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# Medical Marijuana: A Study of Unintended Consequences

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## I. INTRODUCTION

The legal status of medical marijuana is a legislative oddity, perhaps unprecedented, in that state governments authorize possession and use of marijuana in knowing and clear violation of federal criminal law.[1] Today, medical marijuana is simultaneously legal in sixteen states and the District of Columbia and illegal in all fifty states and the District.[2] Nearly one third of the nation's population resides in jurisdictions with legislation authorizing marijuana as a medical treatment.[3] Humanitarian impulses motivated the legislation: compassion for those suffering from serious illnesses, such as HIV/AIDS, cancer, multiple sclerosis, and chronic or severe pain that are unresponsive to conventional treatment or medication.[4] State authorization of the cultivation, possession, and use of marijuana for medical purposes dates back to 1996 in

* Professor of Law, University of the Pacific, McGeorge School of Law. I am indebted to my research assistants, Sean O'Dowd, Amanda MacQueen, and Jared Wigginton, for mightily contributing to the preparation of this study; and to Amanda Allen and Ryan Rey Reyes, who initially helped me collect data. I thank Michele Finerty, Assistant Director for Library Technical Services at McGeorge School of Law, for her valiant efforts to identify source materials and my colleague Michael Vitiello who assisted me throughout.

1. Gonzales v. Raich, 545 U.S. 1 (2005) (holding that the possession, growing, sale, and use of marijuana continues to be illegal because it is classified as a Schedule I drug under federal law, and therefore, per the Supremacy and Commerce Clauses of the Constitution, federal regulation supersedes state legislation; *see also* United States v. Oakland Cannabis Buyers' Cooperative, 532 U.S. 483 (2001) (holding that "there is no medical necessity exception to the Controlled Substances Act's prohibition on growing or distributing marijuana").

2. *16 Legal Medical Marijuana States and DC*, PROCON.ORG, http://www.medicalmarijuana.procon.org/view.resource.php?resourceID=000881 (last visited Sep. 5, 2011) (on file with the *McGeorge Law Review*). The California Attorney General's Guidelines take a novel approach, denying there is a conflict between federal and state law by claiming the difference in approaches between federal and California state law is a mere "incongruity" because ". . . California did not 'legalize' medical marijuana, but instead exercised the state's reserved powers to not punish certain marijuana offenses under state law when a physician has recommended its use to treat a serious medical condition." EDMUND G. BROWN JR., CAL. DEP'T OF JUSTICE, GUIDELINES FOR THE SECURITY AND NON-DIVERSION OF MARIJUANA GROWN FOR MEDICAL USE 3–4 (2008), *available at* http://ag.ca.gov/cms_attachments/press/pdfs/n1601_medicalmarijuanaguidelines.pdf (on file with the *McGeorge Law Review*). This is a play on words that does not fool anyone; common understanding is that conduct not prohibited is legal.

3. MARK EDDY, CONG. RESEARCH SERV., RL 33211, MEDICAL MARIJUANA: REVIEW AND ANALYSIS OF FEDERAL AND STATE POLICIES 18 (2010), *available at* http://www.fas.org/sgp/crs/misc/RL33211.pdf (on file with the *McGeorge Law Review*).

4. U.S. DEP'T OF JUSTICE, THE DEA POSITION ON MARIJUANA 49 (2011), *available at* http://www.justice.gov/dea/marijuana_position.pdf (on file with the *McGeorge Law Review*) (citing Sandy Mazza, *Medical Pot Dispensaries Under Scrutiny*, SAN GABRIEL VALLEY TRIB., Feb. 15, 2007).

California, and is being advanced today in roughly a dozen states,[5] undaunted by longstanding, unbending opposition from the federal government and minimal support from the medical profession.[6]

The Drug Enforcement Agency (DEA) and the Food and Drug Administration (FDA) are the lead agencies in expressing opposition to medical marijuana. The DEA's position is that marijuana "has no currently accepted medical value in treatment in the United States."[7] Marijuana "has a high potential for abuse," even when users ingest it under medical supervision, because "there is a lack of accepted safety for use of the drug."[8] The FDA's stance, though more cautious, is still consistent with the DEA's.[9] Congress, echoing the views of both agencies, continues to accord marijuana the most serious statutory classification, despite protest. The federal Controlled Substances Act (CSA) lists marijuana as a Schedule I drug.[10] It sits alongside heroin, methamphetamine, LSD, and mescaline, and is deemed more dangerous than such Schedule II drugs as morphine and cocaine.[11]

To a large extent, federal law enforcement remains unaffected by states' legalization of medical marijuana. The DEA continues to arrest growers and raid dispensaries that sell marijuana. Seizures of marijuana have steadily risen.[12] Recently, however, the Department of Justice partially ceded jurisdiction,

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5. Legislation to legalize medical marijuana is pending in ten states: Alabama, Connecticut, Idaho, Illinois, Massachusetts, New Hampshire, New York, North Carolina, Ohio, and Pennsylvania. *See 10 States with Pending Legislation to Legalize Medical Marijuana*, PROCON.ORG (May 13, 2011, 12:07:10 PM), http://medicalmarijuana.procon.org/view.resource.php?resourceID=002481 (on file with the *McGeorge Law Review*).

6. For example, most, if not all, medical marijuana statutes list glaucoma as a qualifying condition, although the empirical evidence and expert opinion is to the contrary. Marijuana has a positive effect in reducing high intraocular pressure—which is associated with damage to the optic nerve, but causes no pain—for very short periods of time, only three to four hours. Glaucoma is also associated with painful side effects, which may be deleterious to the optic nerve. *See* Dr. Henry Jampel, *American Glaucoma Society Position Statement: Marijuana and the Treatment of Glaucoma*, J. GLAUCOMA, 75 (2010).

7. *See* U.S. DEP'T OF JUSTICE, *supra* note 4, at 2.

8. 21 U.S.C. § 812(b)(1) (2009).

9. *See* Press Release, U.S. Food and Drug Admin., Inter-Agency Advisory Regarding Claims that Smoked Marijuana is a Medicine, (Apr. 20, 2006), *available at* http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/2006/ucm108643.htm (last visited June 29, 2011) (on file with the *McGeorge Law Review*) ("there is currently sound evidence that smoked marijuana is harmful, that no sound scientific studies support use of marijuana for treatment in the United States, and that no animal or human data support the safety or efficacy of marijuana for general medical use").

10. 21 U.S.C. § 812(c)(C)(10).

11. *Id.*

12. *See generally* CENTRAL VALLEY CAL. HIGH INTENSITY DRUG TRAFFICKING AREA, OFFICE OF NAT'L DRUG CONTROL POLICY, MARIJUANA PRODUCTION IN CALIFORNIA (2010), *available at* http://www.katiearnoldi.com/wp-content/uploads/2010/06/Marijuana-Production-in-California.pdf (on file with the *McGeorge Law Review*) (number of plants seized in 2006 was 2,642,352, 2007 was 4,961,313, 2008 was 5,432,053 and 2009 was 7,519,580); DRUG ENFORCEMENT AGENCY, 2010 DOMESTIC CANNABIS ERADICATION/SUPPRESSION PROGRAM STATISTICAL REPORT (2010), *available at* http://www.justice.gov/dea/programs/marijuana_seizure_results.pdf (on file with the *McGeorge Law Review*) (indicating that the number of plants seized in California in 2010 was 7,392,652).

softening the conflict between federally mandated enforcement and state and locally mandated non-enforcement, pursuant to a pledge made when President Obama was a candidate.[13] In March 2009, Attorney General Eric Holder announced that raids on medical marijuana dispensaries would cease, except when state law was being invoked as a pretext for the production or distribution of marijuana for purposes not authorized by state law.[14] As a practical matter, this position appears to give immunity to physicians and users who are not sellers. The implication is that federal enforcement will focus on growers and dispensaries that unlawfully market and sell marijuana for profit.

This essay describes the effects of the implementation of medical marijuana legislation in multiple states where data is available. It is evaluative only insofar as implementation seems inconsistent with statutory requirements and the reasonable expectations of voters. The focus is on two questions. The first asks whether the legalization of medical marijuana has achieved its intended humanitarian objectives of providing access to marijuana to those who would benefit from it. The second question asks whether the legislation has spawned consequences that the voters and the drafters of the legislation did not intend.

## II. IMPLEMENTING MEDICAL MARIJUANA: SOME STATE SNAPSHOTS

The absence of performance data renders describing the implementation of medical marijuana in the sixteen states and DC somewhat speculative. Most states do not collect data regarding such basics as the number of patients authorized to use or possess marijuana, their conditions and diseases, or their age distribution.[15] Similarly, information regarding compliance issues—whether growers, sellers, physicians, and users are following the law—is sparse and difficult to capture other than on a case-by-case basis. Nonetheless, what data is available suggests common implementation patterns and problems.

With these caveats in mind, this paper first outlines representative practices in three states—Colorado, California, and Michigan—and then moves on to identify five shared program characteristics that were largely unexpected and which conflict with the intentions of the voters and legislators.

Colorado's experience illustrates rather fully the surprising ways that implementation played out over time. In Colorado, as in other states, authorized users who registered with the state can either grow their own plants or designate another party, such as a friend or neighbor, to be a "caregiver" to perform this

13. Carrie Johnson, *U.S. Eases Stance on Medical Marijuana*, WASH. POST, Oct. 20, 2009, at A01.

14. Josh Meyer & Scott Glover, *Medial Marijuana Dispensaries Will No Longer Be Prosecuted, Attorney General Says*, L.A. TIMES, Mar. 19, 2009, *available at* http://articles.latimes.com/2009/mar/19/local/me-medpot19 (on file with the *McGeorge Law Review*).

15. California, Arizona, Delaware, Maine, Hawaii, New Jersey, Washington, Vermont, and the District of Columbia collect little to no data, leaving researchers largely dependent on journalistic studies and estimates.

service for them.[16] During Colorado's first seven years after legalization, 2000 patients registered.[17] But in 2009, after the Obama Administration stated that it would not arrest individuals in compliance with state law, enrollment began to skyrocket.[18] "Over the next two years more than 1,000 dispensaries sprang up to serve the more than 100,000 Coloradans who had suddenly discovered their need for medicinal marijuana and applied for a patient card."[19] Colorado experienced a 871% increase in registrants: from 6369 in January 2009[20] to 55,469 in January 2010.[21] By March 2011, Colorado reported 127,816 registrants.[22] "As Jon Stewart noted, what had been considered the healthiest state in the country rapidly became one of the sickest."[23] To date, "218 pot farms, 808 dispensaries, and 318 businesses that infuse candy, olive oils, pizzas and other edibles with marijuana have applied for state licenses." [24]

Patient growth has accelerated with the advent of what might be called a new medical specialty, a small cluster of physicians whose practice is largely or exclusively devoted to assessing the eligibility of individuals who sought medical marijuana. "Statewide, more than 70% of doctors recommendations were written by fewer than 15 physicians" in Colorado, and severe or chronic pain, a catchall category, accounted for ninety-four percent of all reported conditions.[25]

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16. COLO. CONST. art. XVIII, § 14 (amended 2000).

17. Andrew Ferguson, *The United States of Amerijuana*, TIME MAGAZINE, Nov. 22, 2010, at 32, *available at* http://www.time.com/time/nation/article/0,8599,2030768-2,00.html (on file with the *McGeorge Law Review*).

18. *Id.* Another factor was the publicity given to the state Board of Health's decision not to cap the number of persons a medical-marijuana caregiver can supply at five. Claire Trageser, *Victory for Patients*, DENVER POST, July 21, 2009, at A1, http://www.denverpost.com/breakingnews/ci_12879779 (on file with the *McGeorge Law Review*).

> Real estate brokers say that Colorado's medical-marijuana law has sparked a land rush, as entrepreneurs lured by a growing number of licensed users search for properties for growing or selling pot. In a down real estate market, landlords who might otherwise wait for more conventional tenants are snapping at the opportunity presented by medical-marijuana dispensaries, said Darrin Revious, a broker with Shames Makovsky Realty.

Tom McGhee, *Pot Boom Offsets Real Estate Bust*, THE DENVER POST, Oct. 25, 2009, at B1, http://www.denverpost.com/news/ci_13636549 (on file with the *McGeorge Law Review*).

19. Ferguson, *supra* note 17, at 34.

20. COLO. DEP'T OF HEALTH AND ENV'T, MEDICAL MARIJUANA REGISTRY PROGRAM UPDATE (2009), http://www.cdphe.state.co.us/hs/medicalmarijuana/statArchive/1_2009%20MMR%20report.pdf (on file with the *McGeorge Law Review*).

21. COLO. DEP'T OF HEALTH AND ENV'T, MEDICAL MARIJUANA REGISTRY PROGRAM UPDATE (2010), http://www.cdphe.state.co.us/hs/medicalmarijuana/statArchive/01_2010_%20MMR_report.pdf (on file with the *McGeorge Law Review*).

22. Colo. DEP'T OF HEALTH AND ENV'T, MEDICAL MARIJUANA REGISTRY PROGRAM UPDATE (2011), http://www.cdphe.state.co.us/hs/medicalmarijuana/statistics.html (on file with the *McGeorge Law Review*).

23. Ferguson, *supra* note 17, at 32.

24. Stephanie Simon, *Colorado's Medical-Pot Rules: ID, Video and a Vast Paper Trail*, WALL ST. J., Nov. 23, 2010, http://online.wsj.com/article/SB10001424052748703559504575630760766227660.html (on file with the *McGeorge Law Review*).

25. Ferguson, *supra* note 17, at 36.

Prescriptions seemed readily available, including many for those who did not meet eligibility requirements. Commentary on several blogs suggests that some medical marijuana users were more interested in getting high than in pain relief. For example, one medical marijuana user wrote, "I loved the buzz, which lasted 8 hours."[26] Referring to the RomSpice variety, another commented, "'[t]he strongest body high I've ever felt. It literally makes my whole body feel numb and tingly.'"[27] A third commented, "'I have a very high tolerance and a 2-dose lemon bar will put me on my ass.'"[28]

California was the first state to permit marijuana use for medical purposes. In 1996, voters supported a statewide initiative authorizing marijuana as a treatment for serious illnesses when recommended by a physician.[29] The proposition legalized the cultivation, possession, and use of medicinal marijuana by Californians upon the oral or written recommendation of a physician.[30] Subsequently codified as the Compassionate Use Act (CUA),[31] it legalized cannabis not only for specific conditions, such as anorexia, AIDS, and glaucoma, but also for a broad residual category, which includes "any other illness for which marijuana provides relief."[32] This catchall clause, like the one in Colorado's legislation, confers great discretion on the recommending physician.[33] The CUA permits patients to possess up to six mature marijuana plants or up to eight ounces of processed weed.[34] The law also allows a grower to cultivate marijuana for a patient, as long as the patient designates that person as a primary caregiver.[35]

In California, as in most other states that sanction medical marijuana, individuals can purchase it through a retail outlet rather than grow their own plants. These dispensaries function as caregivers in cities throughout California, though they do not meet the statutory standard. The CUA defines a caregiver as an individual who has "consistently assumed responsibility for the housing, health, or safety" of the patient.[36] Occasional over-the-counter sales would not seem to qualify as care, let alone consistent care. Sellers assume no responsibility for the welfare of their customers.[37] Nonetheless, these storefront establishments

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26. *Id.* at 32 (internal quotations omitted).
27. *Id.* at 36.
28. *Id.* at 37.
29. Cal. Proposition 215 (2006).
30. *Id.*
31. CAL. HEALTH & SAFETY CODE § 11362.5 (West 2007).
32. *Id.* § 11362.5(b)(1)(A).
33. Cal. Proposition 215 (2006); *see also* COLO. CONST. art. XVIII, § 14 (amended 2000).
34. HEALTH & SAFETY § 11362.77(a).
35. *Id.* § 11362.77(f).
36. *Id.* § 11362.5(b)(1)(C)(e).
37. A California appellate court rejected a dispensary's contention that it became a primary caregiver under the CUA simply upon a patient's designation. People *ex rel.* Lungren v. Peron, 59 Cal. App. 4th 1383, 1397 (1997) The court classified such a designation as "transitory and not exclusive," adding "the patient is

have acquired at least temporary legitimacy through guidelines issued by the state's attorney general, and are now commonplace in many cities, particularly the largest ones.[38]

Although dispensaries are prohibited from earning a profit, employees may receive reasonable compensation for their services.[39] Some dispensary owners and employees enjoy very high salaries.[40] One cannot help but wonder whether voters would have supported Proposition 215 had there been language authorizing sellers to do business out of neighborhood establishments.

The CUA, like legislation in other states, allows counties to amend the state guidelines.[41] Counties have done so in very different ways, especially when specifying the number of plants a caregiver may grow for a user. Upstate, in Humboldt County, the heartland of high-grade marijuana farming in California, the District Attorney has stated that residents may grow up to ninety-nine plants at a time on behalf of a patient without fear of prosecution.[42] In contrast, Marin County limits the quantity to six mature plants and/or eight ounces of dried marijuana.[43]

California counties also exhibit great variation as to how much marijuana a patient may possess. State policy allows patients to possess up to eight ounces of dried marijuana and cultivate up to six mature plants or twelve immature plants.[44] But as the United States Supreme Court observed,

> the quantity limitations serve only as a floor. Based on a doctor's recommendation, a patient can possess whatever quantity is necessary to satisfy his medical needs and cities and counties are given *carte blanche* to establish more generous limits. Indeed, several have done just that. For example, patients residing in the cities of Oakland and Santa Cruz and in the counties of Sonoma and Tehama are permitted to possess up to 3

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admittedly free to designate on a daily basis a new primary caregiver dependent solely on whenever and from whom the patient desires to purchase marijuana. *Id.* Thus, the 'consisten[cy]' of . . . claimed health or safety, primary caregiving of each customer is in reality a chimerical myth." *Id.*

38. *See* BROWN, *supra* note 2, at 11.

39. *Id.* at 4, 8.

40. Peter Hecht, *California Medical Pot Advocates Call for Statewide Regulation*, SACRAMENTO BEE, Feb. 13, 2011, at A6, http://www.sacbee.com/2011/02/13/3398738/dispensary.html#storylink=misearch (on file with the *McGeorge Law Review*). Sacramento attorney George Mull, who represents medical marijuana dispensaries, predicted that police raids would continue "as long as operators of some dispensaries are earning hundreds of thousands of dollars in pay and there are no state rules for bookkeeping or salaries." *Id.*

41. CAL. HEALTH & SAFETY CODE § 11362.77(c) (West 2007).

42. David Samuels, *Dr. Kush: How Medical Marijuana is Transforming the Pot Industry*, NEW YORKER, July 28, 2008, http://www.newyorker.com/reporting/2008/07/28/080728fa_fact_samuels?current Page=1 (on file with the *McGeorge Law Review*).

43. *Cal. Med. Marijuana Guidelines, Cannabis Guidelines Adopted by Cities*, SAFE ACCESS NOW (Oct. 29, 2011, 8:45 PM), http://www.safeaccessnow.net/countyguidelines.htm (on file with the *McGeorge Law Review*).

44. CAL. HEALTH & SAFETY CODE § 11362.77(a) (West 2007).

> pounds of processed marijuana . . . . Putting that quantity in perspective, 3 pounds of marijuana yields roughly 3,000 joints . . . ."[45]

And the street price can range from $3,000 to $12,000.[46]

The number of users in California is a matter of speculation since neither the state nor the counties collect this information. Researchers estimated that in 2002, six years after Proposition 215 authorized medical marijuana, users numbered about 30,000.[47] Two years later, in 2004, the estimate more than tripled to over 100,000.[48] It is likely that it has tripled since then. According to Americans for Safe Access, "more than 300,000 doctors' referrals for medical cannabis are on file . . . ."[49]

A third example is Michigan. There, the movement for legalization began at the city level in Ann Arbor, home of the University of Michigan, a town with a longstanding permissive attitude towards marijuana.[50] In 2004, Ann Arbor passed an initiative legalizing marijuana for medical purposes.[51] Four years later, in 2008, Michigan voters followed Ann Arbor's lead. Almost overnight, a dozen

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45. Gonzales v. Raich, 545 U.S. 1, 31 n.41 (2005).

46. On the low end, the "DEA's estimate of $1,000 seem[s] reasonable, but . . . $1,500 [is] more realistic." Lindy Stevens, *How Is the Street Value of Marijuana Determined?* MICH. DAILY, Mar. 6, 2008, *available at* http://www.michigandaily.com/content/how-street-value-marijuana-determined (on file with the *McGeorge Law Review*); However, for estimates of the street price of marijuana in Northern California, where prices are some of the highest in the nation, see THE GREEN RUSH (Bunch Casseday/Living the Dream Productions 2008) (stating that a pound of marijuana sells for $2500–$4000).

47. Dale Grieringer, *The Acceptance of Medicinal Marijuana in the U.S.*, J. CANNABIS THERAPEUTICS (Jan. 29, 2003), *available at* http://medicalmarijuana.procon.org/view.answers.php?questionID=1199 (on file with the *McGeorge Law Review*).

48. Eric Bailey, *Taking a Leaf From 'Pot Docs,'* L.A. TIMES, November 6, 2004, http://articles.latimes.com/2004/nov/06/local/me-potdocs6 (on file with the *McGeorge Law Review*).

49. Soloman Moore, *Los Angeles Prepares for Clash Over Marijuana*, N.Y. TIMES, Oct. 17, 2009, at A21. Of course, any figure that purports the number of authorized medical marijuana users in California is at best an educated guess. In October 2010, *Newsweek* came up with the figure of 400,000 users in California, but did not cite a source. *See* Jessica Bennett, *Welcome to Potopia, California*, NEWSWEEK, Oct. 25, 2010, *available at* http://www.newsweek.com/2010/10/25/prop-19-making-pot-legal-in-california.html (on file with the *McGeorge Law Review*).

> Marijuana consumption—for medical use—has been legal in California since 1996, when voters passed Proposition 215. But 'medicinal' is something of an open joke in the state, where anyone older than 18 with a doctor's note—easy to get for ailments like anxiety or cramps, if you're willing to pay—can obtain an ID card allowing access to any of the state's hundreds of dispensaries. ('You can basically get a doctor's recommendation for anything,' one dispensary told me last October, when I visited his pot shop.).

Jessica Bennett, *Oakland's Growth Industry: Legalized Marijuana Farms*, NEWSWEEK, July 21, 2010, *available at* http://www.newsweek.com/2010/07/21/oakland-legalizes-marijuana-farming.html on file with the *McGeorge Law Review*).

50. Matthew Dolan, *Medical-Pot Law Clouds Community: Liberal College Town Seeks Zoning Solution for Dispensaries*, WALL ST. J., Nov. 15, 2010, http://online.wsj.com/article/SB10001424052748704393604575614520592992804.html (on file with the *McGeorge Law Review*).

51. *Id.*

medical marijuana dispensaries cropped up in Ann Arbor.[52] By November 2010, there were as many as thirty.[53]

By April 2009—eighteen months after enactment—Michigan had already issued 37,330 patient registrations and was still processing a four-month backlog of thousands of more requests.[54] Two years later, May 2011, the number had increased to 75,522 registered patients—about triple the figure from a year earlier.[55] As in Colorado, the vast majority of authorized users have unspecified ailments, primarily severe and chronic pain.[56] Also like Colorado, physician prescriptions were not typically made by the applicant's attending physician, but rather by a small cluster of physicians with what might be called marijuana practices. Fifty-five doctors certified about 45,000 patients.[57]

Despite this proliferation, several cities and counties took a more conservative approach, banning dispensaries and cracking down on shops

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52. *Id.*

53. *Id.*

54. *Id.*

55. LARA Dep't of Licensing and Regulatory Affairs, *Michigan Medical Marihuana Program*, MICHIGAN.GOV (June 10, 2011), http://www.michigan.gov/lara/0,1607,7-154-27417_51869---,00.html (on file with the *McGeorge Law Review*). A fourth example is Montana, which authorized medical marijuana in 2004, but legalization attracted little attention until 2009 when Attorney General Holder announced that the Department of Justice would not prosecute patients who comply with state law. *See* Johnson, *supra* note 13. Shortly thereafter, the number of cardholders sky-rocketed. *See* Gouras, *infra*. "Advocates and distributors [of marijuana] then figured out they could sign up thousands of people who claim to suffer from 'chronic pain'—a vague term covering everything from creaky knees to sore backs to persistent headaches." Matt Gouras, *State Reconsiders Turbulent Medical Marijuana Biz*, HAVRE DAILY NEWS, Feb. 18, 2011, http://www.havredailynews.com/cms/news/story-217565.html (on file with the *McGeorge Law Review*); *see also Drug Overdose: Medical Marijuana Facing a Backlash*, 7KBZK.COM (May 21, 2010), http://www.kbzk.com/news/drug-overdose-medical-marijuana-facing-a-backlash/ (on file with the *McGeorge Law Review*) (stating that in June 2009, there were only 2923 cardholders. Within a year this number rose to approximately 15,000). Today, there are more than 28,000 registered users in a state of less than a million people and one third of these are under thirty years old. Roughly one out of every nineteen households has a card. Gouras, *supra*. More recently, Montana has reversed its position and enacted legislation which makes medical marijuana far more difficult to obtain. *See* SB 423, 62nd Leg., Reg. Session (Mont. 2011), *available at* http://www.dphhs.mt.gov/marijuanaprogram/sb423.pdf (on file with the *McGeorge Law Review*). SB 423, effective as of July 1, 2011, requires that larger marijuana-growing operations and all dispensaries shut down their operations. *Id.* Patients must grow their own marijuana, or obtain it for free from a provider who cannot grow for more than three people. *Id.* In addition, doctors who certify twenty-five patients will have to pay for an investigation into their practices. *Id.*

56. Dawson Bell & John Wisely, *Medical Pot Prescribed Mostly for Aches, Pains*, DETROIT FREE PRESS, Apr. 21, 2011, http://www.freep.com/apps/pbcs.dll/article?AID=2011104210430 (on file with the *McGeorge Law Review*). Several physicians have been arrested in Michigan in regards to certifying patients for marijuana. On April 5, 2011, Dr. Ruth Buck, the owner of Mid-Michigan Medical Marijuana, was indicted for aiding and abetting the distribution of marijuana. Gus Burns, *Federal Agents Jail Michigan Doctor for Issuing Medical Marijuana Recommendations*, SAGINAW NEWS, Apr. 11, 2011, at § A, *available at* http://www.mlive.com/news/saginaw/index.ssf/2011/04/federal_agents_jail_michigan_d.html (on file with the *McGeorge Law Review*). The federal complaint alleges that Buck issued 1,870 medical marijuana certificates over a two-year period, charging $200 per certification and $150 for renewal. *Id.* In particular, she is charged with issuing a certificate to an undercover DEA agent. *Id.* Buck certified that the agent's elbow, which was occasionally numb, was a "debilitating condition" that included "severe and chronic pain." *Id.*

57. Bell & Wisley, *supra* note 56.

believed to be selling marijuana to individuals without state registration cards.[58] The Oakland County Sheriff aggressively raided several dispensaries outside Detroit in the summer of 2010.[59] After one such raid, Sheriff Michael Bouchard reported that "in one of the places deputies found loose alligators running around protecting the product. This is Michigan. This isn't a Cheech and Chong movie."[60]

## III. UNINTENDED CONSEQUENCES

The proponents of medical marijuana likely contemplated that state programs would function in the following ways. First, the beneficiaries would be a small group of individuals, middle-aged and older, suffering from clearly debilitating diseases and illnesses. Those under forty would be in the minority. Second, vague, amorphous, and hard to verify conditions, such as anxiety, stress, and persistent pain, would not predominate. Third, the patient's primary care physician or specialist would make the prescription and would continue treatment, monitoring the effects of using marijuana. Fourth, patients would acquire marijuana by either growing the plants themselves or by having a friend or relative do so. Supporters of medical marijuana did not contemplate a sea of retail outlets and storefronts in many jurisdictions. Nor did they foresee that dispensaries would adopt the business practices of the marketplace, where competitors battle for new customers through creative and diverse marketing practices. No one imagined leaflets hawking the product, let alone a billboard. The assumption was that the number of individuals suffering from qualifying, debilitating conditions would be largely inelastic, limited by sound, professional judgments of primary care physicians. Fifth, the common assumption was that participants—growers, distributors, users, and caregivers—would be law-abiding and that legalization of marijuana would not hinder criminal enforcement. In retrospect, as the following data indicates, these assumptions seem naive.

### *A. Age Distribution of Users*

Contrary to what supporters anticipated, a majority of the patients are under the age of forty. Patient records seized by law enforcement officers from dispensaries during raids in San Diego County, California, in December of 2005 "showed that 72 percent of patients were between 17 and 40 years old . . . ."[61] In

58. Dolan, *supra* note 50.

59. *Id.*

60. *Id.*

61. Jeff McDonald, *15 Held in Raids on Pot Stores: Medical Marijuana Profiteers Targeted*, SAN DIEGO UNION-TRIB., July 7, 2006, http://www.signonsandiego.com/uniontrib/20060707/news_7m7pot.html (on file with the *McGeorge Law Review*). Because this data was based on information gathered during police raids, it may include an unusually large percentage of youths. Nonetheless it fits the typical profile. These businesses

Montana, fifty percent of patients are forty or under, and twenty-five percent of patients are between the age of twenty-one and thirty.[62] Colorado reports that sixty-one percent of patients are male with an average age of thirty-nine.[63] Female patients account for thirty-one percent of all registered patients and have an average age of forty.[64] In Nevada, fifty-three percent of patients are forty-four or younger.[65] Anecdotal evidence from other jurisdictions, particularly California, suggests that this pattern of age distribution is generally the case.[66] Remarkably, the age distribution of medical marijuana users seems to mimic that of recreational users in its concentration of young persons.[67]

### B. *Patient Illnesses and Conditions*

As with age distribution, the conditions and diseases that patients identified varied from expectations. Only a small percentage of users identified specific serious illnesses or conditions. Health records from the state of Colorado, for example, reveal that only two percent of registered patients had cancer and one percent HIV/AIDS, while ninety-four percent claimed to suffer from "severe pain," a residual category that can be hard to diagnose and treat, and even harder to confirm.[68] This distribution holds elsewhere. Chronic pain is far and away the most common condition identified by medical marijuana applicants.[69] For example, in Oregon, fewer than ten percent of the roughly 35,000 patients

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were targeted because state and federal prosecutors had seen enough of "medical marijuana dispensaries doing a brisk business across San Diego County, and many patients showing no signs of serious illness." *Id.*

62. Kacey Drescher, *Medical Marijuana Law; Constitutional Deficiencies*, KULR8.COM (June 21 2011), http://www.kulr8.com/news/local/Medical-Marijuana-Law-Constitutional-Deficiencies- 124277674.html (on file with the *McGeorge Law Review*).

63. *Statistics*, COL. MED. MARIJUANA REGISTRY (May 31, 2011), http://www.cdphe.state.co.us/hs/medical marijuana/statistics.html (on file with the *McGeorge Law Review*).

64. *Id.*

65. NEV. DEP'T OF HEALTH AND HUMAN SERVS., MEDICAL MARIJUANA PROGRAM (2011), *available at* http://health.nv.gov/BudgetDocuments/2012-2013/MMPWHITEPAPR_FY11.pdf (providing that 2898 total patients currently hold cards and 1582 of them are under the age of forty-four) (on file with the *McGeorge Law Review*).

66. *See* McDonald, *supra* note 61.

67. Even proponents of medical marijuana seemingly concede this point. *See* Russ Belville, *Who Are You? Government Statistics on Adult Marijuana Users*, NORML BLOG (APR. 10, 2009), http://blog.norml.org/2009/04/10/who-are-you-us-government-statistics-on-adult-marijuana-users/ (on file with the *McGeorge Law Review*).

68. *See Statistics*, *supra* note 63.

69. Rhode Island and New Mexico are the exceptions. Only 154 of 1459 registered medical marijuana patients in the state of New Mexico (10.6%) cite chronic pain as a condition, by far the lowest of any state. N.M. DEP'T OF HEALTH, MEDICAL CANNABIS PROGRAM FACT AND INFORMATION SHEET 4–5 (2010), *available at* http://www.health.state.nm.us/IDB/medicalcannabis/Medical%20Cananbis%20Program%20Fact%20and%20Information%20Sheet%203-29-10.pdf (on file with the *McGeorge Law Review*). In Rhode Island, less than one-fifth of all cardholders (19.5%) suffer from chronic pain. CHARLES ALEXANDRE, R.I. DEP'T OF HEALTH, RHODE ISLAND MEDICAL MARIJUANA PROGRAM 3 (2011), http://www.health.state.ri.us/publications/programreports/Medical Marijuana2011.pdf (on file with the *McGeorge Law Review*).

holding cards suffered from cancer, multiple sclerosis, glaucoma, or the other specific debilitating conditions cited in the legislation.[70] Ninety percent of registered cardholders cited chronic pain as their qualifying debilitating disease.[71] Nevada's percentages are nearly identical.[72] Montana's are slightly lower, with seventy-one percent of all medical marijuana users suffering from chronic pain.[73]

How does one make sense of the prominence of chronic or severe pain? The most obvious explanation is that pain is a common and episodic life experience for most people. In some cases, it likely refers to residual pain from a qualifying condition, such as cancer following a surgery. Chronic pain might also be a proxy for a debilitating condition, such as testicular cancer or a bowel or rectal condition that the patient prefers not to identify. However, the statistical dominance of "chronic" or "severe" pain, as well as abundant anecdotal evidence, suggests that applicants offer, and physicians accept, chronic pain as a qualifying condition when in fact it is not. As discussed below, this seems to be especially so when a doctor other than the patient's attending physician makes the diagnosis. Evidence of excessive prescribing by physicians can perhaps be inferred from the marketing of marijuana. There is something odd about physicians recommending medication such as Gold Dust, Mango Hash, Frazzleberry, Chemdawg Kief, Blue Dream, Grape Wreck, Qrazy Train, Violator Kush, Burkle, Cheese Melt, and Green Crack Silly Putty.[74] Such names would seem to hold no special appeal for one experiencing nausea following surgery, chemotherapy, or the like. Instead, they suggest that the dispensary, like the doctor, may have the recreational user in mind.[75]

This is not to imply that persons claiming to suffer from chronic or severe pain are pain free, or that smoking marijuana would not bring relief.[76]

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70. Or. Health Auth., *Oregon Medical Marijuana Statistics*, OREGON.GOV (July 1, 2011), http://public.health.oregon.gov/DISEASESCONDITIONS/CHRONICDISEASE/MEDICALMARIJUANAPROGRAM/Pages/data.aspx (on file with the *McGeorge Law Review*) (noting that in Oregon, a patient may have more than one diagnosed qualifying medical condition. 35,793 out of 39,774 patients currently holding cards were diagnosed with chronic pain. Only 3981 were diagnosed for a qualifying medical condition other than chronic pain.)

71. *Id.*

72. *See* NEV. DEP'T OF HEALTH AND HUMAN SERVS., *supra* note 65, at 3. (2610 out of 2898 Nevada cardholders (90.06 percent) cited 'severe pain' as their condition).

73. MONT. DEP'T OF PUBLIC HEALTH & HUMAN SERVS., MEDICAL MARIJUANA PROGRAM (MMP) JUNE 2011 REGISTRY INFORMATION (2011), *available at* http://www.dphhs.mt.gov/medicalmarijuana/mmpregistryinformation.pdf (on file with the *McGeorge Law Review*) (21,460 out of 30,036 or 71.4 percent).

74. *Our Products*, MAGNOLIAWELLNESS.ORG, http://www.magnoliawellness.org/index.php?option=com_content&view=article&id=19&Itemid=4 (on file with the *McGeorge Law Review*) (last visited July 2, 2011).

75. *Id.*

76. Pain is both a commonplace phenomenon and a complex one. There are doctors who specialize in treating patients suffering from severe or chronic pain. Pain, although broad, is a sensation that is known to "[l]ast for days or even weeks at a time, then dissipate, only to return. The problem may be caused by something as common as arthritis, an inflammation of the joints that makes them throb with discomfort. The issue could by fibromyalgia, in which a breakdown of pain signals leaves joints, muscles, and tissues

Understandably, individuals prefer a drug that not only reduces pain (and may be less addictive than other painkillers) but also enhances pleasure. Nevertheless, such commonplace conditions were not what legislators or voters had in mind.[77]

### C. *Physician and Patient Distribution*

Understandably, legislators gave little to no attention to regulating the role of physicians in recommending medical marijuana. The catchall category included in medical marijuana statutes demonstrates their confidence in physician judgment. Legislators assumed that physicians would act ethically both by conducting necessary diagnostic tests and by prescribing standard medication and treatment before turning to medical marijuana. They reasonably believed that physicians would consider marijuana only when traditional approaches failed, and that even then, it would be used on a trial basis given the uncertainty of the drug's effectiveness and the possibility of side effects. They did not foresee the birth of a new specialization in which a physician's practice would be limited to patients seeking marijuana.[78]

The practice of these specialists can be generally described. First, prescribing physicians typically have no prior relationship with the applicant-patient.[79] Their knowledge of the patient's medical condition may be limited by what the patient discloses. They rely on the patient's account and do not insist on reviewing past medical records, if such exist, or on performing relevant physical examinations.[80] Second, these physicians typically lack expertise in the treated condition, whether it is cancer, arthritis, AIDS, chronic muscle spasms, glaucoma, or the complex field of chronic pain. Third, they do not schedule follow-up appointments to monitor the patient's response to marijuana or suggest alternative treatments.[81]

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hypersensitive. It may be a nerve disorder known as neuropathy, triggered by diseases as diverse as cancer and diabetes. It may be that the cause is unidentifiable. Many cases of chronic pain remain unexplained, but they hurt all the same." Alice Park, *Healing the Hurt*, TIME, Mar. 4, 2011, at 65–66, *available at* http://www.time.com/time/health/article/0,8599,2057269,00.html (on file with the *McGeorge Law Review*).

77. *See* U.S. DEP'T OF JUSTICE, *supra* note 4, at 11.

78. In California, as in the other states, a prescribing doctor needs to hold a medical license. Lisa Leff & Marcus Wohlsen, *AP Enterprise: Docs Help Make Pot Available in CA*, SEATTLE TIMES, Nov. 1, 2010, http://seattletimes.nwsource.com/html/nationworld/2013313775_apusmedicalmarijuanadoctors.html (on file with the *McGeorge Law Review*). However, there is no requirement of special training or familiarity with the scientific literature of marijuana as a treatment. *Id.* In California, there is no central database to track doctors or patients and no reporting requirements. *Id.* A study by the *Associated Press* identified 233 doctors and checked their names against medical board files. *Id.* Most had clean records. However, sixty-eight doctors had records blemished by disciplinary actions. *Id.*

79. David Segal, *When Capitalism Meets Cannibis*, N.Y. TIMES, June 27, 2010, at BU1. The medical marijuana referral practice of Dr. Boland is typical where a very small number of doctors approve a majority of certificates. *Id.* Patients are seen in three- to five-minute intervals where a doctor only asks two questions: (1) does the patient have a condition that qualifies them? and (2) is there a risk for an adverse outcome if the patient were to use medical marijuana? *Id.* Dr. Boland's practice accommodates up to 100 patients a day. *Id.*

80. *Id.*

81. *Id.*

There seems to be a tacit understanding between patient and physician that getting high is the end goal or definition of successful treatment. [82] In sum, these physicians do not establish a doctor–patient relationship and have little to no continuing professional interest in or obligation to their patients other than, perhaps, the hope that they will return for a renewal of the recommendation.[83] Locating their office in or nearby a dispensary may indicate their bias in favoring or granting recommendations.[84] In sum, their practices vary from those enunciated by the Medical Board of California as being "the same as any

82. In commercial medicine, the potency of a drug is clearly stated on the label so one knows the correct dose. PHARMACIST'S MANUAL, DEA DIVERSION CONTROL, http://www.deadiversion.usdoj.gov/pubs/manuals/pharm2/pharm_content.htm (on file with the *McGeorge Law Review*) (last visited Sept. 28, 2011) . This is not the case for medical cannabis, as physicians do not prescribe a specific amount. *What Is a Proper Dosage of Medical Marijuana, and How Can Patients Control Their Dose?* MEDICALMARIJUANA. PROCON.ORG, http://medicalmarijuana.procon.org/view.answers.php?questionID=000334 (on file with the *McGeorge Law Review*) (last visited Sept. 28, 2011). Taking the correct dosage of medical cannabis, based on the amount of the active ingredient THC, can bring welcome relief to one's symptoms. *Id.* However, taking too much can impose negative side effects such as nausea and paranoia. *Marijuana*, CANCER.ORG, http://www.cancer.org/Treatment/TreatmentsandSideEffects/ComplementaryandAlternativeMedicine/HerbsVitaminsandMinerals/marijuana (on file with the *McGeorge Law Review*) (last visited Sept. 28, 2011).

83. There seems to be a widespread understanding in California that some physicians are prescribing to almost anyone who knocks on the door. In fact, it is common for many clinics to operate on an "approval or your money back" basis. *See, e.g.*, CANNAMED MEDICAL MARIJUANA EVALUATIONS, http://2.bp.blogspot.com/-7tT5DQpLhCM/Tgz8e4T0d1I/AAAAAAAAACLA/q1X6bWQt4pY/s1600/NEW_VCR_AD.jpg (on file with the *McGeorge Law Review*) (last visited July 4, 2011). Marcos Breton, a well-regarded columnist for *the Sacramento Bee*, recently castigated implementation of California medical marijuana law. *See* Marcos Breton, *Regulating Medical Pot is a Joke*, SACRAMENTO BEE, June 22, 2011, at B1, *available at* http://www.sacbee.com/2011/06/22/3718305/marcos-breton-regulating-medical.html (on file with the *McGeorge Law Review*). "There are very ill people out there who need medical pot . . . . But after years of living with this issue, I think the truly sick are in the minority. With doctors making righteous money by selling medical marijuana cards to whomever they choose, medical pot has become de facto legal pot. And woe to the politicians who try to regulate it." *Id.* Similarly, two researchers concluded that California's requirement that a physician's recommendation is mandatory for a patient or caregiver to possess medical marijuana has resulted in undesirable outcomes such as "wholesale issuance of recommendations by unscrupulous physicians seeking a quick buck, and the proliferation of forged or fictitious physician recommendations . . . . Far too often, California's medical marijuana law is used as a smokescreen for healthy pot users to get their desired drug and for proprietors of marijuana dispensaries to make money off them, without suffering any legal repercussions." *See* SCOTT MCNEELY & JAMES O' SULLIVAN, WHITE PAPER ON MEDICAL MARIJUANA DISPENSARIES 15–16 (2009), *available at* http://fixlosangeles.com/index.php?option=com_docman&task=doc_view&gid=66&tmpl=component&format=raw&Itemid=66&lang=en (on file with the *McGeorge Law Review*).

84. A proposal under consideration in the New Jersey legislature offers a useful definition of a "bona fide physician-patient relationship." N.J. DIV. OF CONSUMER AFFAIRS, PROPOSED NEW RULES: N.J.A.C. 13:35-7A: COMPASSIONATE USE MEDICAL MARIJUANA (2010), *available at* http://www.state.nj.us/lps/ca/proposal/ bmepro_111510.htm (on file with the *McGeorge Law Review*). It is "a relationship in which the physician has ongoing responsibility for the assessment, care and treatment of a patient's debilitating medical condition." *Id.* Furthermore, "ongoing responsibility" requires that the physician-patient relationship has existed for at least one year, that the physician has seen or assessed the patient for the debilitating medical condition on at least four visits, or that the physician has assumed responsibility for providing management and care of the patient's debilitating medical condition after reviewing medical history maintained by other treating physicians and conducting a comprehensive and physical examination. *Id.* This definition, if adhered to by physicians, assures that "the treatment of the patient must include more than authorizing the patient to use medical marijuana or consulting solely for that purpose." *Id.*

reasonable and prudent physician would follow when recommending or approving any other medication and include the following."[85] The doctor should consider "history and an appropriate prior examination of the patient; development of a treatment plan with objectives; provision of informed consent including discussion of side effects; periodic review of the treatment's efficacy; consultation, as necessary; proper record keeping that supports the decision to recommend the use of medical marijuana."[86] The standards emphasize that "it is incumbent upon that physician to consult with the patient's primary treating physician or obtain the appropriate patient records to confirm the patient's underlying diagnosis and prior treatment history."[87]

In Colorado, as noted above, "more than 70% of doctor recommendations were written by fewer than 15 physicians."[88] A similar situation exists in Oregon: "[e]very 15 minutes, Portland physician Sandra Camacho-Otero writes an authorization for an Oregon resident to get a medical marijuana card. Last year, Camacho-Otero wrote 8,760 of these authorizations—far more than any other Oregon physician . . . ."[89] "She is employed by the largest medical marijuana clinic in Oregon—The Hemp and Cannabis Foundation (THCF) in Southeast Portland. Her job, perfectly legal, illustrates how far Oregon's medical marijuana program has come from what voters thought it would be."[90] Working part-time out of a large dispensary, Camacho-Otero earns between $1000 and $1200 a day.[91] The top ten physicians, in terms of number of prescriptions written, authorized 21,293 persons,[92] a remarkable concentration given that the total number of patients in Oregon is only about 35,000.[93] The majority of applicants, especially college-age persons, never sought treatment from a prior physician.

Although only a handful of jurisdictions collect data regarding physicians, occasional stories in local newspapers corroborate the common understanding that some physicians specializing in marijuana cases are willing to recommend applicants who lack qualifying medical conditions. The *Record Searchlight* of July, 2010 provides an example: "on Redding's hip-hop and pop music station, an advertisement proclaims that for just $149, a new doctor in town will evaluate

85. *Medical Marijuana*, MED. BOARD OF CAL. (May 7, 2004), http://www.medbd.ca.gov/medical_marijuana.html (on file with the *McGeorge Law Review*).

86. *Id.*

87. *Id.*

88. *See* Ferguson, *supra* note 17, at 36; *see also Gazette Opinion: 1 Last Chance to Rein in Medical Marijuana*, BILLINGS GAZETTE, Apr. 26, 2011, http://billingsgazette.com/news/opinion/editorial/gazette-opinion/article_182f1f25-2472-5627-8bb1-3c77f605ff92.html (on file with the *McGeorge Law Review*) (as of 2010, only 32 of the 360 physicians recommending marijuana in Montana had more than 100 patients).

89. Peter Korn, *Medical Marijuana: A Broken System*, PORTLAND TRIB., Apr. 15, 2010, http://www.portlandtribune.com/news/story.php?story_id=127128421107102600 (on file with the *McGeorge Law Review*).

90. *Id.*

91. *Id.*

92. *Id.*

93. *Id.*

a patient for medical marijuana," something that would have been unheard of before the (United States) Attorney General announced that the federal government would not prosecute individuals and dispensaries in compliance with state medical marijuana law.[94] In addition to several local doctors, Redding has five who regularly travel to the city to see patients seeking medical marijuana.[95] Of those five, only one is from northern California: Dr. Sumchai.[96] Despite surrendering it in 2001, Dr. Sumchai had her license to practice medicine formally revoked in 2004.[97] In 2007, she ran for mayor of San Francisco against Gavin Newsom.[98] Eventually, in 2009, the state fully reinstated her medical license "under the condition that she continue to see a psychiatrist."[99] "Police, members of the local medical community, advocates for the legalization of marijuana and the doctors at Redding's longest-running cannabis clinic say that they have doubts about the legitimacy of some of the new traveling medical cannabis doctors."[100]

### *D. Marketing/Profit Making*

The great increase in the number of medical marijuana patients over the last decade is something of a surprise. If a drug company, for example, were to come out with a new treatment for leukemia or heart disease, one would not expect the universe of patients to expand. This is because the patient's condition preceded the existence of the drug and is in no way affected by it. Logically, the same relationship would exist between medical marijuana and the serious conditions defined in respective statutes. As indicated above, however, that is not the case in some states.[101]

The great expansion of users is thought to be largely a byproduct of allowing marijuana to be sold through storefront sales outlets. Interestingly, those who voted for California's Proposition 215 in 1996 did not contemplate the establishment of marijuana stores throughout the cities.[102] Perhaps the advent of dispensaries should have been foreseen. After all, buying marijuana from a friendly neighborhood store, though more expensive, is convenient, comfortable, and likely guarantees a higher quality and predictability of the dosage of the

94. Ryan Sabalow, *Medical Marijuana Too Easy?*, REDDING REC., July 10, 2010, http://www.redding.com/news/2010/jul/10/medical-marijuana-too-easy-these-sort-of-road-us/?print=1 (on file with the *McGeorge Law Review*).

95. *Id.*

96. *Id.*

97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.*

101. *See infra* Part III.A–C.

102. *See* U.S. DEP'T OF JUSTICE, *supra* note 4 at 11.

product. However, it is not the existence of the dispensary that is surprising, but rather their great number. Consider an example from California. In November 2005, there were four known medical marijuana dispensaries operating in Los Angeles.[103] In November 2006, there were ninety-eight.[104] By 2008, the number ballooned to approximately 880, a 22,000% increase from 2005.[105] The ease in securing medical approval along with aggressive and ubiquitous advertising through flyers, leaflets, stickers, publications, and even a billboard or two, likely influenced this dramatic growth.[106] As Reverend Scott Imler, a co-author of Proposition 215, exclaimed, "[w]hen we wrote 215, we were selling it to the public as something for the seriously ill."[107] "What we got was a whole different thing, a big new industry."[108]

A dispensary designs its marketing, of course, to induce customers to prefer one outlet over another. The dispensary is a business model and functions to increase its revenue through price and product competition. Marketing may also be designed to encourage more individuals to exploit lax standards for securing a doctor's recommendation in order to enjoy the pleasurable experience of smoking a joint with their friends. Some product advertising is geared toward commonplace health conditions, such as insomnia, that clearly fall short of the statutory requirements for use. For example, a full page advertisement, thinly disguised as an informational piece, speaks to the "35 million adults in the United States [who] suffer from long-term insomnia [as well as] . . . 20 million to 30 million more [who] experience a form of short-term sleeplessness."[109] The article identifies specific types of cannabis products thought to work better than traditional sedatives, and highlights five local sellers who market the product.[110]

More customers mean greater revenues, which enable owners to reward themselves and their employees with higher salaries. Some compensate themselves generously, even in states such as California where the dispensaries

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103. *See* McNeely & O'Sullivan, *supra* note 83, at 12.

104. *Id.*

105. *Id.* at 13.

106. *Id.* at 10–12.

107. *See* U.S. DEP'T OF JUSTICE, *supra* note 4; *see also* Jerry Wade, *A Comparison of Medical Marijuana Programs in California and Oregon*, ALTERNATIVES MAG., Fall 2006, *available at* http://www.alternativesmagaine.zom/39/wade.html (on file with the *McGeorge Law Review*) ("Most of the dispensaries operating in California are a little more than dope dealers with store fronts.").

108. William M. Welch, *L.A.'s Marijuana Stores Take Root*, USA TODAY, Mar. 8, 2007, at 3A, *available at* http://www.usatoday.com/news/nation/2007-03-07-pot-clinics_N.htm (on file with the *McGeorge Law Review*) (quoting Reverend Scott Imler); *see also* Vanessa Grigoridias, *The Great California Weed Rush: How Medical Marijuana is Turning L.A. Pot Dealers into Semilegit Businessmen—No Beeper Required*, ROLLING STONE, Feb.22, 2007, http://www.rollingstone.com/culture/news/the-great-california-weed-rush-20110418 (on file with the *McGeorge Law Review*).

109. Jeff Chinn, *Go to Bud: Millions Suffer From Insomnia. Medical Cannabis Can Help*, SACRAMENTO NEWS & REV., at 33, Apr. 14, 2011, http://www.newsreview.com/sacramento/go-to-bud/content?oid=1958386 (on file with the *McGeorge Law Review*).

110. *Id.*

must be non-profit organizations. There is no law that employees of non-profits cannot be well paid, but the compensation of some employees was great enough to produce criticism from Sacramento attorney, George Mull, who represents dispensaries. Mull said, "police raids will continue . . . as long as operators of some dispensaries are earning hundreds of thousands of dollars in pay and there are no state rules for bookkeeping or salaries."[111]

Marketing sometimes takes the form of glossy, attractively designed magazines that rival those of established retailers. For example, the magazine *Kush* sells advertising space in its three California editions from $475 to $3900.[112] But for the obligatory references to cannabis as "medicine," a casual reader of *Kush* would not know that access to the product is restricted to certain statutorily identified conditions. Promotional offers are also routine. The Green Harmony dispensary, for example, offers a free gram to new customers, as well as to customers who bring a friend.[113] It also features "daily specials."[114] Unity, a "non-profit" collective in Sacramento, is even more generous in its Saturday special, "Buy 1/8, Get Second 1/8 free."[115] The El Camino Wellness Center advertisement offers gifts for new patients, and boasts about its free holistic services, including "massages" and "acupressure." Customer satisfaction seems to be its goal as its motto proclaims, "Patients Spoke, We Listened."[116] 420 Evaluations in San Jose offers doctor evaluations for only $49, well below the going rate of $150, and annual renewals for only $39.[117] Natural Herbal Pain Relief offers a "Happy Hour" every Monday through Thursday from 3:00 PM to 4:20 PM, and has a special for seniors disabled persons and veterans of any age.[118] And Elixir Medical Cannabis Collective will pay all sales tax.[119]

### *E. Policing Medical Marijuana*

The birth of medical marijuana offered new opportunities for individuals who were growing and selling illegally to find some protection from arrest and prosecution by securing a doctor's recommendation for use, or being designated as a caregiver. Overnight, the criminal status of many shifted to one cloaked in legitimacy.[120] Medical marijuana programs also created a new class of illicit

111. Hecht, *supra* note 40.

112. *2011 Media Kit*, KUSH MAG., at 4 (2011) (on file with the *McGeorge Law Review*).

113. KUSH MAG., May 25, 2011, at 73, *available at* http://issuu.com/kushdailybuds/docs/kushnocal_may11 (on file with the *McGeorge Law Review*).

114. *Id.*

115. *Id.* at 66.

116. *Id.* at 3.

117. *Id.* at 13.

118. *Id.* at 5.

119. *Id.* at 53.

120. *See* Samuels, *supra* note 42.

sellers who resell what they purchased from a dispensary, perhaps at a profit, to recreational users. Others who have the skills to grow their own plants have been able to sell at a handsome profit. We know very little about this commerce, other than that it exists.

We do know, however, that policing the implementation of these new medical programs is difficult. Routinely identifying individuals who are growing more than the number of plants legally allowed, who purchased a fake recommendation or forged one themselves, or who are reselling to friends and neighbors is impossible, except by happenstance. Police can distinguish medical marijuana growers from their criminal counterparts only by securing a list of the patients from them and then contacting those listed to determine if they authorized the grower to serve as a caregiver. Similarly, routine auditing of dispensaries to determine whether they are profit-making, paying employees excessive salaries, or conspiring with growers is time-consuming, labor intensive, and perhaps expensive, as well as a diversion from the investigation of violent crime. The United States Supreme Court recognized that medical marijuana will leak into the illegal market: "The exemption for cultivation by patients and caregivers can only increase the supply of marijuana in the California market. The likelihood that all such production will promptly terminate when patients recover or will precisely match the patients' medical needs during their convalescence seems remote; whereas the danger that excesses will satisfy some of the admittedly enormous demand for recreational use seems obvious."[121] It is likely, the Court continued, that "no small number of unscrupulous people will make use of the California [marijuana] exemptions to serve their commercial ends whenever it is feasible. . . ."[122] Distinguishing medical marijuana from recreational marijuana is probably not possible other than by tagging each plant and tracing its movement through the distribution channel. Marijuana is a fungible commodity, like soybeans or rice; there is no way to tell the difference between marijuana that winds up going to patients and marijuana that winds up on the street.

There is one more impediment to effective enforcement that deserves attention. It is the historic problem that attends victimless or consensual crimes—corruption. Unlike other crimes, such as burglary or robbery, consensual crimes like gambling, prostitution, and drug enforcement lack a complainant. The police

121. *See* Gonzales v. Raich, 545 U.S. 1, 31–32 (2005). The Department of Justice made a similar point. For example, a 2007 DOJ report concludes that marijuana availability is widespread, and its abuse is rampant in the Northern California High Intensity Drug Trafficking Area (HIDTA) regions. *See* U.S. DEP'T OF JUSTICE, DOMESTIC CANNABIS CULTIVATION ASSESSMENT 2007, Feb. 2007, at 15–17, *available at* http://www.justice.gov/ndic/pubs22/22486/22486p.pdf (on file with the *McGeorge Law Review*). This situation is a combined result of increasing demand, increased availability of high potency marijuana and exploitation of California Proposition 215 by illegal cannabis cultivators and drug traffickers. *Id.* Numerous federal, state, and local law enforcement agencies and task forces report an increase in the number of illegal outdoor and indoor cannabis grow sites that they encounter. *Id.*

122. *Gonzales*, 545 U.S. at 32.

must discover the illegal conduct on their own through covert investigation, which typically involves the use of informants and undercover agents. Whenever there are victimless crimes, police officials and the public need worry about corruption, especially where, as is here, so much money is at hand and so many citizens favor legalization.[123]

In the face of these challenges to comprehensive enforcement, it is nonetheless clear that enforcement is ongoing. Newspaper accounts of raids on medical marijuana dispensaries and arrests of individuals are commonplace. For example, following months of investigation, recent raids on medical marijuana dispensaries in Fresno resulted in an extraordinary seizure of 4000 live plants, 300 pounds of processed marijuana, and $400,000 in cash. Teams of about 200 local, state, and federal agents served warrants and searched five dispensaries on the basis that they were making a profit from marijuana sales, which is illegal under state law.[124] A more typical case involved the arrest of a fifty-one year old man, stopped for a traffic violation and found to be carrying four pounds of marijuana in his pickup truck. Though authorized to use medical marijuana, the amount seized identified him as a seller. He pled guilty to the felony charge of illegally transporting marijuana and was sentenced to six months in the county jail and three years of probation.[125]

## IV. TODAY AND TOMORROW

When measured solely in terms of providing access to intended beneficiaries, medical marijuana programs are a success. They are achieving the humanitarian goals sought by their supporters. As marijuana's reputation of being a legitimate medical treatment grows, additional states will likely authorize such programs.[126] Going forward, however, it is unlikely that California will serve as a model for other states because of its failure to distinguish between medical and recreational users.[127] As seen already, states considering authorizing medical marijuana will

123. *See* Samuels, *supra* note 42 ("A 2005 State Department report put the country's marijuana crop at twenty-two million pounds. The street value of California's crop alone may be as high as fourteen billion dollars.").

124. *Fresno County Sheriff's Department Seize Thousands of Marijuana Plants* (KSEE 24 News television broadcast June 2, 2011), *available at* http://www.ksee24.com/news/local/Search-Warrant---MKR-123049738.html (on file with the *McGeorge Law Review*).

125. *Guilty Plea For Illegally Transporting Marijuana*, ROCKLIN & ROSEVILLE TODAY (Dec. 12, 2010), http://www.rocklintoday.com/news/templates/community_news.asp?articleid=9538&zoneid=4 (on file with the *McGeorge Law Review*).

126. *See Gonzales*, 545 U.S. 1.

127. *See* Bennett, *supra* note 49.

> [F]or anyone who's been to California recently, it's easy to forget that recreational marijuana isn't permitted there already. In 1996, California became the first of 14 states to sanction medical pot use; getting the state-issued ID card that allows access to medical marijuana may cost you, but it requires little more than convincing a doctor you have cramps. California is now home to thousands of pot dispensaries operating both legally and illegally, as well as a

continue to improve upon existing programs, seeking to close loopholes and fashioning something like a best-practices program.

As to marijuana's success as a medical treatment—whether patients are receiving desired results, whether undesirable side effects or addiction are accompanying pain relief, and whether other drugs are superior—we have next to no knowledge. This is remarkable because feedback from patients is central to understanding and evaluating drug performance, and both drug manufacturers and the Food and Drug Administration rely on it. That none of the seventeen programs collected performance data is truly a lost opportunity.

As for existing programs, if measured against the reasonable expectations of voters and legislators, more than a few state programs fall short. In enacting authorizing statutes, lawmakers provided physicians with broad discretion to prescribe marijuana, and some doctors, typically those whose practices consist primarily of applicants for marijuana recommendations, abused the power conferred on them. A law born of compassion and humanitarian instincts has resulted in a highly competitive industry, with storefront businesses seeking to increase market share through advertising, discounts, promotions, and having doctors at hand or nearby, writing prescriptions.

For better *and* for worse, increased recreational use is certain as more states authorize medical marijuana. With this said, legislators will likely be more concerned with over-inclusion of patients rather than under-inclusion. To curb excesses, as this essay identified, the critical variables are two: dispensaries and physicians. Dispensaries increase the amount of and access to marijuana, and, at the same time, decrease the state's ability to control its use. Thus, if permitted, regulatory oversight is essential. As explained above, the convergence of the vague, qualifying medical conditions, the potential for inordinate profit, and the unreviewable discretion accorded physicians increases access to recreational users. The challenge with physicians then, is to limit their power to authorize use without intruding on their professional judgment. While neither of these tasks is an easy chore, if left undone, the mess will remain.

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number of cities where pot sales are being taxed—and even a marijuana university. It's been estimated that 400,000 Californians smoke pot legally each year—and another 2 million do so illegally.

*Id.*