- Add requirement in Sec. 5 (d) that an employee must disclose to the employer the use of medical marijuana. This would provide the employer information in order to evaluate whether the employee can safely perform his or her job function. The employer would have the option to reassign the employee to a less "safety sensitive" job function.

We appreciate you providing us the opportunity to comment. Please let me know if I can be of further assistance with comments on legislation or in-person testimony before the legislature on this issue. We continue to provide updated information to our customers on this issue who make-up much of the Alaska business sector and who are concerned about the influence of the marijuana law on the workplace.

Sincerely,

Matthew Fagnani, C-SAPA
President

Cc: Representative Lisa Murkowski

Representative Joe Green

Representative Fred Dyson

Subject: Re: "medical marijuana"
Date: Tue, 06 Apr 1999 16:04:52 -0800
From: Senator Loren Leman <Senator_Loren_Leman@legis.state.ak.us>
Organization: Alaska Legislature
To: Brian Trimble <trimble@alaska.net>

Brian Trimble wrote:

> *Dear Senator Leman,*
> *It was a pleasure seeing you recently. I am writing to tell you that I*
> *appreciate your efforts to clarify the "medical marijuana" statute. As a*
> *physician, I recognize the potential for rampant abuse of this statue.*
> *Although you are attracting opposition, please persist in well doing. Brian*
> *Trimble, MD*
>

Subject: Re: SB 94
Date: Tue, 30 Mar 1999 21:20:18 -0900
From: Senator Loren Leman <Senator_Loren_Leman@legis.state.ak.us>
Organization: Alaska Legislature
To: gkwbrown@alaska.net
CC: Mike Pauley <Mike_Pauley@legis.state.ak.us>

Gerald KW Brown wrote:

> *Dear Senator Leman, 3/30/99*
>
> *As a pharmacist, I see no provisions or directions given by the state as to how to provide this marjiuana to the eligible recipents. Since there must be a physcian-patient relationship and a prescription must be given, who and how will that prescription be filled. Who will fill it and how will that pharmacy procure said marijuana for said prescription. Will the patient be able to grow it for themselves only? This would seen hard to control illicit use and determine the difference between licit and illict use. Or they may opt to go the their local pharmacist and request a prescription be filled. Has the State Board of Pharmacy been given a statute directives to establish regulations to govern the acts of pharmacist and pharmacies concerning marijuana distribution in the State of Alaska?*
>
> *If you have and questions, or would like to dicuss further and ideas please feel free to contact me at*
>
> *Gerald KW Brown, pharmacist*
> *Professional Pharmacy*
> *1001 Noble St*
> *Fairbanks, Alaska*
> *99701*
> *907-452-2556(W)*
> *907-451-8314(F)*
> *907-457-7001(H)*
> *gkwbrown@alaska.net*
>
> *--*
> *G KW Brown*

Subject: Medical Marijuana
Date: Tue, 23 Mar 1999 20:44:59 -0500 (EST)
From: "Damien Stella" <dstella@alaskalife.net>
To: "Representative Ethan Berkowitz" <Representative_Ethan_Berkowitz@legis.state.ak.us>
CC: "Senator Loren Leman" <Senator_Loren_Leman@legis.state.ak.us>

Yes, I am one of the people that voted against this measure. Having lost a brother to a drug related suicide, I can tell you I believe that this is a big mistake. Why?

Containment: There will be no (more) effective means of ensuring that only those with a "legal need" have access to and use marijuana than there is for keeping beer out of the hands of teenage boys. This "foothold" measure will increase the availability of marijuana and will certainly paint an image of acceptability to our youth.

Delivery: That we can put a man on the moon, increases my disbelief that we cannot isolate the active ingredient in "hooch" and put it in a pill. Kill the pain and kill the patient with 20 times the tar content of a tobacco cigarette in each joint. C'mon, get real.

Control: If we made this a true prescription medication in pill form we could dispense it from pharmacies. What a concept! Imagine the ability to target the users with a legal, regulated, medication, just like the thousands doctors prescribe every day.

Mr. Berkowitz: I am unsure of your position on this issue. I know the Senator's and I think you now know mine. Please consider your vote carefully when this issue comes before the house.

Oh, perhaps you would take a moment to respond to THIS message. I'd hate to think this is falling on deaf ears.

Damien Stella
4011 Romanzof Circle
Anchorage, AK 99517-1417
dstella@alaskalife.net

April 28, 1999

Senate HESS COMMITTEE

Dear Senators:

My name is Mary Ann Pease and I would like to take this opportunity to urge the Senate HESS Committee to approve SSSB94. The proposed changes that have been requested by the Department of Public Safety and other law enforcement agencies are in the best interest of the citizens of Alaska.

The requirement for registration with the Department of Health and Social Services, as well as access to the registry information, are well needed protections for the medical marijuana patients as well as the general public. Additionally, the establishment of FIRM possession limits is imperative as compared to the "loosey-goosey" language in the Medical Marijuana amendment that merely refers to "medically justified limits."

It is also important to note for the record that the Chief of Police has testified before the Legislature that the lack of a registration requirement and the absence of firm possession limits in the new law will make it difficult for the law enforcement to distinguish between legitimate and illegal users of marijuana. Even the possibility of confusion by law enforcement personnel makes it imperative that the legislature enact SB94 with the tightened security provisions.

One of the most important provisions in SB94 is the closing of numerous loopholes. As a mother, business person and concerned citizen, I am adamantly opposed to any law containing loopholes that could possibly allow marijuana to be smoked in public places, on school grounds, on a school bus, in prisons or at the workplace. Again, the closing of these loopholes is extremely important and SB94 does just that.

In conclusion, I urge the Senate HESS COMMITTEE and the legislature to enact this legislation to amend the medical marijuana law with the current provisions contained in SB94, namely registration requirements, access to registry information, possession limits, limitations on primary care givers, consideration for marijuana alternatives and the closure of onerous loopholes.

RESOLUTION FOLLOWS:

Resolution No. 6

A Resolution Concerning the Marijuana law

By Alaska Federation of Republican Women

In session April 30 – May 1, 1999, Juneau, AK

WHEREAS, Alaskans must safeguard our children from influences of drugs and other harmful chemicals, and

WHEREAS, Alaska must aggressively pursue the "War on Drugs"

NOW, THEREFORE BE IT RESOLVED that the Alaska Federation of Republican Women urges the Alaska Legislature to carefully craft and develop law that will limit the use of marijuana for medicinal purposes only.

Passed this 1st day of May, 1999 in Juneau, Alaska

_____

Pauline Martens, President

Alaska Federation of Republican Women

_____

Eileen VanWyhe, Secretary

Alaska Federation of Republican

The Republican Party of Alaska

Tom McKay, Chairman

REPUBLICAN PARTY OF ALASKA
RESOLUTION 99-001

APR 26 1999

WHEREAS marijuana is an illegal substance which has harmful effects on our communities ranging from increased crime to homicide; and

WHEREAS the American Medical Association recently issued reports stating that smoking marijuana has dubious, if any, medical benefits, and many dangerous side effects; and

WHEREAS the Food and Drug Administration has not approved marijuana as a safe, effective or legal drug; and

WHEREAS the marijuana black market presents a burgeoning and expensive problem for Alaska's communities, law enforcement and local government; and

WHEREAS the potential for rampant corruption and abuse of Alaska's medical marijuana law exists while in its present form; and

WHEREAS for the past decade extensive national efforts and millions of dollars have been expended to teach our children that illegal drug use is wrong, undesirable and dangerous; and

WHEREAS the passage of the initiative in its present form sends a terrible message to our children that smoking marijuana has legitimate medical benefit and is socially redeemable; and

WHEREAS the medical marijuana initiative passed by Alaska voters on November 3, 1998, has serious flaws and loopholes publicly acknowledged by its leading proponent, David Finklestein, which ultimately jeopardizes law enforcement efforts against illegal drug use, production and sale; and

WHEREAS SB 94 has been introduced by Senator Loren Leman in the Alaska Senate, and a companion bill will soon be introduced in the Alaska House by Representative Fred Dyson, to close loopholes and fix flaws to the medical marijuana law.

THEREFORE LET IT BE RESOLVED THAT the Republican Party of Alaska fully supports efforts by Senator Leman, Representative Dyson, and others to fix dangerous flaws to the medical marijuana law.

DATED this 17th day of April, 1999 in Valdez, Alaska.

Tom W. [illegible]

Tom McKay, Chairman

1001 W Fireweed Lane, Anchorage AK 99503 • 907-276-4467 • 907-276-0425 (fax)

Mary Wilber

3542 Carpenter Circle
Anchorage, AK 99517-2316

(907) 248-9868 Fax (907) 243-9868 *email: wilberdm@alaska.net*

April 19, 1999

Senator Loren Leman
Juneau, AK
Fax (907) 465-3810

REF: Support of SB 94: Revocation of Marijuana Law

Dear Senator Loren Leman:

This law was not thought through from the beginning. I personally feel it is a law to re-legalize marijuana under a pretense of "For Medical Use". It is questionable whether marijuana is medically beneficial and could be controlled for this use.

This law does not clearly define "debilitating conditions" and I personally feel that the verbiage of debilitating conditions was used as a sympathy platform without regard to the patient with true debilitating condition.

I don't feel that research on substance abuse and what impact the legalizing of a potentially uncontrollable substance, like marijuana, would have on that issue let alone what long term impact it may have on a patient.

I am sure that there are other illegal substance users that would like to have their drug of choice legalized also. I am also sure other substance abusers feel they have the right to argue that they need their drug of choice legalized so they too can continue "their" quality of life, which encompasses a debilitating condition.

As for a cancer treatment alternative; I am a cancer patient and have been among the ranks of the critically ill and as a result of cancer surgery and treatments I have developed a debilitating condition called Lymphedema. Lymphedema is a progressive non curable condition which alters ones life considerably for the rest of their life. From a patients point of view; I do not think this law was directed as a true benefit for the patient. I feel strongly about this issue and will help your efforts in what ever way I can.

My suggestion to the Alaskans for Medical Rights was to spend more effort on dealing directly with causes, conditions and cures of debilitating diseases instead of trying to mask symptoms.

I have sent my 50 word opinion to the Legislative Opinion line also.

Thank you for your interest on this issue.

Sincerely,
Mary Wilber

2356 Sonstrom Dr.
Anchorage, AK 99517
243-0644

MAR 22 1999

March 17, 1999

Letters
Anchorage Daily News
P. O. Box 149001
Anchorage, AK 99514

Recent issues of the News have carried articles on bills that, if enacted, would make the Medical Marijuana Initiative workable. As it stands, the law merely requires a doctor's recommendation if the patient might benefit from medical use of marijuana, if the patient has a degenerative condition.

What is a recommendation?

How many doctors have sufficient knowledge of marijuana's pain – relieving effects? Where will the patients legally acquire the marijuana? How much is a recommended dose?

From other articles in the News, over the past few years, it appears that marijuana grown in different areas is of varying strength. What strength marijuana does the law consider?

Before the Medical Marijuana Initiative takes effect, some of these questions should be answered. Senator Leman has proposed possible answers. Anyone who can suggest suitable modifications should write the Senator at his Juneau office.

Sincerely yours,

George R. Schmidt

Beowulf Drug Education Consulting

Post Office Box 32043
Juneau, Alaska 99803
(907) 586-9088

May 6, 1999

Senator Fred Dyson
Alaska State Legislature
State Capitol (MS 3100)
Juneau, AK 99801-1182

Dear Representative Dyson,

Thank you for the opportunity to testify in support of House Bill 213 on May 4, 1999. I believe this bill makes significant progress toward realistic implementation of Ballot Measure 8, which permits medicinal use of marijuana. With this letter, I would like to add further detail to some points I mentioned in my testimony on May 4.

I do not support legalized use of medicinal marijuana in its crude form, however, I respect the will of the people through their vote in favor of Ballot Measure 8. I realize that Alaska's health and public safety agencies are in the very difficult position of administering and regulating an activity which remains a crime under federal law. Measure 8 is fraught with implications for all of the regulatory and service agencies involved, federal agencies, employers, medicinal marijuana users, and other citizens who have no direct involvement with medicinal marijuana. House Bill 213 and Senate Bill 94 make significant strides toward implementation and regulation of Measure 8, but much room for abuse of the medicinal marijuana privilege remains.

An area of potential abuse is the combined amount of dried marijuana and live plants which may be possessed legally. These amounts, allowing for possession of one ounce plus six live plants, three of which may be producing usable marijuana, permit possession and cultivation of quantities well in excess of that which is medically necessary. Marijuana grown under optimum conditions can produce a pound or more per plant. With cultivation of marijuana legalized, there is no reason to think plants would not be grown under optimum conditions. Marijuana plants mature within four months, permitting three crops per year.

An average marijuana cigarette contains .5 gram of marijuana. The "therapeutic" effect lasts two hours, or much longer with high quality marijuana. A generous estimate says that a person would use 6 grams per day, smoked at two hour intervals over a twenty-four hour period. A one ounce supply of marijuana, equivalent to about 28 grams, would provide benefits for four days (rounded down for simplicity). A more realistic estimate says that marijuana would be smoked every two hours over a sixteen hour period, with the one ounce supply lasting seven days.

If only half of the six plants produced a pound of usable material, the plants would yield nine pounds of marijuana, while the total amount needed for the year, using the generous twenty-four hour formula, is 5.69 pounds. I have overestimated the amount of medically necessary marijuana

and underestimated the productivity of the plants to demonstrate the significant difference between the two. A patient or caregiver could easily produce twice as much marijuana as would be needed for medical purposes. Clearly, this provides a substantial opportunity for abuse of the law.

My other concern follows the adage "law without enforcement is merely good advice." The law must not be so ambiguous that an officer is unable to clearly identify the elements which constitute a violation of the law. Citizens must also be able to understand what behavior is legal or illegal. Measure 8 opens a floodgate of potential for widespread use and abuse of marijuana, beyond the illegal acts which occur regardless of the law. SB 94 and HB 213 provide essential requirements and clarification for the medicinal marijuana law. Until such time as the component chemicals in marijuana are tested and evaluated for medical efficacy by the Food and Drug Administration, jurisdictions permitting medical use of the crude plant material will face many challenges to separate lawful and unlawful use. Ultimately, the responsibility for enforcement will fall to individual officers on the street who will struggle with delineating an increasingly blurry line between legal and illegal marijuana use and possession.

I encourage the Alaska legislature to do everything possible to protect the interests of all Alaskans, and to the greatest extent possible, limit the damaging effects of substance abuse in our society.

Sincerely,

/s/ Sherrie A. Myers
Owner, Beowulf Drug Education Consulting

cc: Senator Loren Leman

SENATOR LOREN LEMAN

Northwest Anchorage

716 W 4th Ave, Suite 520, Anchorage, AK 99501 (907) 258-8189
Session: State Capitol, Juneau, AK 99801 (907) 465-2095
Web Site: http://www.akrepublicans.org/Leman.htm
Email: Senator_Loren_Leman@legis.state.ak.us

MEMORANDUM

TO: MEMBERS, SENATE HESS COMMITTEE

FROM: SENATOR LOREN LEMAN

DATE: APRIL 26, 1999

RE: SB 94 – MEDICAL MARIJUANA LEGISLATION

I commend to your attention the attached letter from Alaska business leaders supporting SB 94, legislation I have introduced to improve the medical marijuana law.

The following individuals are signatories to the letter:

Matthew Fagnani, Worksafe, Inc. & President-elect, AK Support Industry Alliance
Bob Tallent, Doyon Universal Services
Robert Dickson, Esq., Atkinson Conway
Keith Burke, Natchiq, Inc..
Greg Champion, InterAlaska Hotels, Inc. (dba Sheraton Alaska)
Lowell Humphrey, Kanas Telecom, Inc.
Maynard Tapp, Hawk Consultants
Randy Ruedrich, Arctic E&P Advisors
Bob Southall, Anchorage Hilton
Bob Stinson, Conam Construction Company
Basil Stewart, Arctic Controls, Inc.
Scott Hawkins, Alaska Supply Chain Int., LLC
Mick Brogan, Brogan & Associates
Ray Latchem, Fairbanks Natural Gas
John Rense, NANA Development Corporation
Shaun Pfeiffer, Alaska Sales & Service
Ann Robinson, Alaska Sales & Service

WORKSAFE, Inc.
OCCUPATIONAL HEALTH & SAFETY

4/21/99

Dear House and Senate Legislators:

We are writing in support of CS for Senate Bill 94, sponsored by Senator Leman, relating to medical use of marijuana. As employers in Alaska, we are concerned about the potential of having an employee in the workplace under the influence of marijuana. For the past decade, great strides has been made in workplace safety to the benefit of both the employee and employer. Research has shown that marijuana impairs coordination and judgment, which can contribute to the cause of accidents.

The Alaska Statute approved by voters does not differentiate between on the job and off the job use of marijuana. Research has shown that the use of marijuana even off-the-job has been found to have a long term physical and mental residual effects on workplace performance. We encourage the Alaska Legislature to do what is in its power to assist us in continuing to provide a safe work environment for our employees and the public we serve.

Sincerely,

Matthew Fagnani, President

Other Alaskan Employers Below:

Bob Stevens
CONAM Construction Company

Arctic Controls, Inc.

Scott Hawkins
AK Supply Chain Int., LLC

Alaska Budget & Assoc.

Fairbanks Natural Gas

NANA Development

Kinross Anchorage

Hawk Consultants

Kenai Telecom, Inc.

Natchiq Inc.

Interior Alaska Hotels Inc., dba Sheraton

Arctic E+P Advisors

Bristol Bay

(continued)

- Other Alaskan Employers Below:

Asst. Gen Mgr	Alaska Sales + Svc
Human Relations	Alaska Sales + Svc

SENATOR LOREN LEMAN

Northwest Anchorage

716 W 4th Ave, Suite 520, Anchorage, AK 99501 (907) 258-8189
Session: State Capitol, Juneau, AK 99801 (907) 465-2095
Web Site: http://www.akrepublicans.org/Leman.htm
Email: Senator_Loren_Leman@legis.state.ak.us

Sectional Analysis – CS for SSSB 94 (HES)

"An Act relating to the medical use of marijuana; and providing for an effective date."

The following is a sectional analy is of CS for Sponsor Substitute for Senate Bill 94 (HES) (draft #1-LS0524\M), introduced on April 21, 1999. SSSB 94 proposes several amendments to AS 17.37.010 – 17.37.070, the "Medical Uses of Marijuana for Persons Suffering from Debilitating Medical Conditions Act," approved by voters as "Ballot Measure No. 8" in November 1998. The new law created by the initiative became effective on March 4, 1999.

This analysis addresses only substantive changes. SSSB 94 also incorporates dozens of minor changes affecting the style, grammar, and sentence structure of the new marijuana law. These alterations are designed to add clarity and bring the initiative language into conformity with the drafting style of Alaska statutes. Unless a proposed amendment involves a substantive change to the law, it will not be addressed in this document.

In the interest of brevity, the statute created by Ballot Measure No. 8 will hereinafter be referred to as the **"Medical Marijuana Act"** or simply **"MMA."**

Section 1

This establishes a new section under Title 11 (Criminal Statutes), Chapter 71 (Controlled Substances). It provides that a defendant charged with violating Alaska's controlled substance law may utilize as an "affirmative defense" the fact that the defendant is a patient or a caregiver permitted to use or possess marijuana under the terms of the Medical Marijuana Act.

This affirmative defense provision replaces the broad-based immunity language now found in Sec. 17.37.030(a)-(b) of the Medical Marijuana Act *(see page 8, lines 15-31 & page 9, lines 1-5)*. It also replaces the broad "exception clause" that MMA added to the state's controlled substances law at AS 11.71.190(b), i.e., "Marijuana is a schedule VIA controlled substance *except for marijuana possessed for medical purposes under AS 17.37."* The language emphasized in italics is deleted in Section 2 of SSSB 94 *(see page 2, lines 23-24)*.

The affirmative defense requirement proposed in SSSB 94 closely follows the model of state law relating to concealed weapons at AS 11.61.220(b). That statute provides that a person who "knowingly possesses a deadly weapon... that is concealed on the person" is guilty of a Class B misdemeanor. However, a person charged with this offense may invoke as an "affirmative defense" the fact that he or she is "the holder of a valid permit to carry a concealed handgun."

Under state law at Sec. 11.81.900(b)(1), the term "affirmative defense" means that "some evidence must be admitted which places in issue the defense" and that "the defendant has the burden of establishing the defense by a preponderance of the evidence." This is appropriate in circumstances where the defendant has special custody of, or access to information (e.g., a registration card, written medical diagnosis, etc.), that would clearly demonstrate to law enforcement officials that the person is protected by a statutory exception.

Some have criticized the "affirmative defense" approach in SSSB 94 on the grounds that it places the burden of proof on the defendant rather than law enforcement. However, this is consistent with how Alaska law is applied to all other cases involving drugs on the controlled substance list, whether the substance is legal to prescribe or not. The burden of proof in all cases involving controlled substances is set out clearly in AS 11.71.350, which has been law since 1982: "It is not necessary for the state to negate an exemption or exception provided for in this chapter in a complaint, information, indictment, or other pleading or at a trial, hearing, or other proceeding under this chapter or AS 17.30. *The defendant has the burden of proving by a preponderance of the evidence any exemption or exception claimed by the defendant*" (emphasis added).

Law enforcement officials and gun owners have stated that the "affirmative defense" structure used in Alaska's concealed-carry permit law works very well because it removes any ambiguity about who is allowed to carry a concealed weapon. In similar fashion, SSSB 94 will remove any ambiguity about who is entitled to use marijuana. It establishes what the U.S. Supreme Court has called the "bright line" that will help police distinguish between legitimate and illegitimate users of marijuana. It will help protect medical marijuana patients from being victims of mistaken arrest, and it will likewise allow the state to continue enforcing the state law that prohibits recreational use of marijuana. Alaskans voted to recriminalize possession of marijuana when they approved Ballot Measure No. 2 in 1990.

The affirmative defense provision in SSSB 94 contains appropriate safeguards to ensure marijuana will be legally used only for valid medical reasons and not for "recreational" use. Under Alaska's existing controlled substance law, a person can be charged with the following marijuana-related offenses:

1) manufacture
2) delivery
3) possession
4) possession with intent to manufacture or deliver
5) use
6) display

For <u>any</u> of the six charges referenced above, SSSB 94 requires a person to meet all of the following requirements to establish a valid affirmative defense:

1) Person must be a patient, primary caregiver for a patient, or alternative caregiver for a patient.

2) The patient must be currently registered with the Department of Health & Social Services as a person entitled to use marijuana to address a debilitating medical condition.

3) The entire amount of marijuana in question must have been intended for medical use by the patient in accordance with a physician's recommendation as described in AS 17.37.010(c) *(see page 3, lines 28-31 and page 4, lines 1-9).*

4) The person's use of marijuana must comply with all requirements of AS 17.37, the Medical Marijuana Act. Among these requirements: prohibition on using marijuana in a public place; prohibition on using marijuana in a manner that endangers the health or safety of any person; prohibition on selling or distributing marijuana to any person other than an exchange between the patient and his or her primary caregiver; and possession limits of one ounce of marijuana in usable form and six plants *(see page 10, lines 21-31 & page 11, lines 1-13).*

5) If the defendant is a primary caregiver or alternative caregiver for a patient, the person must be in physical possession of the caregiver registry identification card issued by DHSS.

Section 1 of SSSB 94 concludes with a series of definitional references *(see page 2, lines 15-21).* Some of the definitions are changed slightly from those used in the Medical Marijuana Act. The changes are discussed in Section 7 of this analysis.

Section 2

As described earlier in this analysis, Section 2 of SSSB 94 eliminates the broad exception clause the Medical Marijuana Act tacked on to the state's Controlled Substances Act: "Marijuana is a schedule VIA controlled substance [EXCEPT FOR MARIJUANA POSSESSED FOR MEDICAL PURPOSES UNDER AS 17.37.]. Thus, SSSB 94 restores medical marijuana to the list of controlled substances.

It is not necessary or even wise to remove medical marijuana from Alaska's list of controlled substances – which includes other medications that are available for prescription by doctors. Our law should recognize that marijuana, like morphine or any other prescription drug, is a controlled substance, regardless of how it is used. Indeed, one of the duties of the state's Controlled Substances Advisory Committee is to "recommend regulations... to prevent excessive prescription of controlled substances *and the diversion of prescription drugs into illicit channels*" (emphasis added) *(see AS 11.71.110).*

By completely deleting medical marijuana from Alaska's list of controlled substances, the new Medical Marijuana Act has effectively removed this substance from the reach of any legal or regulatory authority under the Controlled Substances Act (Title 11, Chapter 71). At least for this portion of state law, "medical marijuana" now has no more legal significance than a can of soda, a stick of chewing gum, or a jar of peanut butter. It is difficult to fathom how this serves a public health interest.

Section 3

This section of SSSB 94 proposes several amendments to AS 17.37.010, which establishes a registry under DHSS of patients entitled to use marijuana.

1) To be listed on the registry, a patient must provide the department with a signed statement from his or her physician stating that the patient has been diagnosed with a debilitating medical condition, specifying the nature of the patient's symptoms, and concluding that the patient might benefit from the medical use of marijuana. In the statement, the doctor must certify that he or she personally examined the patient in the context of a "bona-fide physician-patient relationship."

2) The physician's statement described above in (1) must also include a statement that the physician has *"considered other approved medications and treatments that might provide relief, that are reasonably available to the patient, and that can be tolerated by the patient, and that the physician has concluded that the patient might benefit from the medical use of marijuana."* This additional requirement, not found in the original MMA, establishes a level of accountability from physicians who recommend use of marijuana. This higher level of accountability is prudent given the following facts related to the medical use of marijuana:

   A) A recent report from the National Academy of Sciences' Institute of Medicine recommended that short-term marijuana use by certain patients could be accepted only if the **"failure of all approved medications to provide relief has been documented."** *(See Recommendation #6 of the Institute of Medicine Report, "Marijuana & Medicine: Assessing the Science Base," published by National Academy Press, Washington, D.C., 1999).*

      This requirement was deemed prudent by the Institute of Medicine because of the harmful effects of smoking marijuana. As noted in the Institute report, "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 these reasons, the report concludes that the future of cannabinoid drugs lies not in smoked marijuana..." In a separate section devoted to the "physiological risks" of marijuana use, the Institute of Medicine noted: "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... Numerous studies suggest that marijuana smoke is an important risk factor in the development of respiratory disease."

   B) The principle authors of the Institute of Medicine report reiterated their findings in an editorial published in *The Standard-Times* (Massachusetts) on April 13, 1999: "In deciding whether marijuana should be smoked as medicine, society must weigh the reality of this crude drug-delivery system against the benefits it might bestow. Chronic smoking of marijuana increases a person's chances of developing cancer, lung damage, and problems with pregnancies, including low birth weight. Therefore, it is simply not an acceptable long-term option. Smoking should be allowed only for short-term use among patients with debilitating symptoms, or who are terminally ill *and do not respond well to*

approved medications." (emphasis added). The principle authors of the report (and the editorial) are Dr. John A. Benson, Dean and Professor of Medicine Emeritus at the Oregon Health Sciences University School of Medicine in Portland; and Dr. Stanley J. Watson, Jr., Co-Director and Research Scientist at the Mental Health Research Institute, University of Michigan, Ann Arbor.

C) The federal government classifies marijuana as a "Schedule I" drug: dangerous, addictive, and without medical benefit. Under federal law, it cannot be legally prescribed, grown, or sold – regardless of what Alaska statutes say. A doctor who recommends use of marijuana is effectively advising the patient to engage in activity that is prohibited by law. Out of concern for the welfare of the patient, it is reasonable to require that other legal treatments be considered first. Nothing in state law can protect a patient (or a physician) from enforcement action by the federal Drug Enforcement Administration.

D) The main psychoactive ingredient in marijuana, Delta-9-tetrahydrocannabinol (THC), is already available in synthetic form in the drug Marinol, which can be legally prescribed. Unlike marijuana, it is "pure" and can be administered in precise, controlled doses. As the American Medical Association has stated, "Marijuana doesn't fit neatly into traditional protocols because the dosage is inexact, the quality and strength of marijuana varies, and each puff contains more than 400 chemicals, not just a single agent to be isolated." *(Source: editorial of* American Medical News, *April 7, 1997)*

E) The American Medical Association has recommended that marijuana remain classified as a prohibited, Schedule I drug (i.e., illegal to prescribe) until further research can demonstrate whether the substance has any medical utility: "What patients and physicians deserve now is some much-needed clinical research that will decide the issue of whether medical marijuana is even worth talking about... Certainly medical marijuana has a loyal following of patients. As the ballot measures indicate, it has also captured the imagination of the public at large. Unfortunately, unproven therapies often do." *(Source: Report 10 of the Council on Scientific Affairs, American Medical Association & editorial of* American Medical News, *April 7, 1997)*

F) The American Cancer Society has questioned the efficacy of medical marijuana: "Marijuana has also been suggested as a treatment for pain, loss of appetite and depression associated with cancer. To date, there is no scientific evidence that marijuana is as useful as currently available medications in controlling these symptoms. Claims that marijuana smoking can improve some patients' general sense of well-being cannot be readily verified by scientific research. Some states have recently passed legislation intended to promote access to marijuana for patients with cancer and other serious diseases. Evaluation of any medication involves weighing its benefits against adverse effects and other disadvantages. As a medication for controlling nausea and vomiting associated with cancer chemotherapy, smoked marijuana appears to offer little if any benefit over

legally available medications (including dronabinol)." *(Source: statement posted on the American Cancer Society web page, available at www.cancer.org/murphy /week2.html)*

G) Marijuana is a dangerous substance and it is the most commonly abused illegal drug in the United States: "Today's street version [of marijuana], however, is 10 times more potent than what was available a decade or two ago. And it is that many times more dangerous. Marijuana... is far from harmless. It contains more harmful chemicals than cigarettes. The chemical ingredients can stay in the body for up to a month after the smoking of a single joint (marijuana cigarette). Marijuana affects every tissue in the body. It slows down brain activity and impairs concentration, depth perception, reaction time, and the ability to evaluate situations and outcomes. It can damage short-term memory and bring on a totally 'I don't care' attitude... Meanwhile, the smoke from one marijuana joint causes more lung damage than that from a whole pack of cigarettes. Over time the chemicals and smoke can cause lung cancer and emphysema. The body's ability to fight infection may be lowered because marijuana often lowers the white blood cell count." *(Source: "The Perils of Pot," by Dr. Richard Heyman, Chairman of the Committee on Substance Abuse of the American Academy of Pediatrics, published in the American Medical Association book "Teen Talk.")*

3) The registry must include not only the patient, but also the patient's primary caregiver and alternative caregiver, if either is designated. Only <u>one</u> primary caregiver and alternative caregiver can be listed for each patient. To be listed as a caregiver, a person must submit a sworn statement to DHSS stating that the applicant is at least 21 years of age, not currently on probation or parole, and has never been convicted of a felony violation of the drug laws of Alaska or another state. The patient must include the following information about the primary and alternative caregivers in his or her application: name, address, date of birth, Alaska drivers license or identification card number. A person can be a caregiver for only one patient at a time, except in circumstances in which the person is caring for two or more patients who reside in the same household as the caregiver <u>and</u> these patients are related to the caregiver by at least the fourth degree of kinship by blood or marriage.

4) If the patient is a minor, the registry application must be filed by the parent or guardian. The application <u>must</u> include a statement by the minor's parent or guardian that the physician has explained the risks and benefits of medical use of marijuana and that the parent or guardian consents to serve as the primary caregiver for the patient. SSSB 94 further requires that the parent or guardian *"control the acquisition, possession, dosage, and frequency of use of marijuana by the patient."*

5) SSSB 94 deletes much of the sweeping confidentiality language at AS 17.37.010(b) because it unreasonably restricts the ability of law enforcement to access registry information for official purposes *(see page 3, lines 13-24)*. In its place, SSSB 94 stipulates that registry information is confidential and <u>not</u> considered a public record under AS 09.25.100 – 09.25.220 (the public records statute under the Code of Civil Procedure). However, law enforcement personnel are permitted to access registry

information while "in the course of a criminal investigation." This specific type of access is not currently permitted under MMA.

6) DHSS is permitted to deny a registration card to a patient who "is not... qualified to be registered" *(see page 5, lines 15-16)*. This authority is somewhat broader than what is currently permitted under the Medical Marijuana Act, which authorizes a denial only if the patient (1) did not provide the required information; or (2) provided information that was falsified.

7) If a patient's application designates a caregiver and DHSS determines that the caregiver does not meet the statutory requirements to be listed, the department shall proceed to review the patient's application as if there were no designation of a caregiver. The patient may apply to have a new primary caregiver or alternate caregiver listed at any time.

8) When an application is approved, the department will issue a registration card for the patient and a duplicate card for the patient's primary caregiver, if one has been listed. The duplicate card will be clearly identified as the caregiver registry identification card.

9) The Medical Marijuana Act states that if DHSS fails to act on an application within 35 days of receipt, then the application is considered to have been automatically approved. SSSB 94 retains this provision, but adds a stipulation that if the department subsequently registers or denies registration to a patient or caregiver, this action revokes or supersedes the previous "automatic" approval.

10) A patient or primary caregiver who is questioned by a law enforcement officer regarding the medical use of marijuana must present proper identification to the official, and also one of the following documents: (1) the person's registry identification card; or (2) a copy of an application that has been pending before the department for more than 35 days without being approved or denied, along with proof of the date of delivery to the department.

11) The MMA states that a denial of a registry identification card is considered a final agency action subject to judicial review, and that only the patient has the standing to contest the denial. SSSB 94 amends this language to state that, in addition to a denial, the revocation of a registry identification card or the removal of a person from the registry (e.g., a primary caregiver) also constitutes a final action subject to judicial review. In addition to the patient, a parent or guardian of a patient who is a minor also has standing to contest the agency action.

12) The MMA requires a patient to notify the department within 10 days of any changes in the patient's name, address, physician, or primary caregiver. SSSB 94 expands this 10-day notice requirement to include any changes in name or address of the primary caregiver.

13) The MMA requires the patient to return his or her registry identification card within 24 hours of receiving a physician's diagnosis that the patient no longer has a debilitating

condition. SSSB 94 expands this requirement to also require the primary caregiver to return his or her registration card within 24 hours of the new diagnosis.

14) SSSB 94 adds a new provision in subsection (m) designed to prevent abuse of the registration system: "A copy of a registry identification card is not valid. A registry identification card is not valid if the card has been altered, mutilated in a way that impairs its legibility, or laminated." *(see page 7, lines 25-27)*

15) SSSB 94 adds a new subsection (n) permitting DHSS to revoke a patient's registration if the department determines that the patient has violated a provision of AS 17.37 (the Medical Marijuana Act) or AS 11.71 (Controlled Substances Act). *(see page 7, lines 28-29)*

16) SSSB 94 also adds a new subsection (o) allowing DHSS to remove a primary or alternate caregiver from the state registry if it is determined that the caregiver is not qualified to be listed or has violated a provision of AS 17.37 (Medical Marijuana Act) or AS 11.71 (Controlled Substances Act). *(see page 7, lines 30-31 & page 8, lines 1-2)*

Section 4

This section of SSSB 94 proposes several amendments to Sec. 17.37.030 of the MMA, entitled "Privileged medical use of marijuana."

1) In subsection (a), all material from the original MMA is deleted and replaced with new language *(see page 8, lines 12-30)*. The language proposed for deletion is the most problematic in the Medical Marijuana Act, as it grants sweeping immunity to both patients and primary caregivers claiming a medical need for marijuana, even if the patient and primary caregiver are not registered with DHSS. Along with the MMA's removal of "medical marijuana" from Alaska's list of controlled substances *(see page 2, lines 23-24)*, this provision effectively places the burden on law enforcement to prove that a person being questioned about marijuana use is NOT using it for a medical purpose. This shifting of the burden of proof will likely cause police to not bother making arrests in many situations because of the ambiguities in the law. This problematic language is replaced by the new "affirmative defense" provision described in Section 1 of this analysis. The new subsection (a) reads as follows: *"A patient, primary caregiver, or alternate caregiver registered with the department under this chapter has an affirmative defense to a criminal prosecution related to marijuana to the extent provided in AS 11.71.090."*

2) The next subsection (b) begins on page 8, line 31. In its original form, as part of the MMA, this subsection grants sweeping immunity from prosecution related to the medical use of marijuana, though at least this subsection limits the protection to those who are in "lawful possession of a registry identification card." Similar to the change in subsection (a), SSSB 94 deletes the general immunity language in this subsection because protection for medical marijuana use is covered by the affirmative defense provision in Section 1. However, the revised subsection retains the immunity language insofar as it relates to the specific act of applying to be listed on the state registry:

"Except as otherwise provided by law, a person is not subject to arrest, prosecution, or penalty in any manner for applying to have the person's name placed on the confidential registry maintained by the department under AS 17.37.010."

3) The next subsection (c) in the Medical Marijuana Act (beginning on page 9, line 6) provides that a physician who advises a patient regarding the medical use of marijuana shall not be subject to prosecution or other disciplinary action for providing such advice, provided certain conditions are met. SSSB 94 adds a new condition to those already listed – specifically, that the physician's advice must be based on a contemporaneous assessment of *"other approved medications and treatments that might provide relief and that are reasonably available to the patient and that can be tolerated by the patient."*

4) The next subsection (d) of MMA (beginning on page 9, line 28) contains an exclusionary clause stating that a person is not "entitled to the protection of this section" (i.e., AS 17.37.030) for the non-medical use of marijuana. SSSB 94 expands the scope of this exclusionary clause to state that no person is "entitled to the protection of this chapter" (i.e., AS 17.37 in its entirety) for the non-medical use of marijuana. In other words, a person's use of marijuana for non-medical purposes makes that person ineligible for the protections in the entire Medical Marijuana Act, not merely the protections of one section.

5) SSSB 94 deletes the next subsection (e) of the MMA *(see page 10, lines 2-19)*. This subsection contains cumbersome language addressing issues of forfeiture of property arising from seizures of medical marijuana. The deletion of this language was the result of an amendment adopted in the HESS Committee at the recommendation of the Department of Law and Department of Public Safety. Alaska law already includes comprehensive guidelines for seizures and forfeiture of property in the area of controlled substances. These procedures are set out in AS 17.30.100 – 17.37.126, and they apply to all cases involving seizure of drugs on Alaska's list of controlled substances. There is no need to have a separate seizure and forfeiture law that applies exclusively to marijuana used for medical purposes. In addition, the provisions of SSSB 94 requiring registration and the carrying of a registry ID card make it extremely unlikely there will be any cases in which law enforcement officials mistakenly seize marijuana and other paraphernalia from a patient who is legally entitled to possess or use it.

Section 5

In this section, SSSB 94 proposes several amendments to Sec. 17.37.040 of the Medical Marijuana Act, entitled "Restrictions on medical use of marijuana" *(see page 10, lines 21-31; page 11, lines 1-31; & page 12, line 1)*. Unfortunately, as the analysis below demonstrates, the "restrictions" in MMA are illusory:

1) The existing Medical Marijuana Act, now in force, provides in subsection (a) that a patient "in lawful possession of a registry identification card" shall not:

    A) use medical marijuana "in a way that endangers the health or well-being of any person."

B) use medical marijuana "in plain view of, or in a place open to, the general public."

C) knowingly sell or distribute marijuana to any person not in lawful possession of a registry identification card, or eligible to possess such a card.

Curiously, the limitations above do not apply to:

A) a primary caregiver; or

B) a patient who is not in "lawful possession of a registry identification card."

Therefore, under the terms of MMA, a primary caregiver and a patient who qualifies for medical use of marijuana, *but who refuses to participate in the **optional** registration process*, is not prohibited by this section from: (1) using marijuana in a public place; (2) using marijuana in a way that endangers the health and safety of another person; or (3) selling/distributing marijuana to persons who are not in lawful possession of a registry identification card or eligible for such a card.

SSSB 94 corrects these problems: it applies the restrictions to both patients and primary caregivers, and the restrictions apply regardless of whether one has a registration card or not. Also, to help the medical marijuana law work better for patients and caregivers, SSSB 94 adds an exception to the public use prohibition, stating that it is not a violation to carry less than one ounce of marijuana in a public place, provided the drug is kept in a closed container, carried on the person, is not visible to anyone other than the patient or primary caregiver, and the possession is limited to what is necessary to transport the marijuana to a place where the patient and caregiver can lawfully use the substance.

SSSB 94 also adds new requirements to subsection (a) to prohibit the sale or distribution of marijuana to any person, except that marijuana can be transferred between the patient and primary caregiver. It also sets possession limits of one ounce in usable form and six plants, of which no more than three can be mature and flowering and capable of producing usable marijuana at any one tim *(see page 11, lines 7-13).*

2) Subsection (d) of MMA (beginning on page 11, line 25) states that "nothing in this section shall require any accommodation of any medical use of marijuana" in a place of employment, a correctional facility, school bus, etc. Once again, the MMA employs the word "section" instead of the word "chapter" -- which effectively renders the restrictions meaningless and creates a gaping loophole. SSSB 94 corrects this problem by deleting "section" and inserting "chapter" in its place. In addition, SSSB 94 adds a new provision stating that marijuana use need not be accommodated in a "medical facility, or facility monitored by the department of the Dept. of Administration" (e.g., juvenile detention facility, Pioneer Home, etc.). These terms are defined on page 13, lines 14-31 & page 14, lines 1-4.

Section 6

This section of SSSB 94 amends Sec. 17.37.060 of the marijuana initiative, entitled "Addition of debilitating medical conditions."

The Medical Marijuana Act requires DHSS to adopt regulations governing the manner in which new debilitating medical conditions eligible for treatment with marijuana can be added "to the list provided in this section" *(see page 12, lines 3-7)*. However, this statement is meaningless because there is no list of medical conditions in "this section," which is Sec. 17.37.060. Presumably, the drafters of MMA meant to refer to the list provided in the subsequent section, 17.37.070. To provide clarity, SSSB 94 amends this section to refer specifically to the list of debilitating conditions defined in Sec. 17.37.070 *(see page 12, lines 27-31 & page 13, lines 1-11)*.

Section 7

This section of SSSB 94 makes several changes to the definitions section of the Medical Marijuana Act (AS 17.37.070).

1) SSSB 94 adds a new definition of **"alternate caregiver,"** as the original MMA does not provide for alternate caregivers. The alternate caregiver, when in possession of the caregiver ID card, is able to carry out the responsibilities of the primary caregiver when that person is unable to fulfill them (such as during travel out of state).

2) SSSB 94 adds a definition of the term **"bona fide physician-patient relationship."** Although this term is used in the MMA at AS 17.37.030(c)(2), the drafters of the initiative neglected to include a definition. SSSB 94 defines the term as a relationship in which *"the physician obtained a patient history, performed an in-person physical examination of the patient, and documented written findings, diagnoses, recommendations, and prescriptions in written patient medical records maintained by the physician."*

3) The definition of **"correctional facility"** in MMA is deleted in favor of a more comprehensive definition already in Alaska law under Title 33, Chapter 30, entitled "Prison Facilities and Prisoners" (see Section 901): *"a prison, jail, camp, farm, half-way house, group home, or other placement designated by the commissioner for the custody, care, and discipline of prisoners."*

4) SSSB 94 includes a new definition of **"facility monitored by the department or the Department of Administration."** This definition is necessary because SSSB 94 states at AS 17.37.040(d)(2) that the medical use of marijuana is not required to be accommodated at any of these facilities *(see page 11, lines 28-29)*. The definition includes any "institution, building, office, or home" operated, funded, inspected, licensed, designated, or under contract with DHSS or the Department of Administration for the care of juveniles, the elderly, and the mentally ill *(see page 13, lines 14-31)*.

5) A new definition of **"medical facility"** is included, for the same reason identified in (4) above – namely, that SSSB 94 requires no accommodation for the use of medical

marijuana in these facilities *(page 11, line 28)*. Medical facility is defined as an *"institution, building, office, or home providing medical services, and includes a hospital, clinic, physician's office, or health facility as defined in AS 47.07.900, and a facility providing hospice care or rehabilitative services, as those terms are defined in AS 47.07.900."*

6) **"Medical use"** of marijuana is redefined for greater clarity. The existing definition in the Medical Marijuana Act defines "medical use" as marijuana used, manufactured, etc., to "address the symptoms or effects of a debilitating medical condition." SSSB 94 defines medical use in more concise terms, as marijuana used to *"alleviate a debilitating medical condition."*

7) SSSB 94 changes the definition of **"primary caregiver"** to add greater clarity and prevent abuse: *"primary caregiver means a person listed as a primary caregiver under AS 17.37.010 and in physical possession of a caregiver registry identification card; 'primary caregiver' also includes an alternate caregiver when the alternate caregiver is in physical possession of the caregiver registry identification card."*

8) The definition of **"prisoner"** contained in MMA is deleted by SSSB 94. The need for this definition is not apparent, since the term is not employed anywhere in the main body of the initiative language. The only reference to the word "prisoner" is found in the definitions section, under "correctional facility." Since SSSB 94 proposes to use the standard definition of "correctional facility" contained in state statute at AS 33.30.901(4), there appears to be no need for a unique, tailor-made definition of prisoner. State law already defines the term "prisoner" at AS 33.30.901(12).

9) SSSB 94 deletes the definition of **"registry identification card"** because it is superfluous. The meaning of this term is self-evident in SSSB 94 at Sec. 3, AS 17.37.010(e) *(see page 5, lines 26-31 & page 6, lines 1-12)*.

10) SSSB 94 deletes the definition of **"written documentation"** as the meaning of this term is self-evident in Sections 1 & 3 *(see page 3, lines 28-31; page 4, lines 1-9)*.

Section 8

This section of SSSB 94 deletes two sections of the Medical Marijuana Act – AS 17.37.020 and 17.37.050.

1) Section 17.37.020 of MMA, entitled "Medical Use of Marijuana," establishes limits on the amount of marijuana a patient can "use" for medical purposes – no more than one ounce in usable form, and no more than six marijuana plants, with only three mature and flowering. In this context, it is odd that the MMA employs the term "use" rather than "possess." If the language is taken literally, it appears a patient could "possess" an unlimited quantity of marijuana, as long as the patient is currently "using" no more than one ounce in usable form. In fact, the next paragraph of this section [AS 17.37.020(b)] allows even these ill-defined limits to be exceeded if the patient or primary caregiver can prove by a preponderance of evidence that "any greater amount was medically justified

to address the patient's debilitating medical condition." SSSB 94 deletes this entire section of MMA, and restates the limits on possession of marijuana in Section 5 *(see page 11, lines 10-13)*. These limits are restated strictly in terms of "possession," not "use."

2) Section 17.37.050 of the marijuana initiative is entitled, "Medical use of marijuana by a minor." It states requirements that must be met if a minor is to use medical marijuana. SSSB 94 deletes this entire section and instead addresses the use of marijuana by minors in Section 3 of the bill *(see page 3, lines 25-27; page 4, lines 21-25; and page 7, lines 9-11)*.

Section 9

This section of SSSB 94 provides for an immediate effective date, in accordance with AS 01.10.070(c).

Prepared by Mike Pauley, Staff Aide to Senator Loren Leman (465-3841)
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EDITORIAL

Make changes to law

It's been decided by Alaska's voters that, 1. marijuana is an illegal substance, but 2. it should be available to relieve severe pain and nausea of terminally ill patients.

Voters said that in two elections. The latest was this past fall when Ballot Measure No. 8 permitted medicinal use of marijuana.

The state's Department of Public Safety, of course, will uphold the laws. Its officials, however, need more guidelines and specifics in response to the Medical Marijuana Act. Such specifics will prevent abuse and misuse of the law.

The Anchorage Assembly realizes that. It passed a resolution supporting changes to the act. The Alaska Association of Chiefs of Police has added its endorsement for more specific language in the act. Other bodies representing large portions of the state and key officials responsible for upholding the law are expected to follow suit.

The Marijuana Act establishes a state registry for patients using marijuana for medicinal purposes, but it doesn't require registration. Police need a registry requirement to distinguish between legal medical users and illegal recreational users of marijuana. Such a change in the act would protect legitimate marijuana-using patients and prevent abuses.

Law enforcement officials also are asking that the act allow them access to the registry during investigations. Official access during investigations and prosecutions likely would help in separating legal users from non-legal users.

Public Safety seeks possession limits of one ounce of usable marijuana and six plants at any one time for medicinal users. That means legal users would possess only what they use, as prescription drug users do. Changes to the marijuana act also would require marijuana-using patients and their caregivers to carry state identification cards. The caregivers would be limited to one patient, and the patients would be limited to one caregiver. Anyone with a criminal record would not be permitted to be a caregiver. Caregivers, under the act, are not required to be physicians.

All of those proposed changes and others are reasonable. Marijuana is a harmful drug. While it might relieve pain and nausea for terminally ill patients, it also has dangerous side effects. It isn't approved by the Food and Drug Administration, and criminals go to great lengths to produce and sell it. Our children often are their customers. Alaska's marijuana act can and should protect our children. Law enforcement officials need better guidelines, more specific guidelines, to do that. Even supporters of medicinal marijuana use agree with that.

Those guidelines are spelled out in Senate Bill 94. The House has introduced a similar bill (No. 213). The House's Health, Education and Social Services committee will have a hearing on the bill Tuesday. Committee members and the Legislature need to know that while Alaskans are compassionate, we also care when it comes to the health and well-being of our children. Legislators could come to any conclusion if we keep silent — especially if only supporters of unlimited marijuana legalization speak out.

ROBBIE MCCLARAN—SABA FOR TIME

Police Chief Mel Brown averts his gaze when the card-toting citizens around him light a joint

AMERICAN SCENE

Margot Hornblower/Arcata

Here's My Marijuana Card, Officer

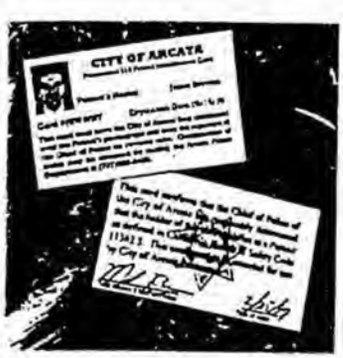
In the capital of legal pot, you don't need much of an excuse

IT IS NOT THAT MEL BROWN, police chief of this tie-dye-and-tofu town, set out to flout federal law. But here he is, a 53-year-old father of two who has never inhaled, issuing laminated and embossed get-out-of-jail-free cards for partakers of the infamous Humboldt bud, a potent local variety of marijuana. "You can photograph me," he tells a reporter genially, "but not reclining on a bearskin rug and smoking a joint."

Arcata (pop. 16,000) lies in the heart of the Emerald Triangle, the three lush California counties of Humboldt, Mendocino and Trinity, 275 miles north of San Francisco as the spotted owl flies. In the '80s, capitalist hippies defended their marijuana plantations here with booby traps and shotguns. George Bush sent in U.S. Army troops to battle the domestic druglords. And even now, early fall is signaled less by migrating geese than by helicopters swooping over redwood forests and dropping camouflaged, machete-wielding agents into any telltale patch of sparkling green. Last year state and local officials eradicated 136,957 plants, many 10 ft. tall, with a wholesale value of $450 million.

But what's a conscientious cop to do when California voters pass a ballot measure legalizing the cultivation and possession of marijuana for medicinal purposes? And when all it takes to prove need is the approval, written or oral, of a friendly doctor? And when not just patients with AIDS, cancer and multiple sclerosis are clamoring for the drug but also people with backaches, stress and drinking problems? One arrested planter told sheriff's deputies he was suffering from an ingrown toenail, an excuse that did not impress them. Lucy Mae Tuck, a volunteer who edits the newsletter at the Humboldt Cannabis Center, a co-op that grows the drug for medicinal use, has a physician's certificate to treat her hot flashes with the weed. Since Prop. 215 passed more than two years ago, says Police Chief Brown, "everyone we try to arrest has a recommendation from Dr. Feelgood."

Though six states—Alaska, Arizona, California, Nevada, Oregon and Washington—have voted to legalize medicinal marijuana, federal law still requires them to prosecute any wheelchair-bound granny smoking a bong. But they aren't doing so, and that has federal drug czar Barry McCaffrey muttering about a new "Whiskey Rebellion," the unsuccessful 1794 farmer's revolt against federal liquor taxes.



Arcata's ID card allows its holder to use medical marijuana

In Arcata, however, where 74% of voters approved the state's marijuana measure, Chief Brown considers his policy one of common sense. "Out of self-preservation," he says, he set up his own system. Now about 100 local residents have sat for mug shots, agreed to let Brown talk to their physicians, and walked away with a "City of Arcata Proposition 215 Identification Card." Flash it as you are toking up and you won't be arrested, unless you've got more than 10 marijuana plants—a limit imposed to distinguish users from illegal dealers.

Other jurisdictions, including Mendocino County, plan to follow Arcata's example, and a task force appointed by Bill Lockyer, California's new attorney general, is looking at Arcata as a possible statewide model. Although other communities might be less mellow about the idea, no dissenters showed up at public hearings when Arcata's city council—composed of two Green Party members, a Libertarian and two Democrats—approved Brown's ID system. That's to be expected, perhaps, in a town that has declared itself a "Nuclear Weapons Free Zone"; that in 1991 passed a resolution—albeit quickly rescinded—offering sanctuary to Persian Gulf War resisters; and where students from Humboldt State University hold an annual Hempfest, promoting a nonpsychoactive form of cannabis for use in clothing, paper and food.

"My Mexican-American aunties used marijuana poultices for their arthritis," says Arcata Mayor Bob Ornelas, a ponytailed electrician. Ornelas boasts of running marathon races while high on the weed but insists, "I don't get stoned that much." ■

"Everyone has a recommendation from Dr. Feelgood."—ARCATA POLICE CHIEF MEL BROWN

The *New* Politics of Pot

When advocates of medical marijuana couldn't make headway with policy makers, they took their campaign directly to the voters.

BY ROSS FREYMAN

Standing in the foyer of a hotel in Washington, D.C., Bill Zimmerman looks a bit uncomfortable talking with a reporter who is sporting a long, gray beard, wearing a lime-green shirt and representing a publication called *High Times*. Both men are attending a conference sponsored by the National Organization for Reform of Marijuana Laws, a group that for many years has pushed for a broad overhaul of national laws governing cannabis. But amid the festival-like atmosphere—"reefer music" blares, vendors hawk products made from hemp, and activists carry guitar cases and pamphlets that tout the benefits of recreational marijuana use—the smartly dressed Zimmerman, with a copy of the *New York Times* tucked under his arm, seems out of place.

Indeed, some members of NORML were overheard condemning him and the speech that he delivered on the opening day of their annual meeting last November. It's not that they question his credentials: Zimmerman holds a doctorate in neuroscience, runs a California political consulting group and recently published a book entitled *Is Marijuana the Right Medicine for You?* Rather, they are critical of the mainstream tactics he has used in recent successful efforts to legalize marijuana for medicinal use in half a dozen states.

Bill Zimmerman of Americans for Medical Rights has led the charge on medicinal marijuana.

Although his strategy has been focused on getting voter referendums passed in individual states, Zimmerman's ultimate goal is to have the federal Drug Enforcement Administration change marijuana from a Schedule I substance (meaning it has no accepted medical use in the United States and is highly addictive) to Schedule III status (on a par with Tylenol with codeine).

Zimmerman's approach does not mollify more radical activists, however. Nor does his personal belief that the drug should be decriminalized. A significant segment of NORML thinks that Zimmerman and Americans for Medical Rights, his Santa Monica-based organization that spearheaded the 1996 initiative allowing certain patients to smoke marijuana for medical purposes in California and Arizona, have betrayed the cannabis movement. They demand removal of all penalties for the private possession of marijuana by adults. For his part, Zimmerman refuses to criticize NORML and its supporters, although his silence when asked about them is telling.

The differences between the two groups go a long way toward explaining why the marijuana debate has reappeared on the political radar screen after a decades-long hiatus. Americans for Medical Rights has been remarkably effective at portraying the medical use of marijuana as an issue of compassion, rather than of potheads and addiction. The group made its mark with the two victories in 1996 and then struck gold this past November, winning votes in Alaska, Nevada, Oregon, Washington and again in Arizona, where the state legislature forced voters to validate their 1996 decision on medical marijuana. Polls indicated similar propositions would have been approved in Colorado, where the secretary of state invalidated the ballot initiative, and the District of Columbia, where Congress refused to appropriate money to certify the results.

How did Zimmerman and Americans for Medical Rights successfully alter the political landscape on which the medical marijuana issue rests? For starters, they ran the campaign like a campaign. Zimmerman brought a wealth of experience managing political races. He helped one member of Congress win reelection in 1998 and has steered several other ballot initiatives to victory this decade. He also introduced time-tested polling tactics to the marijuana measures and, most important, Americans for Medical Rights attempted to appeal to mainstream voters, for whom NORML's agenda of sweeping reform and eventual legalization is taboo.

And while some marijuana advocates spent time debating among themselves whether hemp oil can reduce cholesterol levels, Americans for Medical Rights booked doctors on television and radio

Eric Sander photograph

programs to discuss how those suffering from glaucoma, chemotherapy-related nausea or AIDS "wasting" syndrome can benefit from pot. They talked at length about research and cited a favorable editorial that appeared in the *New England Journal of Medicine*. "It was understood," Zimmerman says, "that this would be a professional campaign."

Dr. Rob Killian is a family practitioner and the leader of Washington Citizens for Medical Rights, which successfully pushed the state's Initiative 692. "More of us are seeing it work," he says of medicinal marijuana. And to him, it seems clear that the messenger is just as important as the message. "We're using spokespeople who are mainstream," Killian says of the effort in Washington, where he told supporters to stop wearing tie-dye and listening to reefer music in public. He laments, however, that "there are some activists who refuse to play the game in a winning way."

Equally significant is the manner in which Americans for Medical Rights and the state organizations associated with them—Killian's group as well as Oregonians for Medical Rights, Coloradoans for Medical Rights and so on—have recast the marijuana issue in terms of the patient's needs. As a result, many hospice workers and nurses, as well as AIDS and cancer-patient advocacy groups, have lent their support.

"Dying and suffering patients should not be arrested for using marijuana as a medicine under their doctor's supervision," says Dr. Richard Bayer, who practices internal medicine in Portland, Oregon, and was the chief petitioner of the state's successful Initiative 67. He was heard by voters across the state advocating the usefulness of marijuana in helping patients deal with pain, fight nausea and help improve their appetite. Apparently, Oregonians responded to his plea to have compassion for those who are very ill.

Despite these recent developments, opponents of legalization efforts—most notably federal and state policy makers and the law enforcement community—remain firm in their belief that the medical marijuana movement is just a smoke screen. General Barry McCaffrey, the White House's drug czar, maintained that proponents in California and Arizona in 1996 were trying to take a step toward full legalization. "This is not medicine," he declared. "This is a Cheech and Chong show."

Law enforcement officers contend that allowing people to use marijuana could lead to the use of harder drugs as well as make pot more accessible to youngsters. In addition, they are critical of the "loose" wording of these ballot initiatives, arguing that the language about possession and distribution is far too ambiguous. Multnomah County Sheriff Dan Noelle, who led the campaign against medicinal marijuana in Oregon, is convinced the public is being hoodwinked. "This is a national effort with the primary funders working on an agenda to legalize," he says.

In fact, "medical rights" groups across the country have been bankrolled, essentially, by three men: billionaire international financier George Soros, insurance magnate Peter Lewis and John Sperling, who founded the for-profit University of Phoenix. All of them have stated publicly that American drug laws make no sense, that governments should focus on treatment more than punishment and that marijuana should be decriminalized.

Rhetoric aside, Noelle's observation that the campaign is coordinated and national in nature is certainly accurate. Although local activists played a role in the marijuana victories in each state, groups such as Oregonians for Medical Rights have led the charge—and acknowledged that they receive some 95 percent of their funding from the national Americans for Medical Rights. "It's no secret that this is a multi-state effort," says Amy Klare, a campaign coordinator for Oregonians for Medical Rights.

University of Southern California Law Professor Charles H. Whitebread, the author of several works detailing the history of marijuana laws, is surprised at the results. But then Americans for Medical Rights, he notes, did something heretofore unheard of. "They demystified this drug and got rid of the notion of reefer madness."

'This is a national effort with the primary funders working on an agenda to legalize,' says Multnomah County Sheriff Dan Noelle.

Many people insist, however, that more research on smoked marijuana must be conducted before doctors should be able to prescribe it. While government health officials are hesitant to approve studies, a key report by the National Academy of Sciences' Institute of Medicine will be released soon. For the time being, the influential American Medical Association has come out against the marijuana initiatives. "Referendums and legislation are not the right way to make scientific decisions," says an AMA spokesman. "Its efficacy should be established through well-controlled clinical trials."

The marijuana lobby responds that cannabis is one of the most studied drugs in history. George Washington University Law Professor Peter H. Meyers, a former NORML attorney who teaches a class on drugs and the law, says, "Perhaps we know more about marijuana than any other drug."

In advocates' minds, the overwhelming opposition boils down to politics. They point to the example of a DEA administrative judge who, in 1988, said a brief filed by NORML calling for a change to Schedule II (narcotic, stimulant and depressant drugs) had merit. "Marijuana, in its natural form, is one of the safest therapeutically active substances known to man," the judge wrote. But the DEA officially rejected the opinion. "The only reason they didn't allow medical use of the drug," asserts Meyers, "is for purely political reasons."

Clearly, the DEA and Congress are not about to change their current opinion on the matter anytime soon. In fact, the House passed a resolution opposing medicinal marijuana in 1998. So Zimmerman is counting on votes in 2000 in Colorado, Maine and Nevada (where state law requires voters to pass an initiative twice before it can be enacted) to further pressure the federal government and state legislatures. Referendums are also possible in Michigan, Ohio and Massachusetts.

Zimmerman is adamant that his group's only goal is to allow patients to smoke marijuana as a medicine. Whether or not that could lead to a slippery slope of use and abuse remains an open question, but it is hard to dispute the effectiveness of his tactics so far. "The fact that they have bitten off a small little piece," says USC's Whitebread, "and treated it like a political campaign is the reason it is successful." G

US MA: OPED: Strike A Balance In The Marijuana Debate

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STRIKE A BALANCE IN THE MARIJUANA DEBATE

Everyone seemed to declare victory when a study on the medical use of marijuana was issued last month. Advocates for legalizing such use said the report aided their cause by concluding that the compounds in marijuana do have some potential as medicine. Their opponents, on the other hand, cheered the report's conclusion that the harmful effects of smoking far outweigh potential benefits for most patients. In reality, both sides are right. The study -- which we led for the Institute of Medicine -- firmly concluded that the active compounds in marijuana do have potential as medicine. But that future does not involve smoking.

Scientific hair-splitting? Hardly. To date it has been nearly impossible to separate scientific evidence about marijuana's potential from larger societal concerns about its use. But doing so may be the key needed to advance the rancorous debate that has engulfed this issue since medical marijuana began to appear on state ballot initiatives in the mid-1990s.

Those who have followed the debate may be surprised to learn that in the scientific realm, we found remarkable consensus that marijuana's components have potential to relieve symptoms such as pain, nausea and vomiting, and the poor appetite associated with wasting in AIDS or cancer. For most symptoms

there are more effective drugs already on the market, but physicians encounter patients who do not respond well to standard medications, or who need additional therapies. These patients could benefit from new drugs based on cannabinoids, the active components in marijuana.

Marijuana's future as medicine rests in developing new ways of delivering these cannabinoids -- including the most common one, THC. Presently there is only one such drug on the market. Marinol, a THC capsule, is approved by the Food and Drug Administration for treatment of nausea and vomiting associated with chemotherapy, as well as poor appetite and weight loss associated with AIDS.

However, some who have used Marinol complain that it takes effect slowly, and its results are variable. Sufferers of pain, nausea and vomiting obviously need fast-acting medication. For that reason, we recommend that clinical trials move forward with the goal of developing a rapid-onset, non-smoked delivery system, such as an inhaler. This type of device could deliver precise doses without the health problems associated with smoking.

Admittedly, an inhaler could take years to produce. What do we do right now?

In deciding whether marijuana should be smoked as medicine, society must weigh the reality of this crude drug-delivery system against the benefits it might bestow. Chronic smoking of marijuana increases a person's chances of developing cancer, lung damage, and problems with pregnancies, including low birth weight. Therefore, it simply is not an acceptable long-term option. Smoking should be allowed only for short-term use among patients with debilitating symptoms, or who are terminally ill and do not respond well to approved medications.

Even in these cases, marijuana use should be limited to carefully controlled settings. Patients who are prescribed marijuana should be enrolled in short-term clinical trials that are approved by an oversight strategy such as institutional review boards, and involve only those patients most likely to benefit. They should be fully informed that they are experimental subjects and are using a harmful drug-delivery system, and their condition should be closely monitored and documented under medical supervision.

These clinical trials of smoked marijuana should not be designed to develop it as a licensed drug, but should be a stepping stone to the development of new, safe delivery systems of cannabinoids. There is no evidence that using marijuana in controlled settings -- or cannabinoids in the form of drugs such as Marinol -- will lead to increased illicit drug use throughout society.

Our review of the science behind marijuana and cannabinoids convinces us that the debate so far has been miscast. Rather than focusing on drug control policy, the medical marijuana debate should really be about the promise of future drug development. Mining the pharmaceutical promise of cannabinoids will require

the same kind of drug development that brought us any number of pain-killing drugs prescribed by physicians today. With public investments in research, or enough incentives to convince private companies to develop these drugs, the perceived need to smoke marijuana to alleviate symptoms could vanish.

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Medicine -- Not Pot

By Robert L. DuPont

Tuesday, April 27, 1999; Page A17

Last month the Institute of Medicine released a report in response to the two-year-long wave of ballot initiatives supporting medical marijuana. It assessed the scientific base of the claim that suffering terminally ill people are unnecessarily deprived of a useful treatment by drug laws that criminalize smoking.

There has never been controversy about the use of purified chemicals in smoke to treat any illness, as witnessed by the availability of synthetic tetrahydrocabinol (THC) since 1985. The only dispute between the drug-law hawks and doves is the place of smoked marijuana in medical treatment. The institute's report, balanced and firmly rooted in three decades of scientific research, reached this conclusion:

"Although 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."

Here are the details of its interim solution:

"Short-term use of smoked marijuana (not more than 6 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 submission by a physician to provide marijuana to a patient for a specified use."

The best hope for a resolution of this medical conflict would be for the National Institute on Drug Abuse (NIDA) to fashion definitive clinical trials of smoked marijuana vs. other standard treatments for the indications the Institute of Medicine identified (anxiety reduction, appetite stimulation, nausea reduction and pain relief). This was how a similar call for legal heroin for terminal cancer pain was disposed of a decade ago. A controlled trial conducted at Sloan-Kettering, (funded by NIDA), showed that heroin offered no advantages compared with standard pain treatments.

If new trials were to show superiority for smoked marijuana, and if there was no way to identify and deliver purified chemicals with less toxicity than smoke, then I would have no objection to a carefully monitored, medically supervised use of smoked marijuana in settings that discouraged diversion. There is no controversy in the United States today about the medical use of opiates (including those derived from natural opium, as is heroin) or cocaine. The concern now is that smoked marijuana has not been shown to be superior to other treatments for any illness.

Most supporters of medical marijuana do not understand three facts that were made clear in the Institute of Medicine's report:

(1) "The effects of cannabinoids on the symptoms studied are generally modest, and in most cases, there are more effective medications." In other words, do not look for anything dramatic from this class of chemicals. This may explain why marijuana's chemicals have produced little enthusiasm from pharmaceutical companies.

(2) Modern medicine does not burn leaves and ask sick patients to inhale the smoke. It identifies individual chemicals and delivers them in purified, often synthetic, form to treat specific illnesses.

(3) Marijuana smoke is not only unstable but toxic, like tobacco smoke. These characteristics make smoked marijuana unsuitable as a medicine.

Clinical trials will take several years, and they are expensive. The most regrettable aspect of this process is that scarce medical research money will be wasted on tests of the chemicals in smoke that have little medical value. Nevertheless, the political momentum created by the marijuana advocates has made it essential that these clinical trials go forward to demonstrate to a skeptical public how smoked marijuana stacks up against standard treatments.

I hope that the people who now are advocating a science-based approach to this politicized problem, including the Institute of Medicine, understand that these efforts, even if completely successful, will have little impact on the pro-marijuana forces, whose only interest is free access to the drug. They do not want clinical trials, and they do not want purified or synthetic cannabinoids. They want smoked dope.

The writer was director of the National Institute on Drug Abuse from 1973 to 1978. He is now a clinical professor of psychiatry at Georgetown Medical School.

Too many loopholes in medical marijuana law

COMPASS
POINTS OF VIEW FROM OUR COMMUNITY

By SEN. LOREN LEMAN

More than eight years ago, Alaska's voters approved Ballot Measure No. 2 to make possession of all amounts of marijuana a criminal offense. On the official election ballot, the question was presented to voters as follows: "This initiative would change Alaska's laws by making all possession of marijuana criminal, with possible penalties of up to 90 days in jail and/or up to a $1,000 fine. Should this initiative become law?" A majority of Alaskans said yes, and marijuana possession was recriminalized in this state.

One of the primary supporters of Ballot Measure No. 2, former state lawmaker Alyce Hanley, stated that a yes vote on Proposition 2 sent a clear message that marijuana is a dangerous drug. Marijuana is not a benign substance. It is dangerous to users and society at large.

On Nov. 3 of last year, voters were once again asked to decide a ballot measure related to marijuana. This time it was Ballot Measure No. 8, which was described by its sponsors as a measure to allow marijuana use by terminally ill patients and others suffering debilitating medical conditions. A majority of Alaska voters said yes to this initiative. Public support was certainly strengthened based on assurances from the initiative's sponsors that a yes vote would not result in a wholesale legalization of marijuana. In the 1998 Official Election Pamphlet, the group sponsoring Ballot Measure No. 8 stated: "Marijuana would still be illegal for nonmedical use. Ballot Measure No. 8 provides full protection against abuse of the new law."

Unfortunately, close scrutiny of the initiative by Alaska's law enforcement personnel has revealed plenty of room for abuse. The initiative contains several gaping loopnoles and other defects. Collectively, these flaws will make it difficult for law enforcement to enforce Alaska's drug laws. Chief Duane Udland of the Anchorage Police Department and deputy commissioner Del Smith of the state's Department of Public Safety have testified before legislative committees regarding the problems with the marijuana initiative. The following are just a few examples:


Leman

- The initiative creates a confidential state registry of patients entitled to use marijuana. However, registration is not mandatory, it is optional. The new law allows the privileged medical use of marijuana even for persons who are not registered with the state. One of the primary advocates for the marijuana initiative, David Finkelstein, testified last month before a legislative committee that registration was intentionally left optional. This makes it difficult for law enforcement personnel to distinguish between medical use of marijuana (now legal under certain conditions) and recreational use of marijuana (still illegal).
- The initiative states that no patient in lawful possession of a registry identification card can use marijuana in a public place or use it in a manner that endangers the health or well-being of any person. However, by the plain language of the initiative, these restrictions do not apply to a person who refuses to register with the state and therefore does not possess a registry ID card. Thus, a person claiming a medical need for marijuana who refuses to register with the state could smoke marijuana publicly in a way that endangers the health and well-being of other people.
- The initiative created new law under Title 17 of Alaska's statutes, designated as Chapter 37. This chapter is further divided into eight different sections. The fourth section of the marijuana initiative states that nothing in this section shall require any accommodation for any medical use of marijuana in any place of employment, in any correctional facility, on or within 500 feet of school grounds, at or within 500 feet of a recreation or youth center, or on a school bus. On the surface, these seem to be very wise precautions, but close scrutiny reveals that these restrictions are an illusion. The initiative says "nothing in this section" requires accommodation of marijuana use in a school, prison, etc. It should say "nothing in this chapter," which would make the restrictions functional by applying them to the entirety of the marijuana initiative, not just one of eight sections. As the law is currently worded, a person using medical marijuana could demand that his or her use of marijuana be accommodated at work, on a school bus, in prison, etc. This is just one of more than a dozen loopholes that make the marijuana initiative a nightmare for law enforcement.

I believe most voters who supported Ballot Measure No. 8 were motivated by a compassionate desire to alleviate the suffering of people with terminal illnesses or other conditions with severe pain or nausea. Like many Alaskans, I have had family members and relatives experience such suffering, so I can understand their motivation to help. However, the fact remains that the initiative is flawed.

Last month I introduced Senate Bill 94, legislation designed to eliminate the loopholes in the medical marijuana initiative while still ensuring that those with a valid medical need can use marijuana to address their condition. This bill is designed to reconcile the provisions of Ballot Measure No. 2 of 1990 and Ballot Measure No. 8 of 1998. Both of these measures represent the majority will of the Alaskan people. Both measures deserve to be respected by those of us who serve in public office.

To protect legitimate medical marijuana patients from unwarranted prosecution, Senate Bill 94 makes registration mandatory yet keeps this information confidential from the public. It also addresses the health and safety of patients by requiring doctors to consider other forms of legal medical treatments that might help address a patient's condition. This latter requirement for physicians was supported by the federal government's Institute of Medicine report on medical marijuana released just last month.

I am pleased that the initiative's primary sponsor, Alaskans for Medical Rights, has recently acknowledged their support for more than a dozen changes proposed in SB 94. They have urged the Department of Health and Social Services to implement these changes through regulations.

Although much of the campaign against SB 94 has been intemperate and misleading, I am hopeful that critics will work constructively with the Legislature to help make the new law work as intended and as represented.

You can learn more about SB 94 by visiting my web site at www.akrepublicans. org/Leman.htm.

❑ Sen. Loren Leman represents northwest Anchorage and Elmendorf Air Force Base. He has served in the Legislature since 1989.

Transcript – Remarks of Anchorage Police Chief Duane Udland

Hearing of the House Health, Education, & Social Services (HESS) Committee

Re: Medical Marijuana Regulations – Thursday, March 25, 1999

Prepared by: Mike Pauley, Staff Aide to Senator Loren Leman (465-3841)

REPRESENTATIVE FRED DYSON, HESS CHAIRMAN: Duane, are you there?

DUANE UDLAND, ANCHORAGE CHIEF OF POLICE: Yes, I am here.

DYSON: Thanks Duane, this is Representative Dyson. And I have here with me Representatives Green, Coghill, Carl Morgan, and Lisa Murkowski. Please, we'd be delighted to hear from you about what problems you're anticipating from the law that passed in the fall.

UDLAND: Yes, thanks for this opportunity, and for the record my name is Duane Udland, you spell my first name D-U-A-N-E, last name is spelled U-D-L-A-N-D. I am the Chief of Police here in Anchorage. I'm also here representing the Alaska Association of Chiefs of Police, of which I am the president.

I think I can fairly represent that the chiefs throughout Alaska certainly support the will of the people and support the intent of this marijuana initiative. And I think most officers are going to reflect the same values that most of the people who voted on the issue would reflect.

Enforcement wise, though, I see a number of problems and I would ask that the Legislature act on what we see are the problems. And I'll enumerate those briefly.

Number one, we think there should be registration, certainly for both the primary caregiver as well as the patient.

Number two…

DYSON: Uh, wait a minute, Duane, that's compulsory registration?

UDLAND: Yes, we would like to see that, yes.

DYSON: OK, go ahead.

UDLAND: Number two, is we don't think the law as written right now is clear as to the amount.

And number 3, we think the law is very unclear, or maybe doesn't even address, the locations where this marijuana can be used.

I haven't read the legislation recently, although I read it just after the law was passed, or just before the law was passed, or the ballot proposition was passed, and it seemed to me that there are an awful lot of things that make it impossible for police officers to enforce what I think the voters intended that we enforce way back in the early 90s when we recriminalized marijuana.

The issue of primary caregiver and the user, or the patient, being registered I think is important. Because I think it's absolutely impossible for a police officer in the middle of the night to start trying to chase down a case with somebody trying to use the defense, "Well, I'm a primary caregiver or I'm a patient who needs to use medical marijuana."

The same goes for the amount. If the amount under the statute, as is now, is unclear... you know, so officers are going to have a very difficult time with that.

And certainly the location – I almost find this one personally to be one of the most troubling aspects. It doesn't really say where you can be after you've smoked the marijuana.

I don't know that I want to see someone who uses medical marijuana going to a school, or getting in a motor vehicle, or any number of things that may endanger public safety.

And also, I think something I'm real concerned with, there aren't clear guidelines for police officers to follow. We're going to end up having a lot of litigation and a lot of dismissed cases because officers are going to be left to their own interpretations. I think any time a statute is written – and I think over the years when I've testified before the legislature – I've always asked for clear, written law as to what it is that officers are supposed to do and not supposed to do. The way this is written right now, it is unclear. And you're going to have individual officers making good faith efforts at interpreting it, but you're going to have a variety of interpretations, and I think that subjects the citizens and the legitimate patients out there to unfair arrests simply because the law is confusing. Not because the officer is trying to do something evil, but only because the law is not clear as it should be.

That's my testimony. And I'd sure be happy to answer any questions if you'd like.

DYSON: Questions for Chief Udland? What do you anticipate will happen with the transportation and growing, when you guys encounter that?

UDLAND: I think it's going to be very problematic in part because, you know, everybody who is an illegitimate dealer is going to try and make the claim that they're a primary caregiver, or they're a patient, and that somebody has authorized them for it. And frankly, I think if this law is pushed, or is unchanged by the Legislature, I think it's going to be very difficult to enforce marijuana laws in Alaska as written. And I certainly know, and I talked with David Finkelstein even before this went, and he assured me that the intent was not to legalize marijuana through the back door. And I think that was David Finkelsteins's intent, and I certainly trust him on that. But I don't think the language, the way it's written right now, does that. In my opinion, you're almost effectively

removing law enforcement from enforcing all marijuana laws in the state. Unless you have something that was, you know, a major grow operation or something. But then, given the way the statute is, I think there's going to be a lot of legal challenges based on any arrests we'd make for [unintelligible] the dealer as opposed to the primary caregiver.

DYSON: Thank you. Do you anticipate, Duane, that, oh I don't know, in essence that permission slips will be counterfeited? That there will be folks, for the non-registered people, that there will be phony doctor recommendations around?

UDLAND: Well, I think that there's a possibility of that happening right now. Unless the state chooses to regulate it in some form and put it on some type of document that the primary caregiver can have and the patient can have and keep with them, I think the chances of counterfeit out there, or the possibility of counterfeit, is very high.

I don't want to see this thing be bureaucratic. I mean, if I put myself in the position of, if I had a dying family member who needed to use marijuana to ease their suffering, I'd be all for it. At the same time, I wouldn't want them subject to arrest because they didn't have the proper credentials. I mean, I think the credentials need to be state-certified in such a manner that it's easy to read, easy to understand, easy to obtain for legitimate purposes, and also not subject to counterfeiting.

DYSON: Yeah, and I appreciate that. Any questions from the panel? Representative Murkowski?

REPRESENTATIVE LISA MURKOWSKI: Thank you, Mr. Chair. Mr. Udland, you've stated that if the Legislature fails to make any revisions, or changes to the statute as it passed through the initiative process, that it's going to be difficult for you to enforce the marijuana laws as written. Given that statement, then, and recognizing that as of March 4 an individual can claim possession of marijuana under the medical marijuana statutes, and recognizing now that we don't have a registration system that is set up, what are you instructing your officers to do if they stop somebody on the street and there is a baggie of marijuana in the car, and the person that's been stopped asserts the defense, that "I'm a patient and my doctor has recommended." Do you go ahead and arrest him, or do you give him the benefit of the doubt? I guess I'm wondering what....

UDLAND: I think the answer to that is it's going to depend on what the officer knows at the time. And we've told the officers to exercise a great deal of caution in enforcing the marijuana laws because of this initiative. My metro drug section, which is a detective and supervisors that are very experienced drug investigators, are very perplexed right now as to what they can enforce and what they can't enforce. I know this much, I don't want my officers taking marijuana from somebody who legitimately has a right to it under the law. And the way it is right now, if you don't have a registration system, and we don't talk about the amount, you're subjecting people out there who legitimately could or should have medical marijuana, you're subjecting them to possible arrest or confiscation of the very drug that they have a right to, simply because we don't have the law set up properly.

DYSON: Any other questions? Thank you, Duane. Del Smith suggested that one of the ways that this might work with the registration is that the information be available on the computerized crime information system, wherein you guys, your officers call in and see if there's outstanding warrants and so on. Do you see that as a viable way to make this work for your field personnel?

UDLAND: I think that would be helpful. I mean, that way if somebody forgot their registration card or something, we can check them on the computer and find out it's legitimate and then send them on their way. I know that some people are going to say, "Well, gee you're probably invading people's privacy, or something like that, by putting it on a computer." And I guess I would answer that by saying this: I would rather put it in a computer and avoid an unlawful arrest, rather than, typically because we don't have access to the information, we carry through with an arrest that later we're sorry for, and end up causing litigation over it.

DYSON: All right. Thank you. I need to talk to you on some other issues. Sure appreciate your help on this. No other questions from the committee? Thanks, Duane.

Statement of Senator Loren Leman Re: Senate Bill 94

Senate Health, Education, & Social Services Committee

Wed., March 24, 1999

Thank you, Mr. Chairman. I appreciate this opportunity to present Senate Bill 94 to the Senate HESS Committee.

SB 94 proposes several amendments to the medical marijuana initiative that was enacted last November. The amendments are designed to close loopholes in the initiative and ensure that it works as advertised. Our aim is to ensure that marijuana is legally available only for valid medical reasons and not for recreational use.

As you know, Mr. Chairman, the people of Alaska voted to criminalize the recreational use of marijuana when they approved Ballot Measure 2 in 1990. Eight years later, the promoters of the medical marijuana initiative assured voters that the intent of the Ballot Measure 8 was not a general legalization of marijuana. In other words, they were not proposing a general repeal of the earlier ballot measure from 1990.

If we look to the 1998 Official Election Pamphlet, the sponsors of the medical marijuana initiative described their proposal as being designed to help "terminally ill patients and others suffering from debilitating medical conditions." The sponsors further stated, *"Marijuana would still be illegal for non-medical use. Ballot Measure No. 8 provides full protection against abuse of the new law."*

Unfortunately, close study of the marijuana initiative by legal experts and those who work in law enforcement reveals that there is plenty of room for abuse of the new law. The initiative is rife with legal "loopholes," ill-defined terms, and vague language. I will not discuss these problems in detail, because they are well-outlined in the sectional analysis that committee members have in their packets.

As public officials, I believe we must respect and honor the views of the voters. In the case of marijuana policy, however, we have two ballot initiatives to consider. On the one hand, we have the 1990 initiative that made possession of marijuana in this state a criminal act, punishable by imprisonment of up to 90 days and fines of up to $1000. These are not trivial punishments, and I believe by approving these

changes the Alaska people spoke volumes about how seriously they take the problem of drug abuse, especially among our youth.

On the other hand, we have Ballot Measure 8 from last year, which proposed to allow limited marijuana use for valid medical reasons. Since the latter ballot initiative does not repeal the earlier ballot initiative, our job as legislators is to make both measures work together in an appropriate fashion. SB 94 is designed to reconcile the provisions of both initiatives – both of which represent the majority will of the Alaskan people.

Mr. Chairman, I believe our constitution's allowance for voter-initiated ballot measures is a great freedom. It gives the Alaskan people a direct voice in crafting the laws under which we all live. However, the authors of Alaska's constitution recognized one potential shortcoming of ballot initiatives. Unlike bills that originate in the legislature, voter initiatives cannot be amended before they are brought forth for a final vote. Legislative bills, including the one before you today, must run a gauntlet of committees. Public hearings are held and the bill is scrutinized by officials with the executive branch of government. An unlimited number of amendments can be proposed. If there are flaws or shortcomings in a piece of legislation, this vigorous process usually ferrets them out before they become part of our statute books.

Unfortunately, ballot initiatives do not undergo this same type of scrutiny, and the authors of the Alaska constitution recognized this as a potential danger. Accordingly, they included in our constitution a provision allowing the Legislature to make needed amendments to approved ballot initiatives. This authority is found in Article XI, Section 6. The legislature has exercised this power in the past, and, in response to legal challenges, the Alaska Supreme Court has upheld the legislature's authority to do so.

In 1975, in the case of *Warren v. Boucher*, the Alaska Supreme Court accurately described why the constitution grants this power to the legislature:

> "The constitution thus vests broad authority in the legislature to vary the terms of an initiated law, after its adoption, by the process of amendment. This power amounts to a check or balance against the initiative process. No doubt the legislature was given this power to assure that initiatives which were ill-advised, which might seriously cripple or frustrate the sound workings of government, or which might be impracticable, could be altered or corrected rapidly by the legislature. It was obviously intended by the framers that the

initiative process should not be permitted to disrupt vital government functions or to impose intolerable burdens upon established administrative systems."

Obviously, this statement by the Supreme Court does not mean that every proposed legislative "fix" to a ballot initiative deserves to be passed. Proposed amendments must be judged on their merits. With respect to SB 94, what this means, Mr. Chairman, is that we need to debate the merits of the bill, not whether the Legislature has the authority to pass it. That authority is well-established by the constitution.

Mr. Chairman, if recent letters to the editor are any indication, you are likely to hear a lot of testimony today about respecting the "will of the people." In this context, it is useful to remember that the Alaska Constitution, which grants the Legislature authority to amend ballot initiatives, was also ratified by the people. And since it was approved by the voters of this state, it is no less valuable as a reflection of public values than any particular ballot initiative. In the same vein, the voter approval of Ballot Measure 2 in 1990 is no less valuable a reflection of public opinion than the passage of Ballot Measure 8 last fall. Again, I bring up these facts in the hope that we can put to rest all of this venemous rhetoric about "defying the will of the public." The greatest service we can provide the public at this point is to have an intelligent, informed, and civil debate on the merits of this legislation.

Mr. Chairman, by agreeing to hold this hearing today you have taken an important first step toward fostering the kind of dialogue we need on this important issue. Thank you, this concludes my remarks. If you have more detailed questions about any particulars of this legislation, my staff aide Mike Pauley will be available to answer them.

###

BALLOT MEASURE NO. 2

Initiative No. 88MARI
Marijuana Law Amendments

BALLOT LANGUAGE

(As it will appear on the November 6, 1990, General Election Ballot)

Under Alaska law it is currently legal for adults over 18 years old to possess under four ounces of marijuana in a home or other private place. The penalty for adults over 18 years old for possessing less than one ounce in public is a fine of up to $100. This initiative would change Alaska's laws by making all such possession of marijuana criminal, with possible penalties of up to 90 days in jail and/or up to a $1000 fine.

Should this initiative become law?

Yes ☐

No ☐

LEGISLATIVE AFFAIRS AGENCY SUMMARY

This initiative amends the criminal laws on marijuana. The law now subjects a person who possesses less than an ounce of the drug in certain public places to a $100 maximum fine. The maximum penalty for a transfer of less than one-half ounce where no money is involved is the same. If the initiative is enacted, the maximum penalty for those crimes will increase to a $1,000 fine, 90 days in jail, or both.

It would also be illegal to possess up to four ounces in a private place. That is now legal. The maximum penalty would also be a $1,000 fine, 90 days in jail, or both.

The initiative does not change marijuana laws that now have the same or more serious penalties.

FULL TEXT OF PROPOSED LAW

This initiative calls for the repeal of subsection (a) of AS 11.71.060, Misconduct involving a controlled substance in the sixth degree, and AS 11.71.070, Misconduct involving a controlled substance in the seventh degree. What follows is the full text of the wording which would replace AS 11.71.060(a) if the measure is passed by the voters. AS 11.71.070 would not be replaced.

*Section 1. AS 11.71.060(a) is repealed and reenacted to read:

(a) Except as authorized in AS 17.30, a person commits the crime of misconduct involving a controlled substance in the sixth degree if the person

(1) uses or displays any amount of a schedule VIA controlled substance or possesses one or more preparations, compounds, mixtures, or substances of an aggregate weight of less than one-half pound containing a scheduled VIA controlled substance; or

(2) refuses entry into a premise for an inspection authorized under AS 17.30.

(b) Misconduct involving a controlled substance in the sixth degree is a class B misdemeanor.

*Section 2. AS 11.71.070 is repealed.

STATEMENT IN SUPPORT

A YES VOTE ON PROPOSITION 2 sends a clear message that marijuana is a dangerous drug. There are many myths circulating in Alaska about the hazards of smoking marijuana. It is time to separate the facts from the myths.

Fact Number 1: Marijuana is an addictive, dangerous drug. It has adverse effects on driving skills for as long as 24 hours after smoking the drug. Judgment, coordination and perception are all affected. Marijuana is not a benign substance. It is dangerous to users and society at large.

Fact Number 2: A YES vote on Proposition 2 sends a clear message to Alaska's youth — marijuana is a dangerous drug and possession is against the law. Alaska is the only state that allows an adult 4 ounces of marijuana for recreational use in the home. Under current law between 4 and 8 ounces is now a Class B Misdemeanor. Over 8 ounces the penalties are greater. A YES vote on Proposition 2 removes any misunderstanding of Alaska's position on the recreational use of marijuana.

Fact Number 3: A YES vote on Proposition 2 does not change the search and seizure laws for our police. Opponents claim a yes vote on Proposition 2 creates a police state and would allow police officers to break down your door without a warrant. THIS IS ABSOLUTELY NOT TRUE!

Fact Number 4: It is already against state law for young people under the age of 19 to use or possess marijuana. Proposition 2 applies the same law to parents and other adults. The May 1990, State of Alaska *Adolescent Health Study* reports that 22.6% of teenagers whose parents smoke marijuana said they smoke it as well. Only 5% of the teenagers whose parents do not smoke marijuana said they used the drug.

Fact Number 5: Proposition 2 does not impose mandatory jail sentences. Nor does it impose mandatory fines. Each judge will decide appropriate punishment: a fine, community service, treatment or

BALLOT MEASURE NO. 2

a jail term. The myth that we will fill our jails with marijuana users is simply that — A MYTH!

Fact Number 6: Alaska's Constitution *does not protect* the use of marijuana. In Ravin vs. State of Alaska, the Supreme Court stated, ". . . Right to privacy in the home must yield when it interferes with the health, safety, right and privileges of others or with the public welfare. . . ."

Fact Number 7: Remember — 4 ounces is not a small amount of marijuana. More than 200 joints can be rolled with 4 ounces of marijuana.

WHAT MESSAGE WILL WE SEND OUR CHILDREN WHEN WE VOTE ON NOVEMBER 6?

A YES vote — Marijuana is a narcotic drug.
THE CHOICE IS YOURS

Representative Alyce Hanley
Alaskans for the Recriminalization of Marijuana
6311 DeBarr Road, Suite 115
Anchorage, Alaska 99504

STATEMENT IN OPPOSITION

This initiative will allow government too much power to regulate what adults do in the privacy of their homes. Alaska's Constitution contains the strongest Privacy Clause of any state. Privacy rights must not be abandoned over emotional and factually inaccurate arguments.

Even one trace of marijuana will allow the State to confiscate your personal assets: firearms, cash, bank accounts, vehicles, and maybe your home. If you refuse police entry to ransack your home, you will be charged with a separate criminal violation, fined and jailed. A criminal record will follow you for a lifetime.

Alaska's jails are already filled beyond capacity. New prisons cost $75 million. We can't afford to house the truly dangerous criminals, let alone large numbers of otherwise, law-abiding citizens. Nor can we bear the costs of more police and courts. Our dollars could be better spent on educational and rehabilitative programs.

It is *our* responsibility as parents and educators to teach our children right and wrong; passing a law is not a substitute. To exaggerate hazards of marijuana while ignoring dangers and abuse of alcohol and tobacco, drugs which have cost our society billions of dollars and millions of lives, does not send our children a clear message about the harms of substance abuse.

Initiative supporters say "Pass the initiative and crime will go down." Not true. They say "If you don't pass the initiative, there will be more cocaine and heroin use." False. They say "Pass the initiative and we'll put the drug pushers out of business." Wrong again. They say "Pass the initiative and it won't cost you anything." Wrong, wrong again. Lying to our kids is not sending them the right moral message about marijuana or anything else. If we lie to them about marijuana, they won't believe us about the effects of truly harmful drugs.

Marijuana use has not increased since its home use was decriminalized. There is no proof that it causes the use of hard drugs. Almost half of adult Alaskans have used marijuana, while only small percentages have used hard drugs. Marijuana does not induce crime, create psychosis, or have toxic effects.

Smoking marijuana by children is already illegal; as it should be. Let's not confuse the issue. Is it fair to "send a message" to children by taking away basic rights of adults? The Right to Privacy, otherwise known as liberty, is a fundamental guarantee of our Constitution. It should only be limited for compelling reasons. Freedom-loving Alaskans, of all people understand this. Sending a message to children which is hypocritical, confusing, and based on falsehoods will have no positive effect. It is hardly a good reason to put people in jail and ruin their lives.

Prohibition did not stop alcohol use nor will it stop marijuana use. Costly government intrusion is not the answer. Do not destroy our Bill of Rights in a misdirected effort to find shortcut answers to complex problems. Vote NO if you think this government intrusion into your home is wrong!

Glenda J. Straube,
Campaign Manager
Alaskans for Privacy
3400 Spenard Rd., Suite 4
Anchorage, Alaska 99503

Ballot Measure 8
Bill Allowing Medical Use of Marijuana

BALLOT LANGUAGE

This bill would allow patients to use marijuana for certain medical purposes. A doctor must find that the patient has a debilitating medical condition that might benefit from marijuana. An eligible minor could use medical marijuana only under the consent and control of a parent. There would be limits on how much medical marijuana a patient could possess. Patients and their primary care-givers who comply with this law would not be guilty of a crime. The state would create a confidential registry of patients who may use medical marijuana. Non-medical use of marijuana would still be a crime.

SHOULD THIS INITIATIVE BECOME LAW?

Yes [ ]

No [ ]

LEGISLATIVE AFFAIRS AGENCY SUMMARY

This measure lets persons who have certain medical conditions possess, grow, and use marijuana under state law if told by their doctors that they might be helped by the use of marijuana. It allows the medical use of marijuana by persons less than 18 years of age who have certain medical conditions if the person's parent or guardian approves and other requirements are met. The medical conditions include cancer and chronic or debilitating diseases that have certain effects. The Department of Health and Social Services can add medical conditions to the list by regulation. The measure limits the amount of marijuana that a person may have at one time for medical use. A person may not be found guilty of a crime under state law that relates to having or using marijuana as allowed by the measure if the person has met the standards set forth in the measure. A doctor who advises certain patients on the medical use of marijuana may not be punished under state law. Marijuana that a person has for medical use would not be a controlled substance for the purpose of the crime and drug laws of this state.

The measure sets up a confidential way for persons to tell the state of their medical use of marijuana and get an I.D. card from the state. To get and keep an I.D. card, a person has to give the state a written statement from the person's doctor each year. A person who is cured must return the I.D. card. A person with an I.D. card may not use marijuana in plain view of the public or in a public place. A person with an I.D. card may not sell or give marijuana to someone the person knows does not have or is not eligible for such an I.D. card. A person with an I.D. card may not use marijuana in a way that endangers the health or well-being of any person.

FULL TEXT OF PROPOSED LAW

Be it enacted by the people of the State of Alaska:

Sec. 1. AS 17 is amended by adding a new chapter which reads as follows:

AS 17.35.010. Registry of Patients. (a) The Department shall create and maintain a confidential registry of patients who have applied for and are entitled to receive a registry identification card according to the criteria set forth in this chapter. Authorized employees of state or local law enforcement agencies shall be granted access to the information contained within the Department's confidential registry only for the purpose of verifying that an individual who has presented a registry identification card to a state or local law enforcement official is lawfully in possession of such card.
(b) No person shall be permitted to gain access to names of patients, physicians, primary care-givers or any information related to such persons maintained in connection with the Department's confidential registry, except for authorized employees of the Department in the course of their official duties and authorized employees of state or local law enforcement agencies who have stopped or arrested a person who claims to be engaged in the medical use of marijuana and in the possession of a registry identification card or its functional equivalent, pursuant to AS 17.35.010(e).
(c) In order to be placed on the state's confidential registry for the medical uses of marijuana, a patient shall provide to the Department:

(1) the original or a copy of the written documentation stating that the patient has been diagnosed with a debilitating medical condition and the physician's conclusion that the patient might benefit from the medical use of marijuana;
(2) the name, address, date of birth, and social security number of the patient;
(3) the name, address, and telephone number of the patient's physician; and
(4) the name and address of the patient's primary care-giver, if one is designated at the time of application.

(d) The Department shall verify all information submitted under AS 17.35.010(c) within 30 days of receiving it. The Department shall notify the applicant that his or her application for a registry identification card has been denied if its review of the information which the patient has provided discloses that the information required pursuant to AS 17.35.010(c) has not been provided or has been falsified. Otherwise, not more than five days after verifying such information, the Department shall issue a serially numbered registry identification card to the patient stating:

(1) the patient's name, address, date of birth, and social security number;
(2) that the patient's name has been certified to the state health agency as a person who has a debilitating medical condition which the patient may address with the medical use of marijuana;
(3) the dates of issuance and expiration of the registry identification card; and
(4) the name and address of the patient's primary care-giver, if any is designated at the time of application.

(e) If the Department fails to issue a registry identification card within thirty-five days of receipt of an application, the patient's application for such card will be deemed to have been approved. Receipt of an application shall be deemed to have occurred upon delivery to the Department or deposit in the United States mails. Notwithstanding the foregoing, no application shall be deemed received prior to June 1, 1999. A patient who is questioned by any state or local law enforcement official about his or her medical use of marijuana shall provide a copy of the written documentation submitted to the Department and proof of the date of mailing or other transmission of the written documentation for delivery to the Department, which shall be accorded the same legal effect as a registry identification card, until the patient receives actual notice that the application has been denied. No person shall apply for a registry identification card more than once every six months.
(f) The denial of a registry identification card shall be considered a final agency action subject to judicial review. Only the patient whose application has been denied shall have standing to contest the final agency action.

(g) When there has been a change in the name, address, physician, or primary care-giver of a patient who has qualified for a registry identification card, that patient must notify the state health agency of any such change within ten days. To maintain an effective registry identification card, a patient must annually resubmit updated written documentation to the state health agency, as well as the name and address of the patient's primary care-giver, if any.
(h) A patient who no longer has a debilitating medical condition shall return his or her registry identification card to the Department within twenty-four hours of receiving such diagnosis by his or her physician.
(i) The Department may determine and levy reasonable fees to pay for any administrative costs associated with its roles in this program.

AS 17.35.020. Medical Use of Marijuana. (a) A patient may not engage in the medical use of marijuana with more marijuana than is medically justified to address a debilitating medical condition. A patient's medical use of marijuana within the following limits is lawful:

(1) no more than one ounce of marijuana in usable form; and
(2) no more than six marijuana plants, with no more than three mature and flowering plants producing usable marijuana at any one time.

(b) For quantities of marijuana in excess of the amounts in AS 17.35.020(a), a patient or his or her primary care-giver must prove by a preponderance of the evidence that any greater amount was medically justified to address the patient's debilitating medical condition.

AS 17.35.030. Privileged medical use of marijuana. (a) Except as otherwise provided in AS 17.35.040, no patient or primary care-giver may be found guilty of, or penalized in any manner for, a violation of any provision of law related to the medical use of marijuana, where it is proved by a preponderance of the evidence that:

(1) the patient was diagnosed by a physician as having a debilitating medical condition;
(2) the patient was advised by his or her physician, in the context of a bona fide physician-patient relationship, that the patient might benefit from the medical use of marijuana in connection with a debilitating medical condition; and
(3) the patient and his or her primary care-giver were collectively in possession of amounts of marijuana only as permitted under this section.

(b) Except as otherwise provided in AS 17.35.040, no patient or primary care-giver in lawful possession of a registry identification card shall be subject to arrest, prosecution, or penalty in any manner for medical use of marijuana or for applying to have his or her name placed on the confidential register maintained by the Department.
(c) No physician shall be subject to any penalty, including arrest, prosecution, disciplinary proceeding, or be denied any right or privilege, for:

(1) Advising a patient whom the physician has diagnosed as having a debilitating medical condition, about the risks and benefits of medical use of marijuana or that he or she might benefit from the medical use of marijuana, provided that such advice is based upon the physician's contemporaneous assessment of the patient's medical history and current medical condition and a bona fide physician-patient relationship; or
(2) Providing a patient with a written documentation, based upon the physician's contemporaneous assessment of the patient's medical history and current medical condition and a bona fide physician-patient relationship stating that the patient has a debilitating medical condition and might benefit from the medical use of marijuana.

(d) Notwithstanding the foregoing provisions, no person, including a patient or primary care-giver, shall be entitled to the protection of this section for his or her acquisition, possession, cultivation, use, sale, distribution, and/or transportation of marijuana for non-medical use.
(e) Any property interest that is possessed, owned, or used in connection with the medical use of marijuana, or acts incidental to such use, shall not be harmed, neglected, injured, or destroyed while in the possession of state or local law enforcement officials where such property has been seized in connection with the claimed medical use of marijuana. Any such property interest shall not be forfeited under any provision of state or local law providing for the forfeiture of property other than as a sentence imposed after conviction of a criminal offense or entry of a plea of guilty to such offense. Marijuana and paraphernalia seized by state or local law enforcement officials from a patient or primary care-giver, in connection with the claimed medical use of marijuana shall be returned immediately upon the determination that the patient or primary care-giver is entitled to the protection contained in this section as may be evidenced, for example, by a decision not to prosecute, the dismissal of charges, or acquittal.

AS 17.35.040. Restrictions on medical use of marijuana. (a) No patient in lawful possession of a registry identification card shall:

(1) engage in the medical use of marijuana in a way that endangers the health or well-being of any person;
(2) engage in the medical use of marijuana in plain view of, or in a place open to, the general public; or
(3) sell or distribute marijuana to any person who is known to the patient not to be either in lawful possession of a registry identification card or eligible for such card.

(b) Any patient found by a preponderance of the evidence to have willfully violated the provisions of this chapter shall be precluded from obtaining or using a registry identification card for the medical use of marijuana for a period of one year.
(c) No governmental, private, or any other health insurance provider shall be required to be liable for any claim for reimbursement for the medical use of marijuana.
(d) Nothing in this section shall require any accommodation of any medical use of marijuana:

(1) in any place of employment;
(2) in any correctional facility;
(3) on or within 500 feet of school grounds;
(4) at or within 500 feet of a recreation or youth center; or
(5) on a school bus.

AS 17.35.050. Medical use of marijuana by a minor. Notwithstanding AS 17.35.030(a), no patient who has not reached the age of majority under AS 25.20 or who has not had the disabilities of a minor removed under AS 09.55.590 shall engage in the medical use of marijuana unless: (a) his or her physician has diagnosed the patient as having a debilitating medical condition;
(b) the physician has explained the possible risks and benefits of medical use of marijuana to the patient and one of the patient's parents or legal guardians residing in Alaska, if any;
(c) the physician has provided the patient with the written documentation specified in AS 17.35.010(c) (1);
(d) the patient's parent or legal guardian referred to in AS 17.35.050(b), consents to the Department in writing to serve as the patient's primary care-giver and to permit the patient to engage in the medical use of marijuana;
(e) the patient completes and submits an application for a registry identification card and the written consent referred to in AS 17.35.050(d) to the Department and receives a registry identification card;
(f) the patient and the primary care-giver collectively possess amounts of marijuana no greater than those

specified in AS 17.35.020(a) (1) and (2); and
(g) the primary care-giver controls the acquisition of such marijuana and the dosage and frequency of its use by the patient.

AS 17.35.060. Addition of debilitating medical conditions. Not later than June 1, 1999, the Department shall promulgate regulations under the Administrative Procedure Act governing the manner in which it may consider adding debilitating medical conditions to the list provided in this section. After June 1, 1999, the Department shall also accept for consideration physician or patient initiated petitions to add debilitating medical conditions to the list provided in this section and, after hearing, shall approve or deny such petitions within one hundred eighty days of submission. The denial of such a petition shall be considered a final agency action subject to judicial review.

AS 17.35.070. Definitions. In this chapter, unless the context clearly requires otherwise: (a) "Correctional facility" means a state prison institution operated and managed by employees of the Department of Corrections or provided to the Department of Corrections by agreement under AS 33.30.031 for the care, confinement or discipline of prisoners.
(b) "Debilitating medical condition" means:

(1) cancer, glaucoma, positive status for human immunodeficiency virus, or acquired immune deficiency syndrome, or treatment for any of these conditions;
(2) any chronic or debilitating disease or treatment for such diseases, which produces, for a specific patient, one or more of the following, and for which, in the professional opinion of the patient's physician, such condition or conditions reasonably may be alleviated by the medical use of marijuana: cachexia; severe pain; severe nausea; seizures, including those that are characteristic of epilepsy; or persistent muscle spasms, including those that are characteristic of multiple sclerosis; or
(3) any other medical condition, or treatment for such condition, approved by the Department, pursuant to its authority to promulgate regulations or its approval of any petition submitted by a patient or physician under AS 17.35.060.

(c) "Department" means the Department of Health and Social Services;
(d) "Medical use" means the acquisition, possession, cultivation, use, and/or transportation of marijuana and/or paraphernalia related to the administration of such marijuana to address the symptoms or effects of a debilitating medical condition only after a physician has authorized such medical use by a diagnosis of the patient's debilitating medical condition.
(e) "Patient" means a person who has a debilitating medical condition.
(f) "Physician" means a person licensed to practice medicine in this state or an officer in the regular medical service of the armed forces of the United States or the United States Public Health Service while in the discharge of their official duties, or while volunteering services without pay or other remuneration to a hospital, clinic, medical office, or other medical facility in this state;
(g) "Primary care-giver" means a person, other than the patient's physician, who is eighteen years of age or older and has significant responsibility for managing the well-being of a patient who has a debilitating medical condition.
(h) "Prisoner" means a person detained or confined in a correctional facility, whether by arrest, conviction, or court order, or a person held as a witness or otherwise, including municipal prisoners held under contract and juveniles held under the authority of AS 47.10.
(i) "Registry identification card" means a document issued by the Department which identifies a patient authorized to engage in the medical use of marijuana and the patient's primary care-giver, if any.
(j) "Usable form" and "usable marijuana" means the seeds, leaves, buds, and flowers of the plant (genus) Cannabis, but does not include the stalks or roots.
(k) "Written documentation" means a statement signed by a patient's physician or copies of the patient's pertinent medical records.

AS 17.35.080. Short title AS 17.35.010 -- 17.35.070 may be cited as the Medical Uses of Marijuana for Persons Suffering From Debilitating Medical Conditions Act.

Sec. 2. AS 11.71.190 (b) is amended to read:

Sec. 11.71.190 (b). Schedule VIA. Marijuana is a schedule VIA controlled substance except for marijuana possessed for medical purposes under AS 17.35.

STATEMENT IN SUPPORT

Yes On #8 Helps Terminally Ill Patients And Others Suffering Debilitating Medical Conditions. Ballot Measure #8 would allow patients to use marijuana as a medicine if they have a debilitating disease and an authorization from their doctor. Dozens of scientific studies, including government and university-sponsored studies, have shown that marijuana can help patients with cancer and other diseases to get relief from severe pain, nausea or muscle spasticity.

Yes On #8 would give physicians the option of authorizing medical use of marijuana for patients in pain, protecting them from being treated as criminals. At the same time, Ballot Measure #8 retains current laws against non-medical use of marijuana, and contains strict controls on medical use. This commonsense measure will help thousands of Alaskans and future Alaskans with debilitating diseases.

Yes On #8 Will Help Many Cancer Chemotherapy Patients. Currently, one in three chemotherapy patients discontinues treatment because of severe nausea and vomiting. When standard anti-nausea drugs fail, marijuana can often ease a patient's nausea and permit continued treatment. New scientific evidence is emerging that helps prove marijuana's value as an alternative treatment for other medical conditions, including stroke and neuropathic pain.

Marijuana Would Still Be Illegal For Non-Medical Use. Ballot Measure #8 provides full protection against abuse of the new law:

Non-medical (or fraudulent medical) use of marijuana would still be a crime.

Only licensed physicians could authorize medical marijuana use.

Amounts that patients could possess would be strictly limited.

No use would be allowed in public or the work place.

A State of Alaska registration and ID card system would be established for medical users.

Only specific diseases would be covered, including cancer, acquired immune deficiency syndrome, multiple sclerosis, glaucoma, epilepsy, or severe pain and nausea.

Doctors Should Be Able To Make Recommendations To Help Their Patients. The opponents of Ballot Measure #8 believe that doctors shouldn't be able to recommend medical marijuana for any medical conditions. However doctors are currently allowed to prescribe morphine and even cocaine. Shouldn't we trust them to recommend a less dangerous substance like medical marijuana?

Yes On #8 Is A Humane Policy For Alaskans Suffering Extreme Pain. Alaska law should show compassion for people who suffer severe medical conditions. Yet while polls show most Alaskans support the medical use of marijuana, both patients and doctors are now subject to prosecution for using or even recommending it. Please vote to join the 24 other states that have adopted a policy of compassion.

Please Vote YES On Ballot Measure #8

Alaskans for Medical Rights
M. Walter Johnson, MD; Arndt von Hippel, MD; Frederick J. Hillman, MD
(907) 277-AKMR

STATEMENT IN OPPOSITION

Marijuana is a debilitating illegal drug. In 1990 the citizens of Alaska voted to "recriminalize" the use of marijuana. Now, at a time when illegal drug use is destroying the very foundation of our Nation and this great State - the family unit - this Act is attempting to legalize marijuana as a "medicine."

This inept Act allows the "patients" and "care-givers" to grow their own "pot." The Act has no provisions to protect against impurities from "street grass." The Act then attempts to hold patients and care-givers, as well as physicians, "harmless" from the use of marijuana. The Act is a license to grow, use, transport and sell marijuana. It is a bad law.

Dronabinol (marinol) is an approved, controlled drug that is the principal "psychoactive" substance in marijuana. Physicians prescribe dronabinol for symptoms ranging from nausea associated with cancer chemotherapy to anorexia in AIDS patients. Due to the "psychoactive" affects of dronabinol, patient supervision, if possible in an inpatient setting is required. Marijuana is no substitute.

The legalizing of street-grade marijuana, grown by its drug-user patients and care-givers, as allowed by this Act borders on "pure folly." What physician would prescribe an illegal drug to patients when there are no quality controls on the purity of the drug? No physician can ignore a basic tenant of medical practice: "Quality care in the best interest of the patient."

This Act is attempting to deceive Alaskans into thinking we are voting for compassion of those having "debilitating" illnesses. The Act is attempting to use the sick, infirm and dying to pry open the door to drug legalization. From 1991 to 1996 marijuana use nationwide among eighth graders tripled from 6% to 18%. Any legalization of marijuana sends the wrong message to the youth of Alaska. Marijuana is the gateway drug to cocaine, heroin and methamphetamine. As a result, this Act is opposed by local, state and federal law enforcement officers.

The use of illegal drugs, including marijuana, leads to lack of individual self respect, as well as lack of respect of others and society in general. Ultimately, marijuana and other illegal drugs destroy an individual's mind, as well as the "soul." Since marijuana users are not able to distinguish between "right from wrong" the burden of use of illegal drugs is ultimately placed on each of us individually and society as a whole.

Legalization of marijuana tells our youth that adults believe illegal drugs can be used responsibly. Within that atmosphere it is very difficult, if not impossible, to reach our youth and convince them that "doing drugs is bad." The youth of Alaska need our support.

Do not be fooled, this Act is not about compassion or care for the sick, infirm and dying. The Act is an attempt to protect those who grow, transport, distribute, sell, possess or use marijuana. Please vote against this Act.

Wevley William Shea
Anchorage
(907) 274-0020

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EXECUTIVE SUMMARY

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

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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.

This Executive Summary is available in limited quantities from the Institute of Medicine, Division of Neuroscience and Behavioral Health, 2101 Constitution Avenue, N.W., Washington, DC 20418. The full text is available on line at: **www.nap.edu**

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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.

Preface

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. 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.)

Information for this study was gathered through scientific workshops, site visits to cannabis buyers' clubs and HIV/AIDS clinics, 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. (Cannabinoids are drugs with actions similar to THC, the primary psychoactive ingredient in marijuana.) 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 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.

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, antiemesis, 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.

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.

We also appreciate the many people who spoke at the public workshops or wrote to share their views on the medical use of marijuana (see Appendix AA).

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.

Contents

The contents of the entire report, from which this Executive Summary is extracted, are listed below.

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.

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.

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.

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.

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.

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RECOMMENDATIONS *Continued*

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.**

Marijuana: Facts Parents Need to Know

(Revised November, 1998)

Contents

A Letter to Parents

Marijuana is the illegal drug most often used in this country. Since 1991, lifetime marijuana use has doubled among 8th- and 10th-grade students, and increased by a third among high school seniors. Our research shows that accompanying this upward pattern of use is a significant erosion in antidrug perceptions and knowledge among young people today. As the number of young people who use marijuana has increased, the number who view the drug as harmful has decreased. Among high school seniors surveyed in 1997, current marijuana use has increased by about 72 percent since 1991. The proportion of those seniors who believe regular use of marijuana is harmful has dropped by about 2(percent since 1991.

These changes in perception and knowledge may be due to a decrease in antidrug messages in the media, an increase in prodrug messages through the pop culture, and a lack of awareness among parents about this resurgence in drug use - most thinking, perhaps, that this threat to their children had diminished.

In December 1994, HHS Secretary Donna E. Shalala, Ph.D., called for an Initiative to alert the public - particularly parents - to the rise in marijuana use, its potential health consequences to young people, and the need for parents to take action to prevent the return of a full-blown epidemic of teenage drug use.

Because many parents of this generation of teenagers experimented with marijuana when they were in college, they often find it difficult to talk about marijuana use with their children and to set strict ground rules against drug use. But marijuana use today starts at a younger age - and more potent forms of the drug are available to these young children. Parents need to recognize that marijuana use is a serious threat - and they need to tell their children not to use it.

We at the National Institute on Drug Abuse (NIDA) are pleased to offer these two short booklets, Marijuana: Facts for Teens and Marijuana: Facts Parents Need to Know, for parents and their children to review the scientific facts about marijuana. While it is best to talk about drugs when children are young, it is never too late to talk about the dangers of drug use.

Talking to our children about drug abuse is not always easy, but it is very important. I hope these booklets can help.

Alan I. Leshner, Ph.D.
Director
National Institute on Drug Abuse

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Fact: There are stronger forms of marijuana available to adolescents today than in the 1960's. Stronger marijuana means stronger effects.

Q: What is marijuana? Are there different kinds?

A: Marijuana is a green, brown, or gray mixture of dried, shredded leaves, stems, seeds, and flowers of the hemp plant *(Cannabis sativa)*. Before the 1960s, many Americans had never heard of marijuana, but today it is the most often used illegal drug in this country.

Cannabis is a term that refers to marijuana and other drugs made from the same plant. Strong forms of cannabis include sinse-milla (sin-seh-me-yah), hashish ("hash" for short), and hash oil.

All forms of cannabis are mind-altering (psychoactive) drugs; they all contain THC

(delta-9-tetrahydrocannabinol), the main active chemical in marijuana. They also contain more than 400 other chemicals.

Marijuana's effect on the user depends on the strength or potency of the THC it contains. THC potency has increased since the 1970s but has been about the same since the mid-1980s. The strength of the drug is measured by the average amount of THC in test samples confiscated by law enforcement agencies.

- Most ordinary marijuana has an average of 3 percent THC.
- Sinsemilla (made from just the buds and flowering tops of female plants) has an average of 7.5 percent THC, with a range as high as 24 percent.
- Hashish (the sticky resin from the female plant flowers) has an average of 3.6 percent, with a range as high as 28 percent.
- Hash oil, a tar-like liquid distilled from hashish, has an average of 16 percent, with a range as high as 43 percent.

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Q: What are the current slang terms for marijuana?

A: There are many different names for marijuana. Slang terms for drugs change quickly, and they vary from one part of the country to another. They may even differ across sections of a large city.

Terms from years ago, such as pot, herb, grass, weed, Mary Jane, and reefer, are still used. You might also hear the names Aunt Mary, skunk, boom, gangster, kif, or ganja.

There are also street names for different strains or "brands" of marijuana, such as "Texas tea," "Maui wowie," and "Chronic." A recent book of American slang lists more than 200 terms for various kinds of marijuana.

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Q: How is marijuana used?

A: Most users roll loose marijuana into a cigarette (called a joint or a nail) or smoke it in a pipe. One well-known type of water pipe is the bong. Some users mix marijuana into foods or use it to brew a tea. Another method is to slice open a cigar and replace the tobacco with marijuana, making what's called a blunt. When the blunt is smoked with a 40 oz. bottle of malt liquor, it is called a "B-40."

Lately, marijuana cigarettes or blunts often include crack cocaine, a combination known by various street names, such as "primos" or "woolies." Joints and blunts often are dipped in PCP and are called "happy sticks," "wicky sticks," "love boat," or "tical."

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Q: How many people smoke marijuana? At what age do children generally start?

A: A recent government survey tells us:

- Marijuana is the most frequently used illegal drug in the United States. Nearly 69 million Americans over the age of 12 have tried marijuana at least once.
- About 10 million had used the drug in the month before the survey.
- Among teens 12 to 17, the average age of first trying marijuana was 14 years.

A yearly survey of students in grades 8 through 12 shows that 23 percent of 8th-graders have tried marijuana at least once, and by 10th grade, 21 percent are "current" users (that is, used within the past month). Among 12th-graders, nearly 50 percent have tried marijuana/hash at least once, and about 24 percent were current users.

Other researchers have found that use of marijuana and other drugs usually peaks in the late teens and early twenties, then declines in later years.

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Fact: Research shows that nearly 50 percent of. teenagers try marijuana before they graduate from high school.

Q: How can I tell if my child has been using marijuana?

A: There are some signs you might be able to see. If someone is high on marijuana, he or she might

- seem dizzy and have trouble walking;
- seem silly and giggly for no reason;
- have very red, bloodshot eyes; and
- have a hard time remembering things that just happened.

When the early effects fade, over a few hours, the user can become very sleepy.

Parents should be aware of changes in their child's behavior, although this may be difficult with teenagers. Parents should look for withdrawal, depression, fatigue, carelessness with grooming, hostility, and deteriorating relationships with family members and friends. In addition, changes in academic performance, increased absenteeism or truancy, lost interest in sports or other favorite activities, and changes in eating or sleeping habits could be related to drug use. However, these signs may also indicate problems other than use of drugs.

In addition, parents should be aware of:

- signs of drugs and drug paraphernalia, including pipes and rolling papers.
- odor on clothes and in the bedroom
- use of incense and other deodorizers
- use of eye drops
- clothing, posters, jewelry, etc., promoting drug use

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Q: Why do young people use marijuana?

A: Children and young teens start using marijuana for many reasons. Curiosity and the desire to fit into a social group are common reasons. Certainly, youngsters who have already begun to smoke cigarettes and/or use alcohol are at high risk for marijuana use.

Also, our research suggests that the use of alcohol and drugs by other family members plays a strong role in whether children start using drugs. Parents, grandparents, and older brothers and sisters in the home are models for children to follow.

Some young people who take drugs do not get along with their parents. Some have a network of friends who use drugs and urge them to do the same (peer pressure). All aspects of a child's environment - home, school, neighborhood - help to determine whether the child will try drugs.

Children who become more heavily involved with marijuana can become dependent, and that is their prime reason for using the drug. Others mention psychological coping as a reason for their use - to deal with anxiety, anger, depression, boredom, and so forth. But marijuana use is not an effective method for coping with life's problems, and staying high can be a way of simply not dealing with the problems and challenges of growing up.

Researchers have found that children and teens (both male and female) who are physically and sexually abused are at greater risk than other young people of using marijuana and other drugs and of beginning drug use at an early age.

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Q: Does using marijuana lead to other drugs?

A: Long-term studies of high school students and their patterns of drug use show that very few young people use other drugs without first trying marijuana. The risk of using cocaine has been estimated to be more than 104 times greater for those who have tried marijuana than for those who have never tried it. Although there are no definitive studies on the factors associated with the movement from marijuana use to use of other drugs, growing evidence shows that a combination of biological, social, and psychological factors are involved.

Marijuana affects the brain in some of the same ways that other drugs do. Researchers are

examining the possibility that long-term marijuana use may create changes in the brain that make a person more at risk of becoming addicted to other drugs, such as alcohol or cocaine. While not all young people who use marijuana go on to use other drugs, further research is needed to determine who will be at greatest risk.

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Q:What are the effects of marijuana?

A: The effects of marijuana on each person depend on the

- type of cannabis and how much THC it contains;
- way the drug is taken (by smoking or eating);
- experience and expectations of the user;
- setting where the drug is used; and
- whether drinking or other drug use is also going on.

Some people feel nothing at all when they first try marijuana. Others may feel high (intoxicated and/or euphoric).

It's common for marijuana users to become engrossed with ordinary sights, sounds, or tastes, and trivial events may seem extremely interesting or funny. Time seems to pass very slowly, so minutes feel like hours. Sometimes the drug causes users to feel thirsty and very hungry-an effect called "the munchies."

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Q: What happens after a person smokes marijuana?

A: Within a few minutes of inhaling marijuana smoke, the user will likely feel, along with intoxication, a dry mouth, rapid heartbeat, some loss of coordination and poor sense of balance, and slower reaction time. Blood vessels in the eye expand, so the user's eyes look red.

For some people, marijuana raises blood pressure slightly and can double the normal heart rate. This effect can be greater when other drugs are mixed with marijuana; but users do not always know when that happens.

As the immediate effects fade, usually after 2 to 3 hours, the user may become sleepy.

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Q: How long does marijuana stay in the user's body?

A: THC in marijuana is readily absorbed by fatty tissues in various organs. Generally, traces (metabolites) of THC can be detected by standard urine testing methods several days after a smoking session. However, in heavy, chronic users, traces can sometimes be detected for weeks after they have stopped using marijuana.

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Q: Can a user have a bad reaction?

A: Yes. Some users, especially someone new to the drug or in a strange setting, may suffer acute anxiety and have paranoid thoughts. This is more likely to happen with high doses of THC. These scary feelings will fade as the drug's effects wear off.

In rare cases, a user who has taken a very high dose of the drug can have severe psychotic symptoms and need emergency medical treatment.

Other kinds of bad reactions can occur when marijuana is mixed with other drugs, such as PCP or cocaine.

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Fact: Marijuana has adverse effects on many of the skills for driving a car. Driving while high can lead to car accidents.

Q: How is marijuana harmful?

A: Marijuana can be harmful in a number of ways, through both immediate effects and damage to health over time.

Marijuana hinders the user's short-term memory (memory for recent events), and he or she may have trouble handling complex tasks. With the use of more potent varieties of marijuana, even simple tasks can be difficult.

Because of the drug's effects on perceptions and reaction time, users could be involved in auto crashes. Drug users also may become involved in risky sexual behavior. There is a strong link between drug use and unsafe sex and the spread of HIV, the virus that causes AIDS.

Under the influence of marijuana, students may find it hard to study and learn. Young athletes could find their performance is off; timing, movements, and coordination are all affected by THC.

Some of the more long-range effects of marijuana use are described later in this document.

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Q: How does marijuana affect driving?

A: Marijuana affects many skills required for safe driving: alertness, the ability to concentrate, coordination, and reaction time. These effects can last up to 24 hours after smoking marijuana. Marijuana use can make it difficult to judge distances and react to signals and sounds on the road.

There are data showing that marijuana can play a role in crashes. When users combine marijuana with alcohol, as they often do, the hazards of driving can be more severe than with either drug alone.

A study of patients in a shock-trauma unit who had been in traffic accidents revealed that 15 percent of those who had been driving a car or motorcycle had been smoking marijuana, and another 17 percent had both THC and alcohol in their blood.

In one study conducted in Memphis, TN, researchers found that, of 150 reckless drivers who were tested for drugs at the arrest scene, 33 percent tested positive for marijuana, and 12 percent tested positive for both marijuana and cocaine. Data also show that while smoking marijuana, people show the same lack of coordination on standard "drunk driver" tests as do people who have had too much to drink.

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Fact: Marijuana users may have many of the same respiratory problems that tobacco smokers have, such as chronic bronchitis and inflamed sinuses.

Q: What are the long-term effects of marijuana?

A: While all of the long-term effects of marijuana use are not yet known, there are studies showing serious health concerns. For example, a group of scientists in California examined the health status of 450 daily smokers of marijuana but not tobacco. They found that the marijuana smokers had more sick days and more doctor visits for respiratory problems and other types of illness than did a similar group who did not smoke either substance.

Findings so far show that the regular use of marijuana or THC may play a role in cancer and problems in the respiratory, immune, and reproductive systems.

Cancer
It is hard to find out whether marijuana alone causes cancer because many people who smoke marijuana also smoke cigarettes and use other drugs. Marijuana smoke contains some of the same cancer-causing compounds as tobacco, sometimes in higher concentrations. Studies show that someone who smokes five joints per week may be taking in as many cancer-causing chemicals as someone who smokes a full pack of cigarettes every day.

Tobacco smoke and marijuana smoke may work together to change the tissues lining the respiratory tract. Marijuana smoking could contribute to early development of head and neck cancer in some people.

Immune system
Our immune system protects the body from many agents that cause disease. It is not certain whether marijuana damages the immune system of people. But both animal and human studies have shown that marijuana impairs the ability of T-cells in the lungs' immune defense system to fight off some infections. People with HIV and others whose immune system is impaired should avoid marijuana use.

Lungs and airways
People who smoke marijuana often develop the same kinds of breathing problems that cigarette smokers have. They have symptoms of daily cough and phlegm (chronic bronchitis) and more frequent chest colds. They are also at greater risk of getting lung infections such as pneumonia. Continued marijuana smoking can lead to abnormal function of the lungs and airways. Scientists have found signs of lung tissue injured or destroyed by marijuana smoke.

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Q: What about pregnancy: Will smoking marijuana hurt the baby?

A: Doctors advise pregnant women not to use any drugs because they might harm the growing fetus. One animal study has linked marijuana use to loss of the fetus very early in pregnancy.

Some scientific studies have found that babies born to marijuana users were shorter, weighed less, and had smaller head sizes than those born to mothers who did not use the drug. Smaller babies are more likely to develop health problems. Other scientists have found effects of marijuana that resemble the features of fetal alcohol syndrome. There are also research findings that show nervous system problems in children of mothers who smoked marijuana.

Researchers are not certain whether a newborn baby's health problems, if they are caused by marijuana, will continue as the child grows. Preliminary research shows that children born to mothers who used marijuana regularly during pregnancy may have trouble concentrating.

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Q: What happens if a nursing mother uses marijuana?

A: When a nursing mother uses marijuana, some of the THC is passed to the baby in her breast milk. This is a matter for concern, since the THC in the mother's milk is much more concentrated than that in the mother's blood. One study has shown that the use of marijuana by a mother during the first month of breastfeeding can impair the infant's motor development (control of muscle movement).

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Fact: Marijuana smoking affects the brain and leads to impaired short-term memory, perception, judgment and motor skills.

Q: How does marijuana affect the brain?

A: THC affects the nerve cells in the part of the brain where memories are formed. This makes it hard for the user to recall recent events (such as what happened a few minutes ago). It is hard to learn while high - a working short-term memory is required for learning and performing tasks that call for more than one or two steps.

Among a group of long-time heavy marijuana users in Costa Rica, researchers found that the people had great trouble when asked to recall a short list of words (a standard test of memory). People in that study group also found it very hard to focus their attention on the tests given to them.

Smoking marijuana causes some changes in the brain that are like those caused by cocaine, heroin, and alcohol. Some researchers believe that these changes may put a person more at risk of becoming addicted to other drugs, such as cocaine or heroin.

It may be that marijuana kills brain cells. In laboratory research, scientists found that high doses of THC given to young rats caused a loss of brain cells such as that seen with aging. At 11 or 12 months of age (about half their normal life span), the rats' brains looked like those of animals in old age. It is not known whether a similar effect occurs in humans.

Researchers are still learning about the many ways that marijuana could affect the brain.

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Q: Can the drug cause mental illness?

A: Scientists do not yet know how the use of marijuana relates to mental illness. Some researchers in Sweden report that regular, long-term intake of THC (from cannabis) can increase the risk of developing certain mental diseases, such as schizophrenia.

Still others maintain that regular marijuana use can lead to chronic anxiety, personality disturbances, and depression.

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Q: Do marijuana users lose their motivation?