherapy-induced nausea and vomiting.⁶² Cesamet is a Schedule II drug.⁶³ In 2005, Canada approved Sativex, “a whole plant extract that contains THC and cannabidiol,”⁶⁴ for use in treating neuropathic pain associated with multiple sclerosis (MS).⁶⁵ Canada also approved the oral spray, which is absorbed in the patient’s mouth, as “adjunctive analgesic treatment in patients with advanced cancer who experience moderate to severe pain during the highest tolerated dose of strong opioid therapy” in 2007.⁶⁶ It is currently in clinical trials, being studied for the treatment of patients with advanced cancer whose pain is not being relieved by strong opioid medications.⁶⁷

The FDA’s approval of synthetic cannabinoid-based medications evidences that marijuana’s components have therapeutic properties. But for a subset of patients, the natural plant is superior because smoking may actually be a preferred drug-delivery system. Oral THC

⁵⁷ *Id.*

⁵⁸ INST. OF MEDICINE, *supra* note 38, at 202.

⁵⁹ EDDY, *supra* note 46, at 8.

⁶⁰ *Id.*

⁶¹ *Id.* In contrast, marijuana in its natural form is a Schedule I drug. See *infra* Part III.A for a discussion about the scheduling of drugs under federal law.

⁶² *Valeant Receives FDA Marketing Approval for Cannabinoid Cesamet*, DRUGS.COM (May 16, 2006), <http://www.drugs.com/news/valeant-receives-fda-marketing-approval-cannabinoid-cesamet-1794.html>.

⁶³ *Cesamet*, RXLIST.COM, <http://rxlist.com/cesamet-drug.htm> (last visited Mar. 31, 2010).

⁶⁴ Wendy Koch, *Spray Alternative to Pot on the Market in Canada*, USA TODAY, June 24, 2005, at 4A.

⁶⁵ *Sativex*, GW PHARMS., <http://gwpharm.com/sativex.asp> (last visited Jan. 4, 2010).

⁶⁶ *Id.*

⁶⁷ *Id.*

is slower to take effect than smoked marijuana and “produces more pronounced, and often unfavorable, psychoactive effects that last much longer than those experienced with smoking.”⁶⁸ In contrast, “smoked THC is quickly absorbed into the blood and effects are experienced immediately.”⁶⁹ The fast-acting nature of smoked marijuana also “allows patients to easily determine the right dose for symptom relief.”⁷⁰ With oral cannabinoid medications, patients cannot similarly “self-titrate”⁷¹ because “absorption is highly variable and unpredictable and often delayed” when THC is taken orally.⁷² For patients whose severe nausea and vomiting prevent them from taking anything orally, such as those undergoing cancer chemotherapy, inhalation is the only alternative.⁷³ Additionally, some doubt that synthetics are sufficient substitutes: “[S]ingle-cannabinoid, synthetic pharmaceuticals like Marinol are poor substitutes for the whole marijuana plant, which contains more than 400 known chemical compounds, including about 60 active cannabinoids in addition to THC.”⁷⁴ Finally, natural marijuana is cheaper and easier to manufacture than synthetic cannabinoid-based medications, which are expensive.⁷⁵

Modern medical evidence supports using marijuana to treat the symptoms of a range of debilitating illnesses, including pain, loss of appetite, nausea, and spasticity.⁷⁶ While some FDA-approved medications are arguably “more effective” than marijuana, some people may not respond well to other medicine—they may not experience relief

⁶⁸ AM. COLL. OF PHYSICIANS, *supra* note 56, at 7 (citing J. Beal et al., *Long-Term Efficacy and Safety of Dronabinol for Acquired Immunodeficiency Syndrome-Associate Anorexia*, 14(1) J. OF PAIN AND SYMPTOM MGMT. 7–14 (1997)).

⁶⁹ *Id.*

⁷⁰ Lester Grinspoon, *Puffing is the Best Medicine*, L.A. TIMES, May 5, 2006, at B13.

⁷¹ *See id.*

⁷² Jill U. Adams, *A Balm for Pain*, L.A. TIMES, Aug. 18, 2008, at F6 (quoting Dr. Igor Grant, a University of California, San Diego psychiatrist who directs the university’s Center for Medicinal Cannabis Research).

⁷³ *See* EDDY, *supra* note 46, at 29.

⁷⁴ *Id.* at 26. In addition to the fact that “many patients have found that they benefit more from the whole plant than from any synthetically produced chemical derivative,” proponents argue that “scientists are a long way from knowing for sure which ones, singly or in combination, provide which therapeutic effects.” *Id.* (internal citation omitted).

⁷⁵ *Id.* at 26–27 (noting that Marinol currently retails for approximately \$17 per pill).

⁷⁶ *See* AM. COLL. OF PHYSICIANS, *supra* note 56, at 3–6.

or may be unable to tolerate the side effects—or may simply respond better to marijuana.⁷⁷

In short, the natural form of marijuana may be preferable for a small subset of patients for whom current products are ineffective, or at least less effective, than marijuana. For example, many cancer patients suffer from “profound nausea and vomiting” as a side effect of chemotherapy.⁷⁸ The cannabinoids in marijuana are an effective treatment for this debilitating adverse effect, which the FDA approval of Marinol and Cesamet evidences. Additionally, a review of thirty clinical studies published in the *European Journal of Cancer Care* reported that cannabinoid drugs have an anti-emetic efficacy superior to conventional anti-nausea drugs.⁷⁹

In AIDS and HIV patients, marijuana relieves a number of symptoms, including wasting (cachexia)⁸⁰ and pain. It can also improve

⁷⁷ INST. OF MEDICINE, *supra* note 38, at 3–4.

⁷⁸ GRINSPOON & BAKALER, *supra* note 21, at 25.

Retching (dry heaves) may last for hours or even days after each treatment, followed by days and even weeks of nausea. Patients may break bones or rupture the esophagus while vomiting. The sense of a loss of control can be emotionally devastating. Furthermore, many patients eat almost nothing because they cannot stand the sight or smell of food. As they lose weight and strength, they find it more and more difficult to sustain the will to live.

Id. “For many patients, the side effects of chemotherapy seem worse than the cancer itself, and they discontinue treatment, not only to eliminate the discomfort but also to regain control over their lives.” *Id.*

⁷⁹ F.C. Machado Rocha et al., *Therapeutic Use of Cannabis Sativa on Chemotherapy-Induced Nausea and Vomiting Among Cancer Patients: Systematic Review and Meta-Analysis*, 17 EUR. J. OF CANCER CARE 431, 440 (2008), available at http://www.phillynorml.org/documents/legis_files/08_Review%20Cannabis%20sativa%20chemotherapy%20enemia_Rocha_EJCC.pdf; see also Martin R. Tramèr et al., *Cannabinoids for Control of Chemotherapy Induced Nausea and Vomiting: Quantitative Systematic Review*, 323 BRIT. MED. J. 16, 20 (2001) (finding cannabinoids to be superior to conventional antiemetics after chemotherapy, that patients preferred them, and that “[i]n selected patients, cannabinoids may be useful as mood enhancing adjuvants for the control of chemotherapy related sickness”). The study authors stated that “potentially serious adverse effects . . . are likely to limit their widespread use,” but also noted that “some side effects could be classified as potentially beneficial (for instance, a sensation of a ‘high,’ euphoria, and drowsiness, sedation, or somnolence).” *Id.* at 18, 20.

⁸⁰ “Wasting syndrome in acquired immune deficiency syndrome (AIDS) patients is defined by the Centers for Disease Control and Prevention as the involuntary loss of more than 10% of baseline average body weight in the presence of diarrhea or fever of more than 30 days that is not attributable to other disease processes.” INST. OF MEDICINE, *supra* note 38, at 154 (internal citation omitted).

mood and sleep.⁸¹ The FDA's approval of Marinol for the treatment of "anorexia associated with weight loss in patients with AIDS" evidences the fact that marijuana and its cannabinoids can stimulate the appetite.⁸² Additionally, according to the American College of Physicians, "research supporting THC as an effective appetite stimulant and antiemetic is abundant," and "[c]linical trials have demonstrated that both oral and smoked marijuana stimulate appetite, increase caloric intake, and result in weight gain among patients experiencing HIV wasting."⁸³ One double-blind study published in the *Journal of Acquired Immune Deficiency Syndromes* compared the effects of Marinol and marijuana on cognitive performance, mood, appetite stimulation, and sleep in HIV-positive marijuana smokers.⁸⁴ It found that Marinol and marijuana both "produced substantial and comparable increases in food intake" and "improved mood without producing disruptions in psychomotor functioning," but that "[smoked] marijuana has the added benefit of improving sleep ratings."⁸⁵ The study also noted that ninety-three percent of the patients surveyed preferred smoked marijuana to Marinol.⁸⁶ Finally, "neither marijuana nor [Marinol] significantly altered performance on any of the tasks (e.g., measures of learning, memory, vigilance, psychomotor ability)," and the researchers stated that the "present data indirectly suggest that tolerance selectively develops to the cognitive effects of marijuana and [Marinol]."⁸⁷

Researchers have also found that smoked marijuana is well-tolerated and effective in treating neuropathic pain in patients with HIV-associated sensory neuropathy.⁸⁸ Although anticonvulsants can also be effective, "some patients fail to respond or cannot tolerate" them.⁸⁹

Marijuana is also effective in the treatment of symptoms of MS. "[P]ainful muscle spasms are among the most common and distress-

⁸¹ See Margaret Haney et al., *Dronabinol and Marijuana in HIV-Positive Marijuana Smokers: Caloric Intake Mood and Sleep*, 45 J. ACQUIR. IMMUNE DEFIC. SYNDR. 545, 552 (2007).

⁸² See EDDY, *supra* note 46, at 8.

⁸³ AM. COLL. OF PHYSICIANS, *supra* note 56, at 4 (internal citation omitted).

⁸⁴ Haney et al., *supra* note 81, at 545.

⁸⁵ *Id.* at 552.

⁸⁶ *Id.*

⁸⁷ *Id.* at 550–52.

⁸⁸ Donald I. Abrams et al., *Cannabis in Painful HIV-Associated Sensory Neuropathy: A Randomized Placebo-Controlled Trial*, 68 NEUROLOGY 515, 515 (2007). HIV-associated sensory neuropathy is a painful nerve disorder. See *id.*

⁸⁹ *Id.* (internal citation omitted).

ing symptoms,” severely influencing patients’ quality of life.⁹⁰ Current therapeutic options are often expensive or unavailable.⁹¹ Most importantly, these drugs do not wholly ameliorate quality of life issues—“available oral anti-spasticity medications often only give partial relief and have gastrointestinal or psychotropic side effects.”⁹² According to researchers, “[a]necdotal evidence, preclinical data, small clinical reports, and phase 2 trials, suggest that cannabis derivatives may play a useful role in alleviating muscle spasms, tremors, pain, and bladder dysfunction associated with MS.”⁹³ In 2005, a “randomized, double-blind, placebo-controlled cross-over study of an orally administered standardized Cannabis sativa plant extract in patients with MS-induced spasticity . . . found the extract to be safe and well tolerated and that it may reduce spasm frequency” and increase mobility.⁹⁴ The study also noted that “beneficial effects upon sleep” were consistent with other studies.⁹⁵ In another study, researchers found smoked marijuana to be “superior to placebo in reducing spasticity and pain.”⁹⁶ Additionally, while the National Multiple Sclerosis Society has not yet recommended that medical marijuana be made widely available to people with MS, it has stated that “it is clear that cannabinoids have potential both for the management of MS symptoms such as pain and spasticity, as well as for neuro-protection.”⁹⁷

Marijuana and its constituent cannabinoids are not completely without their side effects, which include diminished psychomotor performance, unpleasant feelings, and “short term immunosuppres-

⁹⁰ C. Vaney et al., *Efficacy, Safety, and Tolerability of an Orally Administered Cannabis Extract in the Treatment of Spasticity in Patients with Multiple Sclerosis: A Randomized, Double-Blind, Placebo-Controlled, Crossover Study*, 10 *MULTIPLE SCLEROSIS* 417, 417 (2004) (citing L. Provinciali et al., *A Multidimensional Assessment of Multiple Sclerosis: Relationship Between Disability Domains*, 100 *ACTA NEUROL SCAND* 156–62 (1999)).

⁹¹ *Id.*

⁹² *Id.*

⁹³ *Id.* (internal citation omitted).

⁹⁴ *Id.* at 421, 423.

⁹⁵ *Id.* at 422.

⁹⁶ Jody Corey-Bloom et al., *Short-Term Effects of Medicinal Cannabis on Spasticity in Multiple Sclerosis*, http://cmcr.ucsd.edu/images/pdfs/Corey-Bloom_poster_1.pdf (last visited May 28, 2011). Study investigators noted, however, that “although generally well tolerated” smoked cannabis “resulted in statistically significant cognitive effects.” *Id.*

⁹⁷ NAT’L MULTIPLE SCLEROSIS SOCIETY, *EXPERT OPINION PAPER: RECOMMENDATIONS REGARDING THE USE OF CANNABIS IN MULTIPLE SCLEROSIS* (2008), available at <http://www.nationalmssociety.org/for-professionals/healthcare-professionals/publications/expert-opinion-papers/index.aspx>.

sive effects.”⁹⁸ But no “case of human death by cannabis poisoning” has ever been published.⁹⁹ Some have even stated that “[m]arijuana in its natural form is possibly the safest therapeutically active substance known to humanity.”¹⁰⁰ According to the Institute of Medicine, “except for the harms associated with smoking, the adverse effects of marijuana use are within the range of effects tolerated for other medications.”¹⁰¹

Despite conflicting evidence, some have argued that marijuana smoking causes cancer. In fact, “[l]ong term exposure to cannabis smoke has long been thought to increase the risk of respiratory cancers as well as cancers of the mouth, tongue, and esophagus.”¹⁰² Marijuana smoke does contain “many of the components of tobacco smoke,” and far more tar “can be deposited in the lungs” of a marijuana smoker than that of a cigarette smoker with cigarettes of comparable weight.¹⁰³ This is due primarily to the fact that “[m]arijuana cigarettes usually do not have filters, and marijuana smokers typically develop a larger puff volume, inhale more deeply, and hold their breath several times longer than tobacco smokers.”¹⁰⁴

But in a study funded by the National Institute of Health’s National Institute on Drug Abuse, Dr. Donald Tashkin, a pulmonologist at the University of California at Los Angeles, found that “[p]eople who smoke marijuana—even heavy, long-term marijuana users—do not appear to be at an increased risk of developing lung cancer”¹⁰⁵ or other head and neck cancers, including cancer of the tongue, mouth, throat or esophagus.¹⁰⁶ The heaviest smokers that participated in the

⁹⁸ INST. OF MEDICINE, *supra* note 38, at 5. The authors note that “the short term immunosuppressive effects are not well established, but if they exist, they are not likely great enough to preclude a legitimate medical use.” *Id.*

⁹⁹ Stern & DiFonzo, *supra* note 45, at 700 (citing Wayne Hall & Nadia Solowij, *Adverse Effects of Cannabis*, 352 LANCET 1611, 1612 (1998)).

¹⁰⁰ GRINSPOON & BAKALER, *supra* note 21, at 138.

¹⁰¹ INST. OF MEDICINE, *supra* note 38, at 5.

¹⁰² Stern & DiFonzo, *supra* note 45, at 701 (citing Wayne Hall et al., *Cannabinoids and Cancer: Causation, Remediation, and Palliation*, 6 LANCET ONCOLOGY 35, 37 (2005)).

¹⁰³ INST. OF MEDICINE, *supra* note 38, at 111 (internal citations omitted).

¹⁰⁴ *Id.* (citation omitted).

¹⁰⁵ Press Release, Am. Thoracic Soc’y, Study Finds No Link Between Marijuana Use and Lung Cancer (May 23, 2006), *available at* <http://www.thoracic.org/sections/publications/press-releases/conference/articles/2006/press-releases/study-finds-no-link-between-marijuana-use-and-lung-cancer.html>). These findings were presented at the American Thoracic Society International Conference on May 23, 2006. *Id.*

¹⁰⁶ Marc Kaufman, *Study Finds No Cancer-Marijuana Connection*, WASH. POST, May 26, 2006, at A3; Am. Thoracic Soc’y, *supra* note 105; *see also* Tashkin DP et al., *Mariju-*

study had smoked more than twenty-two-thousand marijuana cigarettes in their lives,¹⁰⁷ an amount Dr. Tashkin described as “enormous.”¹⁰⁸ The results surprised Dr. Tashkin, who has studied marijuana for more than thirty years, because “previous studies found that marijuana tar has 50 percent higher concentrations of chemicals linked to cancer than tobacco cigarette tar” and because “marijuana users inhale more deeply and generally hold smoke in their lungs longer than tobacco smokers, exposing them to dangerous chemicals for a longer time.”¹⁰⁹ According to Dr. Tashkin, a possible explanation for the finding is that “THC . . . may encourage aging cells to die earlier and therefore be less likely to undergo cancerous transformation.”¹¹⁰ Ironically, “[f]ederal health and drug enforcement officials have widely used Tashkin’s previous work on marijuana to make the case that the drug is dangerous.”¹¹¹

Other studies have, however, found an increased cancer risk associated with smoking marijuana. A systematic review of “studies assessing the impact of marijuana smoking on lung premalignant findings and lung cancer” concluded the same year as the Tashkin study stated that

[g]iven the prevalence of marijuana smoking and studies predominantly supporting biological plausibility of an association of marijuana smoking and lung cancer on the basis of molecular, cellular, and histopathologic findings, physicians should advise patients regarding potential adverse health outcomes until fur-

ana Use and Lung Cancer: Results of a Case-Control Study, UKCIA, May 24, 2006, <http://www.ukcia.org/research/MjUseAndLungCancer.php>.

¹⁰⁷ Am. Thoracic Soc’y, *supra* note 105.

¹⁰⁸ Neil Osterweill, *ATS: Marijuana Smoking Found Non-Carcinogenic*, MEDPAGE TODAY (May 24, 2006) <http://www.medpagetoday.com/HematologyOncology/LungCancer/3393>.

¹⁰⁹ Kaufman, *supra* note 106.

¹¹⁰ Am. Thoracic Soc’y, *supra* note 105. Further, in regard to the effect of marijuana smoking on lung health, according to Dr. Tashkin, “we can be close to concluding that smoking marijuana by itself does not lead to [chronic obstructive pulmonary disease].” Donald P. Tashkin, *Does Smoking Marijuana Increase the Risk of Chronic Obstructive Pulmonary Disease?*, 180 CANADIAN MED. ASSOC. J. 797, 798 (2009). “COPD (chronic obstructive pulmonary disease) is a serious lung disease which makes it hard to breathe. Also known by other names, such as emphysema or chronic bronchitis, COPD is now the 4th leading cause of death in the United States and also causes long-term disability.” *Chronic Obstructive Pulmonary Disease*, NAT’L HEART LUNG AND BLOOD INST., <http://www.nhlbi.nih.gov/health/public/lung/copd/> (last visited Mar. 27, 2011).

¹¹¹ Kaufman, *supra* note 106.

ther rigorous studies are performed that permit definitive conclusions.¹¹²

Another study published in the *European Respiratory Journal* in 2008 reportedly found a fivefold increase in risk of lung cancer in individuals who smoked marijuana daily for ten years but “no effect in less heavy users.”¹¹³ Responding to these study results, Dr. Tashkin attributed what he referred to as the “vastly inflated estimates” to the small sample size.¹¹⁴

More clinical research is needed to establish definitively whether the medical use of marijuana is detrimental to the lungs or leads to an increase in lung cancer. Unquestionably, however, for some terminally ill patients, the immediate benefits of medical marijuana outweigh the risk of potentially developing lung cancer.¹¹⁵ Even if smoking cannabis does affect lung health, patients can lessen the risk of harm by using a vaporizer, which heats marijuana enough to release the cannabinoids without combustion and the “attendant smoke toxins.”¹¹⁶ In fact, researchers have found that “vaporization of cannabis is a safe and effective mode of delivery of THC.”¹¹⁷ Patients can also cook and eat marijuana in its botanical form.¹¹⁸

Opponents of the medical use of marijuana have also pointed to the effect of marijuana on the immune system, which could be particularly dangerous to patients with compromised immune systems, such as those living with AIDS or cancer. But the “effect is difficult to understand because studies are contradictory.”¹¹⁹ Some studies have shown that “marijuana weakens the immune system”¹²⁰ while others have found that “cannabis stimulates the immune system and plays an

¹¹² Reena Mehra et al., *A Systematic Review: The Association Between Marijuana Smoking and Lung Cancer*, 166 ARCH. INTERN. MED. 1359, 1367 (2006).

¹¹³ Jill U. Adams, *Damaging Habit?*, L.A. TIMES, Aug 18, 2008, at F6.

¹¹⁴ *Id.*

¹¹⁵ See INST. OF MEDICINE, *supra* note 38, at 159 (“Terminal cancer patients pose different issues. For those patients the medical harms associated with smoking is of little consequence. For terminal patients suffering debilitating pain or nausea and for whom all indicated medications have failed to provide relief, the medical benefits of smoked marijuana might outweigh the harm.”).

¹¹⁶ D.I. Abrams et al., *Vaporization as a Smokeless Cannabis Delivery System: A Pilot Study*, 82 CLINICAL PHARMACOLOGY & THERAPEUTICS 571, 571 (2007).

¹¹⁷ *Id.*

¹¹⁸ See EDDY, *supra* note 46, at 29.

¹¹⁹ Stern & DiFonzo, *supra* note 45, at 701–02.

¹²⁰ See *Exposing the Myth of Medical Marijuana*, *supra* note 47 (citing I. B. Adams et al., *Cannabis: Pharmacology and Toxicology in Animals and Humans*, 91 ADDICTION 1585, 1585–1614 (1996)).

important role in controlling immune responses.”¹²¹ Some have criticized the studies that have shown immune suppression as misleading because of the “very high concentrations of drug used to produce” the results.¹²² Ultimately, no conclusive determination can be made as to marijuana’s impact on the immune system.

Opponents and public policy makers involved in the “war on drugs” continue to hold that marijuana is a “gateway” drug because “most users of other illicit drugs have used marijuana first.”¹²³ But “there is no conclusive evidence that the drug effects of marijuana are causally linked to the subsequent abuse of other illicit drugs.”¹²⁴ Furthermore, the Institute of Medicine has noted that any evidence supporting the “gateway” theory is inapplicable to medical marijuana and that whether “medical availability would increase drug abuse” is “beyond the issues normally considered for medical use of drugs and should not be a factor in evaluating the therapeutic potential of marijuana or cannabinoids.”¹²⁵

Data from states with medical-marijuana laws have also consistently shown that legalization of medical marijuana does not send the wrong message to children or increase recreational use of the drug.¹²⁶ According to a study by the Marijuana Policy Project advocacy organization, “data shows that no state with a medical marijuana law has experienced an increase in youth marijuana use since their law’s enactment,” and “all states have reported overall decreases—exceeding 50% in some age groups.”¹²⁷ Additionally, legalizing the medical use of marijuana does not decriminalize *recreational* use of the drug; people who use marijuana for recreational purposes are still subject to federal and state criminal penalties.

¹²¹ Stern & DiFonzo, *supra* note 45, at 702 (citing J. Ludovic Croxford et al., *Cannabinoids and the Immune System: Potential for the Treatment of Inflammatory Disease?*, 166 J. NEUROIMMUNOLOGY 3, 4 (2005)). Additionally, in one study, “oral or smoked cannabinoids did not prove unsafe to patients infected with HIV.” *Id.* (citing Oliver Ulrich et al., *Immune Control by Endocannabinoids—New Mechanisms of Neuroprotection?*, 184 J. NEUROIMMUNOLOGY 127, 129 (2006)).

¹²² See Leo E. Hollister, *Marijuana and Immunity*, 24 J. OF PSYCHOACTIVE DRUGS 159,159–63 (1992).

¹²³ INST. OF MEDICINE, *supra* note 38, at 6 (“[M]ost users of other illicit drugs have used marijuana first.”).

¹²⁴ *Id.*

¹²⁵ *Id.* at 7.

¹²⁶ See KAREN O’KEEFE ET AL., MARIJUANA POLICY PROJECT, MARIJUANA USE BY YOUNG PEOPLE: THE IMPACT OF STATE MEDICAL MARIJUANA LAW (2008), available at http://www.phillynorml.org/documents/legis_files/TeenUseReport_0608.pdf.

¹²⁷ *Id.* at 1.

A large number of organizations “support the use of marijuana as a medicine,”¹²⁸ and many more support medical-marijuana research,¹²⁹ including the Institute of Medicine and the American College of Physicians (ACP).¹³⁰ The ACP also advocates reviewing marijuana’s Schedule I classification and protecting patients using marijuana in compliance with state law from federal criminal prosecution.¹³¹

The bottom line is that marijuana and its constituent cannabinoids can be superior to available alternatives for symptom relief in certain patient populations. While there are health risks associated with smoking marijuana, the benefits appear to outweigh the harms for some patients with debilitating medical conditions, such as the terminally ill. As the Leukemia and Lymphoma Society has stated, “[I]t cannot seriously be contested that there exists a small but significant class of individuals who suffer from painful chronic, degenerative, and terminal conditions, for whom marijuana provides uniquely effective relief.”¹³² Citizens of New Jersey will now have access to that relief.

III. LEGAL BACKGROUND

A. *Federal Prohibition of Marijuana Under the Controlled Substances Act*

The possession, distribution, or cultivation of marijuana, even for medical purposes, violates the federal Controlled Substance Act (CSA) and Title II of the Comprehensive Drug Abuse Prevention and

¹²⁸ See *Health Organizations’ Endorsements*, NAT’L ORG. FOR THE REFORM OF MARIJUANA LAWS (NORML), http://norml.org/index.cfm?Group_ID=3388 (last updated June 17, 2004). These organizations include the American Academy of Family Physicians, AIDS Action Council, the American Medical Student Association, the American Nurses Association, the American Preventive Medical Association, the American Public Health Association, the National Association for Public Health Policy, the New England Journal of Medicine, and the New Jersey State Nurses Association. *Quick Reference*, NAT’L ORG. FOR THE REFORM OF MARIJUANA LAWS (NORML), http://norml.org/index.cfm?Group_ID=3389 (last updated June 16, 2008).

¹²⁹ *Id.* This includes the American Cancer Society. *Id.*

¹³⁰ See INST. OF MEDICINE, *supra* note 38, at 10–11; AM. COLL. OF PHYSICIANS, *supra* note 56, at 3.

¹³¹ AM. COLL. OF PHYSICIANS, *supra* note 56, at 3.

¹³² EDDY, *supra* note 46, at 26 (citing Brief for the Leukemia and Lymphoma Society et al. as Amici Curiae Supporting Respondents at 4, *Gonzales v. Raich*, 545 U.S. 1 (2005) (No. 03-1454)).

Control Act of 1970.¹³³ In fact, the CSA applies even to entirely intrastate marijuana-related activities.¹³⁴ Under the CSA, controlled substances are categorized into five schedules “based on their accepted medical uses, the potential for abuse, and their psychological and physical effects on the body.”¹³⁵ Marijuana is classified as a Schedule I controlled substance.¹³⁶ Schedule I drugs are those considered to have “a high potential for abuse,” to lack “currently accepted medical use in treatment,” and to lack accepted safety for use under medical supervision.¹³⁷ “By classifying marijuana as a Schedule I drug, as opposed to listing it on a lesser schedule, the manufacture, distribution, or possession of marijuana became a criminal offense, with the sole exception being use of the drug as part of a Food and Drug Administration pre-approved research study.”¹³⁸ Additionally, as a Schedule I drug, physicians may not prescribe and pharmacists are precluded from dispensing marijuana.¹³⁹ Simple possession of marijuana for personal use is a misdemeanor under federal law¹⁴⁰ that carries a sen-

¹³³ 21 U.S.C. § 841(a)(1) (2006) (making it unlawful to knowingly or intentionally “manufacture, distribute, or dispense, or possess with intent to manufacture, distribute, or dispense, a controlled substance” except as authorized by this title); *id.* § 844(a) (making it unlawful to knowingly or intentionally possess a controlled substance); *id.* § 812 Schedule I (c)(10) (classifying marijuana as a Schedule I controlled substance).

¹³⁴ Congress is authorized to enact laws regulating interstate commerce under the Commerce Clause of the United States Constitution. *See* U.S. CONST. art. 1, § 8, cl. 3. Congress exercised its Commerce Clause power when it enacted the CSA. *See* Tammy L. McCabe, Comment, *It’s High Time: California Attempts to Clear the Smoke Surrounding the Compassionate Use Act*, 35 MCGEORGE L. REV. 545, 547 (2004) (finding that local cultivation and distribution of controlled substances not integral to the flow of interstate commerce nonetheless have a “substantial and direct effect” on interstate commerce and contribute to the swelling of interstate traffic of controlled substances (citing 21 U.S.C.A. § 801(3)–(6) (West 1999))). The CSA applies to entirely “intrastate marijuana-related activities, including cultivation, possession, transportation and distribution of marijuana” in any state. *See id.*; *see also* *Gonzales v. Raich*, 545 U.S. 1, 9 (2005) (“Congress’ Commerce Clause authority includes the power to prohibit the local cultivation and use of marijuana in compliance with California law.”).

¹³⁵ *Gonzales*, 545 U.S. at 13 (citing 21 U.S.C. §§ 811, 812 (2000)); *see also* 21 U.S.C. § 812 (2006) (listing the criteria for each schedule).

¹³⁶ § 812 Schedule I(c)(10).

¹³⁷ § 812(b)(1). In contrast, drugs with recognized medical uses, such as opium, cocaine, and amphetamine, were assigned to Schedules II through V, depending on their potential for abuse. EDDY, *supra* note 46, at 3 (citation omitted); *see also* § 812.

¹³⁸ *Gonzales*, 545 U.S. at 14 (citing 21 U.S.C. §§ 823(f), 841(a)(1), 844(a) (2000); *United States v. Oakland Cannabis Buyers’ Coop.*, 532 U.S. 483, 490 (2001)).

¹³⁹ *See* 21 U.S.C. § 829 (2006) (detailing how drugs classified in Schedules II through V may be prescribed and dispensed); *see also* *Oakland Cannabis Buyers’ Coop.*, 532 U.S. at 491–92.

¹⁴⁰ *See* H.R. REP. NO. 91-1444 (1970), *reprinted in* 1970 U.S.C.C.A.N. 4566, 4570–77.

tence of up to one year in federal prison and a maximum fine of \$100,000 for a first offense.¹⁴¹ Furthermore, the cultivation of marijuana is a felony under federal law;¹⁴² the growth of just one plant carries up to five years in federal prison and a fine of up to \$250,000 for a first offense.¹⁴³ Despite the widespread recognition of the potential therapeutic benefits of marijuana,¹⁴⁴ repeated attempts to remove marijuana from the CSA or have it re-scheduled on the federal level¹⁴⁵ have failed.¹⁴⁶

B. The States Take Action: A Brief Overview of State Medical-Marijuana Laws

Medical-marijuana advocates have had greater success with legalization at the state level. Between 1978 and 2008, thirty-six states and the District of Columbia enacted some type of medical-marijuana

¹⁴¹ See 21 U.S.C. § 844(a) (2006); 18 U.S.C. § 3571(b)(5) (2006).

¹⁴² See 21 U.S.C. § 802(15) (2006) (defining “manufacture” to include “production” of a drug); § 802(22) (defining “production” to include, *inter alia*, cultivation or growing of a controlled substance); see also *United States v. Angel*, 576 F.3d 318, 321 n.2 (6th Cir. 2009) (“The manufacture or cultivation of marijuana is a felony offense under . . . federal . . . law.” (citing § 841(a)(1), (b)(1)(D)(1))).

¹⁴³ *Id.* § 841(b)(1)(D).

¹⁴⁴ See *supra* Part II.

¹⁴⁵ The CSA authorizes the Attorney General to determine appropriate scheduling of controlled substances and to transfer substances between schedules if it finds that a drug does not meet the criteria for an individual schedule. See 21 U.S.C. § 811 (2006). The Attorney General has delegated this authority to the Administrator of the Drug Enforcement Administration. 28 C.F.R. § 0.100(b) (2006). Additionally, [b]ecause Congress created the Controlled Substances Act (CSA), Congress can change it. Some possibilities include: passing a bill to move marijuana into a less restrictive schedule; moving marijuana out of the CSA entirely; or even replacing the entire CSA with something completely different. In addition, Congress can remove criminal penalties for the medical use of marijuana regardless of what schedule it is in.

MARIJUANA POLICY PROJECT, *supra* note 10, at 4. Finally, “[b]ecause the F[ood] [and] D[rug] A[dministration] is part of the U.S. Department of Health and Human Services (HHS), the U.S. Secretary of Health and Human Services can declare that marijuana meets sufficient standards of safety and efficacy to warrant rescheduling.” *Id.*

¹⁴⁶ See *Alliance for Cannabis Therapeutics v. DEA*, 15 F.3d 1131, 1131, 1137 (D.C. Cir. 1994) (noting that petitions to reschedule marijuana were first filed in 1972 and had been before the U.S. Court of Appeals for the District of Columbia Circuit on four prior occasions and upholding the Administrator of the Drug Enforcement Administration’s denial to reschedule marijuana); Drug Enforcement Administration, Notice of Denial of Petition, 66 Fed. Reg. 20,038 (2001) (denying a petition to reschedule marijuana based on the scientific and medical findings of the Department of Health and Human Services that marijuana has a high potential for abuse); see also *Gettman v. DEA*, 290 F.3d 430 (D.C. Cir. 2002); *Krumm v. Holder*, No. CIV 08-1056 JB/WDS, 2009 U.S. Dist. LEXIS 52748 (D.N.M. May 27, 2009).

law;¹⁴⁷ currently, laws in thirty-one states and the District of Columbia “recognize marijuana’s medicinal value.”¹⁴⁸ Unfortunately, federal restrictions render many of these state laws ineffective and merely symbolic.¹⁴⁹ For instance, a number of state laws allow possession of marijuana obtained by a physician’s prescription.¹⁵⁰ Several other states and the District of Columbia have re-scheduled marijuana at the state level to recognize the drug’s therapeutic value.¹⁵¹ These laws do little to provide individuals with legal access to medical marijuana, however, because physicians are still unable to prescribe and pharmacists are still unable to dispense marijuana without violating federal law.¹⁵² Seven states have also passed “non-binding resolutions urging the federal government to make marijuana medically available.”¹⁵³ While these resolutions carry little legal weight, they clearly symbolize that the states recognize the need to provide individuals with access to a medication that has palliative effects.

In 1996, California was the first state in the nation to pass an effective medical-marijuana law when fifty-six percent of California voters approved ballot Proposition 215, codified as the Compassionate Use Act of 1996.¹⁵⁴ Twelve states followed California’s lead and

¹⁴⁷ MARIJUANA POLICY PROJECT, *supra* note 10, at 10.

¹⁴⁸ *Id.* at 1.

¹⁴⁹ *Id.* at 5.

¹⁵⁰ See, e.g., ARIZ. REV. STAT. ANN. § 13-3412.01 (LEXIS through 2010 legislation); CONN. GEN. STAT. ANN. § 21a-246, § 21a-253 (LEXIS through 2010 legislation) (allowing physicians to prescribe marijuana for chemotherapy or glaucoma); LA. REV. STAT. ANN. § 40:1046 (LEXIS through 2010 Reg. Sess.) (allowing physicians to prescribe marijuana for glaucoma, cancer chemotherapy and spastic quadriplegia); N.H. REV. STAT. ANN. § 318-B:9 (2010) (allowing physicians to prescribe marijuana for cancer chemotherapy and radiology); VA. CODE ANN. § 18.2-251.1 (LEXIS through 2010 Reg. Sess.) (allowing physicians to prescribe marijuana for glaucoma and cancer).

¹⁵¹ See MARIJUANA POLICY PROJECT, *supra* note 10, at app. A-13–16. In addition to the District of Columbia, the following states have re-scheduled marijuana at the state level: Iowa, Tennessee, Arkansas, Maine, New Mexico (only in regard to patients obtaining marijuana for medicinal purposes under the state Lynn and Erin Compassionate Use Act), and Massachusetts. See *id.* at app. A.

¹⁵² See *United States v. Oakland Cannabis Buyers’ Coop.*, 532 U.S. 483, 491 (2001); see also 21 U.S.C. § 829 (2006) (detailing how drugs classified in Schedules II through V may be prescribed and dispensed).

¹⁵³ MARIJUANA POLICY PROJECT, *supra* note 10, at app. A-20. These states include California, Michigan, Missouri, New Hampshire, New Mexico, Rhode Island, and Washington. *Id.*

¹⁵⁴ See NORML, *supra* note 1; see also CAL. HEALTH & SAFETY CODE § 11362.5 (West 2007). California’s medical marijuana law was amended in 2004 by the Medical Marijuana Program, codified as sections 11362.7–.9.

enacted medical-marijuana legislation between 1998 and 2008.¹⁵⁵ In addition to California, medical-marijuana laws in Alaska, Colorado, Maine, Michigan, Montana, Nevada, Oregon, and Washington were enacted through the ballot-initiative process or by statewide referendum.¹⁵⁶ In June 2000, Hawaii was the first state to have its state legislature enact its Medical Use of Marijuana Act¹⁵⁷ rather than using a ballot initiative as previous states had done.¹⁵⁸ New Mexico, Rhode Island, and Vermont soon followed Hawaii's lead.¹⁵⁹ While each state law varies in the protection that it provides, each has "removed state-level criminal penalties for the cultivation, possession, and use of ma-

¹⁵⁵ See COLO. CONST. art. XVIII, § 14 (LEXIS through 67th Gen. Assembly, 1st Sess.); ALASKA STAT. §§ 17.37.010-.080, 11.71.090 (LexisNexis, LEXIS through 2010 Reg. Sess.); COLO. REV. STAT. §§ 18-18-406.3, 25-1.5-106 (LEXIS through 67th Gen. Assembly, 1st Sess.); HAW. REV. STAT. §§ 329-121 to -128 (LexisNexis, LEXIS through 2010 Reg. Sess.); ME. REV. STAT. tit. 22, § 2383-B (LexisNexis, LEXIS through 2009 2d Reg. Legis. Sess.); MICH. COMP. LAWS ANN. §§ 333.26421 to .26430 (LexisNexis, LEXIS through P.A. 383 of 2010 Leg. Sess.); MONT. CODE ANN. §§ 50-46-101 to -210 (LexisNexis, LEXIS through 2009 Reg. and Spec. Sess.); NEV. REV. STAT. §§ 453A.010 to 810 (LexisNexis, LEXIS through 2010 Reg. Sess.); N.M. STAT. ANN. §§ 26-2B-1 to -7 (LexisNexis, LEXIS through 2010 2d Spec. Sess.); OR. REV. STAT. §§ 475.300 to .375 (LEXIS through 2009 Legis. Sess.); R.I. GEN. LAWS § 21-28.6-1 to -12 (LEXIS through Jan. 2010 Legis. Sess.); VT. STAT. ANN. tit. 18, §§ 4472 to 4474(d) (LEXIS through 2010 Sess.); WASH. REV. CODE §§ 69.51A.005 to .902 (LexisNexis, LEXIS through 2010 Reg. and 2d Spec. Sess.). Maryland has also attempted to provide individuals in need of marijuana for medicinal purposes with some protection from criminal prosecution by allowing individuals to raise a defense of medical necessity for the use or possession of marijuana during sentencing. See MD. CODE ANN., CRIM. LAW §§ 5-601(c), -619(c) (LexisNexis, LEXIS through 2010 Reg. Sess.) (allowing defendants to raise a defense of medical necessity for marijuana use or possession and for possession or use of drug paraphernalia, respectively). If use is proven, an individual is subject to a fine not to exceed one-hundred dollars but is not be subjected to jail time. See *id.* The law fails, however, to provide a defense for cultivation by a medical-marijuana user or their caregiver. MARIJUANA POLICY PROJECT, *supra* note 10, at 1. A necessity defense "gives defendants a chance to prove in court that their violation of the law was necessary to avert a greater evil." *Id.* at app. K-1. In addition, on May 4, 2010, Washington, D.C. amended its law to allow the medical use of marijuana by patients suffering from select chronic illnesses. See Ashley Southall, *Washington, D.C., Approves Medical Use of Marijuana*, N.Y. TIMES, May 4, 2010, at A17.

¹⁵⁶ MARIJUANA POLICY PROJECT, *supra* note 10, at 1. See also EDDY, *supra* note 46, at 18. Interestingly, since California enacted the first medical law via ballot initiative in 1996, "voters have approved medical marijuana initiatives in every state where they have appeared on a ballot with the exception of South Dakota, where a medical marijuana initiative was defeated in 2006 by 52% of the voters." *Id.*

¹⁵⁷ HAW. REV. STAT. §§ 329-121 to -128 (LexisNexis, LEXIS through 2010 Reg. Sess.)

¹⁵⁸ See NORML, *supra* note 1; see also MARIJUANA POLICY PROJECT, *supra* note 10, at app. A-2.

¹⁵⁹ See MARIJUANA POLICY PROJECT, *supra* note 10, at 1.

rijuana, if such use has been recommended by a medical doctor.”¹⁶⁰ Each also provides some type of protection for patients, their caregivers, and physicians.¹⁶¹

C. *The Interplay Between State Medical-Marijuana Laws and the CSA*

1. The CSA, Preemption, and States’ Continued Experimentation

The CSA does not preempt state medical-marijuana laws because Congress did not intend to occupy the field of drug regulation when it enacted the CSA, and it sought to leave regulation of the practice of medicine to the states. Further, thus far, no state law has been found to conflict with the federal law.¹⁶² In short, the state and federal governments simultaneously occupy the field of drug regulation. Thus, while Congress enacts criminal drug laws as an exercise of its Commerce Clause power,¹⁶³ states do so also pursuant to their police powers to enact legislation for the protection of the health of their citizens.¹⁶⁴

The Supreme Court has never explicitly ruled that the CSA preempts state medical-marijuana laws.¹⁶⁵ Additionally, it has never invalidated a state medical-marijuana law.¹⁶⁶ In *Gonzales v. Raich*, two California citizens sought “injunctive and declaratory relief prohibiting the enforcement of the CSA” to the extent that it prevented the patients “from possessing, obtaining, or manufacturing” marijuana for their personal use under California’s Compassionate Use Act

¹⁶⁰ EDDY, *supra* note 46, at 17.

¹⁶¹ *See id.*

¹⁶² As stated in a Congressional Research Service report prepared for Congress that reviewed and analyzed federal and state law policies regarding medical marijuana,

[s]tates can statutorily create a medical use exception for botanical cannabis and its derivatives under their own, state-level controlled substances laws. At the same time, federal agents can investigate, arrest, and prosecute medical marijuana patients, caregivers, and providers in accordance with the federal Controlled Substances Act, even in those states where medical marijuana programs operate in accordance with state law.

EDDY, *supra* note 46, at 4.

¹⁶³ *See supra* note 134.

¹⁶⁴ *See* U.S. CONST. amend. X. This power is reserved by the states in the Tenth Amendment of the United States Constitution, which states, “The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.” *Id.*

¹⁶⁵ This observation is based on a Lexis search conducted in October 2009.

¹⁶⁶ *Id.*

(CUA).¹⁶⁷ While the Court held that Congress's Commerce Clause authority "includes the power to prohibit the local cultivation and use of marijuana in compliance with California law," it did not invalidate the state law.¹⁶⁸ In fact, *Gonzales* "was not decided on preemption grounds,"¹⁶⁹ and the Court's holding "does not mean that the CUA is preempted by federal law."¹⁷⁰

Although no lower court has addressed whether the CSA preempts state medical-marijuana laws in their entirety,¹⁷¹ two courts have held that specific portions of the CUA were not preempted by the CSA.¹⁷² In *City of Garden Grove v. Superior Court*, a California appellate court determined that in enacting the CSA, Congress "made it clear" that it had no intention of preempting the states "on the issue of drug regulation."¹⁷³ The court explained:

Indeed, the CSA explicitly contemplates a role for the States in regulating controlled substances It provides: "No provision of the CSA shall be construed as indicating an intent on the part of Congress to occupy the field in which that provision operates, including criminal penalties, to the exclusion of any State law on the same subject matter which would otherwise be within the authority of the State, unless there is a positive conflict between the provision . . . and that State law so that the two cannot consistently stand together."¹⁷⁴

¹⁶⁷ *Gonzales v. Raich*, 545 U.S. 1, 1 (2005).

¹⁶⁸ *See id.* at 9.

¹⁶⁹ *City of Garden Grove v. Superior Ct.*, 68 Cal. Rptr. 656, 673 (Cal. Ct. App. 2007). The court stated:

The upshot of *Raich* is that the federal government and its agencies have the authority to enforce the federal drug laws, even in a state like California that has sanctioned the use of marijuana for medicinal purposes. However, we do not read *Raich* as extending beyond this particular point, into the realm of preemption.

Id. at 674.

¹⁷⁰ *Id.* at 674. In its discussion of *Gonzales v. Raich*, the court specifically stated that "the high court's decision did not sound the death knell of the CUA in state court proceedings." *Id.*

¹⁷¹ This observation is based on a Lexis search conducted in October 2009.

¹⁷² *City of Garden Grove*, 68 Cal. Rptr. at 678 ("[F]ederal supremacy principles do not prohibit the return of marijuana to a qualified user whose possession of the drug is legally sanctioned under state law."); *County of San Diego v. San Diego NORML*, 81 Cal. Rptr. 3d 461, 481–83 (Cal. Ct. App. 2008) (holding that California medical-marijuana identification card laws are not preempted by the CSA).

¹⁷³ *City of Garden Grove*, 157 68 Cal. Rptr. at 675.

¹⁷⁴ *Id.* (citing 21 U.S.C. § 903 (2006)) (internal citations and quotations omitted).

Thus, according to the court, “this express statement by Congress . . . gives the usual assumption against preemption additional force.”¹⁷⁵ Furthermore, the court stated that “Congress enacted the CSA to combat recreational drug abuse and curb drug trafficking,” and that “[i]ts goal was not to regulate the practice of medicine, a task that falls within the traditional powers of the states.”¹⁷⁶ Ultimately, the court found that California’s CUA represents “a state statutory scheme that limits state prosecution for medical marijuana possession but does not limit enforcement of the federal drug laws.”¹⁷⁷ This scenario, according to the court, “simply does not implicate federal supremacy concerns.”¹⁷⁸

After the Supreme Court handed down its ruling in *Gonzales*, the Attorneys General from every state that had removed criminal penalties for the medical use of marijuana responded that the decision would have little impact on the viability of the state laws.¹⁷⁹ And since the ruling, “these laws have continued to provide near total protection for the sick and dying patients they are intended to protect.”¹⁸⁰

While the federal government has authority to enforce its laws throughout the United States, it has no authority to require states to enforce federal law or to “force states to have laws that are identical to federal law.”¹⁸¹ State medical-marijuana laws are not preempted by the CSA because they do not conflict with the federal law, and states may continue to enact medical-marijuana legislation.¹⁸²

2. The Obama Administration: A New Take on Federal Drug Law Enforcement

The Obama administration has vowed to refrain from prosecuting individuals who violate federal drug statutes if their actions are lawful under state law, a move that stands in stark contrast to the policies of both the Clinton and Bush administrations.

¹⁷⁵ *Id.* (internal quotations omitted).

¹⁷⁶ *Id.* (internal quotations omitted).

¹⁷⁷ *Id.* at 676.

¹⁷⁸ *Id.* at 676–77 (internal citations omitted).

¹⁷⁹ See *Implications of U.S. Supreme Court Medical Marijuana Ruling*, MARIJUANA POLICY PROJECT, <http://www.mpp.org/reports/gonzales-v-raich-the-impact.html> (last visited Oct. 31, 2010).

¹⁸⁰ *Id.*

¹⁸¹ MARIJUANA POLICY PROJECT, *supra* note 10, at 8.

¹⁸² See *supra* note 162.

Nevertheless, “the federal government still discourages research into the medicinal uses of smoked marijuana.”¹⁸³ And federal law enforcement agencies can, and until the election of President Obama did, continue to enforce federal law against individuals acting under state exceptions for medical marijuana.¹⁸⁴ Some of the first state medical-marijuana laws were passed while President Bill Clinton was in office.¹⁸⁵ Under his administration, Attorney General Janet Reno and Drug Czar Barry McCaffrey “vowed to enforce violations of federal drug laws, namely the CSA.”¹⁸⁶ The Bush administration went even further, and federal agents raided medical-marijuana distributors that violated federal statutes notwithstanding the dispensaries’ compliance with state law.¹⁸⁷

Even as a presidential candidate, Barack Obama expressed his opinion that “states should be allowed to make their own rules on medical marijuana.”¹⁸⁸ He has also expressed the opinion that marijuana should be treated as a health issue rather than a criminal justice issue.¹⁸⁹ President Obama’s position is that “federal resources should not be used to circumvent state laws.”¹⁹⁰

In February 2009, “in a break from prior policies,” the Obama administration announced “that federal officials would stop raiding dispensaries of medical marijuana authorized under state law.”¹⁹¹

¹⁸³ Harris, *supra* note 9, at A1.

¹⁸⁴ See *infra* notes 186–87 and accompanying text.

¹⁸⁵ See NORML, *supra* note 1. These include laws in California, Alaska, Washington, Maine, Nevada, Colorado and Hawaii. *Id.*

¹⁸⁶ Cathryn L. Blaine, Note, *Supreme Court “Just Says No” to Medical Marijuana: A Look at United States v. Oakland Cannabis Buyers’ Cooperative*, 39 HOUS. L. REV. 1195, 1200 (2002) (citing Nicole Dogwill, Note, *The Burning Question: How Will the United States Deal with the Medical-Marijuana Debate*, 1998 DET. C.L. REV. 247, 253 n.38 (1998) (discussing the federal government’s stance on Proposition 215 in derogation of the CSA)).

¹⁸⁷ See *id.* The effect was particularly felt by California as the first of the states to legalize medical marijuana. *Id.*

¹⁸⁸ Bob Egelko, *U.S. to Yield Marijuana Jurisdiction to States*, S.F. CHRON., Feb. 27, 2009, at A1.

¹⁸⁹ *Id.*

During one campaign appearance, Obama recalled that his mother had died of cancer, and said that he saw no difference between doctor-prescribed morphine and marijuana as pain relievers. He told an interviewer in March that it was “entirely appropriate” for a state to legalize the medical use of marijuana “with the same controls as other drugs prescribed by doctors.”

Id.

¹⁹⁰ *Id.*

¹⁹¹ Brian Seltzer, *A Popular Plant is Quietly Spreading Across TV Screens*, N.Y. TIMES, Sept. 15, 2009, at C1.

Soon after, U.S. Attorney General Eric Holder reported the Justice Department's new policy to only target drug traffickers that use dispensaries as a front.¹⁹² This shift is significant. According to Graham Boyd, director of the American Civil Liberties Union drug law project, states were reluctant to effectuate their medical-marijuana laws because of the previous administrations' policies.¹⁹³ States can now implement their important health policies without interference from the federal government.

True to the Obama administration's earlier representations, on October 19, 2009, the Department of Justice issued a policy memo to the U.S. Attorneys in states with medical-marijuana laws advising them not to allocate federal resources to pursue individuals that are in "clear and unambiguous compliance" with state laws.¹⁹⁴ The memo does not, however, foreclose the possibility that an individual acting in compliance with state law could face federal prosecution for violations of federal law, as it appears to leave prosecution to the discretion of the individual U.S. Attorney.¹⁹⁵ As observed by the *New York Times*, "The new stance was hardly an enthusiastic embrace of medical marijuana, or the laws that allow it in some states, but signaled clearly that the administration thought there were more important priorities for federal prosecutors."¹⁹⁶

¹⁹² David Johnston & Neil A. Lewis, *Obama Administration to Stop Raids on Medical Marijuana Dispensaries*, N.Y. TIMES, Mar. 18, 2009, at A20. But when a federal judge sentenced the owner of a marijuana dispensary in California to a year in prison in June 2009, some worried that the Obama administration's promise was empty. See Solomon Moore, *Prison Term For a Seller of Medical Marijuana*, N.Y. TIMES, June 12, 2009, at A18. According to the U.S. District Attorney for the Central District of California, however, the owner had not been acting in compliance with *state* law, and Justice Department Spokesman Mathew Miller clarified that "as a general rule we are not prioritizing federal resources to go after individuals or organizations unless there is a violation of both federal and state law." *Id.* Therefore, only if an individual violates the very state law that protects his federally prohibited action does he risk prosecution.

¹⁹³ See Johnston & Lewis, *supra* note 192, at A20.

¹⁹⁴ Memorandum on Investigations and Prosecutions in States Authorizing the Medical Use of Marijuana from David W. Ogden, Deputy Att'y Gen., U.S. Dep't of Justice, to Selected United States Att'ys (Oct. 19, 2009), available at <http://www.justice.gov/opa/documents/medical-marijuana.pdf>. Noting that "the Department of Justice is committed to the enforcement of the Controlled Substances Act in all States" and that "[t]his guidance regarding resource allocation does not 'legalize' marijuana or provide a legal defense to a violation of federal law," the memo stated that it "is intended solely as a guide to the exercise of investigative and prosecutorial discretion." *Id.*

¹⁹⁵ See *id.*

¹⁹⁶ David Stout & Solomon Moore, *U.S. Won't Prosecute in States that Allow Medical Marijuana*, N.Y. TIMES, Oct. 20, 2009, at A1. The article notes that "[s]ome federal law enforcement officials opposed the administration's position." *Id.*

3. State Medical-Marijuana Laws Protect Patients In Need

State laws cannot protect individuals from federal prosecution, but they can offer considerable protection to patients. State and local law enforcement are responsible for about ninety-nine percent of marijuana-related arrests.¹⁹⁷ The federal government has not prosecuted anyone living in the first thirteen states with effective medical-marijuana laws for small amounts of marijuana.¹⁹⁸ Thus, state lawmakers are in a position to afford patients almost absolute protection from prosecution related to medical-marijuana use.

IV. THE NEW JERSEY COMPASSIONATE USE MEDICAL MARIJUANA ACT

Until now, existing New Jersey law had failed to distinguish between medical and recreational use, possession, or distribution of marijuana.¹⁹⁹ The NJCMA carves out a narrow exception for the medicinal use of marijuana by individuals who continue to suffer from the symptoms of debilitating medical conditions despite available treatment options.

A. *An Overview of the NJCMA*

1. Purpose of the Act

The NJCMA seeks to protect from arrest and prosecution seriously ill patients who use medical marijuana to “alleviate suffering from debilitating medical conditions.”²⁰⁰ The Act also seeks to protect physicians, caregivers, and authorized producers and distributors of the drug.²⁰¹ This purpose reflects the Legislature’s determination that compassion dictates a distinction in the law’s treatment of those who use marijuana for medical purposes.²⁰²

¹⁹⁷ MARIJUANA POLICY PROJECT, *supra* note 10, at app. R-1.

¹⁹⁸ *Id.*

¹⁹⁹ See N.J. STAT. ANN. §§ 2C:35-1 to -29, 2C:36-1 to -10 (West 2010).

²⁰⁰ N.J. STAT. ANN. § 24:6I-2(e) (West 2010).

²⁰¹ *Id.*

²⁰² See *id.* In addition to the legislature’s determination that “[c]ompassion dictates that a distinction be made between medical and non-medical uses of marijuana,” the New Jersey Legislature has found and declared the following:

a. Modern medical research has discovered a beneficial use for marijuana in treating or alleviating the pain or other symptoms associated with certain debilitating medical conditions, as found by the National Academy of Sciences’ Institute of Medicine in March 1999;

b. According to the U.S. Sentencing Commission and the Federal Bureau of Investigation, 99 out of every 100 marijuana arrests in the country are made under state law, rather than under federal law. Consequently, changing state law will have the practical effect of protecting

2. Registration, Eligibility, and Physician Requirements

The Act requires the Department of Health and Senior Services (DHSS) to establish and maintain a confidential registry of qualifying patients and their primary caregivers.²⁰³ The DHSS must also issue identification cards to qualifying individuals after a verification procedure.²⁰⁴ For a patient and his or her primary caregiver²⁰⁵ to obtain

from arrest the vast majority of seriously ill people who have a medical need to use marijuana;

c. Although federal law currently prohibits the use of marijuana, the laws of Alaska, California, Colorado, Hawaii, Maine, Michigan, Montana, Nevada, New Mexico, Oregon, Rhode Island, Vermont, and Washington permit the use of marijuana for medical purposes, and in Arizona doctors are permitted to prescribe marijuana. New Jersey joins this effort for the health and welfare of its citizens;

d. States are not required to enforce federal law or prosecute people for engaging in activities prohibited by federal law; therefore, compliance with this act does not put the State of New Jersey in violation of federal law;

§ 24:6I-2.

²⁰³ *Id.* § 24:6I-4(a), (f). All information submitted to the DHSS must be kept confidential and may only be disclosed to select individuals who require the information for official purposes, including “authorized employees of State or local law enforcement agencies, only as necessary to verify that a person who has engaged in the suspected or alleged medical use of marijuana is lawfully in possession of a registry identification card.” § 24:6I-4(f)(2). Additionally, a qualifying patient’s patient-physician privilege is not waived by application for, or receipt of, an identification card. § 24:6I-4(g).

²⁰⁴ § 24:6I-4. If the potential primary caregiver otherwise meets the requirements of the Act, a primary-caregiver application will be provisionally approved pending the results of a criminal-background check. § 24:6I-4(b). For a detailed discussion of the primary-caregiver criminal-background check procedures, see § 24:6I-4(c). “The department shall approve or deny an application or renewal within 30 days of receipt of the completed application or renewal, and shall issue a registry identification card within five days of approving the application or renewal.” § 24:6I-4(b). The DHSS may only deny an application or renewal “if the applicant fails to provide the information required . . . or if the department determines that the information was incorrect or falsified or does not meet the requirements of this act.” *Id.* Denial of an application or renewal is a final agency decision, subject to judicial review. *Id.*

²⁰⁵ “Qualifying patient” or “patient” is defined as “a resident of the State who has been provided with a certification by a physician pursuant to a bona fide physician-patient relationship.” *Id.* § 24:6I-3. A “primary caregiver” or “caregiver” is defined as a resident of the State who: (a) is at least 18 years old; (b) has agreed to assist with a registered qualifying patient’s medical use of marijuana, is not currently serving as a primary caregiver for another qualifying patient, and is not the qualifying patient’s physician; (c) has never been convicted of possession or sale of a controlled dangerous substance, unless such conviction occurred after the effective date of this act and was for a violation of federal law related to possession or sale of marijuana that is authorized under this act; (d) has registered with the department pursuant to section 4 of this act, and has satisfied the criminal history record background check requirement of section 4 of this

registry identification cards, which are valid for two years,²⁰⁶ the patient must submit a signed “certification” from the patient’s physician that authorizes the patient to apply for registration to use marijuana medicinally.²⁰⁷ According to the Act, the patient and physician must be in a “bona fide physician-patient relationship,” which the NJCMA defines as “a relationship in which the physician has ongoing responsibility for the assessment, care and treatment of a patient’s debilitating medical condition.”²⁰⁸ A certification cannot be obtained from a physician with whom the patient consults solely for the purpose of obtaining authorization for the medical use of marijuana.²⁰⁹ Only physicians licensed to practice medicine in New Jersey may provide certifications.²¹⁰

Additionally, to qualify under the NJCMA, patients and primary caregivers must be New Jersey citizens.²¹¹ Only those patients with a “debilitating medical condition” are eligible for protection under the NJCMA. The Legislature has defined “debilitating medical condition” to mean:

act; and (e) has been designated as primary caregiver on the qualifying patient’s application or renewal for a registry identification card or in other written notification to the department.

Id. It is important to note that “no applicant shall be disqualified from serving as a registered primary caregiver on the basis of any conviction disclosed by a criminal history record background check . . . if the individual has affirmatively demonstrated to the commissioner clear and convincing evidence of rehabilitation.” § 24:6I-4(c)(5).

²⁰⁶ § 24:6I-4(a).

²⁰⁷ § 24:6I-4(a)(1). “Certification” is defined as “a statement signed by a physician with whom a qualifying patient has a bona fide physician-patient relationship, which attests to the physician’s authorization for the patient to apply for registration for the medical use of marijuana.” § 24:6I-3. In addition to a certification, a qualifying patient must submit an application or renewal fee (to be determined on a sliding scale); the name, address, and birth date of the patient and caregiver (if applicable); and the name, address and telephone number of the patient’s physician. § 24:6I-4(a)(2)–(4).

²⁰⁸ § 24:6I-3.

²⁰⁹ *See id.*

²¹⁰ *Id.* § 24:6I-5(a). “Physician” is defined as:

a person licensed to practice medicine and surgery pursuant to Title 45 of the Revised Statutes with whom the patient has a bona fide patient physician-patient relationship and who is the primary care physician, hospice physician, or physician responsible for ongoing treatment of the patient’s debilitating medical condition, provided, however, that such ongoing treatment shall not be limited to the provision of authorization for a patient to use medical marijuana or consultation solely for that purposes.

§ 24:6I-3.

²¹¹ *Id.*

(1) one of the following conditions, if resistant to conventional medical therapy: seizure disorder, including epilepsy; intractable skeletal muscular spasticity; or glaucoma; (2) one of the following conditions, if severe or chronic pain, severe nausea or vomiting, cachexia, or wasting syndrome results from the condition or treatment thereof: positive status for human immunodeficiency virus, acquired immune deficiency syndrome, or cancer; (3) amyotrophic lateral sclerosis, multiple sclerosis, terminal cancer, muscular dystrophy, or inflammatory bowel disease, including Crohn's disease; (4) terminal illness, if the physician has determined a prognosis of less than 12 months of life; or (5) any other medical condition or its treatment that is approved by the [Department of Health and Senior Services] by regulation.²¹²

Finally, the Act imposes heightened requirements when a qualifying patient is a minor. Specifically, the NJCMA requires written consent to the medical use of marijuana from a parent or legal guardian and a commitment from the parent to “control the acquisition and possession of the medical marijuana and any related paraphernalia.”²¹³

3. Alternative Treatment Centers and Marijuana Quantity

The NJCMA authorizes patients and caregivers to obtain a patient's supply of marijuana from a dispensary — an “alternative treatment center.”²¹⁴ A patient may only register at one alternative treatment center at a time.²¹⁵ The Act requires the DHSS to issue permits to alternative treatment centers and to ensure that the number of dispensaries throughout the state is sufficient to meet demand, including a minimum of two facilities in northern, central, and southern New Jersey.²¹⁶ The first two permits issued in each of the three

²¹² *Id.*

²¹³ § 24:6I-5(b) (defining the fiduciary as a “custodial parent, guardian, or person who has legal custody of the minor”).

²¹⁴ § 24:6I-3. The NJCMA defines “medical marijuana alternative treatment center” or “alternative treatment center” as “an organization approved by the [DHSS] to perform activities necessary to provide registered qualifying patients with usable marijuana and related paraphernalia in accordance with the provisions of [the NJCMA]. This term shall include the organization's officers, directors, board members, and employees.” *Id.*

²¹⁵ *Id.* § 24:6I-10(d).

²¹⁶ *Id.* § 24:6I-7(a). “The department shall approve or deny an application [for an alternative treatment center permit] within 60 days of receipt of the completed application.” § 24:6I-7(e). Denial of an application is a final agency decision, subject to judicial review. *Id.* A permit to operate as an alternative treatment center may be suspended or revoked for cause. *Id.* Such a revocation is also subject to judicial review. *Id.*

regions will be to non-profit entities; for-profit organizations are eligible to apply thereafter.²¹⁷ Precise permit eligibility requirements await the promulgation of regulations by the DHSS.²¹⁸ To obtain a permit, however, every individual involved (including employees, officers, and directors of the centers) must undergo a criminal-background check, for which the applicant must bear the cost.²¹⁹ The DHSS will not issue permits to any person convicted of “a crime involving any controlled dangerous substance or controlled substance analog” under New Jersey law or any similar state or federal law unless the conviction occurs after the NJCMA became effective and is for a violation of *federal* law related to possession or sale of medical marijuana.²²⁰

The NJCMA authorizes the alternative treatment centers to acquire and maintain a “reasonable” inventory, which the DHSS will determine, “of marijuana seeds or seedlings and paraphernalia” and to grow, possess, and supply or sell the marijuana and related supplies to registered patients and their caregivers.²²¹ Centers may charge for “the reasonable costs associated with marijuana production and distribution,” whether they operate on a nonprofit or for-profit basis.²²²

To obtain marijuana from a dispensary under the Act, a patient or caregiver must provide the alternative treatment center with written instructions from the patient’s certifying physician indicating the amount of marijuana that the patient requires over a thirty-day period, which cannot exceed two ounces.²²³ A patient or primary caregiver must also present his or her registry identification card, and the

²¹⁷ § 24:6I-7(a).

²¹⁸ § 24:6I-7(b).

²¹⁹ § 24:6I-7(d)(1).

²²⁰ § 24:6I-7(c) (emphasis added). Note, however, that no alternative treatment center employee will be disqualified “on the basis of any conviction disclosed” by a criminal-background check if the individual shows “clear and convincing evidence of rehabilitation.” See § 24:6I-7(d)(6).

²²¹ § 24:6I-7(a). The Act establishes that alternative treatment centers may “possess, cultivate, plant, grow, harvest, process, display, manufacture, deliver, transfer, transport, distribute, supply, sell, or dispense marijuana, or related supplies to qualifying patients or their primary caregivers who are registered with the [DHSS].” *Id.*

²²² § 24:6I-7(h).

²²³ *Id.* § 24:6I-10(a). “A physician may provide a copy of a written instruction by electronic or other means, as determined by the commissioner, directly to an alternative treatment center on behalf of a registered, qualifying patient.” § 24:6I-10(c). In the event that no amount is noted, no more than two ounces may be dispensed at one time. § 24:6I-10(a). In certain limited situations, a physician may issue multiple instructions at one time, authorizing the patient to receive a total of up to a ninety-day supply. § 24:6I-10(b).

center must verify and log all of the documentation.²²⁴ The DHSS must adopt regulations requiring the dispensaries to document carefully any pickup or delivery for patients.²²⁵

4. Protections Provided by the Act

“Medical use of marijuana” pursuant to the NJCMA means “the acquisition, possession, transport, or use of marijuana or paraphernalia by a registered qualifying patient as authorized by this act.”²²⁶ The Act does not allow patients to cultivate their own marijuana. It does, however, provide patients, caregivers, alternative treatment centers, and physicians acting in conformity with the NJCMA with an affirmative defense to criminal prosecution under New Jersey’s drug laws.²²⁷ Additionally, such individuals will “not be subject to any civil or administrative penalty, or denied any right or privilege, including, but not limited to, civil penalty or disciplinary action by a professional licensing board, related to the medical use of marijuana as authorized” by the Act.²²⁸

The Act provides an explicit exemption from arrest and prosecution—rather than simply an affirmative defense to prosecution—in two instances. First, individuals who are simply in the vicinity or presence of the authorized medical use of marijuana are not subject to arrest or prosecution.²²⁹ Second, parents or guardians are protected from arrest or prosecution “for assisting the minor in the medical use of marijuana as authorized” under the NJCMA.²³⁰

The Act specifically notes that possession of, or application for, a registry card will not constitute probable cause for law enforcement

²²⁴ § 24:6I-10(c). The Act also notes that written physician instructions become void if marijuana is not dispensed pursuant to the instructions within one month. *Id.*

²²⁵ § 24:6I-7(i)(1)–(2). The regulations require written records of “each delivery of marijuana to, and pickup of marijuana for, a registered qualifying patient, including the date and amount dispensed” be maintained by the alternative treatment centers “to ensure effective documentation of the operations of each alternative treatment center.” § 24:6I-7(i)(1).

²²⁶ *Id.* § 24:6I-3

²²⁷ *Id.* § 24:6I-6(b). The Act provides this affirmative defense to prosecution under Chapters 35 and 36 of New Jersey’s Code of Criminal Justice by amending N.J. STAT. ANN. § 2C:35-18 so that a qualifying patient, primary caregiver, physician, alternative treatment center—or any other person acting in accordance with the provisions of the act—may raise an affirmative defense if he or she is in compliance with the NJCMA. *See* § 2C:35-18. A defendant claiming protection under the Act must prove the affirmative defense by a preponderance of the evidence. *Id.* § 24:6I-12(a).

²²⁸ § 24:6I-6(b).

²²⁹ § 24:6I-6(e).

²³⁰ § 24:6I-6(f).

to search one's person or property.²³¹ Law enforcement is also not permitted to destroy marijuana possessed lawfully under the NJCMA, provided that the patient or primary caregiver is in possession of a registry identification card and no more marijuana than is statutorily allowed.²³²

Finally, the Act provides that the State and its employees and agents shall be exempted from liability "for any deleterious outcomes" that may result from a patient's marijuana use.²³³ The Act does not explicitly provide the same protections for physicians or alternative treatment centers.

5. The NJCMA's Sensible Limitations

The Act places sensible limits on when and where a patient may engage in the medical use of marijuana. For instance, patients may not operate a vehicle or heavy equipment "while under the influence of marijuana."²³⁴ This restriction comports with medical evidence suggesting that marijuana may impair motor skills, attention, and reaction time.²³⁵ The NJCMA also restricts where a patient may smoke. For instance, patients are prohibited from smoking marijuana on public transportation, in private cars while in operation, on school grounds, in public parks, beaches and recreational areas, in correctional facilities, and wherever New Jersey law otherwise prohibits smoking generally.²³⁶ The Act seeks to ensure that a patient's medical-marijuana use will not affect other people in public places.

The NJCMA does not require governmental or private insurers to reimburse patients for medical-marijuana costs, and it does not require employers to accommodate marijuana use in any workplace.²³⁷ The Act is silent, however, as to whether employers can fire or refuse to hire an individual for failing a drug test because of lawful marijuana use outside the workplace. This has been an issue in other states, including Oregon, and courts have generally held that employers

²³¹ § 24:6I-6(c).

²³² § 24:6I-6(d).

²³³ *Id.* § 24:6I-15. The Act also protects from liability for "any actions taken in accordance with" the NJCMA. *Id.*

²³⁴ *Id.* § 24:6I-8(a).

²³⁵ AM. COLL. OF PHYSICIANS, *supra* note 56, at 6.

²³⁶ § 24:6I-8(b).

²³⁷ *Id.* § 24:6I-14. Rhode Island is the only state that "specifically protects workers from being fired for their medical use of the drug." Courtney Rubin, *Medical Marijuana Laws Leave Employers Dazed and Confused*, INC.COM (Feb. 12, 2010), <http://www.inc.com/news/articles/2010/02/marijuana-law-confusing.html>.

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need not accommodate medical-marijuana use outside of the workplace.²³⁸

The Act also makes it a crime to transfer or falsify registration cards or to present a false or altered card to law enforcement.²³⁹ This deters abuse of the registration system.

6. Regulation, Reporting Requirements, and Implementation

The NJCMA requires the Commissioner of the DHSS, in consultation with the Department of Law and Public Safety, to “promulgate rules and regulations to effectuate” the Act’s purposes.²⁴⁰ The Act explicitly requires the DHSS to adopt regulations to “monitor, oversee, and investigate all activities performed by an alternative treatment center.”²⁴¹ The Commissioner must also establish standards to “ensure adequate security of all facilities 24 hours per day, including production and retail locations, and security of all delivery methods to registered qualifying patients.”²⁴²

The NJCMA also includes reasonable reporting requirements to detect abuse and ensure that the Act achieves its goal. It mandates that both alternative-treatment centers and participating physicians furnish to the Director of the Division of Consumer Affairs in the Department of Law and Public Safety information for inclusion in a

²³⁸ See, e.g., *Washburn v. Columbia Forest Prods. Inc.*, 104 P.3d 609, 616 (Or. Ct. App. 2005) (reversing a grant of summary judgment, the court stated that “concern about employees coming to work under the influence of marijuana might provide . . . justification for not accommodating [medical-marijuana use outside of the workplace]”).

²³⁹ See N.J. STAT. ANN. § 24:6I-9 (West 2010). These criminal penalties supplement existing criminal law and are not intended to “limit prosecution or conviction for any other offense.” *Id.*

²⁴⁰ *Id.* § 24:6I-16(a). The Commissioner must also adopt interim regulations to implement the provisions of the Act within ninety days of the Act taking effect. § 24:6I-16(b). The regulations will be effective until the adoption of final rules, and regulations may be amended as necessary. *Id.* In terms of financing, the Act would allow the Commissioner of the DHSS to accept from any source grants or contributions to carry out the purpose of the Act. *Id.* § 24:6I-11(a). Additionally, any fees collected pursuant to the Act, including qualifying patient or alternative treatment center application fees, “shall be used to offset the cost of the department’s administration of the provisions of” the Act. § 24:6I-11(b).

²⁴¹ *Id.* § 24:6I-7(i)(2).

²⁴² § 24:6I-7(i)(3).

monitoring system, as is required with other controlled dangerous substances under New Jersey law.²⁴³

The Commissioner of the DHSS must inform the Governor and the Legislature of all actions that the Agency has taken to implement the Act's mandates within one year of the Act's effective date.²⁴⁴ In addition, the Commissioner has extensive annual reporting requirements, including: the number of registry applications, the number of registered patients and primary caregivers, the number of revoked cards, the nature of the reported conditions, the number of permits issued to and revoked from alternative treatment centers, and the number of participating physicians.²⁴⁵ Every two years, starting no later than two years after the Act's effective date, the Commissioner must also report whether the state's total number of alternative treatment centers and the maximum amount of marijuana allowed pursuant to the Act are sufficient to meet patients' needs, in addition to reporting whether the alternative treatment centers are charging excessive prices.²⁴⁶ These reporting requirements will allow the state to assess the law's effectiveness and make any necessary adjustments to it.

Finally, while the NJCMA took effect on October 1, 2010, the DHSS Commissioner and the Director of the Division of Consumer Affairs were authorized to take administrative action in advance to effectuate the Act.²⁴⁷ This timing provision was intended to allow state officials to establish a proper infrastructure before the Act was implemented.

B. Critique of the Legislation

Overall, the NJCMA is among the most restrictive medical-marijuana laws in the nation because it provides considerable safeguards against abuse and diversion. The Act does not conflict with federal law because it requires physicians to provide certifications ra-

²⁴³ N.J. STAT. ANN. § 45:1-45.1(a); *Id.* § 45:1-45. The information provided will be cross-referenced with the electronic system for monitoring controlled dangerous substances currently in existence in New Jersey. *See* § 45:1-45.1(a).

²⁴⁴ *Id.* § 24:6I-12(a)(1).

²⁴⁵ *Id.*

²⁴⁶ § 24:6I-12(c).

²⁴⁷ S. 2105, 214th Leg., 2010–2011 Sess. (N.J. 2010). It is important to note that while the Act was intended to take effect six months after enactment, the legislature approved an amendment to the Act in June 2010 that extended the effective date. *See id.*

ther than prescriptions,²⁴⁸ and it does not remove criminal penalties for violations of federal drug law. More importantly, the NJCMA ensures that citizens of New Jersey who suffer from debilitating medical conditions will have legal access to medical marijuana that is highly regulated and extensively overseen by the DHSS. Despite some room for improvement, New Jersey legislators have crafted a law that has the potential to both achieve its purpose of providing medical marijuana to patients in need and prevent exploitation of the system.

1. Strengths of the NJCMA

The registration requirement and issuance of identification cards are positive aspects of the Act and consistent with the policies of most other states with effective medical-marijuana legislation.²⁴⁹ These safeguards allow New Jersey to track who has authorization to use medical marijuana or to assist in such use. This, in turn, allows law enforcement to know if an individual is operating outside of the NJCMA. The importance of such requirements is evident from examining states that have failed to implement them. In Washington, for example, the lack of a patient registry makes it difficult to track the number of patients using marijuana legally.²⁵⁰ Additionally, because the state does not issue identification cards, law enforcement has had difficulty distinguishing between lawful and unlawful marijuana users.²⁵¹ “As a result, law enforcement varies throughout the state

²⁴⁸ Compare N.J. STAT. ANN. § 24:6I-5 (West 2010), with 21 U.S.C. §§ 812, 829 (2006) (detailing how drugs classified in Schedules II through V may be prescribed and dispensed).

²⁴⁹ See, e.g., COLO. CONST. art. XVIII, § 14 (LEXIS through 67th Gen. Assembly, 1st Sess.); ALASKA STAT. §§ 17.37.030, .080 (LexisNexis, LEXIS through 2010 Reg. Sess.); HAW. REV. STAT. § 329-123 (LexisNexis, LEXIS through 2010 Reg. Sess.); MICH. COMP. LAWS ANN. § 333.26424 (LexisNexis, LEXIS through P.A. 383 of 2010 Leg. Sess.); MONT. CODE ANN. § 50-46-201 (LexisNexis, LEXIS through 2009 Reg. and Spec. Sess.); NEV. REV. STAT. § 453A.200 (LexisNexis, LEXIS through 2010 Reg. Sess.); N.M. STAT. ANN. § 26-2B-4 (LexisNexis, LEXIS through 2010 2d Spec. Sess.); OR. REV. STAT. § 475.309 (LEXIS through 2009 Legis. Sess.); R.I. GEN. LAWS § 21-28.6-4 (2010); VT. STAT. ANN. tit. 18, § 4474(b) (LEXIS through Jan. 2010 Legis. Sess.). Notably, however, some states that have registration programs allow patients and (or) caregivers to raise an affirmative defense to prosecution if they are not registered but otherwise in compliance with the requirements of the statute. E.g., COLO. CONST. Art. XVIII § 14 (LEXIS through 67th Gen. Assembly, 1st Sess.); MICH. COMP. LAWS ANN. § 333.26428 (LexisNexis, LEXIS through P.A. 383 of 2010 Leg. Sess.); MONT. CODE ANN. § 50-46-206 (LexisNexis, LEXIS through 2009 Reg. and Spec. Sess.); NEV. REV. STAT. § 453A.310 (LexisNexis, LEXIS through 2010 Reg. Sess.); OR. REV. STAT. § 475.319 (LEXIS through 2009 Legis. Sess.); R.I. GEN. LAWS § 21-28.6-8 (LEXIS through Jan. 2010 Legis. Sess.).

²⁵⁰ MARIJUANA POLICY PROJECT, *supra* note 10, at app. F-14.

²⁵¹ See *id.*

and several patients have been arrested or had their marijuana seized because police and patients have differing interpretations of the law.”²⁵² Maine has experienced similar problems.²⁵³

The Act also requires that the physician providing the patient’s certification be responsible for the ongoing treatment of the condition for which the patient requires the drug.²⁵⁴ Thus, a patient may not obtain a certification from a physician with whom the patient consulted solely to obtain authorization to use marijuana.²⁵⁵ This provision seeks to prevent abuse by reducing the likelihood that patients will obtain a certification when no real need exists. In California, for instance, patients are only required to obtain an oral recommendation from a physician to obtain medical marijuana.²⁵⁶ The problem, as evidence suggests, is that some physicians freely provide recommendations for medical marijuana—some even advertise their willingness to do so.²⁵⁷

Another positive aspect of the NJCMA is that it allows patients to designate a primary caregiver to assist them in their use or acquisition

²⁵² *Id.* at app. F-15. In addition to proof of identity, patients in Washington are required to have “valid documentation,” which is defined as “a statement signed by a qualifying patient’s physician, or a copy of the qualifying patient’s pertinent medical records, which states that in the physician’s professional opinion, the patient may benefit from the medical use of marijuana.” WASH. REV. CODE § 69.51A.010(5) (a), (b) (LexisNexis, LEXIS through 2010 Reg. and 2d Spec. Sess.). Law enforcement has had difficulty determining what constitutes an appropriate doctor’s recommendation when confronting an individual claiming to be an authorized user. MARIJUANA POLICY PROJECT, *supra* note 10, at app. F-15.

²⁵³ See MARIJUANA POLICY PROJECT, *supra* note 10, at app. F-1, F-10. State authorities in Maine cannot track the number of patients legally using marijuana and law enforcement cannot discern lawful marijuana users from unlawful ones. *Id.* In addition, California has established a voluntary patient registry. See CAL. HEALTH & SAFETY CODE § 11362.71 (Deering, LEXIS through 2010 legislation and 2011 Supp.). Those who register are exempt from arrest and prosecution, while those who do not are exempted only from arrest. See *id.*

²⁵⁴ N.J. STAT. ANN. § 24:6I-3 (West 2010).

²⁵⁵ *Id.*

²⁵⁶ See CAL. HEALTH & SAFETY CODE § 11362.5 (Deering, LEXIS through 2010 legislation and 2011 Supp.). Notably, however, for citizens of California to obtain a voluntary registration card that provides them with an exemption from arrest, heightened requirements must be satisfied. See *id.* § 11362.715 (defining what is required to obtain an identification card, including written documentation from an “attending physician”); *id.* § 11362.7 (defining “attending physician” as, *inter alia*, “an individual . . . who has taken responsibility for an aspect of the medical care, treatment, diagnosis, counseling, or referral of a patient and who has conducted a medical examination of that patient”).

²⁵⁷ See Roger Parloff, *How Marijuana Became Legal*, FORTUNE (Sept. 18, 2009), http://money.cnn.com/2009/09/11/magazines/fortune/medical_marijuana_legalizing.fortune/

of medical marijuana²⁵⁸ and provides the caregiver with the same protection from criminal liability as it does patients, physicians, and dispensary operators.²⁵⁹ This is consistent with each of the thirteen medical-marijuana laws currently in effect, which provide virtually the same protections to caregivers or “designated providers”²⁶⁰ that they do to patients.²⁶¹ Considering that patients in need of marijuana are suffering from debilitating illnesses that could likely require caregiver assistance, caregiver protection is an important aspect of effective medical-marijuana legislation. One potential deficiency in the New Jersey law is that a caregiver may only assist one patient at a time.²⁶² The requirement is arbitrary and a potential barrier to access for patients with no family or friends to serve as a caregiver. The Act should permit professional caregivers to provide assistance to more than one patient at a time.

Another positive aspect of the New Jersey law is that it allows patients to obtain marijuana from dispensaries.²⁶³ The establishment of state-licensed alternative treatment centers under the Act will make New Jersey the fourth state, in addition to New Mexico, Rhode Island, and Maine,²⁶⁴ to establish such strictly regulated medical marijuana

²⁵⁸ N.J. STAT. ANN. § 24:6I-3 (West 2010).

²⁵⁹ See *supra* note 227.

²⁶⁰ See, e.g., WASH. REV. CODE § 69.51A.010 (LexisNexis, LEXIS through 2010 Reg. and 2d Spec. Sess.).

²⁶¹ COLO. CONST. art. XVIII, § 14 (LEXIS through 67th Gen. Assembly, 1st Sess.); ALASKA STAT. §§ 17.37.030, 11.71.090 (LexisNexis, LEXIS through 2010 Reg. Sess.); CAL. HEALTH & SAFETY CODE § 11362.5, 11362.71(e) (Deering, LEXIS through 2010 legislation and 2011 Supp.); COLO. REV. STAT. § 18-18-406.3 (LEXIS through 67th Gen. Assembly, 1st Sess.); HAW. REV. STAT. § 329-125 (LexisNexis, LEXIS through 2010 Reg. Sess.); ME. REV. STAT. tit. 22, § 2383-B (LexisNexis, LEXIS through 2009 2d Reg. Legis. Sess.); MICH. COMP. LAWS ANN. §§ 333.26424, .26428 (LexisNexis, LEXIS through P.A. 383 of 2010 Leg. Sess.); MONT. CODE ANN. §§ 50-46-201, -206 (LexisNexis, LEXIS through 2009 Reg. and Spec. Sess.); NEV. REV. STAT. §§ 453A.200 (LexisNexis, LEXIS through 2010 Reg. Sess.); N.M. STAT. ANN. § 26-2B-4 (LexisNexis, LEXIS through 2010 2d Spec. Sess.); OR. REV. STAT. §§ 475.309 (LEXIS through 2009 Legis. Sess.); R.I. GEN. LAWS § 21-28.6-4 to -8 (LEXIS through Jan. 2010 Legis. Sess.); VT. STAT. ANN. tit. 18, § 4474(b) (LEXIS through 2010 Sess.); WASH. REV. CODE §§ 69.51A.005 (LexisNexis, LEXIS through 2010 Reg. and 2d Spec. Sess.).

²⁶² N.J. STAT. ANN. § 24:6I-3 (West 2010).

²⁶³ *Id.* § 24:6I-7(a).

²⁶⁴ See Abby Goodnough, *A Setback in Maine for Gay Marriage, but Medical Marijuana Law Expands*, N.Y. TIMES (Nov. 4, 2009), <http://www.nytimes.com/2009/11/05/us/politics/05maine.html>. In contrast to the other three states, which each allow only *non-profit* dispensaries, only the first two alternative treatment centers in each of the northern, central and southern regions of New Jersey must function as non-profit entities under the NJCMA. § 24:6I-7(a). Any other alternative treatment center approved by the DHSS may operate as either a non-profit or for-profit entity. *Id.*

dispensaries.²⁶⁵ California, in contrast, does not require dispensaries to obtain licenses, which has resulted in a proliferation of dispensaries and the alleged sale of marijuana to people who should not qualify to receive the drug.²⁶⁶ Opponents of the NJCMA cite California as evidence that dispensaries cause serious abuse and diversion problems.²⁶⁷ The cannabis outlets in California, however, are not state-licensed²⁶⁸ and are thus not regulated adequately by the state.

In comparison, the NJCMA requires licensing, regulation, and extensive oversight of all alternative treatment centers throughout the state.²⁶⁹ This will ensure that New Jersey citizens have safe but controlled access to marijuana. As discussed, the Act requires prospective dispensary operators to obtain a permit from the DHSS.²⁷⁰ To do so, anyone involved in the operations of the center must undergo a criminal-background check.²⁷¹ No one convicted of a crime involving any controlled dangerous substance under New Jersey law or a similar state or federal law would qualify for a permit.²⁷² If, however, the conviction occurred after the NJCMA became effective and was for a violation of *federal* law related to medical marijuana, the person would qualify.²⁷³

Additionally, unlike California dispensaries, New Jersey dispensaries are authorized to distribute marijuana only to patients or care-

²⁶⁵ Goodnough, *supra* note 264. California also allows marijuana cooperatives under its medical marijuana laws, and Oregon allows for marijuana grow sites. See CAL. HEALTH & SAFETY CODE § 11362.775 (Deering, LEXIS through 2010 legislation and 2011 Supp.) (allowing collective or cooperative cultivation of marijuana by qualified persons); OR. REV. STAT. §§ 475.304 to .375 (LEXIS through 2009 Legis. Sess.) (providing for the regulation of marijuana grow sites where individuals are allowed to grow marijuana for qualified patients).

²⁶⁶ Reports vary but they generally indicate that California has more than 700 medical marijuana dispensaries throughout the state. See, e.g., Parloff, *supra* note 257.

²⁶⁷ See, e.g., Mary Pat Angelini, *New Jersey Teens Will Do More Drugs Because We Legalized Medical Marijuana*, NEWJERSEYNEWSROOM.COM (Jan. 26, 2010), <http://www.newjerseynewsroom.com/commentary/new-jersey-teens-will-do-more-drugs-because-we-legalized-medical-marijuana>.

²⁶⁸ See Clark Canfield, *Maine Becomes 5th State to Allow Pot Dispensaries*, ASSOCIATED PRESS, Nov. 5, 2009, available at <http://abcnews.go.com/US/wireStory?id=8997909>.

²⁶⁹ See N.J. STAT. ANN. § 24:6I-7 (West 2010).

²⁷⁰ § 24:6I-7(a).

²⁷¹ § 24:6I-7(d).

²⁷² § 24:6I-7(c). Note, however, that no alternative treatment center employee will be disqualified “on the basis of any conviction disclosed” by a criminal background check if the individual shows clear and convincing evidence of rehabilitation.” See § 24:6I-7(d).

²⁷³ § 24:6I-7(c) (emphasis added).

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givers who present both a registry identification card and written physician instructions that authorize a specific amount to be dispensed.²⁷⁴ The NJCMA also requires centers to verify and log the patient's documentation,²⁷⁵ which ensures that the DHSS will be able to monitor treatment centers' distribution. The added requirement that physicians must report issuing patient certifications and written instructions to the Department of Law and Public Safety, and the inclusion of this information in a monitoring system,²⁷⁶ will also help to prevent abuse and diversion. Furthermore, the Act allows patients to register at only one alternative treatment center at a time.²⁷⁷ This ensures that patients cannot circumvent the quantity limits imposed by the Act.

The requirement that a physician provide written quantity instructions not only eliminates discretion on the part of the alternative treatment centers but also adds legitimacy to the proposed Act. While a physician cannot prescribe marijuana under federal law because it is a Schedule I substance,²⁷⁸ the written instruction requirement brings the process as close to prescribing as possible without violating federal law.

The Act also requires the state to extensively regulate alternative treatment centers. For instance, the DHSS would be responsible for establishing regulations for the approval and monitoring of all alternative treatment center activities.²⁷⁹ It would also set standards to ensure the security of the centers.²⁸⁰ This addresses opponents' concerns about "peripheral crime around these centers in the states that have them."²⁸¹

Another positive aspect of the Act is that it clearly defines the maximum quantity of marijuana that patients are allowed to acquire at any given time.²⁸² When California and Washington first enacted their medical-marijuana laws, neither state's law adequately defined

²⁷⁴ *Id.* § 24:6I-10(c).

²⁷⁵ *Id.*

²⁷⁶ § 24:6I-10(a).

²⁷⁷ § 24:6I-10(d).

²⁷⁸ *See* 21 U.S.C. §§ 812, 829 (2006) (detailing how drugs classified in Schedules II through V may be prescribed and dispensed).

²⁷⁹ N.J. STAT. ANN. § 24:6I-7(b), (i) (West 2010).

²⁸⁰ § 24:6I-7(i).

²⁸¹ *See A804/S119 Passes Assembly Health & Senior Services Committee*, COAL. FOR MEDICAL MARIJUANA – N.J., <http://www.cmmnj.org/id13.htm> (last visited Mar. 27, 2011). During the full General Assembly Health and Senior Services Committee Meeting on June 4, 2009, a representative from the New Jersey Fraternal Order of Police questioned how security would be handled at the centers. *See id.*

²⁸² § 24:6I-10(a).

the allowable quantity.²⁸³ This resulted in confusion among law enforcement that, at least in California, “sometimes err[ed] on the side of prosecuting—or at least hassling—patients if the quantity seem[ed] too large.”²⁸⁴ On the other hand, while it has the potential to prevent abuse and diversion, New Jersey’s limit, two ounces per thirty days,²⁸⁵ appears to be somewhat arbitrary and restrictive. Without knowing the quality of the marijuana, arguing that the amount is inadequate is impossible. But the limit is certainly among the smallest quantities allowed in any of the states that have legalized medical marijuana.²⁸⁶ In addition, some state medical-marijuana laws have

²⁸³ California’s Compassionate Use Act did not define quantity at all. See CAL. HEALTH & SAFETY CODE § 11362.5 (Deering, LEXIS through 2010 legislation and 2011 Supp.). In contrast, Washington’s Medical Use of Marijuana Act defined the quantity as “no more marijuana than is necessary for the patient’s personal, medical use, not exceeding the amount necessary for a sixty-day supply,” but it failed to define sixty-day supply. See WASH. REV. CODE § 69.51A.040 (LexisNexis, LEXIS through 2010 Reg. and 2d Spec. Sess.). The “sixty-day supply” language was subsequently defined in October of 2008 as 24 ounces and 15 plants. See WASH. ADMIN. CODE § 246-75-010 (LEXIS through Aug. 2011); *Medical Marijuana*, WASH. STATE DEP’T OF HEALTH, <http://www.doh.wa.gov/hsqa/medical-marijuana/> (last visited Oct. 1, 2011) [hereinafter *Medical Marijuana Wash. State Dept.*]; see also WASH. REV. CODE § 69.51A.080 (LexisNexis, LEXIS through 2010 Reg. and 2d Spec. Sess.) (defining sixty-day supply, but noting that this amount is presumptive and can “be overcome with evidence of a qualifying patient’s necessary medical use”).

²⁸⁴ See MARIJUANA POLICY PROJECT, *supra* note 10, at app. F-15.

²⁸⁵ N.J. STAT. ANN. § 24:6I-10(a) (West 2010).

²⁸⁶ See, e.g., COLO. CONST. art. XVIII, § 14 (LEXIS through 67th Gen. Assembly, 1st Sess.) (allowing a patient to possess no more than two ounces of usable marijuana and six marijuana plants, but noting that an affirmative defense can be raised if the patient or caregiver is in possession of more when it is medically necessary); ALASKA STAT. § 17.37.040 (LexisNexis, LEXIS through 2010 Reg. Sess.) (“[A] patient, primary caregiver, or alternative caregiver may not . . . possess in the aggregate more than once ounce of marijuana in usable form; and six marijuana plants.”); CAL. HEALTH & SAFETY CODE § 11362.77 (Deering, LEXIS through 2010 legislation and 2011 Supp.) (allowing a qualified patient or primary caregiver to possess “no more than eight ounces of dried marijuana” and “no more than six mature or twelve immature plants” per patient, but also noting that this amount can be overcome if a doctor determines that the amount does not meet the patient’s need, and that counties or cities may increase the amount as they see fit); HAW. REV. STAT. § 329-121 (LexisNexis, LEXIS through 2010 Reg. Sess.) (stating that a qualifying patient and his or her caregiver may possess jointly an “adequate supply” of marijuana, not to exceed three mature plants, four immature plants, and one ounce of usable marijuana per each mature plant); ME. REV. STAT. tit. 22, § 2383-B (LexisNexis, LEXIS through 2009 2d Reg. Legis. Sess.) (defining “usable amount of marijuana for medical use” as “2 1/2 ounces or less of harvested marijuana . . . and a total of 6 plants”); MICH. COMP. LAWS ANN. § 333.26424 (LexisNexis, LEXIS through P.A. 383 of 2010 Leg. Sess.) (stating that a patient may possess no more than 2.5 usable ounces of marijuana and, if they have not designated a caregiver to grow for them, twelve plants kept in an enclosed, locked facility, and stating that a primary caregiver may possess no more than 2.5 ounces of usable marijuana for each patient he cares for and no more than twelve

explicit quantity limits but allow a patient to raise an affirmative defense at trial for possession of an unlawful quantity if the patient is otherwise in compliance with the statute.²⁸⁷ The Legislature should consider amending the NJCMA to include a similar provision; it could include an upper limit on the allowable amount to determine a fixed range it considers reasonable.

2. Deficiencies, Unaddressed Issues, and Suggested Improvements

Although the Act's restrictiveness will help avoid abuse and diversion, certain—and arguably over-restrictive—portions of the NJCMA threaten to prevent it from achieving its purpose by limiting the protections provided by the law and creating barriers to access.

plants to be kept in an enclosed, locked facility); MONT. CODE ANN. § 50-46-201 (LexisNexis, LEXIS through 2009 Reg. and Spec. Sess.) (stating that a patient and his caregiver may not possess more than one ounce of usable marijuana and six marijuana plants each); NEV. REV. STAT. § 453A.200 (LexisNexis, LEXIS through 2010 Reg. Sess.) (stating that a patient or primary caregiver “may collectively possess, deliver or produce” no more than “one ounce of usable marijuana; three mature plants; and four immature plants,” but also providing an affirmative defense if patients or their caregivers are in possession of a larger amount); N.M. STAT. ANN. §§ 26-2B-3 (LexisNexis, LEXIS through 2010 2d Spec. Sess.) (defining adequate supply to as “no more than reasonably necessary to ensure the uninterrupted availability of cannabis for a period of three months”); OR. REV. STAT. § 475.320 (LEXIS through 2009 Legis. Sess.) (“[A] registry identification cardholder or designated primary caregiver may possess up to six mature marijuana plants and 24 ounces of usable marijuana.”); R.I. GEN. LAWS § 21-28.6-4 (LEXIS through Jan. 2010 Legis. Sess.) (stating that a patient may possess no more than twelve marijuana plants and two and a half ounces of usable marijuana and that a caregiver may not possess more than that amount for each patient she aids); VT. STAT. ANN. tit. 18, § 4472 (LEXIS through 2010 Sess.) (stating that a registered patient and their caregiver may collectively possess “no more than two mature marijuana plants, seven immature plants, and two ounces of usable marijuana”); WASH. ADMIN. CODE 246-75-010 (LexisNexis, LEXIS through 2010 Reg. and 2d Spec. Sess.) (defining sixty-day supply, and noting that this amount can be overcome based on the need of the patient); *Medical Marijuana Wash. State Dept.*, *supra* note 283 (defining “sixty-day supply” in October of 2008 as 24 ounces and 15 plants).

It appears that currently in New Mexico patients/primary caregivers can possess six ounces of usable marijuana, and can either obtain marijuana through licensed non-profits (“cannabis production facilities”) within the state or apply to produce their own marijuana (four mature plants and twelve seedlings). See *Medical Cannabis Program Frequently Asked Questions*, N.M. DEP’T OF HEALTH, http://nmhealth.org/idb/mcp_faqs.html (last visited Mar. 27, 2011). The non-profits may be in possession of up to ninety-five mature plants and seedlings, as well as usable inventory to service the patients in the program. See *id.*

²⁸⁷ See, e.g., NEV. REV. STAT. § 453A.310 (LexisNexis, LEXIS through 2010 Reg. Sess.) (providing an affirmative defense to patients and primary caregivers in possession of more than the allowed quantity of marijuana if that person “proves by a preponderance of the evidence that the greater amount is medically necessary as determined by the person’s (or assisted person’s) attending physician to mitigate the symptoms or effects of the person’s chronic or debilitating medical condition.”).

One significant deficiency of the NJCMA is that it exempts patients, primary caregivers, dispensary operators, and physicians from criminal liability but not from arrest or prosecution; the Act allows them only to raise an affirmative defense to prosecution.²⁸⁸ Only parents or guardians assisting minors under the Act receive exemption from arrest or prosecution.²⁸⁹ This appears to be inconsistent with the Act's stated purpose of protecting patients, caregivers, physicians, and dispensary operators from *arrest and prosecution*.²⁹⁰ The distinction is that while the Act protects these individuals from criminal liability if they prove compliance with the Act by a preponderance of the evidence,²⁹¹ they would not necessarily escape the trauma of arrest and prosecution. The other thirteen states vary in the protection that they provide from criminal liability. California, for instance, provides an exemption from prosecution to unregistered patients who comply with its medical-marijuana laws, but an exemption from both arrest and prosecution to registered patients.²⁹² Vermont provides an exemption from arrest and prosecution to all registered patients in compliance with the statute.²⁹³ Montana provides an exemption from arrest and prosecution if a patient is registered, but it also allows unregistered patients to raise an affirmative defense if they are otherwise in compliance with the law.²⁹⁴ Alaska's law, like the NJCMA, only provides patients with an affirmative defense.²⁹⁵

The Legislature should amend the NJCMA to explicitly exempt the aforementioned individuals from arrest and prosecution when they act in compliance with the law. No reason exists for patients authorized to use marijuana for the treatment of a debilitating medical condition to go through the process of arrest and prosecution if they are in compliance with the law. Physicians may be reluctant to provide patients with certifications if they are not exempted from arrest and prosecution. Likewise, caregivers might be hesitant to provide assistance to patients. These results are inconsistent with the Act's purpose.

²⁸⁸ See *supra* note 227.

²⁸⁹ N.J. STAT. ANN. § 24:6I-6(f) (West 2011).

²⁹⁰ *Id.* § 24:6I-2(e) (emphasis added).

²⁹¹ See *supra* note 227.

²⁹² CAL. HEALTH & SAFETY CODE §§ 11362.5, 11362.71(e)–(f) (Deering, LEXIS through 2010 legislation and 2011 Supp.).

²⁹³ VT. STAT. ANN. tit. 18, § 4474b(a) (LEXIS through 2010 Sess.).

²⁹⁴ MONT. CODE ANN. §§ 50-46-201, -206 (LexisNexis, LEXIS through 2009 Reg. and Spec. Sess.).

²⁹⁵ ALASKA STAT. § 17.37.030 (LexisNexis, LEXIS through 2010 Reg. Sess.).

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In lieu of, or in addition to amending the Act, the DHSS or the Attorney General should issue guidance to state and local law enforcement directing them to use discretion in investigating a claim of medical-marijuana use and encouraging arrest only if the patient, caregiver, or operator is not in possession of a valid ID card or permit or if they are unable to verify the patient's lawful registration. California has done this.²⁹⁶

The Legislature should also consider allowing patients who are *unregistered* but otherwise in compliance with the law to raise an affirmative defense at trial, which Montana has done.²⁹⁷ This would certainly require a balancing of the risks and benefits. As the law currently stands, because all patients are required to register with the DHSS²⁹⁸ and because of the extensive tracking of patient certifications and physician instructions by the DHSS and the Department of Law and Public Safety,²⁹⁹ the state will be able to track exactly who is receiving medical marijuana, how much they are receiving, who is recommending it, and who is distributing it. This will help prevent abuse and diversion. But if registering deters patients from obtaining the drug, perhaps providing an affirmative defense to prosecution to those not registered but otherwise in compliance would ensure that the Legislature is achieving its stated purpose of protecting "patients who use marijuana to alleviate suffering from debilitating medical conditions."³⁰⁰

Another arguable deficiency of the NJCMA is that it fails to cover serious health ailments. The definition of "debilitating medical condition" excludes severe or chronic pain (except pain caused by HIV/AIDS or cancer) as a qualifying condition.³⁰¹ "Nearly half of all current physician recommendations for marijuana therapy are for chronic pain," with chronic pain affecting about one in five Ameri-

²⁹⁶ OFFICE OF THE ATTORNEY GEN., CALIF. DEP'T OF JUSTICE, GUIDELINES FOR THE SECURITY AND NON-DIVERSION OF MARIJUANA GROWN FOR MEDICAL USE (Aug. 2008), *available* [at](http://ag.ca.gov/cms_attachments/press/pdfs/n1601_medicalmarijuanaguidelines.pdf) http://ag.ca.gov/cms_attachments/press/pdfs/n1601_medicalmarijuanaguidelines.pdf.

²⁹⁷ See MONT. CODE ANN. §§ 50-46-201, -206 (LexisNexis, LEXIS through 2009 Reg. and Spec. Sess.).

²⁹⁸ N.J. STAT. ANN. § 24:6I-4(a) (West 2010).

²⁹⁹ *Id.* § 24:6I-11.

³⁰⁰ *Id.* § 24:6I-2(e).

³⁰¹ See *id.* § 24:6I-3.

cans.³⁰² The Coalition for Medical Marijuana New Jersey has criticized the law's failure to help so many people suffering from severe or chronic pain.³⁰³ Nearly every other state medical-marijuana law allows patients suffering from chronic or severe pain to obtain the drug.³⁰⁴

But the NJCMA does appear to provide marijuana to patients with some of the most debilitating illnesses, including any terminal illness that results in a prognosis of less than one year to live.³⁰⁵ The Act's restrictive definition prevents abuse and helps ensure that only patients with legitimate needs obtain marijuana. It stands in stark contrast to California's Compassionate Use Act, which includes an expansive catchall provision; in California, qualifying conditions include "any other illness for which marijuana provides relief."³⁰⁶ While initially restrictive, New Jersey's law allows the DHSS to approve, by regulation, "any other medical condition or its treatment."³⁰⁷ Therefore, the definition can expand to provide access to more patients based on need over time.

Another potential drawback of the Act is its failure to permit patients to cultivate their own marijuana. The NJCMA allows patients to acquire, possess, or transport marijuana, but they may not grow it.³⁰⁸ New Jersey will be the only state with a medical-marijuana law that penalizes patients for growing their own marijuana.³⁰⁹ While this may prevent abuse, it is also a potential barrier to access for patients.

³⁰² Ken Wolski, *The New Jersey Compassionate Use Medical Marijuana Act*, COALITION FOR MED. MARIJUANA N.J. (July 21, 2009, 11:27 AM), <http://cmmnj.blogspot.com/2009/09/new-jersey-compassionate-use-medical.html>.

³⁰³ *Id.*

³⁰⁴ See, e.g., COLO. CONST. art. XVIII, § 14 (LEXIS through 67th Gen. Assembly, 1st Sess.); ALASKA STAT. § 17.37.070 (LexisNexis, LEXIS through 2010 Reg. Sess.); CAL. HEALTH & SAFETY CODE § 11362.5 (Deering, LEXIS through 2010 legislation and 2011 Supp.); HAW. REV. STAT. § 329-121 (LexisNexis, LEXIS through 2010 Reg. Sess.); MICH. COMP. LAWS ANN. § 333.26423 (LexisNexis, LEXIS through P.A. 383 of 2010 Leg. Sess.); MONT. CODE ANN. § 50-46-102 (LexisNexis, LEXIS through 2009 Reg. and Spec. Sess.); NEV. REV. STAT. § 453A.050 (LexisNexis, LEXIS through 2010 Reg. Sess.); OR. REV. STAT. § 475.302 (LEXIS through 2009 Legis. Sess.); R.I. GEN. LAWS § 21-28.6-3 (LEXIS through Jan. 2010 Legis. Sess.); VT. STAT. ANN. tit. 18, § 4472 (LEXIS through 2010 Sess.); WASH. REV. CODE § 69.51A.010 (LexisNexis, LEXIS through 2010 Reg. and 2d Spec. Sess.). *But see* ME. REV. STAT. tit. 22, § 2383-B (LexisNexis, LEXIS through 2009 2d Reg. Legis. Sess.).

³⁰⁵ See N.J. STAT. ANN. § 24:6I-3 (West 2010).

³⁰⁶ CAL. HEALTH & SAFETY CODE § 11362.5 (Deering, LEXIS through 2010 legislation and 2011 Supp.).

³⁰⁷ N.J. STAT. ANN. § 24:6I-3 (West 2010).

³⁰⁸ *Id.*

³⁰⁹ EDDY, *supra* note 46, at 18.

In California, federal authorities have “raided more than 190 medical marijuana locations, mostly dispensaries,”³¹⁰ and after California enacted its medical-marijuana law, the United States sued to enjoin a non-profit California dispensary from distributing the drug on the grounds that the cooperative’s activities violated the CSA.³¹¹ In *United States v. Oakland Cannabis Buyer’s Coop.*, the Supreme Court held that no medical-necessity defense exception to the CSA’s prohibition on marijuana manufacturing and distribution exists.³¹² Thus, federal authorities could shut down any New Jersey alternative treatment center and prevent qualified patients from obtaining marijuana. In contrast to New Jersey, California allows patients to cultivate their own marijuana.³¹³ Therefore, the closure of dispensaries in California would be less problematic for patients because they could simply grow their own marijuana.

The NJCMA also requires a patient’s certifying physician to be licensed to practice medicine in New Jersey.³¹⁴ This requirement forecloses a patient’s ability to seek the care of a specialist in a neighboring state. Patients should be free to seek the best care possible. Vermont, for example, allows patients to seek the care of physicians licensed in other states, including New Hampshire, Massachusetts, and New York.³¹⁵ New Jersey should similarly respect patient choice and allow patients to seek the treatment of out-of-state doctors.

The NJCMA should also include two additional provisions. First, the Legislature should consider giving registry identification cards from other states full force and effect, as Montana, Rhode Island, and Michigan have done.³¹⁶ Compassion dictates that no patient using marijuana should face criminal penalties in New Jersey if the patient received proper authorization to use marijuana in another state and is in possession of valid documentation. Second, the law should not interfere with a patient’s parental or custodial rights; unless the parent presents a danger to the child, using medical marijuana in accor-

³¹⁰ MARIJUANA POLICY PROJECT, *supra* note 10, at app. F-17.

³¹¹ *United States v. Oakland Cannabis Buyers’ Coop.*, 532 U.S. 483, 486–87 (2001).

³¹² *Id.*

³¹³ CAL. HEALTH & SAFETY CODE § 11362.5 (Deering, LEXIS through 2010 legislation and 2011 Supp.).

³¹⁴ N.J. STAT. ANN. § 24:6I-3 (West 2010).

³¹⁵ VT. STAT. ANN. tit. 18, § 4472 (LEXIS through 2010 Sess.).

³¹⁶ MICH. COMP. LAWS ANN. §§ 333.26423–.26424 (LexisNexis, LEXIS through P.A. 383 of 2010 Leg. Sess.); MONT. CODE ANN. § 50-46-201 (LexisNexis, LEXIS through 2009 Reg. and Spec. Sess.); R.I. GEN. LAWS ANN. § 21-28.6-4 (LEXIS through Jan. 2010 Legis. Sess.).

dance with the Act should not affect the parent-child relationship. Thus, the Act should include the following provision, modeled after Michigan's law: "A person shall not be denied custody or visitation of a minor for acting in accordance with this act, unless the person's behavior is such that it creates an unreasonable danger to the minor that can be clearly articulated and substantiated."³¹⁷ We must not force individuals suffering from debilitating illnesses to choose between relief and their children.

Finally, the NJCMA does not expressly deal with a number of important issues, which the regulations promulgated by the DHSS should address. The Act is silent as to how and from what sources alternative treatment centers would obtain marijuana or marijuana seeds or seedlings and where the centers' marijuana would be grown. It also places no limits on where alternative treatment centers may be located. Whether the DHSS will impose any zoning limits, such as a requirement that centers be located at a specified minimum distance from residential areas or schools, remains to be seen. The NJCMA also does not explicitly require the DHSS to establish methods for testing and guaranteeing the quality and safety of marijuana sold at alternative treatment centers. To ensure that patients have access to unadulterated, good-quality marijuana, this issue must be addressed by the DHSS. With respect to cost, the Act only specifies that a center may charge "for the reasonable costs associated with the production and distribution of marijuana."³¹⁸ Every two years, the DHSS must evaluate whether centers are charging "excessive prices."³¹⁹ The DHSS should prevent costs from serving as a barrier to patient access.

During the drafting process, New Jersey lawmakers expressed their intention to make the law restrictive enough so that only patients in serious need could obtain marijuana.³²⁰ They did not want to encourage illegal drug use.³²¹ But at the opposite end of the spectrum, the law should not be so restrictive that it fails to serve the purpose for which it was intended—to provide medical marijuana to patients in need. As drafted, the NJCMA generally provides the necessary balance. The aforementioned proposed amendments

³¹⁷ See MICH. COMP. LAWS ANN. § 333.26424 (LexisNexis, LEXIS through P.A. 383 of 2010 Leg. Sess.).

³¹⁸ N.J. STAT. ANN. § 24:6I-7(h) (West 2010).

³¹⁹ *Id.* § 24:6I-14(c).

³²⁰ See Chris Megarian & Susan K. Livio, *Making Sure Medical Marijuana Can Be Used, but Not Abused*, STAR LEDGER, June 7, 2009, at 17.

³²¹ *Id.*

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would also strengthen the protections provided by the Act and help prevent abuse of the system.

V. CONCLUSION

The legalization of medical marijuana will provide New Jersey citizens with legal access to a drug that is safe and effective in soothing the symptoms of debilitating medical conditions. For a subset of patients, botanical marijuana may be the only option for relief. Because marijuana remains a Schedule I controlled substance under federal law, New Jersey must act to ensure that patients with debilitating conditions avoid prosecution for using marijuana medicinally. The extensive state regulation, the prohibition of marijuana cultivation, and the limited definition of debilitating illness make New Jersey's law the most restrictive in the nation. But in addition to preventing abuse and diversion, the NJCMA will provide access to the drug to patients with the greatest need. Compassion, reason, and medical evidence require that we distinguish between the medical and recreational use of marijuana under the law. As of January 18, 2010, this distinction now exists in New Jersey.