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Folder Title:

Medical Marijuana [1]

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Media Availability/Advisory

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Also: (323) 661-1720

Millennium Medical Marijuana

March 2000 Washington, DC

U.S. NATIONAL PARK SERVICES GRANT PERMIT FOR MILLENNIUM MEDICAL MARIJUANA MARCH 2000

**Saturday, April 29, 2000
Washington, DC**

What: MMMM 2000 "PATIENT RALLIES & MARCH"
NOTE: **ORGANIZERS OF INTERNATIONAL EVENT ARE
AVAILABLE FOR MEDIA INTERVIEW IN L.A.**
(CONTACT ABOVE MEDIA CONTACTS IN L.A.)

Where: Event is in **Washington, DC, USA;** pre-event interviews
available in **Los Angeles, CA**

When: **Saturday April 29, 2000**
12:00noon Rally at LAFAYETTE PARK
3:00pm MMMM 2000 March (Patients & Activists)
4pm – 8pm MEDICAL RIGHTS RALLY & CONCERT at
HENRY BACON BALL FIELD
(SPEAKERS & ENTERTAINMENT TBA)

1 October 1999, LOS ANGELES, CA—The United States Park Services took the unprecedented step of issuing the first-ever rally and march permit (#00-0075) to a group of organized patients for a national Millennium Medical Marijuana March 2000. Organized patients and participants from throughout the United States of America will attend the rallies to be followed by the march which is expected to be attended by thousands of Medical Marijuana patients and individuals who support safe access and legal availability now! Participants will hear patients and doctors and others speak on Medical Marijuana. *Concert info and speakers to be announced at a later date.*

What: **MMMM 2000** happens the day before the MILLENNIUM MARCH ON
WASHINGTON FOR EQUALITY SUNDAY APRIL 30, 2000, WASHINGTON DC

HELP SUPPORT SAFE ACCESS FOR MEDICAL MARIJUANA PATIENTS IN ALL 50 STATES AND OUR
NATION'S CAPITAL, WASHINGTON, DC. THANK YOU.

Richard Eastman & Steve M. Corchado, Event Producers

MILLENNIUM MEDICAL MARIJUANA MARCH 2000
1331 Berkeley Street, Suite 3 Santa Monica CA 90404
Tel: (310) 453-2700 Fax: (310) 586-1566

March Slogs On

Millennium March on Washington (MMOW) gets one thumbs-up and one thumbs-down last month

Commentary by Bob Roehr
Contributing Writer

Kerry Lobel, executive director of the National Gay and Lesbian Task Force, resigned from the board of directors of the Millennium March on Washington (MMOW) in a scathing letter outlining her frustrations.

"The Board has largely ignored the fundamental issues that led me to become involved: why we should march, the agenda, and the involvement of the entire LGBT community," Lobel wrote in her April 25 resignation.

"I cannot serve on a Board that will not open itself to greater input and scrutiny from the communities we claim to represent."

"The second reason for my resignation is that I continue to doubt the value of this March at this time," she said. Lobel sees political power and decision making returning to the state and local levels and believes energies should be directed there.

Another MMOW board member had quietly resigned in February. Red Carey, the executive director of the National Youth Advocacy Coalition (NYAC) was out of the country on vacation but her deputy, Michael Kaplan, spoke at length about that decision.

Kaplan knew that Carey had personal reservations about MMOW and decisions made by it, reservations that she made explicit in her letter of resignation, though he did not have a copy to share. He said, "It became a difficult place to be" for Carey.

He defined the central issue as, "Is this the best way in her role at NYAC to meet the needs of our members?"

In an ongoing survey of their members, NYAC found that there was both support and opposition to participating. But, Kaplan said, "It clearly did not come out as a priority where people wanted us and our executive directors putting their attention."

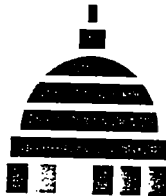
A steady drumbeat of opposition to the march has been sounded over the last year by the Ad Hoc Committee for an Open Process. Their numbers have swelled to nearly 500, primarily from the left of the political spectrum, and their opposition centers upon both the desirability of such a march, and the closed nature of the process by which decisions are made.

News Conference

The board of directors of the MMOW held a news conference on April 30 at the National Press Club in Washington, DC, exactly one year prior to the day of the planned event. It was to "kick off a year long campaign that will have political consequences and offer unparalleled opportunities...to interact and organize like never before," said Duane Cramer, one of four co-chairs of MMOW.

The glitziest presentation was by Tom Riley, chairman of PlanetOut, an online ser-

www.mmow.org



**MILLENNIUM MARCH
ON WASHINGTON
for EQUALITY
APRIL 30
2000**

vice provider targeting the gay community. It claims "over half a million monthly visitors." The company has signed on as a "platinum" sponsor, contributing \$250,000 in cash, and pledging \$750,000 in technical services.

Riley unveiled the MMOW web site (www.mmow.org), which allows people to register for the march and participate "even if they cannot come to Washington, DC." A year from now they will offer streaming audio and video of events as they take place, as well as translations into several languages. He called this "an intersection between technology and the lesbian and gay communities."

Donna Red Wing, a co-chair and organizer for the Human Rights Campaign (HRC), called the names and data gathered by this site "the most valuable thing that comes out of this March or this organization."

However, she acknowledged that they "haven't created a protocol" for who gets access to this information on the people who say they are willing to have it used for marketing purposes.

While there is huge potential in organizing through the Internet, it is still unproven as a tool for moving large numbers of people to an event. Riley's claim of 500,000 hits a month translates into far fewer people because users tend to be frequent visitors to a web site, with some visiting every day.

Red Wing dismissed charges that the MMOW lacked a purpose. She said they would hold town meetings and survey people online to build a platform for the march. "It doesn't make sense to set a date" for having that platform she said, "We have a year."

"Diversity"

"A majority of our board are women" boasted co-chair Nicole Ramirez-Murray. In fact, 9 of the 15 members appear to be female, and 9 are also people of color. The "diversity" of that body even stretches to include a sole GWM: Rev. Elder Troy Perry, head of the Universal Fellowship of

March Slogs On

Continued from page 18

Metropolitan Community Churches.

If you look closely at the resumes of the board, "diversity" assumes a rather crabbed geographic meaning. 12 of the 15 live in either DC or California, while the four paid staff members all reside in California. The DC "office" is a post office box, while the phone is in Los Angeles. Perhaps it should be called the California March on Washington.

And what about political "diversity"? There seems to be a heavy political tilt to the board, perhaps reflecting initial speculation that part of the reason why HRC's Elizabeth Birch jumped on this Millennium March bandwagon was to "deliver" the gay vote to Al Gore.

The press package biography of board member Donna Brazile listed her employment as on the staff of DC Congresswoman Eleanor Holmes Norton. It ignored the report more than a week prior in the Washington Post that Brazile had become political director of Gore's election committee.

Fuzzy Financials

"I have never seen a financial report," Lobel said in a separate interview concerning her one-year involvement with the MMOW.

That was confirmed by Red Wing, who is also Treasurer of MMOW. "Until now we really didn't have any money," she said after the news conference.

But if that was the case, then how did the MMOW function for more than a year?

How did it pay for conference calls, fly people from across the country to periodic board meetings, or retain a staff of four? Those expenses must surely total tens of thousands of dollars.

It is believed that the leading initial proponents of the MMOW, the Human Rights Campaign and the Metropolitan Community Church, have provided "seed money" and most likely in-kind services to the group. Redwing was traveling at press time and unavailable to respond to further questions.

History Lesson

The first MOW, in 1979, languished until the assassination of Harvey Milk in San Francisco energized the community. The second, in 1987, took root in anger at the Supreme Court "Hardwick" decision on sodomy laws that affirmed our second class citizenship.

The third, in 1993, was based on the optimism engendered by Bill Clinton's campaign and election, the belief that legal equality was finally about to be achieved.

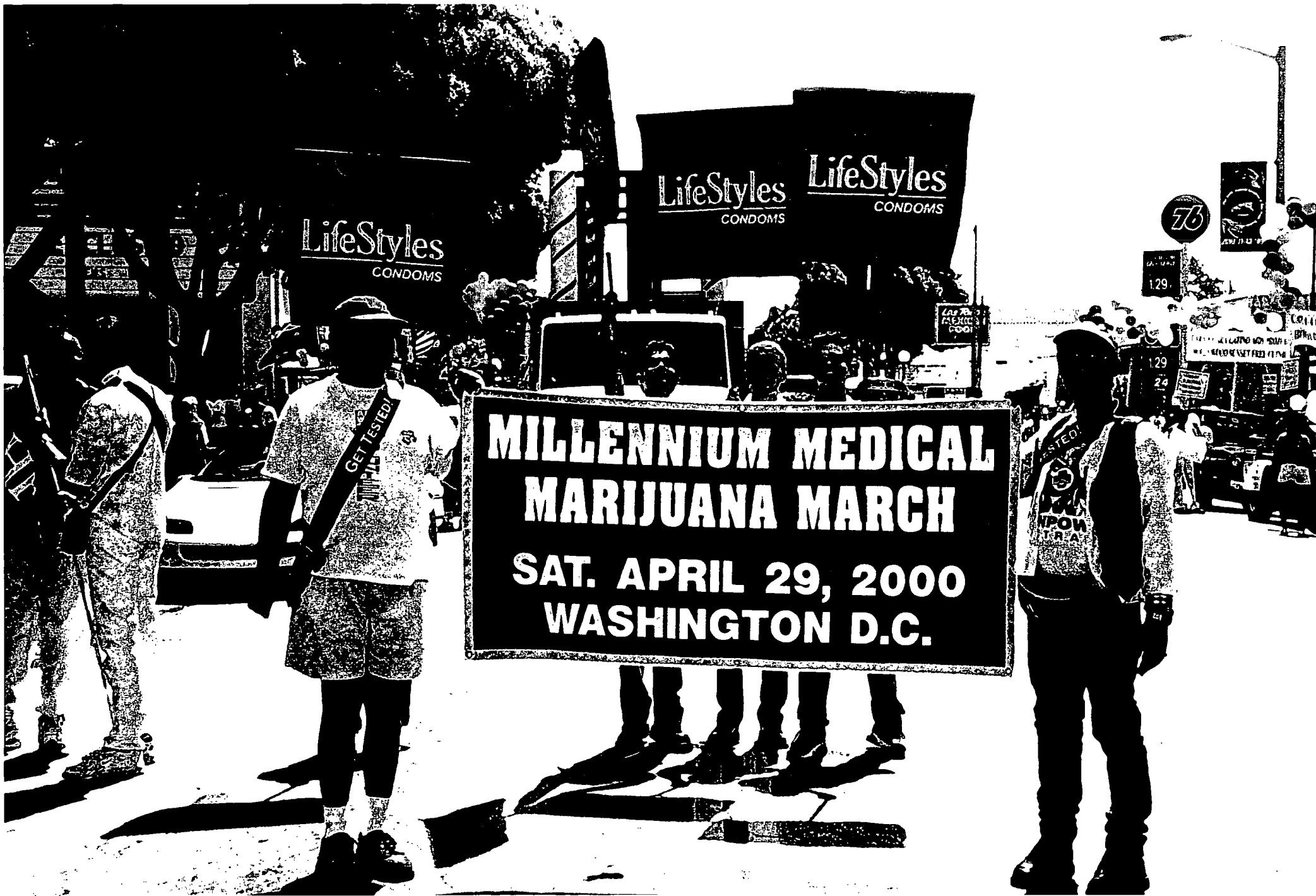
What is the motivating idea behind the MMOW?

It seems to be little more than a marketing plan in search of a reason beyond the generic one of "organizing."

Some have pointed out that the date of the MMOW, April 30, 2000, marks the 25th anniversary of the end of the Vietnam War. That event is likely to garner considerable media attention and perhaps crowd out coverage of the MMOW.

A national march in support of medical marijuana is also in the planning stage to April 29, 2000.

Continued on page 19



LifeStyles
CONDOMS

LifeStyles
CONDOMS

LifeStyles
CONDOMS

**MILLENNIUM MEDICAL
MARIJUANA MARCH**
SAT. APRIL 29, 2000
WASHINGTON D.C.

GET TESTED!

TESTED!
HON
R.A.

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MILLENNIUM MEDICAL MARIJUANA MARCH 2000

RICHARD W. EASTMAN
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Los Angeles Times

FRIDAY, MAY 21, 1999

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LOS ANGELES TIMES

Marijuana Studies to Be Aided by Likely Policy Reversal

■ **Health:** Move by Clinton will make the drug available to scientists to examine its medical effects. A flood of research proposals is anticipated.

By MARLENE CIMONS
TIMES STAFF WRITER

WASHINGTON—In a major policy reversal, the Clinton administration is expected to announce today that it will release its hold on research-quality marijuana and make it available to scientists who want to study its medical effects.

For more than 20 years, the production and distribution of marijuana for clinical research has been restricted under several federal laws and international agreements, making it all but impossible for nonfederally funded researchers to obtain it.

Scientists have had to go through a cumbersome and often bureaucratic process to get it, which few have attempted.

The policy originally was established to ensure uniform quality standards for marijuana used in research. However, the substance became extremely difficult for researchers to obtain.

Under the new policy, which

would loosen these restrictions, private researchers, including physicians, will be allowed to purchase and use the substance for studies. A senior administration official said that the change, to take place in December, could "open the door" to a flood of research proposals and studies.

The issue has been the subject of intense national debate and political pressure. Advocates insist that laws forbidding the medical uses of marijuana are cruel and inhumane. Opponents argue that sanctioning marijuana for any purpose only gives a green light to illegal drug use and would further encourage it.

In March, the Institute of Medicine released a report saying that marijuana did have medicinal benefits: that it eases pain and quells nausea in cancer patients. But the National Academy of Sciences study group called for more research, in part to explore alternatives to smoking pot, such as perfecting a pill form of the drug.

Contradicting administration policy that marijuana has no medical value and can lead to using harder drugs, the panel of experts found that marijuana is not addictive and said there is no clear evidence that smoking it leads to consumption of heroin, cocaine or other narcotics.

A year earlier, an advisory panel to the National Institutes of Health

concluded that marijuana might have promising therapeutic uses and called for clinical trials of its effectiveness.

The news of a shift in administration policy is expected to be welcomed by medical marijuana advocates who have been clamoring for more research, a position bolstered by the recent reports.

"For the last 22 years, the federal government has had a lock on the use of whole smoked marijuana for studies—they grow it at the University of Mississippi. . . and activists and reformers and legitimate scientists have wanted to have access to it to conduct studies, and have had no luck," said Allen St. Pierre, executive director of the National Organization for the Reform of Marijuana Laws Foundation.

"We've pushed very hard for this. We've been imploring the government to come up with a system that will allow these studies to go forward," he added. "We want to do the science, but marijuana has become so politicized."

A senior administration official said that the change is supported by Gen. Barry R. McCaffrey, head of the administration's Office of National Drug Control Policy, who has in the past opposed medical uses of marijuana. The official also predicted that the accessibility will "increase the likelihood that we

finally get honest-to-God scientific answers on this very important issue.

"We really believe this will make it much easier for research to go forward."

The issue is especially volatile in California, where voters passed a 1996 initiative allowing patients to grow and use marijuana, a law that has been challenged by the administration.

The Department of Health and Human Services, in a document laying out the new policy, said that it intends "to facilitate the research needed to evaluate these pending public health questions by making research-grade marijuana available."

The department said that researchers seeking access to the drug must be involved in studies that generally follow guidelines from the Institute of Medicine report—and must pay the government for the drug. Such studies would "be expected to yield useful data and, therefore, will be more likely to be eligible to receive marijuana under the HHS program."

Currently, few studies funded by the National Institutes of Health use marijuana, and only a handful of individuals in the country receive government-owned marijuana for medical reasons.

The Top of Today's News

FRIDAY, MAY 21, 1999 A15

Daily News

SATURDAY, MAY 22, 1999

6 — NEWS / SATURDAY, MAY 22, 1999 / DAILY NEWS

U.S. government to sell pot

By Noah Isackson
Associated Press

Research-grade marijuana to be available to researchers

SACRAMENTO — The Clinton administration's new, less restrictive guidelines for marijuana research are good news for scientists and the state's effort to implement its medical marijuana law, advocates and researchers said Friday.

Previously, the government has required that such research be paid for by scarce grant money from the National Institutes of Health.

That changed Friday when the Clinton administration eased the requirement, announcing that it would sell government-grown marijuana to privately funded scientists.

The new federal guidelines make it easier for academic researchers examining the drug's potential medical benefits to obtain samples of research-grade marijuana grown by the government.

For years, academic and private researchers complained of difficulty getting marijuana from tightly controlled government supplies.

"It was an unintelligible, Catch 22-like maze, filled with roadblocks and obstacles," said Donald Abrams, a professor of clinical medicine at the University of California, San Francisco.

Abrams said he spent five years trying to get government approval

to study how marijuana might fight wasting syndrome, a condition where AIDS patients are no longer able to eat.

Abrams said he eventually won government approval through "furious persistence."

Nationally, Abrams' research team is among four projects working with government-approved marijuana, said Charles Blanchard of the White House's national drug control policy office.

The other projects are affiliated with the Oakland-based Kaiser Permanente Medical Group, the University of Chicago and the Medical College of Virginia, Blanchard said.

At UCSF, Abrams receives about 300 marijuana cigarettes from the National Institute of Drug Abuse upon request.

"Hopefully it will now be easier for people who research marijuana to obtain it for clinical trials," Abrams said. "I think it's very encouraging news."

In the last few months, two major studies have recommended a more extensive program of scientific research into marijuana.

Committees for the National Academy of Sciences and the National Institutes of Health

concluded there is evidence marijuana can be useful in the treatment of some patients who have not responded well to other therapies.

Many cancer patients and people with AIDS have said that marijuana, often obtained illegally, can relieve nausea and restore appetite.

Still, some anti-drug activists say medical marijuana is the wrong move.

"Marijuana just makes sick people sicker," said Art Croney, executive director for the Committee on Moral Concerns in Sacramento. "This is a step toward drug legalization at the expense of suffering people."

After California voters approved Proposition 215 in 1996, medical marijuana distribution centers popped up across the state, openly defying federal law. Many were shut down by federal agents and Attorney General Bill Lockyer's predecessor, Dan Lungren.

"We are convinced there will be no changes in federal law until there is more quality research done," said Nathan Barankin, a Lockyer spokesman. "This decision to authorize and allow more

expansive testing will get us off the gun and start moving towards taking the necessary steps toward determining whether Proposition 215 will be or can be implemented."

Despite federal disapproval, Lockyer has appointed a 20-member task force of prosecutors, medical providers, law enforcement officials and patients to determine how California can make the law work.

The head of the task force, Sen. John Vasconcellos, D-Santa Clara, is sponsoring a bill that would create a medical marijuana research program at the University of California.

"One of the issues hanging over the bill was where do we get the marijuana for research purposes," said Rand Martin, Vasconcellos' chief of staff. "Clinton's decision answers that question in no uncertain terms."

Had the Clinton Administration continued its more restrictive medical marijuana research policy, UC researchers would have been forced to work with marijuana that could compromise their studies, Rand said.

"If we had to find another source, such as confiscated marijuana, there would have been questions about the consistency and the potency," Rand said. "For the research to have integrity you have to have marijuana that is consistently pure and potent."

"All the News
That's Fit to Print"

The New York Times

VOL. CXLVIII . . . No. 51,530 Copyright © 1999 The New York Times

SATURDAY, MAY 22, 1999

**Marijuana Research
Faces Fewer Limits**

THE NEW YORK TIMES NATIONAL SATURDAY, MAY 22, 1999

Restrictions Eased for Studies on Marijuana as Medicine

By SHERYL GAY STOLBERG

WASHINGTON, May 21 — Despite intense interest in the medical benefits of marijuana, only a handful of scientists are studying it because the Government has always required that such work be paid for by scarce grant money from the National Institutes of Health.

Today the Clinton Administration eased that restriction, announcing that it would sell Government-grown marijuana to researchers and allow them to secure their own financing.

The decision, which comes two months after a Government-sponsored study found that marijuana's active ingredient appeared to be useful for some conditions, was issued by the National Institute on Drug Abuse. It is supported by Gen. Barry R. McCaffrey, who as director of the Office of National Drug Control Policy has ardently opposed legalization of medical marijuana.

"Before, the problem was if you wanted marijuana, you had to not

only show that it was high-quality research, you had to show that it was more important than other competing applications for N.I.H. funding," said Chuck Blanchard, chief counsel for McCaffrey's office. "Now, as long as you are willing to show that it is high-quality research and also provide your own funding, you can have access to medical marijuana."

Under the ruling, marijuana studies will still be reviewed for their scientific merit, but it will become easier for state and local governments to pay for the research. Experts hope the studies could lead to the development of a new delivery system for marijuana, like an inhaler, that would enable patients to benefit without suffering the toxic effects of smoke.

Already, some officials say they hope to take advantage of the new rule. "This news today gives us great hope," said Mike Nevin, a member of the Board of Supervisors in San Mateo County, Calif. About a year ago,

Mr. Nevin said, his board allocated \$500,000 for studies of marijuana in cancer and AIDS patients.

"We are hoping the Federal Government will grant us the ability to do this study," he said, "and we are willing to pay."

For years, the National Institute on Drug Abuse has paid a farmer at the University of Mississippi to grow marijuana for research, primarily studies on addiction. The Government also provides the drug to eight patients under a "compassionate use" program, but that program has been closed to new participants since 1992.

In recent years, scientists have tried, with limited success, to persuade the National Institutes of Health to pay for studies on using marijuana as medicine. Only three studies have been approved so far; among them is one being conducted by Dr. Donald Abrams of the University of California at San Francisco who said it took five years to obtain

approval and a \$978,000 N.I.H. grant.

Even then, Dr. Abrams said he had to mask his true research interest. Although he wanted to examine the effects of marijuana on the weight loss associated with AIDS, he pitched the study as one that would look at potentially toxic interactions between marijuana and standard AIDS medications.

"We designed a study that would appeal to the group of people funding the grant," he said.

In the study reported two months ago, the Institute of Medicine, a branch of the National Academy of Sciences, concluded that the active ingredients in marijuana, called cannabinoids, appeared useful for treating pain, nausea and severe weight loss in AIDS patients. Two years ago, a review by N.I.H. officials reached a similar conclusion.

"We have had several pretty distinguished groups now say that cannabinoids, not smoked marijuana, may have some real potential medical usage," said Dr. Steven W. Gust, special assistant to the director of the National Institute on Drug Abuse. "This is a first step towards ultimately developing purified forms of cannabinoids that may be F.D.A.-approvable."

The Clinton Administration has eased restrictions on research into the possible medical benefits of marijuana, announcing that it would sell Government-grown marijuana to researchers and allow them to secure their own financing for studies.

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Article page A11.

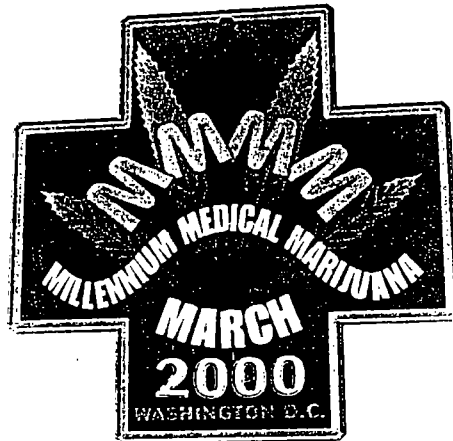
So far, there is only one cannabinoid-based drug on the market, Marinol, manufactured by Unimed Pharmaceuticals Inc. of Buffalo Grove, Ill. But some patients have complained that the effects of the pills were too strong at first, then wore off quickly. Researchers to theorize that an inhaler, similar to those used by asthma patients, might enable patients to better modulate the effects of the drug.

Recognizing that such a method might take years to develop, the Institute of Medicine report recommended that patients who did not respond to other therapy be permitted to smoke marijuana. But the regulation issued today said the Government did not intend to approve "single-patient requests for marijuana," because they did not "produce useful scientific information."

Advocates for legalizing marijuana as medicine had both praise and criticism for today's decision.

"It is a tiny step forward, but far too tiny," said Ethan Nadelmann, director of the Lindesmith Center, which backed initiatives in California and Arizona to make marijuana legal for medical use. "It's an implicit acknowledgement that the Government has blocked research into medical marijuana for explicitly political reasons for the last two decades."

MILLENNIUM MEDICAL MARIJUANA MARCH



APRIL 29, 2000 WASHINGTON D.C.

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"I cannot serve on a Board that will not open itself to greater input and scrutiny from the communities we claim to represent."

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Kaplan knew that Carey had personal reservations about MMOW and decisions made by it, reservations that she made explicit in her letter of resignation, though he did not have a copy to share. He said, "It became a difficult place to be" for Carey.

He defined the central issue as, "Is this the best way in her role at NYAC to meet the needs of our members?"

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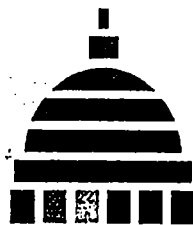
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"Diversity"

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Task Force M

State officials set to green-light medical marijuana

BY MICHAEL SIMMONS

"THIS IS MY THIRTY-THIRD YEAR IN LAW enforcement. When I first started, one seed was a felony," says Pete Herley, chief of police of Tiburon, California, located in Marin County. "I was laughing during the meetings and I said, 'If you'd've told me 33 years ago that I would be sitting at a meeting like this, I would have serious concerns about your sanity.'"

Herley is referring to California Attorney General Bill Lockyer's Medical Marijuana Task Force, a wildly diverse group made up of 30-odd cops, D.A.s, doctors and weed advocates. Convened in February by Lockyer, the task at hand is to fulfill the voter's Proposition 215 mandate which encouraged "the federal and state government to implement a plan to provide for the safe and affordable distribution to all patients in need of medical marijuana."

Co-chaired by Democratic State Senator John Vasconcellos of Santa Clara (who was pro-215 prior to its passage) and George Kennedy, district attorney of Santa Clara County (who was anti-215), the group is expected to issue its recommendations as soon as this week. The text will be amended into a bill sponsored by Vasconcellos, SB 848, which passed the state Senate on June 2 (as did SB 847, which appropriates up to \$3 million for med-mar research at the University of California). "The voters of California have placed us on the cutting edge of this issue," Vasconcellos declared. Both bills are expected to become law on January 1, 2000.

While everyone is zip-lipped as to the substance of the recommendations, the *Weekly* has learned the centerpiece will be a voluntary statewide registration card for legitimate patients that will provide a legal shield to protect sick people from the selective law enforcement they've been subject to since Prop. 215 passed two and a half years ago. Other concerns addressed by the task force have been quantity of medicine, physician guidelines, specific illnesses, requirements for card documentation and a set of definitions for those who are about

to enter this brave new world where the old rules of health and drug policy have been redefined.

Cannabis centers and cooperatives, which many believe were enabled by Prop. 215, may be protected and subject to inspection by county health departments. All parties say that the final draft is in no way etched in stone until approved by the task force, Lockyer, the Legislature and Governor Gray Davis.

HEARTENING AS ALL THIS MAY BE FOR those in medical need of the herb, the process of the task force, as echoed by Chief Herley, may end up as avant-paradigmatic as the end result. "Those who worked together and thought through the issues have come to a pretty remarkable consensus," says Lockyer.

Vasconcellos, who has sponsored three prior med-mar bills that either died natural deaths or were vetoed by Pete Wilson, is even more effusive. He also apparently began his career at the same time Herley began his. "I've not, in my 33 years in the Legislature, taken part in a more collaborative, good-willed operation," says the Silicon Valley maverick. "Fifty folks, of profoundly contrary viewpoints, came to the table, sat at the table and really stretched themselves to find common ground."

Scott Imler, the director of the Los Angeles Cannabis Resource Center, co-author of Prop. 215 and one of the two patients on the task force, agreed that the negotiations have surpassed ideology: "Whatever happens with this bill, California will never be the same. Patients and police are no longer faceless enemies. Vilifying each other serves no useful purpose." Chief Herley, who was representing the California Police Chiefs Association and is still answerable to his board of directors, was also pleased with the conciliatory tone of the proceedings: "We're not here to write law, we're here to enforce law," he said in a concession to the new winds of public opinion. "It seems as if everybody is here to reach consensus while we may not agree on every point."

NONE OF THIS STATE-LEVEL ACTION directly affects federal law, which doesn't recognize any medicinal benefits of pot. "Federal law is supreme," admits Lockyer. "We can't create a system that violates federal law." But wouldn't any system that designates marijuana as medicine violate federal law? "Probably," answers Lockyer, "but one of the problems in getting changes in federal attitude is the vagueness included in Prop. 215."

Stories have circulated that at a private meeting back in March in Washington, federal drug czar Barry McCaffrey personally



threatened Lockyer with arrest if he tried to implement Prop. 215. "That didn't get reported accurately," says Lockyer. "I asked for more support for medical research and also suggested that consideration be given to rescheduling marijuana medicine so that it isn't the same as heroin. The particular issue dealt with the fact that there are research businesses in California that

believe they can develop an inhalator as a better way than smoking to deliver the medicine. I mentioned to General McCaffrey that I may have some authority under California law to authorize that sort of experimentation, and he indicated that one should be careful to not goad or provoke federal enforcement officials."

While Lockyer downplays any threat-

ening intention on McCaffrey's part, the general's spokesperson, Bob Weiner of the Office of National Drug Control Policy, contributes his own cryptic two cents concerning the task force. "It's all hypothetical at this stage," says Weiner. "I'm sure we'll look at it when it's written and see what it means. As will other departments, including the Justice Department."

JUNE 25, 1999

24 TASK FORCE "M"

Since Californians voted to legalize medical marijuana, the cannabis clubs have been closed and their patrons busted. Now state officials are ready to revive a cutting-edge law. MICHAEL SIMMONS previews a new strain of drug law.

Lockyer: Warned by feds to be "careful."

DAVIS Likely to Veto Medical Marijuana Use Measure

► VETO

From Page A11

very seriously."

The developments left Vasconcellos sputtering in anger. "I'm really offended," he said in an interview. "This defies anything I've seen in 30 years here."

"I thought the people of California elected the governor — not Barry McCaffrey," he said.

He said he was offended because Davis's staff had breached protocol by making the governor's position known first to a reporter, and not to him.

The position of the new Democratic governor puts him in the same camp with former Gov. Pete Wilson and former Attorney General Dan Lungren, both foes of medical use of marijuana.

Wilson twice vetoed Vasconcellos' attempts to legalize marijuana for medical use in legislation more limited than Proposition 215. Lungren's agents raided the Cannabis Buyers' Club in San Francisco in 1996.

Davis has repeatedly said elected officials should respect the will of voters when they approve initiatives like Propositions 187 and 209,

which limited government programs for illegal immigrants and outlawed government affirmative action programs.

Asked why Davis did not similarly follow voters' wishes on Proposition 215, Bustamante only repeated. "This is clearly in conflict with federal law."

The bill includes the recommendations of a 30-member task force of prosecutors, police and marijuana advocates who tried to find a way to legalize medical use of pot, even though its cultivation, possession and sale are outlawed by state and federal laws.

"We believe the bill provides for responsible implementation of Proposition 215," Attorney General Lockyer told the committee.

The vote was 9 to 3 to send the measure, SB848, to the Appropriations Committee.

The bill would create a statewide identity card that would be issued to anyone whose physician found to be afflicted with a "serious medical condition," including AIDS, anorexia, arthritis, cancer, chronic pain, glaucoma, migraine or other

"chronic or persistent medical symptom."

Bearers of the card would not be subject to prosecution for possession, transportation or growing marijuana — if the amount is less than will be established later by state regulations.

A separate card would be provided to qualified caregivers.

Assemblyman Howard Wayne, D-San Diego, asked Vasconcellos to reconcile his bill with federal law outlawing pot possession.

"The federal government is so hysterical and unresponsive on this issue that I am not going to let them dictate policy," Vasconcellos responded.

Wayne apparently was unpersuaded. He voted no.

Also approved by the committee, 11 to 1, was a second Vasconcellos bill, SB847, which would appropriate \$1 million for the University of California to study the medical effects of marijuana.

"This is simply to find out the truth," Vasconcellos said.

Davis Likely to Veto Pot Bill, Aide Says

By Robert B. Cunningham
CHRONICLE SACRAMENTO BUREAU

SACRAMENTO — Gov. Gray Davis probably will veto a bill to create a state identification card for users of marijuana for medical reasons, his spokesman said yesterday.

The announcement by the Davis office came as the Assembly Health Committee approved a bill backed by Attorney General Bill Lockyer intended to implement a 1996 ballot measure that legalized pot for medicinal use.

The bill would allow quasi-underground marijuana shops in many Northern California counties to do business in the open.

"This is clearly in conflict with federal law," Davis' press secretary, Michael Bustamante, said of the measure by Sen. John Vasconcellos, D-Santa Clara.

Davis campaigned against the

marijuana measure, Proposition 215, along with law enforcement officers and Gen. Barry McCaffrey, the U.S. drug czar.

"Given the governor's long-standing position, I would be hard pressed to see him sign it," Bustamante said. "Until the federal government legalizes its use or growing, state government should not put itself in a position of sanctioning it."

The statement was a change from Monday, when Bustamante said Davis had no position on the bill, but added: "If good science and good medicine dictate that this is reasonable, the governor will look at this."

► VETO: Page A16, Col. 1

MATIER & ROSS

are on vacation

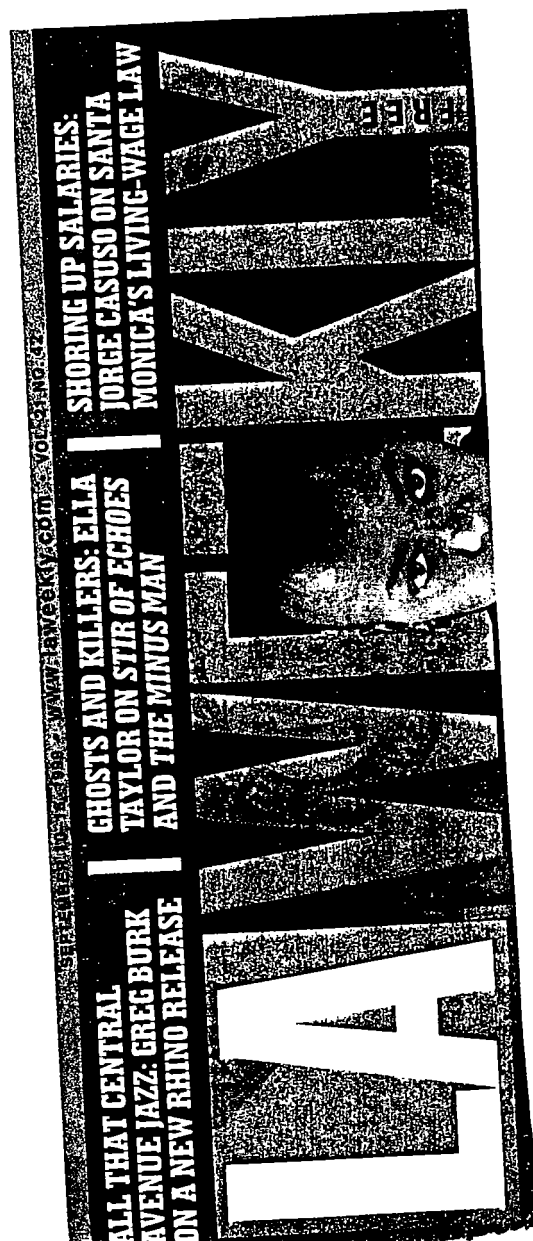
SF Chronicle

July 14, 1999

CALL OR

Write to Gov. DAVIS

TELL Him To Support SB 848



Pot Bill Smolders

Governor Davis off the hook — for now

BY MICHAEL SIMMONS

FACED WITH A SKEPTIC IN THE STATEHOUSE and dissension among their own ranks, the wide range of law-enforcement officials and cannabis activists who constitute the state's Medical Marijuana Task Force has had its legislative-reform agenda put on hold.

After reaching near-consensus in July on steps needed to implement Proposition 215, the medical-marijuana initiative, the group is at an impasse, likely leaving SB 848, the bill that would establish a registry of patients eligible for medical marijuana, on the back burner until next year.

Senator John Vasconcellos (D-Santa Clara), the bill's author, asked Assembly Appropriations Committee member Sheila Kuehl (D-Santa Monica) to act as floor manager for the bill, which has been relegated to the inactive list until the task force settles whether registering to use marijuana should be voluntary or mandatory.

The plan for a registry was conceived by the Medical Marijuana Task Force, convened by Attorney General Bill Lockyer. But law enforcement wants the registry to be mandatory, in order to distinguish between legitimate and fraudulent users, and medical representatives and patient advocates dislike the vague wording of the amendment, which states that a physician "shall notify the County Health Department if he or she finds that a qualified patient has a serious medical condition for which the use of medical marijuana is appropriate."

Supporters of the bill say more time is needed to resolve this problem, as well as to woo Governor Gray Davis away from a threatened veto. "We're still trying to figure out how to satisfy all the interests on the attorney general's task force," says Rand Martin, Vasconcellos' chief of staff. "It's turned out to be a bigger challenge than we'd initially hoped for."

Scott Imler of the Los Angeles Cannabis Resource Center hopes the break will prove constructive: "Maybe between now and the time they take it up again, we can get everybody back together with the governor, and try and work out the remaining differences."

Governor Davis' signature was in doubt whether or not the amendment got tacked on. As the first Democratic governor in 16 years, he's been inundated with ambitious reform legislation, and Davis is reviewing it carefully. "The governor is more moderate than a lot of the members" in the Legislature, says Hilary McLean, Davis' deputy press secretary. The abundant legislation "wasn't a problem for him, necessarily, but not every member's wish list was going to be signed."

Davis has a reputation for playing it close to the vest. "The first person to come out of the woodwork who can divine the governor's intention on a variety of issues [about which] he hasn't articulated strong policy views one way or another — that person's going to be a very wealthy man or woman," says Nathan Barankin, Lockyer's director of communications. "The truth of the matter is the guy's been absolutely nuked with Legislation and policy changes in a lot of different directions, sometimes contradictory directions," Barankin charitably adds. "He and his staff are trying to make heads or tails of a variety of different things that the Legislature isn't entirely clear on — and they're the ones sending it to him." □

Baca Goes Green

Sheriff pushes medical marijuana



Breaking ranks: Baca proves to be a maverick.

"IT MAKES A LOT OF SENSE," LOS ANGELES COUNTY Sheriff Lee Baca says of the medical-marijuana bill currently in the state Legislature.

Perhaps the most extraordinary element of SB 848 is that it was created by state Attorney General Bill Lockyer's Medical Marijuana Task Force, with direct input from representatives of California's major law-enforcement agencies. The *Weekly* was curious to hear what the sheriff had to say about the Vasconcellos bill and the contentious issue of therapeutic cannabis. Baca didn't mince words.

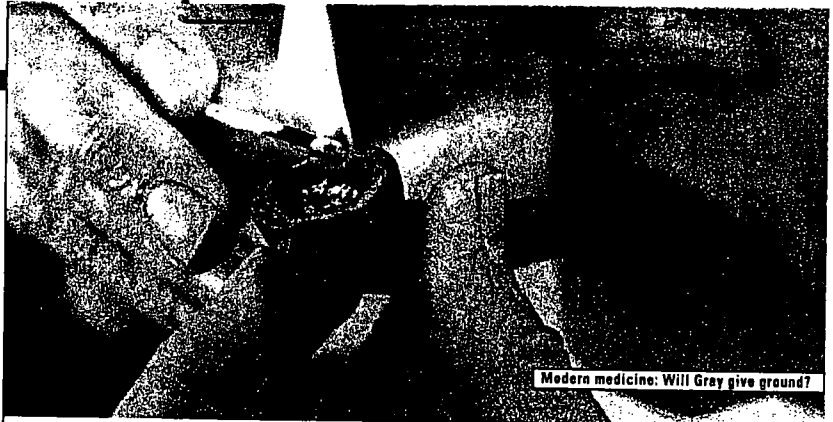
"This is a matter of human decency," the freshman sheriff said in a phone interview last week. "Society doesn't benefit by perpetuating an attitude where people who are ill, possibly terminally ill, are left to their own resources to deal with their problems. Unless you can walk in an HIV-positive person's shoes, you do not have the right to deny that person the ability to find some level of hope."

Baca's main concern is that cannabis not be used recklessly. "Obviously, marijuana is a psychotropic drug and therefore affects your ability to drive, so if you're going to take your medicinal marijuana, you'd better not drive. That's the only area I would make sure of in this kind of legislation, that the person use marijuana in a manner that is safe to the rest of society."

BACA HAS DEVELOPED A STRONG WORKING RELATIONSHIP with the Los Angeles Cannabis Resource Center and its director, Scott Imler, dating back to a "peace conference" at the Crescent Heights United Methodist Church in West Hollywood, held immediately after the 1996 passage of Proposition 215. The LACRC is a 650-member patient self-help group providing information and legal assistance, and maintaining a cooperative cannabis-cultivation project. Eighty percent of the membership has HIV. According to Baca, L.A. County Sheriff's deputies honor the existing registry cards issued by the LACRC as proof of legitimate medical use.

"The issues of law, [if] they conflict with appropriate humanism, then we have to make some changes. That's why I stand up in support of what Scott has been doing," Baca said. "And he's done an excellent job."

PHOTO: DEBRA DINGLO. BACA, TED SOOJUI



Modern medicine: Will Gray give ground?

Pot Reform Stalls in Sacramento

Governor Davis playing it straight
BY MICHAEL SIMMONS

"I HAVE NO IDEA WHAT'S GOING ON," SAYS A FRUSTRATED state Senator John Vasconcellos (D-Santa Clara), summing up the purgatory in which California's medical-marijuana policy is mired. Like characters in a Samuel Beckett play, patients and advocates anxiously await the arrival of a humane resolution, only to learn that the elusive Godot may yet again be waylaid by reefer madness, this time in the form of Governor Gray Davis.

The continuing legal limbo was announced almost as an aside in the July 14 edition of the *San Francisco Chronicle*, when Davis' press secretary, Michael Bustamante, was queried about Senate Bill 848, which would codify regulations to legally protect the sick and dying who use cannabis. Bustamante responded that "given the governor's long-standing position, I would be hard-pressed to see him sign it." Bustamante cited federal law, which schedules pot as a dangerous and medically useless drug.

Vasconcellos, who authored 848, was irate. Not only had he learned of the governor's position by reading it in a newspaper, but he says that Mike Gotch, Davis' legislative secretary, went behind his back to Assemblyman Martin Gallegos (D-Baldwin Park), chairman of the Assembly Health Committee, and met, to no avail, to persuade Gallegos to postpone a vote on the bill (feats to Gotch and Gallegos were not returned). "If I'm going to tamper with your stuff, I'll always tell you first," said Vasconcellos in a phone interview. What about the feds? "I have some word of what [Clinton drug czar Barry] McCaffrey's position is. The czar," Vasconcellos muttered, then added, "This is not Russia. Press secretaries and czars have no place in my world."

Vasconcellos' anger is rooted in the tortuous history of

the state's med-mar policy. After Proposition 215 passed in 1996, former Governor Pete Wilson vetoed corollary legislation, and then Attorney General Dan Lungren refused to enforce the new law, leaving the choice of whether to recognize it to local cops and district attorneys. While federal agencies moved to close several cannabis clubs serving medical users, local authorities tended to honor the new state law, though many patients, particularly in rural counties, continued to be busted and/or had their medicine confiscated.

When Davis and Bill Lockyer replaced Wilson and Lungren this year, medical-marijuana users were hopeful that the state would finally challenge the federal authorities and honor Prop. 215's mandate to "implement a plan to provide for the safe and affordable distribution to all those in need of medical marijuana." Lockyer had supported 215 (citing the cancer deaths of his mother and sister as the primary motivation for his compassion) and got labeled soft-on-dope for it during last fall's campaign. Davis, who as lieutenant governor had opposed 215 and who had participated in an anti-215 press conference with drug czar McCaffrey, was more of a question mark. Vasconcellos moved to test the new political waters with Senate Bill 848, which puts forth regulations to legally protect the sick and dying who use cannabis. "All we knew was, we did not have to deal with Pete Wilson," recalls Rami Martin, Vasconcellos' chief of staff.

Almost immediately after his inauguration, Lockyer — with Vasconcellos — convened the Medical Marijuana Task Force, a pluralistic committee of three dozen, representing

SEE POT, NEXT PAGE

The sheriff explained how the relationship with the L.A. cannabis center works: "Our policy is, one, we have open communication; two, we recognize the importance of the work they're doing; three, we respect the right of people to privately respond to their medical needs; four, [that] there is no public danger associated with the center. . . . People who are going to the center are getting their HIV needs met, and to me it's done on a level that's respectful to the general society's concerns, and there's no need for reactionary, alarmist behavior to occur on the part of people who don't understand this problem [or] those who are trying to solve it."

"All of the alarmists who want to say that we're just turning drugs loose, creating a bigger problem for ourselves, are wrong. The ability to help people who need help is important. And quite frankly, when you look at marijuana, it has somewhat of a controversial reputation, but so did every other psychotropic drug that's [now] used medically, before it was certified federally by the FDA."

AS BACA WARMED TO HIS SUBJECT, HE SOUNDED MORE like a medical-marijuana advocate than the county's top lawman. "Let's not mistake the fact that drugs are chemicals that have been invented by man. Ironically, marijuana is a chemical

as well — not necessarily invented by man," he chuckled. "But the important thing is that those who have HIV-positive experiences understand the effect that marijuana has on them. Science often does not catch up to common sense, and I'm going to let [HIV-positive people who use medical marijuana] tell me that they feel better. It relieves them of a significant amount of their pain, and that's good enough for me."

Certainly, for a cop, Baca takes progressive political stands. The afternoon he was interviewed, Baca attended the signing of the so-called "junk gun" bill by Governor Davis the following day in Mission Hills. And Baca is on record as supporting needle exchange to inhibit the spread of HIV.

Baca said he'd lean on Davis to sign SB 848. The governor is "very open about doing the right thing," the sheriff said. "He's a resident of West Hollywood. I'll see him tomorrow, and I'll mention it to him then. If there are some things that the bill needs to tighten up to ensure public safety, then I can understand the governor's reluctance. On the other hand, as the sheriff of this county, I've not had any federal agencies come in and pre-empt the Sheriff's Department's policing efforts when it comes to the [cannabis] center." □

—Michael Simmons

historically unbridgeable biases (patients, cops, D.A.s, doctors, lawyers) with the goal of protecting sick people from erratic and ambiguous enforcement of 215. The task force released a set of recommendations on July 12, the heart of which is a patient-registration card. The recommendations were promptly slotted into SB 848, which had already passed the Democratic state Senate (along with its companion, 847, which calls for up to \$3 million for med-mar research in the UC system). But Bustamante's declaration threw into doubt hopes for a cogent new state approach.

In an interview with the *Weekly*, Bustamante stood by his statement to the *Chronicle*. "The federal laws still make the possession and use of marijuana illegal, and the state shouldn't be in the business of sanctioning it," Bustamante said that Davis opposed 215 in part because "at the time, which was two and a half years ago now, there really wasn't any scientific evidence that would demonstrate the medical use of marijuana." But Scott Linler of the Los Angeles Cannabis Resource Center isn't buying this. "Just because Davis still thinks the world is flat doesn't mean there isn't scientific evidence to the contrary." Linler, a co-author of 215 and one of two patients on the task force, maintains that the federal-vs.-state argument is another

homotopy. It's not the state's job to enforce federal law. California's always in court with the feds over something. So why is this any different? Because it's marijuana. The governor is playing games with people's lives."

UNDER SB 848, COUNTY HEALTH DEPARTMENTS would process applications for patients and their caregivers and require written documentation by physicians of the condition. Patients and caregivers who qualify would receive a photo identification card. Qualified patients/caregivers can collectively cultivate, allowing for tightly restricted versions of cannabis cooperatives. The state Department of Health Services (DHS) would issue regulations to ensure quality,

noncontamination and nondiscrimination of medicine, and county health departments would have the right to inspect cooperatives in order to ensure compliance.

It was a solution designed to cover all bases. "In most situations, patients want the registry because they want to avoid arrest," says Bill Zimmerman, a task force member and executive director of Americans for Medical Rights, the advocacy group that coordinated the 215 campaign and five other state med-mar initiatives (Alaska and Oregon currently have statewide registries, and one is under consideration in Washington state). "As it happens, the cops also want the registry because they want to be able to tell in the field who's a legitimate patient."

But already, the coalition backing 848 is beginning to splinter. Some law-enforcement authorities have serious problems with the registration system, which is voluntary and allows smoking anywhere cigarettes are permitted (except within 1,000 feet of a school or while driving a car). "Unless it becomes some kind of compulsory reporting by doctors so that we know who is entitled to medicinal marijuana and that it be [smoked] discreetly — not in open places — it's not gonna have the governor's endorsement," says a highly placed source in Sacramento who spoke on the condition of anonymity.

To assuage law enforcement and the governor, five amendments have been drafted, including a ban on smoking in public and a mandatory requirement that doctors notify the health department "that a qualified patient has a serious medical condition for which the use of medicinal marijuana is appropriate."

That mandatory provision is now drawing fire from med-mar advocates. "I think that amendment is a misuse of the health department, because there's no public-health purpose to that reporting — it's for legal purposes so that police can trace patients to see if they are bona fide users," says Dr. Jane Marmor, the California Medical Association's med-mar point person and a member of Lockyer's committee. "I suspect that health officers and the CMA will not support this bill with that in it."

Nor is there any guarantee that Davis would respond favorably. "Let's see what the amendments look like, but the governor is not inclined to support something like this," says Bustamante. Adds Hilary McLean, Davis' deputy press secretary, "Until it's in front of him we can never say it's final, but I think it's unlikely that he would sign it."

LOST IN THE POLITICAL WRANGLING AND ideological perspectives is the desperate medical *raison d'être* that informs this issue. Tim Weltz is a 38-year-old terminal-lymphoma patient with a legitimate doctor's recommendation who's been raided and had his medicine confiscated twice in one year. The last visit by the San Bernardino County Sheriff's Department was on June 2. Detective Michael Wirz explained that his officers can't determine whether a patient is legitimate or not, nor can they "allow release of a person that violates a law based on him giving us a note saying it's okay." Wirz admitted that when his deputies entered Weltz's residence, the dying man was hooked up to an intravenous morphine drip, that a home health-care worker was present and that Weltz presented his doctor's letter as prescribed under 215.

Weltz is currently bedridden and "has very few days left," according to his wife, Brenda. "The patients are not the ones who get thought of," she says. "There's nothing more traumatic than watching somebody die and knowing there's things out there which can help them eat and feel a little better. Unfortunately the people in politics don't seem to be human." Her husband had a question for the governor: "I'd like to look Governor Davis right in the eye and ask him, 'If it was your family member or you, would you still hold the same position?'"

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Dog Ma: One Woman's Doberman Rescue
(John McCormick)

L.A.entric: Inside Two New Local Novels
(Ben Ehrenreich)

Drug Trials: Experimenting on the Mentally Ill
(Sara Catania)

LA WEEKLY

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As Featured On
Channel 2 News

19 POT REFORM STALLS

When Democrats won both the Legislature and the state house, medical-marijuana activists thought their day had finally arrived. Wrong. MICHAEL SIMMONS tracks Gray on green.

and Greg Glass,



Scott Imler, above, president and executive director of Los Angeles Cannabis Resource Center and co-author of Proposition 215, with some of the medical marijuana plants the center cultivates, refines and distributes for its more than 660 clients. Imler is also a patient and has used medical marijuana to help ease his epilepsy symptoms. Kent Grant, below, who is HIV-infected, has used medical marijuana center in West Hollywood since October 1998. Almost 80% of patients at the center have AIDS or are HIV-infected.

Smoke signals



West Hollywood's
Cannabis Resource Center
is a model for medical
marijuana distribution,
following passage of
Proposition 215

Story by Marcela Rojas

Photos by Ryan Miller

When Neal McCarty, an HIV patient who uses medical marijuana, was busted last year for growing three marijuana plants in his backyard, he spent a night in jail he'll never forget.

"I got really sick," McCarty said. "It was hard on me. I had the dry heaves and flu-like symptoms, only worse."

McCarty, a member of the Los Angeles Cannabis Resource Center in West Hollywood, says he smokes marijuana mainly to have an appetite.

"I went from 170 pounds to 125 in four months," he said. "Whenever I try to eat, it's like eating a piece of paper. But when I smoke, I can eat ice cream and all kinds of food."

Last year's drug charges were dropped, but McCarty said he's still afraid to grow his own marijuana for fear of being arrested.

There have been at least 21 legal medical marijuana patients in Los Angeles who have been cited for possessing or cultivating.

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Westside Weekly

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Angeles Times published by Times Community News

SEPTEMBER 3, 1999

SMOKE

CONTINUED FROM 1

ing marijuana, despite the passage of Proposition 215 in November 1996.

Advocates say the predicament for McCarty and the others cited could have been avoided by a better understanding of state law by police and other officials.

Proposition 215 gives seriously ill patients the right to use marijuana for medicinal purposes, with consent from their doctors, said Scott Imler, the cannabis resource center's executive director.

Imler hopes a proposed law will pass that would tackle the proposition's vague language, standardize enforcement, clarify any doubts law enforcement officials may have and define the legally accepted use of medical marijuana throughout the state.

Known as state Senate Bill 848, the proposal is based on recommendations from a 30-member task force of attorneys, police officers, physicians and medical marijuana experts throughout California.

The bill has passed the Senate and is being considered by the Assembly's Appropriations Committee. It still faces a vote by the full Assembly and must be signed by Gov. Gray Davis before it would become law.

Imler, a task force member, explained that the bill does not change any rights conveyed by Proposition 215; it merely clarifies its language.

"Patients have been arrested and prosecuted and continue to be, because no two counties in California can implement Proposition 215 in the same way," Imler said.

Under the proposed law, patients would carry state-issued ID cards that would make them immune from arrest for possession, transportation, delivery or cultivation of medicinal marijuana.

The revamped regulations would also require state officials to define the amounts of marijuana a patient can legally possess. And centers that distribute marijuana would be monitored in terms of product quality and purity, he explained.

One supportive lawmaker thinks SB 848 is a good idea.

"This bill represents a remarkable compromise, [reached] after one of the most elegant collaborative processes I've enjoyed in my 33 years in the Legislature," state

Sen. John Vasconcellos (D-San Jose) said.

"The bill meets Proposition 215's key objective — allowing access to medicinal marijuana for persons with legitimate need. And it carefully balances concerns of patients, physicians and law enforcement."

Those officials also hope the bill will make enforcement easier.

"The position of the California Peace Officers Assn. is one of nonopposition," said San Luis Obispo Police Chief Jim Gardiner, president of the association that has 4,000 members statewide.

"The street officers need a way to identify a person who is legally using marijuana for medicinal purposes. The system proposed will do that."

At the West Hollywood center, the more than 660 members already have a registry system in place, serving as a model for the Legislature's bill.

Members must also present a center-issued photo identification card to enter the facility.

The center, which is open three days a week, allows patients to purchase a maximum of 27 grams

of marijuana per week. The marijuana is grown on the premises.

"The LAPD honors these cards, because we've built up a respectable reputation with them," Imler said. "It is the official policy of the county Sheriff's Department to honor these registry cards. And it really works."

Center member Sheral Thomas — who has epilepsy and neuropathy, a numbing and tingling sensation in her neck — has been stopped by the police three times for possession of marijuana. On all occasions, officers let her go after seeing the center's photo ID card she carries.

"If medical marijuana patients have an identification card like we do, all over the state, then it will make it more legitimate for the people being harassed," Thomas said. "If they don't fix the problem, then there will be more drug dealers on the street."

HIV patient Kent Grant added that he has to smoke pure marijuana because it cuts down on the abundance of medication he must take every day.

"Fatigue is one of the biggest problems with this disease. It

comes from all the pills we have to take. Marijuana helps to round out my energy," Grant said.

It also eases the side effects of such HIV medications as protease.

"The pills can cause neuropathy and narcolepsy and the protease can cause diabetes," he added. "If the disease doesn't get you, the cure will. That's why it's so important that patients have access [to medical marijuana]."

Los Angeles Times

FRIDAY SEPTEMBER 3, 1999

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Medical Need a Factor in Pot Cases, Court Says

■ **Health:** Federal appeals panel rules that marijuana centers may distribute drug if patient faces serious harm.

By MAURA DOLAN
and MARY CURTIUS
TIMES STAFF WRITERS

SAN FRANCISCO—A federal appeals court created a potentially major opening in federal drug laws Monday, ruling that medical marijuana centers may be allowed to distribute cannabis if they can prove that the drug is needed to protect patients against imminent medical harm.

In its decision, the three-judge panel of the 9th U.S. Circuit Court of Appeals said that a federal judge should have considered patients' medical needs for marijuana when he ordered a cannabis club in Oakland last year to stop distributing the drug.

The ruling "means that the federal law is not an absolute barrier to distribution of marijuana," said Santa Clara University law professor Gerald F. Uelmen, who helped represent the Oakland center. "It requires courts to exercise discretion to look at the circumstances of individual patients and weigh that against the public interest."

The court did not overturn U.S. District Judge Charles Breyer's injunction against the club, but said he must consider the case again, taking into account evidence that some patients need cannabis to treat debilitating and life-threatening conditions.

The decision could lead to the Oakland Cannabis Buyers Cooperative and others being allowed to distribute marijuana to some severely ill patients, said Robert Raich, another attorney for the center.

"It may provide a method under federal law in which medical patients, some medical patients, can be provided with the medical cannabis they need . . . legally," the Oakland attorney said.

California voters in November 1996 approved Proposition 215, which permitted seriously ill patients to obtain and use marijuana with their doctors' recommendations without being prosecuted under state law. Some doctors and patients say that the drug quiets nausea, eases pain and restores appetite.

The Clinton administration, however, sued six Northern California clubs on the grounds that a federal ban on marijuana distribution prevails over the state initiative.

Oakland's center stopped distributing marijuana, three clubs

Please see POT, A8

Continued from A1
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AN EDITION OF THE LOS ANGELES TIMES
National Edition

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By MAURA DOLAN
and MARY CURTIS
TIMES STAFF WRITERS

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BILL NUMBER: SB 848 AMENDED
BILL TEXT

AMENDED IN ASSEMBLY AUGUST 16, 1999
AMENDED IN ASSEMBLY JULY 8, 1999

INTRODUCED BY Senator Vasconcellos

FEBRUARY 25, 1999

An act to add Article 2.5 (commencing with Section 11362.7) to Chapter 6 of Division 10 of the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

SB 848, as amended, Vasconcellos. Medicinal marijuana.

Existing law, the Compassionate Use Act of 1996, prohibits any physician from being punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes. The act prohibits the provisions of law making unlawful the possession or cultivation of marijuana from applying to a patient, or to a patient's primary care giver, who possesses or cultivates marijuana for the personal medical purposes of the patient upon the written or oral recommendation or approval of a physician.

This bill would require the State Department of Health Services to establish and maintain a voluntary program for the issuance of registry identification cards to qualified patients and would establish procedures under which a qualified patient with a registry identification card may use marijuana for medical purposes.

The bill would impose various duties upon county welfare departments relating to the issuance of registry identification cards, thus creating a state-mandated local program.

The bill would create various crimes related to the registry identification card program, thus imposing a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed \$1,000,000 statewide and other procedures for claims whose statewide costs exceed \$1,000,000.

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. (a) The Legislature finds and declares all of the following:

(1) On November 6, 1996, the people of the State of California enacted the Compassionate Use Act of 1996 (hereafter the act), codified in Section 11362.5 of the Health and Safety Code, in order http://www.marijuana.org/sb_848_bill_19990816_amended_asm.htm

9/6/99

to allow seriously ill residents of the state, who have the oral or written approval or recommendation of a physician, to use marijuana for medical purposes without fear of criminal liability under Sections 11357 and 11358 of the Health and Safety Code.

(2) However, reports from across the state have revealed problems and uncertainties in the act that have impeded the ability of law enforcement officers to enforce its provisions as the voters intended and, therefore, have prevented qualified patients and designated primary care givers from obtaining the protections afforded by the act.

(3) Furthermore, the enactment of this law, as well as other recent legislation dealing with pain control, demonstrates that more information is needed to assess the number of individuals across the state who are suffering from serious medical conditions that are not being adequately alleviated through the use of conventional medications.

(4) In addition, the act called upon the state and the federal government to develop a plan for the safe and affordable distribution of marijuana to all patients in medical need thereof.

(b) It is the intent of the Legislature, therefore, to do all of the following:

(1) Clarify the scope of the application of the act and facilitate the prompt identification of qualified patients and their designated primary care givers in order to avoid unnecessary arrest and prosecution of these individuals and provide needed guidance to law enforcement officers.

(2) Promote uniform and consistent application of the act among the counties within the state.

(3) Collect data to ascertain the extent of serious medical conditions that are not being adequately relieved in order to plan for future research and resource allocation.

(4) Enhance the access of patients and care givers to medical marijuana through collective, cooperative cultivation projects.

(c) It is also the intent of the Legislature to address additional issues that were not included within the act, and that must be resolved in order to promote the fair and orderly implementation of the act.

(d) The Legislature further finds and declares both of the following:

(1) A state registry identification card program will further the goals outlined in this section.

(2) With respect to individuals, the registry identification system established pursuant to this act must be wholly voluntary, and a patient entitled to the protections of Section 11362.5 of the Health and Safety Code need not possess a registry identification card in order to claim the protections afforded by that section.

SEC. 2. Article 2.5 (commencing with Section 11362.7) is added to Chapter 6 of Division 10 of the Health and Safety Code, to read:

Article 2.5. Medical Marijuana Program

11362.7. For purposes of this article, the following definitions shall apply:

(a) "Attending physician" means ~~any physician~~
an individual who possesses a license in good standing to practice medicine or osteopathy issued by the Medical Board of California and 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 before recording in the patient's medical record the physician's assessment of whether the patient has a serious medical condition and whether the medical use of marijuana is appropriate.

(b) "Department" means the State Department of Health Services.

(c) "Person with a registry identification card" means an

individual who is a qualified patient who has applied for and received a valid registry identification card pursuant to this article.

~~(d) "Physician" means an individual who possesses a license in good standing to practice medicine or osteopathy issued by the Medical Board of California or the Osteopathic Medical Board of California.~~

~~(e)~~

(d) "Primary care giver" means the individual, designated by a qualified patient or by a person with a registry identification card, who has consistently assumed responsibility for the housing, health, or safety of that patient or person, and may include any of the following:

(1) The owner or operator, or ~~an employee of~~ no more than three employees who are designated by the owner or operator of a clinic licensed pursuant to Chapter 1 (commencing with Section 1200) of Division 2, a health care facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, a residential care facility for persons with chronic life-threatening illness licensed pursuant to Chapter 3.01 (commencing with Section 1568.01) of Division 2, a residential care facility for the elderly licensed pursuant to Chapter 3.2 (commencing with Section 1569) of Division 2, a hospice, or a home health agency licensed pursuant to Chapter 8 (commencing with Section 1725) of Division 2, and from which a qualified patient or person with a registry identification card receives medical care or supportive services, or both.

(2) An individual who has been designated as a primary care giver by one or more qualified patients or persons with a registry identification card, or who has been designated as a primary care giver by only one qualified patient or person with a registry identification card if the designated primary care giver is in a city or county other than that in which the qualified patient or person with a registry identification card resides.

(3) A primary care giver shall be at least 18 years of age, unless the primary care giver is the parent of a minor child who is a qualified patient or a person with a registry identification card or the primary care giver is a person otherwise entitled to make medical decisions under state law pursuant to Sections 6922, 7002, 7050, or 7120 of the Family Code.

~~(f)~~

(e) "Qualified patient" means a person who is entitled to the protections of Section 11362.5, but who does not have a registry identification card issued pursuant to this article.

~~(g)~~

(f) "Registry identification card" means a document issued by the State Department of Health Services which identifies a person authorized to engage in the medical use of marijuana and the person's designated primary care giver, if any.

~~(h)~~

(g) "Serious medical condition" means all of the following medical conditions:

- (1) Acquired immune deficiency syndrome (AIDS).
- (2) Anorexia.
- (3) Arthritis.
- (4) Cachexia.
- (5) Cancer.
- (6) Chronic pain.
- (7) Glaucoma.
- (8) Migraine.
- (9) Persistent muscle spasms, including, but not limited to, spasms associated with multiple sclerosis.
- (10) Seizures, including, but not limited to, seizures associated with epilepsy.

(11) Severe nausea.

(12) Any other chronic or persistent medical symptom that either:

(A) Substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990 (Public Law 101-336).

(B) If not alleviated, may cause serious harm to the patient's safety or physical or mental health.

~~(i)~~

(h) "Written documentation" means accurate reproductions of those portions of a patient's medical records that have been created by the attending physician, containing the information required by paragraph (2) of subdivision (a) of Section 11362.715, which the patient may submit to a county health department or its designee as part of an application for a registry identification card.

11362.71. (a) The department shall establish and maintain a voluntary program for the issuance of registry identification cards to qualified patients who satisfy the requirements of this article and voluntarily apply to the registry identification card program.

(b) Every county health department shall do all of the following:

(1) Provide applications upon request to individuals seeking to join the registry identification card program.

(2) Receive and process completed applications in accordance with Section 11362.72.

(3) Maintain records of registry identification card programs in accordance with Section 11362.75.

(4) Utilize protocols developed by the department pursuant to paragraph (2) of subdivision (d).

(c) The county health department may designate another governmental or a nongovernmental entity or organization to perform the functions described in subdivision (b), except for an entity or organization that cultivates or distributes marijuana.

(d) The department shall develop ~~both~~ all of the following:

(1) Protocols that shall be used by county health departments and their designees to implement the responsibilities described in subdivision (b), including, but not limited to, protocols to confirm the accuracy of information contained in an application and to protect the confidentiality of program records.

(2) Application forms that shall be issued to requesting applicants.

(3) A registry identification card that identifies a person authorized to engage in the medical use of marijuana and a registry identification card that identifies the person's designated primary caregiver if any. The two registry identification cards developed pursuant to this paragraph shall be easily distinguishable from each other.

(e) The county health department or its designee shall submit an annual report to the department indicating the number of persons whose applications for registry identification cards have been approved and the types of serious medical conditions from which the applicants suffer. However, except as provided in subdivision (b) of Section 11362.72, in no case shall the identities of persons be reported to the department.

(f) No person or designated primary care giver ~~with~~ in possession of a valid registry identification card shall be subject to arrest for possession, transportation, delivery, or cultivation of medical marijuana in an amount approved by the department pursuant to Section 11362.77, unless there is reasonable cause to believe that the information contained in the card is false or falsified, the card has been obtained by means of fraud, or the person is otherwise in violation of the provisions of this article.

(g) It shall not be necessary for a person to obtain a registry identification card in order to claim the protections of Section 11362.5.

11362.715. (a) A person who seeks a registry identification card shall pay the fee, if any, as provided in Section 11362.755, and provide all of the following to the county health department or its designee:

(1) The name, address, telephone number, social security number, and date of birth of the person, and proof of his or her residency within the county.

(2) Written documentation by the attending physician in the person's medical records stating that the person has been diagnosed with a serious medical condition and that the medical use of marijuana is appropriate.

(3) The name, office address, office telephone number, and California medical license number of the person's attending physician.

(4) The name, address, telephone number, social security number, and date of birth of the person's designated primary care giver, if any, and the duties of the primary care giver.

(5) A copy of a photo identification card of the person and of the designated primary care giver, if any. If the applicant is a person under 18 years of age, a certified copy of a birth certificate shall be deemed sufficient proof of identity.

(b) If the person applying for a registry identification card lacks the capacity to make medical decisions, the application may be made by the person's legal representative, including, but not limited to, any of the following:

(1) A conservator with authority to make medical decisions.

(2) An attorney-in-fact under a durable power of attorney for health care or surrogate decisionmaker authorized under another advanced health care directive.

(3) Any other individual authorized by statutory or decisional law to make medical decisions for the person.

(c) The legal representative described in subdivision (b) may also designate in the application an individual, including himself or herself, to serve as a primary care giver for the person, provided that the individual meets the definition of a primary care giver.

(d) The person or legal representative submitting the written information and documentation described in subdivision (a) shall retain a copy thereof, as well as proof of date of mailing or other method of delivery to the county health department or its designee.

11362.72. (a) Within 30 days of receipt of an application for a registry identification card, a county health department or its designee shall do all of the following:

(1) For the purpose of processing the application, as well as for the purpose of obtaining data to assess the number of individuals in this state suffering from serious medical conditions that are not being adequately alleviated through the use of conventional medications, verify that the information contained in the application is accurate. In any case where the person is less than 18 years of age, the county health department or its designee shall also contact the parent with legal authority to make medical decisions, legal guardian, or other person or entity with legal authority to make medical decisions, to verify the information. In any case where proof of identity is uncertain, the county health department or its designee may require an in-person meeting with the person or primary care giver, or the production of additional identification materials for verification purposes, or both. In all cases, the county health department or its designee shall do both of the following:

(A) Verify with the Medical Board of California or the Osteopathic Medical Board of California that the attending physician has a license in good standing to practice medicine or osteopathy in the state.

(B) Contact the attending physician by telephone or mail to http://www.marijuana.org/sb_848_bill_19990816_amended_asm.htm

9/6/99

confirm that the medical records submitted by the patient are a true and correct copy of those contained in the physician's office records. When contacted by a county health department or its designee, the attending physician shall confirm or deny that the contents of the medical records are accurate.

(2) Take a photograph or otherwise obtain an electronically transmissible image of the applicant and of the designated primary care giver, if any.

(3) Approve or deny the application. If an applicant who meets the requirements of Section 11362.715 can establish that a registry identification card is needed on an emergency basis, the county or its designee shall issue a temporary registry identification card, which shall be valid for 30 days from the date of issuance. The county, or its designee, may extend the temporary registration card for no more than 30 days at a time, so long as the applicant continues to meet the requirements of this paragraph.

(b) If the county health department or its designee approves the application, it shall, within 24 hours, or by the end of the next working day of that determination, electronically transmit the following information to the department:

(1) The name of the applicant.

(2) The name of the designated primary care giver, if any, of the applicant.

(3) The photographic image of the applicant and of the designated primary care giver, if any.

(4) The name and telephone number of the county health department or its designee that has approved the application.

(c) The department shall issue a registry identification card to the applicant and to his or her designated primary care giver, if any, within five working days of receipt of that determination.

(d) In any case involving an incomplete application, the county health department shall send notice of a deficiency within 30 days of receipt of an application. The applicant shall have 30 days from the date of receipt of that notification to rectify the deficiency. The county shall have 14 days from the receipt of information from the applicant pursuant to this subdivision to approve or deny the application. If the applicant does not provide the county with information that rectifies the deficiency within the 30-day period, the application may be denied in accordance with Section 11362.74.

11362.735. (a) A registry identification card issued by the department shall be serially numbered and shall state all of the following:

(1) The cardholder's name, home address, and date of birth.

(2) The date of expiration of the registry identification card.

(3) The name and telephone number of the county health department or its designee that has approved the application.

(4) A 24-hour, toll-free telephone number which will enable state and local law enforcement officers to have immediate access to information necessary to verify the validity of the card.

(5) Photo identification of the cardholder.

(b) A separate registry identification card shall be issued to the person's designated primary care giver, if any, and shall include a photo identification of the care giver.

11362.74. (a) The county health department or its designee may deny an application only for either of the following reasons:

(1) The applicant did not provide the information required by Section 11362.715, and upon notice of the deficiency pursuant to subdivision (e) of Section 11362.72, did not provide the information within 30 days.

(2) The county health department or its designee determines that the information provided was false.

(3) The applicant does not meet the criteria set forth in this article.

(b) Any person whose application has been denied pursuant to

subdivision (a) may not reapply for six months from the date of denial unless otherwise authorized by the county health department or its designee or by a court of competent jurisdiction.

(c) The county health department or its designee shall transmit its determination of denial to the department

11362.745. (a) A registry identification card shall be valid for a period of one year.

(b) No later than 45 days before the expiration of the term of a registry identification card, the county health department or its designee shall send a renewal notice to the person and to the designated primary care giver, if any, at the addresses shown in the program records, as provided in Section 11362.75.

(c) Upon annual renewal of a registry identification card, the county health department or its designee shall verify all new information and may verify any other information that has not changed.

(d) The county health department or its designee shall transmit its determination of approval or denial of a renewal to the department.

11362.75. (a) The county health department or its designee shall keep complete program records, including, but not limited to, all of the following:

(1) All written information and documentation contained in an application for a registry identification card, including photographic identification of the applicant and his or her designated primary care giver, if any.

(2) The nature and results of the efforts of the county health department or its designee to verify the accuracy of the information contained in an application.

(3) A list of persons for whom applications for registry identification cards have been approved.

(4) A list of the persons whose applications for issuance or renewal of registry identification cards have been denied pursuant to Section 11362.74 or 11362.745, including the reason for, and date of, the denial.

(b) The department shall maintain program records containing all of the following:

(1) The name of each registry identification cardholder.

(2) The name of the designated primary care giver of the registry identification cardholder, if any.

(3) Photographic identification of the cardholder and his or her designated primary care giver, if any.

(4) The identification number of the registry identification card.

(5) The name and telephone number of the county health department or its designee that has approved the application for the issuance or renewal of the registry identification card.

(c) The records described in subdivisions (a) and (b) shall be confidential and not subject to public disclosure.

(d) Notwithstanding this section, names and other identifying information from program records may be disclosed to both of the following:

(1) Authorized employees of the department or of a county health department or its designee, as necessary to perform official duties of the program.

(2) Authorized employees of state or local enforcement agencies, but only as necessary to review and verify that a person is a lawful possessor of a registry identification card or that an individual is the designated primary caregiver of a person with a registry identification card.

(e) The department shall transmit the information described in subdivision (b) to the California Law Enforcement Telecommunications System (CLETS) after issuance of a registry identification card. The department shall make the identical

information available through a 24-hour toll-free telephone number.

11362.755. The department may establish application and renewal fees for persons seeking to obtain or renew registry identification cards that are sufficient to cover the expenses incurred by the department and each county health department of administering the registry identification card program. However, upon satisfactory proof of indigence, these fees shall be waived. The department shall reimburse each county health department for its costs of administering the program from the revenue generated by the fees.

11362.76. (a) A person who possesses a registry identification card shall:

(1) Within seven days, notify the county health department or its designee of any change in the person's name, address, attending physician, or designated primary care giver, if any.

(2) Annually submit to the county health department or its designee the following:

(A) Updated written documentation of the person's serious medical condition.

(B) The name, home address, and duties of the person's designated primary care giver, if any, for the forthcoming year.

(b) If a person who possesses a registry identification card fails to comply with this section, the card shall be deemed expired. If a registry identification card expires, the registry identification card of any designated primary care giver of the person shall also expire. The county health department shall notify the department within seven days that the card is deemed expired.

(c) If the designated primary care giver has been changed, the previous primary care giver shall return his or her registry identification card to the department or to the county health department or its designee.

(d) If the owner or operator or an employee of the owner or operator of a provider has been designated as a primary care giver pursuant to paragraph (1) of subdivision (d) of Section 11362.7, ~~or~~ of the qualified patient or person with a registry identification card, the owner or operator shall notify the county health department or its designee, pursuant to Section 11362.715, if a change in the designated primary care giver has occurred.

11362.765. (a) Subject to the requirements of this article, the individuals specified in subdivision (b) shall not be subject, on that sole basis, to criminal liability under Section 11357, 11358, 11359, 11360, 11366, 11366.5, or 11570. However, nothing in this section shall authorize the individual to smoke or otherwise consume marijuana unless otherwise authorized by this article.

(b) Subdivision (a) shall apply to all of the following:

(1) A qualified patient or a person with a registry identification card who transports or processes marijuana for his or her own personal medical use.

(2) A designated primary care giver who transports, processes, administers, delivers, or gives away marijuana for medical purposes, in amounts not exceeding those established by regulations that shall be adopted by the department pursuant to Section 11362.77, only to the qualified patient of the primary care giver, or to the person with a registry identification card who has designated the individual as a primary care giver.

(3) Any individual who provides assistance to a qualified patient or a person with a registry identification card, or his or her designated primary care giver, in administering medical marijuana to the qualified patient or person or acquiring the skills necessary to cultivate or administer marijuana for medical purposes to the qualified patient or person.

(c) The following individuals who receive reasonable compensation

for services, payment for out-of-pocket expenses incurred, or both, shall not, on the sole basis of that fact, be subject to prosecution or punishment under Section 11359 or 11360:

(1) A designated primary care giver who cultivates, transports, delivers, or administers medical marijuana to a qualified patient or to a person with a registry identification card, in amounts not exceeding those established by regulations to be adopted by the department pursuant to Section 11362.77.

(2) Any other individual who delivers, administers, or provides other assistance as described in paragraph (3) of subdivision (b) to a qualified patient or a person with a registry identification card.

11362.77. A qualified patient or a person holding a valid registry identification card, or the designated primary care giver of that qualified patient or person, may possess amounts of marijuana for the qualified patient's or person's own personal medical use in amounts to be determined by emergency regulations that shall be adopted by the department, after public comment and consultation with interested organizations. The regulations shall be based on currently available scientific research and knowledge and shall be reviewed annually to determine if revision is necessary to reflect material changes in research and knowledge.

11362.775. Qualified patients, persons with valid registry identification cards, and the designated primary care givers of qualified patients and persons with registry identification cards, may associate or incorporate *within the state of California*, or both, in order collectively or cooperatively to cultivate marijuana for medical purposes and these individuals participating in cooperative cultivation projects shall not solely on the basis of that fact be subject to criminal sanctions under Section 11357, 11358, 11359, 11360, 11366, 11366.5, or 11570. The department shall adopt regulations, after public comment and consultation with interested organizations, governing the operation and supervision of these cooperatives, no later than December 31, 2000. The regulations shall specify ~~the only methods or protocols~~ *only the methods, procedures, and criteria* that the cultivation projects shall employ to ensure the consistency of composition, noncontamination and nondiversion of medical marijuana. The county health department or its designee shall have the right to inspect the cultivation projects to ensure compliance with the methods ~~or protocols~~ *, procedures, and criteria*.

11362.78. A state or local law enforcement agency or officer shall not refuse to accept a registry identification card issued by the department unless the state or local law enforcement agency or officer has reasonable cause to believe that the information contained in the card is false or fraudulent, or the card is being used fraudulently.

11362.785. (a) Nothing in this article shall require any accommodation of any medical use of marijuana on the property or premises of any place of employment or during the hours of employment or on the property or premises of any jail, correctional facility, or other type of penal institution in which prisoners reside or persons under arrest are detained.

(b) Notwithstanding subdivision (a), a person shall not be prohibited or prevented from obtaining and submitting the written information and documentation necessary to apply for a registry identification card on the basis that the person is incarcerated in a jail, correctional facility, or other penal institution in which prisoners reside or persons under arrest are detained.

(c) Nothing in this article shall prohibit a jail, correctional facility, or other penal institution in which prisoners reside or persons under arrest are detained, from permitting a prisoner or a person under arrest who has a registry identification card, to use

marijuana for medical purposes under circumstances that will not endanger the health or safety of other prisoners or the security of the facility.

(d) Nothing in this article shall require a governmental, private, or any other health insurance provider or health care service plan to be liable for any claim for reimbursement for the medical use of marijuana.

11362.79. Nothing in this article shall authorize a qualified patient or person with a registry identification card to engage in the smoking of medical marijuana:

(a) In any place where smoking is prohibited by law.

(b) In or within 1,000 feet of the grounds of a school, recreation center, or youth center, unless the medical use occurs within a residence.

(c) On a schoolbus.

(d) While in a motor vehicle that is being operated.

(e) While operating a boat.

11362.795. With respect to the conditions of probation or parole or release on bail, the burden of proof shall be on the recipient of the conditions to demonstrate that use of medical marijuana by the recipient should not be included in the conditions. The court shall consider the proof and shall provide a written record describing the reasons for its denial of the request.

11362.8. No professional licensing board may impose a civil penalty or take other disciplinary action against a licensee based solely on the fact that the licensee has performed acts that are necessary or appropriate to carry out the licensee's role as a designated primary care giver to a person who is a qualified patient or who possesses a lawful registry identification card issued pursuant to Section 11362.72. However, this section shall not apply to acts performed by a physician relating to the discussion or recommendation of the medical use of marijuana to a patient. These discussions or recommendations, or both, shall be governed by Section 11362.5.

11362.81. (a) Any person specified in subdivision (b) shall be punishable as follows:

(1) For the first offense, imprisonment in the county jail for no more than six months or a fine not to exceed one thousand dollars (\$1,000), or both.

(2) For a second or subsequent offense, imprisonment in the county jail for no more than one year, or a fine not to exceed one thousand dollars (\$1,000), or both.

(b) Subdivision (a) applies to any of the following:

(1) A person who fraudulently represents a medical condition or fraudulently provides any material misinformation to a physician, county health department or its designee, or state or local law enforcement agency or officer, for the purpose of falsely obtaining a registry identification card.

(2) A person who steals or fraudulently uses any person's registry identification card in order to acquire, possess, cultivate, transport, use, produce, or distribute marijuana.

(3) A person who counterfeits, tampers with, or fraudulently produces a registry identification card.

(4) A person who breaches the confidentiality requirements afforded by this article to information provided to, or contained in the records of, the department or of a county health department or its designee pertaining to a registry identification card program.

(c) In addition to the penalties prescribed in subdivision (a), any person described in subdivision (b) may be precluded from attempting to obtain, or obtaining or using, a registry identification card for a period of up to six months at the discretion of the court.

11362.82. If any section, subdivision, sentence, clause, phrase, or portion of this article is for any reason held invalid or unconstitutional by any court of competent jurisdiction, that portion

shall be deemed a separate, distinct, and independent provision, and that holding shall not affect the validity of the remaining portion thereof.

11362.83. Nothing in this article shall prevent a city or other local governing body from adopting and enforcing laws consistent with this article.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIIIIB of the California Constitution for certain costs that may be incurred by a local agency or school district because in that regard this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIIIIB of the California Constitution.

However, notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. If the statewide cost of the claim for reimbursement does not exceed one million dollars (\$1,000,000), reimbursement shall be made from the State Mandates Claims Fund.

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COMMUNICATION W O R K S

FAX TRANSMITTAL

Date: 2/18 Pages to follow: 6
To: SANDRA THURMAN
Organization: 202 456 2438
Fax: 202 456 2438
From: NICHOL SHULLENBERGER
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**EMBARGO FOR RELEASE UNTIL: 06:00a.m. E.S.T., Thursday
February 18, 1999**

Contact: Rachel Swain, Tommy McDonald, Communication Works: 415-255-1946

AIDS Groups Issue First Call For Drug Czar to Approve Medical Marijuana on Fast Track for People with AIDS

**Unprecedented Statement Comes As Institute of Medicine Prepares to Publish
Full Review of Medical Marijuana Science**

WASHINGTON, D.C. – Physicians should be allowed to prescribe marijuana as an emergency measure to people with HIV/AIDS without further research, says a letter to be sent February 17th from the heads of seventeen AIDS organizations to General Barry McCaffrey, director of the Office for National Drug Control Policy. This is the first time that AIDS groups have come together to call for legal, immediate access to marijuana.

Citing a fast-track system that has allowed physicians to prescribe protease inhibitors and other AIDS medications before the completion of clinical trials, the letter calls on McCaffrey to give immediate approval to what they say is another life-saving drug – marijuana.

"(W)e urge you to help break the bureaucratic logjam that is keeping a potentially life-saving medicine, marijuana, virtually inaccessible to thousands of people living with AIDS," says the letter, signed by AIDS Action Council, San Francisco AIDS Foundation, Latino Commission on AIDS, National Native American AIDS Prevention Center, AIDS National Interfaith Network, Mothers' Voices to End AIDS, AIDS Project Los Angeles, and other organizations around the country.

Copies of the letter were also sent to the Secretary of Health and Human Services, the Director of the U.S. Food and Drug Administration, the Office of National AIDS Policy and the U.S. House and Senate Majority and Minority leaders.

The AIDS organizations are urging McCaffrey to make good on an October, 1997 statement to Congress, which said: "If sound medical research demonstrates that there are medical uses for smoked marijuana, there are appropriate and responsive procedures for rescheduling this mind-influencing drug through the time-tested process."

-MORE-

"The FDA has already demonstrated flexibility in accelerating procedures for allowing the use of emerging AIDS-related drugs without jeopardizing science or the public health."

Thousands of Americans with HIV/AIDS use marijuana to relieve the nausea caused by multiple-drug therapies, and to combat the 'wasting syndrome' associated with the late, often fatal, stages of AIDS by stimulating appetite. But, with marijuana classed as a highly-controlled Schedule I substance under federal law, most patients use the medicine illegally, risking prosecution and exposure to contaminated products.

Recent studies and editorials in prestigious scientific journals *Lancet*, *New Scientist*, *New England Journal of Medicine* and the *Journal of the American Medical Association* have concluded that marijuana's medical benefits outweigh its risks. Convinced by existing research, Britain and Israel recently sanctioned the compassionate use of marijuana on a provisional basis, and six U.S. states have passed ballot initiatives to legalize medical marijuana – throwing state policies into conflict with federal law.

In 1996, McCaffrey commissioned the Institute of Medicine at the National Academy of Sciences to conduct a full review of the science surrounding medical marijuana. That study is expected to be released next month, and may lead to calls for new research into medical marijuana. Just one clinical trial has been approved by the federal government since 1985.

AIDS organizations say terminally-ill patients cannot afford to wait for years of research to prove something they already know: medical marijuana works.

"Science and compassion should dictate our nation's policy regarding medical treatment," says the letter. "However, politics has stood in the way of the approval of marijuana as a legal medication, and the full development of a science base leading to FDA approval could still be years away."

"Under these circumstances, making marijuana immediately available on a quasi-experimental basis to people living with AIDS [...], is a moderate step that can add to the federal government's responsiveness to the epidemic."

###

**EMBARGOED FOR RELEASE UNTIL: 06:00 A.M. EST, THURSDAY,
FEBRUARY 18, 1999**

February 17, 1999

General Barry McCaffrey
Director
Office of National Drug Control Policy

Dear General McCaffrey;

As advocates and care givers for people living with HIV disease and AIDS, we are writing to urge you to help break the bureaucratic logjam that is keeping a potentially life-saving medicine virtually inaccessible to thousands of people living with AIDS and other debilitating illnesses.

That medicine is marijuana. Marijuana's therapeutic uses are well documented in scientific literature. Recent scientific studies have confirmed what has been reported to us by hundreds of people living with HIV - that marijuana can be safely used to reduce nausea and vomiting, stimulate appetite, and promote weight gain. Marijuana is widely recognized by physicians specializing in AIDS care as an important component of treatment for some patients who suffer from symptoms of advanced-stage HIV disease and the multiple-drug therapies used to manage HIV.

Today, thanks to one federally approved clinical study of marijuana for people living with AIDS, sixty-four patients receive marijuana legally from supplies grown by the federal government. However, thousands of Americans, many of them people living with HIV, use marijuana as a medicine illegally, putting themselves at risk of arrest and prosecution. Because the practice is illegal, most patients use marijuana without medical supervision. Marijuana's illegality means that patients cannot be sure of obtaining standardized products that are free of contaminants. People should not have to risk their health or jail to receive needed medical care.

For this reason, thirty-five state legislatures have passed laws supporting the use of marijuana as a medicine. In addition, voters in six states (Alaska, Arizona, California, Nevada, Oregon, and Washington) and the District of Columbia have recently approved ballot measures legalizing the medical use of marijuana within their borders - nearly one in five Americans lives in a state whose voters have approved medical marijuana. Now, the nation is looking to the federal government to begin to show compassion and flexibility on this issue.

You may be aware that the standard Food and Drug Administration approval process has been streamlined for several medications important to people living with HIV disease and AIDS. Drugs shown to fall within an acceptable standard of safety have been made available to patients before completion of all scientific

trials proving effectiveness. This special procedure has helped thousands of patients to obtain life-extending benefits from new medications, and has contributed directly to building the science base for such new drugs.

Our request is simple. Just as other promising AIDS medications have been made available prior to final FDA approval, so too should marijuana, when recommended by a physician, be made available to patients who choose to use it.

There is not much question about the relative safety of marijuana - it has been heavily studied around the world. These studies have revealed an important fact: there is no lethal dose of marijuana. Besides this finding, occasional marijuana smoking under controlled circumstances has not been proved to be dangerous. In sum, the known risks of marijuana are clearly within a range of acceptability sufficient to allow individual physicians and patients to monitor its use, and its results. Under these circumstances, making marijuana immediately available on a quasi-experimental basis to people living with AIDS, when their physicians request it, is a moderate step that can add to the federal government's responsiveness to the epidemic.

We appeal to you, General McCaffrey, because you are in a unique position to provide leadership on this issue. Science and compassion should dictate our nation's policy regarding medical treatment. However, politics has stood in the way of the approval of marijuana as a legal medication, and the full development of a science base leading to FDA approval could still be years away. We call upon you to be a part of the political solution. We ask that you publicly encourage your colleagues in the administration to respond positively to the scientific and public support for making marijuana medically available.

Sincerely,

cc: Donna Shalala, Secretary of Health and Human Services
Jane Henney, director, Food and Drug Administration
Sandra Thurman, director, Office of National AIDS Policy
Sen. Trent Lott (R-MS) Senate Majority Leader
Sen. Tom Daschle (D-SD) Senate Minority Leader
Rep. J. Dennis Hastert (R-IL), Speaker of the House
Rep. Dick Armey (R-TX) House Majority Leader
Rep. Richard Gephardt (D-MO) House Minority Leader

SIGNATORIES

- Daniel Zingale/Jeff Jacobs
Executive Director/Legislative Director
AIDS Action Council
- Regina Aragón
Public Policy Director
San Francisco AIDS Foundation
- Herb K. Schultz
Director of Government Affairs
AIDS Project Los Angeles
- Martin Ornelas-Quintero
National Latina/o Lesbian, Gay, Bisexual and Transgender Organization
Washington, DC
- Julian B. Rush
United Methodist Minister / Colorado AIDS Project
Denver, CO
- Mary Margaret Bush
Executive Director
The Center for AIDS Services
Oakland, CA
- Donna Rae Palmer
Executive Director
Mobilization Against AIDS
San Francisco, CA
- Matt Patrick
Executive Director
Boulder County AIDS Project
Boulder, CO
- Kenneth T. South
Executive Director
AIDS National Interfaith Network
Washington, D.C.

- Ron Rowell
Executive Director
National Native American AIDS Prevention Center
Oakland, CA
- Chris Norwood
Health Force: Women and Men Against AIDS
Bronx, NY
- Dennis de Leon
Latino Commission on AIDS
New York, NY
- David E. Munar
Director of Public Policy
AIDS Foundation of Chicago
Chicago, IL
- Trish Moyan Torruella
Executive Director
Mothers Voices to End AIDS
New York, NY
- Dr. Pat Hawkins
Associate Executive Director
Whitman-Walker Clinic
Washington, DC
- Steven B. Johnson
Director of Public Policy and Communications
Northwest AIDS Foundation
Seattle, WA
- Mark D. Garvey
Being Alive Program Specialist
AIDS Project Arizona
Phoenix AZ
- Lupe Lopez
Executive Director
People of Color Against AIDS Network
Seattle, WA
- Axel Mairero
Director of Public Policy and Legal Services
Hyacinth AIDS Foundation of New Jersey
New Brunswick, NJ

March 16, 1999

MEMORANDUM

TO: DEMAND REDUCTION INTERAGENCY WORKING

FROM: Dr. Donald Vereen, ONDCP Deputy Director

RE: Institute of Medicine Report

The purpose of this memorandum is to inform you of the major conclusions of the report *Marijuana and Medicine: Assessing the Science Base* which will be released by the Institute of Medicine (IOM) on Wednesday. IOM prepared this report in response to a January 1997 ONDCP request for a review of the scientific evidence that assesses the potential health benefits and risks of marijuana and its constituent cannabinoids. ONDCP commissioned this IOM study in the belief that an objective and independent evaluation of research regarding the use of marijuana for medicinal purposes was appropriate given the ongoing debate about cannabis and its health effects.

The IOM report represents the most thorough analysis to date of the relevant scientific literature. It summarizes recent advances in molecular and behavioral neuroscience, in particular, and newly elaborated systems of transmitters, receptors, and antagonists – all illuminating the physiological effects of cannabinoids. IOM has addressed all issues that ONDCP requested be examined, including: the science base and gaps in scientific knowledge regarding use of marijuana for medicinal purposes; scientific information about marijuana's mechanism of action; peer-reviewed literature on the uses of marijuana; and health costs associated with various forms of the component chemical compounds in marijuana and other pharmacotherapies for special medical conditions.

The report contains six specific recommendations that address:

1. Continued research into the physiological effects of cannabinoids;
2. Clinical trials of cannabinoid drugs for symptom management;
3. Evaluation of psychological effects of cannabinoids in clinical trials;
4. Studies of individual health risks in smoking marijuana;
5. Clinical trials of marijuana use under limited circumstances for medical purposes;
6. Short-term use of smoked marijuana under strict conditions for patients with debilitating symptoms;

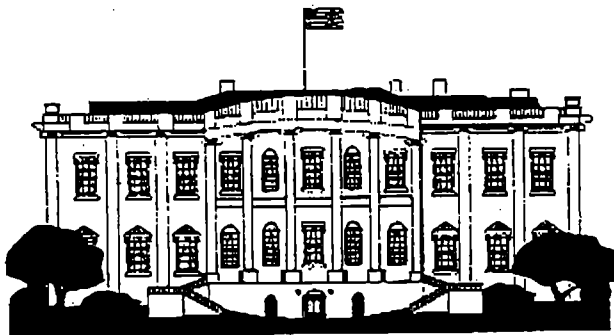
These IOM recommendations are supported by the following observations:

- Scientific data indicate a potential therapeutic value of cannabinoids for pain relief, control of nausea and vomiting, and appetite stimulation. This value would be enhanced by a rapid onset of drug effect.
- The psychological effects of cannabinoids may contribute to their potential therapeutic value. They can influence symptoms indirectly, which could create false impressions of the drug effect or be beneficial as a form of adjunctive therapy.
- Numerous studies suggest that marijuana smoke is an important risk factor in the development of respiratory diseases, but the data that could conclusively establish or refute this suspected link have not been collected.
- Because marijuana is a crude THC delivery system that also delivers harmful substances, smoked marijuana generally should not be recommended for medical use. Nonetheless, marijuana is widely used by certain patient groups, which raises both safety and efficacy concerns.
- If there is any future for marijuana as medicine, it lies in its isolated components -- the cannabinoids and their synthetic derivatives. Isolated cannabinoids will produce more reliable results than crude plant mixtures. Therefore, the purpose of clinical trials of smoked marijuana would not be to develop marijuana as a licensed drug, but such trials could be a first step towards the development of rapid-onset, nonsmoked cannabinoid delivery systems.

ONDCP will carefully study the conclusions and recommendations contained in this report. We will continue to rely on the professional judgement of the Secretary of Health and Human Services, the Director of the National Institutes of Health, and the Surgeon General on all issues related to the medical value of marijuana and its constituent cannabinoids. We note the report's conclusion that "the future of cannabinoid drugs lies not in smoked marijuana, but in chemically-defined drugs that act on the cannabinoid systems that are a natural component of human physiology."

EXECUTIVE OFFICE OF THE PRESIDENT

Office of National Drug Control Policy
Washington, DC 20503

**PUBLIC AFFAIRS****FACSIMILE MESSAGE**TO: SANDY THURMON

ORGANIZATION: _____

PHONE: _____

FAX: 456-2439

DATE: _____ TIME: _____ PAGES: _____ (Including Cover)

FROM:

Bob Weiner, Director, Office of Public Affairs

FAX NUMBER:

202-395-6730

OFFICE NO:

202-395-6618

COMMENTS:

FIT
Regards
Bsh

***JOE LOCKHARDT*****EXECUTIVE OFFICE OF THE PRESIDENT**

66423

OFFICE OF NATIONAL DRUG CONTROL POLICY

Washington, D.C. 20503

MARCH 17, 1999

MEMORANDUM FOR JOE LOCKHARDT/BARRY TOIV/MARK NESCHIS

FROM: BOB WEINER *bw*

SUBJECT: IOM COVERAGE EXPECTED AT NEWS CONFERENCE WED. NOON EST

Major national coverage is expected at Director's news conference today in Los Angeles on Institute of Medicine(IOM)/National Academy of Sciences Medical Marijuana report commissioned by ONDCP two years ago. CNN is not only sending crew but is going live with pre-interview of Director at 8:30 AM PST (11:30 AM EST), ½ hour before start of actual news conference at noon. John Roberts, subbing for Dan Rather as CBS Evening News anchor this week, called and is sending crew. Expect all other networks, and all major papers, to cover at or near lead or on front pages (Wash. Post, NY Times both expect to do major stories). AP and Reuters requested Director's statement and are doing stories. All above, plus our 300 majors' fax list, have been provided advisory and Director's statement embargoed for 11AM EST – therefore will be in evening TV news and Thursday AM papers.

Key points about report: Delighted that science is driving the discussion, as it should; Confirms that smoke is not medicine and research needed to develop alternative delivery systems. However, also recommends extremely limited compassionate use of marijuana, in short term until alternatives developed, with close monitoring and medical protocols, both for patients' benefit and to establish data. Administration will study recommendations carefully, and ONDCP will work with HHS/NIH/NIDA/FDA to assure effective and safe medicine.



**EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503**

**FOR IMMEDIATE RELEASE
Monday, March 15, 1999**

Contact:

**In Washington: Bob Weiner (202) 395-6618
In Los Angeles: Mike Hegarty, pager 1-888-346-0765
Steve Panton, pager 1-800-759-7243, PIN 1452761**

**WHITE HOUSE DRUG CZAR BARRY McCaffrey
TO CONDUCT PRESS CONFERENCE ON TWO-YEAR INSTITUTE OF
MEDICINE (I.O.M) REPORT ON ASSESSING THE SCIENCE BASE OF
MARIJUANA AND MEDICINE;
WED, MARCH 17, 9 A.M. PST, LOS ANGELES (NOON EST), COMMUNITY
COALITION CENTER, 8101 S. VERMONT AVE.**

**ALSO WILL HOLD TOWN HALL MEETING WITH STUDENTS FROM
THE LOS ANGELES AREA AT 11:30 A.M.;**

WILL MEET WITH MAYOR, ABC EXECUTIVES

(WASHINGTON, D.C.) -- Barry R. McCaffrey, Director of the Office of National Drug Control Policy, will comment on the Institute of Medicine's (I.O.M.) two-year report, "Marijuana and Medicine: Assessing the Science Base," during a press conference at 9 a.m. PST (noon EST) Wednesday, March 17, in Los Angeles at the Community Coalition for Substance Abuse, Prevention, and Treatment, 8101 S. Vermont Ave.

The I.O.M., a division of the National Academy of Sciences, was commissioned by Director McCaffrey in January 1997 for a report on assessing the science base of marijuana and medicine. The 290-page report will be released Wednesday at 11 a.m. EST (8 a.m. PST) by the I.O.M. in Washington D.C.

Immediately following the press conference in the same building, McCaffrey will meet with the directors of the South Central L.A. Youth Community Coalition program. Students from the program will also participate in the meeting. The media is invited to attend.

At 11:30 a.m., McCaffrey will travel to Channel One studios, 5300 Melrose Ave., for a Town Hall meeting with students from Los Angeles and other areas. McCaffrey will speak about the drug issue and respond to the students' questions during the 90-minute program. McCaffrey will be available to the media following the unique opportunity for a large group of youths to discuss with the nation's top anti-drug official their own thoughts and concerns about drugs.

In addition, McCaffrey will meet with Mayor Richard Riordan. McCaffrey will discuss the National Youth Anti-Drug Media Campaign with executives from ABC and the creative community. Entertainment media interested in a roundtable discussion with McCaffrey should contact either Mike Hegarty at ONDCP: pager 1-888-346-0765; or Kevin Brockman at ABC: 310-557-6655.



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

ANTI-DRUGS/MEDICAL MARIJUANA FEDERAL REPORT

EMBARGOED UNTIL:

11:00 A.M. E.S.T. Wed., March 17, 1999

CONTACT: Bob Weiner/Steve Panton
(202) 395-6618

**WHITE HOUSE DRUG POLICY OFFICE ISSUES STATEMENT
ON INSTITUTE OF MEDICINE'S REPORT
ON MARIJUANA AND MEDICINE**

(Washington, D.C.) – The White House Office of National Drug Policy (ONDCP) issued the following statement today following the release of the Institute of Medicine's report, *Marijuana and Medicine: Assessing the Science Base*:

We are delighted that science is the basis of the discussion of this issue, as it must be. In January 1997, ONDCP asked the Institute of Medicine to conduct a review of the scientific evidence for assessing the potential health benefits and risks of marijuana and its constituent cannabinoids. ONDCP believed that an objective and independent evaluation of research regarding the use of marijuana for medicinal purposes was appropriate given the ongoing debate about cannabis and its health effects.

The report released today by the Institute of Medicine represents the most thorough analysis to date of the relevant scientific literature. It summarizes recent advances in molecular and behavioral neuroscience, in particular newly elaborated systems of transmitters, receptors, and antagonists -- all illuminating the physiological effects of cannabinoids. The Institute of Medicine has addressed all issues that ONDCP requested be examined, including: the science base and gaps in scientific knowledge regarding use of marijuana for medicinal purposes; scientific information about marijuana's mechanism of action; peer-reviewed literature on the uses of marijuana; and costs associated with various forms of the component chemical compounds in marijuana and other pharmacotherapies for special medical conditions. We thank the principal investigators, members of the advisory panel, biomedical and social scientists, patients, advocates, report reviewers, and all who supported the Institute of Medicine in developing this comprehensive report.

The report contains six specific recommendations that address:

1. Continued research into the physiological effects of cannabinoids.
2. Clinical trials of cannabinoid drugs for symptom management.
3. Evaluation of psychological effects of cannabinoids in clinical trials.
4. Studies of individual health risks in smoking marijuana.

-2-

5. Clinical trials of marijuana use under limited circumstances for medical purposes.
6. Short-term use of smoked marijuana under strict conditions for patients with debilitating symptoms.

These recommendations are supported by the following observations:

- Scientific data indicate the potential therapeutic value of cannabinoids for pain relief, control of nausea and vomiting, and appetite stimulation. This value would be enhanced by a rapid onset of drug effect.
- The psychological effects of cannabinoids are probably important determinants of their potential therapeutic value. They can influence symptoms indirectly, which could create false impressions of the drug effect or be beneficial as a form of adjunctive therapy.
- Numerous studies suggest that marijuana smoke is an important risk factor in the development of respiratory diseases, but the data that could conclusively establish or refute this suspected link have not been collected.
- Because marijuana is a crude THC delivery system that also delivers harmful substances, smoked marijuana generally should not be recommended for medical use. Nonetheless, marijuana is widely used by certain patient groups, which raises both safety and efficacy issues.
- If there is any future for marijuana as medicine, it lies in its isolated components -- the cannabinoids and their synthetic derivatives. Isolated cannabinoids will provide more reliable effects than crude plant mixtures. Therefore, the purpose of clinical trials of smoked marijuana would not be to develop marijuana as a licensed drug, but such trials could be a first step towards the development of rapid-onset, nonsmoked cannabinoid delivery systems.

The Office of National Drug Control Policy appreciates the contributions made by the Institute of Medicine to the debate on the medical efficacy and safety of cannabinoids. We will carefully study the recommendations and conclusions contained in this report. We will continue to rely on the professional judgement of the Secretary of Health and Human Services, the Director of the National Institutes of Health, and the Surgeon General on all issues related to the medical value of marijuana and its constituent cannabinoids. We note in the report's conclusion that "the future of cannabinoid drugs lies not in smoked marijuana, but in chemically-defined drugs that act on the cannabinoid systems that are a natural component of human physiology." We look forward to the considered responses from our nation's public health officials to the interim solutions recommended by the report.

The full text of the report is available from I.O.M. on line at <http://www.nap.edu> or call 1-800-624-6242.

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MARIJUANA AND MEDICINE: ASSESSING THE SCIENCE BASE

ADVANCE COPY

NOT FOR PUBLIC RELEASE BEFORE

«Wednesday, March 17, 1999»

«11 a.m. EST»

PLEASE CITE AS A REPORT OF THE
INSTITUTE OF MEDICINE

Janet E. Joy, Stanley J. Watson, Jr., and John A. Benson, Jr., *Editors*

Division of Neuroscience and Behavioral Health

INSTITUTE OF MEDICINE

NATIONAL ACADEMY PRESS
Washington, D.C. 1999

Preface

Why study the medical value of marijuana now? What circumstances provoked this analysis and report? There have been a variety of influences since the IOM Report of 1982. First, advocates of personal choice with a growing distrust of scientific medicine sought alternatives congruent with their values about health and life. This view was expressed at the ballot box in recent state referenda. Proponents claimed their own "scientific evidence" of marijuana's safety and effectiveness. Others, distressed by the societal ravages of drug abuse, especially among young people, view legalized medical marijuana as a subterfuge enabling liberalization, the potential "gateway" to even more harmful substance abuse. Meanwhile, there have been remarkable and accelerating advances of relevant knowledge in molecular and behavioral neuroscience, in particular newly elaborated systems of transmitters, receptors, and antagonists—all illuminating the physiological effects of cannabinoids, both those found in nature and those normally found in the brain. (Cannabinoids are the group of compounds related to THC, the primary psychoactive ingredient in marijuana.) The new science could inform policies responding to the public divide.

In January 1997, the White House Office of National Drug Control Policy (ONDCP) asked the Institute of Medicine to conduct a review of the scientific evidence to assess the potential health benefits and risks of marijuana and its constituent cannabinoids. That review began in August 1997 and culminates with this report.

Information for this study was gathered through analysis of the relevant scientific literature, scientific workshops, site visits to cannabis buyers' clubs and HIV/AIDS clinics, and extensive consultation with biomedical and social scientists. Three 2-day workshops—in Irvine, California; New Orleans, Louisiana; and Washington, DC—were open to the public and included scientific presentations and also reports, mostly from patients and their families, about their experiences with and perspectives on the medical use of marijuana. Scientific experts in various fields were selected to talk about the latest research on marijuana, cannabinoids, and related topics. In addition, advocates for and against the medical use of marijuana were invited to present scientific evidence in support of their positions. Finally, the Institute of Medicine appointed a panel of nine experts to advise the study team on technical issues.

Public outreach included setting up a Web site that provided information about the study and asked for input from the public. The Web site was open for

comments from November 1997 until November 1998. Some 130 organizations were invited to participate in the public workshops. Many people in the organizations—particularly those opposed to the medical use of marijuana—felt that a public forum was not conducive to expressing their views; they were invited to communicate their opinions (and reasons for holding them) by mail or telephone. As a result, roughly equal numbers of persons and organizations opposed to and in favor of the medical use of marijuana were heard from.

Advances in cannabinoid science of the last 16 years have given rise to a wealth of new opportunities for the development of medically useful cannabinoid-based drugs. The accumulated data suggest a variety of indications, particularly for pain relief, nausea, and appetite stimulation. For patients, such as those with AIDS or undergoing chemotherapy, who suffer simultaneously from severe pain, nausea, and appetite loss, cannabinoid drugs might offer broad spectrum relief not found in any other single medication.

Marijuana is not a completely benign substance. It is a powerful drug with a variety of effects. However, the harmful effects to individuals from the perspective of possible medical use of marijuana are not necessarily the same as the harmful physical effects of drug abuse.

Although marijuana smoke delivers THC and other cannabinoids to the body, it also delivers harmful substances, including most of those found in tobacco smoke. In addition, plants contain a variable mixture of biologically-active compounds and cannot be expected to provide a precisely defined drug effect. For those reasons, the report concludes that the future of cannabinoid drugs lies not in smoked marijuana, but in chemically-defined drugs that act on the cannabinoid systems that are a natural component of human physiology. Until such drugs can be developed and made available for medical use, the report recommends interim solutions.

John A. Benson, Jr., M.D.

Stanley J. Watson, Jr. M.D., Ph.D.

Principal Investigators

EXECUTIVE SUMMARY

Public opinion on the medical value of marijuana has been sharply divided. 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. Proponents of both views cite 'scientific evidence' to support their views and have expressed those views at the ballot box in recent state elections. In January 1997, the White House Office of National Drug Control Policy (ONDCP) asked the Institute of Medicine to conduct a review of the scientific evidence to assess the potential health benefits and risks of marijuana and its constituent cannabinoids (see box: *Statement of Task*). That review began in August 1997 and culminates with this report.

The ONDCP request came in the wake of state "medical marijuana" initiatives. In November 1996, voters in California and Arizona passed referenda designed to permit the use of marijuana as medicine. Although Arizona's referendum was invalidated five months later, the referenda galvanized a national response. In November 1998, voters in six states (Alaska, Arizona, Colorado, Nevada, Oregon, and Washington) passed ballot initiatives in support of medical marijuana. (The Colorado vote will not count, however, because after the vote was taken a court ruling determined there had not been enough valid signatures to place the initiative on the ballot.)

Can marijuana relieve health problems? Is it safe for medical use? Those straightforward questions are embedded in a web of social concerns, most of which lie outside the scope of this report. Controversies concerning the nonmedical use of marijuana spill over onto the medical marijuana debate and obscure the real state of scientific knowledge. In contrast with the many disagreements bearing on social issues, the study team found substantial consensus among experts in the relevant disciplines on the scientific evidence about potential medical uses of marijuana.

This report summarizes and analyzes what is known about the medical use of marijuana; it emphasizes evidence-based medicine (derived from knowledge and experience informed by rigorous scientific analysis), as opposed to belief-based medicine (derived from judgment, intuition, and beliefs untested by rigorous science).

Throughout this report, *marijuana* refers to unpurified plant substances, including leaves or flower tops whether consumed by ingestion or smoking. References to "the effects of marijuana" should be understood to include the composite effects of its various components; that is, the effects of THC, the primary psychoactive ingredient in marijuana, are included among its effects, but not all the effects of marijuana are necessarily due to THC. *Cannabinoids* are the group of compounds related to THC, whether found in the marijuana plant, in animals, or synthesized in chemistry laboratories.

EXECUTIVE SUMMARY

Three focal concerns in evaluating the medical use of marijuana are:

- Evaluation of the effects of isolated cannabinoids.
- Evaluation of the health risks associated with the medical use of marijuana.
- Evaluation of the efficacy of marijuana.

EFFECTS OF ISOLATED CANNABINOID

Cannabinoid Biology

Much has been learned since a 1982 IOM *Marijuana and Health* report. Although it was clear then that most of the effects of marijuana were due to its actions on the brain, there was little information about how THC acted on brain cells (neurons), which cells were affected by THC, or even what general areas of the brain were most affected by THC. Additionally, too little was known about cannabinoid physiology to offer any scientific insights into the harmful or therapeutic effects of marijuana. That all changed with the identification and characterization of cannabinoid receptors in the 1980s and 1990s. During the last 16 years, science has advanced greatly and can tell us much more about the potential medical benefits of cannabinoids.

CONCLUSION: At this point, our knowledge about the biology of marijuana and cannabinoids allows us to make some general conclusions:

- Cannabinoids likely have a natural role in pain modulation, control of movement, and memory.
- The natural role of cannabinoids in immune systems is likely multifaceted and remains unclear.
- The brain develops tolerance to cannabinoids.
- Animal research demonstrates the potential for dependence, but this potential is observed under a narrower range of conditions than with benzodiazepines, opiates, cocaine, or nicotine.
- Withdrawal symptoms can be observed in animals, but appear to be mild compared to opiates or benzodiazepines, such as diazepam (Valium®).

CONCLUSION: The different cannabinoid receptor types found in the body appear to play different roles in normal human physiology. In addition, some effects of cannabinoids appear to be independent of those receptors. The variety of mechanisms through which cannabinoids can influence human physiology underlies the variety of potential therapeutic uses for drugs that might act selectively on different cannabinoid systems.

RECOMMENDATION 1: Research should continue into the physiological effects of synthetic and plant-derived cannabinoids and the natural function of cannabinoids found in the body. Because different cannabinoids appear to have different effects, cannabinoid research should include, but not be restricted to, effects attributable to THC alone.

Efficacy Of Cannabinoid Drugs

The accumulated data indicate a potential therapeutic value for cannabinoid drugs, particularly for symptoms such as pain relief, control of nausea and vomiting, and appetite stimulation. The therapeutic effects of cannabinoids are best established for THC, which is generally one of the two most abundant of the cannabinoids in marijuana. (Cannabidiol, the precursor of THC, is generally the other most abundant cannabinoid.)

The effects of cannabinoids on the symptoms studied are generally modest, and in most cases, there are more effective medications. However, people vary in their responses to medications and there will likely always be a subpopulation of patients who do not respond well to other medications. The combination of cannabinoid drug effects (anxiety reduction, appetite stimulation, nausea reduction, and pain relief) suggests that cannabinoids would be moderately well suited for certain conditions, such as chemotherapy-induced nausea and vomiting and AIDS wasting.

Defined substances, such as purified cannabinoid compounds, are preferable to plant products which are of variable and uncertain composition. Use of defined cannabinoids permits a more precise evaluation of their effects, whether in combination or alone. Medications that can maximize the desired effects of cannabinoids and minimize the undesired effects can very likely be identified.

Although most scientists who study cannabinoids agree that the pathways to cannabinoid drug development are clearly marked, there is no guarantee that the fruits of scientific research will be made available to the public for medical use. Cannabinoid-based drugs will only become available if public investment in cannabinoid drug research is sustained, and if there is enough incentive for private enterprise to develop and market such drugs.

EXECUTIVE SUMMARY

CONCLUSION: Scientific data indicate the potential therapeutic value of cannabinoid drugs, primarily THC, for pain relief, control of nausea and vomiting, and appetite stimulation; smoked marijuana, however, is a crude THC delivery system that also delivers harmful substances.

RECOMMENDATION 2: Clinical trials of cannabinoid drugs for symptom management should be conducted with the goal of developing rapid-onset, reliable, and safe delivery systems.

Influence Of Psychological Effects On Therapeutic Effects

The psychological effects of THC and similar cannabinoids pose three issues for the therapeutic use of cannabinoid drugs. First, for some patients—particularly older patients with no previous marijuana experience—the psychological effects are disturbing. Those patients report experiencing unpleasant feelings and disorientation after being treated with THC, generally more severe for oral THC than for smoked marijuana. Second, for conditions such as movement disorders or nausea, in which anxiety exacerbates the symptoms, the anti-anxiety effects of cannabinoid drugs can influence symptoms indirectly. This can be beneficial or can create false impressions of the drug effect. Third, in cases where symptoms are multifaceted, the combination of THC effects might provide a form of adjunctive therapy; for example, AIDS wasting patients would likely benefit from a medication that simultaneously reduces anxiety, pain, and nausea while stimulating appetite.

CONCLUSION: The psychological effects of cannabinoids, such as anxiety reduction, sedation, and euphoria can influence their potential therapeutic value. Those effects are potentially undesirable for certain patients and situations, and beneficial for others. In addition, psychological effects can complicate the interpretation of other aspects of the drug effect.

RECOMMENDATION 3: Psychological effects of cannabinoids such as anxiety reduction and sedation, which can influence medical benefits, should be evaluated in clinical trials.

RISKS ASSOCIATED WITH MEDICAL USE OF MARIJUANA

Physiological Risks

Marijuana is not a completely benign substance. It is a powerful drug with a variety of effects. However, except for the harms associated with smoking, the adverse effects of marijuana use are within the range of effects tolerated for other medications. The harmful effects to individuals from the perspective of possible medical use of marijuana are not necessarily the same as the harmful physical effects of drug abuse. When interpreting studies purporting to show the harmful effects of marijuana, it is important to keep in mind that the majority of those studies are based on *smoked* marijuana, and cannabinoid effects cannot be separated from the effects of inhaling smoke of burning plant material and contaminants.

For most people, the primary adverse effect of *acute* marijuana use is diminished psychomotor performance. It is, therefore, inadvisable to operate any vehicle or potentially dangerous equipment while under the influence of marijuana, THC, or any cannabinoid drug with comparable effects. In addition, a minority of marijuana users experience dysphoria, or unpleasant feelings. Finally, the short-term immunosuppressive effects are not well established but, if they exist, are not likely great enough to preclude a legitimate medical use.

The *chronic* effects of marijuana are of greater concern for medical use and fall into two categories: the effects of chronic smoking, and the effects of THC. Marijuana smoking is associated with abnormalities of cells lining the human respiratory tract. Marijuana smoke, like tobacco smoke, is associated with increased risk of cancer, lung damage, and poor pregnancy outcomes. Although cellular, genetic, and human studies all suggest that marijuana smoke is an important risk factor for the development of respiratory cancer, proof that habitual marijuana smoking does or does not cause cancer awaits the results of well-designed studies.

CONCLUSION: Numerous studies suggest that marijuana smoke is an important risk factor in the development of respiratory disease.

RECOMMENDATION 4: Studies to define the individual health risks of smoking marijuana should be conducted, particularly among populations in which marijuana use is prevalent.

EXECUTIVE SUMMARY

Marijuana Dependence And Withdrawal

A second concern associated with chronic marijuana use is dependence on the psychoactive effects of THC. Although few marijuana users develop dependence, some do. Risk factors for marijuana dependence are similar to those for other forms of substance abuse. In particular, antisocial personality and conduct disorders are closely associated with substance abuse.

CONCLUSION: A distinctive marijuana withdrawal syndrome has been identified, but it is mild and short-lived. The syndrome includes restlessness, irritability, mild agitation, insomnia, sleep EEG disturbance, nausea, and cramping.

Marijuana As A "Gateway" Drug

Patterns in progression of drug use from adolescence to adulthood are strikingly regular. Because it is the most widely used illicit drug, marijuana is predictably the first illicit drug most people encounter. Not surprisingly, most users of other illicit drugs have used marijuana first. In fact, most drug users begin with alcohol and nicotine before marijuana—usually before they are of legal age.

In the sense that marijuana use typically precedes rather than follows initiation of other illicit drug use, it is indeed a "gateway" drug. But because underage smoking and alcohol use typically precede marijuana use, marijuana is not the most common, and is rarely the first, "gateway" to illicit drug use. There is no conclusive evidence that the drug effects of marijuana are causally linked to the subsequent abuse of other illicit drugs. An important caution is that data on drug use progression cannot be assumed to apply to the use of drugs for medical purposes. It does not follow from those data that if marijuana were available by prescription for medical use, the pattern of drug use would remain the same as seen in illicit use.

Finally, there is a broad social concern that sanctioning the medical use of marijuana might increase its use among the general population. At this point there are no convincing data to support this concern. The existing data are consistent with the idea that this would not be a problem if the medical use of marijuana were as closely regulated as other medications with abuse potential.

CONCLUSION: Present data on drug use progression neither support nor refute the suggestion that medical availability would increase drug abuse. However, this question is beyond the issues normally considered for medical uses of drugs, and should not be a factor in evaluating the therapeutic potential of marijuana or cannabinoids.

USE OF SMOKED MARIJUANA

Because of the health risks associated with smoking, smoked marijuana should generally not be recommended for long-term medical use. Nonetheless, for certain patients, such as the terminally ill or those with debilitating symptoms, the long-term risks are not of great concern. Further, despite the legal, social, and health problems associated with smoking marijuana, it is widely used by certain patient groups.

RECOMMENDATION 5: Clinical trials of marijuana use for medical purposes should be conducted under the following limited circumstances: trials should involve only short-term marijuana use (less than six months); be conducted in patients with conditions for which there is reasonable expectation of efficacy; be approved by institutional review boards; and collect data about efficacy.

The goal of clinical trials of smoked marijuana would not be to develop marijuana as a licensed drug, but rather as a first step towards the possible development of nonsmoked, rapid-onset cannabinoid delivery systems. However, it will likely be many years before a safe and effective cannabinoid delivery system, such as an inhaler, will be available for patients. In the meantime, there are patients with debilitating symptoms for whom smoked marijuana might provide relief. The use of smoked marijuana for those patients should weigh both the expected efficacy of marijuana and ethical issues in patient care, including providing information about the known and suspected risks of smoked marijuana use.

EXECUTIVE SUMMARY

RECOMMENDATION 6: Short-term use of smoked marijuana (less than six months) for patients with debilitating symptoms (such as intractable pain or vomiting) must meet the following conditions:

- failure of all approved medications to provide relief has been documented;
- the symptoms can reasonably be expected to be relieved by rapid-onset cannabinoid drugs;
- such treatment is administered under medical supervision in a manner that allows for assessment of treatment effectiveness;
- and involves an oversight strategy comparable to an institutional review board process that could provide guidance within 24 hours of a submission by a physician to provide marijuana to a patient for a specified use.

Until a non-smoked, rapid-onset cannabinoid drug delivery system becomes available, we acknowledge that there is no clear alternative for people suffering from *chronic* conditions that might be relieved by smoking marijuana, such as pain or AIDS wasting. One possible approach is to treat patients as n-of-1 clinical trials, in which patients are fully informed of their status as experimental subjects using a harmful drug delivery system, and in which their condition is closely monitored and documented under medical supervision, thereby increasing the knowledge base of the risks and benefits of marijuana use under such conditions.

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MARIJUANA AND MEDICINE: ASSESSING THE SCIENCE BASE

Janet E. Joy, Stanley J. Watson, Jr., and John A. Benson, Jr., *Editors*

Division of Neuroscience and Behavioral Health

INSTITUTE OF MEDICINE

NATIONAL ACADEMY PRESS
Washington, D.C. 1999

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NOTICE: The project that is the subject of this report was approved by the Governing Board of the National Research Council, whose members are drawn from the councils of the National Academy of Sciences, the National Academy of Engineering, and the Institute of Medicine. The Principal Investigators responsible for the report were chosen for their special competences and with regard for appropriate balance.

The Institute of Medicine was chartered in 1970 by the National Academy of Sciences to enlist distinguished members of the appropriate professions in the examination of policy matters pertaining to the health of the public. In this, the Institute acts under both the Academy's 1863 congressional charter responsibility to be an adviser to the federal government and its own initiative in identifying issues of medical care, research, and education. Dr. Kenneth I. Shine is president of the Institute of Medicine.

This study was supported under contract No. DC7C02 from the Executive Office of the President, Office of the National Drug Control Policy.

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The full text of this report is available on line at <http://www.nap.edu>

For more information about the Institute of Medicine, visit the IOM home page at <http://www2.nas.edu/iom>.

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The serpent has been a symbol of long life, healing, and knowledge among almost all cultures and religions since the beginning of recorded history. The image adopted as a logotype by the Institute of Medicine is based on a relief carving from ancient Greece, now held by the Staatliche Museen in Berlin.

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This report has been reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise, in accordance with procedures approved by the National Research Council's Report Review Committee. The purpose of this independent review is to provide candid and critical comments that will assist the Institute of Medicine in making the published report as sound as possible and to ensure that the report meets institutional standards for objectivity, evidence, and responsiveness to the study charge. The review comments and draft manuscript remain confidential to protect the integrity of the deliberative process. The committee wishes to thank the following individuals for their participation in the review of this report:

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While the individuals listed above have provided constructive comments and suggestions, it must be emphasized that responsibility for the final content of this report rests entirely with the authoring committee and the Institute of Medicine.

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Preface

Why study the medical value of marijuana now? What circumstances provoked this analysis and report? There have been a variety of influences since the IOM Report of 1982. First, advocates of personal choice with a growing distrust of scientific medicine sought alternatives congruent with their values about health and life. This view was expressed at the ballot box in recent state referenda. Proponents claimed their own "scientific evidence" of marijuana's safety and effectiveness. Others, distressed by the societal ravages of drug abuse, especially among young people, view legalized medical marijuana as a subterfuge enabling liberalization, the potential "gateway" to even more harmful substance abuse. Meanwhile, there have been remarkable and accelerating advances of relevant knowledge in molecular and behavioral neuroscience, in particular newly elaborated systems of transmitters, receptors, and antagonists—all illuminating the physiological effects of cannabinoids, both those found in nature and those normally found in the brain. (Cannabinoids are the group of compounds related to THC, the primary psychoactive ingredient in marijuana.) The new science could inform policies responding to the public divide.

In January 1997, the White House Office of National Drug Control Policy (ONDCP) asked the Institute of Medicine to conduct a review of the scientific evidence to assess the potential health benefits and risks of marijuana and its constituent cannabinoids. That review began in August 1997 and culminates with this report.

Information for this study was gathered through analysis of the relevant scientific literature, scientific workshops, site visits to cannabis buyers' clubs and HIV/AIDS clinics, and extensive consultation with biomedical and social scientists. Three 2-day workshops—in Irvine, California; New Orleans, Louisiana; and Washington, DC—were open to the public and included scientific presentations and also reports, mostly from patients and their families, about their experiences with and perspectives on the medical use of marijuana. Scientific experts in various fields were selected to talk about the latest research on marijuana, cannabinoids, and related topics. In addition, advocates for and against the medical use of marijuana were invited to present scientific evidence in support of their positions. Finally, the Institute of Medicine appointed a panel of nine experts to advise the study team on technical issues.

Public outreach included setting up a Web site that provided information about the study and asked for input from the public. The Web site was open for

comments from November 1997 until November 1998. Some 130 organizations were invited to participate in the public workshops. Many people in the organizations—particularly those opposed to the medical use of marijuana—felt that a public forum was not conducive to expressing their views; they were invited to communicate their opinions (and reasons for holding them) by mail or telephone. As a result, roughly equal numbers of persons and organizations opposed to and in favor of the medical use of marijuana were heard from.

Advances in cannabinoid science of the last 16 years have given rise to a wealth of new opportunities for the development of medically useful cannabinoid-based drugs. The accumulated data suggest a variety of indications, particularly for pain relief, nausea, and appetite stimulation. For patients, such as those with AIDS or undergoing chemotherapy, who suffer simultaneously from severe pain, nausea, and appetite loss, cannabinoid drugs might offer broad spectrum relief not found in any other single medication.

Marijuana is not a completely benign substance. It is a powerful drug with a variety of effects. However, the harmful effects to individuals from the perspective of possible medical use of marijuana are not necessarily the same as the harmful physical effects of drug abuse.

Although marijuana smoke delivers THC and other cannabinoids to the body, it also delivers harmful substances, including most of those found in tobacco smoke. In addition, plants contain a variable mixture of biologically-active compounds and cannot be expected to provide a precisely defined drug effect. For those reasons, the report concludes that the future of cannabinoid drugs lies not in smoked marijuana, but in chemically-defined drugs that act on the cannabinoid systems that are a natural component of human physiology. Until such drugs can be developed and made available for medical use, the report recommends interim solutions.

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Principal Investigators

Acknowledgments

This report covers such a broad range of disciplines—neuroscience, pharmacology, immunology, drug abuse, drug laws, and a variety of medical specialties including neurology, oncology, infectious diseases, and ophthalmology—that it would not have been complete without the generous support of many people. Our goal in preparing this report was to identify the solid ground of scientific consensus, and steer clear of the muddy distractions of opinions that are inconsistent with careful scientific analysis. To this end, we consulted extensively with experts in each of the disciplines covered in this report. We are deeply indebted to each of them.

Members of the Advisory Panel, selected because each is recognized as among the most accomplished in their respective disciplines (see list), provided guidance to the study team throughout the study—from helping to lay the intellectual framework to reviewing early drafts of the report.

The following people wrote invaluable background papers for the report: Steven R. Childers, Paul Consroe, J. Richard Gralla, Howard Fields, Norbert Kaminski, Paul Kaufman, Thomas Klein, Donald Kotler, Richard Musty, Clara Sanudo-Pena, C. Robert Schuster, Stephen Sidney, Donald P. Tashkin, and J. Michael Walker.

Others provided expert technical commentary on draft sections of the report: Richard Bonnie, Keith Green, Frederick Fraunfelder, Andrea Hohmann, John McAnulty, Craig Nichols, John Nutt, and Robert Pandina.

Still others responded to many inquiries, provided expert counsel, or shared their unpublished data: Paul Consroe, Geoffrey Levitt, Richard Musty, David Pate, Roger Pertwee, Raphael Mechoulam, Clara Sanudo-Pena, Carl Soderstrom, J. Michael Walker, and Scott Yarnell.

Miriam Davis, consultant to the study team, provided excellent written material for the chapter on cannabinoid drug development.

The reviewers for the report (see list) provided extensive and constructive suggestions for improving the report. It was greatly enhanced by their thoughtful attentions.

Many of these people assisted us through many iterations of the report. All of them made contributions that were essential to the strength of the report. At the same time, it must be emphasized that responsibility for the final content of report rests entirely with the authors and the Institute of Medicine.

We would also like to thank the people who hosted our visits to their organizations. They were unfailingly helpful and generous with their time. Jeffrey Jones and members of the Oakland Cannabis Buyers' Cooperative, Denis Peron of

the San Francisco Cannabis Cultivators Club, Scott Imler and staff at the Los Angeles Cannabis Resource Center, Victor Hernandez and members of Californians Helping Alleviate Medical Problems (CHAMPS), Michael Weinstein of the AIDS Health Care Foundation, and Marsha Bennett of the Louisiana State University Medical Center.

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Jane Sanville, project officer for the study sponsor, was consistently helpful during the many negotiations and discussion held throughout study process.

Many IOM staff members provided much appreciated administrative, research, and intellectual support during the study. Robert Cook-Deegan, Marilyn Field, Constance Pechura, Daniel Quinn, Michael Stoto provided thoughtful and insightful comments on draft sections of the report. Others provided advice and consultation in many other aspects of the study process: Kathleen Stratton, Susan Fourt, Carolyn Fulco, Carlos Gabriel, Linda Kilroy, Catharyn Liverman, Clyde Behney, Dev Mani. As project assistant throughout the study, Amelia Mathis was tireless, gracious, and reliable.

Deborah Yarnell's contribution as Research Associate for this study was outstanding. She organized site visits, researched and drafted technical material for the report, and consulted extensively with relevant experts to ensure the technical accuracy of the text. The quality of her contributions throughout this study was exemplary.

Finally, the Principal Investigators on this study wish to personally thank Janet Joy for her deep commitment to the science and shape of this report. In addition, her help in integrating the entire data gathering and information organization of this report were nothing short of essential. Her knowledge of neurobiology, her sense of quality control, and her unflagging spirit over the 18 months illuminated the subjects and were indispensable to the study's successful completion.

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EXECUTIVE SUMMARY

Public opinion on the medical value of marijuana has been sharply divided. 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. Proponents of both views cite 'scientific evidence' to support their views and have expressed those views at the ballot box in recent state elections. In January 1997, the White House Office of National Drug Control Policy (ONDCP) asked the Institute of Medicine to conduct a review of the scientific evidence to assess the potential health benefits and risks of marijuana and its constituent cannabinoids (see box: *Statement of Task*). That review began in August 1997 and culminates with this report.

The ONDCP request came in the wake of state "medical marijuana" initiatives. In November 1996, voters in California and Arizona passed referenda designed to permit the use of marijuana as medicine. Although Arizona's referendum was invalidated five months later, the referenda galvanized a national response. In November 1998, voters in six states (Alaska, Arizona, Colorado, Nevada, Oregon, and Washington) passed ballot initiatives in support of medical marijuana. (The Colorado vote will not count, however, because after the vote was taken a court ruling determined there had not been enough valid signatures to place the initiative on the ballot.)

Can marijuana relieve health problems? Is it safe for medical use? Those straightforward questions are embedded in a web of social concerns, most of which lie outside the scope of this report. Controversies concerning the nonmedical use of marijuana spill over onto the medical marijuana debate and obscure the real state of scientific knowledge. In contrast with the many disagreements bearing on social issues, the study team found substantial consensus among experts in the relevant disciplines on the scientific evidence about potential medical uses of marijuana.

This report summarizes and analyzes what is known about the medical use of marijuana; it emphasizes evidence-based medicine (derived from knowledge and experience informed by rigorous scientific analysis), as opposed to belief-based medicine (derived from judgment, intuition, and beliefs untested by rigorous science).

Throughout this report, *marijuana* refers to unpurified plant substances, including leaves or flower tops whether consumed by ingestion or smoking. References to "the effects of marijuana" should be understood to include the composite effects of its various components; that is, the effects of THC, the primary psychoactive ingredient in marijuana, are included among its effects, but not all the effects of marijuana are necessarily due to THC. *Cannabinoids* are the group of compounds related to THC, whether found in the marijuana plant, in animals, or synthesized in chemistry laboratories.

EXECUTIVE SUMMARY

Three focal concerns in evaluating the medical use of marijuana are:

- Evaluation of the effects of isolated cannabinoids.
- Evaluation of the health risks associated with the medical use of marijuana.
- Evaluation of the efficacy of marijuana.

EFFECTS OF ISOLATED CANNABINOIDS

Cannabinoid Biology

Much has been learned since a 1982 IOM *Marijuana and Health* report. Although it was clear then that most of the effects of marijuana were due to its actions on the brain, there was little information about how THC acted on brain cells (neurons), which cells were affected by THC, or even what general areas of the brain were most affected by THC. Additionally, too little was known about cannabinoid physiology to offer any scientific insights into the harmful or therapeutic effects of marijuana. That all changed with the identification and characterization of cannabinoid receptors in the 1980s and 1990s. During the last 16 years, science has advanced greatly and can tell us much more about the potential medical benefits of cannabinoids.

CONCLUSION: At this point, our knowledge about the biology of marijuana and cannabinoids allows us to make some general conclusions:

- Cannabinoids likely have a natural role in pain modulation, control of movement, and memory.
- The natural role of cannabinoids in immune systems is likely multifaceted and remains unclear.
- The brain develops tolerance to cannabinoids.
- Animal research demonstrates the potential for dependence, but this potential is observed under a narrower range of conditions than with benzodiazepines, opiates, cocaine, or nicotine.
- Withdrawal symptoms can be observed in animals, but appear to be mild compared to opiates or benzodiazepines, such as diazepam (Valium®).

CONCLUSION: The different cannabinoid receptor types found in the body appear to play different roles in normal human physiology. In addition, some effects of cannabinoids appear to be independent of those receptors. The variety of mechanisms through which cannabinoids can influence human physiology underlies the variety of potential therapeutic uses for drugs that might act selectively on different cannabinoid systems.

RECOMMENDATION 1: Research should continue into the physiological effects of synthetic and plant-derived cannabinoids and the natural function of cannabinoids found in the body. Because different cannabinoids appear to have different effects, cannabinoid research should include, but not be restricted to, effects attributable to THC alone.

Efficacy Of Cannabinoid Drugs

The accumulated data indicate a potential therapeutic value for cannabinoid drugs, particularly for symptoms such as pain relief, control of nausea and vomiting, and appetite stimulation. The therapeutic effects of cannabinoids are best established for THC, which is generally one of the two most abundant of the cannabinoids in marijuana. (Cannabidiol, the precursor of THC, is generally the other most abundant cannabinoid.)

The effects of cannabinoids on the symptoms studied are generally modest, and in most cases, there are more effective medications. However, people vary in their responses to medications and there will likely always be a subpopulation of patients who do not respond well to other medications. The combination of cannabinoid drug effects (anxiety reduction, appetite stimulation, nausea reduction, and pain relief) suggests that cannabinoids would be moderately well suited for certain conditions, such as chemotherapy-induced nausea and vomiting and AIDS wasting.

Defined substances, such as purified cannabinoid compounds, are preferable to plant products which are of variable and uncertain composition. Use of defined cannabinoids permits a more precise evaluation of their effects, whether in combination or alone. Medications that can maximize the desired effects of cannabinoids and minimize the undesired effects can very likely be identified.

Although most scientists who study cannabinoids agree that the pathways to cannabinoid drug development are clearly marked, there is no guarantee that the fruits of scientific research will be made available to the public for medical use. Cannabinoid-based drugs will only become available if public investment in cannabinoid drug research is sustained, and if there is enough incentive for private enterprise to develop and market such drugs.

EXECUTIVE SUMMARY

CONCLUSION: Scientific data indicate the potential therapeutic value of cannabinoid drugs, primarily THC, for pain relief, control of nausea and vomiting, and appetite stimulation; smoked marijuana, however, is a crude THC delivery system that also delivers harmful substances.

RECOMMENDATION 2: Clinical trials of cannabinoid drugs for symptom management should be conducted with the goal of developing rapid-onset, reliable, and safe delivery systems.

Influence Of Psychological Effects On Therapeutic Effects

The psychological effects of THC and similar cannabinoids pose three issues for the therapeutic use of cannabinoid drugs. First, for some patients—particularly older patients with no previous marijuana experience—the psychological effects are disturbing. Those patients report experiencing unpleasant feelings and disorientation after being treated with THC, generally more severe for oral THC than for smoked marijuana. Second, for conditions such as movement disorders or nausea, in which anxiety exacerbates the symptoms, the anti-anxiety effects of cannabinoid drugs can influence symptoms indirectly. This can be beneficial or can create false impressions of the drug effect. Third, in cases where symptoms are multifaceted, the combination of THC effects might provide a form of adjunctive therapy; for example, AIDS wasting patients would likely benefit from a medication that simultaneously reduces anxiety, pain, and nausea while stimulating appetite.

CONCLUSION: The psychological effects of cannabinoids, such as anxiety reduction, sedation, and euphoria can influence their potential therapeutic value. Those effects are potentially undesirable for certain patients and situations, and beneficial for others. In addition, psychological effects can complicate the interpretation of other aspects of the drug effect.

RECOMMENDATION 3: Psychological effects of cannabinoids such as anxiety reduction and sedation, which can influence medical benefits, should be evaluated in clinical trials.

RISKS ASSOCIATED WITH MEDICAL USE OF MARIJUANA

Physiological Risks

Marijuana is not a completely benign substance. It is a powerful drug with a variety of effects. However, except for the harms associated with smoking, the adverse effects of marijuana use are within the range of effects tolerated for other medications. The harmful effects to individuals from the perspective of possible medical use of marijuana are not necessarily the same as the harmful physical effects of drug abuse. When interpreting studies purporting to show the harmful effects of marijuana, it is important to keep in mind that the majority of those studies are based on *smoked* marijuana, and cannabinoid effects cannot be separated from the effects of inhaling smoke of burning plant material and contaminants.

For most people, the primary adverse effect of *acute* marijuana use is diminished psychomotor performance. It is, therefore, inadvisable to operate any vehicle or potentially dangerous equipment while under the influence of marijuana, THC, or any cannabinoid drug with comparable effects. In addition, a minority of marijuana users experience dysphoria, or unpleasant feelings. Finally, the short-term immunosuppressive effects are not well established but, if they exist, are not likely great enough to preclude a legitimate medical use.

The *chronic* effects of marijuana are of greater concern for medical use and fall into two categories: the effects of chronic smoking, and the effects of THC. Marijuana smoking is associated with abnormalities of cells lining the human respiratory tract. Marijuana smoke, like tobacco smoke, is associated with increased risk of cancer, lung damage, and poor pregnancy outcomes. Although cellular, genetic, and human studies all suggest that marijuana smoke is an important risk factor for the development of respiratory cancer, proof that habitual marijuana smoking does or does not cause cancer awaits the results of well-designed studies.

CONCLUSION: Numerous studies suggest that marijuana smoke is an important risk factor in the development of respiratory disease.

RECOMMENDATION 4: Studies to define the individual health risks of smoking marijuana should be conducted, particularly among populations in which marijuana use is prevalent.

Marijuana Dependence And Withdrawal

A second concern associated with chronic marijuana use is dependence on the psychoactive effects of THC. Although few marijuana users develop dependence, some do. Risk factors for marijuana dependence are similar to those for other forms of substance abuse. In particular, antisocial personality and conduct disorders are closely associated with substance abuse.

CONCLUSION: A distinctive marijuana withdrawal syndrome has been identified, but it is mild and short-lived. The syndrome includes restlessness, irritability, mild agitation, insomnia, sleep EEG disturbance, nausea, and cramping.

Marijuana As A "Gateway" Drug

Patterns in progression of drug use from adolescence to adulthood are strikingly regular. Because it is the most widely used illicit drug, marijuana is predictably the first illicit drug most people encounter. Not surprisingly, most users of other illicit drugs have used marijuana first. In fact, most drug users begin with alcohol and nicotine before marijuana—usually before they are of legal age.

In the sense that marijuana use typically precedes rather than follows initiation of other illicit drug use, it is indeed a "gateway" drug. But because underage smoking and alcohol use typically precede marijuana use, marijuana is not the most common, and is rarely the first, "gateway" to illicit drug use. There is no conclusive evidence that the drug effects of marijuana are causally linked to the subsequent abuse of other illicit drugs. An important caution is that data on drug use progression cannot be assumed to apply to the use of drugs for medical purposes. It does not follow from those data that if marijuana were available by prescription for medical use, the pattern of drug use would remain the same as seen in illicit use.

Finally, there is a broad social concern that sanctioning the medical use of marijuana might increase its use among the general population. At this point there are no convincing data to support this concern. The existing data are consistent with the idea that this would not be a problem if the medical use of marijuana were as closely regulated as other medications with abuse potential.

CONCLUSION: Present data on drug use progression neither support nor refute the suggestion that medical availability would increase drug abuse. However, this question is beyond the issues normally considered for medical uses of drugs, and should not be a factor in evaluating the therapeutic potential of marijuana or cannabinoids.

USE OF SMOKED MARIJUANA

Because of the health risks associated with smoking, smoked marijuana should generally not be recommended for long-term medical use. Nonetheless, for certain patients, such as the terminally ill or those with debilitating symptoms, the long-term risks are not of great concern. Further, despite the legal, social, and health problems associated with smoking marijuana, it is widely used by certain patient groups.

RECOMMENDATION 5: Clinical trials of marijuana use for medical purposes should be conducted under the following limited circumstances: trials should involve only short-term marijuana use (less than six months); be conducted in patients with conditions for which there is reasonable expectation of efficacy; be approved by institutional review boards; and collect data about efficacy.

The goal of clinical trials of smoked marijuana would not be to develop marijuana as a licensed drug, but rather as a first step towards the possible development of nonsmoked, rapid-onset cannabinoid delivery systems. However, it will likely be many years before a safe and effective cannabinoid delivery system, such as an inhaler, will be available for patients. In the meantime, there are patients with debilitating symptoms for whom smoked marijuana might provide relief. The use of smoked marijuana for those patients should weigh both the expected efficacy of marijuana and ethical issues in patient care, including providing information about the known and suspected risks of smoked marijuana use.

EXECUTIVE SUMMARY

RECOMMENDATION 6: Short-term use of smoked marijuana (less than six months) for patients with debilitating symptoms (such as intractable pain or vomiting) must meet the following conditions:

- **failure of all approved medications to provide relief has been documented;**
- **the symptoms can reasonably be expected to be relieved by rapid-onset cannabinoid drugs;**
- **such treatment is administered under medical supervision in a manner that allows for assessment of treatment effectiveness;**
- **and involves an oversight strategy comparable to an institutional review board process that could provide guidance within 24 hours of a submission by a physician to provide marijuana to a patient for a specified use.**

Until a non-smoked, rapid-onset cannabinoid drug delivery system becomes available, we acknowledge that there is no clear alternative for people suffering from *chronic* conditions that might be relieved by smoking marijuana, such as pain or AIDS wasting. One possible approach is to treat patients as n-of-1 clinical trials, in which patients are fully informed of their status as experimental subjects using a harmful drug delivery system, and in which their condition is closely monitored and documented under medical supervision, thereby increasing the knowledge base of the risks and benefits of marijuana use under such conditions.

Statement of Task

The study will assess what is currently known, and not known about the medical use of marijuana. It will include a review of the science base regarding the mechanism of action of marijuana, an examination of the peer-reviewed scientific literature on the efficacy of therapeutic uses of marijuana, and the costs of using various forms of marijuana versus approved drugs for specific medical conditions (e.g., glaucoma, multiple sclerosis, wasting diseases, nausea, and pain).

The study will also include an evaluation of the acute and chronic effects of marijuana on health and behavior; a consideration of the adverse effects of marijuana use compared with approved drugs; an evaluation of the efficacy of different delivery systems for marijuana (e.g., inhalation vs. oral); and an analysis of the data concerning marijuana as a gateway drug; and an examination of the possible differences in the effects of marijuana due to age and type of medical condition.

Specific Issues

Specific issues to be addressed fall under three broad categories: the science base, therapeutic use, and economics.

Science Base

- Review of neuroscience related to marijuana, particularly relevance of new studies on addiction and craving
- Review of behavioral and social science base of marijuana use, particularly assessment of the relative risk of progression to other drugs following marijuana use
- Review of the literature determining which chemical components of crude marijuana are responsible of possible therapeutic effects and for side effects

Therapeutic Use

- Evaluation of any conclusions on the medical use of marijuana drawn by other groups
- Efficacy and side-effects of various delivery systems for marijuana compared to existing medications for glaucoma, wasting syndrome, pain, nausea, or other symptoms
- Differential effects of various forms of marijuana that relate to age or type of disease.

Economics

- Costs of various forms of marijuana compared with costs of existing medications for glaucoma, wasting syndrome, pain, nausea, or other symptoms
- Assessment of differences between marijuana and existing medications in terms of access and availability

These specific areas, along with the assessments described above will be integrated into a broad description and assessment of the available literature relevant to the medical use of marijuana.

Recommendations

RECOMMENDATION 1: Research should continue into the physiological effects of synthetic and plant-derived cannabinoids and the natural function of cannabinoids found in the body. Because different cannabinoids appear to have different effects, cannabinoid research should include, but not be restricted to, effects attributable to THC alone.

Scientific data indicate the potential therapeutic value of cannabinoid drugs for pain relief, control of nausea and vomiting, and appetite stimulation. This value would be enhanced by a rapid onset of drug effect.

RECOMMENDATION 2: Clinical trials of cannabinoid drugs for symptom management should be conducted with the goal of developing rapid-onset, reliable, and safe delivery systems.

The psychological effects of cannabinoids are probably important determinants of their potential therapeutic value. They can influence symptoms indirectly which could create false impressions of the drug effect or be beneficial as a form of adjunctive therapy.

RECOMMENDATION 3: Psychological effects of cannabinoids such as anxiety reduction and sedation, which can influence perceived medical benefits, should be evaluated in clinical trials.

Numerous studies suggest that marijuana smoke is an important risk factor in the development of respiratory diseases, but the data that could conclusively establish or refute this suspected link have not been collected.

continued on next page

Recommendations, *continued*

RECOMMENDATION 4: Studies to define the individual health risks of smoking marijuana should be conducted, particularly among populations in which marijuana use is prevalent.

Because marijuana is a crude THC delivery system that also delivers harmful substances, smoked marijuana should generally not be recommended for medical use. Nonetheless, marijuana is widely used by certain patient groups, which raises both safety and efficacy issues.

RECOMMENDATION 5: Clinical trials of marijuana use for medical purposes should be conducted under the following limited circumstances: trials should involve only short-term marijuana use (less than six months); be conducted in patients with conditions for which there is reasonable expectation of efficacy; be approved by institutional review boards; and collect data about efficacy.

If there is any future for marijuana as a medicine, it lies in its isolated components, the cannabinoids and their synthetic derivatives. Isolated cannabinoids will provide more reliable effects than crude plant mixtures. Therefore, the purpose of clinical trials of smoked marijuana would not be to develop marijuana as a licensed drug, but such trials could be a first step towards the development of rapid-onset, nonsmoked cannabinoid delivery systems.

RECOMMENDATION 6: Short-term use of smoked marijuana (less than six months) for patients with debilitating symptoms (such as intractable pain or vomiting) must meet the following conditions:

- failure of all approved medications to provide relief has been documented;
- the symptoms can reasonably be expected to be relieved by rapid-onset cannabinoid drugs;
- such treatment is administered under medical supervision in a manner that allows for assessment of treatment effectiveness;
- and involves an oversight strategy comparable to an institutional review board process that could provide guidance within 24 hours of a submission by a physician to provide marijuana to a patient for a specified use.

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Chapter 1. Introduction

This report summarizes and analyzes what is known about the medical use of marijuana; it emphasizes evidence-based medicine (derived from knowledge and experience informed by rigorous scientific analysis), as opposed to belief-based medicine (derived from judgment, intuition, and beliefs untested by rigorous science).

Scientific data on controversial subjects are commonly misinterpreted, overinterpreted, and misrepresented, and the medical marijuana debate is no exception. We have tried to present the scientific studies in such a way as to reveal their strengths and limitations. One of the goals of this report is to help people to understand the scientific data, including the logic behind the scientific conclusions, so it goes into greater detail than previous reports on the subject. In many cases, we have explained why particular studies are inconclusive and what sort of evidence is needed to support particular claims about the harms or benefits attributed to marijuana. Ideally, this report will enable the thoughtful reader to interpret the new information about marijuana that will continue to emerge rapidly well after this report is published.

Can marijuana relieve health problems? Is it safe for medical use? Those straightforward questions are embedded in a web of social concerns, which lie outside the scope of this report. Controversies concerning nonmedical use of marijuana spill over onto the medical marijuana debate and tend to obscure the real state of scientific knowledge. In contrast with the many disagreements bearing on the social issues, the study team has found substantial consensus, among experts in the relevant disciplines, on the scientific evidence bearing on potential medical use.

This report analyzes science, not the law. As in any policy debate, the value of scientific analysis is that it can provide a foundation for further discussion. Distilling scientific evidence does not in itself solve a policy problem. What it can do is illuminate the common ground, bringing to light fundamental differences out of the shadows of misunderstanding and misinformation that currently prevail. Scientific analysis cannot be the end of the debate, but it should at least provide the basis for an honest and informed discussion.

Our analysis of the evidence and arguments concerning the medical use of marijuana focuses on the strength of the supporting evidence, and does not refer to the motivations of people who put forth the evidence and arguments. That is, it is not relevant to scientific validity whether an argument is put forth by someone who believes that all marijuana use should be legal or by someone who believes that any marijuana use is highly damaging to individual users and to society as a whole. Nor does this report comment on the degree to which scientific analysis is compatible with current regulatory policy. Although many have argued that current drug laws pertaining to marijuana are inconsistent with scientific data, it is important to understand that decisions about drug regulation are based on a variety of moral and social considerations, as well as on medical and scientific ones.

INTRODUCTION

Even when a drug is used only for medical purposes, value judgments affect policy decisions concerning its medical use. For example, the magnitude of a drug's expected medical benefit affects regulatory judgments about the acceptability of risks associated with its use. Also, although a drug is normally approved for medical use only on proof of its "safety and efficacy," patients with life-threatening conditions are sometimes (under protocols for "compassionate use") allowed access to unapproved drugs whose benefits and risks are uncertain. Value judgments play an even more substantial role in regulatory decisions concerning drugs, such as marijuana, that are sought and used for nonmedical purposes. Then policy-makers must take into account not only the risks and benefits associated with medical use, but also possible interactions between the regulatory arrangements governing medical use and the integrity of the legal controls set up to restrict nonmedical use.

It should be clear that many elements of drug control policy lie outside the realm of biology and medicine. Ultimately, the complex moral and social judgments that underlie drug control policy must be made by the American people and their elected officials. A goal of this report is to evaluate the biological and medical factors that should be taken into account in making those judgments.

How This Study Was Conducted

Information was gathered through scientific workshops, site visits, analysis of the relevant scientific literature, and extensive consultation with biomedical and social scientists. The three 2-day workshops—in Irvine, California; New Orleans, Louisiana; and Washington, DC—were open to the public and included scientific presentations and reports, mostly from patients and their families, about their experiences with and perspectives on the medical use of marijuana. Scientific experts in various fields were selected to talk about the latest research on marijuana, cannabinoids, and related topics (listed in appendix A). The selection of the experts was based on recommendations by their peers, who ranked them among the most accomplished scientists and the most knowledgeable about marijuana and cannabinoids in their own fields. In addition, advocates for (John Morgan) and against (Eric A. Voth) the medical use of marijuana were invited to present scientific evidence in support of their positions.

Information presented at the scientific workshops was supplemented by analysis of the scientific literature, and evaluating the methods used in various studies and the validity of the authors' conclusions. Different kinds of clinical studies are useful in different ways: results of a controlled, double-blind study with adequate sample sizes can be expected to apply to the general population from which study subjects were drawn; an isolated case report can suggest further studies, but cannot be presumed to be broadly applicable; and survey data can be highly informative, but are generally limited by the need to rely on self-reports of drug use and on unconfirmed medical diagnoses. This report relies mainly on the most

relevant and methodologically rigorous studies available, and treats the results of more limited studies cautiously. In addition, study results are presented in such a way as to allow thoughtful readers to judge the results themselves.

IOM appointed a panel of nine experts to advise the study team on technical issues. These included neurology and the treatment of pain (Howard Fields), regulation of prescription drugs (J. Richard Crout), AIDS wasting and clinical trials (Judith Feinberg), treatment and pathology of multiple sclerosis (Timothy Vollmer), drug dependence among adolescents (Thomas Crowley), varieties of drug dependence (Dorothy Hatsukami), internal medicine, health care delivery, and clinical epidemiology (Eric B. Larson), cannabinoids and marijuana pharmacology (Billy R. Martin), and cannabinoid neuroscience (Steven R. Childers).

Public outreach included setting up a Web site that provided information about the study and asked for input from the public. The Web site was open for comment from November 1997 until November 1998. Some 130 organizations were invited to participate in the public workshops. Many people in the organizations—particularly those opposed to the medical use of marijuana—felt that a public forum was not conducive to expressing their views; they were invited to communicate their opinions (and reasons for holding them) by mail or telephone. As a result, roughly equal numbers of persons and organizations opposed to and in favor of the medical use of marijuana were heard from.

The study team visited four cannabis buyers' clubs in California (the Oakland Cannabis Buyers' Cooperative, the San Francisco Cannabis Cultivators Club, the Los Angeles Cannabis Resource Center, and Californians Helping Alleviate Medical Problems, or CHAMPS) and two HIV-AIDS clinics (the AIDS Health Care Foundation in Los Angeles and the Louisiana State University Medical Center in New Orleans). We listened to many individual stories from the buyers' clubs about using marijuana to treat a variety of symptoms and heard clinical observations on the use of Marinol® to treat AIDS patients. Marinol® is the brand name for dronabinol, which is Δ^9 -tetrahydrocannabinol (THC) in pill form and is available by prescription for the treatment of nausea associated with chemotherapy and AIDS wasting.

Marijuana Today

The Changing Legal Landscape

In the 20th century, marijuana has been used more for its euphoric effects than as a medicine. Its psychological and behavioral effects have concerned public officials since the drug first appeared in the southwestern and southern states during the first two decades of the century. By 1931, at least 29 states had prohibited use of the drug for nonmedical purposes.³ Marijuana was first regulated at the federal level by the Marijuana Tax Act of 1937, which required anyone producing, distributing, or using marijuana for medical purposes to register and pay a tax, and which effectively prohibited nonmedical use of the drug. Although the Act did not make medical use of marijuana illegal, it did make it expensive and inconvenient. In 1942, marijuana was removed from the U.S. Pharmacopoeia because it was believed to be a harmful and addictive drug that caused psychoses, mental deterioration, and violent behavior.

In the late 1960s and early 1970s, there was a sharp increase in marijuana use among adolescents and young adults. The current legal status of marijuana was established in 1970 with the passage of the Controlled Substances Act, which divided drugs into five Schedules and placed marijuana in Schedule I, the category for drugs with high potential for abuse and no accepted medical use (see appendix B, scheduling criteria). In 1972, the National Organization for the Reform of Marijuana Legislation (NORML), an organization which supports decriminalization of marijuana, unsuccessfully petitioned the Bureau of Narcotics and Dangerous Drugs to move marijuana from Schedule I to Schedule II. NORML argued that marijuana is therapeutic in numerous serious ailments, is less toxic, and in many cases more effective than conventional medicines.¹³ Thus, for 25 years, the medical marijuana movement has been closely linked with the marijuana-decriminalization movement, which has colored the debate. Many people criticized that association in their letters to IOM and during the public workshops of this study. The argument against the medical use of marijuana presented most often to the IOM study team is that “the medical marijuana movement is a Trojan horse”; that is, it is a deceptive tactic used by advocates of marijuana decriminalization who would exploit the public’s sympathy for seriously ill patients.

Since NORML’s petition in 1972, there have been a variety of legal decisions concerning marijuana. From 1973 to 1978, eleven states adopted statutes that decriminalized use of marijuana, although some of them recriminalized marijuana use in the 1980s and 1990s. During the 1970s, reports of the medical value of marijuana began to appear, particularly claims that marijuana relieved the nausea associated with chemotherapy. Health departments in six states conducted small studies to investigate the reports. When the AIDS epidemic spread in the 1980s, patients found that marijuana sometimes relieved their symptoms, most dramatically those associated with AIDS wasting. Over this period, a number of defendants

charged with unlawful possession of marijuana claimed that they were using the drug to treat medical conditions and that violation of the law was therefore justified (the so-called "medical necessity" defense). Although most courts rejected these claims, some accepted them.⁸

Against that backdrop, voters in California and Arizona in 1996 passed two referendums that attempted to legalize the medical use of marijuana under particular conditions. Public support for patient access to marijuana for medical use appears substantial; public opinion polls taken during 1997 and 1998 generally report 60-70 percent of respondents in favor of allowing medical uses of marijuana.¹⁵ However, those referendums are at odds with federal laws regulating marijuana, and their implementation raises complex legal questions.

Despite the current level of interest, referendums and public discussions have not been well informed by carefully reasoned scientific debate. Although previous reports have all called for more research, the nature of the research that will be most helpful depends greatly on the specific health conditions to be addressed. And while there have been important recent advances in our understanding of the physiological effects of marijuana, few of the recent investigators have had the time or resources to permit detailed analysis. The results those advances, only now beginning to be explored, have significant implications for the medical marijuana debate.

Several months after the passage of the California and Arizona medical marijuana referendums, the Office of National Drug Control Policy (ONDCP) asked whether IOM would conduct a scientific review of the medical value of marijuana and its constituent compounds. In August 1997, IOM formally began the study and appointed John A. Benson Jr. and Stanley J. Watson Jr. to serve as principal investigators for the study. The charge to IOM was to review the medical use of marijuana and the harms and benefits attributed to it (details are given in appendix C).

Medical Marijuana Legislation Among the States

The 1996 California referendum known as Proposition 215 allowed seriously ill Californians to obtain and use marijuana for medical purposes without criminal prosecution or sanction. A physician's recommendation is needed. Under the law, physicians cannot be punished or denied any right or privilege for recommending marijuana to patients who suffer from any illness for which marijuana will provide relief.

The 1996 Arizona referendum known as Proposition 200 was largely about prison reform but also gave physicians the option to prescribe controlled substances, including those in Schedule I (e.g., marijuana), to treat the disease or relieve the suffering of seriously or terminally ill patients. Five months after the referendum was passed, it was stalled when Arizona legislators voted that all prescription medications must be approved by the Food and Drug Administration, and marijuana is not so approved. In November 1998, Arizona voters passed a second referendum designed to allow physician's to prescribe marijuana as medicine, but this is still at odds with federal law.⁸

As of summer 1998, eight states—California, Connecticut, Louisiana, New Hampshire, Ohio, Vermont, Virginia, and Wisconsin—had laws that permit physicians to prescribe marijuana for medical purposes or to allow a medical necessity defense.⁸ In November 1998, five states—Arizona, Alaska, Oregon, Nevada, and Washington—passed medical marijuana ballot initiatives. The District of Columbia also voted on a medical marijuana initiative, but was barred from counting the votes because an amendment designed to prohibit them from doing so was added to the federal appropriations bill; however, exit polls suggested that a majority of voters had approved the measure.

Marijuana and Medicine

Marijuana plants have been used since antiquity for both herbal medication and intoxication. The current debate over the medical use of marijuana is essentially a debate over the value of its medicinal properties relative to the risk posed by its use.

Marijuana's use as an herbal remedy before the 20th century is well documented.^{1,10,11} However, modern medicine adheres to different standards from those used in the past. The question is not whether marijuana can be used as an herbal remedy, but rather how this remedy meets today's standards of efficacy and safety. We understand much more than previous generations about medical risks. Our society generally expects its licensed medications to be safe, reliable, and of proven efficacy, and contaminants and inconsistent ingredients in our health treatments are not tolerated. That refers not only to prescription and over-the-counter drugs, but also to the vitamin supplements and herbal remedies purchased at the grocery store. For example, the essential amino acid *L*-tryptophan was widely sold in health food stores as a natural remedy for insomnia until early 1990 when it became linked to an epidemic of a new and potentially fatal illness (eosinophilia-myalgia syndrome).^{9,12} When it was removed from the market shortly thereafter, there was little protest, despite the fact that it was safe for the vast majority of the population. The 1536 cases and 27 deaths were later traced to contaminants in a batch produced by a single Japanese manufacturer.

Although few herbal medicines meet today's standards, they have provided the foundation for modern Western pharmaceuticals. Most current prescriptions have their roots either directly or indirectly in plant remedies.⁷ At the same time, most current prescriptions are synthetic compounds that are only distantly related to the natural compounds that led to their development.. Digitalis was discovered in foxglove, morphine in poppies, and taxol in the yew tree. Even aspirin (acetylsalicylic acid) has its counterpart in herbal medicine: for many generations, American Indians relieved headaches by chewing the bark of the willow tree, which is rich in a related form of salicylic acid.

Although plants continue to be valuable resources for medical advances, drug development is likely to be less and less reliant on plants and more reliant on the tools of modern science. Molecular biology, bioinformatics software, and DNA array-based analyses of genes and chemistry are all beginning to yield great advances in drug discovery and development. Until recently, drugs could only be *discovered*; now they can be *designed*. Even the discovery process has been accelerated through the use of modern drug screening techniques. It is increasingly possible to identify or isolate the chemical compounds in a plant, determine which compounds are responsible for the plant's effects, and select the most effective and safe compounds—either for use as purified substances or as tools to develop even more effective, safer, or less expensive compounds.

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Yet even as the modern pharmacological toolbox becomes more sophisticated and biotechnology yields an ever greater abundance of therapeutic drugs, people increasingly seek alternative, low-technology therapies.^{4, 5} In 1997, 46 percent of Americans sought nontraditional medicines and spent over 27 billion unreimbursed dollars; the total number of visits to alternative medicine practitioners appears to have exceeded the number of visits to primary care physicians.^{5, 6} Recent interest in the medical use of marijuana coincides with this trend toward self-help and a search for “natural” therapies. Indeed, several people who spoke at the IOM public hearings in support of the medical use of marijuana said that they generally preferred herbal medicines to standard pharmaceuticals. However, few alternative therapies have been carefully and systematically tested for safety and efficacy, as is required for FDA-approved medications.²

Who Uses Medical Marijuana?

There have been no comprehensive surveys of the demographics and medical conditions of medical marijuana users, but a few reports provide some indication. In each case, survey results should be understood to reflect the situation in which they were conducted and are not necessarily characteristic of medical marijuana users as a whole. Respondents to surveys reported to the IOM study team were all members of “buyers’ clubs,” organizations that provide their members with marijuana, although not necessarily through direct cash transactions. The atmosphere of the marijuana buyers’ clubs ranges from that of the comparatively formal and closely regulated Oakland Cannabis Buyers’ Cooperative to that of a “country club for the indigent,” as Dennis Peron described the San Francisco Cannabis Cultivators Club (SFCCC), which he directed.

John Mendelson, an internist and pharmacologist at the University of California, San Francisco (UCSF) Pain Management Center, surveyed 100 members of the SFCCC who were using marijuana at least weekly. Most of the respondents were unemployed men in their forties. Subjects were paid \$50 to participate in the survey; this might have encouraged a greater representation of unemployed subjects. All subjects were tested for drug use. About half tested positive for marijuana only; the other half tested positive for drugs in addition to marijuana (23% for cocaine and 13% for amphetamines). The predominant disorder was AIDS, followed by roughly equal numbers of members who reported chronic pain, mood disorders, and musculoskeletal disorders (table 1.1).

Table 1.1 Self-Reported Disorders Treated with Marijuana by Members of San Francisco Cannabis Cultivators Club

Disorder	Number of Subjects
HIV	60
Musculoskeletal disorders and arthritis	39
Psychiatric disorders (primarily depression)	27
Neurological disorders and nonmusculoskeletal pain syndromes	9
Gastrointestinal disorders (most often nausea)	7
Other disorders glaucoma, allergies, nephrolithiasis, and the skin manifestations of Reiter syndrome	7
Total disorders	149
Total number of respondents	100

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The membership profile of the San Francisco club was similar to that of the Los Angeles Cannabis Resource Center (LACRC), where 83% of the 739 patients were men, 45% were 36-45 years old, and 71% were HIV-positive. Table 1.2 shows a distribution of conditions somewhat different from that in SFCCC respondents, probably because of a different membership profile. For example, cancer is generally a disease that occurs late in life; 34 (4.7%) of LACRC members were over 55 years old; only 2% of survey respondents in the SFCCC study were over 55 years old.

Jeffrey Jones, executive director of the Oakland Cannabis Buyers' Cooperative, reported that its largest group of patients is HIV-positive men in their forties. The second largest group is patients with chronic pain.

Among the 42 people who spoke at the public workshops or wrote to the study team, only six identified themselves as members of marijuana buyers' clubs. Nonetheless, they presented a similar profile: HIV-AIDS was the predominant disorder, followed by chronic pain (table 1.3). All HIV-AIDS patients reported that marijuana relieved nausea and vomiting and improved their appetite. About half the patients who reported using marijuana for chronic pain also reported that it reduced nausea and vomiting.

Table 1.2 Self-Reported Disorders Treated with Marijuana by Members of Los Angeles Cannabis Resource Center (LACRC) According to Center Staff^a

Treated Disorder	Number of Subjects	Percent of Subjects
HIV ^b	528	71
Cancer	40	5.4
Terminal cancer	10	1.4
Mood disorders (depression)	4	0.5
Musculoskeletal (multiple sclerosis, arthritis)	30	4.1
Chronic pain and back pain	33	4.5
Gastrointestinal	17	2.3
Neurological disorders (epilepsy, Tourette syndrome, brain trauma)	7	0.9
Seizures or migraine ^c	13	1.8
Glaucoma	15	2.0
Miscellaneous	42	5.7
Total number	739	100

^a Results are based on review of 739 individual records by LACRC staff members. In contrast with Mendelson's survey of SFCCC (table 1.1), only the primary disorder is indicated here. Membership in LACRC is contingent on a doctor's letter of acknowledgment, but diagnoses are not independently confirmed.

^b HIV patients use marijuana to control nausea, increase appetite (to combat wasting), and relieve gastrointestinal distress caused by AIDS medications. These uses are not indicated separately.

^c As described by LACRC staff; some of these cases might also be neurological disorders.

^d Because of rounding error, percentages do not add up to 100.

Table 1.3 Summary of Reports to IOM Study Team by 43 Individuals

Symptoms	Dominant Disease	Symptoms	Dominant Disease
Anorexia, nausea, vomiting	AIDS	Pain	Migraine
	AIDS		Injury
	AIDS		Injury
	AIDS		Epilepsy and Postpolio syndrome
	AIDS		Trauma and epilepsy
	AIDS		Degenerative disk disease
	AIDS		Rheumatoid arthritis
	AIDS and cancer		Nail-patella syndrome
	Cancer		Reflex sympathetic dystrophy
	Testicular cancer		Gulf War chemical exposure
	Cancer and multiple sclerosis		Multiple congenital cartilaginous exostosis
	Thyroid condition*		Histiocytosis X
	Migraine	Muscle spasticity	Spasticity*
Mood disorders	Wilson's disease		Multiple sclerosis
	Depression		Multiple sclerosis
	Depression		Multiple sclerosis
	Depression and anxiety		Paralysis
	Depression and anxiety		Spinal-cord injury
	Manic depression		Spasmodic torticollis
	Manic depression	Intraocular pressure	Glaucoma
	Posttraumatic stress		
	Premenstrual syndrome	Diarrhea	Crohn's disease

Table 1.3. This table lists the people who reported to the IOM study team during the public workshops, or through letters, that they use marijuana as medicine; it should not be interpreted as a representative sample of the full spectrum of people who use marijuana as medicine. Each dominant disease represents an individual report.

* Not specified.

Table 1.4 Primary Symptoms of 43 Individuals who Reported to IOM Study Team

Primary Symptom	Symptom Frequency		Multiple Symptoms	
	Number of Reports ^f	% of Total Symptoms Reported	Number who Reported (Primary) Additional Symptoms	% of those who reported Primary Symptoms
Anorexia, nausea, vomiting	21	31	13	62
Diarrhea	4	6	3	75
Intraocular pressure	2	3	1	50
Mood disorders	12	18	7	58
Muscle spasticity	12	18	7	58
Pain	16	24	13	81
Totals	67		44	66

^f Forty-three persons reporting; 20 reported relief from more than one symptom.

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Note that the medical conditions referred to are only those reported to the study team or to interviewers; they cannot be assumed to represent complete or accurate diagnoses. Michael Rowbotham, a neurologist at the UCSF Pain Management Center, noted that many pain patients referred to that center arrive with incorrect diagnoses or with pain of unknown origin. At that center, the patients who report medical benefit from marijuana report that marijuana does not reduce their pain but enables them to cope with it.

Most—not all—people who use marijuana to relieve medical conditions have previously used it recreationally. An estimated 95% of the LACRC members had used marijuana before joining the club. It is important to emphasize the absence of comprehensive information on marijuana use before its use for medical conditions. Frequency of prior use almost certainly depends on many factors, including membership in a buyers' club, membership in a population sector that uses marijuana more often than others (for example, men 20-30 years old), and the medical condition being treated with marijuana (for example, there are probably relatively fewer recreational marijuana users among cancer patients than among AIDS patients).

Patients who reported their experience with marijuana at the public workshops said that marijuana provided them with great relief from symptoms associated with disparate diseases and ailments, including AIDS wasting, spasticity from multiple sclerosis, depression, chronic pain, and nausea associated with chemotherapy. Their circumstances and symptoms were varied, and the IOM study team was not in a position to make medical evaluations or confirm diagnoses. Three representative cases presented to the IOM study team are presented here; the stories have been edited for brevity, but each case is presented in the patient's words and with the patient's permission.

Boxes 1.1-1.3: Selected Cases From the Public Sessions

G.S. spoke at the IOM workshop in Louisiana about his use of marijuana first to combat AIDS wasting syndrome and later for relief from the side effects of AIDS medications.

Skin rashes, dry mouth, foul metallic aftertaste, numbness of the face, swelling of the limbs, fever spikes, headaches, dizziness, anemia, clinical depression, neuropathy so crippling that I could not type, so painful that the bed sheets felt like sandpaper, nausea so severe that I sometimes had to leave the dinner table to vomit, and diarrhea so unpredictable that I dared not leave the house without diapers.

These are some of the horrors that I endured in the last 10 years during my fight for life against the human immunodeficiency virus. But these ravages were not caused by HIV itself, or by any of the opportunistic infections that mark the steady progression of AIDS. Each of these nightmares was a side effect of one of the hundreds of medications I have taken to fight one infection after another on my way to a seemingly certain early grave.

Had you known me three years ago, you would not recognize me now. After years of final-stage AIDS, I had wasted to 130 lb. The purple Kaposi's sarcoma lesions were spreading. The dark circles under my eyes told of sleepless nights and half-waking days. I encountered passages of time marked by medication schedules, nausea, and diarrhea. I knew that I was dying. Every reflection shimmered with death, my ghost-like pallor in the mirror, the contained terror on the face of a bus passenger beside me, and most of all, the resigned sadness in my mother's eyes.

But still I was fortunate because along the way I rediscovered the ancient understanding of marijuana's medicinal benefit. So I smoked pot. Every day. The pot calmed my stomach against handfuls of pills. The pot made me hungry so that I could eat without a tube. The pot eased the pain of crippling neural side effects so that I could dial the phone by myself. The pot calmed my soul and allowed me to accept that I would probably die soon. Because I smoked pot I lived long enough to see the development of the first truly effective HIV therapies. I lived to gain 50 lb, regain my vigor, and celebrate my 35th birthday. I lived to sit on the bus without frightening the passenger beside me.

Even at this stage of my recovery, I take a handful of pills almost every day, and will probably continue to do so for the rest of my life. While I am grateful for the life-saving protease-inhibitor therapies, they bring with them a host of adverse reactions and undesirable side effects. Different patients experience different reactions, of course, but almost all patients experience some. Smoking marijuana relieves many of these side-effects.

I am not one of the exceptional eight patients in the United States with legal permission to smoke marijuana. Every day I risk arrest, property forfeiture, fines, and imprisonment. But I have no choice, you see, just as I have no choice but to endure the side effects of these toxic medications. So many patients like me are breaking the law to enjoy relief that no other therapy provides.

I sit here, I believe, as living proof that marijuana can have a beneficial effect in staving off wasting. Every pound was a day. I figured that for every pound of body weight I could maintain, that was another day that I could live in hopes that some effective therapy would emerge.

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B.D. spoke at the IOM workshop in Louisiana. She is one of eight patients who are legally allowed to smoke marijuana under a Compassionate Use Protocol. She uses marijuana to relieve nausea, muscle spasticity, and pain associated with multiple sclerosis.

I was diagnosed with multiple sclerosis in 1988. Prior to that, I was an active person with ballet and swimming. I now have a swimming pool, so I swim each and every day, and I smoke marijuana. The government has given me the marijuana to smoke. Each month, I pick up a can filled with the marijuana cigarettes rolled by the government.

At one time, I weighed 85 lb and I now weigh 105. Twenty pounds is quite a bit to put on. I could not walk. I did not have the appetite. I use a scooter now for distance. I can get around the house. I have a standard poodle who is kind of like an assistant dog. She is good at it. She helps me.

When I found out that there was a program to get marijuana from the government, I decided that was the answer. I was not a marijuana-smoker before that. In fact, I used to consider the people I knew who smoked the marijuana as undesirables. Now, I myself am an undesirable.

But it works. It takes away the backache. With multiple sclerosis, you can get spasms, and your leg will just go straight out and you cannot stop that leg. You may have danced all of your life and put the leg where you wanted it to be, but the MS takes that from you. So I use the swimming pool, and that helps a lot. The kicks are much less when I have smoked a marijuana cigarette. Since 1991, I've smoked 10 cigarettes a day. I do not take any other drugs. Marijuana seems to have been my helper. At one time, I did not think much of the people who smoke it. But when it comes to your health, it makes a big difference.

J.H. spoke at the IOM workshop in Washington, DC. He was seriously injured in an accident, suffers from a form of arthritis associated with abnormal activity of the sympathetic nervous system known as reflex sympathetic dystrophy, and has hepatitis C. He uses marijuana to relieve nausea from liver disease, pain, and muscle spasms.

I am 48 years old, married with two children. I am a veteran who served during the Vietnam War. I was exposed to hepatitis C in 1972 by a blood transfusion, which I needed because of a motor-vehicle accident that broke my back, ruined my right shoulder, my left thumb, and hand, and almost amputated my right leg at the knee. My hepatitis C was not diagnosed until 1997—after the disease had destroyed my pancreas⁹ and I had four heart attacks, one angioplasty, and a minor stroke. In 1989, while at work, I was involved in an accident with a large soil-survey auger. My pelvis was crushed, and serious nerve damage was the result. I also have reflex sympathetic dystrophy, which is a neurological disease that has a tremendous amount of pain and muscle spasms.

I have reached what the doctors call 'end-stage liver disease from the hepatitis C. I have lost 85 lbs due to the severe bouts of nausea and vomiting. Every time I come home from a hospital stay, my 7-year-old asks if I got the liver transplant. I am on a transplant list, but I am not a candidate until I am seven days from death.

In October 1997, after trying four different antinausea medications, four of the doctors that I see told me to go to Europe and see a doctor and try medicinal cannabis. My primary-care doctor wrote me a letter to carry with my medical records asking that the doctor help me in any way that he can to alleviate the symptoms of the hepatitis C and the reflex sympathetic dystrophy. Those symptoms are severe nausea and pain from the hepatitis C and pain and muscle spasms from the neurological disease.

I went to Europe in November 1997, where I saw a doctor of internal medicine. He prescribed me cannabis, 1-2 g a day. I got the medicine and a pipe and tried it. Within two minutes of taking two puffs from the pipe, the nausea was gone. I don't think that I felt the high, although I was quite elated. In about 45 min., I was starving. Normally, I have a fear of eating because I vomit almost always after I eat or take a pill. I forgot about that, and I think I ate more that night than I had eaten in months. I did feel a little nauseated after about four hours, but I smoked two more puffs, and in about two hours I went to bed. The next morning, I felt hungry. During my nine-day stay in Europe, I was able to stay free of vomiting and the waves of nausea became less frequent.

I had experienced four years of pain control using Tegretol®, a drug used by epileptics to control seizures. Now, I can't use that medication because of the damage that it causes to my cirrhotic liver. When I smoked about two grams of marijuana a day, the nausea was gone and I was no longer losing weight. The pain was at an acceptable level. Sometimes, I still find it necessary to use an opiate pain-killer, but only when the pain is at its worst. Surprisingly, I lost an associated high within a few days. I also think the cannabis has an antidepressant effect on me, as I no longer have what I call the "poor me" feelings that I experienced after learning about the hepatitis C.

⁹ This is an unlikely consequence of hepatitis C; it is more likely that the patient's liver was damaged.

The variety of stories presented left the study team with a clear view of people's beliefs about how marijuana had helped them. But this collection of anecdotal data, although useful, is limited. We heard many positive stories, but no stories from people who had tried marijuana but found it ineffective. This is a fraction with an unknown denominator. For the numerator, we have a sample of positive responses; for the denominator, we have no idea of the total number of people who have tried marijuana for medical purposes. Hence, it is impossible to estimate the clinical value of marijuana or cannabinoids in the general population based on anecdotal reports. Marijuana clearly seems to relieve some symptoms for some people—even if only as a placebo effect. But what is the balance of harmful and beneficial effects? That is the essential medical question that can be answered only by careful analysis of data collected under controlled conditions.

Cannabis and the Cannabinoids

Marijuana is the common name for *Cannabis sativa*, a hemp plant that grows throughout temperate and tropical climates. The most recent review of the constituents of marijuana lists 66 cannabinoids (table 1.5).¹⁶ But that does not mean that there are 66 different cannabinoid effects or interactions. Most of the cannabinoids are closely related; they fall into only 10 groups of closely related cannabinoids, many of which differ by only a single chemical moiety and might be midpoints along biochemical pathways—that is, degradation products, precursors, or byproducts.^{16, 18} Δ^9 -tetrahydrocannabinol (Δ^9 -THC) is the primary psychoactive ingredient; depending on the particular plant, either THC or cannabidiol is the most abundant cannabinoid in marijuana (figure 1.1). Throughout this report, THC is used to indicate Δ^9 -THC. In the few cases where variants of THC are discussed, the full names are used. All the cannabinoids are lipophilic—they are highly soluble in fatty fluids and tissues but not in water. Indeed, THC is so lipophilic that it is aptly described as “greasy”.

Throughout this report, *marijuana* refers to unpurified plant extracts, including leaves and flower tops, regardless of how they are consumed—whether by ingestion or by smoking. References to the effects of marijuana should be understood to include the composite effects of its various components; that is, the effects of THC are included among the effects of marijuana; but not all the effects of marijuana are necessarily due to THC. Discussions concerning *cannabinoids* refer only to those particular compounds and not to the plant extract. This distinction is important; it is often blurred or exaggerated.

Cannabinoids are produced in epidermal glands on the leaves (especially the upper ones), stems, and the bracts that support the flowers of the marijuana plant. Although the flower itself has no epidermal glands, it has the highest cannabinoid content anywhere on the plant, probably because of the accumulation of resin

secreted by the supporting bracteole (the small, leaf-like part below the flower). The amounts of cannabinoids and their relative abundance in a marijuana plant vary with growing conditions, including humidity, temperature, and soil nutrients (reviewed in Pate 1994¹⁴). The chemical stability of cannabinoids in harvested plant material is also affected by moisture, temperature, sunlight, and storage. They degrade under any storage condition.

Figure 1.1 Cannabinoid Biosynthesis

Figure legend: Arrows indicate cannabinoid biosynthesis pathway; dark arrows indicate established pathways, the light gray arrow indicates a probable, but not well established, pathway (R. Mechoulam, personal communication, 1999).¹⁷ The great majority of studies reporting on effects of cannabinoids refer to THC; most of the rest are about CBD and CBN. Other cannabinoids found in marijuana do not appear to play an important role in effects of marijuana.